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THE FUTURE OF CHIP: IMPROVING THE HEALTH OF AMERICA'S CHILDREN

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

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CONTENTS

OPENING STATEMENTS

CONGRESSIONAL WITNESSES

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

THE FUTURE OF CHIP: IMPROVING THE HEALTH OF AMERICA'S CHILDREN

THURSDAY, FEBRUARY 1, 2007

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Kerry, Lincoln, Stabenow, Cantwell, Salazar, Grassley, Hatch, Snowe, Thomas, Smith, Bunning, and Roberts.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Today we will survey the success of the State Children's Health Insurance Program, otherwise known as CHIP. Some call it SCHIP, some call it CHIP. I am going to call it CHIP.

It is the program that affects families like the one in Helena, MT. A single mother from Helena learned that her son had epilepsy. She found out right after her son lost private health insurance.

She checked into other insurance plans, but none would cover the expensive medications that her son needed. All those insurance plans considered her son's epilepsy to be a preexisting condition.

Then a friend told her about CHIP. She applied and she found out that her son was eligible. Thanks to CHIP, this young man got the medications that he needed and his mother got the peace of mind that she deserved.

This is just one story among millions. CHIP has helped millions of families over the past decade in Montana, and across the Nation. Since 1997, the share of American children without health insurance dropped by one-fifth. For the poorest children, the uninsured rate has dropped by one-third. CHIP has made a dramatic difference.

During the same decade, private health coverage has eroded. Nearly 47 million Americans lack basic health insurance; 9 million of these Americans are children. CHIP's success is, thus, even more significant.

It matters whether a child has health insurance. Children without health insurance are 5 times more likely to have unmet medical needs or to delay necessary care. They do not have a usual place of care or a health provider who knows them, and they are

half as likely to have had well child visits in a given year; their health and development are at risk.

Lack of health insurance can affect school attendance. It can impair a child's ability to grow up healthy and ready to learn. Lack of health insurance coverage matters to all Americans. It can lead to a crowded emergency room, it can strain access to care, it can burden our safety net health providers. When care is delayed, diseases that should be easily and cheaply treated become major medical crises.

Investing in children's health, by contrast, improves our public health, lowers costs, and it will reap a healthy economy for tomorrow's workforce. We applaud CHIP's accomplishments, but we cannot turn a blind eye to its shortcomings.

Today, three out of four of our Nation's 9 million uninsured children are eligible for either CHIP or Medicaid, but they are not enrolled. We must do a better job of covering all eligible children.

In recent years, my home State of Montana has experienced an increase in the number of uninsured children, despite recent expansions of the CHIP program. Thirty-seven thousand children, one in every six Montana children, are uninsured. Many of these children live on tribal lands. We must improve outreach and enrollment in Indian country, and everywhere else in this country.

Congress has simply not given CHIP enough funds to meet the current demand for services. Over the next 5 years, the program will need $12 to $15 billion in Federal funds just to maintain services for those now receiving coverage.

CHIP has also faced problems distributing funds effectively. Some State allotments are too small to cover children already enrolled, other States routinely had far more than they needed. In all, Congress intervened 7 times in 10 years to add or redistribute funds. We should improve and strengthen CHIP financing to provide a more secure future and more stability.

We can learn a great deal from States. Simplifying applications can make a big difference, and so can making children eligible automatically if they are already eligible, say, for other programs like school lunches; so can providing continuous eligibility.

Some States have used their flexibility to expand coverage. Some States have included parents of CHIP and Medicaid children, pregnant women, and even childless adults. We will discuss CHIP expansions to these and other populations in today's hearing.

When former CMS Administrator Mark McClellan testified before this committee in August, he strongly supported State efforts to expand coverage. He cited evidence that covering parents in CHIP actually increases access, and he said that it helped retain children in CHIP programs.

States now report voluntarily on four standard measures in CHIP. But we can do more. We should invest in measures to assess children's health. Let us make sure that we are using the right ruler to measure quality for kids. We need more data to make sure that they are getting it.

Both CHIP and Medicaid rely on safety net health care providers—that is, hospitals, community health centers, and sole practitioners—to deliver needed care. But budget cuts are trimming

Medicaid, trimming CHIP, and other health care providers. We need to ensure that the safety net remains in place.

We need more reliable financing information about these safety net programs and providers, perhaps including a Payment Advisory Commission like MedPAC does for Medicare, but instead in this case for Medicaid.

There is no greater priority for the Finance Committee in health care this year than CHIP reauthorization. It is number one. Millions depend on CHIP, millions more are eligible but not covered. Today we can increase coverage, and on this, as with other issues that come before this committee, I hope to work, and will work, very closely with Senator Grassley, my partner, along with Senator Rockefeller, Senator Hatch, and others who are the fathers of the CHIP program. We have a lot to learn from them, their experience, and their ideas.

We must act quickly. Fourteen States will run short of Federal funds this fiscal year if we do not reauthorize or enact new funding by mid-May. We hope to have floor action soon.

As we begin our consideration of CHIP today, let us remember those uninsured children whom CHIP has not yet reached, let us remember those moms whose sons have epilepsy and struggle to get coverage, and let us improve the health of America's children.

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Mr. Chairman, for holding the hearing. You spoke about bipartisanship, and you have demonstrated that very well in this hearing, because we have a very balanced panel. You have worked very closely, our staffs have, to do that, and I thank you very much for that consideration.

I know that the Chairman will introduce the panel formally, but I would at least like to recognize Anita Smith from Iowa, who is here. She works very closely with this program for the State of Iowa and for the citizens of Iowa, and we will have a lot to learn from her recommendations. I thank you for being here, and I thank you, Mr. Chairman, for inviting her.

I am hopeful that we can find common ground as we go to markup in a few weeks. Our staffs are already working in that direction, trying to find that.

The SCHIP program—I suppose I should say S-CHIP program. It is so easy. We have a SHIP program for senior citizens, so it is easy to get the two confused. The CHIP program has significantly improved the health and well-being of low-income children. More than 60 million children receive health coverage through the program.

SCHIP and Medicaid have helped reduce the percentage of uninsured children from 13.9 10 years ago to 8.9 percent in 2005. Senator Rockefeller and Senator Hatch led that effort in the Senate, so they can take great pride in that accomplishment, because that is a 37-percent drop in the number of uninsured children.

The importance of both SCHIP and Medicaid in this decline is all the more significant because there has been a concurrent decline

in private coverage for both adults and children during that particular time frame.

In other words, a lot has been expected of the SCHIP program, and the program has delivered. That is not to say, however, that there are no improvements that can be made. During these first 10 years of the program we have learned a lot of lessons, and we are going to learn a lot more this morning from the panel. We can use these lessons to improve.

I am pleased that there is a significant State presence on the panel. That will help us, because that is where the administration comes. The SCHIP program, as everyone knows, was intentionally designed to give States the flexibility to design effective programs and to manage costs.

In other words, people in Des Moines, IA will understand Iowans and their needs better than people who have never been to Iowa and who are trying to administer programs out of Washington, DC. So, I am interested in learning whether or not there is additional flexibility that we can extend to the States.

I have had a chance to peruse Ms. Smith's testimony to some extent, but I think you are going to have her testify about some families in Iowa who are eligible for Medicaid and prefer to enroll their children in the SCHIP program in Iowa that we call hawk-i.

Upon hearing that they cannot choose hawk-i over what they perceive to be welfare, these families do not enroll their children in Medicaid, so consequently they are not getting the protection that they ought to have.

One of the biggest challenges that we have to face with the SCHIP program, of course, is financing. I am always a skunk at a picnic when you bring up these sorts of issues, but we all have to work towards this in considering that.

And as we look at the program today, we have many States that have been facing funding shortfalls, and Congress has already had to step in to patch up those shortfalls. Many States are facing potential funding shortfalls yet this year. We have only patched that for a few months last December going into this year.

As we work to reauthorize the program, we have to work out a way to make the funding formula work better. The funding has to be stable. It has to be predictable so that States will not be putting their children at risk.

Additionally, I am concerned that some States have been using the Federal SCHIP allotment to provide coverage to adults, when Congress designed the program for children. Federal SCHIP funding was set aside by Congress for the younger people. I believe everybody knows that. In fact, I would like to refer to President Clinton when he signed that law 10 years ago: "An investment in our Nation's children."

I fear that using these limited Federal dollars for adults has undermined the coverage for low-income children. The issue is not whether or not coverage for adults is desirable. It is. The issue is not whether or not coverage for adults is beneficial to the family. It is. No one would argue with that. The issue is whether SCHIP funds used to cover adults has drained resources targeted by Congress for kids.

Today, 75 percent of uninsured children in this country are eligible for coverage either through Medicaid or SCHIP. When States use funds intended for children to instead cover adults, that means fewer dollars are available for the youngest of our citizens. These are funds that cannot then be used for kids, and these are funds that cannot be used for outreach. That is a terrible emphasis we have to put into the next effort, to get people who are not in the program enrolled. That takes money.

As we get into the broader discussions about health care reform and small business, we have to also face how to get more people covered, and this means the adults being covered as well. But the SCHIP program is for kids. The "C" stands for "children." There is no letter "A" in SCHIP.

So, Mr. Chairman, I know that we want to get moving. There are other issues that are important to me, such as how to make outreach and enrollment improvements in SCHIP funding, that I will raise during my question period of time.

I would end with this fact. Just to continue the program as it is today will cost $12 to $15 billion over the next 5 years. This new spending includes the cost of coverage for pregnant women, parents, and childless adults who get coverage through the SCHIP program.

Several proposals have been discussed that would capture the estimated eligible, but uninsured, children and could bring that cost up to $45 billion. I have not heard advocates for these proposals say how we should pay for these estimated funding increases, but with the new rules that are presumably going to be adopted called "pay-as-you-go" rules, that is something that is very, very important, to consider that side of the equation.

I think a critical part of the discussion needs to be about how we are going to pay for the existing services before we can discuss expanding services. I am not opposed to discussing expanding services, but I think we have to go with what was intended and where we are, and how we can make that work without the problems that we have seen. So, I hope we can effectively manage expectations as we go through this reauthorization.

Thank you.

The CHAIRMAN. Thank you very much. Thank you, Senator, very much.

The statements of all Senators who wish to have any will be included in the record.

I would like, now, to turn to the witnesses. We are very blessed this morning to have two of our colleagues here who would like to introduce a couple of witnesses, and I will start with you, Senator Cardin. I believe you have kind of a unique introduction here.

STATEMENT OF HON. BEN CARDIN,
A U.S. SENATOR FROM MARYLAND

Senator CARDIN. Well, Senator Baucus and Senator Grassley, thank you very much for inviting the Bedford family to be with you today. I am pleased to introduce the Bedford family. They are from my home town of Baltimore, MD. Craig and Kim Lee Bedford and their 5 children are here to tell their story in regards to the SCHIP program.

I also want to thank Kathleen Westcote, president of Baltimore HealthAccess, which administers the MCHIP program in Baltimore, and Dr. Josh Sharfstein, who is the Baltimore Health Commissioner, for their extraordinary work in getting families enrolled in the program.

Mr. Chairman, you pointed out how many people in our country are without health insurance, over 46 million. We also know, for those children who are in the SCHIP program, their health care outcomes are much better. They get preventive health care, they have immunizations and dental care, and they are far less likely to use emergency rooms.

I appreciate very much the committee having a hearing on the SCHIP program and making a commitment to act early on this program. You hear the statistics, but you are going to hear today from the families that are directly involved. Every one of those numbers represents a family, and every family is impacted by our decisions to move forward on health care.

The SCHIP program is an extremely important part of our health care initiatives. I am proud of what we have done with SCHIP, and I am equally proud of what the State of Maryland has done in providing access. It is my pleasure to introduce the Bedford family, and thank them very much for being here today.

The CHAIRMAN. Well, thank you, Senator. I understand more of the family is here, too.

Senator CARDIN. They have all 5 of their children here.

The CHAIRMAN. Well, this is a big day. Why do you not introduce the whole family, including those who are not at the witness table?

Mrs. BEDFORD. Good morning. My name is Kim Lee Bedford. Let me briefly introduce our family, who is with us.

The CHAIRMAN. Sure.

Mrs. BEDFORD. This is my husband, Craig, our oldest son, Job Bedford.

The CHAIRMAN. Job.

Mrs. BEDFORD. And if the children will stand while I introduce them.

The CHAIRMAN. Their grandmother is here, I understand.

Mrs. BEDFORD. Yes. Craig's mother is here, Reverend Theresa Bedford, who is kindly helping us with the youngest, Montgomery Bedford.

The CHAIRMAN. There you are.

Mrs. BEDFORD. He is 6 months. Then we also have Maya, who is 12; Josiah, who is 8; and John Gideon, who is 4.

The CHAIRMAN. Great.

Mrs. BEDFORD. We feel very privileged to be here today.

The CHAIRMAN. Wonderful. That is wonderful. That is great.

Do you want, Senator, to introduce your witness now or at a later time?

Senator CHAMBLISS. Let me go ahead and do it now.

The CHAIRMAN. Sure. Absolutely.

Senator CHAMBLISS. He is not as good-looking as these kids. [Laughter.] That is the only thing.

STATEMENT OF HON. SAXBY CHAMBLISS,
A U.S. SENATOR FROM GEORGIA

Senator CHAMBLISS. Well, thank you, Mr. Chairman, Senator Grassley, and members of the committee. It is a privilege to be here to appear before you this morning. I am honored to introduce an individual whom I have known as a friend and a colleague for many years, Hon. Sonny Perdue, Governor of my State of Georgia.

Governor Perdue has given many years of public service to our great State. He has served in numerous capacities, as a State Senator in the Georgia legislature, as Senate Majority Leader, and as Senate president pro tem.

He was elected in 2002 as Georgia's first Republican Governor since reconstruction. During his first term he stuck to his promise of getting things done for the people of my State, and we reelected him overwhelmingly this past November.

He understands the challenges facing our State, and that is exactly why he is here today. He is currently Chairman of the Republican Governors Association, but he has been asked to appear before you today on behalf of the Southern Governors Association. I know he speaks on behalf of the many low-income families who depend on the State Children's Health Insurance Program, or what we all commonly know as SCHIP.

In Georgia, previously uninsured children are now receiving health insurance provided by our State's PeachCare Program. PeachCare was created during the time that Sonny Perdue was a member of the Georgia State Senate, and under his continued leadership as Governor it has been held up as a model program and now serves nearly 273,000 children in our State.

But, unfortunately, Georgia is one of several States experiencing a shortfall in fiscal year 2007. Mr. Chairman, time is running out on this funding issue for Georgia's children, as well as children in other States. Governor Perdue has been a leader in keeping a dialogue open between CMS and members of the Georgia delegation, but unfortunately there has been no resolution.

Senator Isakson, Congressman Nathan Deal, and I have been working relentlessly with the Governor to find a short-term solution for the children of Georgia who depend on this program.

It is also critical for Congress to find a long-term solution that addresses the current flaws in the SCHIP formula when we reauthorize the program this year. I concur exactly with what Senator Grassley just commented relative to the fact that this should be a program for children, as it was intended to be.

I know the people of Georgia are so grateful for this hearing today. Mr. Chairman, it is my privilege to introduce to the committee my good friend and my Governor, Hon. Sonny Perdue. Thank you.

The CHAIRMAN. Thank you, Senator, very, very much. I appreciate that.

Now I will introduce the rest of the panelists. Next, after the Bedford family, is Cindy Mann, who is the executive director of Georgetown University's Center for Children and Families, and she will discuss trends for the program, financing issues, and provide recommendations for reform.

Also, one of the panelists is Anita Smith. I will introduce her again. She is Chief of the Bureau of Medical Support for Iowa's Department of Human Services. Thank you for coming.

Kathryn Allen is the Health Care Director with the U.S. Government Accountability Office, and she will provide an overview of the program, especially on financing and structure.

All right. Let us start with the Bedford family. Mr. and Mrs. Bedford? I would remind everybody, the rule is 5 minutes, so please keep your remarks within 5 minutes. Anything else you want to say will be included in the record in a printed statement.

STATEMENTS OF KIM LEE, CRAIG, AND JOB BEDFORD, BALTIMORE, MD

Mrs. BEDFORD. Thank you. Good morning. My name is Kim Lee Bedford, and I am honored to be here with my family today. It is an honor to share our family's experience with the Children's Health Insurance Program, or CHIP, and how it has helped our family in so many ways.

Today, my husband, our son Job, and I will talk about what CHIP has meant to us. We understand we represent thousands of American families who cannot be here today to share their opinions with you, and we hope we speak well as their voice to you today.

Before my husband and I started our own business, our entire family had private health insurance coverage through my husband's job. When we started our own business, we continued our family's coverage under COBRA, then purchased a private plan, but the costs were extremely high.

While our business was in its infancy, the prospect of our children going without health care insurance was unthinkable, so we maintained the crippling cost of private health insurance coverage as long as we could.

We considered many options, including the value health plans that are not really insurance coverages, but rather discounts on medical services, and we delayed applying for the Maryland Children's Health Insurance Program because we did not think we would be eligible. With both of us working, we thought our income would be too high to qualify.

Finally, feeling thoroughly discouraged in our search for affordable health care, we decided to apply for MCHIP and, to our surprise, we were within the financial range for a family of our size.

Perhaps the greatest impact MCHIP has had on our family medically is that we no longer have to make impossible health choices based on a financial perspective. We no longer have to decide whether a child is really sick enough to warrant a doctor's visit.

We no longer have to decide whether a child really needs a certain medication prescribed by his pediatrician. We no longer have to choose between reactive medical care and proactive medical care for our children.

For example, two of our children have asthma. In the past, under our private health insurance we had to make choices among prescriptions. For example, we would choose between the asthma medication that saved his life during an asthma attack, or purchase the asthma medication that prevented an asthma attack.

Needless to say, our first choice was always the reactive benefit medicine before the proactive benefit medicine, and do we really need to fill the prescription for two asthma inhalers or could we do with one and just hope our son did not lose it?

These are impossible choices for a family to have to make, impossible choices which equated to average health care at best, despite the very high monthly premiums we were paying. Under MCHIP, our children have access to their regular pediatrician and needed prescriptions with no co-payments. Under our private coverage before, we had paid a minimum of a $20 co-pay per child, per visit. Prescription co-pays were up to $30 per prescription, with some medicines simply not covered.

When you have several children requiring several medications routinely every month, as we do, the co-payment expenses are very heavy. For working people of modest means, these costs are burdensome. MCHIP also guarantees access to critical benefits like dental and vision care.

Under MCHIP, our children have access to full dental coverage. With our private insurance, even with our high monthly premium expense, we had no dental coverage. Dental appointments were a luxury in our family rather than a basic medical necessity, and, since our income at the time with the fledgling business did not allow for luxuries, our children did not go to the dentist for several years. I fear this is very often the case in many working American families.

Since enrollment in MCHIP, all of our children routinely visit their dentist every 6 months as needed, and look at their beautiful smiles!

Another benefit of MCHIP which may not be readily seen is the impact it has had on the entire family, on the health of the entire family. Although MCHIP is intended to provide quality affordable health insurance for children, we have found that this program has made an enormous impact on health care for our entire family. As I am sure many of you can understand, if we were struggling to fit our children's medical expenses into our family budget, you can imagine what this meant for my husband and I in terms of health care at the time.

Of course, as nearly every parent will agree, our children's health concerns came first. Even though our entire family was covered under a private insurance plan, Craig and I saw our health insurance as simply a safety net in the event of a serious illness which required hospitalization.

We did not schedule proactive doctors' appointments and we did not get regular physicals, and we did not do any of the recommended incremental medical screenings for major illnesses. We definitely did not go to the dentist.

The only medical care we took advantage of during that time was prenatal care for the birth of one of our children. Monthly health insurance premiums were so cripplingly high, the co-payments for the children were a struggle, so we deemed them non-essential. Any non-essential medical care for ourselves was not necessary.

For our family, enrollment in CHIP for our children meant that Craig and I were able to begin routine proactive health care for ourselves again. Thus, I would venture to surmise for many Amer-

ican families that the Children's Health Insurance Program has served to make their whole family healthier, and not just the children in their families.

CHIP has also given us great peace of mind. The times that we would have to make medical decisions for our children based on financial criteria were extremely stressful as parents, full of those impossible choices.

Those are not the kind of choices that parents, in a society as advanced and with such resources as ours, should be forced to make, not when we and our elected government officials in whom we have placed our trust and well-being have choices in how they direct government resources.

The Children's Health Insurance Program is by far the next best thing for the health and well-being for all of America's beautiful children, who hold the future and greater promise of this enduring Nation in their little hearts and hands.

Funding for children's health care should be a budgetary issue requiring no debate, or even major decision-making. Fund health care for all of America's children. It really is that simple.

Today, members of this committee are gathered together in this room to consider the quality of health for a huge portion of America's children. You hold the answer to whether our Nation's children are worthy of the additional funding necessary to provide them with quality health care or whether those dollars would be better allocated elsewhere.

I challenge each of you to consider what choice you would make if your child or grandchild's health care depended solely on the funding allocation you make on this issue. For so many of us in this great Nation, this is the case. Our beautiful children's health and well-being lie in your hands.

We ask you, please: your commitment to do whatever it takes to continue and increase funding for quality, affordable health care coverage for so many of America's children through the Children's Health Insurance Program is absolutely critical. Thank you.

The CHAIRMAN. Thank you, Mrs. Bedford.

Mr. Bedford?

Mr. BEDFORD. Good morning. I am an insurance agent with Erie Insurance in Baltimore. I sell both property, casualty, and life insurance. In 2001, I had the chance to live the American dream by opening my own business. What kept me from leaving my big-company employer at the time was, what am I going to do about health insurance? I kept asking myself, how am I going to maintain health insurance for my family?

When we started our business, our monthly health insurance premiums were like a new mortgage. The first 12 months, our health insurance costs were 36 percent of our gross income. In 2003, our health insurance premiums increased by 18 percent, to a cost of nearly $800 a month, not including co-pays or prescription costs.

After our children enrolled in CHIP in 2004, we were able to cut our health spending by 60 percent. My wife and I still buy our own health insurance on a separate plan. My business is still growing, as is my family. Unfortunately, health costs have also grown.

In 2006, health insurance premiums for my wife and me cost the same as the family plan we had in 2002, and it still accounts for 13 percent of our total gross income. The face of CHIP is families such as ours, families that work hard and play by the rules, trying to live the American dream.

Providing quality health care to our children should be a Congressional budgetary item requiring no debate or major decision-making. We urge you to continue to fund the Children's Health Insurance Program. Thank you for the opportunity to testify.

I would now like to introduce my eldest son, Job, who is a 13-year-old honor student who has to deal with medical issues relating to his asthma. He is an incredible child to parent, and a wonderful role model for his siblings and other friends.

Mr. Job BEDFORD. Good morning. I am honored to be here before the Senate Committee on Finance, and distinguished others. My name is Job Timothy Bedford. I am 13, oldest of 5 children, and I have been living with asthma ever since I was 5. Thank you for allowing me to speak today about CHIP on behalf of many other kids with chronic illness.

Asthma is a chronic illness that inhibits your breathing. Asthma can make you feel like your throat has shrunk and you are breathing through a straw. When I have an asthma attack, I start wheezing really hard because of lack of air going to my lungs.

When this happens, I try to find my inhaler. An inhaler is a small device which releases a drug into your muscles that relaxes your airways. This usually stops my wheezing and makes it easier for me to breathe. Having good health insurance means I can get an inhaler and any other medical treatment I need. I really like the security of knowing I always have an inhaler when and where I need it. We keep one at home, in the nurse's office, and I carry one everywhere I go with me. It makes me feel a lot safer.

Asthma attacks are kind of scary. They are very unpredictable. There is always the thought in the back of your mind that you may just die. When I was younger, I did not like riding on the highways because it seemed too difficult to get off if I suddenly needed to go to the hospital. Asthma gives you a feeling of uneasiness. Thanks to MCHIP, I always have an inhaler and other stabilizing drugs, like Flovent, available.

I also have medicines like the Epi-pen for allergic reactions. The Epi-pen can save my life if I have an allergic reaction, stabilizing me until I can get more advanced medical care. I feel very secure in knowing that I always have an Epi-pen with me in my bookbag, at home, or even in the nurse's office at school.

However, all these medicines are very expensive without MCHIP. I researched with my parents—a single Epi-pen would cost $76, an inhaler would cost $32, and a Flovent would cost $102 each. Additional daily medicines would take the cost of $200 per month without MCHIP. My 4-year-old brother, who also has asthma and food allergies, too, has had his prescription costs double.

I feel a little sad about having asthma because it limits the things I can do. I cannot play certain sports that require a lot of endurance, and I also have to stay off some kinds of roller coaster rides. But those are small worries compared to the ability to get health care.

Having good health care through the Children's Health Insurance Program means the health care that my siblings and I need is available to us. There are no words to describe how safe that makes me feel. I wish everyone had the means to get the medicine they need to make their lives a lot easier. Thank you.

The CHAIRMAN. Thank you very much, Job, for that compelling and courageous statement. We deeply appreciate that.

[The prepared statements of the Bedfords appear in the appendix.]

The CHAIRMAN. Ms. Allen?

STATEMENT OF KATHRYN G. ALLEN, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. ALLEN. Mr. Chairman, Senator Grassley, and members of the committee, thank you for inviting me to be here today as you address reauthorization of SCHIP.

As you have already pointed out, Congress created SCHIP in 1997 to help cover low-income uninsured children living in families whose incomes exceeded eligibility requirements for Medicaid. SCHIP offers States considerable flexibility in how they provide health insurance coverage to children.

States have three different options in designing their programs. They can choose a Medicaid expansion which allows them to offer the same benefits and services that they offer in their Medicaid program, they can offer a separate children's health program distinct from Medicaid where they can use specified public or private insurance plans, or they can offer a combination program which incorporates elements of both.

At the time of enactment, Congress appropriated a fixed amount of funds, about $40 billion over 10 years, to be distributed among States with approved SCHIP plans. Unlike Medicaid, however, SCHIP is not an entitlement to services for beneficiaries, but it is a capped grant or allotment to States.

Each State's annual allotment is available as a Federal match based on State expenditures, and it is available for 3 years, after which time any unspent funds may be redistributed to States that have already spent their allotments.

My remarks today will focus on three issues: first, recent trends in SCHIP enrollment and the current design of States' SCHIP programs; second, States' spending experiences during these past 10 years; and, three, certain issues for consideration during reauthorization.

First, as you have already pointed out, SCHIP enrollment has increased rapidly during the program's early years, but it has stabilized more recently. Total annual enrollment has leveled off at about 6 million individuals, including over 600,000 adults now, with about 4 million individuals enrolled at any point in time.

States' SCHIP programs reflect, indeed, the flexibility afforded them in their overall program design. Eighteen States now operate a separate Children's Health Program, 11 States use a Medicaid expansion, and 21 use a combination of the two.

Forty States have opted to cover children and families with incomes up to 200 percent of the Federal poverty level or higher, and

7 States cover children and families up to 300 percent of Federal poverty or higher.

Almost as many States—39 States—require families to contribute to the cost of their children's care through some form of cost sharing, such as premiums or co-payments.

Few States, however—only nine—operate premium assistance programs, using funds to help pay premiums for available employer-sponsored coverage, in part, because States often find these programs very difficult to administer in cooperation with employers.

As of February of this year, we identified 14 States that had approved waivers to cover one or more of three categories of adults in their SCHIP programs. These include parents of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

Second, SCHIP program spending was low initially as States were designing and implementing their programs, but now threatens to exceed available funding. Some States have consistently spent more than their allotment, while others consistently less.

In the first years of the program, States that over-spent their annual allotments over the 3-year period of availability could rely on other States' unspent funds, which were redistributed to cover excess expenditures.

Over time, however, spending has grown and the pool of funds available for redistribution has shrunk. As a result, 18 States were projected to have funding shortfalls in at least one of the final 3 years of the program. That is, they were expected to exhaust available funds, including current and prior year allotments.

These States were more likely than those without shortfalls to have a Medicaid expansion or combination program, to cover children across a broader range of income groups, and to cover adults through their programs.

It is not clear, however, to what extent these characteristics contributed to States' overall spending experiences, as many other factors have also affected States' program balances, including prior coverage of children under Medicaid and SCHIP eligibility criteria, their benefit packages, enrollment policies, outreach efforts, and provider payment rates.

In addition, the formula for allocating funds to States has been criticized by some for containing flaws that led to under-estimates of the number of eligible children in some States and, thus, underfunding.

To respond to these shortfalls, as you have already pointed out, Mr. Chairman, Congress has acted numerous times to appropriate additional funds or even to redistribute funds. Even so, 14 States are projected to exhaust their allotments in this fiscal year.

Third, and finally, Mr. Chairman, we observe that SCHIP authorization is occurring within the context of broader national health care reform and competing budgetary priorities.

There is an obvious tension between the desire to provide affordable health insurance coverage for uninsured individuals, including children, and the recognition of the high cost that health care coverage exerts as a growing share of Federal and State budgets.

As Congress addresses SCHIP authorization, the single issue at the forefront of consideration is the one that Senator Grassley ex-

actly pointed out, and that is how to finance the program. But yet, this involves many moving and interdependent parts.

We would like to just point out that three of these include how to maintain State flexibility within a program without compromising the over-arching goal of covering children; how to help ensure stable, yet fiscally sustainable future public commitments at both State and Federal levels; and, third, how to assess issues associated with equity, including better targeting of funds to achieve certain policy goals more consistently nationwide.

Mr. Chairman, this concludes my remarks, and I would be happy to respond to any questions.

The CHAIRMAN. Thank you, Ms. Allen, very much.

[The prepared statement of Ms. Allen appears in the appendix.]

The CHAIRMAN. I would like, now, to introduce Sonny Perdue. Governor, thank you very much for taking the time to come up and give us the benefit of your experience.

Governor PERDUE. Well, good morning, Mr. Chairman.

The CHAIRMAN. We look forward to what you have to say.

STATEMENT OF HON. SONNY PERDUE, GOVERNOR OF GEORGIA, REPRESENTING THE SOUTHERN GOVERNORS ASSOCIATION, ATLANTA, GA

Governor PERDUE. Thank you very much. Senator Grassley, members of the committee, thank you for inviting me today. Thank you, especially, for your compassion in placing Ms. Allen between me and the compelling testimony of Job Bedford. [Laughter.] But as we consider the reauthorization of SCHIP and the State Children's Health Insurance Program, it is an honor to provide the perspective of a Governor.

I am pleased to be here today representing, really, the Southern Governors Association. Those are 16 States and two territories. As you know, demographically the South has been especially successful in implementing the SCHIP program, a program that Congress created 10 years ago to give children the same healthy start in life that we all desire for our own children.

Georgia, which is the ninth largest State in the Union, has the fourth largest enrolled population in the country. In fact, more than 41 percent of the SCHIP population is enrolled in southern States. In our job, we are usually presented with ideas in terms of a big-picture impact: the argument that nationwide there are more than 6 million kids enrolled in SCHIP; in Georgia alone we have more than 270,000 children. These are large, impressive numbers, but we often get lost in the big picture, forgetting about the human impact.

Ladies and gentlemen, these are children. They are the Job Bedfords and his family and his siblings, and they need our help. They are mostly families, moms and dads, many times single mothers with two or more children, with household incomes, in Georgia, of just slightly more than $26,000 annually.

These families are not on welfare. Ninety-three percent of these parents go to work every day. They simply want for their children what we all want for our children, to have an annual check-up, to get basic immunizations, to get regular screenings. They want to be able to get a cough treated before it turns into pneumonia. They

want to catch asthma before it means a hospital stay. The families on SCHIP are working for a small income, and they need all of our help to keep their children healthy.

Without question, States have made dramatic progress in reducing the number of uninsured low-income children through this wonderful program. Governors look to your reauthorization of SCHIP as assurance that we will continue in our partnership to provide a safety net for our children.

Reauthorization gives Congress the opportunity to evaluate the current program and refocus on our common goals. As Governors, we are responsible for achieving the goals set forth in the program. In that role, we have learned some lessons and established some principles that I would like to pass along to you as you consider the future direction of the program.

I want you to keep in mind today that I am representing 16 States, and so you can imagine, these priorities must be pretty important for a third of the States in the Union to come to a consensus.

The key principle that we agree on is that children should be the primary population for SCHIP, as the name implies. This means that our resources must first be focused on children. This is not the case in every State now, as you know.

Some States have expanded their programs to include health insurance coverage for pregnant women, adults with children, and in some States, even childless adults. The problem here is, these States are paying the same Federal match rate as States like Georgia who are struggling just to cover our uninsured children.

As Governor of a State with a constitutional requirement for a balanced budget, I recognize that we simply do not have unlimited funds for SCHIP, but we are going to meet our State's obligation for SCHIP. We are asking you, as our Federal partners, to join us in that commitment.

The hard fact is, if you do not, 15 States, including Mr. Kerry's State of Massachusetts, Mr. Lott's State of Mississippi, Mr. Grassley's State of Iowa, Ms. Snowe's State of Maine, are going to run out of Federal funds this year, and very soon.

If that happens, we will not be able to cover even our low-income eligible children, while other States have so much excess funding that they will be covering SCHIP populations SCHIP never intended to cover.

That leads me to the important lessons that we have learned over the last 10 years of implementing SCHIP. The southern States have run into two main problems in the funding formulas: the first is the State cost factor, and the second is the calculation for the number of children.

The State cost factor falsely equates wages in the health services industry to health care costs, but there is not a real correlation between these two measures. This factor just ends up reducing funding to States with low wages. This works directly against the core mission of directing SCHIP funds to low-income uninsured children.

The number of children factor calculation is equally flawed. Today, for example, Georgia insures over 70,000 more children than the formula says should even be eligible in our State, and in

fact we believe we have another 100,000 that are currently eligible for the program now. That is a gross mismatch between reality and what the formula allows.

Allotments are based on data that is sometimes 3 and 4 years old, and in a State like Georgia, the fourth-fastest growing State in the country, this lag has serious, serious consequences. The method of calculating the number of children factor has proven ineffective in southern States.

This has resulted in the most severe funding shortfalls in the country. This number counts half of our State's low-income children and adds to it half of the State's uninsured low-income children. This means the better you are at implementing SCHIP, the fewer children who are uninsured and the less funding you receive for them.

If the State's SCHIP program is 100-percent successful, then the next year's funding will be drastically cut because no children will be uninsured. This just does not make good sense. How can we keep these children insured if we are penalized for insuring them? The most egregious example of these shortfalls have been in North Carolina and in Georgia.

North Carolina was successful at implementing SCHIP, successful enough that their funding became insufficient to cover the number of enrolled children. North Carolina was forced to shift infants and toddlers to Medicaid, reducing SCHIP payments to providers, and to limit enrollment growth.

Georgia's experience with our SCHIP program, called PeachCare, further highlights the challenges that must be addressed in reauthorization. As I indicated, Georgia has the fourth-largest enrollment in the Nation. We have spent, over the period, $432 million in State funds and are now covering more than 270,000 children in PeachCare. Georgians trust and value this program. Monthly enrollment has increased 19 percent in over 2 years, and we are committed to keeping these kids covered.

Let me tell you, we run a tight ship in Georgia, thanks to the flexibility allowed under this program. We only cover children. Ninety-five percent of our PeachCare population make less than 200 percent of the Federal poverty level.

We employ a sliding scale premium so that families that make more, pay more. We do not guarantee a continuous eligibility. Families must report changes in income or status, and we verify that. Further, families have a 2-week grace period to pay their premiums. Our grace period is half the length of other States. Families who do not pay on time, just like a regular insurance program, are locked out of the program for a period of time.

We make it clear in Georgia—personal responsibility. This is not simply a hand-out. If Georgians do not demonstrate personal and financial responsibility, their children do not benefit from this program. This emphasis on personal responsibility, I believe, has contributed to our success.

Flexibility is what has allowed the States to continue covering these children when they would have been dropped from other programs during difficult budget times. In fact, when I became Governor 4 years ago, we faced 2 years of back-to-back revenue decreases and we had to cut out a lot of things, but we remain stead-

fast in our funding share of SCHIP. SCHIP's flexibility is a critical element that must be maintained in reauthorization.

In closing, though, I have to tell you that Georgia's successful implementation of SCHIP has left us, unfortunately, with a $131 million shortfall of Federal funding and has put this program in jeopardy. Without additional Federal matching funds, the PeachCare program will be out of Federal funds by March, just 2 months, just a few weeks from now.

Georgia stands ready to meet its obligation to this program, but we simply cannot go it alone. I would like to think of this program as one of access. Georgia engaged quickly. In fact, we engaged so much, we got married with our Federal partners and our fruitful union produced over 270,000 children.

Now we are concerned that we are talking about divorce, and we do not know what will happen to the health care of those children. In fact, as you know, in Federal law and State law—we believe we are the custodial parents—usually the health care responsibility falls to that non-custodial parent.

America is a compassionate Nation, and we must continue to take care of our most vulnerable citizens. You have heard from the SCHIP family, the Bedfords, just a few minutes ago. It is important to realize the individual human impact of this program.

Remember, we are not just talking about numbers, we are talking about families and children. As we focus on new ways to reach the Nation's uninsured children, I ask each of you distinguished members of Congress to preserve the State Children's Health Insurance Program, a program that is already meeting their needs.

We are all familiar with the story of the Good Samaritan, where two pious men walked by, turned their hearts and their heads away, and looked away, while the Samaritan reached down, took that person to the innkeeper—today it would be known as a hospital—gave the innkeeper the money, and said, "Take care of this man, and when I return, if it costs more, I will pay you more then." Why can't we all be Good Samaritans? I hope that you will find these principles and lessons learned to be helpful.

On behalf of southern Governors, we hope you will use us as a resource as you consider reauthorization and the future of our children.

Thank you very much.

The CHAIRMAN. Thank you, Governor, very, very much. We are going to work to help make sure this marriage works. [Laughter.]

[The prepared statement of Governor Perdue appears in the appendix.]

The CHAIRMAN. Next, Dr. Mann?

STATEMENT OF DR. CINDY MANN, EXECUTIVE DIRECTOR, CENTER FOR CHILDREN AND FAMILIES, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE, WASHINGTON, DC

Dr. MANN. Thank you, Chairman Baucus, Senator Grassley, and other members of the committee. Thank you very much for the invitation to participate today in this hearing about the reauthorization of the State Children's Health Insurance Program.

My written testimony covers a number of areas, but I am going to focus my remarks this morning particularly on the central issue,

I think, facing the State Children's Health Insurance Program as it moves into reauthorization, which is the need for substantial new funding to cover more of the Nation's children.

Reauthorization creates the opportunity to assess, after 10 years' of experience, what the program has accomplished, what its challenges have been, and what we can do to move forward.

When CHIP was first adopted in 1997, one of the big questions was, would States even adopt the CHIP option? Would States decide that this was a good thing to do? To many people's surprise, every State in the Nation has taken up the CHIP program. In 1997, three States covered children up to 200 percent of the poverty line; now 41 States do so, thanks to the CHIP program and the underlying Medicaid program.

Just, again, to give a reference point, in 2007, for a family of four in which both parents work full-time, each earning $10 an hour, that is the equivalent of 200 percent of the poverty line. We are talking about families who are struggling to make ends meet and for whom health insurance is often unaffordable.

After a modest start, CHIP enrollment took off. I have some charts here that are also attached to my testimony. I am just going to go through a couple of them.

As Ms. Allen noted, we have, now, about 6 million children enrolled in the program. But coverage gains did not stop with CHIP enrollment, and it is really important also to look at the Medicaid side of the equation.

CHIP was successful not just in gaining coverage in the CHIP program, but in triggering major changes, improvements, in Medicaid, eliminating a lot of the barriers that had been in place in Medicaid that prevented children from enrolling in the program and retaining coverage in the program.

Thanks to outreach, coordination between Medicaid and CHIP, and simplification efforts that got rid of longstanding barriers in many States across the Nation, including Georgia and Iowa, as many kids enrolled in Medicaid as enrolled in CHIP between 1997 and 2005.

As you can see from the chart, Medicaid remains the much larger and more significant program in terms of children's coverage. CHIP stands on the shoulders of Medicaid. Both programs have to remain strong and viable if the Nation is to continue making progress.

So what has the new enrollment meant in terms of accomplishments for children? Together, these programs have reduced the uninsured rate among low-income children by a third. That is a remarkable achievement in a short period of time when, as noted in your comments, the Nation was swimming upstream against rising health care costs and declining employer-based coverage.

During this same period of time when we were lowering the rate of uninsurance among low-income children, the number of uninsured adults rose by 6 million because we did not have, on the adult side, the kind of coverage opportunities that we have for children.

But as I think everybody here knows, in 2005 the uninsured rate for children ticked up for the first time since 1998, and we have

about 9 million children who are uninsured. That is our challenge going forward.

The good news is, for most of these uninsured children, they are now eligible for CHIP or for Medicaid. The good news also is that the public strongly supports moving forward, and there is growing energy across the Nation to do just that.

More than half of the States represented by the Senators on this committee have taken, or are poised to take, significant action to improve the coverage for children through their Medicaid and CHIP programs, which brings us to the CHIP funding level.

The level for 2007, $5 billion, was picked 10 years ago. It was picked before Congress had any experience with the program, before we knew how many States would even take the CHIP option, before we knew what kinds of programs States would create, and before we knew what families would do when offered the opportunity to enroll in CHIP.

Ten years later, we know a lot more. What we know, fundamentally, is that $5 billion falls well short of what is needed over the next period of time. The mismatch between CHIP funding levels and need is apparent.

This chart shows the annual allotments in orange for the Nation as a whole, and the spending in the blue bars. In the early years, States did not fully spend their allotments because their programs were just ramping up. But now their spending levels, collectively, are more than the annual allotments they receive. This was anticipated. States were given, in the CHIP law, the opportunity to use carry-over funds from earlier years and to get redistributed funds from other States that did not fully spend their allotments.

But those carry-over funds and the redistributed funds are drying up, and they are drying up because it is not just one or two States that are fully spending their allotments, it is the majority of States.

The CRS—Congressional Research Service—reports that 37 States have spending levels in 2007 which exceed their 2007 allotments. This program needs additional substantial funding to keep moving forward.

Formula changes and quicker reallocation of funds could help, but when most States are already spending their annual allotments and we still have 9 million uninsured children, it is apparent that the formula adjustments alone will not be sufficient to address funding needs.

Cutting off coverage to certain groups of people might also help stretch the dollars, but only by taking away health insurance coverage from children or from their parents and other adults who have no other source of coverage. If coverage gains are the goal, it is clear that these steps would take us in exactly the wrong direction.

Real progress, as others on this panel have said, will require Federal leadership and a commitment of Federal resources. Without strong CHIP reauthorization, the movement that we see across the Nation among States will stall, and in those States that have the least resources to fall back on it will come to a complete halt, and children will be the victims.

In addition to looking at adequate funding for CHIP, further success will require some new steps to reduce enrollment and renewal barriers that keep eligible children from participating, granting States the option to cover legal immigrant children and pregnant women.

Funding is also needed for outreach, if there is adequate coverage dollars there to support those outreach efforts. Reauthorization also presents a wonderful opportunity to establish new child health policies——

The CHAIRMAN. I am going to have to ask you to wrap up the best you can.

Dr. MANN. In closing, Chairman Baucus, we are, I would say, as the evidence establishes, too close to turn back. Now is the time to move forward. CHIP reauthorization is the time to make children's coverage a national priority.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Mann appears in the appendix.]

The CHAIRMAN. Ms. Smith?

STATEMENT OF ANITA SMITH, CHIEF, BUREAU OF MEDICAL SUPPORTS, IOWA DEPARTMENT OF HUMAN SERVICES, DES MOINES, IA

Ms. SMITH. Good morning. I am Anita Smith with the Iowa Department of Human Services. In my role as Chief of the Bureau of Medical Supports, I am responsible for the administration of Iowa's CHIP program and Medicaid eligibility policy. It is a pleasure to be able to come before you today and share Iowa's CHIP experience and some thoughts on reauthorization.

Currently, over 30,000 children are enrolled in Iowa's CHIP program. We believe one of the primary factors why Iowa's program has been so successful is that, before we designed our program, we asked the public what they wanted.

We conducted surveys and held town hall meetings across the State to find out from the public, medical providers, and advocates what elements they would like to see in the design of a State Children's Health Insurance Program.

The three messages that consistently rose to the top were: we want insurance that looks like everyone else's; we do not want to have to go to the welfare office to apply; and we would be willing to pay what we can towards the cost.

Using these principles, Iowa's program was developed as a combination program, consisting of both a moderate Medicaid expansion and a stand-alone CHIP program called Healthy and Well Kids in Iowa, or hawk-i.

The hawk-i program was designed to mimic the commercial insurance market to the greatest extent possible within the Federal guidelines. Because of the public's perception of CHIP and the long-ingrained association of Medicaid with the stigma of welfare, families repeatedly asked to be enrolled in the hawk-i program rather than Medicaid, despite the fact that the Medicaid program has a more comprehensive benefit package.

However, because of the current screen-and-enroll requirements of CHIP, families are not allowed to choose and are forced into Medicaid. As a result, some families choose to go without coverage.

With the help of SCHIP and some 178,000 children enrolled in Medicaid, along with private health insurance, for many years now Iowa has consistently ranked in the top five States with the lowest uninsured rates for children, but it is still estimated there are over 40,000 uninsured children under 200 percent of the Federal poverty level not yet enrolled in Iowa.

Iowa took a conservative approach in implementing CHIP and developed our program within the original intent of the legislation. As such, we have focused only on covering uninsured children up to 200 percent of the Federal poverty level. We have not used CHIP funds to cover parents, childless adults, or other populations.

Even so, this is the third year in a row in which we will outspend our annual allotment. In fiscal year 2005, we relied on redistribution dollars. In fiscal year 2006, we had to rely on the supplemental appropriation. And in fiscal year 2007, we project that all available dollars will be exhausted at the end of June.

To date, the redistribution dollars and supplemental funding have allowed us to maintain our program without making any cuts, increasing cost sharing, or decreasing benefits.

However, if Iowa's allotment remains at the current level, we will not be able to sustain any program growth and, in fact, we will have to cut approximately 15,700 kids, which is 70 percent, from our stand-alone hawk-i program.

We believe that the CHIP funding formula is fundamentally flawed in that it provided windfall funding in the early years, but 5 years into the program State allotments were decreased significantly, while at the same time States were getting up to speed and enrollments were increasing.

The formula penalizes States that are successful in reducing the number of uninsured children because it factors in only the number of uninsured children without recognizing the State's progress in reducing those numbers.

It does not include a built-in inflation factor for ever-increasing health care costs, and it unfairly disadvantages States that chose to take the option to implement a separate CHIP program than merely expand Medicaid.

Currently, some States are sitting on large amounts of unspent allotments, while Iowa and other States are facing funding shortfalls with no clear direction of how, or even if, they will be met.

In closing, if Iowa is to sustain the gains we have made and continue making progress in reducing the number of uninsured children, it is essential that we have a predictable and stable funding stream that will provide sufficient resources to identify, enroll, and retain all eligible children under 200 percent of the Federal poverty level in the program, yet have the flexibility to design benefit packages and delivery systems, and be protected against unfunded mandates such as PERM that use up resources needed to provide coverage to children.

I hope the information about Iowa's experience will be helpful to you as you go forward in your work to ensure that all children have the health care coverage they deserve.

[The prepared statement of Ms. Smith appears in the appendix.]

The CHAIRMAN. Thank you all very much. I am going to limit myself to 5 minutes, and I would ask other Senators to do the same.

A basic question, it seems to me, is the degree to which this is a national program and the degree to which it is a State program, and it gets to flexibility. I mean, States like flexibility. What State does not? But it cuts different ways. One wants flexibility to expand coverage, another wants flexibility to thin the soup, if you will, and add co-pays and so forth, which makes it more difficult.

I would like a couple, three of you to just get at that core question as we move forward here. Certainly a lot of this comes down to funding, and that is an issue we will have to wrestle with here. I think more Senators would like, I guess it is about $15 billion to maintain the current program. That is $15 billion more we have to find. Then we have to find more dollars to expand.

I will just start with you, Governor. It is a fundamental question here. To what degree is this a State program, to what degree do we have national standards? How much flexibility should States have? Some States want to be flexible, but tend to reduce coverage, that is, the quality of the coverage. Other States want to expand, and so forth.

If you could just address that, please, very briefly. Then I am going to ask a couple of the panelists the same question.

Governor PERDUE. I think the real key issue, Mr. Chairman, is if the Congress, in being the major partner in this process, wants to set parameters, I believe we as Governors are delighted to follow in those parameters and those guidelines.

The fact is, flexibility is important to keep this not as an entitlement program with the gold card in Medicaid for unlimited services, but where we can help to guide people. We do not want people to stay at $26,000 worth of income. We want them to grow into jobs where they can afford health insurance through their employer or others.

So, we believe we are helping to train families to be responsible in the proactive care of their children, as the Bedfords have been, in doing that. We need the flexibility to guide those programs. When we had the revenue downfall, we had some orthodontic coverage in our plan and we restricted that. We added a sliding scale of premiums that we think is important in helping for all of us to be partners.

We believe families value health care when they have some investment in there as well, and which they can afford. So, flexibility is important, but flexibility is not nearly as important as the funding to continue this program, and that is where we find ourselves in a crisis.

The CHAIRMAN. We are several States, but we are one country. People travel, move to different States. I would guess, to some degree, it would be important to have CHIP programs that are somewhat similar rather than a huge, wide variation among CHIP programs.

Governor PERDUE. I would think that would be helpful.

The CHAIRMAN. Dr. Mann?

Dr. MANN. I think that is right, Chairman Baucus. There is considerable flexibility in the program. You can see it in the benefit packages. The Bedford family in Maryland has access to dental care, which has been very important to them. That is not the case in all States around the country. There are limitations. The program was built on flexibility.

I guess one of the points I would like to focus on is, some have suggested to eliminate that flexibility by not allowing States to cover children with incomes above 200 percent of poverty.

That would not only cut off coverage to a large number of children in certain States around the country, but it really gets at the very issue of State flexibility.

It costs more to live in certain States than in others, and States make determinations as to what the right income level is for covering children in their program. But I totally agree with the Governor, because when you have a block grant you necessarily have tugs and pulls.

When one State covers dental benefits and one State goes to 205 percent of the poverty line or 230 percent of the poverty line, that necessarily creates some tension for other States in terms of funding. I think, because of the priority, if we put adequate funding in this program, then we can accommodate that flexibility without hurting families.

The CHAIRMAN. Ms. Allen, your response?

Ms. ALLEN. Yes. Mr. Chairman, I would only add that States started at very different places in their program because, under their former Medicaid programs, some had already expanded their Medicaid programs beyond minimum requirements, whereas others had not.

So when Congress decided to appropriate money, there were other issues of equity in terms of, some States wanted to share in their initial allotment, but they were already covering children up to 200 percent of poverty.

So then the question became, how could they spend those monies? Sometimes that is why some decided to opt to cover adults with that share of money, whereas others were focusing more on children. So that is where there are other issues of equity and using the funds as well.

The CHAIRMAN. All right.

Ms. Smith, I will give you a shot at this, too.

Ms. SMITH. In our State, I think flexibility is key. As I indicated in my remarks, the public and advocates, all they were asking for is insurance that looked like everyone else's. They are not asking for the gold standard. It is important that we have the flexibility to design programs that meet the need and use the funding in the most reasonable manner.

The CHAIRMAN. Thank you. My time has expired.

Senator Grassley?

Senator GRASSLEY. Thank you all very much for your testimony. I appreciate it very much. It will be very helpful. It is very helpful already to staff who are on top of this stuff more so than members are.

Let me start with the Governor and ask you the reasons for Georgia running a shortfall. Then do you believe that States have

the flexibility and tools that they need to maintain a program within the SCHIP allocation?

Governor PERDUE. Senator Grassley, we have been very aggressive in outreach to children. We thought that was the motive and the mission of the program, and we went after those uninsured kids. I believe the fundamental problem in the formula is that, when we enroll those children, they become ineligible for future funding allocations.

The allocation is only disclosed to States the first week of October for that year, and we are doing our budget negotiations right now. I am having to guess what our allocations will be 18 months out based on what the potential reauthorization is.

This match is fine, but the lack of certainty in the allocation is a significant challenge to States, and certainly we will continue to outreach because we think we have more children eligible.

Flexibility is important, but a certain level of funding is even more important. As a Governor, I am willing to manage our program to a block grant if that allocation is known ahead of time.

Senator GRASSLEY. And the main reason for that is because State fiscal years differ from Federal fiscal years?

Governor PERDUE. That is one of the challenges. We, as many States, end on June 30 and the Federal fiscal year ends on September 30.

Senator GRASSLEY. Yes.

Then for Ms. Smith, my staff have often referred to the flexibility that you have just spoken so much about as the Vilsack option, because he has come here and advocated for that over a long period of time before he just left the Governor's office.

So in regard to that, you stated in your testimony that you consistently—and you just repeated it to Senator Baucus about people wanting to have private insurance as opposed to going to the welfare office.

Could you elaborate on why you think that is the case, and can you expand on your testimony and describe tools States should have to address the desire by many to be on SCHIP rather than Medicaid?

Ms. SMITH. Well, I think, as you know, Iowans are very proud. There is a stigma associated with Medicaid of being on welfare and taking a handout. People want insurance that looks like everyone else's. They perceive they are treated differently when they go to the doctor's office if they have a Medicaid card versus a Blue Cross/Blue Shield card, for example.

We have had families who have chosen not to enroll in Medicaid and have their children go without coverage, as opposed to being on the Medicaid program even though it has more benefits.

What we have suggested in the past is that families be allowed to choose between Medicaid and the CHIP program. We would not ask for the enhanced funding for those families. We would ask to draw down just regular title XIX matching dollars. We have suggested that families be allowed to opt back in to Medicaid at any point if they would choose to do that.

As I indicated, we have a number of uninsured children in our State yet to be enrolled, and I think this might go a long way to getting those people in the program.

Senator GRASSLEY. Ms. Allen, I'd like to read a quote from a 2004 report that Senator Baucus and I received from your agency: "We believe that in allowing States to use unspent SCHIP funds for their own adult populations, HHS is reducing the unspent SCHIP funds available for future redistribution to States that have exhausted their allotment for covering uninsured low-income children."

A simple question: is that still as true today as it was 3 years ago in 2004?

Ms. ALLEN. Well, Senator Grassley, the SCHIP law allows for coverage of adults under two provisions. If States can demonstrate that it is cost-effective to cover families, it is permissible, but they have to demonstrate the cost-effectiveness test. Second, the Secretary can approve waivers for demonstration projects that are likely to promote the program's objectives.

In the report that we wrote in 2004, we had two concerns. One was that we believed that providing SCHIP funds for childless adults did not promote program objectives, and the Congress agreed and, in the Deficit Reduction Act of 2005, ceased funds for childless adults. The second issue that we raised with you was, we pointed out that in approving waivers, that at that point in time we did not see that the Secretary was looking for the cost-effectiveness test.

In the absence of that, we could not see which was taking priority, cost-effectiveness or promoting the objectives of the program. So we think until that policy question is resolved, that tension is still in the program.

The CHAIRMAN. Thank you, Ms. Allen.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman. I thank our committee leaders for their kind remarks about how this bill originated. I certainly want to thank Senator Rockefeller for the work that he has done.

I really welcome the Bedford family. I think your testimony has been very helpful to us. I want you to know, Job, you did a good job.

Governor, I really appreciated your testimony because you brought up the southern approach to this that I think is absolutely crucial to the working of this overall program, so we are really pleased to have you here. I thought you did a terrific job, and the rest of you as well.

But let me just ask a few questions. Ms. Allen, let me direct this to you. According to CMS, five of the shortfall States expanded coverage to adults under the CHIP program. Now 60 percent of Illinois's CHIP expenditures are for adults, 61 percent of Minnesota's CHIP expenditures are for adults, 57 percent in Rhode Island, 75 percent in Wisconsin, and 43 percent in New Jersey.

I want to know what is going on here. When we first created CHIP, the whole purpose of this was to help children of the working poor who were the ones left out of Medicaid, left out of the system at the time. Now, its purpose was to provide coverage for low-income children. Now, are there are unique circumstances in these States that encouraged them to target a large part of their CHIP fund to adults?

Ms. ALLEN. Senator, GAO has not had an opportunity to look at the expenditure level.

Senator HATCH. Would you look at that and get us some information on that?

Ms. ALLEN. Yes, sir. We would be happy to do that. We have looked somewhat at the enrollment numbers, and those numbers are included in our testimony.

One thing that we are aware of, again, is that many States have already expanded their eligibility levels under Medicaid to children at 200 percent, or even higher, so they were already using a lot of their allotments for children up to certain levels. So when they still had allotments available, they were then choosing to spend available funds for parents.

Senator HATCH. But were those allotments not supposed to go back into the fund so we could help other States that were short?

Ms. ALLEN. Again, the law permits the use of the funds——

Senator HATCH. I understand.

Ms. ALLEN [continuing]. If they pass a cost-effectiveness test or under waivers. So to the extent that waivers were approved by the Secretary, that is permissible under the statute. That is the policy question on the table.

Senator HATCH. So we have to question whether these waivers have been properly approved.

Ms. ALLEN. Exactly.

Senator HATCH. That is the point I am trying to make.

Ms. ALLEN. Exactly.

Senator HATCH. Yes. Because it would take waivers to do some of these things that are being done.

Governor, let me just ask you this question. I would like to know why there is inconsistent data, if you know, on uninsured children. How can we improve this? And others can answer as well.

How can we improve this data collection, especially since the State's CHIP funding allocations were based on the number of low-income children without health insurance and the number of low-income children in a State, in addition to the State variation in health care costs? I would just kind of like to start with you, since you have highlighted this in your testimony.

Governor PERDUE. Certainly, Senator Hatch. One of the problems is the lag. The latest data was from 2001 to 2003. In a growing State like Georgia, as I indicated, our enrollee population has increased 19 percent in 2 years, and it does not keep up.

There is a significant lag in that effort, and that hurts the population. The very fact that we are enrolling, have already enrolled, 70,000 more children than the formula says we have eligible, is an indication that there is a serious flaw in the funding formula.

The other problem is, once we enroll children, they come off of that 50 percent of uninsured, and it is a disincentive for being successful in this program. Georgia aggressively pursued the engagement of families through the Right From the Start Program, and we have done a great job in that.

We have a 10-year history of data now, Senator. We do not have to guess any more. We can see where the trends are going. It is a mature program and statistics will help us determine how these allocations should be appropriated between the States.

Senator HATCH. Well, great.

Dr. Mann, let me just ask you this question, and you can all comment on the other, too. In your testimony, you talk about the Balanced Budget Act of 1997—and it would not have happened had we not had CHIP added to it, in my opinion. It became the glue that put together the first Balanced Budget Act in over 40 years—permitted States to set their upper income eligibility level at 200 percent of the Federal poverty level, or 50 percentage points above the State's Medicaid income eligibility level prior to CHIP. It also had States establish their own rules in how they would calculate income.

Now, could you just tell us a little bit more about this in detail, particularly the various income disregards that come into play when the States themselves determine income factors?

Dr. MANN. Certainly, Senator Hatch. The law was very explicit about leaving States the flexibility, going back to the issue of the balance of flexibility, to determine how they would calculate income and whose income they would count.

Some States, for example, will count a grandparent's income if they are in the home. Some States will say, no, we will just look at the parents' income. In addition, some States—a minority, about 13 States—look at gross income only. Some States, like Maryland, will look at expenses to reduce income.

So, for example, in Maryland's program, for the Bedford family, they would not just look at the gross income from their self-employment, but they would look at employment-related expenses. So, States have the flexibility of doing that. So when you actually look at States, whether they cover at 200 percent of poverty, or 250, or 150, it does not really tell you what the real net threshold is because States have different——

Senator HATCH. We put that flexibility in the bill.

Dr. MANN. That is right.

Senator HATCH. But would it be better for us to set the rules a little stronger?

Dr. MANN. Senator, if you set the rules, it would make the program, frankly, much more restrictive in the rule-setting on the Federal level than the Medicaid program.

Senator HATCH. And that was the problem.

Dr. MANN. The Medicaid program sets a bottom line goal, but allows it to be less restrictive, because you would not just say it is 200 percent, but you would say, what deductions would be allowed, whose income could be counted. So, it is a very difficult path that would actually go very much against the grain of flexibility in the program.

The CHAIRMAN. Senator Hatch's time has expired, but, Governor, I see you raising your hand. If you could, very briefly respond.

Governor PERDUE. I would like to respond.

The CHAIRMAN. Very briefly.

Governor PERDUE. Certainly. Flexibility is important, but from a Governor's perspective who has to balance a budget, flexibility is less important than the funding and the certainty of funding for the number of children that we already have on the program. I would like to emphasize that. We like flexibility, but we like the funding more.

The CHAIRMAN. You want the money.

Governor PERDUE. Yes.

The CHAIRMAN. All right. And more certainty, clearly.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

Welcome to all of our witnesses. I, too, want to welcome the Bedfords. You must be very proud of your family and your eldest child. Job, welcome as well. I am sure, as we are talking about funding formulas and all these other changes, you represent the perspective of what we are really all about, which is trying to provide health care for children and for families. Welcome, Governor, and all of our witnesses today.

I did want to start by speaking from the perspective of a State, in Michigan, that has been one of those States that decided before SCHIP to really work hard to cover children and, because of a lot of savings through Medicaid and, frankly, just a lot of hard work, had covered more children before SCHIP than other States.

So when the dollars became available and so on, our State really looked to cover families and then to ask for a waiver, which 15 States have received waivers, I believe, or at least 15, of which Michigan was one, to look at adults making $4,300 a year—a year—who did not have health insurance.

Through the approval of the Federal Government and the administration, they have been able to stretch their dollars to cover those very, very low-income individuals. I realize now it is a very legitimate discussion on SCHIP and where we go.

But I think, Mr. Chairman, it was wise in the Deficit Reduction Act that we grandfathered in States that had worked very hard to cover individuals so we are not taking away health care from some individuals to cover other individuals, which I hope will continue to be our position as we move forward, recognizing all of these challenges because of the States that took their flexibility and tried to, I am sure as you do, Governor, stretch every penny to help provide health care coverage.

I am also—a comment before a question—feeling that we really have an opportunity, and Mr. Chairman, I appreciate your making this a priority for the committee, and your vision to look for ways to cover every child. We really have, I think, an exciting opportunity. We have all kinds of groups that have come together, from the Children's Defense Fund and Families USA, to the U.S. Chamber, and Pfizer, and American Health Plans, people who are coming forward, saying, we need to get this done.

One of the things that they have suggested is, as we look at the 9 million children now who are not covered, is to use free and reduced lunch programs as a marker for ease and efficiency to look at—and we realize the cost of this, but just from a process standpoint of how it would work—as children sign up and are eligible for free and reduced lunch, to then automatically sign them up for SCHIP.

I guess I would start with Dr. Mann, but Governor, as well, and anyone on the panel who would like to respond to the framework of using free and reduced lunch as one way of identifying children and using that mechanism.

Dr. MANN. Yes. Thank you, Senator. I would like to respond. The option that I think people have been talking about is the idea to create what has been known as "express lane" eligibility.

The idea is that, if we see children in different programs—school lunch, WIC, food stamps—States should be able to take the information they glean from those programs and be able to apply it to a Medicaid or CHIP determination.

The real issue of "express lane" is to just use the income eligibility determination of those programs and not go through a whole new calculation in the Medicaid and CHIP program. It would be an important tool, I think, going forward for States to improve their enrollment of eligible, but unenrolled, children.

Senator STABENOW. Thank you.

Governor?

Governor PERDUE. I think one challenge, Senator Stabenow, would be, as I understand it, there is no income verification on the free and reduced lunch currently. I do not know how we, as States, would live within those guidelines that you all have prescribed for that.

The other challenge in Georgia is that we already have people through the checkout line whom we cannot provide for. It is not a matter of finding those who are still uninsured. We cannot provide for those there. We have some very unpalatable decisions facing us very quickly.

Senator STABENOW. I understand. And I do understand that resources are the number-one issue for covering children who have been identified.

Mr. Chairman, I think Ms. Smith wanted to respond. Would you mind?

The CHAIRMAN. Very briefly.

Senator STABENOW. Thank you.

The CHAIRMAN. Yes.

Ms. SMITH. I just wanted to add that in Iowa we have partnered with our free and reduced meals programs through the schools. We have put what we call a passive release on the applications. If families specifically say they do want information about the programs, then we send it to them, but it is still up to them to send it back.

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much.

Senator Roberts?

Senator ROBERTS. Job, I think you ought to run for office. [Laughter.]

The CHAIRMAN. Job, that is you. That is you.

Senator ROBERTS. Do you want to set up an exploratory committee? [Laughter.] Well, if you can't be a quarterback and you can't be a point guard and you can't run the 100-yard dash—and at my age I can't either. Of course, this is sort of a roller coaster business here, so I do not know if you want to do that. But you did a fine job, young man, and I truly appreciate it. Thank you so much. Good luck to you.

Let me just say that renewing this program is a top priority for all of us, and I am looking forward to working with all of my colleagues to make this reauthorization a reality, despite all the

bumps in the road that we have heard of today. The thing is, you have a set amount of funds that goes for 3 years.

States have flexibility, they take advantage of the flexibility, but you are supposed to redistribute those funds back to States that do not have enough for children. Children. Not adults, children. And I am not trying to quarrel with the States that are doing that with adults, at least to some degree.

I think you run a great risk in regards to granting waivers hither, thither and yon for States to do with what they want, because States will do that. So, I worry a little bit about that.

Let me just say that our CHIP/SCHIP and Medicaid programs in Kansas had a pilot project for something called "presumptive eligibility" for kids—pardon me, young people; I do not like "kids," I like "young people"—in three different sites, plans to expand the pilot State-wide.

The project allows each health care provider who cares for a presumptively eligible child to be reimbursed for medical services provided at the Medicaid reimbursement rate instead of having to provide uncompensated care. For the first 6 months, our young people were enrolled in either Medicaid or SCHIP as a result of this presumptive eligibility.

This has been a learning experience for our program in Kansas. The result from the pilot suggests the need for additional training, obviously, of our health care providers, monitoring, and our program improvement, mainly expanding an electronic eligibility tool before the program can be expanded State-wide.

Ms. Smith, are there similar efforts under way in the great State of Iowa?

Ms. SMITH. No. We do presumptive eligibility for pregnant women in Medicaid in Iowa, but we have not implemented anything.

Senator ROBERTS. What do you think, would this be helpful?

Ms. SMITH. Yes, I think it would be. Oftentimes the first time we know that a child may be eligible is when they are at the provider's office.

Senator ROBERTS. Right.

Well, then, we also have an effort in Kansas called a pilot Community Health Record, CHR. I do not know how to pronounce that acronym. It was launched last year in conjunction with the Cerner Corporation that is located in Kansas City to improve the quality, safety, and cost-effectiveness of care.

It is a web-based, secure—let me emphasize secure—application that allows the authorized providers online access to more than 12 months of data regarding a person's office visits, their hospitalizations, their medication, their immunizations, their screening.

So the clinic can really document the allergies and the screening information, and work is under way to incorporate the lab results into the CHR. Our physicians are also able to e-prescribe with this tool. So you just do not have to show up in the doctor's office, you can tell ahead.

Essentially it gives our providers a one-stop point of access for information on their patients, improving the quality of care for Kansans. Our feedback has been very positive. It emphasizes the simplicity and ease of the e-prescribing solution.

Let me just ask anybody there on the panel, more especially, Governor, do you have any similar efforts under way in the 16 States that you are representing, or is it 14?

Governor PERDUE. It is 16 States and two territories.

Senator ROBERTS. Sixteen and two territories.

Governor PERDUE. And we do have information taken——

Senator ROBERTS. You are not going to secede again, are you? [Laughter.]

Governor PERDUE. No, sir.

Senator ROBERTS. All right. Thank you.

Governor PERDUE. Depending on the outcome of SCHIP. [Laughter.]

Senator ROBERTS. Yes. All right. [Laughter.]

Governor PERDUE. But we are actively pursuing information technology efficiencies in health care, e-prescribing being one of them, transparent health records.

We are also doing something in Georgia that we think will help reconnect the patient and the provider, with the transparency of cost and value, quality assessments, and cost comparisons that customers—in health care, patients—can use to make evaluations on their own. That is what SCHIP allows, people to make those choices in those various providers for their care.

Senator ROBERTS. I am going to do my overtime 30 seconds, with the nod of the Chairman who does not know I am doing this. That Good Samaritan you talked about stopping by the way of the road, saying, "Please help this individual, and then, if that person needs more money, I can come back," we have a price tag that reaches as high as $60 billion. Sixty billion dollars to cover all eligible children.

We are looking at $12 to $15 billion now. I do not know where on earth we are going to get the money to do this for this very worthy cause, and I hope that we can do it on a step-by-step basis. But can you expand on this issue from your perspective of States that do not cover adults? I am not trying to pick on these people, but we have one State that covers more adults than they do children. I mean, is that Good Samaritan going to hand out the money to the adults as well as the kids—pardon me, young people—or is this SCHIP program as it is named, or what? What are we talking about here?

The CHAIRMAN. Very briefly, please, a very brief response.

Senator ROBERTS. I have his attention again.

The CHAIRMAN. I might point out that we have a vote at 11:55. There are three Senators who have not yet asked questions.

Senator ROBERTS. All right. A 10-word answer, Governor.

The CHAIRMAN. I am trying to budget all the rest of the Senators in here.

Senator ROBERTS. A 10-word answer.

Governor PERDUE. The name implies that it was a children's health program. I believe those children were already aggressively moved off on Medicaid and would not show up on those uninsured roles anyway. So, I am not sure how they contribute to the allocation. The allocation and the certainty are the key issues for Governors here.

Senator ROBERTS. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Next on my list is Senator Salazar.

Senator SALAZAR. Thank you very much, Chairman Baucus and Senator Grassley, for holding this hearing.

First, Job, let me just say that you should not form an exploratory committee, you should just run. [Laughter.] There would be lots of us who would be supporting you.

Second of all, I have two questions, one to Dr. Mann and one to Governor Perdue.

First, to Dr. Mann. As we look at this program and try to figure out how we reauthorize it and how we improve on it, one of the programs that I have been familiar with for many years in Colorado is called the Nurse Family Partnership Program. That is a program now that operates in 22 States. It is what we call a blueprint program. It has been thoroughly evaluated in terms of its results.

Very briefly, the results are, when you have this program and it is implemented, it reduces child abuse and neglect by 48 percent, reduces child arrests by 59 percent, reduces criminal convictions long-term by 70 percent, and the list goes on in terms of it being a very effective program.

Is it your opinion that, as we look at the reauthorization of CHIP, that that kind of a program is something we ought to look at relative to how we might be able to improve upon CHIP at this point?

Dr. MANN. I think programs like that, Senator, are very important links and keys to families, to look overall at what is going on in families. One of the things that I think is important is how to make sure, when we have visiting nurses programs and similar efforts, that part of their agenda, and that they get funded for it, is to look at the coverage of children.

One of the things that can be done with presumptive eligibility, for example, is to allow those visiting nurses and folks going into people's homes to not only inquire about health insurance, but actually to begin the process of signing the child up. So, I think there are lots of opportunities as we go forward to think about how to maximize some of the successes of that program and marry it with the potentials for CHIP to cover more children.

Senator SALAZAR. Thank you, Dr. Mann.

And to you, Governor Perdue, I am going to follow up on a question from Senator Baucus and from other members of the committee. On the one hand, I hear you and others on the panel saying, flexibility, flexibility.

I see what is happening in the States. Some require dental care, some require co-payments, some require premiums. But this is a program that we fund significantly, and we are going to be asked to fund it some more.

So between this flexibility perspective that many of the States have and the need for some kind of standards, tell us how far we ought to go in pushing for those standards. It seems to me that a poor kid who is uninsured in Georgia is no different than a poor kid who is uninsured in Colorado, Kentucky, Iowa, Montana, or Washington.

So if the goal here is to provide health insurance to the uninsured poor children of America at some level, why not push with very rigorous standards in terms of eligibility here as we reauthorize CHIP and forego the flexibility that you and other Governors have talked about?

Governor PERDUE. Well, if you will recall, Senator, flexibility was not nearly as important as funding, from our testimony. I think you would find Governors, in the Southern Governors Association and National Governors Association, very delighted in working with Congress on appropriate parameters in this program. I do not think we are asking for unlimited flexibility to do as we wish.

It is more important about certainty, about the partnership of funding, and about continuing to meet the needs of States who have been very aggressive and very successful in implementing the pure motive and mission of this program, and Georgia is one of those.

Senator SALAZAR. So your answer would be that you are all right with standards and parameters for the program, but you want certainty relative to be able to deal with funding requirements on down the road?

Governor PERDUE. I think you would find most Governors willing to accept. As the majority funding partner in this program, I think you would find most Governors willing to abide by those parameters. Certainly some flexibility is good in that, but I do not believe that flexibility should extend to adults. It is a children's health program. I think you would find Governors very willing to accept that and work within the confines of the program that Congress prescribes.

Senator SALAZAR. Has the National Governors Association come up with some recommendations on what those parameters might be?

Governor PERDUE. We are working with your policy staff now, and we will be glad to fine-tune those, as urgently as we need the program.

Senator SALAZAR. All right. I look forward to working with you, Governor Perdue, and with the NGA and your region.

Thank you very much, Chairman Baucus.

The CHAIRMAN. Thank you, Senator.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman. Thank you for holding this hearing, and for your attention to Washington State and for traveling out to Washington State last year to look at our State Children's Health Insurance Program.

Some of you may know that, in 1994, Washington State became one of the first States in the Nation to cover children up to 200 percent of the poverty level under Medicaid. But when the SCHIP program was implemented in 1997, there was a provision that basically penalized those States who were already covering children.

I should say not every single State, because a few States got grandfathered in. Some States like Washington got left out, which leads us then to the challenges of our State being on a different system than the rest of the Nation. Obviously, at times of State economic downturn, this puts our children at a disadvantage to other States.

So while I am glad we are having this larger discussion about adults, we are still at a disadvantage in Washington State with regards to children under 200 percent of the poverty level.

So, Dr. Mann, if you would comment on that. What eventually will happen to those children in our State, the disparity of treatment between Washington residents, in fact, being penalized for actually being forerunners to the Federal program?

Dr. MANN. I think that is a very important point, Senator Cantwell, and one that has been of concern and one that relates very directly to the discussion we have had this morning about parent coverage.

The first set of States that got parent waivers included two States, Minnesota and Rhode Island, that were in similar circumstances of Washington State. They had expanded their Medicaid programs for children.

They were pretty much blocked out of using their CHIP allotments for those children because of the previous good deeds, and so they said, well, we would like to help some low-income parents and do some family coverage, and those waivers, pursuant to some guidance that was issued pursuant to a specific authorization in the CHIP statute to issue waivers, was granted.

Each State's waivers are very different circumstances, and many of them reflect exactly the dilemma that Washington finds itself in. I understand your State has a pending waiver to do something similar.

One of the provisions that we have had temporarily in place in CHIP, but which I think needs to be looked at on a permanent basis, is to allow States that expanded coverage to children prior to CHIP being enacted, to be able to draw down some of their allotments for their children above certain income levels.

Senator CANTWELL. Well, we certainly would want to applaud States for being aggressive in trying to cover children, not penalize them. I think what people do not realize is, we literally could say these children are not covered for a year, and then the following year, then they would be eligible. But basically we would deny those children, during that year time period, the benefit of a program, which does not make sense either, I believe.

So, hopefully, Mr. Chairman, this is something that the committee can look at, address, and continue to work with the allotments that are basically sitting in an account, unable to be used because of this particular statute and the way it was written.

So, I thank the Chair.

The CHAIRMAN. Thank you, Senator.

Senator Bunning?

Senator BUNNING. Thank you, Mr. Chairman. Thank you for having this hearing.

Ms. Allen, you said in your testimony that, of the 18 States projected to have a shortfall of SCHIP dollars in one of the last 3 years of the program's authorization, that they were more likely to cover adults, cover children across broader incomes, and have a Medicaid component to their programs. Could you please expand on this?

Ms. ALLEN. Yes. We tried to look at a number of different characteristics of the shortfall States, and these were three that seemed to be characteristics more than some others.

But at the same time, we cannot draw any conclusions about causality specifically because, as you know, we have other panelists today from Iowa and Georgia who also have shortfalls, and they do not cover adults.

Senator BUNNING. I am about to ask them those questions.

Ms. ALLEN. Yes. So there are other reasons at play as well. In terms of these characteristics, the fact that 80 percent of the shortfall States, which are 15 of those 18 States, had Medicaid expansions or combination programs, that actually can be seen as both a good and a bad thing for States.

For example, once those States experience shortfalls, those children are still going to be covered if the States are covering them under their Medicaid programs, whereas, in a stand-alone program those children will not receive coverage. Once the CHIP allotments are exhausted, the children will not be covered. So, that is one way to look at the situation.

Senator BUNNING. All right.

Governor and Ms. Smith, I do not believe either of your States covers any adults under SCHIP. Some people have said that offering coverage to parents is an incentive for them to enroll their children in the program. Do you find that parents in your States are reluctant to enroll their kids if they cannot get coverage as well?

Governor PERDUE. Senator, we have not found that to be the case. Obviously it would be great if we could have the money and the funds to enroll the parents as well, but we do not have enough money to fund it for the children right now, and we think that is a priority of the Children's Health Insurance Program.

Senator BUNNING. That is the priority that we had when we passed the program.

Ms. Smith. Anectdotally, what we have heard from families is, once they are assured that their children have coverage, they feel that they can then get coverage on their own through their employer or through a personal plan, or whatever.

But we have heard from families that it is just knowing that their children are covered and they do not have to worry about medical expenses, that they are willing to then spend the money to get insurance for themselves.

Governor PERDUE. I think the Bedford's testimony is the more likely case: when you protect the kids, we will care for ourselves. That is what they have testified to.

Senator BUNNING. I think that is why the program was designed the way it was designed, I believe, to start with.

Ms. Smith, you said in your testimony that some families who qualify for Medicaid choose to go without coverage if they cannot enroll in the Iowa SCHIP program. How does your department combat this mind-set?

Ms. SMITH. We have done several things. We have changed our application to highlight the benefits of Medicaid over the CHIP program. We point out that they can get more benefits, that they can get up to 3 months of retroactive coverage.

We also have workers that, if somebody indicates that on an application, they actually call them up and try to explain the benefits of the Medicaid program over the CHIP program.

Senator BUNNING. Lastly, Governor Perdue, you said in your testimony that Georgia has a strict rule about families paying their premiums on time. What has the result of this been?

Governor PERDUE. I think it has trained people to be personally responsible as they move off to other insurance programs. We had a severe drop-off initially and then we have had very little effect afterwards by people paying it.

When we instituted a premium policy, people learned very quickly that it was not voluntary. They are complying with a high degree of compliance. We think it is healthy. We think they have some proactive issues and "skin in the game" that makes this program work even better.

Senator BUNNING. In other words, that might be applicable to other States, too?

Governor PERDUE. It has worked well for Georgia.

Senator BUNNING. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Just very briefly, Dr. Mann, could you just address a little bit, I guess, that some Medicaid benefits are better than CHIP benefits, primarily. Right?

Dr. MANN. In some States, yes.

The CHAIRMAN. In some States. Some or most?

Dr. MANN. In most States they are better, some States they are the same.

The CHAIRMAN. All right.

Let me see if I understand this. One question. If they are better, why do States not provide more coverage under Medicaid? Is there a stigma attached to Medicaid? What is going on here? I do not quite understand.

Dr. MANN. Well, Medicaid is the much broader program, much larger program. States do provide coverage to children under Medicaid. Twenty-eight million kids—young people—are covered under Medicaid compared to 6 million under the State Children's Health Insurance Program.

So, that really is the bedrock of our public coverage system for children. I think the issue of stigma has really been one that most States have addressed over the years.

I think it was a much bigger issue in 1997 when we were starting the State Health Insurance Program because we had Medicaid kind of locked into the old ages of how people applied. It was attached to the welfare office and it was a 28-page application, and it had a lot of extra forms and verification. But most States moved away from that.

You have States like many represented by Senators on this panel, States like Massachusetts, Maine, Kansas, where they have a Medicaid program—Washington State also—and a separate CHIP program, but they are hand in hand and you really cannot tell, as a family outside or as a provider, which is which.

There is nothing really in Federal law that would prevent the State from carrying over some of the family-friendly aspects that they saw as so important in SCHIP to the Medicaid program. Many States have done that. Not all States have done it fully, but part of it is a funding question.

I think in the next period of time, one of the things we should think about in CHIP reauthorization is ensuring how we can make sure that those barriers are gone in both programs, because they need not be there for any family.

The CHAIRMAN. This hearing, to me, begs another deeper question, and that is about the lack of sufficient health insurance coverage generally in this country. Some suggest we get at it by expanding CHIP, which probably is practically about the only option available in the short term today.

My time has expired here. Any thoughts you have, just generally, about whether this is a good way to expand coverage, that is, try to expand CHIP?

Dr. MANN. It has clearly been a wonderful way to expand coverage to children. We have had a very strong track record. There are few programs where we can look back and say, in a very bipartisan way with very strong public support, that it has worked.

It has done what we asked it to do with Medicaid as its partner in terms of covering children. It is not the panacea for the Nation, but it has worked. It has worked for some parents.

The CHAIRMAN. Right.

Dr. MANN. I want to point out, Senator, if I can, that the discussion about adults needs to be put in perspective. There are about 631,000 adults covered in this program, pregnant women and some parents.

The CHAIRMAN. Right.

Dr. MANN. Compared to an overall number of 6 million. The program is primarily about kids. It has a good track record, and I think it does provide a great vehicle for moving forward.

The CHAIRMAN. Great. This is not fair to you, Job, but you get a chance to give the last word here, what you think about all of this. What is your impression of all this hearing? I am just curious. You have talked to your parents about all this, and you have gone through a lot with your parents, and you made a great statement about the problems with asthma and how much this program has helped you. But has anybody said anything here that kind of makes sense?

Mr. Job BEDFORD. What the Governor said about being a Good Samaritan. He said we should care about others. We should bring them to the hospital and pay a little extra, just help them out. I think that is what CHIP is trying to do, and I think we should fund it a little bit more to help it out.

The CHAIRMAN. Nobody could say it better. Thank you very much.

[Applause.]

The CHAIRMAN. I thank the panelists. Thank you.

Governor PERDUE. One last comment, Mr. Chairman. Time is of the essence.

The CHAIRMAN. It is. We know. Thank you. Thank you.

[Whereupon, at 11:57 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

United States Government Accountability Office

GAO

Testimony
Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EST
Thursday, February 1, 2007

CHILDREN'S HEALTH INSURANCE

State Experiences in Implementing SCHIP and Considerations for Reauthorization

Statement of Kathryn G. Allen
Director, Health Care

On March 12, 2007, table 3 on page 22 was revised, primarily to eliminate the state of Utah, which does not use SCHIP funds for adult coverage. Removing Utah from this table resulted in changes to the text on the Highlights page, as well as pages 3, 12, 21, 31, 33, and 35. See next page for more details.

GAO-07-447T

Children's Health Insurance: State Experiences in Implementing SCHIP and Considerations for Reauthorization (GAO-07-447T)

Changes by Line Number

Page	Line no.	Change
Highlights (under "What GAO Found")	15	Replace "January" with "February"
	16	Replace "15" with "14"
p. 3	13	Replace "January" with "February"
	14	Replace "15" with "14"
p. 12	14	Replace "January" with "February" and "15" with "14"
p. 21	24	Replace "January" with "February"
	25	Replace "15" with "14"
p. 22 (table 3) Arkansas	6	In the Childless Adults, remove checkmark
Illinois	11	Under Percentage of FPL, delete "200 (parents);" and (childless"
Illinois	12	Under Percentage of FPL, delete "adults)"
Oregon	19	Under Pregnant Women, remove checkmark; Under Childless Adults, add checkmark
Utah	22	Delete this row from the table
Virginia	23	Replace "200" with "166"
	25	Replace "GAO analysis of waiver documents and correspondence" with "CMS"; and replace "January" with "February"
p. 31 Footnote 43	1	Replace "January" with "February" and "15" with "14"
Footnote 43	2-3	Delete "One state, Utah, had an approved waiver but had not yet implemented it.";
Footnote 43	3	Replace "additional" with "of the 14"
p. 33	23	Replace "January" with "February" and "15" with "14"
	24	Replace "Six" with "Five" and "15" with "14"
	26	Replace "three" with "two"
	28	Delete ", while Utah had not implemented its approved waiver"
p. 35	24	Replace "15" with "14"

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Highlights

Highlights of GAO-07-447T, a testimony before the Committee on Finance, U.S. Senate

Why GAO Did This Study

In August 1997, Congress created the State Children's Health Insurance Program (SCHIP) with the goal of significantly reducing the number of low-income uninsured children, especially those who lived in families with incomes exceeding Medicaid eligibility requirements. Unlike Medicaid, SCHIP is not an entitlement to services for beneficiaries but a capped allotment to states. Congress provided a fixed amount—$40 billion from 1998 through 2007—to states with approved SCHIP plans. Funds are allocated to states annually. States have 3 years to use each year's allocation, after which unspent funds may be redistributed to states that have already spent all of that year's allocation.

GAO's testimony addresses trends in SCHIP enrollment and the current composition of SCHIP programs across the states, states' spending experiences under SCHIP, and considerations GAO has identified for SCHIP reauthorization.

GAO's testimony is based on its prior work; analysis of the Current Population Survey, a monthly survey conducted by the U.S. Census Bureau (2003-2005); information from states' annual SCHIP reports (2002-2005); and SCHIP enrollment and expenditure data from the Centers for Medicare & Medicaid Services (1998-2005).

www.gao.gov/cgi-bin/getrpt?GAO-07-447T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

February 1, 2007

CHILDREN'S HEALTH INSURANCE

State Experiences in Implementing SCHIP and Considerations for Reauthorization

What GAO Found

SCHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. As of fiscal year 2005, the latest year for which data were available, SCHIP covered approximately 6 million enrollees, including about 639,000 adults, with about 4.0 million enrollees in June of that year. States' SCHIP programs reflect the flexibility the statute allows in structuring approaches to providing health care coverage. As of July 2006, states had opted for the following from among their choices of program structures allowed: a separate child health program (18 states), an expansion of a state's Medicaid program (11), or a combination of the two (21). In addition, 41 states opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher, with 7 of these states covering children in families with incomes at 300 percent of FPL or higher. Thirty-nine states required families to contribute to the cost of their children's care in SCHIP programs through a cost-sharing requirement, such as a premium or copayment; 11 states charged no cost-sharing. As of February 2007, GAO identified 14 states that had waivers in place to cover adults in their programs; these included parents of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

SCHIP spending was initially low, but now threatens to exceed available funding. Since 1998, some states have consistently spent more than their allotments, while others spent consistently less. States that earlier overspent their annual allotments over the 3-year period of availability could rely on other states' unspent SCHIP funds, which were redistributed to cover other states' excess expenditures. By fiscal year 2002, however, states' aggregate annual spending began to exceed annual allotments. As spending has grown, the pool of funds available for redistribution has shrunk. As a result, 18 states were projected to have "shortfalls" of SCHIP funds—meaning they had exhausted all available funds—in at least one of the final 3 years of the program. These 18 states were more likely than the 32 states without shortfalls to have a Medicaid component to their SCHIP programs, cover children across a broader range of income groups, and cover adults in their programs. To cover projected shortfalls faced by several states, Congress appropriated an additional $283 million for fiscal year 2006.

SCHIP reauthorization occurs in the context of debate on broader national health care reform and competing budgetary priorities, highlighting the tension between the desire to provide affordable health insurance coverage to uninsured individuals, including low-income children, and the recognition of the growing strain of health care coverage on federal and state budgets. As Congress addresses reauthorization, issues to consider include (1) maintaining flexibility within the program without compromising the primary goal to cover children, (2) considering the program's financing strategy, including the financial sustainability of public commitments, and (3) assessing issues associated with equity, including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you address the reauthorization of the State Children's Health Insurance Program (SCHIP). In August 1997, Congress created SCHIP with the goal of significantly reducing the number of low-income uninsured children.[1] Prior to SCHIP, approximately 19 million Medicaid beneficiaries were children, and combined federal and state expenditures on their behalf totaled $32 billion. However, there remained an estimated 9 million to 11.6 million children who were uninsured at some time during 1997. SCHIP was established to provide health coverage to uninsured children in families whose incomes exceeded the eligibility requirements for Medicaid. Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses.

SCHIP offers states flexibility in how they provide health insurance coverage to children. States implementing SCHIP have three approaches in designing their programs: (1) a Medicaid expansion, which affords SCHIP-eligible children the same benefits and services that a state's Medicaid program provides; (2) a separate child health program distinct from Medicaid that uses, for example, specified public or private insurance plans; and (3) a combination program, which has a Medicaid expansion and a separate child health program. At the time of enactment, Congress appropriated a fixed amount of funds—approximately $40 billion from 1998 through 2007—to be distributed among states with approved SCHIP plans. Unlike Medicaid, SCHIP is not an entitlement to services for beneficiaries, but a capped grant—or allotment—to states. SCHIP funds are allocated annually to the 50 states, the District of Columbia, and the U.S. commonwealths and territories.[2] Each state's annual SCHIP allotment is available as a federal match based on state expenditures and is available for 3 years, after which time any unspent

[1]Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552-570 (Aug. 5, 1997) (adding Title XXI and new sections 2101-2110 to the Social Security Act, codified, as amended, at 42 U.S.C. §§ 1397aa-1397jj). For the remainder of this report, we will only refer to provisions of the U.S. Code when referencing SCHIP requirements.

[2]This testimony focuses on SCHIP programs in the 50 states and the District of Columbia. Tennessee did not have a SCHIP program, as of October 2002. However, on September 6, 2006, the state submitted a SCHIP plan for Centers for Medicare & Medicaid Services (CMS) approval.

funds may be redistributed to states that have already spent their allotments.[3]

As Congress considers reauthorization of the SCHIP program, my remarks will address (1) recent data regarding trends in SCHIP enrollment and the estimated number of children who remain uninsured, (2) the current composition of SCHIP programs—including their overall design—across the states, (3) states' spending experiences under SCHIP, and (4) issues we have identified for consideration during SCHIP reauthorization. My testimony is based on prior GAO work;[4] analysis of the Current Population Survey (CPS) data (from 2003 through 2005), which is a monthly survey conducted by the U.S. Census Bureau for the Bureau of Labor statistics; information obtained from states' annual SCHIP reports (from fiscal year 2002 through 2005);[5] and SCHIP enrollment and expenditure data (from fiscal year 1998 through 2005), from the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS), which oversees states' Medicaid and SCHIP programs. We considered these data sufficiently reliable for purposes of reporting overall expenditure trends in SCHIP. We discussed the highlights of this statement with CMS officials, and they provided us additional information, which we incorporated as appropriate. We conducted our work from December 2006 through January 2007 in accordance with generally accepted government auditing standards.

In summary, SCHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. SCHIP programs reported total enrollment of approximately 6 million individuals—including about 639,000 adults—as of fiscal year 2005, the latest year for which data were available, with about 4.0 million individuals enrolled in June of that year. Nevertheless, about 11.7 percent of children nationwide remain uninsured, many of whom are eligible for SCHIP or Medicaid. The rate of uninsured children varies widely across states, ranging from a low of 5.6 percent to a high of 20.4 percent.

[3]In some cases, states have been allowed to retain a portion of unspent allotments.

[4]Related GAO Products are included at the end of this statement.

[5]Federal law requires states to assess the operation of their state child health plans and report to the Secretary of Health and Human Services on the results of the assessment. In addition, as part of this assessment, states must evaluate the progress made in reducing the number of uncovered, low-income children. See 42 U.S.C. § 1397hh.

States' SCHIP programs reflect the flexibility allowed in structuring approaches to providing health care coverage through a Medicaid expansion or a separate child health program. In fiscal year 2005, 41 states had opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher; including 7 states that covered children in families with incomes at 300 percent of FPL or higher. In addition, 39 states required families to contribute to the cost of their children's care in SCHIP programs through some type of cost-sharing requirement, such as premiums or copayments; 11 states charged no cost-sharing. Few states (9) reported operating premium assistance programs, which allow states to use SCHIP funds to help pay premiums for available employer-based health plan coverage, in part because states often find these programs are difficult to administer. As of February 2007, we identified 14 states that had approved waivers to cover one or more of three categories of adults: parents of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

SCHIP program spending was low initially but now threatens to exceed available funding. Since 1998, some states have consistently spent more than their allotments, while others consistently spent less. In the first years of the program, states that overspent their annual allotments over the 3-year period of availability could rely on other states' unspent SCHIP funds, which were redistributed to cover excess expenditures. Over time, however, spending had grown, and the pool of funds available for redistribution had shrunk. As a result, in at least one of the final 3 years of the program, 18 states were projected to have "shortfalls" of SCHIP funding—that is, they were expected to exhaust available funds, including current and prior-year allotments. These 18 states were more likely than the 32 states without shortfalls to have a Medicaid component to their SCHIP program, to cover children across a broader range of income groups, and to cover adults through their programs. To cover projected shortfalls faced by states, Congress appropriated an additional $283 million for fiscal year 2006.

SCHIP reauthorization is occurring within the context of consideration of broader national health care reform and competing budgetary priorities. There is an obvious tension between the desire to provide affordable health insurance coverage for uninsured individuals, including low-income children, and the recognition of the high cost that health care coverage exerts as a growing share of federal and state budgets. As Congress addresses SCHIP reauthorization, issues that may be considered include (1) maintaining flexibility within the program without compromising the primary goal to cover children, (2) considering the program's financing

strategy, including the financial sustainability of public commitments, and (3) assessing issues including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

Background

In general, SCHIP funds are targeted to uninsured children in families whose incomes are too high to qualify for Medicaid but are at or below 200 percent of FPL.[6] Recognizing the variability in state Medicaid programs, federal SCHIP law allows a state to cover children up to 200 percent of the poverty level or 50 percentage points above its existing Medicaid eligibility standard as of March 31, 1997.[7] Additional flexibility regarding eligibility levels is available, however, as Medicaid and SCHIP provide some flexibility in how a state defines income for purposes of eligibility determinations.[8] Congress appropriated approximately $40 billion over 10 years (from fiscal year 1998 through 2007) for distribution among states with approved SCHIP plans. Allocations to states are based on a formula that takes into account the number of low-income children in a state. In general, states that choose to expand Medicaid to enroll eligible children under SCHIP must follow Medicaid rules, while separate child health programs have additional flexibilities in benefits, cost-sharing, and other program elements. Under certain circumstances, states may also cover adults under SCHIP.

SCHIP Allotments to States

SCHIP allotments to states are based on an allocation formula that uses (1) the number of children, which is expressed as a combination of two estimates—the number of low-income children without health insurance and the number of all low-income children, and (2) a factor representing

[6]FPL refers to the federal poverty guidelines, which are used to establish eligibility for certain federal assistance programs. The guidelines are updated annually to reflect changes in the cost of living and vary according to family size. For example, in 1998, 200 percent of FPL for a family of four was $32,900, compared with $41,300 in 2007.

[7]42 U.S.C. § 1397jj(b). For example, Alabama covered children aged 15 to 18 up to 15 percent of FPL, while Washington covered this same group up to 200 percent of FPL. Therefore, Alabama would be allowed to establish SCHIP eligibility for children in families with incomes up to 200 percent of FPL, while Washington would be allowed to go as high as 250 percent FPL.

[8]Some states have expanded income eligibility levels for families through "income disregards," which ignore certain types of family income for purposes of determining eligibility. Such disregards have been imposed as high as 100 percent of FPL, which means that a family with an income equal to 300 percent of FPL is treated as if its income were 200 percent of FPL.

state variation in health care costs. Under federal SCHIP law and subject to certain exceptions, states have 3 years to use each fiscal year's allocation, after which any remaining funds are redistributed among the states that had used all of that fiscal year's allocation.[9] Federal law does not specify a redistribution formula but leaves it to the Secretary of Health and Human Services to determine an appropriate procedure for redistribution of unused allocations.[10] Absent congressional action, states are generally provided 1 year to spend any redistributed funds, after which time funds may revert to the U.S. Treasury. Each state's SCHIP allotment is available as a federal match based on state expenditures. SCHIP offers a strong incentive for states to participate by providing an enhanced federal matching rate that is based on the federal matching rate for a state's Medicaid program—for example, the federal government will reimburse at a 65 percent match under SCHIP for a state receiving a 50 percent match under Medicaid.

There are different formulas for allocating funds to states, depending on the fiscal year. For fiscal years 1998 and 1999, the formula used estimates of the number of low-income uninsured children to allocate funds to states. For fiscal year 2000, the formula changed to include estimates of the total number of low-income children as well.[11]

SCHIP Design Choices

SCHIP gives the states the choice of three design approaches: (1) a Medicaid expansion program, (2) a separate child health program with more flexible rules and increased financial control over expenditures, or (3) a combination program, which has both a Medicaid expansion program and a separate child health program. Initially, states had until September 30, 1998, to select a design approach, submit their SCHIP plans, and obtain HHS approval in order to qualify for their fiscal year 1998

[9]42 U.S.C. § 1397dd(e),(f).

[10]42 U.S.C. § 1397dd(f).

[11]For fiscal year 2000, the allocation formula used 75 percent of the number of uninsured low-income children plus 25 percent of the number of all low-income children. For fiscal year 2001 and subsequent fiscal years, the allocation formula evenly weighted the number of uninsured low-income children (50 percent) and total number of low-income children (50 percent). 42 U.S.C. § 1397dd(b). See also Congressional Research Service (CRS), *SCHIP Original Allotments: Funding Formula Issues and Options* (Washington, D.C.: Apr. 18, 2006).

allotment.[12] With an approved state child health plan, a state could begin to enroll children and draw down its SCHIP funds.

The design approach a state chooses has important financial and programmatic consequences, as shown below.

- **Expenditures.** In separate child health programs, federal matching funds cease after a state expends its allotment, and non-benefit-related expenses (for administration, direct services, and outreach) are limited to 10 percent of claims for services delivered to beneficiaries. In contrast, Medicaid expansion programs may continue to receive federal funds for benefits and for non-benefit-related expenses at the Medicaid matching rate after states exhaust their SCHIP allotments.

- **Enrollment.** Separate child health programs may establish separate eligibility rules and establish enrollment caps. In addition, a separate child health program may limit its own annual contribution, create waiting lists, or stop enrollment once the funds it budgeted for SCHIP are exhausted. A Medicaid expansion must follow Medicaid eligibility rules regarding income, residency, and disability status, and thus cannot limit enrollment.

- **Benefits.** Separate child health programs must use, for example, benchmark benefit standards that use specified private or public insurance plans as the basis for coverage. However, Medicaid—and therefore a Medicaid expansion—must provide coverage of all benefits available to the Medicaid population, including certain services for children. In particular, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requires states to cover treatments or stabilize conditions diagnosed during routine screenings—regardless of whether the benefit would otherwise be covered under the state's Medicaid program.[13] A separate child health program does not require EPSDT coverage.

[12]In May 1998, Congress extended this deadline, allowing states to receive fiscal year 1998 funding if they had submitted and received approval of a state child health plan by September 30, 1999. 1998 Supplemental Appropriations and Rescissions Act, Pub. L. No. 105-174, § 4001, 112 Stat. 1500 (May 1, 1998).

[13]While coverage of EPSDT is difficult to measure, federal studies have generally found state efforts to be inadequate. See GAO, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001).

- **Beneficiary cost-sharing.** Separate child health programs may impose limited cost-sharing—through premiums, copayments, or enrollment fees—for children in families with incomes above 150 percent of FPL up to 5 percent of family income annually. Since the Medicaid program did not previously allow cost-sharing for children, a Medicaid expansion program under SCHIP would have followed this rule.[14]

SCHIP Coverage of Adults

In general, states may cover adults under the SCHIP program under two key approaches.

- First, federal SCHIP law allows the coverage of adults in families with children eligible for SCHIP if a state can show that it is cost-effective to do so and demonstrates that such coverage does not result in "crowd-out"—a phenomenon in which new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.[15] The cost-effectiveness test requires the states to demonstrate that covering both adults and children in a family under SCHIP is no more expensive than covering only the children. The states may also elect to cover children whose parents have access to employer-based or private health insurance coverage by using SCHIP funding to subsidize the cost.

- Second, under section 1115 of the Social Security Act, states may receive approval to waive certain Medicaid or SCHIP requirements. The Secretary of Health and Human Services may approve waivers of statutory requirements in the case of experimental, pilot, or demonstration projects that are likely to promote program objectives.[16] In August 2001, HHS indicated that it would allow states greater latitude in using section 1115 demonstration projects (or waivers) to modify their Medicaid and SCHIP programs and that it would expedite consideration of state proposals. One initiative, the Health Insurance Flexibility and Accountability Initiative (HIFA), focuses on proposals for covering more uninsured people while at the same time not raising program costs. States have received approval of

[14]As of March 31, 2006, states may impose cost sharing for children whom the state has chosen to cover under Medicaid. 42 U.S.C. § 1396o-1. If a state imposes cost sharing for Medicaid, a Medicaid expansion program for SCHIP eligible children would follow this rule.

[15]42 U.S.C. § 1397ee(c)(3).

[16]42 U.S.C. § 1315.

section 1115 waivers that provide coverage of adults using SCHIP funding.[17]

SCHIP Enrollment Has Grown Rapidly; States' Rates of Uninsured Children Vary Significantly

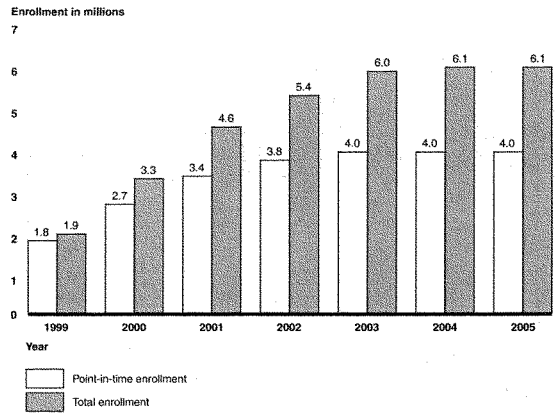
SCHIP enrollment increased rapidly over the first years of the program, and has stabilized for the past several years. In 2005, the most recent year for which data are available, 4.0 million individuals were enrolled during the month of June, while the total enrollment count—which represents a cumulative count of individuals enrolled at any time during fiscal year 2005—was 6.1 million. Of these 6.1 million enrollees, 639,000 were adults. Because SCHIP requires that applicants are first screened for Medicaid eligibility, some states have experienced increases in their Medicaid programs as well, further contributing to public health insurance coverage of low-income children during this same period. Based on a 3-year average of 2003 through 2005 CPS data, the percentage of uninsured children varied considerably by state, with a national average of 11.7 percent.

SCHIP annual enrollment grew quickly from program inception through 2002 and then stabilized at about 4 million from 2003 through 2005, on the basis of a point-in-time enrollment count. Total enrollment, which counts individuals enrolled at any time during a particular fiscal year, showed a similar pattern of growth and was over 6 million as of June 2005 (see fig. 1).[18] Generally, point-in-time enrollment is a subset of total enrollment, as it represents the number of individuals enrolled during a particular month. In contrast, total enrollment includes an unduplicated count of any individual enrolled at any time during the fiscal year; thus the data are cumulative, with new enrollments occurring monthly.

[17]As of October 1, 2005, the Secretary of Health and Human Services was prohibited from approving new section 1115 waivers that use SCHIP funds to provide coverage of nonpregnant childless adults. See Deficit Reduction Act of 2006 (DRA), Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397gg).

[18]The 4 million enrollment count is based on "point-in-time enrollment," representing the number of enrollees in states' SCHIP programs for the month of December for 1999 through 2004; for 2005, data for the month of June were used. See Vernon K. Smith, David Rousseau, and Caryn Marks, *SCHIP Program Enrollment: June 2005 Update* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, December 2006). The total enrollment count reflects all enrollees in the SCHIP program for fiscal years 1999 through 2005. See, for example, the 2005 annual enrollment report, at http://www.cms.hhs.gov/NationalSCHIPPolicy/06_SCHIPAnnualReports.asp (downloaded Jan. 28, 2007).

Figure 1: SCHIP Enrollment, 1999-2005



Source: CMS and state enrollment data

Note: Point-in-time enrollment represents the number of enrollees in states' SCHIP programs for the month of December for 1999 through 2004; for 2005, data for the month of June were used. Total enrollment represents the cumulative number of individuals who enrolled in the program at any time during the fiscal year. We obtained enrollment data from Vernon K. Smith, David Rousseau, and Caryn Marks, *SCHIP Program Enrollment: June 2005 Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, December 2006); Vernon K. Smith and David M. Rousseau, *SCHIP Enrollment in 50 States: December 2004 Data Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, September 2005); and Vernon K. Smith, David M. Rousseau, and Molly O'Malley, *SCHIP Program Enrollment: December 2003 Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2004).

Because states must also screen for Medicaid eligibility before enrolling children into SCHIP, some states have noted increased enrollment in Medicaid as a result of SCHIP. For example, Alabama reported a net increase of approximately 121,000 children in Medicaid since its SCHIP program began in 1998. New York reported that, for fiscal year 2005, approximately 204,000 children were enrolled in Medicaid as a result of outreach activities, compared with 618,973 children enrolled in SCHIP. In contrast, not all states found that their Medicaid enrollment was significantly affected by SCHIP. For example, Idaho reported that a negligible number of children were found eligible for Medicaid as a result

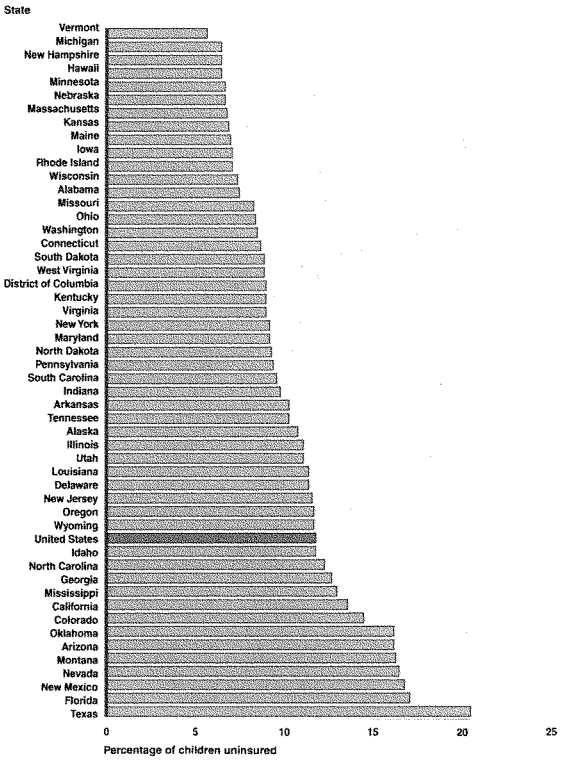
of outreach related to its SCHIP program. Maryland identified an increase of 0.2 percent between June 2004 and June 2005.

Based on a 3-year average of 2003 through 2005 CPS data, the percentage of uninsured children varied considerably by state and had a national average of 11.7 percent.[19] The percentage of uninsured children ranged from 5.6 percent in Vermont to 20.4 percent in Texas (see fig. 2).[20] Generally, the proportion of children without insurance tended to be lower in the Midwest or Northeast and higher in the South and the West.

[19]Estimates of the number of uninsured children are derived from the annual health insurance supplement to the CPS. Health insurance information is collected through the Annual Social and Economic Supplement, formerly termed the March supplement.

[20]Because sample sizes can be relatively small in less populous states, state estimates are developed using a 3-year average, which is the same method used in the formula to allocate funds to states for SCHIP. Since the authorization of SCHIP in 1997, there have been changes to the CPS. In March 2001, the CPS sample was expanded, which was expected to result in more precise state estimates of individuals' health insurance status for all states.

Figure 2: Percentage of Uninsured Children, by State, 2003-2005



Source: GAO analysis of CPS data, 3-year average (2003 through 2005).

States' SCHIP Programs Reflect a Variety of Approaches to Providing Health Care Coverage

States' SCHIP programs reflect the flexibility allowed in structuring approaches to providing health care coverage, including their choice among three program designs—Medicaid expansions, separate child health programs, and combination programs, which have both a Medicaid expansion and a separate child health program component. As of fiscal year 2005, 41 state SCHIP programs covered children in families whose incomes are up to 200 percent FPL or higher, with 7 of the 41 states covering children in families whose incomes are at 300 percent FPL or higher. States generally imposed some type of cost-sharing in their programs, with 39 states charging some combination of premiums, copayments, or enrollment fees, compared with 11 states that did not charge cost-sharing. Nine states reported operating premium assistance programs that use SCHIP funding to subsidize the cost of premiums for private health insurance coverage. As of February 2007, we identified 14 states with approved section 1115 waivers to cover adults, including parents, pregnant women, and, in some cases, childless adults.

States Employ All Three Design Approaches, with Coverage Generally Extending to 200 Percent of FPL

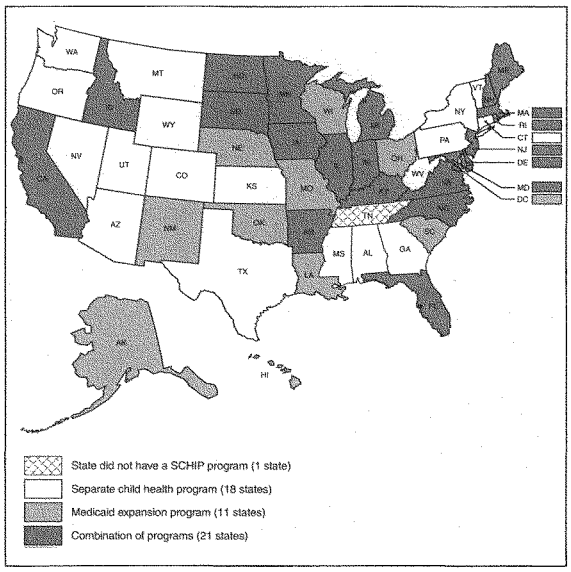
Of the 50 states currently operating SCHIP programs, as of July 2006, 11 states had Medicaid expansion programs, 18 states had separate child health programs, and 21 states had a combination of both approaches (see fig. 3).[21] When the states initially designed their SCHIP programs, 27 states opted for expansions to their Medicaid programs.[22] Many of these initial Medicaid expansion programs served as "placeholders" for the state—that is, minimal expansions in Medicaid eligibility were used to guarantee the 1998 fiscal year SCHIP allocation while allowing time for the state to plan a separate child health program. Other initial Medicaid expansions—whether placeholders or part of a combination program—also accelerated the expansion of coverage for children aged 14 to 18 up to 100 percent of FPL, which states are already required to cover under federal Medicaid law.[23]

[21]The 50 states include the District of Columbia. Tennessee did not have a SCHIP program, as of October 1, 2002. On September 6, 2006, however, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL.

[22]See GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999).

[23]42 U.S.C. § 1396a(a)(10)(A)(i)(vii) requires states to provide Medicaid coverage to children born after September 30, 1983, aged 6 to 18.

Figure 3: State SCHIP Design Choices as of July 2006



Source: Copyright © Corel Corp. All rights reserved (map), GAO analysis of CMS data.

A state's starting point for SCHIP eligibility is dependent upon the eligibility levels previously established in its Medicaid program. Under federal Medicaid law, all state Medicaid programs must cover children aged 5 and under if their family incomes are at or below 133 percent of FPL and children aged 6 through 18 if their family incomes are at or below 100 percent of FPL.[24] Some states have chosen to cover children in families

[24]42 U.S.C. § 1396a(a)(10)(A)(i), (iv), (vi), (vii).

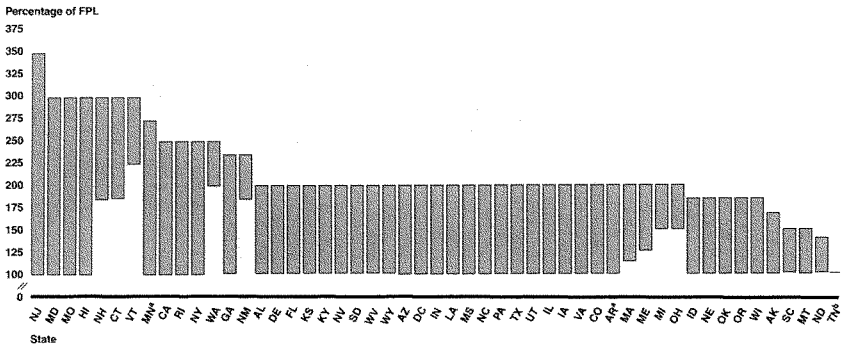
with higher income levels in their Medicaid programs.[25] Each state's starting point essentially creates a "corridor"—generally, SCHIP coverage begins where Medicaid ends and then continues upward, depending on each state's eligibility policy.[26]

In fiscal year 2005, 41 states used SCHIP funding to cover children in families with incomes up to 200 percent of FPL or higher, including 7 states that covered children in families with incomes up to 300 percent of FPL or higher. In total, 27 states provided SCHIP coverage for children in families with incomes up to 200 percent of FPL, which was $38,700 for a family of four in 2005. Another 14 states covered children in families with incomes above 200 percent of FPL, with New Jersey reaching as high as 350 percent of FPL in its separate child health program. Finally, 9 states set SCHIP eligibility levels for children in families with incomes below 200 percent of FPL. For example, North Dakota covered children in its separate child health program up to 140 percent of FPL. (See fig. 4.)

[25]States also have the option under federal Medicaid law to extend coverage of children in families with incomes at or below 185 percent of FPL, or even at higher income levels under a section 1115 waiver. 42 U.S.C. §§ 1315, 1396a(a)(10)(A)(ii)(ix).

[26]The corridor represents the FPL levels in states' SCHIP programs above the levels offered by their Medicaid programs. A state's starting point for SCHIP eligibility is dependent on the eligibility levels previously established in their Medicaid programs. However, states' SCHIP programs may provide coverage to individuals who have incomes at the Medicaid level if they cannot qualify for Medicaid. For example, states may offer SCHIP coverage to individuals whose incomes are at the Medicaid level, but who cannot qualify for Medicaid because they cannot meet citizenship or other Medicaid eligibility requirements.

Figure 4: Corridor of SCHIP Eligibility for Children Aged 6 through 18 Years, Fiscal Year 2005



Source: GAO analysis of states' annual SCHIP reports for 2005 and the National Academy for State Health Policy

Note: The corridor represents the FPL levels in states' SCHIP programs above the levels offered by their Medicaid programs. A state's starting point for SCHIP eligibility is dependent on the eligibility levels previously established in its Medicaid programs. However, states' SCHIP programs may provide coverage to individuals who have incomes at the Medicaid level if they cannot qualify for Medicaid. For example, states may offer SCHIP coverage to individuals whose incomes are at the Medicaid level, but who cannot qualify for Medicaid because they cannot meet citizenship or other Medicaid eligibility requirements. In some cases, we obtained data from Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

[a]State did not have an FPL eligibility level for SCHIP that was above its Medicaid eligibility level for this age group because its Medicaid program also covered children up to this FPL level. The state provided SCHIP coverage to individuals whose incomes are at the Medicaid level but who cannot qualify for Medicaid because of citizenship or other requirements.

[b]Tennessee did not have a SCHIP program, as of October 2002. However, on September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL.

Separate Child Health Program Benefit Packages Reflect the Full Range of SCHIP Options

Under federal SCHIP law, states with separate child health programs have the option of using different bases for establishing their benefit packages. Separate child health programs can choose to base their benefit packages on (1) one of several benchmarks specified in federal SCHIP law, such as the Federal Employees Health Benefits Program (FEHBP) or state employee coverage; (2) a benchmark-equivalent set of services specified in the statute; (3) coverage equivalent to state-funded child health programs

in Florida, New York, or Pennsylvania; or (4) a benefit package approved by the Secretary of Health and Human Services (see table 1).

Table 1: Basis for Required Scope of Health Insurance Coverage for States with Separate Child Health Programs

Basis of coverage	Description	State
Benchmark (14 states)	Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield standard option, or coverage generally available to state employees, or coverage under the states' health maintenance organization with the largest insured commercial non-Medicaid enrollment.	Alabama, California, Connecticut, Delaware, Iowa,[a] Kansas, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, North Carolina, Texas
Benchmark-equivalent (12 states)	Basic coverage for inpatient and outpatient hospital, physicians' surgical and medical, laboratory and x-ray, and well-baby and well-child care, including age-appropriate immunizations. Coverage must be equal to the value of benchmark coverage.	Colorado, Georgia, Illinois, Indiana, Iowa,[a] Kentucky, Montana, North Dakota, Rhode Island, Utah, Virginia, West Virginia
Existing comprehensive state coverage (3 states)	Coverage equivalent to state-funded child health programs in Florida, New York, or Pennsylvania.	Florida, New York, Pennsylvania
Secretary-approved (8 states)	Coverage determined appropriate for targeted low-income children.	Arizona, Arkansas, Idaho, Maine, Nevada, Oregon, Vermont, Wyoming

Sources: Assistant Secretary for Planning and Evaluation SCHIP Database, 2001, states' annual SCHIP reports for 2002 through 2005; and GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C., May 14, 1999).

[a]State's SCHIP program reports using two bases of coverage—benchmark and benchmark-equivalent.

In some cases, separate child health programs have changed their benefit packages, adding and removing benefits over time, as follows:

- In 2003, Texas discontinued dental services, hospice services, skilled nursing facilities coverage, tobacco cessation programs, vision services, and chiropractic services. In 2005, the state added many of these services (chiropractic services, hospice services, skilled nursing facilities, tobacco cessation services, and vision care) back into the SCHIP benefit package and increased coverage of mental health and substance abuse services.
- In January 2002, Utah changed its benefit structure for dental services, reducing coverage for preventive (cleanings, examinations, and x-rays) and emergency dental services in order to cover as many children as possible with limited funding. In September 2002, the dental benefit package was further restructured to include coverage for an accidental dental benefit, fluoride treatments, and sealants.

Most SCHIP Programs Require Cost-Sharing, but Amounts Charged Vary Considerably

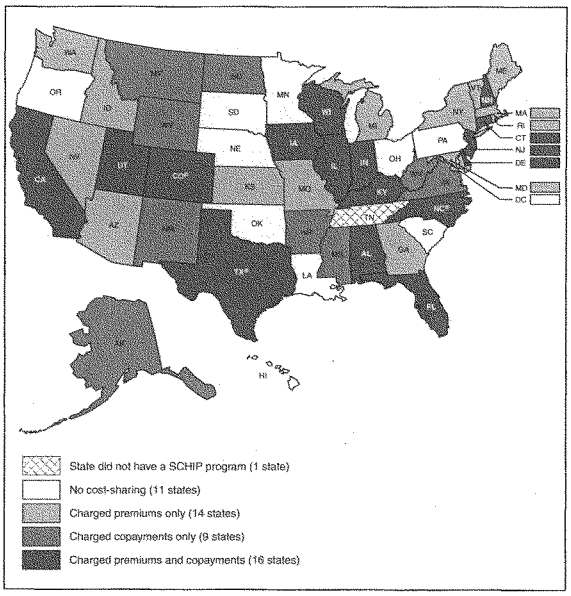
In 2005, most states' SCHIP programs required families to contribute to the cost of care with some kind of cost-sharing requirement. The two major types of cost-sharing—premiums and copayments—can have different behavioral effects on an individual's participation in a health plan.[27] Generally, premiums are seen as restricting entry into a program, whereas copayments affect the use of services within the program. There is research indicating that if cost-sharing is too high, or imposed on families whose income is too low, it can impede access to care and create financial burdens for families.[28]

In 2005, states' annual SCHIP reports showed that 39 states had some type of cost-sharing—premiums, copayments, or enrollment fees—while 11 states reported no cost-sharing in their SCHIP programs. Overall, 16 states charged premiums and copayments, 14 states charged premiums only, and 9 states charged copayments only (see fig. 5).

[27]Opinions differ over the extent to which different types of cost-sharing are appropriate and useful tools for managing health care utilization among low-income populations. Premiums are sometimes viewed as promoting personal responsibility by having the beneficiary participate in the cost of coverage. Proponents of cost-sharing believe that copayments can make individuals more price-conscious consumers of health care services, which may reduce the use of unnecessary services. Others believe that cost-sharing requirements may limit service use, such as physician visits, causing individuals to defer necessary treatment, resulting in more severe conditions and potentially higher expenses. See GAO, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries*, GAO-04-491 (Washington, D.C.: Mar. 31, 2004).

[28]See Tricia Johnson, Mary Rimsza, and William G. Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health* (April 2006); Leighton Ku and Teresa A. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington, D.C.: The Urban Institute, March 1, 1997); and Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, May 2005).

Figure 5: Types of Cost-Sharing under SCHIP, Fiscal Year 2005



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of states' annual SCHIP reports

[a]State charged an enrollment fee.

[b]Tennessee did not have a SCHIP program, as of October 2002. However, on September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL.

Cost-sharing occurred more frequently in the separate child health programs than in Medicaid expansion programs. For example, 8 states with Medicaid expansion programs had cost-sharing requirements, compared with 34 states operating separate child health program

components.[29] The amount of premiums charged varied considerably among the states that charged cost-sharing. For example, premiums ranged from $5.00 per family per month for children in families with incomes from 150 to 200 percent of FPL in Michigan to $117 per family per month for children in families with incomes from 300 to 350 percent of FPL in New Jersey. Federal SCHIP law prohibits states from imposing cost-sharing on SCHIP-eligible children that totals more than 5 percent of family income annually.[30] In addition, cost-sharing for children may be imposed on the basis of family income. For example, we earlier reported that in 2003, Virginia SCHIP copayments for children in families with incomes from 133 percent to below 150 percent of FPL were $2 per physician visit or per prescription and $5 for services for children in families with higher incomes.[31]

Few States Offer Premium Assistance Programs

In fiscal year 2005, nine states reported operating premium assistance programs (see table 2), but implementation remains a challenge. Enrollment in these programs varied across the states. For example, Louisiana reported having under 200 enrollees and Oregon reported having nearly 6,000 enrollees.[32] To be eligible for SCHIP, a child must not be covered under any other health coverage program or have private health insurance. However, some uninsured children may live in families with access to employer-sponsored health insurance coverage. Therefore, states may choose to establish premium assistance programs, where the state uses SCHIP funds to contribute to health insurance premium

[29]States that opt for Medicaid expansions must follow Medicaid rules—and cost-sharing for children is generally not allowed.

[30]42 U.S.C. § 1397cc(e). Federal SCHIP regulations include other limits on cost-sharing. For example, states with separate child health programs are not permitted to impose any cost-sharing on covered well-baby and well-child care services. Additionally, states may require cost-sharing for children in families with incomes at or below 150 percent of FPL, but premium amounts cannot exceed the maximum charges that are permitted under Medicaid. States are also prohibited from charging cost-sharing to American Indians or Alaska Natives. 42 C.F.R. §§ 457.520, et. seq.

[31]GAO-04-491.

[32]Data for premium assistance program enrollment for Louisiana were obtained from CMS's 2005 annual SCHIP report and for Oregon from Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September, 2006).

payments.[33] To the extent that such coverage is not equivalent to the states' Medicaid or SCHIP level of benefits, including limited cost-sharing, states are required to pay for supplemental benefits and cost-sharing to make up this difference. Under certain section 1115 waivers, however, states have not been required to provide this supplemental coverage to participants.

Table 2: Premium Assistance Programs in Nine States, Fiscal Year 2005

State	Design of SCHIP program	Authority for premium assistance program	Population covered under authority		Supplemental coverage for benefits or cost-sharing
			Children	Adults	
Idaho	Combination	Section 1906	✔		No
		Section 1115 HIFA	✔	✔	
Illinois	Combination	Section 1115 HIFA	✔	[a]	No
Louisiana	Medicaid expansion	Section 1906	✔	✔	Yes, for benefits and cost-sharing
Massachusetts	Combination	Premium assistance under SCHIP plan	✔		No
		Section 1115 non-HIFA	✔		
New Jersey	Combination	Section 1115 non-HIFA	✔	✔	Yes, for benefits and cost-sharing
Oregon	Separate program	Section 1115 HIFA	✔	✔	No
Rhode Island	Combination	Premium assistance under SCHIP plan	✔		Yes, for benefits and cost-sharing
		Family coverage under SCHIP plan	✔	✔	
		Section 1115 non-HIFA	✔	✔	
		Section 1906		✔	
Virginia[b]	Combination	Premium assistance under SCHIP plan	✔		Yes, for benefits[c]
		Section 1115 HIFA	✔		
		Section 1906	✔	✔	
Wisconsin	Medicaid expansion	Section 1115 non-HIFA	✔	✔	Yes, for benefits and cost-sharing

Sources: CMS, states' Annual SCHIP Reports for 2005, and Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

[a]Coverage of adults under Illinois' program became effective January 1, 2006.

[33]States may establish premium assistance programs under separate child health programs or under Medicaid programs, including as part of a section 1115 waiver. See 42 U.S.C. §§ 1315, 1396e; 42 C.F.R. § 457.810.

[h]Virginia offered a SCHIP premium assistance program from October 2001 until July 31, 2005, entitled the Employer Sponsored Health Insurance (ESHI) program. On August 1, 2005, the ESHI program was replaced by a new SCHIP premium assistance program entitled Family Access to Medical Insurance Security (FAMIS) Select. CMS approved this program on July 1, 2005, as part of a section 1115 waiver.

[i]Virginia's supplemental payments were limited to immunizations not covered by the employer/private health plan.

Several states reported facing challenges implementing their premium assistance programs. Louisiana, Massachusetts, New Jersey, and Virginia cited administration of the program as labor intensive. For example, Massachusetts noted that it is a challenge to maintain current information on program participants' employment status, choice of health plan, and employer contributions, but such information is needed to ensure accurate premium payments. Two states—Rhode Island and Wisconsin—noted the challenges of operating premium assistance programs, given changes in employer-sponsored health plans and accompanying costs. For example, Rhode Island indicated that increases in premiums are being passed to employees, which makes it more difficult to meet cost-effectiveness tests applicable to the purchase of family coverage.[34]

Adult Coverage in SCHIP Is Primarily Accomplished through Waivers

States opting to cover adult populations using SCHIP funding may do so under an approved section 1115 waiver. As of February 2007, we identified 14 states with approved waivers to cover at least one of three categories of adults: parents of eligible Medicaid and SCHIP children, pregnant women, and childless adults. (See table 3.) The DRA, however, has prohibited the use of SCHIP funds to cover nonpregnant childless adults.[35] Effective October 1, 2005, the Secretary of Health and Human Services may not approve new section 1115 waivers that use SCHIP funds for covering nonpregnant childless adults. However, waivers for covering these adults that were approved prior to this date are allowed to continue until the end of the waiver. Additionally, the Secretary may continue to approve section 1115 waivers that extend SCHIP coverage to pregnant adults, as well as parents and other caretaker relatives of children eligible for Medicaid or SCHIP.

[34]The cost-effectiveness test requires the states to demonstrate that covering both adults and children in a family under SCHIP is not more expensive than covering only the children.

[35]DRA, Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified as amended at 42 U.S.C. § 1397gg).

Table 3: States Covering Adults in SCHIP under Section 1115 Waivers, Categories of Covered Adults, and Upper Income Eligibility Thresholds as a Percentage of FPL

	Covered adults			
State	Parents	Pregnant women	Childless adults*	Percentage of FPL
Arkansas	✓			200
Arizona	✓		✓	200 (parents); 100 (childless adults)
Colorado		✓		200
Idaho	✓	✓	✓	185
Illinois	✓		✓	185
Michigan			✓	35
Minnesota	✓			200
Nevada	✓	✓		200 (parents); 185 (pregnant women)
New Jersey	✓	✓		200
New Mexico	✓		✓	200
Oregon	✓		✓	185
Rhode Island	✓	✓		185 (parents); 250 (pregnant women)
Virginia		✓		166
Wisconsin	✓			200

Sources: CMS, as of February 2007

*The DRA prohibited the use of SCHIP funds to cover nonpregnant childless adults. Effective October 1, 2005, the Secretary of Health and Human Services may not approve new section 1115 waivers that use SCHIP funds for covering nonpregnant childless adults. However, waivers approved prior to that date are allowed to continue until the end of the waiver.

States' SCHIP Spending Was Initially Low but Now Threatens to Exceed Available Funding

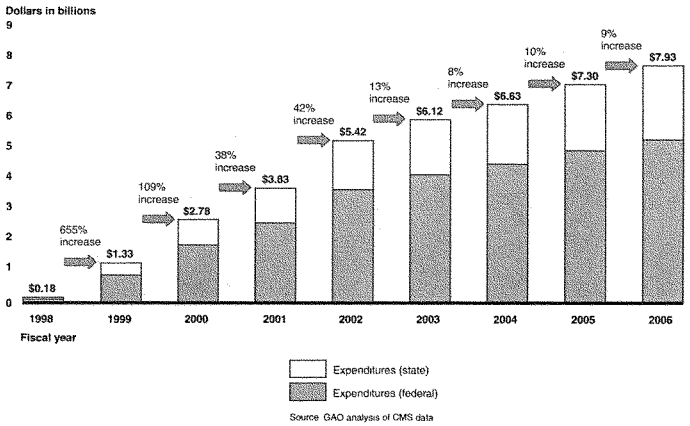
SCHIP program spending was low initially, as many states did not implement their programs or report expenditures until 1999 or later, but spending was much higher in the program's later years and now threatens to exceed available funding. Beginning in fiscal year 2002, states together spent more federal dollars than they were allotted for the year and thus relied on the 3-year availability of SCHIP allotments or on redistributed SCHIP funds to cover additional expenditures. But as spending has grown, the pool of funds available for redistribution has shrunk. Some states consistently spent more than their allotted funds, while other states consistently spent less. Overall, 18 states were projected to have shortfalls—that is, they were expected to exhaust available funds, including current and prior-year allotments—in at least 1 year from 2005

through 2007. These shortfall states were more likely to have a Medicaid component to their SCHIP program, cover children across a broader range of income groups, and cover adults through section 1115 waivers than were the 32 states that were not projected to have shortfalls. In addition, the shortfall states that covered adults generally began covering them earlier than nonshortfall states. To cover projected shortfalls that several states faced, Congress appropriated an additional $283 million in fiscal year 2006.

Program Spending, Low in SCHIP's Early Years, Exceeded Allotments by 2002

SCHIP program spending began low, but by fiscal year 2002, states' aggregate annual spending from their federal allotments exceeded their annual allotments. Spending was low in the program's first 2 years because many states did not implement their programs or report expenditures until fiscal year 1999 or later. Combined federal and state spending was $180 million in 1998 and $1.3 billion in 1999. However, by the end of the program's third fiscal year (2000), all 50 states and the District of Columbia had implemented their programs and were drawing down their federal allotments. Since fiscal year 2002, SCHIP spending has grown by an average of about 10 percent per year. (See fig. 6.)

Figure 6: Combined State and Federal SCHIP Expenditures, Fiscal Year 1998-2006



Source: GAO analysis of CMS data

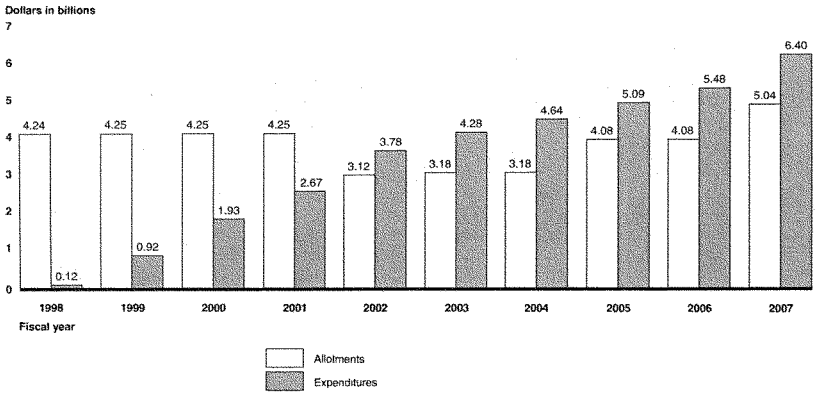
Note: Tennessee did not have a SCHIP program as of October 2002. However, on September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL.

From fiscal year 1998 through 2001, annual federal SCHIP expenditures were well below annual allotments, ranging from 3 percent of allotments in fiscal year 1998 to 63 percent in fiscal year 2001. In fiscal year 2002, the states together spent more federal dollars than they were allotted for the year, in part because total allotments dropped from $4.25 billion in fiscal year 2001 to $3.12 billion in fiscal year 2002, marking the beginning of the so-called "SCHIP dip."[35] However, even after annual SCHIP appropriations increased in fiscal year 2005, expenditures continued to exceed allotments (see fig. 7). Generally, states were able to draw on unused funds from prior years' allotments to cover expenditures incurred in a given year that were in excess of their allotment for that year, because, as discussed earlier, the

[35]The SCHIP dip refers to the decrease in SCHIP appropriations for fiscal years 2002 through 2004, which was necessary to address budgetary constraints applicable at the time the BBA was enacted.

federal SCHIP law gave states 3 years to spend each annual allotment. In certain circumstances, states also retained a portion of unused allotments.

Figure 7: SCHIP Allotments and Federal Expenditures, Fiscal Year 1998-2007

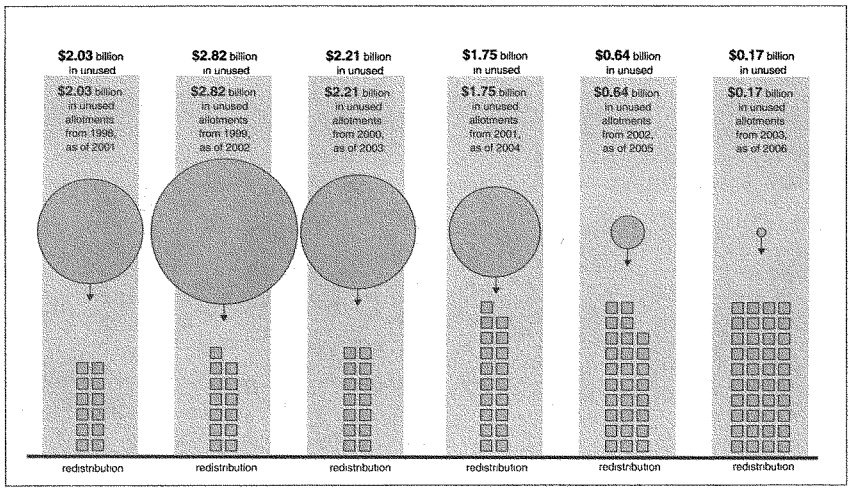


Source: GAO analysis of CMS data

Notes: Fiscal year 2007 expenditures are estimates based on budgets submitted by the states to CMS in November 2006. Expenditures may exceed allotments in any single year because allotments are available for 3 years and may be expended in years later than allotted.

States that have outspent their annual allotments over the 3-year period of availability have also relied on redistributed SCHIP funds to cover excess expenditures. But as overall spending has grown, the pool of funds available for redistribution has shrunk from a high of $2.82 billion in unused funds from fiscal year 1999 to $0.17 billion in unused funds from fiscal year 2003. Meanwhile, the number of states eligible for redistributions has grown from 12 states in fiscal year 2001 to 40 states in fiscal year 2006. (See fig. 8.)

Figure 8: Unused SCHIP Allotments from Fiscal Year 1998 through 2003 and Number of States Eligible for Redistribution, Fiscal Year 2001-2006



Source: GAO analysis of CMS data

Note: States are eligible to receive redistribution in a particular fiscal year if they have expended all of their allotment for that year.

Congress has acted on several occasions to change the way SCHIP funds are redistributed. In fiscal years 2000 and 2003, Congress amended statutory provisions for the redistribution and availability of unused

SCHIP allotments from fiscal years 1998 through 2001,[37] reducing the amounts available for redistribution and allowing states that had not exhausted their allotments by the end of the 3-year period of availability to retain some of these funds for additional years. Despite these steps, $1.4 billion in unused SCHIP funds reverted to the U.S. Treasury by the end of fiscal year 2005.

Congress has also appropriated additional funds to cover states' projected SCHIP program shortfalls. The DRA included a $283 million appropriation to cover projected shortfalls for fiscal year 2006.[38] CMS divided these funds among 12 states as well as the territories.

In the beginning of fiscal year 2007, Congress acted to redistribute unused SCHIP allotments from fiscal year 2004 to states projected to face shortfalls in fiscal year 2007.[39] The National Institutes of Health Reform Act of 2006 makes these funds available to states in the order in which they experience shortfalls. In January 2007, the Congressional Research Service (CRS) projected that although 14 states will face shortfalls, the $147 million in unused fiscal year 2004 allotments will be redistributed to the five states that are expected to experience shortfalls first. The NIH Reform Act also created a redistribution pool of funds by redirecting fiscal

[37]The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) allowed states that used their fiscal year 1998 and 1999 allotments to receive redistributed funds and allowed states that had not used these allotments to retain a portion of remaining funds. BIPA also extended the availability of all redistributed and retained funds through the end of fiscal year 2002. BIPA, Pub. L. No. 106-554, § 1(a)(6), 114 Stat. 2763, 2763A-578—580 (Dec. 21, 2000) (codified, as amended, at 42 U.S.C. § 1397dd(g)). The State Children's Health Insurance Program Allotments Extension Act (SCHIP Extension Act) further extended the availability of redistributed and retained allotments from fiscal years 1998 and 1999 another 2 years, to the end of fiscal year 2004. The law also established a new method for reallocating unspent allotments from fiscal years 2000 and 2001, allowing states that did not expend these funds to retain 50 percent of the funds and redistributing the remaining 50 percent to states that had spent their allotments. In addition, the law established authority for certain states—generally, states that covered at least one category of children other than infants up to at least 185 percent of FPL—to use up to 20 percent of original fiscal year allotments for 1998 through 2001 for Medicaid eligible children with family income over 150 percent of FPL. SCHIP Extensions Act, Pub. L. No. 108-74, §§ 1(a)(4), 1(b), 117 Stat. 895-896 (Aug. 15, 2003) (codified, as amended, at 42 U.S.C. § 1397dd(g), 1397ee(g)).

[38]DRA, Pub. L. No. 109-171, § 6101(a), 120 Stat. 130 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397dd(d)).

[39]National Institutes of Health Reform Act of 2006 (NIH Reform Act), Pub. L. No. 109-482, § 201, 120 Stat. 3675 (Jan. 15, 2007) (to be codified at 42 U.S.C. § 1397dd(h)).

year 2005 allotments from states that at midyear (March 31, 2007) have more than twice the SCHIP funds they are projected to need for the year.[40]

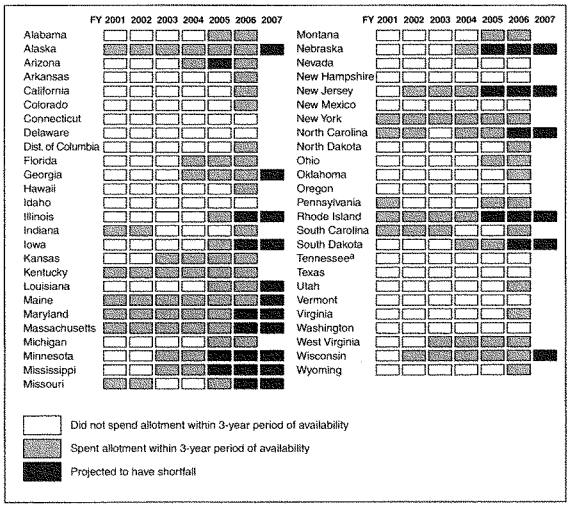
Some States Consistently Spent More than Their Allotted Funds

Some states consistently spent more than their allotted funds, while other states consistently spent less. From fiscal years 2001 through 2006, 40 states spent their entire allotments at least once, thereby qualifying for redistributions of other states' unused allotments; 11 states spent their entire allotments in at least 5 of the 6 years that funds were redistributed. Moreover, 18 states were projected to face shortfalls—that is, they were expected to exhaust available funds, including current and prior-year allotments—in at least 1 of the final 3 years of the program.[41] (See fig. 9).

[40]These states are required to contribute half of their remaining 2005 allotments, up to a maximum of $20 million, to the redistribution pool. NIH Reform Act, Pub. L. No. 109-482, § 201, 120 Stat. 3675 (Jan. 15, 2007) (to be codified at 42 U.S.C. § 1397dd(h)). CRS estimates the redistribution pool to have $125 million available.

[41]In fiscal years 2005 and 2006, CMS projected that 13 states would face shortfalls of SCHIP funds in one or both of those years, and in October 2006, CRS projected that 17 states would face shortfalls in fiscal year 2007. The 17 states CRS identified include 12 of the 13 states CMS identified, for a total of 18 states identified as facing shortfalls in fiscal years 2005, 2006, and/or 2007.

Figure 9: States that Did or Did Not Spend Allotments and/or Were Projected to Have Shortfalls



Source: GAO analysis of data obtained from CMS and Congressional Research Service (CRS).

Note: The years refer to the fiscal years in which unspent allotments from 3 years prior became available for redistribution. Under federal SCHIP law, subject to certain exceptions, states were given 3 years to spend each allotment, after which any unspent funds were to be redistributed among states that had spent their entire allotments. States projected to have shortfalls were projected to exhaust available funds, including current and prior-year allotments. Shortfalls for 2005 and 2006 were projected by CMS in those years. Shortfalls for 2007 were projected by CRS in October 2006 on the basis of states' budget data from August 2006. CRS has since updated its projections and, as of January 2007, was no longer projecting shortfalls for Louisiana, North Carolina, or South Dakota. States that had spent their entire 2004 allotments had not been announced by the Secretary of Health and Human Services as of January 25, 2007.

[a]Although Tennessee did not have a SCHIP program as of October 2002, it continued to be allotted SCHIP funds. On September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL.

When we compared the 18 states that were projected to have shortfalls with the 32 states that were not, we found that the shortfall states were more likely to have a Medicaid component to their SCHIP program, to have a SCHIP eligibility corridor broader than the median,[42] and to cover adults in SCHIP under section 1115 waivers (see table 4). Fifteen of the 18 shortfall states (83 percent) had Medicaid expansion programs or combination programs that included Medicaid expansions, which must follow Medicaid rules, such as providing the full Medicaid benefit package and continuing to provide coverage to all eligible individuals even after the states' SCHIP allotments are exhausted. The shortfall states tended to have a broader eligibility corridor in their SCHIP programs, indicating that, on average, the shortfall states covered children in SCHIP from lower income levels, from higher income levels, or both. For example, 33 percent of the shortfall states covered children in their SCHIP programs above 200 percent of FPL, compared with 25 percent of the nonshortfall states. Finally, 6 of the 18 shortfall states (33 percent) were covering adults in SCHIP under section 1115 waivers by the end of fiscal year 2006, compared with 6 of the 32 nonshortfall states (19 percent).

[42]The SCHIP eligibility corridor is defined as the difference between the highest and lowest income levels (expressed as a percentage of FPL) eligible for SCHIP within a specified age group. For example, if a state covers children aged 6 and older with family incomes from 100 percent to 200 percent of FPL, the eligibility corridor for this age group is 100 percentage points (200 minus 100). In 2006, the median SCHIP eligibility corridor for children aged 6 and older was 100 percentage points.

Table 4: Selected SCHIP Program Characteristics of Shortfall and Nonshortfall States

SCHIP program characteristic	Percentage of states	
	Shortfall states (n=18)	Nonshortfall states (n=32)
Medicaid expansion or combination programs	83	53
Eligibility corridor for children aged 6 and older that is broader than the median[a]	28	16
Adult coverage in SCHIP under section 1115 waivers before FY 2007[b]	33	19

Source: GAO analysis, as of January 29, 2007, of data obtained from CMS, CRS, and NASHP

Note: Shortfall states are states that were identified by CMS or CRS as being unable to cover their projected SCHIP expenditures with available funds in fiscal years 2005, 2006, and/or 2007 in the absence of redistributions or additional appropriations. Nonshortfall states are states that were not projected to experience such shortfalls in any of the 3 years. Tennessee did not have a SCHIP program as of October 2002. However, on September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL.

[a]The SCHIP eligibility corridor is defined as the difference between the highest and lowest income levels (expressed as a percentage of FPL) eligible for SCHIP within a specified age group. For example, if a state covers children aged 6 and older with family incomes from 100 percent to 200 percent of FPL, the eligibility corridor for this age group is 100 percentage points (200 minus 100). In 2006, the median SCHIP eligibility corridor for children aged 6 and older was 100 percentage points.

[b]In fiscal year 2007, two nonshortfall states implemented SCHIP-funded coverage for adults—Arkansas on October 1, 2006, and Nevada on December 1, 2006.

On average, the shortfall states that covered adults began covering them earlier than nonshortfall states and enrolled a higher proportion of adults. At the end of fiscal year 2006, 12 states covered adults under section 1115 waivers using SCHIP funds.[43] Five of these 12 states began covering adults before fiscal year 2003, and all 5 states faced shortfalls in at least 1 of the final 3 years of the program. In contrast, none of the 5 states that began covering adults with SCHIP funds in the period from fiscal year 2004 through 2006 faced shortfalls.[44] On average, the shortfall states covered

[43]As of February 2007, we had identified 14 states with approved section 1115 waivers to cover adults with their SCHIP allotments (see table 3). In fiscal year 2007, two of the 14 states began covering adults under SCHIP—Arkansas on October 1, 2006, and Nevada on December 1, 2006.

[44]Three states began covering adults under section 1115 waivers in fiscal year 2003; one faced shortfalls and two did not.

adults more than twice as long as nonshortfall states (5.1 years compared with 2.3 years by the end of fiscal year 2006).

Shortfall states also enrolled a higher proportion of adults. Nine states, including six shortfall states, covered adults using SCHIP funds throughout fiscal year 2005.[45] In these nine states, adults accounted for an average of 45 percent of total enrollment. However, in the shortfall states, the average proportion was more than twice as high as in nonshortfall states. Adults accounted for an average of 55 percent of enrollees in the shortfall states, compared with 24 percent in the nonshortfall states. (See table 5.)

[45]On July 1, 2005, three additional states (Idaho, New Mexico, and Virginia) began using SCHIP funds to cover adults under section 1115 waivers.

Table 5: SCHIP Total Enrollment in States Using SCHIP Funds to Cover Adults under Section 1115 Waivers throughout Fiscal Year 2005

	Total enrollment			
State[a]	Total	Children	Adults	Adults as a percentage of total[b]
Shortfall states[c]				
Arizona	201,626	88,005	113,621	56
Illinois	457,426	281,432	175,994	38
Minnesota	40,087	5,076	35,011	87
New Jersey	196,418	129,591	66,827	34
Rhode Island	51,313	27,144	24,169	47
Wisconsin	165,973	57,165	108,808	66
Nonshortfall states[d]				
Colorado	61,105	59,530	1,575	3
Michigan	190,540	89,257	101,283	53
Oregon	64,088	52,722	11,366	18
Summary				
Shortfall states (6)	1,112,843	588,413	524,430	55
Nonshortfall states (3)	315,733	201,509	114,224	24
All states (9)	1,428,576	789,922	638,654	45

Source: GAO analysis of CMS data.

[a]As of February 2007, we had identified 14 states with approved section 1115 waivers to cover adults with their SCHIP allotments. Five of these 14 states were omitted from the table. Idaho, New Mexico, and Virginia implemented section 1115 waivers for adults on July 1, 2005, and are omitted from the table because only partial-year data are available for them for fiscal year 2005. The remaining two states had not implemented their waivers as of 2005: Arkansas and Nevada implemented section 1115 coverage for adults in fiscal year 2007.

[b]Summary data shown in this column are averages of the state percentages.

[c]Shortfall states are states that were identified by CMS or the Congressional Research Service (CRS) as being unable to cover their projected SCHIP expenditures with available funds in fiscal years 2005, 2006, and/or 2007.

[d]Nonshortfall states are states that were not projected to experience such shortfalls in any of the 3 years.

While analyses of states as a group reveal some broad characteristics of states' programs, examining the experiences of individual states offers insights into other factors that have influenced states' program balances. States themselves have offered a variety of reasons for shortfalls and surpluses. These examples, while not exhaustive, highlight a few factors that have shaped states' financial circumstances under SCHIP, including the following:

- **Inaccuracies in the CPS-based estimates on which states' allotments were based**. North Carolina, a shortfall state, offers a case in point. In 2004, the state had more low-income children enrolled in the program than CPS estimates indicated were eligible. To curb spending, North Carolina shifted children through age 5 from the state's separate program to a Medicaid expansion, reduced provider payments, and limited enrollment growth.

- **Annual funding levels that did not reflect enrollment growth**. Iowa, another shortfall state, noted that annual allocations provided too many funds in the early years of the program and too few in the later years. Iowa did not use all its allocations in the first 4 years and thus the state's funds were redistributed to other states. Subsequently, however, the state has faced shortfalls as its program matured.

- **Impact of policies designed to curb or expand program growth**. Some states have attempted to manage program growth through ongoing adjustments to program parameters and outreach efforts. For example, when Florida's enrollment exceeded a predetermined target in 2003, the state implemented a waiting list and eliminated outreach funding. When enrollment began to decline, the state reinstituted open enrollment and outreach. Similarly, Texas—commensurate with its budget constraints and projected surpluses—has tightened and loosened eligibility requirements and limited and expanded benefits over time in order to manage enrollment and spending.

Considerations for SCHIP Reauthorization

Children without health insurance are at increased risk of forgoing routine medical and dental care, immunizations, treatment for injuries, and treatment for chronic illnesses. Yet, the states and the federal government face challenges in their efforts to continue to finance health care coverage for children. As health care consumes a growing share of state general fund or operating budgets, slowdowns in economic growth can affect states' abilities—and efforts—to address the demand for public financing of health services. Moreover, without substantive programmatic or revenue changes, the federal government faces near- and long-term fiscal challenges as the U.S. population ages because spending for retirement and health care programs will grow dramatically.[46] Given these

[46]GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, GAO-05-325SP (Washington, D.C.: February 2005); and GAO, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, GAO-02-544T (Washington, D.C.: Mar. 21, 2002).

circumstances, we would like to suggest several issues for consideration as Congress addresses the reauthorization of SCHIP. These include the following:

- **Maintaining flexibility without compromising the goals of SCHIP.** The federal-state SCHIP partnership has provided an important opportunity for innovation on the part of states for the overall benefit of children's health. Providing three design choices for states—Medicaid expansions, separate child health programs, or a combination of both approaches—affords them the opportunity to focus on their own unique and specific priorities. For example, expansions of Medicaid offer Medicaid's comprehensive benefits and administrative structures and ensure children's coverage if states exhaust their SCHIP allotments. However, this entitlement status also increases financial risk to states. In contrast, SCHIP separate child health programs offer a "block grant" approach to covering children. As long as the states meet statutory requirements, they have the flexibility to structure coverage on an employer-based health plan model and can better control program spending than they can with a Medicaid expansion.

  However, flexibility within the SCHIP program, such as that available through section 1115 waivers, may also result in consequences that can run counter to SCHIP's goal—covering children. For example, we identified 14 states that have authority to cover adults with their federal SCHIP funds, with several states covering more adults than children. States' rationale is that covering low-income parents in public programs such as SCHIP and Medicaid increases the enrollment of eligible children as well, with the result that fewer children go uninsured.[47] Federal SCHIP law provides that families may be covered only if such coverage is cost-effective; that is, covering families costs no more than covering the SCHIP-eligible children. We earlier reported that HHS had approved state proposals for section 1115 waivers to use SCHIP funds to cover parents of SCHIP- and Medicaid-eligible children without regard to cost-effectiveness.[48] We also reported that HHS approved state proposals for section 1115 waivers to use SCHIP funds to cover childless adults, which in our view was inconsistent with federal SCHIP law and allowed SCHIP

[47]See Leighton Ku and Matthew Broaddus, *Coverage of Parents Helps Children, Too* (Washington, D.C.: Center on Budget and Policy Priorities, Oct. 20, 2006), 2.

[48]GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

funds to be diverted from the needs of low-income children.[49] We suggested that Congress consider amending the SCHIP statute to specify that SCHIP funds were not available to provide health insurance coverage for childless adults. Under the DRA, Congress prohibited the Secretary of Health and Human Services from approving any new section 1115 waivers to cover nonpregnant childless adults after October 1, 2005, but allowed waivers approved prior to that date to continue.[50]

It is important to consider the implications of states' use of allowable flexibility for other aspects of their programs. For example, what assurances exist that SCHIP funds are being spent in the most cost-effective manner, as required under federal law? In view of current federal fiscal constraints, to what extent should SCHIP funds be available for adult coverage? How has states' use of available flexibility to establish expanded financial eligibility categories and covered populations affected their ability to operate their SCHIP programs within the original allotments provided to them?

- **Considering the federal financing strategy, including the financial sustainability of public commitments.** As SCHIP programs have matured, states' spending experience can help inform future federal financing decisions. CRS testified in July 2006 that 40 states were now spending more annually than they received in their annual original SCHIP allotments.[51] While many of them did not face shortfalls in 2006 because of available prior-year balances, redistributed funds, and the supplemental DRA appropriation, 14 states are currently projected to face shortfalls in 2007. With the pool of funds available for redistribution virtually exhausted, the continued potential for funding shortfalls for many states raises some fundamental questions about SCHIP financing. If SCHIP is indeed a capped grant program, to what extent does the federal government have a responsibility to address shortfalls in individual states, especially those that have chosen to expand their programs beyond certain parameters? In contrast, if the policy goal is to ensure that states do not exhaust their federal SCHIP allotments, by providing for the

[49]See GAO-02-817 and GAO, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals*, GAO-04-166R (Washington, D.C.: Jan. 5, 2004).

[50]DRA, Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397gg).

[51]Congressional Research Service, *Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee*, (Washington, D.C.: July 25, 2006).

continuing redistribution of funds or additional federal appropriations, does the program begin to take on the characteristics of an entitlement similar to Medicaid? What overall implications does this have for the federal budget?

- **Assessing issues associated with equity**. The 10 years of SCHIP experience that states now have could help inform any policy decisions with respect to equity as part of the SCHIP reauthorization process. Although SCHIP generally targets children in families with incomes at or below 200 percent of FPL, 9 states are relatively more restrictive with their eligibility levels, while 14 states are more expansive, ranging as high as 350 percent of FPL. Given the policy goal of reducing the rate of uninsured among the nation's children, to what extent should SCHIP funds be targeted to those states that have not yet achieved certain minimum coverage levels? Given current and future federal fiscal constraints, to what extent should the federal government provide federal financial participation above certain thresholds? What broader implications might this have for flexibility, choice, and equity across state programs? Another consideration is whether the formulas used in SCHIP—both the formula to determine the federal matching rate and the formula to allocate funds to states—could be refined to better target funding to certain states for the benefit of covering uninsured children. Because the SCHIP formula is based on the Medicaid formula for federal matching funds, it has some inherent shortcomings that are likely beyond the scope of consideration for SCHIP reauthorization.[53]

  For the allocation formula that determines the amount of funds a state will receive each year, several analysts, including CRS, have noted alternatives that could be considered. These include altering the methods for estimating the number of children at the state level, adjusting the extent to which the SCHIP formula for allocating funds to states includes the number of uninsured versus low-income children, and incorporating

[53]The Medicaid formula uses a state's per capita income (PCI) in relation to national PCI to determine the federal share of matching funds for a state's allowable Medicaid spending. We earlier reported, however, that the use of PCI as a measure of states' funding ability is problematic because it does not accurately represent states' funding ability or account for the size and cost of serving states' poverty populations. See GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620 (Washington, D.C.: July 10, 2003). We also recently reported on potential strategies to help make the Medicaid formula more responsive to economic downturns, which could have implications for the SCHIP formula. GAO, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97 (Washington, D.C.: Oct. 18, 2006).

states' actual spending experiences to date into the formula. Considering the effects of any one or combination of these—or other—policy options would likely entail iterative analysis and thoughtful consideration of relevant trade-offs.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other members of the Committee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please contact Kathryn G. Allen at (202) 512-7118 or at allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Carolyn L. Yocom, Assistant Director; Nancy Fasciano; Kaycee M. Glavich; Paul B. Gold; JoAnn Martinez-Shriver; and Elizabeth T. Morrison made key contributions to this statement.

Related GAO Products

Children's Health Insurance: Recent HHS-OIG Reviews Inform the Congress on Improper Enrollment and Reductions in Low-Income, Uninsured Children. GAO-06-457R. Washington, D.C.: March 9, 2006.

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Medicaid Formula: Differences in Funding Ability among States Often Are Widened. GAO-03-620. Washington, D.C.: July 10, 2003.

Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care. GAO-03-222. Washington, D.C.: January 14, 2003.

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Responses to Post-Hearing Questions for the Record
The Future of CHIP: Improving the Health of America's Children
Committee on Finance
United States Senate
Submitted June 14, 2007

Questions for Kathryn G. Allen, Director
Health Care
Government Accountability Office

Questions for the Record Submitted by Chairman Max Baucus

1. Your testimony implies there is some causal relationship between a state having a shortfall and its coverage of non-child populations, but only 6 of the 14 states running short of FY 07 funds have expanded coverage—that's less than half. What evidence do you have that restricting coverage to so called core populations will do anything to prevent shortfalls in the future? What effect would restricting populations have on children's coverage? Or on insurance rates generally?

In our testimony on the State Children's Health Insurance Program (SCHIP), we described the characteristics of states that were projected to have shortfalls in at least 1 of the final 3 years of the program, but we did not attempt to determine the extent to which these characteristics contributed to shortfalls. We found that the 18 states that faced shortfalls in at least 1 of the final 3 years of SCHIP were more likely than the 32 states that did not face shortfalls to cover adults in SCHIP under section 1115 waivers.[1] We also found that these states were more likely to have a Medicaid component to their SCHIP program and a SCHIP eligibility corridor broader than the median.

In my oral statement, I testified that it was unclear to what extent these characteristics contributed to states' overall spending experiences with the program, as many other factors have affected states' program balances. These factors include states' prior coverage of children under Medicaid, and SCHIP eligibility criteria, benefit packages, enrollment policies, outreach efforts, and provider payment rates, as well as the accuracy of the estimates of the number of eligible children. Of the 14 states that were projected to have shortfalls in fiscal year 2007, 5 had expanded SCHIP coverage to adults. In our testimony we provided perspectives from some of the other 9 states about the reasons they incurred shortfalls. For example, North Carolina cited inaccuracies in the Current Population Survey (CPS)-based estimates on which states' allotments were based, and Iowa cited annual funding levels that did not reflect enrollment growth.

[1]States that covered adults in SCHIP under section 1115 waivers before fiscal year 2007 constituted 33 percent of the 18 shortfall states compared with 19 percent of the 32 nonshortfall states. One state (Tennessee) did not have a SCHIP program during this period.

Restricting SCHIP coverage to children would make more funds available for children's coverage but would not necessarily prevent future shortfalls. Whether shortfalls occur in the future will depend on the amount of federal SCHIP funds allocated to states as well as on states' program design choices.

We did not examine the effect of SCHIP coverage on insurance rates. However, our testimony provides the most recent data available from the Centers for Medicare & Medicaid Services (CMS), indicating that about 639,000 adults were covered under SCHIP section 1115 waivers during fiscal year 2005, the most recent year for which enrollment data were available. This is obviously a very small percentage of the total population of insured adults nationwide.

2. Do states have the resources they need to evaluate the status of safety-net providers in their communities? Would an entity like SNOPAC, similar to MedPAC, help us improve care and ensure that children are obtaining access to the care that they need?

GAO has not assessed the adequacy of state resources to evaluate the status of safety-net providers or the potential of an entity like a Safety Net Organizations and Patient Advisory Commission (SNOPAC) to improve care and ensure that children have access to services. However, if an entity like SNOPAC provided data and insight on the adequacy of safety-net providers in the varying communities, such information could be helpful in prioritizing and allocating resources.

Question for the Record Submitted by Senator Rockefeller

1. There has been a lot of debate about whether or not the CHIP program should allow states to cover parents of eligible children. I think such a debate is ironic because if the question were posed to Members of Congress -- "How many of you have separate health insurance policies for your children" – I doubt that any of us would raise our hands.

Therefore, I don't believe we should be setting a different standard for low-income families by suggesting that it is somehow bad policy to insure entire families. In my mind, the CHIP statute clearly envisioned coverage of families. I also believe that coverage of parents meets the ultimate program objective of covering children.

Ms. Allen, the Government Accountability Office has issued several reports questioning CHIP coverage of parents on the grounds that it is not cost-effective. Isn't it true that restricting states' ability to cover populations other than children will have little impact on the projected $15 billion federal funding shortfall (between 2008 and 2012) because most of the shortfalls come from covering children? According to the data I have, roughly 639,000 adults are covered by CHIP, which is only one percent of the covered population, meaning the overwhelming majority are children.

While restricting SCHIP coverage to children would make more funds available for children's coverage, it would not necessarily prevent shortfalls. Overall, 5 of the 14 states that were projected to have shortfalls in fiscal year 2007 had expanded SCHIP coverage to adults; however, we did not attempt to determine the extent to which adult coverage or other program characteristics contributed to shortfalls. As you noted, 639,000 SCHIP enrollees were adults, which comprised approximately 10.5 percent of individuals ever enrolled in SCHIP during fiscal year 2005, the most recent year for which enrollment data were available.

Under certain circumstances, the SCHIP statute allows for the coverage of adults. In creating SCHIP, Congress authorized states to cover health benefits for entire families—parents or custodians and their children—if it is cost effective to do so. The cost-effectiveness requirement for family coverage under SCHIP specifies that the expense of covering adults and children in a family must not exceed the cost of covering SCHIP-eligible children. In 2002, we raised concerns that the Department of Health and Human Services (HHS) had approved state proposals for section 1115 waivers to use SCHIP funds to cover parents of SCHIP- and Medicaid-eligible children, but without regard to cost-effectiveness as required by statute.[2] In 2002 and 2004, we reported that HHS approved state proposals for section 1115 waivers to use SCHIP funds to cover nonpregnant childless adults, which we viewed as inconsistent with federal SCHIP law.[3] Congress agreed, and in passing the Deficit Reduction Act (DRA) of 2005, it prohibited HHS from approving additional new waivers for covering nonpregnant childless adults but allowed HHS to approve section 1115 waivers extending SCHIP coverage to pregnant adults and parents of SCHIP- and Medicaid-eligible children.

Questions for the Record Submitted by Senator Hatch

1. I am very interested in coverage for children and coverage for adults under the CHIP program. Did GAO study what was typically in a CHIP benefit package? Do the CHIP benefits differ dramatically from state to state? Could you tell the Committee what benefits are covered and the typical cost for such a benefit package? Is a CHIP benefit package more expensive for adults -- what is the average cost of a CHIP package for a child versus an adult? How much money did states typically spend to cover adults under the CHIP program?

SCHIP gives the states the choice of three design approaches: (1) a Medicaid expansion program, (2) a separate child health program with more flexible rules, and (3) a combination program, which has both a Medicaid expansion program and a separate child health program. Medicaid expansion programs must provide coverage of all benefits available to the Medicaid population, including certain services for children. In particular, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requires

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[2]GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

[3]GAO-02-817 and GAO, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals*, GAO-04-166R (Washington, D.C.: Jan. 4, 2004).

states to cover treatments or stabilize conditions diagnosed during routine screenings, regardless of whether the benefit would otherwise be covered under the state's Medicaid program. A separate child health program does not require EPSDT coverage. States operating separate child health programs base their benefit packages on one of several benchmarks specified in federal SCHIP law, such as (1) the Federal Employees Health Benefits Program or a state employee benefits program (14 states); (2) a statutorily specified benchmark-equivalent set of services (12 states); (3) coverage equivalent to state-funded child health programs in Florida, New York, or Pennsylvania (3 states); or (4) a benefit package approved by the Secretary of Health and Human Services (8 states). GAO did not conduct a cost analysis of states' specific benefit packages.

2. In your statement, you say that CHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. We know that there are several million CHIP eligible children out there who are not currently enrolled in the program. So what caused the enrollment to stabilize, especially since there are so many eligible children who are not covered?

During the early years of SCHIP many states adopted innovative outreach strategies and simplified their enrollment processes in order to reach children and overcome obstacles that were known to hinder program enrollment. For example, in our prior work we reported that states launched ambitious SCHIP public education campaigns; reduced verification requirements that exceeded federal requirements; shortened the length of applications; and placed eligibility workers in schools, child care centers, and churches to help families with the initial processing of applications.[4] It is possible that such strategies helped boost enrollment during the program's early years.

As the program matured, the stabilization that occurred in SCHIP enrollment may be due to factors such as the fixed amount of federal SCHIP funds available to the states, as well as states' own spending limitations based on their particular funding priorities. As health care consumes a growing share of state general fund or operating budgets, slowdowns in economic growth can affect states' abilities to address the demand for public financing of health services. In response to their financial circumstances, some states have attempted to manage program growth through ongoing adjustments to their programs, thus restricting enrollment as needed. For example, when Florida's SCHIP enrollment exceeded a predetermined target in 2003, the state implemented a waiting list and eliminated outreach funding. When enrollment began to decline, the state reinstituted open enrollment in 2005 and outreach in 2006.

3. We have had a lot of discussions on shortfall states over the past several years. How would you define a shortfall state? Why are some states experiencing shortfalls and others are not? What can be done to prevent these shortfalls in the future, besides the obvious, which is to give these states more money? Why did some states consistently spend more than their allotment and

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[4]See GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May. 14, 1999).

other states spend consistently less? I'd like to hear your thoughts on this first, Ms. Allen, but I am also interested in hearing from the other panelists.

In our testimony, we defined shortfall states as states that were identified by CMS or the Congressional Research Service (CRS) as being unable to cover their projected SCHIP expenditures with available funds in the absence of redistributions or additional appropriations by the federal government. Many factors have contributed to states' spending experiences with the SCHIP program. These factors include states' prior coverage of children under Medicaid, and SCHIP eligibility criteria, benefit packages, enrollment policies, outreach efforts, and provider payment rates. In addition, the formula for allocating funds to states has been criticized by some for containing flaws that led to underestimates of the number of eligible children in some states and thus underfunding. North Carolina, for example, attributed its shortfalls to inaccuracies in the CPS-based estimates used to determine states' allocations. In 2004, the state had more low-income children enrolled in the program than CPS estimates indicated were eligible.

As we observed in our testimony, the continued potential for funding shortfalls for many states raises fundamental questions about SCHIP financing, including the extent to which the federal government has a responsibility to address shortfalls, especially in states that have expanded their programs beyond certain parameters. As Congress addresses the reauthorization of SCHIP, one issue for it to consider is whether it will continue to ensure that states do not experience shortfalls by providing for redistribution of funds or by making additional federal appropriations—and the impact that these policies might have on the federal budget.

4. In your testimony you say that states are more likely to spend all of their CHIP funding if they have a Medicaid component to their CHIP program. Could you talk about this in more detail for the Committee?

When we compared the 18 states that were projected by CMS or CRS to experience shortfalls in at least 1 of the final 3 years of the program with the 32 states that were not projected to face shortfalls, we found that the shortfall states were more likely to have a Medicaid component to their SCHIP program.[5] Specifically, 83 percent of the shortfall states had either a Medicaid expansion or a combination program that included a Medicaid expansion, compared with 53 percent of nonshortfall states. Unlike separate child health programs, Medicaid expansion programs generally must follow Medicaid rules, such as providing the full Medicaid benefit package and continuing to provide coverage to all eligible individuals even after the states' SCHIP allotments are exhausted. Although we found that states with a Medicaid component to their SCHIP program were more likely to experience shortfalls, it is not clear to what extent this program design choice contributed to the shortfalls, as many other factors influenced states' financial experiences in SCHIP.

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[5]One state (Tennessee) did not have a SCHIP program during this period.

Question for all witnesses:

1. What is your opinion on giving states three years to spend their CHIP funding for a fiscal year? Does that policy make sense? Are some states taking advantage of this system? If so, how do we resolve this issue?

Federal SCHIP law generally permits states 3 years to use each fiscal year's allocation. It is not clear how states could take advantage of this policy to spend more than they are allotted. In the early years of the program, annual state spending was well below annual allotments. Only 12 states spent their 1998 allotments by the time the period of availability for these funds ended in 2001. It was not until 2005 that a majority of states began spending their full allotments within 3 years. States' spending experiences indicate that without the 3-year period of availability for SCHIP allotments, many states would likely have lost access to a high proportion of their allotted funds during the initial start-up years as they were designing and ramping up their programs.[6] In addition, making SCHIP funds available for more than 1 year may be helpful to states in budgeting and planning. This may be particularly true for the 20 states with biennial budget cycles.

Questions for the Record Submitted by Senator Kerry

1. Your testimony implies there is a causal relationship between a state having a shortfall and its policies to cover non-child populations. But the data shows that only 6 of the 14 states running short of funds for FY07 have expanded coverage—that's less than half. Clearly there is more going on here than just expanded coverage. Concerns with the funding formula, population data, regional variation in health care costs, even the way in which we define income in different states are factors that contribute to shortfalls which even your testimony acknowledges. The most important factor in causing shortfalls, however, may simply be not enough money to cover increasing numbers of eligible children and exploding health care costs.

What evidence do you have that restricting coverage to so-called "core populations" will do anything to prevent shortfalls in the future? What effect would restricting populations have on children's access to coverage? Moving forward, do we really want to make changes in CHIP that will increase the number of uninsured children and families in this country?

Our testimony described the characteristics of states that were projected to have shortfalls in at least 1 of the final 3 years of the program; we did not attempt to determine the extent to which these characteristics contributed to shortfalls. In our written testimony, we noted that the 18 states that faced shortfalls were more likely than the 32

[6]While states were allotted a total of $4.24 billion in 1998, for example, total federal expenditures for 1998 were just $0.12 billion.

states that did not face shortfalls to cover adults in SCHIP under section 1115 waivers.[7] In my oral statement before the Committee, I testified that it is unclear to what extent this or other characteristics of the shortfall states contributed to their spending experiences with the program. As you observe, many other factors have affected states' program balances; these include states' prior coverage of children under Medicaid, and SCHIP eligibility criteria, benefit packages, enrollment policies, outreach efforts, and provider payment rates, as well as the accuracy of estimates of the number of eligible children.

Restricting SCHIP coverage to children would make more funds available for children's coverage but would not necessarily prevent future shortfalls—which are a function of several factors, including the breadth and cost of SCHIP coverage in a state and the federal funding available to that state. As we suggested in our testimony, two important considerations for Congress as it addresses the reauthorization of SCHIP are the extent to which it will maintain states' flexibility to structure coverage to meet their own priorities and the implications of that flexibility for state and federal financing.

2. Childhood obesity has reached epidemic proportions in this country. Overweight kids are more likely to contract conditions like diabetes and hypertension, which lead to chronic diseases later in life. By engaging children in the health care system earlier in life, we can help kids avoid and/or better manage these painful, life-altering, and expensive conditions – and in the process, reduce future expenditures in programs like Medicare.

Isn't this yet another reason to invest in programs like CHIP that improve our children's health?

Congress established SCHIP to provide health coverage to uninsured children in families whose incomes exceeded the eligibility requirements for Medicaid. Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses.

GAO has not conducted an analysis of direct impacts of health insurance coverage on the prevention and treatment of obesity and obesity-related chronic illnesses experienced by children. However, in a 2005 report, GAO noted that research has shown an association between obesity and health care expenditures.[8] For example, according to one estimate, total health care spending for children who receive a diagnosis of obesity is

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[7]States that covered adults in SCHIP under section 1115 waivers before fiscal year 2007 constituted 33 percent of the 18 shortfall states compared with 19 percent of the 32 nonshortfall states. One state (Tennessee) did not have a SCHIP program during this period.

[8]GAO, *Childhood Obesity: Most Experts Identified Physical Activity and the Use of Best Practices as Key to Successful Programs*, GAO-06-127R (Washington, D.C.: Oct. 7, 2005).

approximately $750 million per year.[9] Studies also suggested that childhood obesity appears to be a predictor of adult obesity and may increase health care expenditures over the lifespan. Another study found that Medicaid and Medicare finance nearly half of all medical spending related to adult obesity.[8]

Questions for the Record Submitted by Senator Thomas

1. Should the policy of SCHIP be one where states can cover more adults than children? Especially when states need more money to cover low-income children?

In determining SCHIP policy, it is important that Congress weigh the goal of the SCHIP legislation to cover low-income children and possibly families if it is cost-effective with the flexibility afforded states to create programs that waive requirements but are tailored to address states' varying needs.

In creating SCHIP, Congress authorized states to cover health benefits for entire families—parents or custodians and their children—if it is cost-effective to do so. The cost-effectiveness requirement for family coverage under SCHIP specifies that the expense of covering adults and children in a family must not exceed the cost of covering SCHIP-eligible children. In our prior work, we questioned HHS's approval of state proposals for section 1115 waivers to use SCHIP funds to cover parents of SCHIP- and Medicaid-eligible children without regard to cost-effectiveness. We also took issue with the approval of section 1115 waivers to use SCHIP funds to cover nonpregnant childless adults and suggested that Congress consider amending the SCHIP statute to prohibit such coverage with SCHIP funds.

Under the DRA, Congress addressed this issue by prohibiting the Secretary of Health and Human Services from approving any new section 1115 waivers to cover nonpregnant childless adults after October 1, 2005. Section 1115 proposals that waive the cost-effectiveness requirement to cover parents with SCHIP funds are still permitted.

2. What incentives do states have to focus their programs on the neediest children, instead of higher income children and adults, if Congress continues to provide more funds when states spend all their allotments?

The SCHIP legislation specifies that in screening low-income children for SCHIP eligibility, states that identify children as Medicaid-eligible must enroll them in Medicaid rather than SCHIP. Thus, a state's starting point for SCHIP eligibility is dependent upon the eligibility levels previously established in its Medicaid program. Under federal Medicaid law, all state Medicaid programs must cover children aged 5 and under if their family incomes are at or below 133 percent of the federal poverty level (FPL) and children aged 6 through 18 if their family incomes are at or below 100 percent of the FPL.

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[9]GAO, *Childhood Obesity: Factors Affecting Physical Activity*, GAO-07-260R (Washington, D.C.: Dec. 6, 2006).

While some states have chosen to cover children in families with higher income levels in their Medicaid programs, the minimum Medicaid eligibility requirements are essentially the floor, with SCHIP coverage beginning where Medicaid ends. Flexibility is inherent in both the Medicaid and SCHIP statutes, as states can determine the eligibility level and populations they intend to cover in their programs. Medicaid's mandatory eligibility levels ensure that states cover at least some of the neediest children; however, coverage beyond this minimum level in Medicaid, and how states focus their SCHIP programs, are matters of state prerogative.

3. States receive capped allotments. They all know what they have to spend every year. Why are some states setting up programs that spend more than their yearly allotments?

For this testimony, we did not explore with state officials the reasons behind their SCHIP program design choices or their spending experiences. However, as we specified in our written testimony, the majority of states are now spending more than their yearly allotments. In 2006, the last year for which we have data, 40 states spent their 2003 allotments within the 3-year period of availability. The federal SCHIP law provides for states that spend their full allotments to receive some portion of unused funds from states that have not. In the earlier years of the program, states that spent more than they were allotted could therefore count on redistributed funds from other states to cover some or all of their excess expenditures. Now, however, with the pool of funds available for redistribution virtually exhausted, states can no longer expect to receive more federal funds than they are allotted.

Questions for the Record Submitted by Senator Smith

Questions for all witnesses:

1. Though the federal statute allows all states to cover children whose family incomes are less than 200 percent of the federal poverty level, or $40,000 for a family of four, wide variation remains from state to state. Some states only cover children up to 140 percent of poverty, while others are at 350 percent. Given the potential that Congress may not have adequate funding to allow every state to cover all of the children they may want, is there a value in Congress establishing a "priority population," which would mean some states wouldn't get more money to expand until the lower states have had a chance to catch up?

In the federal SCHIP statute, Congress essentially established a priority population by generally targeting coverage to children in families with incomes up to 200 percent of the FPL. Recognizing the variability in state Medicaid programs and that some states may already be covering this population in Medicaid, the SCHIP statute allows a state to expand eligibility up to 50 percentage points above its existing Medicaid eligibility standard that was in effect as of March 31, 1997. While these provisions gave states the flexibility to structure their SCHIP programs to meet their unique needs, the implication that higher-income children in some states are covered while lower-income children in other states remain uninsured is an important policy consideration.

Such differences in eligibility across states touch upon issues associated with equity that Congress should consider along two dimensions: (1) whether or not all children below a certain income level should be covered under Medicaid or SCHIP and (2) whether or not all states should receive a share of the available funding. These issues, as well as the recognition that states have different funding capabilities and priorities, are important to consider in determining whether efforts to further specify minimum levels of SCHIP coverage will achieve policy goals for more consistent coverage nationwide.

2. Is there a value in Congress providing extra assistance to "poorer" states to help them extend coverage to more children?

Whether or not to provide extra assistance to selected states is another important policy decision for Congress that relates to equitable distribution of SCHIP funds across the states. As we testified, another consideration is whether the formula used in SCHIP—both the formula to determine the federal matching rate and the formula used to allocate funds to states—could be refined to better target funding to certain states for the benefit of covering uninsured children. The SCHIP federal matching rate, to some extent, takes into account the needs of "poorer" states, as it is based on the Medicaid formula, which adjusts for differences in state fiscal capacity to provide more federal funds to states with weaker tax bases. However, we have previously reported that some aspects of the Medicaid formula are problematic and not necessarily the best indicators of states' funding ability.[10] Ultimately, Congress must decide whether it is appropriate to provide additional funding to certain states to assist them in reaching certain policy goals; additionally, if such goals are deemed appropriate by Congress, it may need to establish the criteria for providing additional assistance and consider how other states will fare in any further funding distributions.

3. Concerns have been raised by mental health groups that some S-CHIP programs are not providing adequate mental health coverage. In fact, there is concern that the benefit is not comprehensive and higher cost-sharing may be in place in some states for these benefits. Are you aware of any research into this area to determine how specific states address mental health coverage under S-CHIP?

GAO did not evaluate the mental health benefits covered by the states' SCHIP programs. However, in 2005 the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a comprehensive state-by-state profile of mental health benefits

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[10]The Medicaid formula uses a state's per capita income (PCI) in relation to national PCI to determine the federal share of matching funds for a state's allowable Medicaid spending. However, our prior work concluded that PCI is not a comprehensive indicator of states' total available resources and thus does not accurately represent states' funding ability. See GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620 (Washington, D.C.: July 10, 2003). We also recently reported on potential strategies to help make the Medicaid formula more responsive to economic downturns, which could have implications for the SCHIP formula. See *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97 (Washington, D.C.: Oct. 18, 2006).

covered under SCHIP and Medicaid programs, including services covered, the limits of covered services, cost-sharing, service-delivery systems used, and other features.[11] SAMHSA reported three relevant key findings:

- All states provided mental health services to their Medicaid and SCHIP program participants, and most provided some substance abuse services.
- Limits on mental health services and substance abuse services in Medicaid and SCHIP tended to follow common patterns and were based on a relatively small number of criteria.
- Most states used some form of managed care to deliver mental health and substance abuse services in Medicaid and SCHIP.

4. Does Congress need to do more during reauthorization to ensure all states are addressing mental health care treatment as equitably as physical health conditions?

GAO has not evaluated the extent to which states' SCHIP programs cover mental health problems on a par with physical health conditions. Recently, the first national study of comprehensive parity of mental health and substance abuse treatment benefits compared seven large Federal Employees Health Benefits Program (FEHBP) plans that offered parity of coverage to a matched set of seven nonfederal health plans that did not offer parity of coverage. The study found that, when coupled with management of care, implementation of parity in insurance benefits for mental health and substance abuse treatment for federal employees enrolled in the seven FEHBP plans improved insurance protection without increasing total costs.[12] However, this study does not address how reauthorization of the SCHIP program should address equity in covering mental health and physical health conditions.

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[11]HHS, SAMHSA, Center for Mental Health Services, *State Profiles of Mental Health and Substance Abuse Services in Medicaid* (Washington, D.C.: 2005). Available at http://mentalhealth.samhsa.gov/publications/allpubs/State_Med/default.asp. Accessed 5/24/2007. Appendix A of SAMHSA's report contains state-by-state profiles of mental health services covered, limits of covered services, cost-sharing, service-delivery systems used, and other features under SCHIP and Medicaid.

[12]Howard H. Goldman, Richard G. Frank, M. Audrey Burnam, and others, "Behavioral Health Insurance Parity for Federal Employees," *New England Journal of Medicine* (2006), vol. 354, 1378-1886. HHS and private foundations funded this study.

Shared Testimony of Craig and Kim Lee Bedford

February 1, 2007
United States Senate Committee on Finance
HEARING: "The Future of CHIP: Improving the Health of America's Children"

KIM LEE BEDFORD

Good Morning. My name is Kim Lee Bedford and I am here today with my family from Baltimore, Maryland: my husband Craig and our children Job, 13; Maia, 12; Josiah, 8; Johngideon, 4; and Montgomery, 6 months; and my mother-in-law, Rev. Theresa Bedford, who was gracious enough to join us today. It is an honor to share our family's experience with the Children's Health Insurance Program, or CHIP. CHIP has been a great help to our family in so many ways. This morning, I would like to share with you what CHIP has meant medically and emotionally for us. My husband will talk about CHIP's impact on our family financially. My son Job will talk about how CHIP has improved his health and helped him cope with his struggles with asthma.

We are honored to be invited to testify today and understand that we represent thousands of American families who can not be here today to share their opinions with you. We hope that we speak well as their voice.

Before my husband and I started our own business, our entire family had private health insurance coverage through my husband's job. When we started our own business, we continued our family coverage under COBRA, then purchased a private plan, but the costs were extremely high. While our business was in its infancy, the prospect of our children going without health care insurance was unthinkable, so we maintained the crippling cost of private health insurance coverage as long as we could. We considered many options, including the value health plans that are not really insurance coverage, but rather discounts on medical services. We delayed applying for the Maryland Children's Health Insurance Program because we did not think we would be eligible. With both of us working, we thought our income was too high to qualify.

Finally, feeling thoroughly discouraged in our search for affordable health care, we decided to apply for MCHIP. To our great surprise, we were within the financial range for a family of our size. However, because our children were still covered under private health insurance, we were initially told that we would be unable to enroll in MCHIP for six months, due to the required waiting period mandated in Maryland for those with private insurance who apply for MCHIP.

Had we given up our struggle to provide private health insurance for our children six months earlier, and had left our children completely uninsured – with no medical coverage – for a six month period, then we would have been eligible to enroll in MCHIP. What an unthinkable choice for any parent to have to make: pay unaffordable costs for coverage or risk a child's illness while they are uninsured waiting for MCHIP.

As wonderful a program as CHIP has been for our family, I believe the waiting period guidelines are a serious flaw.

Thankfully, because we were a self-employed household, the MCHIP waiting period did not to apply to our family's application and our children were enrolled. As grateful as we were, I could not help wondering about the impact the waiting period might have on other 2-parent working families, where the parent whose employment provides health insurance coverage for the family is relieved of their position, leaving the family with no health insurance. Six months is a very long time for a child to be without medical care.

Perhaps the greatest impact MCHIP has had on our family medically is that we no longer have to make impossible health choices based on a financial perspective. We no longer have to decide whether a child is "really sick enough" to warrant a doctor's visit. We no longer have to decide whether a child "really needs" a certain medication prescribed by his pediatrician. We no longer have to choose between reactive medical care and proactive medical care for our children. For example, two of our children have asthma. In the past, under our private health insurance, we had to make choices among prescriptions. For example, we would choose between the asthma medication that strengthened his lungs to prevent asthma attacks, or the asthma medication that saved his life during an asthma attack. Needless to say, our first choice was always the reactive benefit medicine before the proactive benefit medicine. Did we "really" need to fill the prescription for two asthma inhalers or could we make do with one, and just hope our son didn't lose it?

A year ago, we had just one of these impossible choice experiences. After our then three-year-old son ate a piece of Valentine's candy that had nuts in it, his lips and throat turned red, hives developed, his face swelled, and he began to have trouble breathing. We talked to our pharmacist and he urged us to go to the emergency room as soon as possible. As it turns out, our son has a severe allergy to tree nuts. If we did not have MCHIP, we might have hesitated in choosing to seek emergency care. Before MCHIP, the costs of ephinedrine "Epi-pens" to halt allergic attacks for our two children with allergies became a questionable expense. Do we really need the Epi-pens or in the event of an allergic reaction, or could we just rush them to the hospital in time? Or is it better to invest in the Epi-pens and possibly avoid the costs of a hospital emergency room visit? *Impossible choices*, equating to average health care at best, despite the very high monthly premiums we were paying.

Under MCHIP our children have access to their regular pediatrician and needed prescriptions with no co-payments. Under our private coverage before, we had paid a minimum of a $20 co-pay per child per visit and, prescription co-pays were up to $30 per prescription, with some medications simply not covered. When you have several children requiring several medications routinely every month, as we do, the co-payment expenses are very heavy. For working people of modest means, these costs are so burdensome.

MCHIP also guarantees access to critical benefits like dental and vision care. Under MCHIP our children have access to full dental coverage. With our private insurance, even with the high monthly premium expense, we had no dental coverage. Dental

appointments were a luxury in our family rather than a basic medical necessity. And since our income at the time, with the fledgling business, did not allow for luxuries, our children did not go to the dentist, for several years. I fear this is very often the case in many working American families. Since enrollment in MCHIP, all of our children routinely visit their dentist every six months as recommended, and all of their dental repair work needed from the time period when we held private medical insurance but did not have dental coverage, has been completed. Just look at those beautiful smiles!

Under MCHIP, our children also have access to vision care. Vision benefits were limited under our private health insurance, and were also expensive. We believe that our oldest daughter could have used glasses several years prior to her receiving them under MCHIP, but once again, optometrist appointments fell within the range of "luxury" health care for us at the time.

And another benefit of MCHIP which may not be readily seen is the impact it has on the health of the entire family. Although MCHIP is intended to provide quality affordable health insurance for children, we have found that this program has made an enormous impact on health care for our entire family. As I am sure many of you could understand, if we were struggling to fit our children's medical expenses into our family budget, you can imagine what this meant for my husband and I in terms of heath care at the time. Of course, as nearly every parent will agree, our children's health concerns came first. Even though our entire family was covered under our private insurance plan, Craig and I saw our health insurance as simply a safety net in the event of a serious illness which required hospitalization. We did not schedule proactive doctor's appointment, we did not have regular physicals, we did not go and get the recommended, standard, incremental medical screenings for major illnesses, and we did not go to the dentist unless we had a very serious dental emergency. The only medical care I took advantage of during that period of time was prenatal care for the birth of one of our children. Monthly health insurance premiums were so cripplingly high that co-payments for the children were a struggle, so we deemed non-essential medical care for ourselves as totally unnecessary.

Surely, I believe, it was only the grace of God that kept us in reasonably good health during those years, because we did not follow *any* of the recommended guidelines for our own health care at the time. For our family, enrollment in MCHIP for our children meant that Craig and I were able to begin routine proactive health care for ourselves again. I visited the dentist for the first time in several years, and will not scare you with the costs of the repair work needed on my teeth after so long. Thus, for us, and I would venture to surmise, for many American families, the Children's Health Insurance Program has served to make our whole family healthier, and not just the children in our family.

CHIP also has given us great peace of mind. From a mental health standpoint, it is depressing for a parent to be unable to provide the excellent quality healthcare that you want to be able to give your children – and it is depressing to see no end in sight. I found that I began to care less about my health because even with the premiums we were paying monthly, good health care seemed unavailable financially. The times when we would

have to make medical decisions for our children based on financial criteria were extremely stressful as parents -- full of those impossible choices.

Those are not the kinds of choices that parents in a society as advanced and as resourced as ours should be forced to make, not when we and our elected governmental officials in whom we have placed our trust and well-being – have choices in how they direct government resources. The Children's Health Insurance Program is by far the next best thing for the health and well-being of all of America's beautiful children, who hold the future and greater promise of this enduring nation in their little hands and hearts. Funding for children's health care should be a budgetary item requiring no debate or even major decision making. Fund health care for all of America's children! It is really that simple.

Today, members of this Committee are gathered together in this room to consider the quality of health for a huge portion of America's citizens. You hold the answer to whether our nation's children are worthy of the additional funding necessary to provide them with quality health care or whether those dollars would be better allocated elsewhere. I challenge each of you to consider what choice you would make if your children or grandchildren's health care depended solely on the funding allocation decision you make on this issue. For so many of us in this great nation, this is the case. Our beautiful children's health and well-being lie in your hands.

We are a unique nation – unlike any other on the face of this earth - where a person's worth is not determined by the circumstances of their birth, not determined by their lineage or genealogical pedigree, nor even determined by the choices of their parents or ancestors. In this great nation of ours, each person's worth is equally determined solely by their drawing their first breath of life on American soil. We can do much more to achieve our forefathers' great vision of equality for our nation's children. Your positive stance on doing whatever it takes to continue and even increase funding for quality affordable health care insurance for so many of America's children such as the Children's Health Insurance Program represents, is absolutely critical.

Thank You.

CRAIG BEDFORD

Good Morning. My name is Craig Bedford. I am so very pleased to be here with my family today. We are eager to share how the Children's Health Insurance Program has helped our family.

I am an Insurance Agent for Erie Insurance Group in Baltimore, Maryland selling Property, Casualty and Life Insurance. Our nation was built on the spirit of entrepreneurship and I believe that deep down in every American dwells the spirit to strike out on his or her own, to be their own boss, to live that part of The American Dream, and no matter what happens, success or failure, that individual can say they had

control of their own destiny. In 2001, I had the chance to pursue the American Dream by opening my own insurance agency and I wanted to take it. I knew the business would not fail, I worked out ways to keep my overall business expenses to a minimum, but what kept me from leaving the comfort of my big company employer was the health plan. I kept asking myself, "How am I going to maintain health insurance for my family, and what am I willing to sacrifice to acquire such a plan?"

Many of my associates began their businesses without health insurance and acquired it later as their businesses became more profitable, but I didn't have that liberty. I had three children at the time, one with asthma, so I could not take that risk. I continued our family coverage under COBRA when I left my employer, but our monthly premiums were like a new mortgage. The first 12 months of being in business, our health insurance costs were 36% of our *gross* income. In 2003 our health insurance premiums increased by 18% to a cost of nearly $800 monthly for a family plan, not including the co-pays and prescription costs. That is when things began to look glum. Even though the business was growing, our health insurance costs were still close to 25% of our *gross* income.

In 2004, a friend told us about the CHIP program. My wife took the lead, researched, and applied. We qualified and were able to cut our health spending by 60%. My wife and I still maintain our own health insurance on a separate private plan. My business is still growing, as is our family, now at 5 children. Unfortunately, the cost of our coverage has grown also. In 2006, health insurance premiums for my wife and me cost the same as the family plan we had in 2002, and still account for 13% of our gross income.

The face of CHIP is families such as ours, families that work hard and play by the rules, trying to live the American dream. Providing quality health care to our children should be a congressional budgetary item requiring no debate or major decision making. We urge you to continue to fund the Children's Health Insurance Program.

Thank you for the opportunity to testify. I would now like to introduce our oldest son Job. Job is a 13-year-old honor student who has had to deal with medical issues relating to his asthma and severe food allergies. He is an incredible child to parent and a wonderful role model for his siblings and friends.

Testimony of Job Timothy Bedford

February 1, 2007
United States Senate Committee on Finance
HEARING: "The Future of CHIP: Improving the Health of America's Children"

Good morning. I am honored to be here in the presence of the Senate Committee on Finance and distinguished others.

I am Job Timothy Bedford, a 13-year-old 8th grader at The Boys' Latin School of Maryland in Baltimore, and the oldest of five children. Thank you for allowing me to speak today on behalf of many other kids with chronic illnesses like myself.

At the age of five I was diagnosed with asthma. Asthma is a chronic illness that inhibits your breathing from time to time. Nearly 9 million American children have this disease. Asthma can make you feel like your throat has shrunken and like you are breathing through a straw. When I have an asthma attack, I start wheezing very hard because of the lack of air going into my lungs. When this happens, I try to find my inhaler. An inhaler is a small device that releases a drug that relaxes the muscles in your air ways. This usually stops my wheezing and any other asthmatic symptoms I may have at the time.

Having good health insurance gives me the means of obtaining inhalers and all other necessary medical treatments I need. I really like the security of knowing I always have an inhaler when and where I need it. We keep one at home, and one at the nurse's office at school, and I always carry one with me wherever I go. It makes me feel safer. Asthma attacks are kind of scary. They are very unpredictable and there is always the worry in the back of my mind that I just might die. When I was younger, I used to not like driving on highways, because they seemed endless and too difficult to get off of if I suddenly needed to go to a hospital. I would always ask my mom, "how long are we going to be on this road," and "do you know where a hospital is around here?" Having asthma makes you feel uneasy.

There are certain circumstances that can trigger asthma attacks. They are different for different kids. One of my main triggers, and the one that makes me most fearful is my allergy to shellfish. If I eat shellfish, like shrimp or crabs, the reaction to my body is very extreme. I get hives and swelling and many other symptoms, but the worst is that it triggers an intense asthma attack. While I do not ever knowingly eat shellfish, and try to be very careful checking to make sure that wherever I eat there is no shellfish present, sometimes it is unavoidable. Sometimes, people who cook food do what I call "cross-pollination," meaning they may cook shellfish in one pot and something harmless like vegetables in another, but they use the same spoon to stir both dishes. For kids with food allergies, this can be very dangerous, and for me can trigger an asthma attack. My family avoids buffet-style restaurants, especially ones that highlight seafood dishes, because when other customers there eat shellfish, and then go and pick up the salad tongs or other serving utensils for dishes I *can* eat, the shellfish residue from their hands gets on the

serving utensils or even on bathroom doorknobs, and causes me to have an allergic reaction, which leads to an asthma attack and having to use my inhaler. There are many things to be constantly aware of for kids like me that have lingering medical conditions.

Having the excellent health care we have through M-CHIP means that I always have my inhalers and other asthma stabilizer drugs, like Flovent, available and I also have medicines like the Epi-pen for allergic reactions. The Epi-pen can save my life if I have a severe allergic reaction, because the epinephrine injection can stop the effects of the shellfish on my body and stabilize me until I can get more advanced medical care. I feel very secure knowing that I always have an Epi-pen with me in my bookbag, one at home, and one in the nurse's office at school.

However all of these medicines I need are expensive. I researched with my parents and learned that a *single* Epi-pen without the medical insurance we have through M-CHIP would cost $76.18 *each*. The asthma inhalers would cost $32.99 *each*, the Flovent would cost $102.89 each. And, additional medicines that I take daily would cost $203.82 *per month* without health insurance. I wanted to give these exact figures to show how expensive prescriptions can be. And these are just for me. My 4-yr-old brother also has asthma and food allergies, and so his prescriptions cost about the same amount as mine.

I feel a little sad about having asthma because it sometimes limits the things I can do. For example, some sports require a lot of endurance, and when you have asthma, it can limit the amount of stamina you need to keep playing . Some warnings like the ones on some roller coasters say kids that have asthma shouldn't go on them. But these are small worries, compared to being able to have the medical care I need.

Having good health insurance through the Children's Health Insurance Program means that necessary medicines and anything we may need medically are always available to me and my siblings. There are no words to describe how safe that makes me feel. I wish everyone had the ability to get the medicine they needed to make their lives easier.

Thank you.

Statement for the Record
Senator Jeff Bingaman
State Children's Health Insurance Program, Finance Committee Hearing
February 1, 2007

In the 10 years since passage of the State Children's Health Insurance Program or "SCHIP," the number of uninsured children has decreased while at the same time the ranks of uninsured adults have grown alarmingly. This is a great achievement on behalf of children, by any measure, but there is still more work to do. Six million children remain eligible for Medicaid or SCHIP, but are not currently enrolled. Thus, the re-authorization of SCHIP must build on this past success to expand the program and ensure that all children in America have access to meaningful health insurance coverage.

Medicaid, our gold standard safety net insurance program for children, was designed at a time when people who worked full time could expect to be able to afford health care. This is no longer true. Today, a full time worker earning minimum wage is at 50% of poverty level. Furthermore, two working adults with wages of $10 per hour do not have enough earning power to afford their health care, yet are at 200% of poverty. Insurance premiums have risen faster than inflation, as have health care costs.

SCHIP priorities for the Nation should be to continue coverage of all currently covered under SCHIP, expand the number of enrollees to capture eligible yet uninsured children, parents and other adults, create incentives for New Mexico and other states to use Medicaid and SCHIP to reduce the number of uninsured, expand coverage to include documented immigrant children and pregnant women, and ensure that Medicaid and SCHIP documentation requirements do not serve as a barrier to U.S. Citizens receipt of SCHIP and Medicaid services. Let me elaborate on each of these.

The first issue of import relates to the ability of New Mexico and a group of other states to use up to 20% of our SCHIP allotment to cover children previously enrolled in Medicaid. I will work through SCHIP reauthorization to ensure this provision is permanent so that states need not face changes in funding that could endanger health coverage for our residents. On the whole, the "20 % states" have chosen to enact policies that cover more uninsured individuals than other states. This innovation and initiative should not be precluded from access to SCHIP funds because of the choice to cover more people. In fact, the federal government should be encouraging such policies. The burden of the uninsured takes its toll on the physical and economic health of our entire country, and extending coverage to more individuals is beneficial for all of us.

The second issue of import relates to ensuring no change in current federal law permitting New Mexico and other states to provide parent coverage under SCHIP waivers, as well as allowing a small subset of "grandfathered" states to provide other forms of adult coverage under SCHIP. Many states extend coverage to low-income adults and parents of children enrolled in SCHIP through these provisions. The coverage we provide has been given prior federal approval and has significantly lowered the rate of un-insurance in our states. Many of our states utilize

this adult coverage to ensure access to "family-based coverage." Research, including the recent report by the Center on Budget and Policy Priorities entitled *"Coverage of Parents Helps Children, Too,"* indicates that such coverage, which ensures parents, along with children, receive health insurance, is critical to ensuring ultimate access of children to meaningful healthcare.

I respectfully ask that this report be entered into the record.

It would be a gross mistake to enact a policy that would risk any loss of coverage for adults, and I strongly urge the Committee to ensure that states will have the flexibility to provide adult coverage through SCHIP as we move forward with reauthorization.

New Mexico has a keen interest in the health of immigrants and it is a priority for me to ensure that the Immigrant Children's Health Improvement Act (ICHIA) is included within SCHIP reauthorization. This critical legislation, which has previously passed the Senate, would ensure that legal immigrant children and pregnant women who, but for their immigration status, are currently eligible for SCHIP may access the program. Given that under current law these children and pregnant women (and U.S. citizen-children eventually born to these pregnant women) will become eligible for SCHIP and Medicaid, it is counterproductive to prevent these legal immigrants from accessing services more immediately. Without such access to healthcare, research shows individuals may become sicker resulting in long-term higher costs to federal and state governments.

SCHIP reauthorization must also include important changes to the citizenship documentation requirements included in Section 6036 of the Deficit Reduction Act of 2005 (Pub. Law.109-171). These requirements were recently operationalized by the Centers for Medicare and Medicaid Services (CMS). As the report released by the Center on Budget and Policy Priorities, *New Medicaid Citizenship Documentation Requirements is Taking a Toll*, indicates, tens-of-thousands of citizen children and other citizens born and raised within the United States being needlessly denied the Medicaid benefits to which they are entitled simply because they do not have access to a passport, original birth certificate, or other newly required documentation. As the OIG report from July 2005 (*OEI-02-03-00190*) indicates, prior to enactment of this provision there was no indication of wide-spread fraud in relation to Medicaid recipients claiming U.S. citizenship status.

I respectfully ask that these reports be entered into the record.

I would ask all members of the Finance Committee's assistance to ensure that SCHIP reauthorization provides state Medicaid agencies greater flexibility to determine citizenship status of applicants, which would include the ability to require documentation when such agencies had legitimate concerns about the citizenship status of an applicant.

In summary we must ensure that through reauthorization of SCHIP that all those individuals covered currently by Medicaid and by SCHIP do not fall into the ranks of the uninsured. That would be a step backward. Furthermore, we must redouble our efforts to enroll the more than 6 million children who remain uninsured.

I respectfully ask that this statement be entered into the record.

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October 20, 2006

COVERAGE OF PARENTS HELPS CHILDREN, TOO

By Leighton Ku and Matthew Broaddus

Summary

The nation has made an important commitment to reducing the number of uninsured children. Over the past decade, the creation of the State Children's Health Insurance Program (SCHIP) and related changes made by states in their Medicaid programs have boosted children's enrollment and led to a marked reduction in the number of uninsured children. Nonetheless, almost 9 million children (18 or younger) remain uninsured, and about two-thirds of them are low-income children who are eligible for public coverage but are not enrolled. Most of these eligible but uninsured children are children in low-income working families.

A growing body of research demonstrates that one highly effective way of boosting coverage among these low-income children is to broaden health insurance programs so that the programs also cover their parents. The research shows, for example, that states that have expanded Medicaid coverage for low-income parents have experienced significantly greater gains in enrollment among eligible children than states that did not expand parents' coverage.

KEY FINDINGS

- An extensive body of research shows that covering low-income parents increases enrollment by eligible children in health insurance programs, thereby reducing the number of children who are uninsured.
- Parental coverage also appears to improve children's use of health care, such as preventive care.
- Policies that cut back coverage for low-income parents are likely to result in reduced coverage for children as well, and hence in more children becoming uninsured.
- Covering low-income parents also increases their own insurance coverage and access to care.

Such findings are especially relevant now, because two actions that Congress may take (or fail to take) in coming months could reduce coverage among low-income working parents. A program known as Transitional Medical Assistance (TMA), under which low-income parents who work their way off welfare may receive Medicaid coverage for 12 months after doing so, expires on December 31, 2006.[1] To maintain this program — which is regarded as successful, has traditionally enjoyed bipartisan support, and was originally created under President Ronald Reagan in 1988 — Congress will need to act in its upcoming "lame duck" session to continue the program. To date, Congress has taken no action on this matter.

[1] If TMA expires on December 31, pre-existing rules, under which parents working their way off welfare received only four months of transitional coverage, will go into effect.

In addition, at the state level, a number of states have cut back parents' Medicaid coverage in recent years as a budget-cutting measure. For example, between 2001 and 2005, Missouri lowered the Medicaid net income eligibility limit for parents from 100 percent of the poverty line to just 22 percent, disqualifying nearly all working-poor parents.

Finally, nine states (Arkansas, Arizona, Illinois, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island and Wisconsin) use a modest portion of their SCHIP funds to provide health insurance coverage for some low-income parents.[2] Some Members of Congress have begun floating the idea of disallowing the use of SCHIP funds to cover parents when SCHIP is reauthorized next year.

An extensive body of research indicates that such actions (or in the case of the impending expiration of Transitional Medical Assistance, the lack of action) almost certainly would result in the loss of coverage for some eligible low-income children. The research also shows that expansions of parents' coverage lead to enrollment gains among children. The research, conducted by a number of research teams across the country using a variety of data sources and research methods, yields the following findings:

- **Covering low-income parents in programs such as Medicaid and SCHIP increases enrollment by eligible children, with the result that fewer children go uninsured.** Studies show that expansions of coverage for low-income parents lead to greater Medicaid or SCHIP participation by eligible children and reduce the percentage of eligible children who remain uninsured. The studies also indicate that covering parents helps eligible low-income children retain their coverage when it comes up for renewal so that fewer children lose insurance at that time, improving the continuity of children's coverage and reducing the number of periods without insurance. In reviewing the research concerning health insurance and families, the highly regarded Institute of Medicine (an arm of the National Academy of Sciences) concluded: "Extension of publicly supported health insurance to low-income uninsured parents is associated with increased enrollment among children."[3]

- **When their parents are insured, children gain better access to health care and improve their use of preventive health services.** Even among children who *are* covered by Medicaid or SCHIP, enrolling their parents produces gains. Insured children whose parents also are insured are more likely to receive health care services they need, such as preventive health care, than insured children whose parents lack coverage.

- **Expanding coverage for parents strengthens insurance coverage and health care access for the parents themselves.** More than one-third of all low-income parents — 36 percent — have no health insurance. As would be expected, the research shows that expanding eligibility for health insurance programs to cover more low-income parents reduces the percentage of low-income parents who are uninsured. Increased Medicaid coverage for low-income parents also has been found to boost their use of preventive health care such as Pap smears and breast

[2] Arkansas, New Mexico and Oregon provide SCHIP-funded coverage for parents under premium assistance programs, as compared to their regular SCHIP or Medicaid programs. Arkansas' program is scheduled for implementation in 2007.

[3] Committee on the Consequences of Uninsurance, Institute of Medicine, *Health Insurance Is a Family Matter*, Washington, DC: National Academy Press, 2002.

exams, and to lower the extent to which low-income parents postpone or skip necessary health care due to cost.

Background: Health Insurance Coverage Among Low-Income Children and Parents

Eligibility for Medicaid and SCHIP is usually determined on an individual basis: a child may eligible for health insurance, but her mother may not be. Eligibility generally is considerably more restrictive for parents than for children.

- In 2005, the median income eligibility limit under Medicaid and SCHIP for a child was 200 percent of the poverty line ($32,200 for a family three that year).

- In contrast, the median Medicaid income limit for parents stood at 67 percent of the poverty line (about $10,800 for a family of three), or about one-third of the income limit for children.[4]

A key reason that Medicaid income limits for parents often are extremely low is that many states set their Medicaid income limits for parents at the same level as their income limits for cash welfare assistance. Those limits usually are far below the poverty line. States are allowed to set Medicaid eligibility limits for parents at higher levels than that and many do so, but many other states do not.[5] In Texas, for example, the income limit for parents was $4,800 for family of three (30 percent of the poverty line) in 2005. In Arkansas, the limit in 2005 was $3,060 (19 percent of the poverty line).

The advent of SCHIP, as well as the changes that a number of states made over the past decade to simplify the procedures for enrolling children in Medicaid, led to increased insurance coverage among children. As Figure 1 illustrates, Census data show that the number of uninsured low-income children has fallen markedly since 1997.[6]

But parents have not fared as well. The number of uninsured low-income parents *increased* over the first half of this decade, from 6.0 million uninsured low-income parents in 2000 to 7.2 million uninsured low-income parents in 2005. While the gains in SCHIP and Medicaid coverage for children were sufficient to offset the losses of employer-sponsored coverage for children, this was not the case for parents.

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[4] Donna Cohen Ross and Laura Cox, "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families," Kaiser Commission on Medicaid and the Uninsured, Oct. 2005.

[5] States can expand Medicaid eligibility for parents beyond the limits used for state welfare programs; states may do so either under demonstration project waivers (based on Section 1115 of the Social Security Act) that are approved by the Centers for Medicaid and Medicare Services (CMS) or under Medicaid rules that allow states to use less restrictive methods to count income (and thereby effectively to raise Medicaid income limits for parents). Under Section 1115, states also may secure waivers to use a portion of their SCHIP funds to cover parents; to secure such a SCHIP waiver, a state must already extend SCHIP eligibility to children with incomes up to 200 percent of the poverty line.

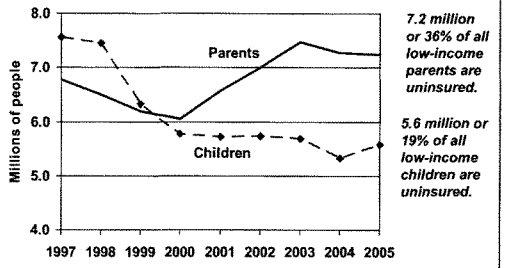
[6] Both the CPS and the Center for Disease Control and Prevention's National Health Interview Survey (NHIS) indicate that the percentage of low-income children who are uninsured has fallen substantially since 1997. The CPS data, reflected in Figure 1, show that the percentage of low-income children who are uninsured rose slightly in 2005, while the NHIS data indicate that the percentage of low-income children who are uninsured continued to decline in 2005. Although the general trends in the two surveys are similar, it is not clear why the CPS and NHIS results for 2005 diverge slightly.

More than a third (36 percent) of low-income parents (i.e., of parents with incomes below 200 percent of the poverty line) were uninsured in 2005. In contrast, 19 percent of low-income children were uninsured. About two-thirds of the low-income parents who were uninsured (62 percent) were mothers.

More than four of every five low-income uninsured parents (81 percent) are members of working families. Uninsured low-income working parents are especially likely to be employed by small businesses. Almost half of low-income parents who work for firms with fewer than 25 employees are uninsured.[7]

FIGURE 1

Over the Past Decade, Fewer Uninsured Low-income Children But More Uninsured Low-income Parents



Source. Those below 200% of poverty. CBPP analyses of Current Population Survey data. Census methods changed in 2000 and 2004, so data are not completely comparable

Research Findings on the Effects of Covering Parents on Enrollment Among Eligible Children

In 2000, we issued a study examining whether there is a connection between Medicaid coverage for parents and coverage for children.[8] We compared trends from 1990 to 1998 in the participation of eligible low-income children in Medicaid in one set of states — states that, during those years, raised their Medicaid income eligibility limits for parents above their cash welfare income limits — to trends in other states that did not take such action. Although children under six with incomes below 133 percent of the poverty line were eligible for Medicaid in *all* states during this period, children's participation grew much more robustly in the states where parent eligibility was expanded than in states where it was not, as Figure 2 demonstrates. Not surprisingly, these family-based expansions also increased Medicaid participation among low-income parents.

Parents sometimes do not enroll their children in Medicaid or SCHIP because they do not know about the programs, do not realize their children are eligible, or encounter enrollment barriers such as excessive documentation requirements or complicated applications forms or procedures. Even if they gain coverage for their children, the children may subsequently lose it because of complicated requirements for periodically renewing their coverage. Covering *both* parents and children (as opposed to children only) generally makes it simpler and provides more incentive for families to obtain and keep coverage, because a single visit to the eligibility office or submission of a single

[7] These statistics are based on CBPP analyses of the March 2006 Current Population Survey. Working families are defined as those earning more than $5,150 per year, the amount earned by working at the minimum wage for 1,000 hours in a year. The risk that a low-income parent is uninsured is similar whether a family resides in a central city, a suburb or a rural area.

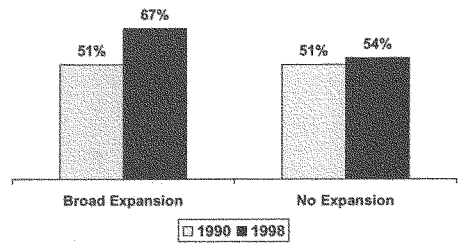
[8] Leighton Ku and Matthew Broaddus, "The Importance of Family-based Insurance Expansions: New Research Findings about State Health Reforms," Center on Budget and Policy Priorities, September 5, 2000.

form may lead to coverage for all members of the family. Broader eligibility also may raise the visibility of Medicaid and SCHIP to these families.

Since we conducted this study in 2000, a number of other researchers have analyzed more recent data sources and used other research methodologies. Their findings are consistent with those of our 2000 study. The recent research buttresses the conclusion that covering parents stimulates enrollment by eligible children.

FIGURE 2

States with Broad Family Expansions Increased Medicaid Participation Rates Among Young Low-income Children



Source: Ku and Broaddus, 2000. Analyses of Current Population Survey data.

- Lisa Dubay and Genevieve Kenney of the Urban Institute analyzed data from the National Survey of America's Families and found that public insurance (Medicaid or SCHIP) participation rates among eligible children were about 20 percentage points higher in states that had raised the Medicaid income limit for parents above the state's welfare income limit than in states that had not done so.[9]

- Anna Aizer of Brown University and Jeffrey Grogger of UCLA examined data from the Census Bureau's Current Population Survey (CPS) for 1995-2002. They found that expansion in Medicaid eligibility for parents led to increased enrollment among both children and their parents and to reduced levels of uninsurance among both groups. Parent expansions led the percentage of eligible children who enroll in Medicaid to rise by 5.3 percentage points and caused the percentage of children who are uninsured to fall by 4.1 percentage points. Their analyses also indicated that parent coverage expansions helped narrow insurance gaps among white, African American and Latino children.[10]

- Barbara Wolfe of the University of Wisconsin at Madison used CPS data to examine program characteristics associated with higher enrollment of children in SCHIP. One of her analyses found parent coverage to be associated with higher child enrollment.[11]

- Sylvia Guendelman of the University of California at Berkeley and her colleagues studied data from the California Health Interview Survey. They compared insured children whose parents were *uninsured* to insured children whose parents were *insured*. They found that children with

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[9] Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid," *HSR: Health Services Research*, 38(5):1283-1301, 2003. In a more detailed assessment of changes in Massachusetts, Dubay and Kenney similarly found that the state's Medicaid expansion for parents resulted in increased Medicaid enrollment by eligible children and produced a significant decrease in the percentage of children who were uninsured.

[10] Anna Aizer and Jeffrey Grogger, "Parental Medicaid Expansions and Health Insurance Coverage," NBER Working Paper 9907, August 2003.

[11] Barbara Wolfe and Scott Scrivner, "The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-up," *Journal of Policy Analysis and Management*, 24(3):499-522, 2005.

uninsured parents were more likely to experience breaks in their insurance coverage, while children whose parents were insured were more likely to have continuous coverage.[12]

- Benjamin Sommers of Harvard examined the retention of Medicaid and SCHIP coverage over a year. His analysis, based on CPS data from 1999 to 2004, indicated that children enrolled in Medicaid or SCHIP were about 38 percent to 76 percent more likely to retain coverage when their parents also were covered. He concluded that "Attempts to expand health insurance to the 8.5 million uninsured children in the U.S. would be much more effective if they covered parents and children in the same program."[13]

Covering Parents Also Improves Children's Health Care Access and Utilization

While covering uninsured children improves their access to health care,[14] research indicates that children's access to care improves to a greater degree when their parents also are covered.

- Amy Davidoff and her colleagues at the Urban Institute analyzed data from the 1999 National Survey of America's Families. They found that insured children had better access to care than uninsured children but that there were additional access gains when the children's parents also were covered. Those children whose parents were insured were more likely to have seen a health care provider and more likely to had a well-child health visit. The researchers concluded that extending public insurance coverage to parents "will have a positive spillover effect on access to care for children."[15]

- Elizabeth Gifford and her colleagues at Pennsylvania State University used the 1996 Medical Expenditure Panel Survey to examine children's use of preventive health services in the form of well-child visits. Only 29 percent of uninsured children had a well-child visit, compared with 43 percent of children who were covered by Medicaid but whose parents were uninsured. In contrast, 67 percent of the children whose parents also were covered by Medicaid had a well-

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[12] Sylvia Guendelman, Megan Wier, Veronica Angulo and Doug Oman, "The Effects of Child-only Insurance Coverage and Family Coverage on Health Care Access and Use: Recent Findings Among Low-income Children in California," *HSR: Health Services Research*, 41(1):125-47, Feb. 2006.

[13] Benjamin Sommers, "Insuring children or insuring families: Do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP?" *Journal of Health Economics*, in press, 2006. (Accepted April 2006).

[14] See, for example, Judith Wooldridge, et al. " Congressionally Mandated of the State Children's Health Insurance Program: Final Report to Congress," Mathematica Policy Research and the Urban Institute, Oct. 2005, Andrew Dick, et al., "SCHIP's Impact in Three States: How Do the Most Vulnerable Children Fare," *Health Affairs*, 23(5):63-75, Sept./Oct. 2004; Michael Seid, et al., "The Impact of Realized Access to Care on Health-Related Quality of Life: A Two-year Prospective Cohort Study in California's State Children's Health Insurance Program," *Journal of Pediatrics*, 149: 254-6, Sept. 2006; Amy Davidoff, et al. "Effects of the State Children's Health Insurance Program Expansions on children with chronic health conditions," *Pediatrics*. 2005 Jul;116(1):e34-42; Leighton Ku and Sashikala Nimalendran, "Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP," Center on Budget and Policy Priorities, Jan. 2004.

[15] Amy Davidoff, Lisa Dubay, Genevieve Kenney and Alshadye Yemane, "The Effect of Parents' Insurance Coverage on Access to Care for Low-income Children," *Inquiry*, 40:254-268, Fall 2003.

Parent Coverage Also May Improve Earnings

A study that Barbara Wolfe conducted of Wisconsin's Medicaid coverage expansion for low-income parents (BadgerCare) found that parent coverage was associated with a 3 percent to 7 percent increase in mothers' earnings. Wolfe reasoned that being assured that parents would continue to have health insurance coverage when they earned more than the welfare income limits gave women incentives to work longer hours or to take jobs that paid more without worrying they would lose their health insurance.*

* BadgerCare offers eligibility for parents who have worked their way off welfare as long as the parents' incomes are below 185 percent of the poverty line. Wolfe's study examined earnings for more than a year after people left welfare. Barbara Wolfe, Thomas Kaplan, Robert Haveman and Yoon Young Cho, "Extending Health Care Coverage to the Low-income Population: The Influence of the Wisconsin BadgerCare Program on Labor Market Outcomes," Institute for Study of Labor Discussion Paper, Sept. 2005.

child visit.[16]

- Guendelman and her colleagues found that when parents are also insured, children are more likely to have a usual source of health care — that is, to have a regular doctor or clinic where they can go for care.[17]

The Institute of Medicine concluded in its report on health insurance and families: "If parents use health care, their children are more likely to use health care as well."[18]

Parents' Health Can Affect Children's Health

The Institute of Medicine also reported in its study: "The health of one family member can affect the health and well-being of other family members. In particular, the health of parents can play an important role in the well-being of their children."[19] The Institute noted that a parent's poor physical or mental health can create a stressful family environment that may impair the health or well-being of a child. For example, one study found that the children of parents who suffer from depression have a higher rate of mental health problems themselves and require greater amounts of mental health care and general health care.[20] These findings suggest that better insurance coverage and treatment for parents may ultimately improve the family environment in which children grow up and may contribute to better child health.

[16] Elizabeth Gifford, Robert Weech-Maldonado, Pamela Farley Short, "Low-income Children's Preventive Service Use: Implications of Parents' Medicaid Status," *Health Care Financing Review*, 26(4):81-94, Summer 2005.

[17] Sylvia Guendelman, *op cit.*

[18] Committee on the Consequences of Uninsurance, Institute of Medicine, *op cit.*

[19] *Ibid.*

[20] Mark Olfsson, et al. "Parental Depression, Child Mental Health Problems and Health Care Utilization," *Medical Care*, 41(6):716-21, 2003.

Covering Parents Improves Their Own Insurance Coverage and Access to Care

A number of studies demonstrate that, as one would expect, expanding eligibility for parents increases their insurance coverage and improves their access to health services.

- Jeanne Lambrew of George Washington University found that the percentage of low-income parents who are uninsured was more than 40 percent lower in states that had expanded the Medicaid income eligibility limits for parents at least to the poverty line than in states without such expansions.[21]

- Aizer and Grogger found that Medicaid expansions for parents increased Medicaid enrollment by parents and reduced the percentage of low-income parents who are uninsured.[22]

- Susan Busch of Yale University and Noelia Duchovny (now at the Congressional Budget Office) examined CPS data for non-disabled parents and concluded that parent eligibility for public health insurance programs is associated with a 12 percent to 15 percent increase in Medicaid enrollment and an 11 percent decrease in the uninsurance rate among parents.[23]

- Barbara Wolfe and her colleagues found that Wisconsin's parent expansion program (BadgerCare) elevated coverage for low-income mothers. Wolfe observed, "BadgerCare was successful in increasing coverage for this group of vulnerable women as they left cash assistance and moved into the labor force."[24]

Similarly, research has shown that expanded eligibility for parents improves their access to care and increases their use of preventive and primary health services:

- Using data from the 1999 National Survey of America's Families, Dubay and Kenny found that, when compared with uninsured parents, parents with Medicaid coverage were more likely to receive health care they needed on a timely basis, more likely to have seen a doctor or dentist, more likely to have a usual source of health care, more likely to have a breast exam and more confident that they could get health care when they needed it.[25]

- Busch and Duchovny used data from the Behavioral Risk Factor Surveillance System to assess the effect of parent coverage expansions on health access. Parent eligibility expansions were associated with greater use of Pap smears and breast exams. In addition, parents were less likely

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[21] Jeanne Lambrew, "Health Insurance: A Family Affair" Commonwealth Fund, May 2001.

[22] Aizer and Grogger, *op cit.*

[23] Susan Busch and Noelia Duchovny, "Family Coverage Expansions: Impact on Insurance Coverage and Health Care Utilization of Parents," *Journal of Health Economics*, 24:876-89-, 2005.

[24] Barbara Wolfe, Thomas Kaplan, Robert Haveman and Yoonyoung Cho, "SCHIP expansion and parental coverage: An evaluation of Wisconsin's BadgerCare." *Journal of Health Economics* (in press, 2006). Accepted Dec 2005. The quote is from an interview with Wolfe conducted by the University of Michigan's Economic Research Initiative on the Uninsured, April 2005.

[25] Lisa Dubay and Genevieve Kenney, "Addressing Coverage Gaps for Low-income Parents," *Health Affairs*, 23(2):225-234, Mar/Apr 2004.

to forgo health care because they could not afford it.[26]

Conclusions

The nation has made significant progress in lowering the number of low-income children who lack health insurance coverage. Even so, almost 9 million children remain uninsured, and two-thirds of them are eligible for Medicaid or SCHIP coverage but are not enrolled. A key component of efforts to reduce the number of uninsured children consequently must be to increase participation among low-income children who already are eligible.

A large body of research shows that addressing this issue is tied to coverage for low-income parents. The research is clear that covering more low-income parents will result in significant gains in enrolling eligible children. The research also indicates that policy measures that would curtail — rather than broaden — parents' coverage would not only result in more uninsured parents but lead to more uninsured children as well.

[26] Busch and Duchovny, *op at.*

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February 2, 2007

NEW MEDICAID CITIZENSHIP DOCUMENTATION REQUIREMENT IS TAKING A TOLL:

States Report Enrollment is Down and Administrative Costs Are Up

by Donna Cohen Ross

Introduction

A new federal law that states were required to implement July 1 is creating a barrier to health-care coverage for U.S. citizens — especially children — who are eligible for health insurance through Medicaid. The new law, a provision of the Deficit Reduction Act of 2005, requires U.S. citizens to present proof of their citizenship and identity when they apply for, or seek to renew, their Medicaid coverage. Prior to enactment of the law, U.S. citizens applying for Medicaid were permitted to attest to their citizenship, under penalty of perjury.

In the six months following implementation of the new requirement, states are beginning to report marked declines in Medicaid enrollment, particularly among low-income children. States also are reporting significant increases in administrative costs as a consequence of the requirement.

This analysis presents the data available so far on this matter. The available evidence strongly suggests that those being adversely affected are primarily U.S. citizens otherwise eligible for Medicaid who are encountering difficulty in promptly securing documents such as birth certificates and who are remaining uninsured for longer periods of time as a result.

The new requirement also appears to be reversing part of the progress that states made over the past decade in streamlining access to Medicaid for individuals who qualify, and especially for children. For example, to improve access to Medicaid and reduce administrative costs, most states implemented mail-in application procedures, and many states reduced burdensome documentation requirements. The new Medicaid citizenship documentation requirement now appears to be pushing states in the opposite direction, by impeding access to Medicaid. Families must furnish more documentation and may be required to visit a Medicaid office in person to apply or renew their coverage, bypassing simpler mail-in and on-line enrollment opportunities, because they must present original documents such as birth certificates that can take time and money to obtain. This is likely to cause the most difficulty for working-poor families that cannot afford to take time off from work to visit the Medicaid office and for low-income families residing in rural areas.

Laura Cox, Leighton Ku and Melanie Nathanson contributed to this paper.

The new citizenship documentation requirement — which the Bush Administration did not request and the Senate initially did not adopt, but which the House of Representatives insisted upon in conference — was presented by its proponents as being necessary to stem a problem of undocumented immigrants securing Medicaid by falsely declaring themselves to be U.S. citizens. The new requirement was adopted despite the lack of evidence that such a problem existed. In response to a report in 2005 by the Inspector General of the Department of Health and Human Services, Mark McClellan, then the Administrator of the Centers for Medicare and Medicaid Services at HHS, noted: "The [Inspector General's] report does not find particular problems regarding false allegations of citizenship, nor are we aware of any."[1]

What State Officials Are Saying About the Citizenship Documentation Requirement

"[Kansas] Gov. Kathleen Sebelius ... recently said the state's enrollment has declined by 18,000 people since the citizenship documentation requirement took effect. Many of those people are likely citizens who simply lack documents, she said, who may experience a harmful gap in health insurance coverage."

United Press International (UPI)
Friday December 1, 2006

"While we understand that the new law targets illegal immigrants, we must point out that the impact of the law in our state is mostly falling on eligible citizens."

Andrew Allison,
Deputy Director, Kansas Health Policy Authority
Lawrence Journal World
Friday January 19, 2007

"There is no evidence that the [enrollment] decline is due to undocumented aliens leaving the program. Rather, we believe that these new requirements are keeping otherwise eligible citizens from receiving Medicaid because they cannot provide the documents required to prove their citizenship or identity."

Anita Smith
Chief of the Bureau of Medical Supports Iowa Department of Human Services
December 8, 2006

"These numbers [the Medicaid enrollment decline] are not driven primarily by the loss of population from New Orleans and other parishes affected by Hurricane Katrina...We are quite confident that the overwhelming majority of these children are citizens — born right here in Louisiana — and not ineligible alien children."

J. Ruth Kennedy
Deputy Medicaid Director
Louisiana Department of Health and Hospitals
November 13, 2006

[1] U.S. Department of Health and Human Services, Office of Inspector General, "Self-declaration of U.S. Citizenship for Medicaid," July 2005.

Impact of the Citizen Documentation Requirement on Medicaid Applicants and Beneficiaries: The Early Evidence

Medicaid enrollment figures for all states for the period since the new requirement was implemented on July 1 are not yet available. By contacting several individual states that do have such data, however, we were able to secure enrollment information from Wisconsin, Kansas, Iowa, Louisiana, Virginia and New Hampshire. The data show the following:

- All six states report a significant drop in enrollment since implementation of the requirement began.
- Medicaid officials in these states attribute the downward trend primarily or entirely to the citizenship documentation requirement.

Two types of problems are surfacing:

- Medicaid is being denied or terminated because some beneficiaries and applicants cannot produce the specified documents despite, from all appearances, being U.S. citizens; and
- Medicaid eligibility determinations are being delayed, resulting in large backlogs of applications, either because it is taking time for applicants to obtain the required documents or because eligibility workers are overloaded with the new tasks and paperwork associated with administering the new requirement.

Some states have designed mechanisms specifically to track enrollment changes resulting from the new procedures. Wisconsin, for example, has established computer codes to distinguish when Medicaid eligibility is denied or discontinued due to a lack of citizenship or identity documents. In other states, a comparison of current and past enrollment trends strongly suggests that the new requirement is largely responsible for the enrollment decline. For example, in many states aggressive "back to school" outreach activities conducted in August and September usually result in increased child enrollment in September and October. In 2006, however, states such as Virginia and Louisiana reported that child enrollment declined despite vigorous promotional campaigns, indicating that the new requirement undermined the value of the outreach efforts.

The Medicaid enrollment declines identified in this memo do not appear to be driven by broader economic trends or a change in the employment of low-income families. If that were the case, parallel enrollment decline trends would appear in the Food Stamp Program, which is the means-tested program whose enrollment levels are most responsive to such developments. Instead, Food Stamp caseloads have been increasing slightly in recent months. Moreover, each of the states identified in this memo as having sustained a drop in Medicaid enrollment saw its food stamp caseload *rise* during a similar period (Figure 1).[2] An example comparing Food Stamp and Medicaid enrollment in Wisconsin is shown (Figure 2).[3]

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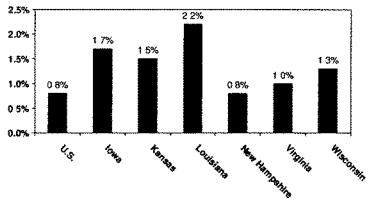
[2] Data from Food and Nutrition Service, USDA, June 2006 through October 2006

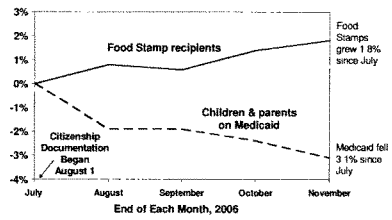
[3] Wisconsin Department of Health and Family Services

Figure 1
Food Stamp Caseloads Have Been Rising as Medicaid Enrollment Has Declined
Percentage Food Stamp Program Growth, June and October 2006



Source: Food and Nutrition Service, USDA. Data for October are initial

Figure 2
Wisconsin: Medicaid Enrollment Dropped When Citizenship Documentation Began, Even as Food Stamp Enrollment Climbed



Source: Wisconsin Dept. of Health and Family Services

Both Medicaid and the Food Stamp Program serve similar populations of low-income families and are often administered by the same agencies and caseworkers. A key difference is that the citizenship documentation rules were applied to Medicaid but there were no such changes in the Food Stamp Program. It thus appears that the changes in Medicaid enrollment are a result of changes in Medicaid policies — particularly citizenship documentation — that do not affect eligibility for food stamps.

The following states have documented declines in Medicaid enrollment since the implementation of the Medicaid citizenship documentation requirement[4]:

- **Wisconsin:** In five months — between August and December 2006 — a total of 14,034 Medicaid-eligible individuals were either denied Medicaid or lost coverage as a result of the documentation requirement. The loss of Medicaid coverage occurred despite Wisconsin's efforts to minimize the impact of the requirement by obtaining birth records electronically from the state's Vital Records agency. Obtaining proof of identify, rather than proof of citizenship, was the major problem for people in Wisconsin who were otherwise eligible during this period: 69 percent of those who were denied Medicaid or who lost Medicaid coverage due to the new requirement did not have a required identity document, as compared to 17 percent who did not provide the required citizenship documents and 14 percent who were missing both a citizenship and identity document.[5] This indicates that most of those who were denied were, in fact, U.S. citizens.

- **Kansas:** The Kansas Health Policy Authority (KHPA) reports that between 18,000 and 20,000 applicants and previous beneficiaries, mostly children and parents, have been left without health insurance since the citizenship documentation requirement was implemented. About 16,000 of these individuals are "waiting to enroll" or "waiting to be re-enrolled;" the state says these eligibility determinations are being delayed because of a large backlog of applications related to the difficulties confronting individuals and eligibility workers alike who are attempting to comply with the new rule. Documents on the KHPA website state that the "majority of

[4] Data from Iowa, Louisiana, Virginia and New Hampshire first published in: *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006* by Donna Cohen Ross, Laura Cox and Caryn Marks, Kaiser Commission on Medicaid and the Uninsured, January 2007.

[5] Wisconsin Department of Health and Family Services

of families with pending applications will qualify for coverage under the new requirements when we are able to complete processing."[6] In the meantime, these children and parents are barred from getting the health coverage for which they qualify and are, in most cases, uninsured.

> "We recently saw a toddler in our pediatrics clinic. Her grandmother, who has custody, brought her in. She was worried that her granddaughter was behind in her immunizations, and since the little girl has no health insurance, the grandmother turned to us for help. We then discovered that the child, who had been born prematurely, suffers from chronic lung disease and her development is considerably delayed. She needs a nebulizer to deliver the medication to help her breathe and she also needs speech and other therapy. This child is eligible for Medicaid, but because her grandmother does not have the required birth certificate, she could not be enrolled. The child will get Medicaid coverage when we obtain her birth certificate, most likely at least a month from now. But in the meantime, necessary treatment has been delayed because her grandmother cannot afford to pay the bills during the wait for an eligibility determination. For a child with developmental delays, every day without the necessary therapy and treatment makes it more difficult for her to catch up with her peers… It has gotten so complex that we've added a lawyer to our clinic to help sort things out."
>
> Pam Shaw
> Chief of the Division of Ambulatory Pediatrics
> KU Medical Center
> January 31, 2007

- **Iowa:** Iowa has identified an unprecedented decline in Medicaid enrollment that state officials attribute to the Medicaid citizenship documentation requirement. Prior to July 1, 2006, overall Medicaid enrollment had steadily increased for the past several years. While sporadic declines occurred in rural counties, no county in the state's larger population centers experienced a decline in the months leading up to the implementation of the new requirement. However, between July and September 2006, Medicaid enrollment sustained *the largest decrease in the past five years*; this also was the first time in five years that the state has experienced an enrollment decline for three consecutive months.

  Although other factors may contribute to the recent decrease in enrollment, state officials point out the state is now experiencing a more severe effect on enrollment than it has following any of the Medicaid changes that have occurred over the past several years. The state's conclusion that the citizenship documentation requirement is driving the decline is supported by the fact that enrollment has dropped among the populations subject to the requirement (children and families) but has remained steady among groups not affected by the requirement (individuals receiving Medicare and SSI).[7]

- **Louisiana:** In two months — September and October of 2006 — Louisiana experienced a net loss of more than 7,500 children in its Medicaid program despite a vigorous back-to-school outreach effort and a significant increase in applications during the month of September.

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[6] Kansas Health Policy Authority, Factsheet, www.khpa.ks.gov , December 4, 2006.

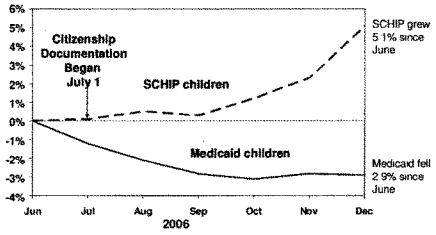
[7] Communication with Anita Smith, Bureau Chief, Bureau of Medical Supports, Iowa Department of Human Services, December 8, 2006.

According to state officials, the enrollment decline is not driven by population loss from Hurricane Katrina and contrasts dramatically with enrollment spikes that usually occur in September and have reached up to 13,000 in the past.[8] The reason for the drop-off is two-fold, according to the state: for some people, Medicaid is being denied or terminated because they have not presented the required citizenship or identity documents. In addition, the additional workload generated by the new requirement is diverting the time and effort eligibility workers normally would spend on activities to ensure that Medicaid beneficiaries do not lose coverage at renewal.

- **Virginia:** Since July, enrollment of children in the state's Medicaid program has declined steadily each month. By the end of November, the total net decline stood at close to 12,000 children. During the same period, enrollment of children in the state's separate SCHIP program, *not* subject to the new requirement, increased (Figure 3). Virginia also reported a substantial backlog in application processing at its central processing site, with 2,600 cases pending approval for Medicaid in September, when normally no more than 50 such cases are pending at the end of a month.

Figure 3

Virginia: Medicaid Enrollment of Children Fell When Citizenship Documentation Began, While Enrollment in SCHIP Continued to Rise



Source: Virginia Dept. of Medical Assistance Services

After the plunge in children's Medicaid enrollment over several months, a small increase occurred in December 2006 (although Medicaid enrollment for children then began dropping again in January). State officials say the December "up-tick" suggests that some families are finally "getting over the hurdles" imposed by the new law and children (who were eligible at the time they applied but lacked the required documentation) are getting health coverage after a significant delay during which they were without coverage.[9]

- **New Hampshire:** Data from the New Hampshire Healthy Kids Program, a private organization that processes mail-in applications for the state's Medicaid and SCHIP programs, indicate that the percentage of applications submitted with all necessary documents in September of this year dropped by *almost half* compared to the percentage of complete applications submitted in September 2005. If applicants do not supply missing documentation within 28 days, New Hampshire closes the application. The percentage of applications closed due to missing documents has also increased significantly: from around 10 percent of applications before the new requirement to 20 percent in August 2006. In addition, New Hampshire Healthy Kids reports that between June 2006 and September 2006, enrollment of

[8] Communication with J. Ruth Kennedy, Deputy Medicaid Director Louisiana Department of Health and Hospitals, November 13, 2006.

[9] Communication with Linda Nablo, Director, Division of Maternal and Child Health, Virginia Department of Medical Assistance services, November 13, 2006 and January 16, 2007.

children in Medicaid dropped by 1,275.[10]

Impact on State Administrative Costs

Data on state Medicaid administrative costs for the months since July 1 are not available from CMS or any other national source. Several states, however, have examined the impact of the new Medicaid citizenship documentation requirement on their administrative expenditures. Their findings are as follows:

- **Illinois:** Illinois is projecting $16 million to $19 million in increased staffing costs in the first year of implementation of the requirement.[11]

- **Arizona:** The Arizona legislature has allocated $10 million to implement the citizenship documentation requirement. This included the costs associated with staffing, training and payments for obtaining birth records.[12]

- **Colorado:** The FY07-08 budget request for the Colorado Department of Health Care Policy and Financing includes a request for an additional $2.8 million for county administration costs. This request is based on an assumption by the Centers for Medicare and Medicaid Services (CMS) that it will take an additional 5 minutes per application for a caseworker to process citizenship and identity documents. The Department stated in a Joint Budget Committee Hearing that this amount "may not be sufficient for Colorado counties and special record storage needs."[13]

- **Washington:** Washington State is projecting additional costs associated with hiring 19 additional FTEs in FY07 due to the new requirement, and retaining seven of them in FY08 and FY09. The state estimates that the costs will be $2.7 million on FY07 and $450,000 in each of the succeeding two years.[14]

- **Wisconsin:** Wisconsin is expecting increased costs of $1.8 million to cover the increased workload associated with administering the requirement in FY07 and $600,000 to $700,000 per year for the two years after that.[15]

- **Minnesota:** Minnesota is estimating that it will spend $1.3 million in FY07 for new staff, birth record fees and other administrative expenses.[16]

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[10] Communication with Tricia Brooks, President and CEO, New Hampshire Healthy Kids, November 14, 2006.

[11] Illinois Department of Healthcare and Family Services

[12] Communication with Tom Betlach, Deputy Director, Arizona AHCCCS, October 23, 2006.

[13] Colorado Center on Law and Social and Social Policy, December 14, 2006.

[14] Communication with Mary Wood, Office Chief, Washington Health and Recovery Services Administration, December 21, 2006.

[15] Communication with James Jones, Director, Bureau of Eligibility Management, WI Department of Health and Family Services, December 21, 2006.

[16] Communication with Pat Callaghan, Minnesota Department of Human Services, December 21, 2006.

Conclusion

Based on these findings and reports, and strong anecdotal evidence, it seems increasingly clear that the new Medicaid citizenship documentation requirement is having a negative impact on Medicaid enrollment, especially among children. Insufficient information is available to determine the precise extent to which individuals whose Medicaid eligibility has been delayed, denied or terminated are U.S. citizens, eligible legal immigrants, or ineligible immigrants. However, the fact that significant numbers of individuals are being approved for Medicaid after delays of many months, during which they were uninsured, demonstrates that the requirement is adversely affecting substantial numbers of U.S. citizens, especially children who are citizens. Moreover, a large body of research conducted over a number of years has conclusively shown that increasing documentation and other administrative burdens generally results in eligible individuals failing to obtain coverage as a result of the enrollment and renewal processes having become more complicated to understand and more difficult to navigate.[17] Regarding the Medicaid enrollment declines, Anita Smith, Chief of the Bureau of Medical Supports for the Iowa Department of Human Services has stated: "There is no evidence that the [enrollment] decline is due to undocumented aliens leaving the program. Rather, we believe that these new requirements are keeping otherwise eligible citizens from receiving Medicaid because they cannot provide the documents required to prove their citizenship or identity."[18]

A number of governors across the nation are announcing their intentions to push new initiatives to cover the uninsured, particularly children. These proposals are being designed to build upon existing public coverage programs, of which Medicaid is the largest, and invariably these proposals call for the enrollment of individuals who are currently eligible for existing programs but remain uninsured. Success will depend, in large measure, on policies and procedures that facilitate rather than frustrate such efforts so that eligible individuals can obtain the benefits for which they qualify. The Medicaid citizenship documentation requirement, which appears to be an extremely blunt instrument, stands to undercut such efforts by placing a daunting administrative obstacle in the way of many low-income U.S. citizens who otherwise have shown that they qualify or by discouraging potentially eligible citizens from applying because the process appears too complex or intimidating. The requirement also appears to be deflecting state human and financial resources away from activities designed to reach eligible children and families and to enroll them in the most efficient and effective manner.

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[17] Michael Perry, Susan Kannel, R. Burciaga Valdez and Christina Chang, "Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey," Kaiser Commission on Medicaid and the Uninsured, January 2000; Zoe Neuberger, "Reducing Paperwork and Connecting Low-Income Children With School Meals: Opportunities Under the New Child Nutrition Reauthorization Law," Center on Budget and Policy Priorities, November 2004.

[18] Communication with Anita Smith, Bureau Chief, Bureau of Medical Supports, Iowa Department of Human Services, December 8, 2006.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SELF-DECLARATION OF U.S. CITIZENSHIP FOR MEDICAID

Daniel R. Levinson
Inspector General

July 2005
OEI-02-03-00190

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

OBJECTIVES

Our objectives were to determine the extent to which States allow self-declaration of U.S. citizenship for Medicaid and related programs and to identify potential vulnerabilities, if any, associated with quality control activities and evidence used to document citizenship.

BACKGROUND

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricts eligibility for Medicaid to U.S. citizens, nationals of the United States, or qualified aliens. Since 1986, verification of U.S. citizenship for purposes of Medicaid eligibility has been governed by section 1137(d) of the Social Security Act (the Act). The Act requires "a declaration in writing, under penalty of perjury . . . stating whether the individual is a citizen or national of the United States." Pursuant to the Act, the Centers for Medicare & Medicaid Services (CMS) allows, but does not require, States to accept self-declaration of citizenship without requiring submission of additional documentary evidence. In September 2002, CMS planned to issue a final rule that would permit States to continue using self-declarations of citizenship for Medicaid eligibility.[1] At that time, OIG agreed to conduct an inspection on the extent to which States allow self-declaration. Subsequently, CMS withdrew the proposed rule. However, OIG completed the inspection because of its potential value in the administration of the program.

In recent years, CMS has encouraged self-declaration in an effort to simplify and accelerate the Medicaid application process.[2] While the policy to allow applicants to self-declare citizenship can result in rapid enrollment, it can also result in inaccurate eligibility determinations for applicants who provide false citizenship statements. As such, there are inherent challenges in trying to provide Medicaid benefits expeditiously while still ensuring the accuracy of eligibility determinations. In a 2001 pamphlet, CMS provided information on how to maintain program integrity while attempting to simplify the

[1] Centers for Medicare & Medicaid Services, "Medicaid Program: Self-Declaration of Citizenship," CMS-2085-P, Sept. 12, 2002.

[2] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

application process. These strategies include verifying the accuracy of citizenship statements against other nonapplicant sources, such as State vital statistics databases, and/or conducting posteligibility-focused reviews.[3]

For this inspection, we gathered information from State Medicaid directors and their staff responsible for quality control activities. Additionally, we surveyed State Temporary Assistance for Needy Families (TANF) directors, State foster care directors, and Social Security Administration (SSA) officials.

FINDINGS

Forty-seven States allow self-declaration of U.S. citizenship for Medicaid; nearly all of these require evidence if statements seem questionable. Pursuant to Federal policy, States may accept a signed declaration as proof of U.S. citizenship from applicants seeking Medicaid benefits. Currently, 40 Medicaid directors report that their State allows self-declaration of citizenship. An additional seven report that self-declaration is sometimes allowed. The four remaining directors report that self-declaration is not permitted in their State. These States are Montana, New Hampshire, New York, and Texas.

Forty-four of the forty-seven States that allow or sometimes allow self-declaration have "prudent person policies" which require evidence of citizenship if statements seem questionable to eligibility staff. Thirty-two of these have written prudent person policies, and the remaining 12 have unwritten, informal policies requiring documentation for questionable statements.

Twenty-seven States do not verify the accuracy of any U.S. citizenship statements as part of their posteligibility quality control activities. In fiscal year 2003, 27 of the 47 States that allow self-declaration did not conduct quality control activities that included verification of statements of U.S. citizenship. Of the 20 States that did review statements, 9 did so for a nonrepresentative sample of the entire Medicaid population. Consequently, some groups that could pose vulnerability to Medicaid integrity were not included in the review sample.

[3] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

Some States use types of evidence that are not accepted by CMS or SSA to document citizenship for Medicaid. As reported earlier, seven States sometimes allow and four States do not allow Medicaid applicants to self-declare citizenship. Of these 11 States, 4 use types of evidence to document citizenship that are not accepted by CMS or SSA. Furthermore, 13 of the 20 States that report conducting quality control to verify statements of U.S. citizenship use types of evidence that are not accepted by CMS or SSA, such as school records, family Bibles, voter registration records, and marriage licenses.

Medicaid-related programs are more likely to verify citizenship; their verifications may be a useful resource for Medicaid. SSA states that all applicants must provide documentary evidence of U.S. citizenship in order to receive a Social Security number or qualify for Supplemental Security Income (SSI) benefits. Forty-two of fifty-one foster care directors report that staff document U.S. citizenship when determining eligibility for Title IV-E foster care maintenance payments. Twenty-seven of fifty-one TANF directors report documenting or sometimes documenting citizenship for purposes of eligibility.

In the majority of instances, we found that these Medicaid-related programs draw on evidence accepted by CMS or SSA to document statements of U.S. citizenship. These citizenship verifications may be a useful resource for Medicaid.

RECOMMENDATIONS

We recognize that there are challenges in providing Medicaid benefits expeditiously while ensuring the accuracy of eligibility determinations. By their nature, self-declaration policies have inherent vulnerabilities in that they can allow applicants to provide false statements of citizenship. As such, it is vital to have protections in place to prevent such practices.

Based on the descriptive information we collected from States, we conclude that existing safeguards at the point of entry into Medicaid and during posteligibility quality control could allow false statements of citizenship to go undetected. Below are three recommendations for improving safeguards:

- CMS should strengthen posteligibility quality controls in States that allow self-declaration.

- CMS should issue a complete list of evidence that States may reference when determining eligibility.
- CMS should explore allowing State Medicaid staff to use citizenship verifications from other Medicaid-related programs as an additional resource.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has already taken steps to improve safeguards to prevent applicants from providing false statements of citizenship. The full text of CMS's comments is included in Appendix D.

We note several issues with CMS's current efforts. Specifically, CMS explained that, pursuant to Federal regulations, States must verify statements of citizenship for sampled active cases as part of their posteligibility quality control procedures. We reiterate that this regulation applies only to States that operate traditional quality control. States that operate under a pilot or a section 1115 waiver with a quality control component are not required to verify all elements of eligibility, including statements of citizenship, as part of their posteligibility case file review.

CMS also commented that States choosing to accept self-declaration of citizenship need to have systems in place for some type of posteligiblity check to ensure that the self-declaration procedure is reliable. CMS stated that it is taking steps to do this by requiring a review of the accuracy of eligibility determinations as part of the Payment Error Rate Measurement (PERM) project. Currently, the Office of Management and Budget is working with CMS to define the scope of the PERM project. As of June, no decision has been made regarding the inclusion of errors related to Medicaid eligibility determinations.

TABLE OF CONTENTS

INTRODUCTION

OBJECTIVES

Our objectives were to determine the extent to which States allow self-declaration of U.S. citizenship for Medicaid and related programs and to identify potential vulnerabilities, if any, associated with quality control activities and evidence used to document citizenship.

BACKGROUND

Title XIX of the Social Security Act (the Act) establishes Medicaid as a jointly funded, Federal-State health insurance program. To qualify for the full range of Medicaid benefits provided under a State plan, an applicant must be either a citizen or a national of the United States or a qualified alien.[4] Since 1986, verification of U.S. citizenship for purposes of Medicaid eligibility has been governed by section 1137(d) of the Act, which requires "a declaration in writing, under penalty of perjury . . . stating whether the individual is a citizen or national of the United States."[5] Pursuant to the Act, the Centers for Medicare & Medicaid Services (CMS) allows, but does not require, States to accept self-declaration of citizenship without requiring submission of additional documentary evidence. In September 2002, CMS planned to issue a final rule that would permit States to continue using self-declarations of citizenship for Medicaid eligibility.[6] At that time, OIG agreed to conduct an inspection on the extent to which States allow self-declaration. Subsequently, CMS withdrew the proposed rule. However, OIG completed its inspection because of its potential value in the administration of the program.

In recent years, CMS has encouraged self-declaration in an effort to simplify and accelerate the Medicaid application process.[7] While the policy to allow applicants to self-declare citizenship can result in rapid

[4] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104-193).

[5] Social Security Act § 1137 (d)(1)(A).

[6] Centers for Medicare & Medicaid Services, "Medicaid Program: Self-Declaration of Citizenship," CMS-2085-P, Sept. 12, 2002.

[7] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

enrollment, it can also result in inaccurate eligibility determinations for applicants who provide false citizenship statements. As such, there are inherent challenges in trying to provide Medicaid benefits expeditiously while still ensuring the accuracy of eligibility determinations. In a 2001 pamphlet, CMS provided information on how to maintain program integrity while attempting to simplify the application process. These strategies include verifying the accuracy of citizenship statements against other nonapplicant sources, such as State vital statistics databases, and/or conducting posteligibility-focused reviews.[8]

Personal Responsibility and Work Opportunity Reconciliation Act of 1996

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) restricts eligibility for means-tested, federally funded public benefit programs to U.S. citizens or qualified aliens. This same legislation directed the Attorney General to establish verification guidance and procedures that States must follow in verifying the citizenship or immigration status of individuals applying for federally funded public benefit programs. The U.S. Department of Justice (DOJ) issued interim guidance in 1997 (62 FR 61344) and proposed regulations (63 FR 41662) in 1998. Final rules have not yet been issued.

The proposed DOJ regulations would require that both citizens and qualified aliens who are applying for Medicaid provide documentary evidence to verify their status. However, the proposed regulations would permit Federal benefit-granting agencies to establish alternative procedures for verifying citizenship. The agencies would be required (1) to publish regulations that provide for fair and nondiscriminatory procedures for verifying the citizenship of applicants for the benefit in question and (2) to obtain approval from the Attorney General for the alternative procedures.

CMS set forth its policy concerning self-declaration in a letter dated September 10, 1998, to State Medicaid directors. The letter explained that States may accept self-declaration of citizenship without

[8] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

requiring submission of additional documentary evidence. On January 11, 2001, CMS published final regulations (42 CFR 457.320(c)) that permit States to accept self-declaration of citizenship for applicants applying for coverage under the State Children's Health Insurance Program, a State-run insurance program intended to provide health care coverage to certain low-income families.[9]

Evidence of Citizenship

The Department of Homeland Security (DHS), Bureau of Citizenship and Immigration Services is responsible for determining U.S. citizenship for persons in the United States.[10] Currently, DHS does not have a comprehensive list of acceptable evidence that may be used to document citizenship.

The CMS State Medicaid Manual contains two lists of evidence that may be accepted as proof of citizenship. These lists differ somewhat and neither is comprehensive. Examples of acceptable evidence listed in the manual include:

- Birth certificate,
- U.S. passport,
- Report of Birth Abroad of a Citizen of the United States, and
- Naturalization Certificate (INS Forms N-550 or N-570).[11]

In its operations manual, the Social Security Administration (SSA) provides additional sources of evidence that may be used to document U.S. citizenship for purposes of establishing eligibility for SSA-sponsored benefits.

See Appendix A for a listing of the evidence accepted by CMS or SSA to document U.S. citizenship.

Medicaid Eligibility Quality Control

Federal regulations require State Medicaid agencies to conduct posteligibility quality control activities to "eliminate or substantially reduce dollar losses resulting from eligibility errors."[12] From 1978 to

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[9] 66 FR 2490.

[10] Homeland Security Act of 2002 § 402(3).

[11] State Medicaid Manual, § 3212.3, "Methods of Documenting United States Citizenship."

[12] 42 CFR § 431.800.

1993, States were required to conduct "traditional" eligibility case reviews of the Medicaid-eligible population. As part of these traditional reviews, all States were required to review and verify elements such as citizenship and alienage, wage information, age, and residency. To verify information on citizenship, quality control staff were required to obtain documentation supporting the content of the declaration of citizenship.[13]

In 1994, CMS offered States three options for conducting Medicaid Eligibility Quality Control (MEQC). States could continue using traditional quality control, participate in a demonstration pilot program, or conduct quality control as part of a section 1115 waiver.[14] In fiscal year 2003, 39 States operated under a section 1115 waiver or an MEQC pilot.[15]

MEQC pilots. MEQC pilots allow States to develop innovative and targeted approaches for conducting quality control. Under pilots, States may tailor their programs to look at error-prone areas, high-dollar areas, or special populations. While operating under pilots, States are not required to conduct reviews of self-declaration of citizenship statements.

Section 1115 waivers. Under section 1115 waivers, States may allow certain kinds of deviations from their State Medicaid plans, including the expansion of eligibility for those who would otherwise not be eligible for the Medicaid program. Unless outlined in their contract with CMS, States operating under section 1115 waivers with quality control components are not required to conduct reviews of citizenship statements.

Related Benefit Programs

Other programs in which Medicaid recipients could potentially participate include Supplemental Security Income (SSI), Title IV-E foster care, and Temporary Assistance for Needy Families (TANF). We examined eligibility requirements and State policies and practices

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[13] State Medicaid Manual, Chapter III, 7269.130.

[14] CMS Medicaid Quality Control Program, http://www.cms.hhs.gov/medicaid/mcqc/mqcguid.asp, accessed Jan. 22, 2004.

[15] Centers for Medicare & Medicaid Services, "National Overview of Medicaid Eligibility Quality Control for 2003," May 9, 2003.

regarding self-declaration of U.S. citizenship for these related programs in an effort to identify a potential resource for Medicaid staff. Throughout this report, we refer to the SSI, foster care, and TANF programs as "Medicaid-related programs."

SSI. In general, States are required to provide Medicaid coverage to recipients of SSI. SSA requires that

> all Supplemental Security Income (SSI) applicants alleging U.S. citizenship must submit evidence. However, if an individual actually provided proof of his/her citizenship status in a prior claim for benefits from SSA, he/she will not have to resubmit that evidence.[16]

Title IV-E foster care. Section 471(21) of the Act requires States to provide Medicaid or equivalent health insurance coverage to children eligible to receive Title IV-E foster care program maintenance funds. For all children receiving Federal foster care maintenance payments, States are required to verify citizenship or immigration status.[17]

TANF. Similar to Federal requirements related to documenting U.S. citizenship for Medicaid, current Federal law does not impose any specific documentation requirements, other than a signed declaration of U.S. citizenship, for TANF applicants claiming to be U.S. citizens.[18]

SCOPE

This inspection describes State practices to determine and document U.S. citizenship for Medicaid and related program eligibility, as well as State quality control activities. It does not identify the extent to which current Medicaid beneficiaries are ineligible on the basis of their citizenship. In addition, this inspection does not examine the extent to which eligible individuals fail to apply for Medicaid in States that require proof of U.S. citizenship as a condition of eligibility.

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[16] The SSA Program Operations Manual System, "Special Procedure for Establishing U.S. Citizenship for SSI Benefits," GN 00303.350, May 1995.

[17] "ACF Child Welfare Policy Manual – WC Policy Database – Policy Questions & Answers," Question 9, June 4, 2003.

[18] Social Security Act § 1137 (d)(1)(A).

METHODOLOGY

To identify States that allow self-declaration of U.S. citizenship for Medicaid and related programs, we gathered information from State Medicaid Directors and their staff responsible for quality control, as well as SSA officials, State foster care directors, and State TANF directors.

The data presented in this report were collected from State representatives in the 50 States and the District of Columbia. For reporting purposes, we refer to the District of Columbia as a State throughout our analysis.

State Medicaid Directors

To obtain descriptive information on all States' practices with regard to self-declaration of U.S. citizenship, we administered telephone surveys to all 51 State Medicaid directors and their staff. We asked directors about their States' self-declaration practices and whether their State has a policy instructing eligibility staff to obtain additional verification when applicants' statements appear incomplete, unclear, or inconsistent, which some States refer to as a "prudent person policy." We also asked directors to submit any evaluations or audits that were conducted within the last 5 years that looked at self-declaration of U.S. citizenship for Medicaid. We were able to speak with all directors during June and July 2003, giving us an overall response rate of 100 percent.

MEQC Supervisors/ Medicaid Directors

We administered another telephone survey to the 47 MEQC supervisors and/or Medicaid directors in States that permit self-declaration of U.S. citizenship during December 2003. We spoke with all 47 directors and/or supervisors in these States. Survey questions for the 47 Medicaid directors and/or supervisors focused on:

- Whether MEQC was conducted in a traditional format, under a section 1115 waiver, or under an MEQC pilot format during fiscal year 2003;
- The extent to which citizenship statements were checked during quality control activities;
- The types of documentation used to prove statements of U.S. citizenship; and

- Whether, as part of the States' quality control practices, self-declaration of U.S. citizenship was included for review.

For States operating a traditional MEQC program, we asked if staff conducted the required activities, as outlined in the CMS State Medicaid Manual.

CMS Representatives

We conducted interviews with representatives from the Medicaid State Operations group at CMS. These interviews focused on how States are permitted to conduct MEQC activities.

Social Security Administration Management Staff

In January 2004, we conducted a telephone interview with management staff at SSA to determine if statements of U.S. citizenship are documented during and throughout the Social Security enumeration process and for SSI benefits. We also asked questions on the extent to which citizenship data collected for SSA program eligibility are shared with State Medicaid agencies.

Foster Care Directors

We conducted a Web-based, self-administered survey of State foster care directors. All 51 directors responded to our survey during October 2003. The survey requested information on whether foster care staff document a child's U.S. citizenship when determining eligibility for federally funded foster care maintenance payments.

TANF Directors

We conducted a self-administered, Web-based survey of State TANF directors. All 51 directors responded to our survey during September 2003. The survey requested States' policies on self-declaration of U.S. citizenship to qualify for TANF benefits.

Citizenship Evidence Accepted by CMS or SSA

As mentioned earlier, DHS, the agency responsible for determining citizenship for a person in the United States, does not currently have a comprehensive reference list of acceptable evidence. In the absence of an official document from DHS, we developed a comprehensive list of "accepted evidence" by combining the evidence accepted by CMS[19] or

[19] State Medicaid Manual, §§ 3212.3 and 7269.130.

SSA[20] for purposes of documenting citizenship for program eligibility. We then compared the forms of evidence States report using to document U.S. citizenship for Medicaid and related programs with this comprehensive list. See Appendix A for a complete listing of accepted evidence used during our analysis.

We conducted this inspection in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency.

[20] The SSA Program Operations Manual System, "Establishing U.S. Citizenship for all SSA Programs," GN 00303.300, July 12, 2002.

FINDINGS

Forty-seven States allow self-declaration of U.S. citizenship for Medicaid; nearly all of these require evidence if statements seem questionable

Pursuant to the Act, States may accept a signed declaration as proof of U.S. citizenship from applicants seeking Medicaid benefits.[21] Forty-seven of fifty-one Medicaid directors report that their State allows or sometimes allows self-declaration of U.S. citizenship. For the four remaining States (Montana, New Hampshire, New York, and Texas) directors report that applicants must submit documentary evidence to verify U.S. citizenship statements. Table 1 displays each State's policy on self-declaration of U.S. citizenship for Medicaid.

Seven directors report that although their State sometimes allows applicants to self-declare U.S. citizenship, documentation is required under some circumstances. Four of these directors indicate that documentation is required for the aged, blind, and disabled populations. Other circumstances in which States sometimes ask for documentation include when the applicant was born outside of the United States or if information related to the applicant's place of birth does not exist in the State's vital statistics database.

With the exception of one State that verifies self-declaration statements through its vital statistics database, no other States volunteer that they obtain verification of citizenship statements from other nonapplicant sources. Further, none of the directors volunteer that eligibility staff currently utilize citizenship verification information from related programs such as TANF or foster care.

Nearly all States that allow self-declaration require evidence of U.S. citizenship if statements seem questionable during the eligibility process Forty-four of the forty-seven States that permit or sometimes permit self-declaration report that they have a written or informal "prudent person policy" requiring documentation if the statements of the applicant seem questionable. Of these, 32 States have a written policy to guide staff in these situations. An example of a written policy instructs Medicaid eligibility staff that

[21] CMS letter to State Medicaid directors, September 10, 1998.

Table 1: State Policies on Self-Declaration of Citizenship for Medicaid

State	Allowed	Sometimes Allowed	Not Allowed	Prudent Person Policy
AL	✓			Written
AK		✓		Written
AZ	✓			Written
AR	✓			Informal
CA		✓		Written
CO	✓			None
CT	✓			Written
DE	✓			Informal
DC	✓			None
FL		✓		Written
GA	✓			Written
HI	✓			Informal
ID	✓			Informal
IL	✓			Informal
IN		✓		Informal
IA	✓			Written
KS	✓			Written
KY	✓			Written
LA	✓			Written
ME	✓			Informal
MD	✓			Written
MA	✓			None
MI	✓			Written
MN	✓			Written
MS		✓		Written
MO	✓			Informal
MT			✓	NA
NE	✓			Written
NV	✓			Written
NH			✓	NA
NJ		✓		Written
NM	✓			Written
NY			✓	NA
NC	✓			Written
ND	✓			Written
OH	✓			Written
OK	✓			Written
OR	✓			Written
PA	✓			Written
RI		✓		Informal
SC	✓			Written
SD	✓			Informal
TN	✓			Informal
TX			✓	NA
UT	✓			Written
VT	✓			Written
VA	✓			Informal
WA	✓			Written
WV	✓			Written
WI	✓			Written
WY	✓			Written
Totals	40	7	4	-
Written	-	-	-	32
Informal	-	-	-	12
None	-	-	-	3

Source OIG analysis of State policies on self-declaration of U.S. citizenship, 2004

> when statements of client are incomplete, unclear, or inconsistent, or when other circumstances in the particular case indicate to a prudent person that further inquiry must be made, the worker shall obtain additional verification before eligibility is determined.

The remaining 12 States have unwritten, informal prudent person policies requiring additional verification when eligibility staff deem statements questionable.

Medicaid directors report they allow self-declaration to increase access and express concern about increased costs if the policy is prohibited

We asked the 47 State Medicaid directors in States allowing self-declaration their reasons for not requiring evidence of U.S. citizenship. Twenty-five respondents say that they have been encouraged by CMS to simplify their application processes in order to reduce barriers to health care access. In addition, 17 respondents report that through their posteligibility quality control activities, they have not seen a problem with self-declaration of citizenship.

We asked what costs, if any, Medicaid applicants would incur if all were required to provide documentary evidence of U.S. citizenship. Twenty-eight of forty-seven directors report that it would delay eligibility determination. In addition, 25 directors comment that it would result in increased eligibility personnel costs. Twenty-one directors also report that it would be burdensome and/or expensive for applicants to obtain copies of birth certificates or other documentation.

Twenty-seven States do not verify the accuracy of U.S. citizenship claims as part of their posteligibility quality control activities

Federal regulations require State Medicaid agencies to conduct posteligibility quality control activities to "eliminate or substantially reduce dollar losses resulting from eligibility errors."[22] States may conduct MEQC activities in a traditional format, under an MEQC pilot format, or as part of a section 1115 waiver. In fiscal year 2003, 27 of the 47 States that allow self-declaration did not conduct quality control activities that included verification of statements of U.S. citizenship.

[22] 42 CFR § 431.800.

Of the 20 States that did review statements of U.S. citizenship, 9 did so for a nonrepresentative sample of the entire Medicaid population. Consequently, some groups that may pose vulnerability to Medicaid integrity were not included in the sample of applications that were reviewed. See Appendix B for a list of States' quality control activities.

Three States operating traditional MEQC programs do not conduct required quality control activities

Under traditional MEQC, States are required to verify that sampled applicants are U.S. citizens. Three of the eleven States that operated a traditional MEQC program and allowed self-declaration in fiscal year 2003 did not conduct required eligibility quality control for U.S. citizenship. These States report that they did not collect documentary evidence to support statements of U.S. citizenship for sampled applicants. (See Table 2.)

Table 2: Medicaid Quality Control on Self-Declaration of U.S. Citizenship by Type of MEQC Program

Type of MEQC Program	Does Not Conduct MEQC for Self-Declaration	Conducts MEQC for Self-Declaration	Total Number of States That Allow Self-Declaration
Traditional	3	8	11
Pilot*	20	8	28
Waiver	4	4	8
Overall total States	**27**	**20**	**47**

*In fiscal year 2003, Tennessee operated under both an MEQC pilot and an 1115 waiver. We considered Tennessee a pilot program because it conducted MEQC activities under its pilot, which included the entire Medicaid population.

Source. OIG analysis of State MEQC practices, 2004

Twenty MEQC pilot States do not monitor self-declaration of U.S. citizenship

While operating under an MEQC pilot, States may, but are not required to, conduct posteligibility reviews of self-declaration of citizenship statements. Twenty of the twenty-eight States that permit self-declaration of U.S. citizenship and operated under a pilot program in fiscal year 2003 did not obtain documentary evidence to support beneficiaries' statements of U.S. citizenship for any portion of their Medicaid population. Eight States conducted quality control on self-declarations of citizenship, but seven did so for a nonrepresentative sample which accounted for less than 8 percent of the Medicaid population. These samples did not include certain populations that may pose vulnerability to Medicaid integrity.

Four section 1115 waiver States do not address self-declaration of U.S. citizenship

While operating under a section 1115 waiver with a quality control component, a State may, but is not required to, conduct reviews of self-declaration of citizenship statements. Four of the eight States that allow Medicaid applicants to self-declare U.S. citizenship and operated under section 1115 waivers in fiscal year 2003 did not obtain and verify documentary evidence to support statements of U.S. citizenship. Of the four section 1115 waiver States that verify statements of U.S. citizenship for quality control purposes, two conducted MEQC for only a subset of the entire Medicaid population.

Only one State reports conducting an audit looking at self-declaration of U.S. citizenship, and it found vulnerabilities

We asked States for any quality control audits or evaluations that looked at self-declaration of citizenship. Only one State director provided an audit on this topic. This audit report found vulnerabilities related to the process of self-declaration of U.S. citizenship.

Specifically, the audit, conducted in January 2002 by the Secretary of the State of Oregon, found that the State provided full Medicaid benefits to 25 beneficiaries (of the sample of 812) who were noneligible noncitizens. The audit report concludes that there are potential risks involved in allowing applicants to self-declare their U.S. citizenship on mail-in applications, which do not allow workers to verify the accuracy of statements of U.S. citizenship. They estimate

that the risk could result in an annual cost of about $2 million, based on a 1 percent estimate of noneligible noncitizens receiving Medicaid benefits.[23]

Some States use types of evidence that are not accepted by CMS or SSA to document citizenship for Medicaid

Four States use forms of evidence that are not accepted by CMS or SSA to document citizenship for initial Medicaid eligibility

As reported earlier, seven States sometimes allow and four States do not allow Medicaid applicants to self-declare citizenship. Of these 11 States, 4 use types of evidence to document citizenship that are not accepted by CMS or SSA. Specifically, two States allow the use of a school record to document citizenship and two allow use of a family Bible as documentation.[24]

Seven of eleven States that sometimes allow or do not allow self-declaration report accepting documentation that is accepted by CMS or SSA. These include public birth records, U.S. passports, and naturalization certificates.

Thirteen States use types of evidence that are not accepted by CMS or SSA to verify statements of U.S. citizenship for posteligibility quality control purposes

Thirteen of the twenty States that report conducting quality control to verify statements of U.S. citizenship use forms of documentation that are not accepted by CMS or SSA. For example, 11 of these 13 States report using records of receipt of SSI to verify citizenship. While one of the primary sources included in the CMS State Medicaid Manual to verify citizenship and alienage declarations is "Record of receipt of

[23] Audit Report: "Department of Human Services Oregon Health Plan Eligibility Review," Report No. 2002-03, January 3, 2002, p. 1.

[24] According to section 7269.1 of the State Medicaid Manual, States may accept evidence of continuous residence in the United States prior to June 30, 1948. Among the records accepted to prove continuous residence are school records, a marriage license, a voter registration card, an insurance policy, military service records, and a Social Security number. The directors identified here did not report accepting documentation that was dated prior to June 30, 1948.

SSI,"[25] in discussions with SSA, we found that verification of receipt of SSI does not guarantee that the Medicaid applicant or beneficiary is a U.S. citizen. Medicaid agencies must take the additional step of verifying the Alien/Refugee code in the State Data Exchange report files, which provide States with eligibility, payment, and demographic data relating to SSI recipients, to substantiate that evidence of U.S. citizenship was submitted for SSI eligibility purposes.

Other examples of documentation that is not accepted by CMS or SSA but which State Medicaid directors report using for quality control purposes are voter registrations, proof of Medicare Part A, school records, children's birth certificates to prove a parent's citizenship status, marriage licenses, and even other self-declaration statements.

Medicaid-related programs are more likely to document citizenship; their verifications may be a useful resource for Medicaid

Medicaid applicants may potentially participate in related programs such as SSI, foster care, and TANF. We found that these related programs are more likely than Medicaid to document citizenship and most often use evidence that is accepted by CMS or SSA to verify this status. These verifications may be a useful resource for Medicaid staff. Appendix C provides information on related programs' policies and use of documentation on a State-by-State basis.

United States citizenship is always documented for enumeration and SSI

The SSA officials report that all applicants must provide documentary evidence of U.S. citizenship or legal status in order to receive a Social Security number (enumeration) or to qualify for SSI benefits. In some cases, SSA's prior determination of citizenship is accepted as a means for documenting U.S. citizenship. However, SSA is currently reviewing this policy to ensure that it does not rely on inadequate documentation that was submitted for purposes of enumeration and SSI in prior years.

As indicated earlier, in discussions with SSA officials, we found that verification of receipt of SSI does not prove U.S. citizenship.

[25] It is important to note that this list does not distinguish between appropriate sources to verify U.S. citizenship versus appropriate sources to verify alienage.

Eligibility staff must take the additional step of verifying the Alien/Refugee code in the State Data Exchange report files.

Forty-two States document the citizenship status of children receiving Title IV-E foster care benefits, as required by the Administration for Children and Families

The Administration for Children and Families requires that foster care eligibility staff document U.S. citizenship status for purposes of federally funded Title IV-E foster care maintenance payment eligibility.[26] Forty-two of fifty-one foster care directors report that staff document U.S. citizenship when determining eligibility for federally funded foster care maintenance. Seven directors report that staff sometimes document U.S. citizenship, and two say citizenship is never documented.

Among the seven foster care directors who indicate that U.S. citizenship is sometimes not documented, circumstances under which no documentation occurs vary significantly. Examples include "the rare occurrence when a child falls under category 85, undocumented alien emergency situation coverage" and "when a parent or other reliable source reports a child is a citizen."

Fifteen States document citizenship to determine TANF eligibility

Similar to requirements for Medicaid, States may permit TANF applicants to self-declare U.S. citizenship status as a condition of eligibility. Fifteen of fifty-one directors report verifying citizenship for TANF eligibility. Twelve directors report that it is their State's policy to sometimes verify applicants' statements of U.S. citizenship. Twenty-four TANF directors report that their State allows self-declaration for eligibility purposes.

Related programs commonly use types of evidence that are accepted by CMS or SSA to verify citizenship

Thirty-five of the forty-nine foster care directors that verify or sometimes verify U.S. citizenship for children entering their State's foster care program use types of evidence that are accepted by CMS or SSA. The remaining 14 include forms of documentation that are not accepted. Examples of these include green cards, Social Security

[26] "ACF Child Welfare Policy Manual – WC Policy Database – Policy Questions & Answers," Question 9, June 4, 2003.

numbers, citizenship declarations by parents/caregivers, military service records, and family Bibles.

Twenty of the twenty-seven States that verify or sometimes verify U.S. citizenship for TANF eligibility purposes use evidence accepted by CMS or SSA. The remaining States report using evidence that is not accepted, such as voter registration cards, school records, and/or family Bibles.

In the majority of instances, we found that related programs draw on evidence that is accepted by CMS or SSA to verify statements of citizenship. In States where related programs both verify statements of citizenship and use generally accepted documentation to do so, these verifications may be a useful resource for Medicaid.

RECOMMENDATIONS

We recognize that there are challenges in providing Medicaid benefits expeditiously while ensuring the accuracy of eligibility determinations. By their nature, self-declaration policies have inherent vulnerabilities in that they can allow applicants to provide false statements of citizenship. As such, it is vital to have protections in place to prevent such practices.

Based on the descriptive information we collected from States, we conclude that existing safeguards at the point of entry into Medicaid and during posteligibility quality control could allow false statements of citizenship to go undetected. Below are three recommendations for improving safeguards:

CMS should strengthen posteligibility quality controls in States that allow self-declaration

Currently, 47 States allow self-declaration of citizenship for Medicaid. Over half of these never verify citizenship statements as part of their posteligibility quality control procedures. In States that do check statements, most do so for a subset of the entire Medicaid population. More examinations are needed to determine if there are problems resulting from this policy. Therefore, CMS should encourage States that allow self-declaration of citizenship to conduct reviews on the accuracy of these statements. Findings from these reviews could then be used to determine the extent to which this policy results in inaccurate eligibility determinations.

CMS should issue a complete list of evidence that States may reference when determining eligibility

Four of the eleven States that require or sometimes require evidence of citizenship for initial Medicaid eligibility use types of evidence that are not accepted by CMS or SSA. Further, 13 of the 20 States that report conducting quality control to verify statements of citizenship use types of evidence that are not accepted by CMS or SSA. In its State Medicaid Manual, CMS has two lists of evidence that are slightly different, and neither is comprehensive. To better ensure that States collect evidence that is consistent with CMS standards, CMS should issue a complete list of evidence that States may reference when determining eligibility.

CMS should explore allowing State Medicaid staff to use citizenship verifications from other Medicaid-related programs as an additional resource

When looking at related programs including SSI, Title IV-E, and TANF, we found that these programs are more likely to verify citizenship as a condition of eligibility and, in most cases, use types of evidence that are accepted by CMS or SSA. If CMS determines it appropriate, States that allow applicants to self-declare citizenship could perform checks on the accuracy of these statements using related programs' verification information. This step would not add a burden to applicants and would not require the collection of additional documentation. In Appendix C, we identify which States and programs verify statements of citizenship and use evidence accepted by CMS or SSA.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has already taken steps to improve safeguards to prevent applicants from providing false statements of citizenship. The full text of CMS's comments is included in Appendix D.

We note several issues with CMS's current efforts. Specifically, CMS explained that, pursuant to Federal regulations, States must verify statements of citizenship for sampled active cases as part of their posteligibility quality control procedures. We reiterate that this regulation applies only to States that operate traditional quality control. States that operate under a pilot or a section 1115 waiver with a quality control component are not required to verify all elements of eligibility, including statements of citizenship as part of their posteligibility case file review.

CMS also commented that States choosing to accept self-declaration of citizenship need to have systems in place for some type of posteligiblity check to ensure that the self-declaration procedure is reliable. CMS stated that it is taking steps to do this by requiring a review of the accuracy of eligibility determinations as part of the Payment Error Rate Measurement (PERM) project. Currently, the Office of Management and Budget is working with CMS to define the scope of the PERM project. As of June, no decision has been made regarding the inclusion of errors related to Medicaid eligibility determinations.

APPENDIX ~ A

Types of Evidence Accepted by CMS or SSA to Document U.S. Citizenship		
Documentation Type	**CMS**	**SSA**
A birth certificate showing birth in the United States	✓	✓
Religious record of birth recorded in the United States or its territories within 3 months of birth, which indicates a U.S. place of birth	✓	✓
United States passport	✓	✓
Form FS-240 (Report of Birth Abroad of a Citizen of the United States)	✓	✓
Form FS-545 (Certification of Birth)	✓	✓
U.S. Citizen I.D. Card Form I-97 (United States Citizen Identification Card)	✓	✓
Form N-550 and N-570 (Certificate of Naturalization)	✓	✓
Forms N-560 and N-561	✓	✓
Evidence of continuous residence in the United States prior to June 30, 1948 (including school records; marriage license; voter registration card; insurance policy; military service records; Social Security number issued prior to June 30, 1948, etc.)	✓	
Record receipt of SSI*	✓	✓
Bureau of Vital Statistics, local government, hospital, or clinic records of birth and parentage	✓	
Court records of parentage, juvenile proceedings, or child support	✓	

Sources CMS State Medicaid Manual §§ 3212 and 7269 and the SSA Program Operations Manual System: GN 00303.300

APPENDIX A

Documentation Type	CMS	SSA
American Indian Card (first issued by INS in 1983)	✓	✓
Form DS-1350 (Certification of Report of Birth) issued by the State Department		✓
Northern Mariana Identification (NMI) Card, first issued by INS in 1987, to identify naturalized citizens born in the NMI before November 3, 1986	✓	✓
Evidence of civil service employment by the U.S. Government before June 1, 1976		✓

Sources: CMS State Medicaid Manual §§ 3212 and 7269 and the SSA Program Operations Manual System: GN 00303.300

*Note: In discussions with SSA, we found that verification of receipt of SSI alone does not guarantee that the Medicaid applicant or beneficiary is a U.S. citizen. Medicaid agencies must take the additional step of verifying the Alien/Refugee code in the State Data Exchange report files. Therefore, while CMS does accept this form of documentation, we determined that this might not prove U.S. citizenship.

APPENDIX ~ B

Fiscal Year 2003 MEQC in the 47 States Allowing Self-Declaration of U.S. Citizenship		
State	**CMS MEQC Categorization**	**Conducts Some MEQC On Self-Declaration Of U.S. Citizenship**
Alabama	Traditional	Yes
Alaska	Pilot	No
Arizona	Waiver	Yes
Arkansas	Waiver	Yes
California	Pilot	Yes
Colorado	Pilot	No
Connecticut	Traditional	Yes
Delaware	Pilot	No
District of Columbia	Pilot	No
Florida	Traditional	Yes
Georgia	Traditional	No
Hawaii	Waiver	Yes
Idaho	Pilot	No
Illinois	Pilot	Yes
Indiana	Pilot	Yes
Iowa	Pilot	No
Kansas	Pilot	No
Kentucky	Pilot	No
Louisiana	Pilot	No
Maine	Traditional	No
Maryland	Waiver	Yes
Massachusetts	Waiver	No
Michigan	Traditional	Yes
Minnesota	Waiver	No
Mississippi	Traditional	Yes
Missouri	Waiver	No
Nebraska	Pilot	No

A P P E N D I X ~ B

State	CMS MEQC Categorization	Conducts Some MEQC On Self-Declaration Of U.S. Citizenship
Nevada	Pilot	No
New Jersey	Pilot	No
New Mexico	Pilot	No
North Carolina	Pilot	No
North Dakota	Traditional	Yes
Ohio	Pilot	No
Oklahoma	Traditional	No
Oregon	Waiver	No
Pennsylvania	Pilot	Yes
Rhode Island	Traditional	Yes
South Carolina	Pilot	Yes
South Dakota	Pilot	No
Tennessee	Pilot*	Yes
Utah	Pilot	Yes
Vermont	Traditional	Yes
Virginia	Pilot	No
Washington	Pilot	No
West Virginia	Pilot	No
Wisconsin	Pilot	Yes
Wyoming	Pilot	No
Total Traditional	11	-
Total Pilot	28	-
Total Waiver	8	-
Total Yes	-	20
Total No	-	27

Source: OIG analysis of State MEQC practices, 2004

*In fiscal year 2003, Tennessee operated under both an MEQC pilot and an 1115 waiver. We considered Tennessee a program because it conducted MEQC activities under its pilot, which included the entire Medicaid population.

APPENDIX - C

Related Programs Policies on Self-Declaration and Their Use of Documentation Accepted by CMS or SSA: A Guide for Medicaid Eligibility Staff					
State	Medicaid	TANF	TANF Uses Evidence Accepted by CMS or SSA	Foster Care	Foster Care Uses Evidence Accepted by CMS or SSA
AL	▲	Δ	Yes	●	No
AK	Δ	Δ	Yes	●	Yes
AZ	▲	Δ	No	●	Yes
AR	▲	▲	NA	●	Yes
CA	Δ	●	Yes	●	Yes
CO	▲	▲	NA	●	Yes
CT	▲	Δ	No	Δ	No
DE	▲	●	No	●	Yes
DC	▲	▲	NA	●	Yes
FL	Δ	▲	NA	●	No
GA	▲	▲	NA	●	No
HI	▲	●	Yes	●	No
ID	▲	▲	NA	●	No
IL	▲	Δ	Yes	●	Yes
IN	Δ	●	Yes	●	Yes
IA	▲	Δ	Yes	●	Yes
KS	▲	▲	NA	●	Yes
KY	▲	▲	NA	●	No
LA	▲	▲	NA	Δ	Yes
ME	▲	▲	NA	●	Yes
MD	▲	Δ	Yes	●	Yes
MA	▲	Δ	No	▲	NA
MI	▲	Δ	Yes	●	Yes
MN	▲	▲	NA	▲	NA
MS	Δ	▲	NA	●	Yes
MO	▲	Δ	Yes	Δ	Yes
MT	●	●	Yes	●	Yes
NE	▲	▲	NA	●	No

A P P E N D I X C

State	Medicaid	TANF	TANF Uses Evidence Accepted by CMS or SSA	Foster Care	Foster Care Uses Evidence Accepted by CMS or SSA
NV	▲	●	Yes	●	Yes
NH	●	●	No	●	Yes
NJ	Δ	●	No	Δ	Yes
NM	▲	▲	NA	Δ	No
NY	●	●	Yes	●	Yes
NC	▲	▲	NA	●	No
ND	▲	●	Yes	Δ	No
OH	▲	●	Yes	●	Yes
Ok	▲	▲	NA	●	Yes
OR	▲	▲	NA	●	Yes
PA	▲	Δ	No	●	Yes
RI	Δ	●	Yes	●	Yes
SC	▲	▲	NA	●	Yes
SD	▲	▲	NA	●	Yes
TN	▲	▲	NA	●	Yes
TX	●	●	Yes	Δ	No
UT	▲	▲	NA	●	No
VT	▲	Δ	Yes	●	Yes
VA	▲	▲	NA	●	Yes
WA	▲	▲	NA	●	Yes
WV	▲	▲	NA	●	Yes
WI	▲	●	Yes	●	Yes
WY	▲	●	Yes	●	No
Total ▲	40	24	-	2	-
Total Δ	7	12	-	7	-
Total ●	4	15	-	42	-
Total Yes	-	-	20	-	35
Total No	-	-	7	-	14
Total NA	-	-	24	-	2

Source. OIG analysis of related program policies on self-declaration of U.S. citizenship, 2004

* Because SSA always verifies the citizenship status of applicants for a Social Security number or for SSI, a State-by-State description of this policy does not appear in this table.

▲ Denotes a State that reports permitting self-declaration of U.S. citizenship or reports not requiring evidence of citizenship to qualify for federally funded benefits.

Δ Denotes a State that reports sometimes permitting self-declaration of U.S. citizenship.

● Denotes a State that reports never permitting self-declaration or requiring evidence of U.S. citizenship to qualify for this federally funded benefit.

APPENDIX - D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

2005 APR 12 PM 3:50

OFFICE OF INSPECTOR GENERAL

DATE: APR - 8 2005

TO: Daniel R. Levinson
Acting Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Self-Declaration of U.S. Citizenship for Medicaid" (OEI-02-03-00190)

Thank you for the opportunity to review and comment on the above OIG draft report. OIG reviewed the extent to which states allow self-declaration of U.S. citizenship for Medicaid and related programs and identified potential vulnerabilities associated with quality control activities and evidence used to verify citizenship.

States must provide Medicaid to all United States citizens who otherwise meet the eligibility criteria of the state's Medicaid program. Aliens' eligibility for full Medicaid coverage is limited to certain "qualified aliens." Per section 1137(d) of the Social Security Act, states must require, as a condition of eligibility, a declaration in writing, signed under penalty of perjury, that an applicant is a citizen or national of the United States. Pursuant to that statutory provision, the Centers for Medicare & Medicaid Services (CMS) permits states to accept applicants' self-declaration of citizenship, but also to require further verification, if necessary. This flexible policy allows states to enroll eligible individuals while preserving program integrity. It is in line with a larger effort promoted by CMS to help states simplify the Medicaid application process.

As there are inherent challenges in trying to provide Medicaid benefits expeditiously, while still ensuring the accuracy of eligibility determinations, OIG conducted this review. We appreciate OIG's efforts. OIG's findings reinforced our policy approach. The review found that, while there are vulnerabilities in states' accepting self-declaration of citizenship, states have little evidence that many non-eligible, non-citizens are receiving Medicaid as a result. The review also recommended steps for improving safeguards that CMS and states have already undertaken.

The OIG's draft report provided three specific recommendations for improving safeguards. Those recommendations and our responses are as follows.

A P P E N D I X ~ D

OIG Recommendation

The CMS should strengthen post-eligibility quality controls in states that allow self-declaration.

CMS Response

We concur. We agree that states should have strong post-eligibility quality control activities in place in order to reduce losses from all eligibility errors, including self-declaration of citizenship. In fact, CMS' Medicaid Eligibility Quality Control regulations require states to verify that the state properly determined the citizenship status of sampled active cases. Pursuant to Federal regulations at 42 CFR 431.812(e), states "must collect and verify all information necessary to determine the eligibility status of each individual included in an active case selected in the sample as of the review month and whether Medicaid payments were for services which the individual was eligible to receive."

The report does not find particular problems regarding false allegations of citizenship, nor are we aware of any. However, we believe that, as with self-declarations of income, states that accept self-declaration of citizenship need to have systems in place for some type of post-eligibility check to ensure that the self-declaration procedure is reliable. CMS is taking steps to have states strengthen post-eligibility controls by requiring a review of the correctness of eligibility determination under the proposed Payment Error Rate Measurement regulation, published on August 27, 2004. In the absence of any indication that there are improper self-declarations, we do not think we need to do more at this time. The CMS also will reiterate its policy at the 2005 fall meeting of the National Association of State Medicaid Directors.

OIG Recommendation

The CMS should issue a complete list of evidence that states may reference when determining eligibility.

CMS Response

We concur. For states that choose to require documentation of applicants' citizenship, CMS has provided a list of acceptable documentation in its State Medicaid Manual, which is posted on its Web site. The U.S. Citizenship and Immigration Services (formerly the Immigration and Naturalization Service) recently published a regulation containing a longer list of documentation that states may use. The CMS currently references that regulation on its Web site, but will adopt the OIG's recommendation and post the new list per se. In addition, at the time we publish our next State Medicaid Manual update, we will include the new list.

A P P E N D I X ~ D

OIG Recommendation

The CMS should explore allowing state Medicaid staff to use citizenship verifications from other Medicaid-related programs as an additional resource.

CMS Response

We concur. This recommendation reinforces our current approach, which permits states to accept citizenship verification from other programs. We articulated the principle of permitting states to accept other programs' determinations with respect to particular eligibility requirements in our Guide to Medicaid eligibility, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage." We will provide technical assistance to states that request it.

While OIG's report reinforces our current policy approach to provide states with the flexibility to enroll eligible individuals while preserving program integrity, we will follow up on OIG's recommendations as stated above.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Acting Regional Inspector General for Evaluation and Inspections in the New York Regional Office. Other principal Office of Evaluation and Inspections staff who contributed include:

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Statement for Senator Bunning
SCHIP Hearing
February 1, 2007

Mr. Chairman, thank you for holding this important hearing today. The SCHIP program has been a very successful program over the past 10 years, providing health care coverage to millions of children across the country. Now, it is time for this Committee and Congress to reauthorize the program.

It is estimated that about 6½ million individuals were on SCHIP in fiscal year 2006. In my state, over 64,000 children relied on the program for their health care. I think everyone would agree that providing health care to low-income, uninsured children is critical, and the SCHIP program helps fulfill this goal. Specifically, the program helps provide health coverage to families whose incomes are above the Medicaid eligibility limits, but who cannot afford private insurance.

States run their SCHIP programs and receive a match from the federal government. States have a considerable amount of flexibility in designing their programs and setting their standards.

While many states, including Kentucky, cover just kids under 200% of the federal poverty level, others have expanded coverage to pregnant women, parents of children and even childless adults. In fact, it is estimated that 406,000 childless adults are covered, 260,000 parents and 4,000 pregnant women. Several states cover almost as many parents or childless adults as they do children. Two states – Wisconsin and Minnesota – cover more parents than they do children.

The Deficit Reduction Act of 2005 prohibits the Department of Health and Human Services from providing waivers to new states looking to cover childless adults with their SCHIP dollars. This was definitely a step in the right direction last year.

However, this year we will have to look carefully at whether these expansions are acceptable in an environment where many states have children who are eligible for SCHIP but not enrolled and when many states are facing shortfalls in funding.

SCHIP wasn't designed as an entitlement program, but instead as a block grant program. This means that states have a limited amount of money to use, and have to set priorities in spending and coverage.

Several advocacy groups are requesting a significant increase in spending for SCHIP during reauthorization – upwards of $60 billion in new money. This money has to come from somewhere, so it is critical for us to take an honest look at the program, determine if states are meeting the core goal of covering kids, and decide when it is acceptable for health dollars for children to pay for adults.

Thank you. I appreciate the time our witnesses have taken to be here today.

"The Future of CHIP: Improving the Health of America's Children"

Testimony Submitted
to the

Senate Committee on Finance

By
Cindy Mann, JD
Executive Director
Georgetown University
Center for Children and Families

February 1, 2007

Chairman Baucus, Senator Grassley, and Members of the Committee:

Thank you for the invitation to participate in this hearing on the State Children's Health Insurance Program. I am Cindy Mann, the Executive Director of the Center for Children and Families, a research and policy center at Georgetown University's Health Policy Institute that focuses on children and family health coverage issues. I am also a Research Professor at Georgetown University and an Associate Commissioner with the Kaiser Commission on Medicaid and the Uninsured. My involvement with SCHIP has been long and varied. Soon after enactment of SCHIP, I served as the Director of the Family and Health Programs Group within the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services). This group oversaw the implementation of SCHIP at the federal level. Since then I have worked with states, foundations, and community organizations as they have attempted to bring the promise of SCHIP to fruition, and I have analyzed how federal and state policies and procedures have affected children's coverage.

A great deal has been accomplished as a result of Congress's action in 1997 to establish SCHIP. When the legislation was first debated, the big questions were, would states take up the opportunity to expand coverage for low-income children and would families enroll their children in the coverage offered to them. We now know the answers to these questions. Every state has a SCHIP program, and SCHIP has been successful not only in covering newly eligible children but also in triggering major improvements in Medicaid that allowed millions of uninsured children who had been eligible for Medicaid but not enrolled to gain coverage and access to care. As a result of these two programs – SCHIP and its larger companion program, Medicaid – the portion of low-income children in America without coverage declined by one-third between 1997 and 2005.

With success come challenges, however. Few would disagree that SCHIP's key challenge has to do with its financing. While there are a number of SCHIP financing issues, the single most important issue is whether sufficient federal funds will be made

available to assure further gains in covering children. The SCHIP funding level for 2007 – $5 billion – was picked ten years ago before Congress had any experience with the program. This level of funding falls far short of what is needed when measured against what states are spending now and particularly in light of the growing interest in covering more children and the compelling need to do so. According to the most recent U.S. Census data, some nine million children in America still lack coverage.

SCHIP reauthorization comes at just the right moment. The substantial coverage gains achieved for children over the past decade demonstrate that the nation is on the right track. The public strongly supports efforts to cover children, and many states across the nation – including most of the states represented by the Senators on this Committee – have recently taken steps to reach more children or are poised to do so. SCHIP reauthorization creates the opportunity for Congress to again take leadership to move the nation closer to the broadly shared goal of assuring that every child in America has coverage.

My testimony this morning will cover three areas: Trends in eligibility and coverage; key SCHIP financing issues; and steps that can be taken to help reach uninsured children. The focus here is not intended to negate the importance of other SCHIP reauthorization issues, including the scope of coverage provided to children, quality care issues, and outreach strategies.

Eligibility and Coverage Trends

In 1997, right before SCHIP was enacted, only three states covered children under age 19 with family incomes up to 200 percent of the federal poverty line. (In 2007, 200 percent of the poverty line is equivalent to $2,862 per month in total earnings for a family of three.) To encourage states to expand coverage, Congress established SCHIP and offered states federal matching payments at a more favorable matching rate as compared to Medicaid. (On average, states pay 30 percent of the cost of SCHIP coverage compared to 43 percent of the cost of Medicaid coverage.) Federal SCHIP funds could be used to

cover children through Medicaid, a separate (non-Medicaid) child health program, or a combination of the two approaches. By 1999, every state had an approved SCHIP plan. Currently, 18 states use their SCHIP funds only in a separate program; 10 states and the District of Columbia use SCHIP funds only to expand Medicaid; and 22 states rely on a combination approach. As shown in Figure 1, as of July 2006, 41 states plus the District of Columbia now cover children with family incomes at or above 200 percent of the federal poverty line.

The variation across states in income eligibility levels reflect individual state choices permitted by the SCHIP law. Indeed, the law is premised on the notion that states should have broad discretion to design their programs guided by federal standards particularly with respect to benefits and cost sharing. The law permits states to set their upper income eligibility level at 200 percent of the federal poverty line or 50 percentage points above their Medicaid income eligibility level prior to SCHIP and also to establish their own rules for how they will calculate income (i.e., whose income will be counted and whether deductions, exclusions or disregards will be permitted). Of the 36 states that had separate SCHIP programs in 2005, 13 considered gross income and 23 took work-related expenses and/or other income exclusions and disregards into account. Each state's income eligibility threshold and income counting rules reflect state-level considerations, including how much funding a state is prepared to commit to SCHIP, state personal incomes and poverty rates, and the cost of living. California covers children at higher income levels than Texas, but a family in San Diego with income at 250 percent of the federal poverty level has the same buying power as a family living in Houston with income equal to only 154 percent of the federal poverty level.

Enrollment grew slowly at first, particularly in states that were starting new child health programs, but it soon took off and has grown every year except for 2003-2004. Nationwide, by 2002, more than two-thirds (68 percent) of children without private coverage whose family incomes made them eligible for SCHIP were enrolled, a significant achievement for a new initiative. Participation rates vary from state to state. The most recent data available show that in 2005, SCHIP covered six million children

during the course of the year and about four million children on the last day of the year. Of the six million children enrolled in 2005, about 1.7 million were covered in SCHIP-funded Medicaid expansions and the remaining 4.4 million through SCHIP-funded separate programs. (Figure 2)

SCHIP's impact, however, extended far beyond the confines of the coverage financed with SCHIP funds. SCHIP was designed to stand on the shoulders of the much larger Medicaid program. As part of the broader effort to cover eligible children and to coordinate enrollment between SCHIP and Medicaid, SCHIP touched off widespread efforts to simplify the process for enrolling and retaining children eligible for Medicaid. In addition, sometimes for the first time in the history of the Medicaid program, a vast array of entities, including states and local community organizations, governors and mayors, schools, churches and synagogues, health centers and hospitals, engaged in outreach efforts to inform families about eligibility for coverage, including Medicaid. As a result of the simplification and outreach initiatives, as many children gained coverage through Medicaid as through SCHIP. In 2005, Medicaid covered about 28 million children. (Figure 2)

These enrollment gains occurred in the context of a particularly challenging health coverage environment. Over the past decade, health care costs rose sharply, and many fewer families had access to employer-based insurance. As a result, according to data collected by the Centers for Disease Control and Prevention, between 1997 and 2005, the number of uninsured adults grew by more than six million. During this same time period, however, SCHIP and Medicaid more than offset the declines in job-based coverage for children, and the portion of low-income children who were uninsured declined by one-third, from 22.3 percent in 1997 to 14.9 percent in 2005. (Figure 3)

For the first time since 1998, U.S. Census Bureau data (the Current Population Survey) showed that the number of uninsured children rose in 2005, with near-poor children (those with incomes between 100 and 200 percent of the poverty line) experiencing the largest increase. Over nine million children under age 19 were uninsured in 2005. Most

(88 percent) are in families with at least one employed parents, and about one-third (35 percent) have incomes below 100 percent of the federal poverty line ($1,431 a month for a family of three). A disproportionate share of uninsured children resides in the South (43 percent) and in the West (29 percent), and a disproportionate share (38 percent) is Hispanic. As explained below, the good news in terms of the potential for achieving significant additional coverage gains for children in the future is that most uninsured children are now eligible for either SCHIP or Medicaid and when informed that their child may be eligible their parents report they are eager to enroll them into coverage.

Financing Challenges

Financing challenges have been at the center of most of the controversies having to do with SCHIP since the enactment of the program. Since 1997, the law has been amended several times to alter the rules for how SCHIP funds are distributed to states and how long states can use SCHIP funds. Formula and distribution questions continue to be important, but the key financing issue facing the Congress today relates to the overall level of funding that will be made available for SCHIP and related Medicaid improvements as part of SCHIP reauthorization. Consistent with the public's strong support for children's coverage, an election-eve poll conducted for the Center for Children and Families last November found that 82 percent of voters supported investing more money in SCHIP. Of these, two thirds want to see Congress provide a funding level that allows states to cover more children in SCHIP.

Enrollment and spending data show that the fiscal year 2007 SCHIP allotment level is well below what is needed to sustain current coverage efforts and move forward. This is not surprising. The fiscal year 2007 commitment of $5 billion was set ten years ago as part of the original legislation that established SCHIP. At the time, there was no experience with the program and little evidence upon which Congress could rely to project what the program might need five or ten years later. Moreover, SCHIP was part of a much larger budget bill, the Balanced Budget Act of 1997 (P.L. 105-33), a 537-page law that affected a large number of programs and areas of federal spending, estimated to

achieve $160 billion in gross federal savings over five years. The five-year commitment of $20 billion for children's health initiatives (SCHIP and Medicaid) was set within a context of a complex bill with many competing demands.

There has long been a mismatch between SCHIP spending and the allocation of funds to states. As might have been expected, SCHIP spending started slow and ramped up as programs got underway and costs rose. The ten-year funding levels, however, did not ramp up. They were set at $4.3 billion in 1998, stayed at that level through 2001, dropped to $3.2 billion in fiscal years 2002 – 2004, and grew to a little over $4 billion in 2005 and 2006. (Figure 4) The 2007 allotment totals $5 billion, but in 2007 states are projected to spend more than $6.3 billion, according to the Congressional Research Service. CRS estimates that 37 states will spend more than their total fiscal 2007 allotment in 2007. The mismatch grows over time; the Center on Budget and Policy Priorities projects that by 2010, spending just to maintain current enrollment will exceed annual allotments in 44 states, assuming a continuation of the $5 billion in total annual SCHIP allotments.

SCHIP's financing structure was built on the assumption that some states might spend more than their current year allotments. Under the law, states have access to their annual allotments for three years, and some states receive funds redistributed from other states that do not spend their full allotments. These carry-over and redistributed funds were intended to help move the dollars to the states with the greatest needs. This worked for a while (with occasional adjustments by Congress), but as enrollment and costs grew carry-over-funds were depleted in many states and the amount of funds available for redistribution declined considerably.

The mismatch between current allocation levels and spending needs is now painfully apparent and growing. As health care costs rise and many states recommit to the goal of covering children, including the uninsured children who are already eligible for SCHIP but not enrolled, a significant increase in the federal financial commitment to this program is needed to keep the progress that has been made intact and to move forward.

In just the past year, a number of states have improved coverage rules and removed barriers that were keeping eligible children from enrolling or retaining coverage. Other states are planning to take similar steps, and some states have adopted or are considering coverage expansions. This movement forward on behalf of children will stall, particularly in those states with fewer resources to fall back on, if the federal commitment of funds falls short of what is needed.

Some changes to the formula for targeting SCHIP funds to states with the greatest needs could address some of the funding problems, but they will do relatively little to reduce the need for additional federal funding over the longer term. Some have suggested that narrowing the groups of people – children and adults – who can be covered with SCHIP funds would also help to address SCHIP funding problems. Currently, there is no federally-imposed cap on the income level of the children who can be covered in SCHIP; indeed, as explained above, the SCHIP law permits states broad flexibility to set income levels and to define and determine the income they will count. A change in this policy would not only result in children losing coverage, but would also require Congress to set detailed new federal rules for a program that has prided itself on the flexibility it accords to states.

In addition to children, according to the Centers for Medicare & Medicaid Services (CMS), five states have waivers to cover pregnant women and nine states provide pregnancy-related care to women through a regulation that allows states to cover unborn children. Twelve states have waivers to cover parents although several have not been implemented or have very limited enrollment. A few states also use SCHIP funds to cover childless adults; the Congress eliminated the Secretary's authority to approve additional SCHIP waivers to cover childless adults as part of the Deficit Reduction Act of 2005. In fiscal year 2005, about 638,789 adults (pregnant women, parents, and childless adults) were covered with SCHIP funds compared to more than 6.1 million children (in these CMS data, pregnant women covered through the unborn child option are counted among the 6.1 million children).

States with parent or pregnant women waivers have relied on and conformed to waiver guidance that dates back to the early days of the program. The waiver authority that has been used to allow states to cover populations other than children was explicitly authorized in the SCHIP legislation (Section 2107(e)). States and the Congress were apprised of the guidelines the Secretary intended to apply in guidance issued in July 2000. Acknowledging the tension of covering populations other than children in the context of a program funded through a block grant, the guidance permitted waivers to cover pregnant women or parents if the state was covering children up to at least 200 percent of the federal poverty line and had taken certain specified steps aimed at promoting enrollment of eligible children. In addition, once a state began using SCHIP funds to cover parents or pregnant women, the funding for parent or pregnant women coverage would stop if the state closed enrollment for children or if it ran short of the funds it needed to cover children. The 2000 waiver guidance explicitly declined to permit states to use SCHIP funds to cover childless adults.

Additional SCHIP waiver guidance was issued in August 2001 as part of the Bush Administration's broader waiver initiative called the Health Insurance Flexibility and Accountability ("HIFA") initiative. HIFA guidelines permitted states to use SCHIP funds to cover childless adults, and, in general, the waivers granted under HIFA did not include specific simplification requirements aimed at improving participation rates for children. The HIFA waivers still require states to keep enrollment for children open as a condition of covering adults and they prioritize funds to be spent for children. As noted above, the DRA stopped further waivers using SCHIP funds to cover childless adults.

The Secretary's waiver authority must, according to statute, be exercised in a way that "furthers the objectives of the (SCHIP) program' (Section 1115 of the Social Security Act). Coverage for pregnant women and parents promotes children's health and well being in a number of different ways. Coverage of pregnant women promotes healthy babies, and several members of Congress, including members of the Finance Committee, have offered legislation to explicitly permit states to use SCHIP funds to cover pregnant women without a waiver (supplementing the current authority for states to cover unborn

children). Parent coverage also benefits children, by helping parents stay or become healthy allowing them to work and take better care of their children. In addition, there is considerable evidence that when states cover families – parents as well as children – eligible children are more likely to enroll. There is also evidence that parent coverage leads to improved utilization of health services for children. In addition, family-based coverage makes it more feasible for states to pursue premium-assistance approaches, where they use SCHIP (or Medicaid) funds to subsidize the purchase of insurance offered to the family through the work place.

The central issue with respect to covering parents or pregnant women seems not to be whether it is improper for states to have received waiver authority to make this coverage possible – the objectives are reasonable within the context of the purposes of SCHIP and the policy is longstanding and transparent –but whether there are sufficient funds to sustain these modest efforts to offer family coverage and premium assistance. Cutting off this source of coverage for low-wage parents who generally lack any other viable insurance options will not resolve the SCHIP funding gap but will deepen the problems so many families face trying to secure coverage.

Getting To The Finish Line

While states have made substantial progress in recent years boosting participation rates in both SCHIP and Medicaid, the single most important step that can be taken to lower the uninsured rate among children is to enroll the children eligible under current program rules. The fact that there are large numbers of eligible but unenrolled children is essentially a "good news" story. Since 1997, states have expanded their programs increasing the size of the eligible population. Therefore, despite the fact that states are considerably more successful than they have been in the past enrolling eligible children, a significant number of uninsured children are eligible but not enrolled. Close to seven out of ten (68 percent) of all uninsured children in 2004 were eligible for either Medicaid or SCHIP, and among low-income children, about 87 percent were eligible but not enrolled.

(Figure 5) Lack of information about program eligibility and barriers to enrollment and retention are the key reasons why eligible children remain uninsured. One study found that nearly 90 percent of parents surveyed responded that they would enroll their child in SCHIP or Medicaid if they knew the child was eligible.

States generally have the flexibility in both SCHIP and Medicaid to simplify enrollment and improve retention rates, and they can draw down federal matching payments to help pay for outreach activities. They are, however, sometimes reluctant to take these steps because of the resulting coverage costs. A survey conducted for the Kaiser Commission on Medicaid and the Uninsured showed that between April 2003 and June 2004, when state budgets were under considerable pressure, nearly half the states (23 states) imposed enrollment barriers that made it more difficult for eligible children and families to enroll or retain coverage in SCHIP or Medicaid. In addition, seven states imposed SCHIP enrollment freezes.

These procedural barriers can lead to significant enrollment declines. Washington's experience is instructive. In 2003, after the state dropped a series of procedural simplifications, enrollment among children dropped by over 40,000. In 2005, when many of these changes were reversed enrollment again began to rise.

The challenge going forward is to consider ways to reduce these policy fluctuations that lead to children gaining and losing coverage notwithstanding their eligibility. One approach may be to provide greater federal assistance with coverage costs if a state adopts and maintains policies aimed at promoting participation of eligible children (e.g., 12-month continuous eligibility, express lane enrollment, simplified renewals) or reaches certain enrollment goals or targets. Since about 70 percent of the uninsured children who are eligible for public coverage but unenrolled are eligible for Medicaid, it will be important to apply such policies to Medicaid as well as SCHIP so that the greatest possible coverage gains are achieved and the lowest income children are not left behind.

If the goal is to reach and enroll eligible children, it will be important in the context of SCHIP reauthorization to address the new citizenship/identity documentation requirement imposed in Medicaid by the Deficit Reduction Act of 2005. The new rules are beginning to cause tens of thousands of children to lose out on coverage or to experience delays in gaining coverage. According to a new report issued by the Center on Budget and Policy Priorities:

- Between August and December 2006, 14,000 people lost or were denied or coverage in Wisconsin as a result of the requirement. Most could prove citizenship but could not establish "identity" under the stringent new rules, indicating that the people losing coverage were citizens.
- Virginia reports a decline of 12,000 children since July 2006 when the new rules went into effect. A recent up-tick in enrollment suggests that after long delays some people are gaining coverage and that lack of documentation, not lack of citizenship, is the problem.
- The Kansas Health Policy Authority reports that between 18,000 and 20,000 individuals—mostly children and parents have experienced delays or denials in coverage. A story of a seven-month old baby shared by the Chief of Ambulatory Pediatrics at the Kansas University Medical Center in an opinion piece appearing in the *Kansas City Star*, shows that these delays are affecting citizen children (the baby's coverage was delayed even though he was born in the same Kansas hospital that was hoping to treat him) and can lead to serious and sometimes permanent health problems.

Of the one-third of uninsured children who are ineligible for SCHIP or Medicaid (13 percent of low-income uninsured children), some have family incomes above the income eligibility levels in their state. Many of these children cannot afford employer-based coverage even if it is offered. Others are income-eligible for the programs but are barred from participating in SCHIP or Medicaid due to restrictions relating to their immigration status. States are prohibited by a federal law that pre-dates SCHIP from using federal SCHIP (or Medicaid) funds to cover legally present immigrant children who have been in

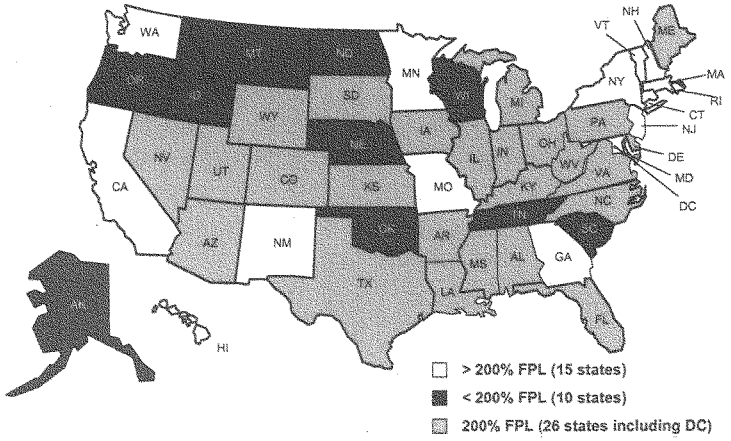
the country for less than five years, regardless of their income or need for medical care. Allowing states the option to cover these children in SCHIP or Medicaid, if otherwise eligible, could provide children with access to needed and timely care and offer states and health care providers federal matching funds for care that they might be providing with limited state, local or charity funds. The experience in localities that cover children in these circumstances (with state or local funds) also shows that the elimination of eligible confusing rules about children's eligibility helps with outreach and promotes enrollment among a broader group of children.

Conclusion

Americans strongly believe that children should have health care coverage. SCHIP, along with its companion program, Medicaid, has brought the nation closer to this broadly held goal. A new wave of activity is moving across the country as Governors and state legislators from both parties commit themselves to cover eligible but unenrolled children and some seek to expand coverage to all children. Further progress for children, however, requires federal leadership and action to assure adequate funding to keep the progress going and to put in place policies that can support and encourage states to move forward. SCHIP reauthorization is the opportunity for this Congress to make children's coverage a priority.

Figure 1

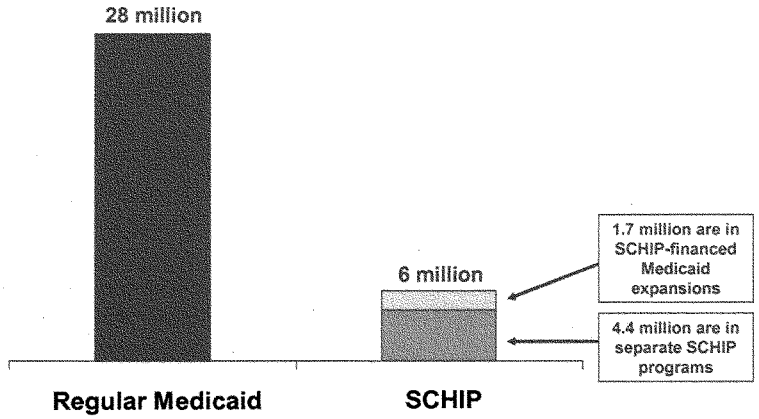
Children's Eligibility for Medicaid/SCHIP by Income, July 2006



Note The Federal Poverty Line (FPL) for a family of three in 2007 is $17,170
Source Based on a national survey conducted by the Center on Budget and Policy Priorities for Kaiser Commission of Medicaid and the Uninsured, 2006

Figure 2

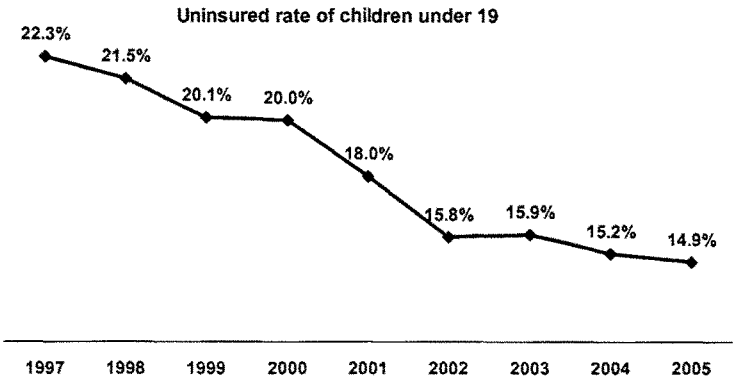
Children's Enrollment in Medicaid and SCHIP, 2005



Source Kaiser Commission on Medicaid and the Uninsured analysis of CBO March 2006 baseline and CMS Statistical Enrollment Data System, 2006, and CMS FY 2005 SCHIP Enrollment Report (July 12, 2006)

Figure 3

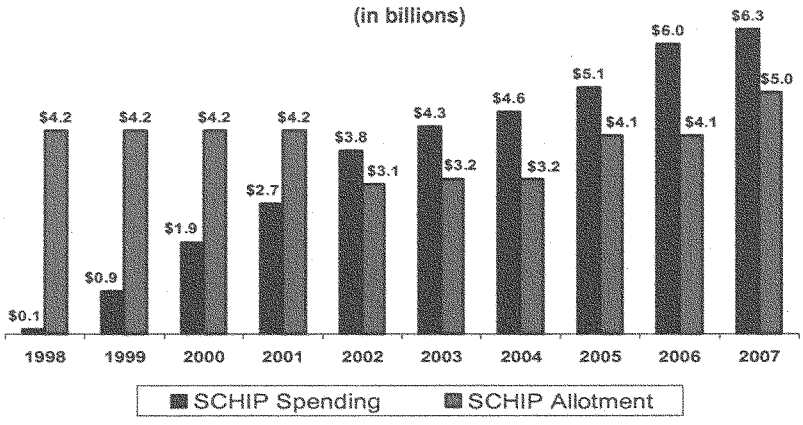
Trends in the Uninsured Rate of Low-Income Children, 1997 - 2005



Source Georgetown CCF analysis based on data from the National Health Interview Survey, November 2006 Beginning in 2004, the NHIS changed its methodology for counting the uninsured This results in the data for 2004 and later years not being directly comparable to the data for 1997 – 2003

Figure 4

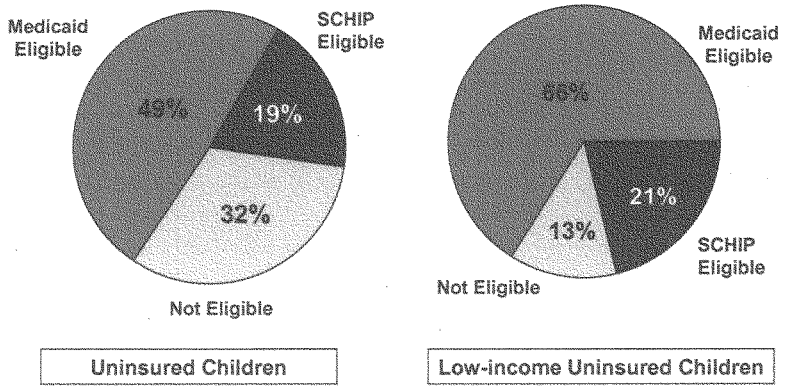
SCHIP Spending is Outpacing New Funds Being Made Available



Source: 1998-2007 data from Chris Peterson *SCHIP Original Allotments Funding Formula Issues and Options* Congressional Research Service (October 2006) FY2006 and FY2007 spending are projected

Figure 5

Most Uninsured Children are Eligible for Public Coverage, 2004



Source L Dubay analysis of March 2005 Current Population Survey using July 2004 eligibility rules

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Written Statement of
Georgia Governor Sonny Perdue
On behalf of the Southern Governors' Association

Before the

Senate Committee on Finance
Regarding the
State Children's Health Insurance Program (S-CHIP)

February 1, 2007

Good afternoon, Mr. Chairman, and members of the Committee. Thank you for the opportunity to come before you today as you consider the reauthorization of the State Children's Health Insurance Program, commonly referred to as S-CHIP. I am here today representing the 15 states and two territories of the Southern Governors' Association.

I am pleased to be here on behalf of a state and a region that has been successful in implementing the program Congress created to expand the availability of health insurance to uninsured, low-income children. In fact, Georgia the 9th largest state in the Union has the fourth largest S-CHIP program in the country. Overall, SGA member states have enrolled more than 41% of the current S-CHIP population.

According to the FY2005 S-CHIP Enrollment Report prepared by the Centers for Medicare and Medicaid Services (CMS), the number of enrolled children nationally was more than 6 million. Ten years after S-CHIP was created with strong bipartisan support, it is clear that we have surpassed the original goal of the program—to provide health insurance coverage to 5 million low-income children within 10 years. However, there is still work to be done, and I want you to know that Southern governors are committed to doing all we can to ensure that our low-income children can get access to quality health care.

Without question, states have made dramatic progress in reducing the number of uninsured low-income children through the S-CHIP program. Governors look to the reauthorization of S-CHIP as a primary means of ensuring that we can continue in our partnership with the federal government to provide health insurance to those children already enrolled in our S-CHIP programs and offer coverage to those eligible children not yet enrolled.

The 2007 reauthorization of S-CHIP provides Congress an opportunity to evaluate the current program and update our shared goals. As governors, we are responsible for achieving the goals set forth for this program, and in that role, we have learned some lessons and established some principles that I'd like to pass along to you as you consider the future direction of the program.

Making Children a Priority

First, we believe **children should be the priority population for S-CHIP**. This means that the resources for the program must be focused first on children. This is not necessarily the case in every state right now. CMS has allowed some states to make changes to their programs to include health insurance coverage for pregnant women and adults with children; arguably, these populations are directly connected to the targeted population of children. However, some states also have been allowed to expand coverage to include childless adults under their S-CHIP program. In all of these cases, these states are paying the same 70/30 Federal match rate as those states, like Georgia, that are only covering children.

Respectfully, if we had unlimited funds to put toward this program, this might not be an issue. I recognize though, as a Governor who has a constitutional requirement to balance a budget, that this is simply not the reality. In fact, there are currently 15 states that do not have enough Federal matching fund allocations to cover their projected S-CHIP expenditures for FY2007. Therefore, while some states struggle with shortfalls and are unable to cover even their low income, eligible children, others have so much excess funding that they are covering populations that were never the intended recipients under the program.

Fixing Formula Flaws

Second, there are two primary factors in the S-CHIP funding formula that have a negative effect on southern states: the state "Cost Factor" and the calculation for "Number of Children."

The "State Cost Factor" is a geographic cost factor based on annual wages in the health care industry for each State and is meant to serve as a proxy for health care costs. This factor, however, does not take into account the many variables that reflect actual health care costs. In fact, there is very little correlation between this measure and overall health care costs. Use of this factor serves to reduce the allotments to states with low wages, which is contrary to the interest of directing S-CHIP funds to low-income uninsured children.

The "Number of Children" is calculated as 50 percent of the number of low-income children and 50 percent of the number of *uninsured* low-income children. There are two problems with this aspect of the formula:

1. **Inaccuracy of the Count Reduces Allotments**. The measures used to count uninsured and eligible children have proven ineffective in Southern states, resulting in the most severe funding shortfalls in the country.

Until this fiscal year, CMS has relied on the U.S. Census Bureau's Current Population Survey (CPS) to estimate both the overall number of low-income children and the number of low-income children who are *uninsured*. The CPS survey estimates come from only a sample of the population, and as a result, those estimates can differ widely from the results of a complete census. To compensate for sampling errors, the CMS is then required to use a three-year average of these estimates. But this overall approach still leaves tremendous room for errors. For example:

- In FY2006 original allotments were based on data averaged over the three-year period 2001-2003. In a state like Georgia where the population growth is twice the national average, this kind of lag has significant consequences.

- Sampling errors further complicate an already unmanageable situation. On average, the states' share of S-CHIP allocations has been shown to vary by as much as 30% over a nine-year period. Governors cannot have this kind of unpredictability if they are to properly manage their S-CHIP enrollment.

While it is difficult to pinpoint the best solution for this obviously complex projection model, there can be little doubt that there is a major disconnect between the survey results and the actual number of eligible children. While CMS has begun using a full census data source to address some of these problems, we are not convinced this change alone can correct an annual projection that has proven to be so consistently and dramatically wrong.

2. **Number of "Uninsured Kids" Undermines Goal of Program.** The other 50 percent of the "Number of Children" factor is determined by the number of uninsured children. So as you enroll children, you receive less funding in the following years. The successful implementation of S-CHIP in any state automatically undermines maintaining funding to keep these kids enrolled in the program. Two primary examples of the formula problems are North Carolina and Georgia.

Georgia. In Georgia, we are providing coverage to 273,000 eligible children, and Georgia State University has estimated another 100,000 children are eligible to participate in PeachCare. Yet CMS figures project an eligible population of only 130,000, so Georgia is already covering more than twice the CMS-projected population. Meanwhile, our average monthly enrollment has increased 19% since FY2005. Georgia's successful implementation of this program has left us facing a $131 million Federal funding shortfall in FY2007. Without additional Federal matching funds, the PeachCare program will be depleted of federal funds by March of this year. Georgia stands ready to meet its obligation to this program but we cannot go it alone.

North Carolina. In North Carolina's situation, the S-CHIP allocation methodology understated the number of potential eligibles. As a result, North Carolina's annual S-CHIP Federal funding allocation was insufficient to cover the number of enrolled children, requiring North Carolina to take drastic action. That action included shifting children aged 0 to 5 to Medicaid, reducing S-CHIP payments to providers and limiting S-CHIP enrollment growth for the remaining population to only 3% every six months.

Unfortunately, these measures are not long-term solutions and increase the liability for Federal government expenditures as Medicaid is an entitlement program and allows for fewer options for flexibility and management of the program than does S-CHIP.

Maintaining Flexibility

Finally, Southern governors have recognized that flexibility has been the key to success in implementing S-CHIP, and as such, maintaining the flexibility of how each state meets the health care needs of the program's targeted population should be maintained in reauthorization. Unlike traditional entitlement programs, S-CHIP has allowed states to tailor benefit packages to meet the needs of recipients. This has allowed governors to increase efficiencies resulting in a more sustainable health care delivery program. Additionally, state legislatures have used S-CHIP flexibilities to make decisions that have allowed the program to continue to operate during budget deficits and rebound as fiscal circumstances have allowed. As a result, states have been able to rely on S-CHIP help them meet the most critical needs of its low-income children.

In closing, I'd like to outline some of the basics of Georgia's PeachCare program because I believe it further highlights the challenges that must be addressed within reauthorization.

As I have already noted, Georgia has the fourth largest enrollment in the country, with more than 270,000 eligible children receiving coverage. Georgia only covers children. Ninety-five percent of our PeachCare families have incomes below 200% Federal Poverty Level and we place priority on those families by implementing a sliding scale premium which requires families that make more to pay more. Unlike most states, Georgia does not provide a guarantee of continuous eligibility. Families are obligated to report changes in income or status and we undertake an independent verification of income. Beginning this summer we will have 100% income and citizenship verification. Further, families have a two-week grace period to pay their premiums. Georgia is the **only** state in the country that has a grace period of less than one month. Families who do not pay premiums on time in Georgia are temporarily locked out of the program. Georgia's program is designed to ensure our families have affordable health insurance options for their children while also encouraging personal and financial responsibility.

America is a compassionate nation and we must continue to take care of our most vulnerable citizens. As we focus on new ways to reach the Nation's uninsured, I ask you, distinguished members of Congress, to preserve, secure and improve the State Children's Health Insurance Program because it is already making great strides in meeting the needs of our most vulnerable population. I hope that you find these principles and lessons learned by states to be helpful. On behalf of the members of the Southern Governors' Association, I hope you will use us as a resource as you consider reauthorization.

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Answers to Senate Finance Committee Questions
Governor Sonny Perdue
on behalf of the Southern Governors' Association

On February 1, 2007, Georgia Governor Sonny Perdue testified before the Senate Finance Committee on behalf of the Southern Governors' Association (SGA) at a hearing entitled *The Future of CHIP: Improving the Health of America's Children.* Governor Perdue's answers to the follow-up questions posed by Committee members are attached. Governor Perdue's answers to these questions reflect the perspective of governors throughout the region, but draw specifically on Georgia's experience administering S-CHIP.

SGA is a bipartisan association representing the governors of 16 states and two territories. SGA members adopted the attached consensus principles concerning S-CHIP reauthorization. Southern governors urge Congress to consider these principles as it moves forward with reauthorizing this important program.

Chairman Baucus

1. Three out of four of the 9 million uninsured children in America today are eligible for CHIP or Medicaid but are not enrolled. What options should we pursue in CHIP reauthorization to address this problem and expand coverage for uninsured children? What can we learn from states' experience that will aid our work? How can we encourage states to do more?

Although Southern states have been tremendously successful in enrolling eligible children, current flaws in the program's formula need to be corrected to ensure states receive adequate federal S-CHIP allotments to cover eligible children. Specifically, allotments must be calculated in a manner that accurately reflects both the size of the population it is trying to serve and the economic factors influencing the cost of the service. These flaws undermine states' ability to enroll eligible children.

Southern governors remain concerned about the accuracy of census data about eligible children. In addition, the Health Care Wage Index, based primarily on wages in nursing care facilities, is not indicative of the actual state-by-state cost of providing children's health care. While we have not yet identified appropriate alternatives to these data sources and are not prepared to make recommendations at this time, we encourage Congress to continue to be mindful of the negative impact these data collection issues can have, and consider including language directing the development of recommendations for improving data so that it can more accurately reflect the realities of each state's population.

As an example, the State of Georgia has demonstrated its ability to successfully find and enroll eligible children into its S-CHIP program, *PeachCare for Kids*. However, Georgia is already covering more than twice the CMS-projected number of eligible children. Furthermore, it should be noted that Georgia's outreach efforts have resulted in enrollment of many children into Medicaid. In the first eight months of the program, *PeachCare for Kids* enrolled over 35 percent of Georgia's estimated eligible children. In that same time period, an additional 21,882 children were identified as potentially eligible for Medicaid.

2. *How do you reconcile support for flexibility with wanting to constrain CHIP eligibility only to children? How should Congress treat states that have already expanded coverage?*

SGA has adopted S-CHIP reauthorization principles recognizing that children should be the priority population covered by S-CHIP as originally intended by the statute. Some states have expanded coverage to other populations due to unusual circumstances—such as maintenance of effort requirements imposed on them by Congress. In most instances, however, Southern governors believe that the program's limited resources should be directed to eligible children.

In Georgia, we do not use our limited S-CHIP resources to cover adults. Congress created S-CHIP as a block grant program benefiting children and provided states with the flexibility to respond to the unique needs and circumstances of their eligible population. States should continue to have the flexibility to develop creative S-CHIP programs that meet the law's intent of covering eligible low-income children.

3. *In your testimony, you note that Georgia does not provide continuous eligibility and instead disenrolls families when their income exceeds the eligibility level or if they fail to pay their premiums within two weeks. Has your state done a cost-benefit analysis on these policies and whether they are cost-effective? Given that we know that families routinely cycle on and off the program, does the cost of enrolling, disenrolling and then often re-enrolling them have an impact on state administrative spending? Have you done any analysis of whether gaps in coverage undermine a child's access to necessary well-child screenings and annual exams? What happens to the kids who are disenrolled? Do they have any coverage 6 months later?*

Regarding the administrative cost, *PeachCare for Kid's* highly automated enrollment system allows for disenrollment and reinstatements to happen with virtually no manual intervention and at minimal cost to our vendor. Families can pay premiums on line and over the phone. Georgia strongly believes that families want to and should be responsible for sharing in the cost of health care coverage for their children. We believe monthly premiums are an effective approach to achieving that goal and preparing families to move into their employer sponsored insurance plans when and if they are able to do so.

Between November 1999 and April 2000, the Georgia Health Policy Center surveyed families who had voluntarily disenrolled from *PeachCare for Kids* (this excludes children who aged out, became Medicaid eligible, or moved out of the state). The primary reasons for voluntary disenrollment were: the children received private insurance (23%); parents accidentally got behind on payments (19%); there was a change in family income (7%); and the program cost too much (7%). Overall, 58% of those who disenrolled had insurance by the time of the survey. Of those who said they disenrolled due to a change in income, 62% had other insurance, suggesting their income increased.

Senator Rockefeller
Questions for Governor Sonny Perdue:

1. I introduced the Keep Children Covered Act (S. 401), legislation to prevent any child from losing CHIP coverage ahead of the program's reauthorization. I understand that Georgia is expected to experience a federal CHIP funding shortfall as early as March, despite the legislation that was passed at the end of last year to fill state shortfalls through May. Can you talk a little bit about the shortfall situation in Georgia? I am specifically interested in knowing why the provision enacted didn't help your state sufficiently and whether you think the Keep Children Covered Act will address the problem.

The provisions enacted in the National Institute of Health Reform Act of 2006 (H.R. 6164) provided less than what Georgia needed to cover its Federal Fiscal Year 2007 shortfall. Since then Congress has twice provided additional funding to avert shortfalls in a number of states, including Georgia.

As you are aware, the flawed data used to estimate the number of uninsured eligible children led to an underestimate and overall inconsistent approach to evaluating each State's funding needs, and is a primary cause of state shortfalls. State Health Access Data Assistance Center has done some very

relevant research on this topic.[1] *PeachCare* exceeded its two-year enrollment goal in the first six months. There are still approximately 100,000 eligible uninsured children in Georgia.
The Chip Dip: Although not an aspect of the formula per se, the national allotment methodology mandated that allotments be reduced in 2002 and 2003. This was intended based on the assumption that the S-CHIP programs would be leveling out enrollment growth by these years. The opposite was true. States (Georgia included) were continuing to see enrollment increases. Because we had to return dollars in the first two years, we were forced to rely on redistributed funds to cover the lower allotments in 2002 and 2003.

The "low income uninsured variable:" As we have increased the number of insured children, our allotment has decreased. The only way this variable would work in our favor is by increasing as a percent of the national total our population of low income insured and uninsured kids.

2. Some have argued that perhaps Congress should consider capping CHIP eligibility at 200% of poverty. However, states currently enjoy the flexibility to use certain work expense and childcare disregards when determining CHIP eligibility. In fact, according to data from the Urban Institute, Iowa's income disregards effectively mean that program eligibility goes up to 241% of poverty. In Georgia, the eligibility level goes up to 253% of poverty. That flexibility is why Mr. and Mrs. Bedford (the witness family) were able to deduct their small business income in order to enroll their children in CHIP. Governor Perdue, wouldn't you agree that there is significant enough variation in median and per capita income among the states that this type of flexibility in determining eligibility should be continued?

Flexibility on which populations states choose to cover should be maintained. However, Georgia recommends two approaches to address the need to focus on the target population. The first approach would be requiring States wanting to expand, to demonstrate that eligible children under 200% FPL have been successfully enrolled by some sort of penetration rate measurement. A second approach would be to only cover the Medicaid FMAP for expansion populations beyond the target population.

Senator Hatch
Questions for the Honorable Governor Sonny Perdue:
1. Governor Perdue, why do you believe that there is a disproportionate number of uninsured children in the South?

Unfortunately, many Southern states have a higher poverty rate than the nation as a whole. Many families living in poverty, as well as those close to the poverty threshold, lack health insurance. In order to provide insurance to children in these families, Southern Governors believe it is imperative that the data used to determine states' allocations accurately reflect the number of eligible children in each state. As you know, Georgia's *PeachCare for Kids* program has been shortchanged due to flaws in federal data sources. Georgia, therefore, has not received a fair allocation. This lack of resources has contributed to the disproportionate number of uninsured children in Georgia.

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[1] Blewett, L., Davern, Michael, "Distributing SCHIP Funds. A Critical Review of the Design and Implementation of the SCHIP Funding Formula" Journal of Health Policy Politics and Law, 2007 32(3) and Davern, M., Blewett, L., Bershadksy, B., Call, KT, Rockwood L., "State Variation in S-CHIP Allocations: How Much Is There, What Are Its Sources and Can It Be Reduced?" Inquiry, 2003 Summer 40(2): 184-97

2. Governor, I agree with you – children should be the priority population for the CHIP program. Do you have any idea how much it would cost the federal government and the states to coverage all CHIP eligible children? And if you don't have national numbers, I'd be curious to hear what those numbers would be for the southern region of our country.

Because there is no agreed-upon data source that is specifically intended to measure either the number of uninsured children or the actual cost of health care for this population, I cannot estimate accurate national costs. However, Georgia commissioned a study that documented the number of eligible children in the state. Using a 3-year average from 2003 to 2005, there are an estimated 101,934 S-CIHP eligible uninsured in Georgia. Additionally, there are an estimated 117,809 Medicaid eligible uninsured children in our State. There is much more work to be done to find and enroll these children in the existing programs as they stand today.

This study confirms that there are significantly more eligible children in the state than the number estimated by CPS. However, not all states have conducted similar assessments of their eligible population. Congress should prioritize fixing the data flaws so that we may get a reasonable estimation of the cost of insuring all children eligible for S-CHIP.

Question for all witnesses:
1. What is your opinion on giving states three years to spend its CHIP funding for a fiscal year? Does that policy make sense? Are some states taking advantage of this system? If so, how do we resolve this issue?

Some states have not been aggressive in enrolling the target population in the time in which they've had. I believe 2 years is an appropriate timeframe in which to spend an allotment. However, from a regional perspective, I know my colleagues have some concerns about reducing the number of years states have to spend their allotments.

As states work to adjust to the new parameters of the reauthorized S-CHIP program and implement reforms that improve the quality of services and increase program enrollment, it becomes harder to predict the response and participation of families. Therefore, Southern Governors believe Congress should be thoughtful when making changes to the current time period in which states have to spend their allotments. Congress should not make changes that would negatively impact states that are currently working to increase the number of enrollees or provide additional benefits.

Senator Kerry
Question for the Honorable Governor Sonny Perdue:
1. *Some at today's hearing have focused on targeting CHIP to only certain uninsured populations. Let me make my position clear: I do not have a problem with low-income working parents receiving the same coverage as their children – it helpsget uninsured kids enrolled and research shows that continuity of coverage has real health benefits. If covering all currently eligible kids is a shared goal, don't you agree that we need to dedicate adequate Federal dollars to GUARANTEE that states can provide coverage for all 6 million of the children who are eligible for CHIP and Medicaid but remain uninsured?*

This is more a question of available federal resources and priorities. These are issues that must be decided on the federal level in the reauthorization debate.

Question for all witnesses:
1. Childhood obesity has reached epidemic proportions in this country. Overweight kids are more likely to contract conditions like diabetes and hypertension, which lead to chronic diseases later in life. By engaging children in the health care system earlier in life we can help kids avoid and/or better manage these painful, life-altering, and expensive conditions – and in the process, reduce future expenditures in programs like Medicare. Isn't this yet another reason to invest in programs like CHIP that improve our children's health?

Yes. However, access to health care isn't the only answer to addressing the problem of childhood obesity. Parental education and involvement and programs that address healthy behaviors and active lifestyles are an essential part of the solution.

Senator Thomas
Questions for the Honorable Governor Sonny Perdue, Kathryn Allen, and Anita Smith:
1. Should the policy of S-CHIP be one where states can cover more adults than children? Especially when states need more money to cover low income children?

The primary goal of the S-CHIP program is to provide health care coverage to eligible children, and therefore, Southern Governors believe children should receive priority coverage under this program. In Georgia, we do not use our limited S-CHIP resources to cover adults.

2. *What incentives do states have to focus their programs on the neediest children, instead of higher income children and adults, if Congress continues to provide more funds when states spend all their allotments?*

Georgia recommends two approaches to address the need to focus on the target population. The first approach would be requiring states wanting to expand, to demonstrate that eligible children under 200% FPL have been successfully enrolled by some sort of penetration rate measurement. A second approach would be to only cover the Medicaid FMAP for expansion populations beyond the target population.

3. States receive capped allotments. They all know what they have to spend every year. Why are some states setting up programs that spend more than their yearly allotments?

Southern Governors believe that states should live within their S-CHIP allotments. However, to do that, allotments must be calculated in a manner that accurately reflects both the size of population it is trying to serve and the economic factors influencing the cost of the service. Southern Governors remain concerned about the accuracy of Census data on eligible children, which has contributed to inadequate allotments for certain states, including Georgia.

Senator Smith

Question for Governor Sonny Perdue:

1. As we heard during the hearing, roughly six million children are eligible for S-CHIP, but not enrolled. I've often heard one of the reasons for this unfortunate situation is that states are hesitant to aggressively outreach into the community for fear of attracting Medicaid-eligible children. Short of providing states with a 100 percent federal match for the programs, what incentives can Congress provide that would encourage states to more aggressively perform outreach into their communities to identify and enroll more eligible children?

As noted in the attached SGA-adopted consensus principles, when considering how much funding is required to both maintain and expand S-CHIP, Congress should anticipate the growth in Medicaid enrollment that results from S-CHIP expansion efforts. On average, states report that S-CHIP outreach efforts result in the provision of services to two Medicaid-eligible children for every additional child enrolled in S-CHIP. Because the Medicaid federal matching rate is lower than the S-CHIP matching rate, state budgets are stretched even further. It is critical that Congress recognizes this fact when moving forward with S-CHIP reauthorization.

Questions for all witnesses:

1. *Though the federal statute allows all states to cover children whose family incomes are less than 200 percent of the federal poverty level, or $40,000 for a family of four, wide variation remains from state to state. Some states only cover children up to 140 percent of poverty, while others are at 350 percent. Given the potential that Congress may not have adequate funding to allow every state to cover all of the children they may want, is there a value in Congress establishing a "priority population," which would mean some states wouldn't get more money to expand until the lower states have had a chance to catch up?*

Georgia recommends two approaches to address the need to focus on the target population. The first approach would be requiring states wanting to expand, to demonstrate that eligible children under 200% FPL have been successfully enrolled by some sort of penetration rate measurement. A second approach would be to only cover the Medicaid FMAP for expansion populations beyond the target population.

2. Is there a value in Congress providing extra assistance to "poorer" states to help them extend coverage to more children?

The program already anticipates this question of distribution by varying the federal matching rates for states according to state per capita income levels. To my knowledge, there have been no concerns expressed about this approach.

3. Concerns have been raised by mental health groups that some S-CHIP programs are not providing adequate mental health coverage. In fact, there is concern that the benefit is not comprehensive and higher cost sharing may be in place in some states for these benefits. Are you aware of any research into this area to determine how specific states address mental health care coverage under S-CHIP?

Georgia's S-CHIP program is a Medicaid look-a-like, whose benefits mirror the Medicaid benefits. As a result, our benefits have been on par with regular medical benefits. I am not aware of how other states address mental health care coverage.

4. Does Congress need to do more during reauthorization to ensure all states are addressing mental health care treatment as equitably as physical health conditions?

It is important that each state be allowed the flexibility to design their program to best meet the unique needs of their uninsured low-income children.

SOUTHERN
GOVERNORS' ASSOCIATION

SGA S-CHIP Reauthorization Principles

Congress Must Act to Reauthorize S-CHIP by the End of FY07
In order to ensure that states can continue to operate their S-CHIP programs for current enrollees, it is essential that Congress complete its work on S-CHIP reauthorization before the program sunsets on September 30, 2007. After that date, states will have no ability to reasonably project the amount of funding that will be made available for FY08 and beyond. Moreover, if the current program is simply extended at its present funding level and without formula changes, more and more states would begin to experience shortfalls in the coming years, and children currently enrolled in the program would be at risk of losing their health care.

Reauthorization Must Provide Adequate Funding
Southern governors strongly support maintaining S-CHIP as a capped block grant program. However, if states are to continue to cover all children currently enrolled and expand the number of eligible low-income children that have access to health insurance through this program, it is imperative that Congress provides sufficient funding to allow them to do so.

Congress Must Recognize the Anticipated Growth in Medicaid Related to Improved S-CHIP Coverage
When considering how much funding is required to both maintain and expand S-CHIP, it is important to anticipate the growth in Medicaid enrollment that results from S-CHIP expansion efforts. On average, states report that S-CHIP outreach efforts result in the provision of services to two Medicaid-eligible children for every additional child enrolled in S-CHIP. Because the Medicaid Federal matching rate is lower than the S-CHIP matching rate, state budgets are stretched even further. It is critical that Congress recognizes this by providing adequate additional resources to support reasonably anticipated Medicaid growth within S-CHIP reauthorization.

States Need to Receive their Allotments in a Predictable, Up-Front Manner
Providing up-front annual allotments from which states draw down as funds are expended allows states to be confident that funding is available. An effective federal-state partnership requires that funding be predictable and stable. To improve predictability, total funding for S-CHIP should increase each year to account for rising costs and increased enrollment. In addition, Congress should require the Centers for Medicare and Medicaid Services (CMS) to provide states with redistribution funding in a timely, predictable fashion. In most states, governors are constitutionally required to present a balanced budget, so predictability of funding is of utmost importance.

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Accuracy of Data is Essential For States to be Able to Live Within Their Allotments
Southern governors believe that states should live within their S-CHIP allotments. However, to do that, allotments must be calculated in a manner that accurately reflects both the size of population it is trying to serve and the economic factors influencing the cost of the service. Southern governors remain concerned about the accuracy of Census data on eligible children. In addition, the Health Care Wage Index, based primarily on wages in nursing care facilities, is not indicative of the actual state-by-state cost of providing children's health care. While we have not yet identified appropriate alternatives to these sources of data that we are prepared to recommend at this time, we encourage Congress to continue to be mindful of the negative impact these data collection issues can have, and consider including language directing the development of recommendations for improving data so that it can more accurately reflect the realities of each state's population.

Congress Should Allow States Multiple Years to Spend S-CHIP Allotments
As states work to adjust to the new parameters of the reauthorized S-CHIP program and implement reforms that improve the quality of services and increase program enrollment, it becomes harder to predict the response and participation of families. Therefore, Congress should be thoughtful when making changes to the current time period in which states have to spend their allotments. Congress should not make changes that would negatively impact states that are currently working to increase the number of enrollees or provide additional benefits.

The Distribution Formula Should Reflect Both Current Spending and the Number of Uninsured Children in Each State
Any new distribution formula must provide states with an allotment that reflects their current S-CHIP program expenditures and funding needs, so that states are able to maintain their current program. In addition, if Congress intends for states to expand their programs, the distribution formula must provide additional resources so that states may cover eligible uninsured children who now do not receive assistance. Because the current S-CHIP formula bases each state's allotment on its number of low-income children and number of uninsured low-income children, and does not consider current spending, aspects of the formula in effect penalizes states for insuring children.

Congress Should Not Impose Additional Mandates on State Programs
Southern governors are concerned that Congress may use S-CHIP reauthorization to impose additional mandates on states that administer stand-alone S-CHIP programs. Many states have chosen to operate a stand-alone S-CHIP program in order to maximize program flexibility and manage benefits to best meet children's health care needs with the available resources. We are specifically concerned about any efforts to require states to provide EPSDT services and their equivalent for dental benefits. Not only would such a requirement incur unnecessary administrative burdens on states, but it would also be extremely costly, leaving less funding available to expand coverage to more eligible children.

Make Children a Priority
Children should be the priority population for S-CHIP. This means that the resources for the program must be focused first on children. CMS has allowed some states to make changes to their programs to include health insurance coverage for pregnant women and adults with

children. Arguably, these populations are directly connected to the targeted population of children. However, some states have been allowed to expand coverage to include childless adults under their S-CHIP programs. At the same time, some Southern states do not have enough S-CHIP resources to cover their eligible children under 200 percent of poverty. Many of the waivers that allow states to cover childless adults through S-CHIP funds were created because of the initial limitations on states that had expanded Medicaid prior to the enactment of S-CHIP. These inequities should be remedied in order to maintain the focus on coverage of children.

Congress Should Streamline Premium Assistance Rules

As Congress considers expanding eligibility to households earning more than 200 percent of poverty, it should also take steps to streamline the currently cumbersome rules to which states must adhere in order to establish a premium assistance program. Moreover, Congress should refrain from adding new requirements that would be a disincentive for states seeking to develop premium assistance programs. In some cases, eligible families, especially those earning more than 200 percent of poverty, have access to employer-sponsored health care, and parents may wish to have their entire family covered under the same employer-sponsored health plan. Unfortunately, some statutory requirements have made it administratively burdensome for states to provide premium assistance programs, and therefore few do without a waiver from CMS allowing them to by-pass some of these rules.

Reauthorization Should Provide Parity for Stand-Alone Programs

The current S-CHIP authorizing legislation has imposed certain limitations on stand-alone programs to which Medicaid expansion programs are not subject. As part of reauthorization, Congress should provide parity to stand-alone program states and do away with some of these inherently unfair requirements. Specifically, stand-alone program states should be able to:

- Use federal S-CHIP funds to cover eligible children of state employees.
- Participate in the Vaccine for Children Program.
- Negotiate the best possible prices and rebates for drugs through an exemption from the Medicaid Best Price Drug Provision.

Statement of Senator Ken Salazar
Senate Committee on Finance Hearing
The Future of CHIP: Improving the Health of America's Children
February 1, 2007

I want to thank Chairman Baucus and Ranking Member Grassley for their leadership in holding this important hearing and for making the health of America's children a top priority.

By all accounts, the State Children's Health Insurance Program has been successful, with over six million low-income, uninsured children receiving the health care that they need to grow, learn and thrive. In Colorado, over 46,000 children and pregnant women are enrolled in our state children's health insurance program. For them and their families, the dividends of quality health care are not simply measured in healthier lives, but in better learning opportunities and more stable and productive families and communities.

As successful as CHIP has been, however, it is clear that the program can be improved. Federal funding shortfalls threaten existing coverage of millions of children in many states. And, an estimated 9 million children in this nation still do not have health insurance. The majority of them are eligible for coverage under CHIP or Medicaid, but are not enrolled. We must make children a top priority and fully fund CHIP.

The reauthorization of CHIP also gives us an opportunity to strengthen CHIP by enacting effective initiatives that further enhance the well-being of children and families. In particular, I want to highlight the Nurse Family Partnership as a program that can build upon the success of CHIP by empowering women and children to lead healthy and economically stable lives.

Nurse Family Partnership is a Colorado-based program that operates in 150 sites in 22 states to provide 20,000 low-income pregnant women with trained registered nurses who work closely with them and their families to increase access to prenatal care, foster child health and development and promote parental economic self-sufficiency.

The success of these programs in the lives of American families is inspiring. These programs have demonstrated, consistent, quantifiable outcomes in:

- reducing child abuse and neglect by 48%;
- reducing child arrests by 59%;
- reducing arrests of the mother by 61%;
- reducing criminal convictions for the mother by 72%;
- increasing father presence in household by 42%; and
- reducing subsequent pregnancies by 32%.

The program has had a demonstrable benefit on early childhood education and development by:

- reducing language delays in 21-month-old children by 50%; and
- reducing behavioral/intellectual problems of children at age 6 by 67%.

Furthermore, Nurse Family Partnership has received national recognition for its work in changing the lives of children and families. In fact, in a Report issued on Monday by the Brookings Institute entitled Cost-Effective Investments in Children, Nurse Family Partnership was praised as one of the most effective returns on investment in the healthy development of the next generation. Nurse Family Partnership has also been highlighted as a blueprint for effective violence prevention programs.

I believe that we must build upon CHIP and invest in the healthy development of our children. That is why I will soon introduce legislation to make Nurse Family Partnership an authorized program within SCHIP.

Nurse Family Partnership is a smart, proven program that will build upon the success of CHIP to make a difference in the lives of children, families and the communities in which they live and work.

I want to thank the witnesses, whose testimony is instructive to this Committee as we evaluate ways to strengthen CHIP. I look forward to working with the members of this Committee to successfully reauthorize CHIP so that it fulfills its promise to provide health coverage to all low-income children. And, I again, thank Chairman Baucus and Ranking Member Grassley for their vision and leadership.

**Testimony of Anita Smith, Chief of the Bureau of Medical Supports,
Iowa Department of Human Services (DHS),
Before the United States Senate Finance Subcommittee
February 1, 2007**

Good morning. I am Anita Smith from the Iowa Department of Human Services. In my role as Chief of the Bureau of Medical Supports, I am responsible for the administration of Iowa's State Children's Health Insurance Program (SCHIP) and the development of eligibility policy for the Medicaid program.

It is a pleasure to be able to come before you today and share Iowa's SCHIP experience and some thoughts on reauthorization.

Iowa's Success

- Currently, over 30,000 children are enrolled in Iowa's SCHIP program.

- We believe one of the primary factors why Iowa's program has been so successful is that before we designed our program, we asked the public what they wanted. We conducted surveys and held town hall meetings all across the state to find out from the public, medical providers and advocates what elements they would like to see in the design of a state children's health insurance program. The three messages that consistently rose to the top were:
    - We want insurance that looks like everyone else's.
    - We don't want to have to apply at the 'welfare' office; and
    - We would be willing to pay what we can towards the cost.

- Using these principles, Iowa's program was developed as a combination program consisting of both a moderate Medicaid expansion and a stand-alone SCHIP program called 'Healthy and Well Kids in Iowa' (known as ***hawk-i***).

- The ***hawk-i*** program was designed to mimic the commercial insurance market to the greatest extent possible, within the federal guidelines.
    - We contract with commercial health plans to provide coverage, and benefits are delivered in a private market model.
    - As in the private sector, providers are paid at rates they negotiate with the health plans.
    - Children receive an insurance card from the health plan in which they are enrolled.
    - Families with income over 150% of the federal poverty level pay a modest premium, but coverage is free for families below 150%.
    - Since over 95% of the dentists in Iowa participate in at least one of the two participating dental plans, a child enrolled in the ***hawk-i*** program can be assured of being able to access dental care.

- Mail-in and on-line applications are all processed centrally, so there is no need for the family to go into a county DHS office. The centralized customer service center is able to assist callers with the application process and answer questions.

- Although media has proven to be the most effective outreach tool, due to its cost, our modest outreach budget primarily funds local grassroots efforts through Title V agencies. Local outreach coordinators are required to work with the schools, medical providers, businesses and faith-based organizations to tailor effective strategies designed to identify and enroll children from the many diverse populations in their communities.

- To ensure that children receive quality care:
    - We contract only with National Committee on Quality Assurance (NCQA) or Joint Commission on Accreditation of Health Care Organizations (JCAHO) accredited health plans;
    - We conduct a quarterly network analysis to ensure adequate provider access;
    - We measure provider access, client satisfaction and provider access through a Consumer Assessment of Health Plan Study (CAHPS)-like survey; and
    - We report on the four national core performance measures related to 1) well-child visits during the first 15 months of life, 2) well-child visits ages 3 through 6 years, 3) the use of appropriate medications for children with asthma, and 4) children's access to primary care practitioners.

- Because of the public's perception of SCHIP and the long ingrained association of Medicaid with the stigma of 'welfare', families repeatedly ask to be enrolled in the ***hawk-i*** program rather than in Medicaid, despite the fact that Medicaid has a more comprehensive benefit package. However, because of the current 'screen and enroll' requirements of SCHIP, families are not allowed to choose and are forced into Medicaid. As a result, some families choose to go without coverage.

Sustaining Success

- With the help of SCHIP and some 178,000 children enrolled in Iowa Medicaid, along with private health insurance, for many years now, Iowa has consistently ranked in the top five states with the lowest uninsured rates for children. But it is estimated there are still over 40,000 uninsured children under 200% of the federal poverty level not yet enrolled.

- Iowa took a conservative approach in implementing SCHIP and developed our program within the original intent of the legislation. As such, we have focused only on covering uninsured children up to 200% of the federal poverty level. We have not used SCHIP funds to cover parents, childless adults or other populations.

- Even so, this is the third year in a row in which we will outspend our annual allotment.
    - In fiscal year '05, we relied on 2002 redistribution dollars of $4.4 million.
    - In fiscal year '06, we relied on supplemental funding of $6.1 million; and
    - In fiscal year '07, we project that all available dollars will be exhausted at the end of June.

- To date, the redistribution dollars and supplemental funding have allowed us to maintain our program without making any cuts, increasing cost-sharing or decreasing benefits. However, if Iowa's allotment remains at the current level, we will not be able to sustain any program growth and, in fact, will have to cut approximately 15,700 children (70%) from the ***hawk-i*** program.

Funding Challenges

- We believe that the SCHIP funding formula is fundamentally flawed:
    - It provided windfall funding in the early years. Allotments were the same amount, or more, in the first years of the program, as are available today. The clock for spending the funds began ticking before most states, including Iowa, had authorizing state legislation to implement a program or a state appropriation to provide the matching funds. As a result, states could not spend all the available money within the allotted time and eventually, over $1 billion dollars that was intended to provide health care to children was reverted to the U.S. Treasury.
    - Five years into the program, state allotments were decreased significantly (known as the 'SCHIP dip') while at the same time, states were getting up to speed and enrollments were increasing.
    - The formula penalizes states that are successful in reducing the number of uninsured children because it factors in only the number of uninsured children, without recognizing the state's progress in reducing those numbers.
    - It does not include a built-in inflation factor for ever-increasing health care costs; and
    - It unfairly disadvantages states that chose to take advantage of the flexibility afforded in the federal legislation to implement a separate program rather than to merely expand Medicaid. This is because when federal Title XXI funding is exhausted, Medicaid expansion states can revert to Title XIX funding to continue their programs, whereas, states with separate programs must fund any shortfall with state-only dollars.

- Currently, some states are sitting on large amounts of unspent allotments while Iowa and other states are facing funding shortfalls with no clear direction of how, or even if, they will be met.

In closing, if Iowa is to sustain the gains we have made and continue making progress in reducing the number of uninsured children, it is essential:

1. That we have a predictable and stable funding stream that will provide sufficient resources to identify, enroll and retain all eligible children under 200% of the federal poverty level in the program.
2. That we have flexibility to design benefit packages and delivery systems.
3. That we are protected against unfunded mandates, such as PERM (Payment Error Rate Measurement), that use up resources needed to provide coverage to children.

I hope information about Iowa's experience will be helpful to you as you go forward in your work to assure that all children have the health care coverage they need. Thank you.

United States Senate Committee on Finance Hearing
The Future of CHIP: Improving the Health of America's Children
February 1, 2007

Questions Submitted for the Record

Anita Smith

Chairman Baucus

Questions for Anita Smith:

1. Three out of four of the 9 million uninsured children in America today are eligible for CHIP or Medicaid but not enrolled. What options should we pursue in CHIP reauthorization to address this problem and expand coverage for uninsured children? What can we learn from states' experience that will aid our work? How can we encourage states to do more?

   Response:

   States have demonstrated a willingness to meet the challenge of providing coverage to uninsured children. However, past experience with the uncertainty of federal funding makes states cautious. The reauthorization of CHIP needs to ensure the availability of adequate and predictable funding so that states have the necessary federal resources to conduct outreach and provide coverage to the children they enroll. Additionally, states need the flexibility to design programs and policies to best meet their needs. Many uninsured children are legal permanent resident alien children who are not eligible for federal means tested programs for 5 years. CHIP reauthorization should include a state option to allow coverage of these children; the children of state employees and consideration should be given to increasing the age limit to include college-aged youth.

2. What steps has Iowa taken to monitor and improve the quality of health care that children receive? Is there more that we should be looking at to address the quality of care in CHIP, including whether children have sufficient access to preventive care services or having a usual place of care with a provider who knows them? How does the strength and predictability of CHIP funding affect quality?

   Response:

   Iowa has several processes in place to monitor quality. In accordance with section 2107(a) of the Social Security Act and the intent of the Government Performance and Results Act of 1993 (GPRA), proposed

Sec. 457.710 encourages program evaluation and accountability by requiring the state plan to describe strategic objectives, performance goals, and performance measures the state has established for providing quality child health assistance to targeted low-income children.

Section 9 of the Title XXI State Plan requires strategic objectives, performance goals and performance measures for the plan administration (Section 2107).

The Department of Human Services' (DHS) Quality Assessment and Improvement Plan was implemented in 1998 and is updated annually. The Plan provides a means of directing and enhancing health outcomes and functional status for enrollees through encouraging delivery of high quality health care.

Quality management is the integrative process that links knowledge, structure and processes together to improve access and quality. To assure access to quality services, the Department and CHIP Board instituted the Clinical Advisory Committee to review and evolve the quality of clinical services to enrollees. Committee members include, doctors, dentists, nutritionists, mental health providers and pharmacists. The following components are included in the Health Quality Strategy Plan:

- Performance Measures: The Department has been directed to examine national performance measures. The goal of the Department, Clinical Advisory Committee and contracted health and dental plans is to assess health care services provided to eligible enrollees for compliance with state, federal and contract requirements. To help achieve this goal, the Department and all participating health plans work in a collegial manner to establish objectives and timetables for improvement of service delivery.

  The following HEDIS ™ outcome measures are reported to the Center for Medicare and Medicaid annually.

  - Children's Access to Primary Care Practitioners
  - Use of Appropriate Medications for Children with Asthma
  - Well Child Visits for Children in the First 15 Months of Life
  - Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
  - Annual Dental Visit
  - Access to Care –Reduce the number of uninsured children in Iowa 0 – 19 years of age below 200% of the Federal Poverty Level.

- Health and Dental Plan Performance: The health and dental plans the Department contracts with to provide services to enrollees are

required to report information related to quality of care and services. Periodic report requirements of health and dental plan contracts specifies that the following reports be submitted to the Department:

- Encounter claims data submitted to the Department monthly.
- Summaries of appeals and resolutions.
- Summaries of amounts recovered from third-party payers.
- Summaries of the plan's quality improvement, health education and preventative programs.
- Information regarding disciplinary actions against participating providers by any state licensing board.
- Immunization reports.
- Fraud and Abuse Plan
- Quality Assurance Plan including credentialing, accreditation, and health performance goals.

- Tools to Measure and Report on Access to Quality, and Health Access: In addition to monitoring health services through performance measures and health and dental plan quality initiatives, the Department evaluates access and health status utilizing the following tools:

  - Analysis of Functional Health Assessment Surveys
    The Department, researchers and the Clinical Advisory Committee developed two survey instruments to evaluate the effect of the participating health and dental plans on access to care, health status and family environment of enrolled children. The survey questions were developed after review of existing documents such as the National Health Survey (NHIS), the Consumer Assessment of Health Plan Study (CAHPS), the SCHIP Program Evaluation Guidelines established by the American Academy of Pediatrics, and enrollee surveys used to evaluate the Iowa Medicaid program. Questions were also added about children with special health care needs that were developed by the Children with Special Needs Subcommittee.

    The first survey evaluation, parents respond to a survey given at the time they joined the program (the baseline survey). These responses are compared with their responses to a survey given after their child has been enrolled for about a year (the follow-up survey) to determine if there are differences in the perceived ability to receive health services or their child's health status. Also, included in the follow-up survey and presented in the report are questions specific to SCHIP, such as the impact of having insurance on their children and family.

The Department released the seventh evaluation report in December 2006. The annual report analyzes information valuable for assessing both accessibility and utilization of

- Provider Network Analysis: The Provider Network Analysis report generated quarterly analyzes the SCHIP health and dental plans provider network in Iowa. Provider networks of each health and dental plan participating in the SCHIP program by specific provider types, including primary care providers, dental providers, hospitals and behavioral health providers.

- Encounter/Claim Data Validation: A medical record review to validate encounter/claim information for members enrolled in the SCHIP program is completed annually. For this validation a random sample of encounters/claims for services received by members in the SCHIP program is selected. Medical records are requested from providers for dates of service submitted on the claim. Encounter/claim information is compared to the medical record to verify data integrity.

Is there more that we should be looking at to address the quality of care in CHIP, including whether children have sufficient access to preventative care services to having a usual place of care with provider who knows them?

Response:

As indicated above, Iowa's CHIP program has an integrative quality process that links knowledge, structure and processes together to improve access and quality services. The "Functional Health Assessment Survey" and "Provider Network Analysis" and "Performance Measures" assist the Department, Clinical Advisory Committee and contracted health and dental plans with monitoring and evaluating access to care, improving health status, and the family environment of enrolled children.

An integrated quality process provides the opportunity for comparative analysis key to assuring that children have sufficient access to preventative care services and an adequate number of providers that the family can choose from allowing children consistency of health care services.

How does the strength and predictability of CHIP funding affect quality?

Response:

In addition to steps that the Department has taken to monitor and improve the quality of health care that children receive, additional quality processes have been implemented:

- Eligibility Quality Reviews
  - Statistical Reports
  - Quality Eligibility Case Reviews (600 per year)
  - SAS 70 & Procedural Audit
  - Insurance Data Match

- Fraud and Overpayment Detection
  - Department of Inspections and Appeals Contract
    - Front-end Investigation
    - Overpayment Recovery
    - Fraud Investigation
    - Prosecution
  - Health and Dental Plans Fraud and Abuse Policies and Procedures

- PERM – Iowa was selected as a 2008 PERM state.

- Financial Quality Reviews:
  - Annual State Financial Audit
  - Health and Dental Capitation Payment Reconciliation
  - Fraud and Overpayment Recoupment

- Contract Management
  - Performance monitoring
  - Health and Dental Plans Quality Plans

- Outreach
  - Reduce the number of uninsured children in Iowa

As noted above, the Department's Quality Strategy Plan has several components to assure the integrity of Iowa's CHIP program. Currently, the Department has a 10% cap on the amount of federal funding that can be used for administrative costs. Costs associated with quality management are required to be funded with administrative capped federal funds.

Iowa has been selected to participate in the Payment Error Rate Measurement (PERM) in FFY 2008, and every three years thereafter. No additional federal funding has been made available and there continues to be concern that the fiscal impact of providing claims information and technical assistance to contractors, conducting eligibility reviews and implementing corrective actions will increase the projected funding shortfall in FFY 2007 and FFY 2008 and every three years thereafter if

additional funding is not appropriated. Iowa is projecting that PERM will cost Iowa, at a minimum, $650,000 for just the CHIP program alone.

In order to assure that all components of the Quality Strategy Plan (outlined above) utilized to assess the structure, access, process and outcomes remain in place; the reauthorization of CHIP needs to ensure the availability of adequate funding for quality management. Currently, Iowa is restricted to funding all components of the Quality Strategy Plan with 10% administrative dollars. Funding beyond the 10% administrative cap needs to be allocated to states to fund in order for Iowa to continue the quality management tools currently in place.

3. What has your experience in Iowa been? How have these requirements affected access to coverage for the ~~178,000~~ 16,500 children covered under Iowa's Medicaid expansion? Or on Hawk-I, the separate CHIP program? What problems do you anticipate in the future?

Response:

No. Quality initiatives have not affected access to coverage for children in either the Medicaid expansion or ***hawk-i*** programs. We believe the quality initiatives that Iowa has in place enhance access by identifying where provider networks need to be enhanced or other program issues that need attention. These may otherwise be overlooked without these initiatives.

4. I have been reading a great deal about the impact the new Deficit Reduction Act citizenship documentation rules are having on access to Medicaid for low-income beneficiaries. What has your experience in Iowa been? Like other states are now reporting, have you seen a substantial downturn in enrollment or an increase in the number of delayed applications since the rule became effective on July 1 of last year? How have these requirements affected access to coverage for the ~~178,000~~ 16,500 children covered under Iowa's Medicaid expansion under CHIP? What effect, if any, do you find these new rules are having on the Iowa's outreach and enrollment simplification procedures for Hawk-I, the separate program? What problems do you anticipate in the future?

Response:

Since July 2006, 11,717 individuals* have been denied or cancelled from Iowa Medicaid, specifically for failure to provide the required citizenship or identity verification.

While the citizenship and identity verification requirements are not an eligibility factor for CHIP, they do impact children that are referred to Medicaid from CHIP through the Medicaid 'screen and enroll' requirements because approximately 40 percent of children that apply for CHIP are actually Medicaid eligible. Since implementing the citizenship verification requirements, there have been more months of Medicaid enrollment declines than in any of at least 5 of the previous state fiscal years. In each of the past 5 state fiscal years, Iowa's Medicaid program experienced only three months of enrollment declines (not the same months). Since implementing the verification requirements in July, Iowa has experienced Medicaid enrollment declines in six of the ten months of this fiscal year. Since the declines are generally in population groups for which verification is a requirement, as opposed to exempt groups (SSI and Medicare recipients), it can be assumed that the additional documentation requests are resulting in the decline.

* This number does not reflect individuals who have been denied or cancelled for failure to provide other types of verification or documentation in addition to citizenship or identity verification.

Senator Rockefeller

Question for Anita Smith:

1. Some have argued that perhaps Congress should consider capping CHIP eligibility at 200% of poverty. However, states currently enjoy the flexibility to use certain work expense and childcare disregards when determining CHIP eligibility. In fact, according to data from the Urban Institute, Iowa's income disregards effectively mean that program eligibility goes up to 241% of poverty. In Georgia, the eligibility level goes up to 253% of poverty.

That flexibility is why Mr. and Mrs. Bedford (the witness family) were able to deduct their small business income in order to enroll their children in CHIP.

Ms. Smith, wouldn't you agree that there is significant enough variation in median and per capita income among the states that this type of flexibility in determining eligibility should be continued?

Response:

Yes. Income deductions are applied only to the earned income of people who are employed. These are low-income families that incur transportation and childcare costs in order to work and the cost of working needs to be recognized when determining eligibility. Particularly now that gas prices are exceeding $3 per gallon across the country.

Additionally, for states with separate CHIP programs, the ability to allow the same deductions in CHIP that are allowed in the state's Medicaid program is essential because families often move between the two programs. By not allowing the same deductions, families may wind up in a situation where they are over income for Medicaid when considering income after deductions but don't qualify for CHIP either when considering gross income.

Senator Hatch

Question for all witnesses:

1. What is your opinion on giving states three years to spend its CHIP funding for a fiscal year? Does that policy make sense? Are some states taking advantage of this system? If so, how do we resolve this issue?

   Response:

   Three years to spend allotments made sense initially because states needed time to design programs and obtain state authorizing legislation and appropriations. Now that the program is mature, allowing states that aren't using the funding to retain allotments for three years reduces the ability to redistribute funds within the program to states with greater funding need.

Senator Kerry

Question for all witnesses:

1. Childhood obesity has reached epidemic proportions in this country. Overweight kids are more likely to contract conditions like diabetes and hypertension, which lead to chronic diseases later in life. By engaging children in the health care system earlier in life we can help kids avoid and/or better manage these painful, life-altering, and expensive conditions – and in the process, reduce future expenditures in programs like Medicare.

   Isn't this yet another reason to invest in programs like CHIP that improve our children's health?

Response:

Yes. Parents are more likely to get proactive care for their children rather than reactive treatment when the child is insured. Obesity and other health issues can be detected and treated, or prevented, at a much earlier age if a medical professional regularly sees the child.

Senator Thomas

Questions for Kathryn Allen, Honorable Governor Sonny Perdue and Anita Smith:

1. Should the policy of SCHIP be one where states can cover more adults than children? Especially when states need more money to cover low-income children?

   Response:

   The intent of CHIP was to cover children. However, studies have shown that by offering coverage to parents, they are more likely to also cover their children. If the original intent of the legislation can be met by bringing more children into the program through covering their parents, then coverage of parents could be justified. Since covering an adult is more costly than covering a child, the increased per person cost should be factored into the formula when calculating the amount of allotments to states. However, the cost of covering parents should not be allowed if it reduces available funding to the extent that all the eligible children cannot be covered first.

2. What incentives do states have to focus their programs on the neediest children, instead of higher income children and adults, if Congress continues to provide more funds when states spend all their allotments?

   Response:
   By covering lower income populations over higher income populations, the state can reduce overall health care costs. Ensuring that those who have the fewest resources to pay for care, have access to preventive health care and early treatment for illness or injury can do this. Having access to regular medical care will reduce the need for costly care in an emergency room setting.

3. States receive capped allotments. They all know what they have to spend every year. Why are some states setting up programs that spend more than their yearly allotments?

Response:

States receive a portion of the total federal allotment. The amount of that portion is not known at the time states are doing budget planning for the fiscal year that the allotment is for. When the SCHIP program first started, states took time to add enrollees, and subsequently ended up with leftover funds at the end of the federal fiscal year. As time passed, states' programs expanded, and allotments were becoming used within the 3-year time limit. Now, the programs that states set up years ago, are taking more dollars to fund because of increased enrollment.

It is difficult for states to budget into the future without knowing the amount of the total federal allotment that will be distributed to their state. Programs cannot be adjusted to fit the allotment amount since many times, the allotment amount is not known until after that federal fiscal year has already begun.

Senator Smith

Questions for all witnesses:

1. Though the federal statute allows all states to cover children whose family incomes are less than 200 percent of the federal poverty level, or $40,000 for a family of four, wide variation remains from state to state. Some states only cover children up to 140 percent of poverty, while others are at 350 percent. Given the potential that Congress may not have adequate funding to allow every state to cover all of the children they may way, is there a value in Congress establishing a "priority population," which would mean some states wouldn't get more money to expand until the lower states have had a chance to catch up?

   Response:

   Iowa does not believe this would be an effective approach due to the variance in the cost of living among states. For example, covering children up to 250 percent of poverty in a state where the cost of living is high may not actually be reaching as many children as could be covered in a state with income limits at 185 percent of poverty when comparing actual family disposable income. Additionally, this type of approach would tie up otherwise available funds for those states that want to expand.

2. Is there a value in Congress providing extra assistance to "poorer" states to help them extend coverage to more children?

Response:

Enhanced federal funding to reduce the cost to the state is always helpful in advancing programs that have state matching fund requirements.

3. Concerns have been raised by mental health groups that some S-CHIP programs are not providing adequate mental health coverage. In fact, there is concern that the benefit is not comprehensive and higher cost sharing may be in place in some states for these benefits. Are you aware of any research into this area to determine how specific states address mental health care coverage under S-CHIP?

Response:

We are aware of the following reports related to this subject.

a) "Access to Children's Mental Health Services under Medicaid and SCHIP", author: Embry M. Howell, 2004 published by the Urban Institute.

Summary: This paper summarizes the issues associated with covering a comprehensive range of mental health benefits under the State Children's Health Insurance Program, and provides estimates of the cost of such services. The authors conclude that, since states are already largely responsible for low-income children with serious mental health problems through various state-funded programs, states should consider broadening SCHIP coverage to include the range of treatments that are considered effective. **(*Health Affairs* 2000 November/December; 19(8): 291-297).**

b) " Mental Health Benefits in Non-Medicaid SCHIP Plan" http://www.ncsl.org/programs/health/schiptable05.htm

Summary: This is a table of mental health benefits by state for separate S-CHIP programs.

c) Balancing Budgets And Health Services: Children's Mental Health Care In An Era Of Budget Cuts (File Date: **8/23/2005**)
Summary: States already have enacted substantial cost containment strategies to cope with shortfalls, but they are likely to consider additional cuts or changes to balance budgets that may affect mental health services. All funding streams that provide children's mental health services, in particular, state mental health agencies, Medicaid and State Children's Health Insurance Program (SCHIP) programs have sustained budget cuts....

4. Does Congress need to do more during reauthorization to ensure all states are addressing mental health care treatment as equitably as physical health conditions?

Response:

State's need flexibility to design programs that best meet their needs. A majority of states now have mental health parity that provides for the treatment of mental disease in the same manner as physical disease.

Statement of Senator Gordon H. Smith
"The Future of CHIP: Improving the Health of America's Children"
February 1, 2007

According to the U.S. Census Bureau, in 2006 over 46 million Americans, clearly 15 percent of the population, lacked health care coverage at some point during the year, and almost nine million of these were children.

As the new Congress begins, we have an exciting opportunity to extend health care coverage to more Americans, especially to low income children.

And while many proposals are being introduced, the top priority for this Congress must be reauthorization of the State Children's Health Insurance Program, known as SCHIP.

For the past nine years, this program has been a beacon on light leading the way toward health care coverage for millions of our nation's children. Yet, of the nine million American children who lack coverage, nearly three million are eligible for SCHIP, but not enrolled.

While I recognize the budget is tight and many difficult decisions will need to be made, I hope that we can come together to reauthorize SCHIP and ensure that adequate funding is provided to cover at least all of those who are eligible for the program, and hopefully more.

In September, I was joined by nine of my Republican colleagues, including two whom serve on this Committee, in sending a letter to President Bush urging him to provide adequate funding through his fiscal year 2008 budget. We encouraged him to make SCHIP a priority by providing adequate funding to cover existing beneficiaries, expand coverage to all children and pregnant women up to 200 percent of the federal poverty level, and implement a yearly inflationary adjustment.

SCHIP, along with Medicaid is the foundation of the nation's health care safety-net. Given this role, it is imperative that we keep both programs strong to ensure that those who most need help in obtaining health care coverage receive it.

As we look toward reauthorization, our biggest hurdle remains identifying adequate funding. It is my understanding, that to simply continue covering those persons who are presently enrolled, Congress would need to identify almost $15 billion in additional funding. What's more, to expand coverage to those children who are eligible, but not enrolled would require almost $45 billion.

While these figures present a significant challenge. However, I remain hopeful that we can find bipartisan solutions way to get the funding needed to help America's children.

I look forward to working with my colleagues and President Bush as we work to reauthorize SCHIP.

Senate Finance Committee Hearing
The Future of SCHIP: Improving the Health of America's Children

Statement of Senator Craig Thomas (R-WY)

Chairman Baucus and Ranking Member Grassley, thank you for holding today's hearing so that we can continue our discussions about the State Children's Health Insurance Program (SCHIP).

We all want to ensure that our most vulnerable children have access to the health care services they need. Undoubtedly, there will be competing ideas on how to accomplish this goal. Working together toward reauthorization in 2007, I do believe we can find reasonable, commonsense solutions that improve SCHIP financing. We have an obligation to make sure this program runs effectively and efficiently.

As you all know, SCHIP is a capped federal allotment, not an entitlement program. It does not have an unlimited draw on the federal treasury like Medicare and Medicaid do. The States know how much federal money they will have to spend each year. Although the federal dollars are set annually, there is no limit on the amount of money individual states can use if they chose to create a more generous SCHIP program than current law allows. In fact, many states have used waivers to cover one or more categories of adults as well as alter benefit packages. Unfortunately, some states have overspent their yearly federal allotments in the process.

States that have used all their federal money now find themselves in a financial bind. It seems to me that we have encouraged states to assume the federal government will always put more money into their capped allotments when they have reached their limit. Congress created SCHIP with a simple, targeted purpose: to help low income children in working class families get access to health insurance. I must admit that I wonder if we are serving our children and the taxpayer well when a handful of states are covering more adults than children.

Many people are talking about how much Congress should spend to expand SCHIP. I do not hear the same enthusiasm from those folks about making needed structural improvements! It is very important that we use this opportunity to review the programs goals and make the necessary adjustments to improve it. Adding more money to SCHIP without making common sense reforms is something I find very troubling.

Mr. Chairman, I appreciate the opportunity to hear from the panel of experts testifying before the Committee today. We have many issues to discuss in preparation for SCHIP reauthorization, and I look forward to participating in the debate.

COMMUNICATIONS

Statement

For the Record

of the

American Medical Association

to the

Committee on Finance
United States Senate

RE: The Future of CHIP: Improving the Health of America's Children

February 1, 2007

Division of Legislative Counsel
202 789-7426

As the Senate Committee on Finance begins its work to reauthorize the State Children's Health Insurance Program (SCHIP) in today's hearing, the American Medical Association (AMA) is pleased to share the views of our physician and medical student members on SCHIP and ensuring access to care for the millions of uninsured children in America. Increasing access to medical coverage for the uninsured is a top priority of the AMA and America's physicians.

According to U.S. Census Bureau data from August 2006, an estimated 46.6 million Americans were uninsured in 2005, approximately 9 million of whom were children. Put another way, 11.2 percent of children under the age of 18 had no coverage, compared with 10.8 percent the previous year. The AMA finds this situation unacceptable. Physicians see first-hand the devastating consequences of not having health care coverage. Research shows that uninsured patients live sicker and die younger. The uninsured often postpone preventive care and going to the doctor until their health problems reach crisis proportions, leading to more difficult and more costly conditions to treat.

Being uninsured has especially negative consequences for the health and well-being of children. When children lack health insurance coverage, they do not receive timely immunizations or see a doctor when they are sick. They tend to develop conditions, such as asthma, that could have been treated more affordably and effectively if diagnosed sooner. Having insurance leads to better access to care and better health outcomes, particularly for children with serious illnesses and disabilities.

SCHIP provides a critical safety net for health insurance for low-income children. The program has helped to significantly reduce the number and percentage of low-income children without coverage since its creation in 1997. In fact, children are more likely to have health coverage now than in 1997 as the uninsured rate of low-income children has dropped by a third. According to a 50-state survey released in January 2007 by the Kaiser Commission on Medicaid and the Uninsured, 17 states (one-third) increased access to health coverage in 2006, and for the first time in four years, no states cut income eligibility in Medicaid and SCHIP. At least 10 states are currently planning to increase coverage for children, or have already done so.

By any measure, SCHIP has been a success in expanding coverage for children. Despite this progress, however, of the nine million children who still lack health insurance coverage, about six million children are eligible for health insurance coverage under SCHIP or Medicaid but are not enrolled. The AMA believes that it is critically important to focus first on enrolling these children. A key reason why millions of eligible children are not participating in SCHIP or Medicaid is that enrollment and re-enrollment procedures are often cumbersome. The AMA supports state efforts to maximize outreach and enrollment of SCHIP-eligible children, using all available state and federal funding, and to streamline the enrollment process within their Medicaid and SCHIP programs by allowing mail-in applications, developing shorter application forms, coordinating application processes among multiple low-income programs, placing eligibility workers in strategic locations to best reach potential beneficiaries and administering their

Medicaid and SCHIP programs through a single state agency. AMA policy encourages physicians to enroll children in adequately funded Medicaid and SCHIP programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

The AMA recognizes that a variety of proposals are being advanced to cover the uninsured. We believe that the current health coverage system should enable uninsured individuals and families to obtain affordable coverage, with financial assistance for those with low incomes, including those patients who are eligible for or enrolled in Medicaid or SCHIP. Over the long-term, the AMA supports implementation of individual tax credits that are advanceable, refundable, and inversely related to income for the purchase of health insurance. However, in the short term, in the absence of private sector reform, the AMA supports special efforts being made to enroll all patients who are eligible for public sector programs, such as SCHIP, with the goal of improving access to health care coverage to otherwise uninsured groups.

The AMA favors providing states with the support and flexibility needed to improve coverage rather than dictating the details of specific mechanisms. With recent evidence of successful state efforts and planned initiatives to increase coverage for uninsured children, the AMA believes it is important to support state autonomy in extending health insurance coverage. Thus, the AMA believes that state governments should be given the freedom to develop and test different models for improving coverage for patients with low incomes. The AMA supports changes in federal rules and federal financing to support the ability of states to develop and test such alternatives.

Another critical factor in the success of SCHIP is ensuring that a sufficient number of physicians participate as providers in the program. Therefore, SCHIP payment rates need to be at a level that adequately covers physicians' costs in providing care to SCHIP beneficiaries.

The AMA is working to achieve some of our policy recommendations with a diverse coalition of major national organizations (including AARP, Families USA, American Hospital Association, America's Health Insurance Plans) interested in decreasing the number of uninsured Americans, especially children. The Health Coverage Coalition for the Uninsured (HCCU) proposes to expand coverage to the uninsured in two phases, the first of which is comprised of the "Kids First" initiative and support for state experimentation.

The HCCU Kids First initiative proposes to expand public-sector coverage by improving enrollment of children who are uninsured but currently eligible for SCHIP and Medicaid. This would be done by giving states the flexibility to deem low-income uninsured children eligible and enroll them in SCHIP or Medicaid when they qualify for other means-tested programs, such as free or reduced-price school lunches, food stamps, or the Women, Infants and Children (WIC) program. A more user-friendly, "one-stop"

shopping system would make it easier to reach this critical targeted group of uninsured children.

States will need additional federal SCHIP funds to pay for the increased enrollment of all eligible children from lower-income families. This is in addition to increased funding necessary just to maintain coverage for those beneficiaries currently enrolled in SCHIP. Unlike Medicaid, an entitlement program whose federal funding increases automatically to compensate for increases in health-care costs (as well as increases in caseloads), SCHIP is a block grant with a fixed annual funding level. As a result, the federal SCHIP funding that states receive is not keeping pace with the rising cost of health care or population growth.

State efforts to expand health insurance coverage come at a time when future funding is uncertain, and a number of states are projected to face significant shortfalls in their SCHIP funding this year. Although Congress approved, as part of the National Institutes of Health Reform Act of 2006 (Public Law No: 109-482), an amendment to redistribute unspent SCHIP allotments from fiscal years 2004 and 2005, these funds only delay the date that states will start experiencing shortfalls until early May 2007. The remaining shortfalls for the fiscal year are projected at over $716 million. The continued success of SCHIP is largely dependent on adequate future federal funding.

The HCCU proposal also supports increasing children's health insurance coverage in the private sector, including through employer-sponsored health insurance, by creating a new family tax credit for the purchase of children's health coverage. The refundable and advanceable tax credit would be available to families with incomes up to 300 percent of the federal poverty level.

In addition, the proposal would establish a state demonstration program giving states flexibility to experiment with new, innovative approaches to expand health insurance coverage. Competitive grants would be provided to the states which, unlike Medicaid waivers, would provide additional funding over and above current federal funds provided to states for Medicaid and SCHIP. More information about the HCCU consensus agreement is available at www.coalitionfortheuninsured.org.

In conclusion, the AMA is committed to working with Congress to reauthorize the State Children's Health Insurance Program and to reducing the number of uninsured children in America.

SENATE FINANCE COMMITTEE HEARING
STATEMENT OF MARIAN WRIGHT EDELMAN
PRESIDENT, CHILDREN'S DEFENSE FUND
and on Behalf of:
Dr. William Shaw, President, National Baptist Convention USA, Inc.
Dr. T. DeWitt Smith, President, Progressive National Baptist Convention
Dr. Stephen Thurston, President, National Baptist Convention of America
Dr. C.C. Robertson, President, National Missionary Baptist Convention
Presiding Bishops and the Women's Missionary Societies, African Methodist Episcopal Church
African Methodist Episcopal Zion Church
Christian Methodist Episcopal Church
Dr. Dorothy Height, Chair Emerita, National Council of Negro Women

It is difficult and heartbreaking to believe that, in 2007, in the wealthiest nation in the world, with a $13.3 trillion GDP, our political leaders are debating how many or how few *children* should have health coverage. The real debate should be about why there are 9 million uninsured children in America, almost 90 percent of whom live in working households, and how we are going to end this economically costly and morally intolerable reality *now*.

Over the next few months, as Congress considers reauthorization of funding for the State Children's Health Insurance Program (SCHIP), we hope the goal and end result will be to ensure *all* 9 million uninsured children and pregnant women in America access to all necessary health care they would have if they lived in almost every other – and far less wealthy – industrialized nation. No child should have to wait until 65 for the health care guarantee we provide America's senior citizens. No child should be born at low birthweight or die in the first year of life because they did not have adequate prenatal or postnatal care. Children cannot wait! Their brains, bones and sense of self are being formed this minute and this day. The extraordinary opportunity and responsibility the Congress and President have this year to finish the job of covering all children, building on the great progress made by Medicaid and SCHIP and efforts of many states, must not be missed. Katrina's children and the 9 million other children are waiting! A child's chance to survive and thrive should not depend on the lottery of geography. God did not make two classes of children and United States policy should not continue to do so by leaving any child without coverage, certainly not millions, and not ensuring every SCHIP and uninsured child the guaranteed benefits Medicaid children receive.

As you consider SCHIP's renewal and other children's health legislation which CDF proposes this year – your decision may dictate Congressional action on child health for the next 5 years as the nation moves into election year debates about long overdue health coverage for all Americans (which we favor but which has eluded us for decades). Until all in America are covered, it is imperative that we leave not one of the 9 million uninsured children behind; not leave the benefit inequities between children's Medicaid and SCHIP; millions of uninsured and underinsured children; and not leave the array of unnecessary bureaucratic barriers across all 50 states in each of these important programs

which has resulted in 5-6 million currently eligible children not getting coverage. And it is important that Katrina's children, scattered over 40 states, still struggling with monstrous losses of homes, relatives, schools, pets, their sense of security and future shattered, get the mental health, health care and protection any sensible and compassionate nation would provide.

If children are our anchor concern; if making sure children are born healthy, are ready for and able to learn in school is important; if preventing far higher emergency room and uncompensated care costs which cost taxpayers billions every year can be prevented; and if preventing unbearable parental stress, missed school and work days and family bankruptcies from escalating health costs, is of concern, then the Congress and the President must and can make needed policy changes to cover all children and to correct current system gaps and inequities that protect all children this year and over the next years until our nation enacts health coverage for all. Millions of children should not be medically neglected and left to suffer when we can prevent and alleviate such suffering. Covering all children first is an affordable incremental down payment on health coverage for all.

The Children

Listen to the stories and struggles of the children and families below and ask how can our nation's leaders not act now.

- **JOSEPH,** a 19-year-old boy from Hayward, California, lives with his working parents, Patrick and Josephina whose total family income is $50,000. Joseph's parents and three younger siblings do not have health insurance. The family cannot afford the monthly costs to cover the family. When Joseph was 15 he was hit by a car. The driver did not have insurance coverage for third-party medical expenses. Joseph was taken to the local hospital where he was operated on and kept for seven days. With no health insurance the hospital billed the family $72,000 for Joseph's hospitalization - over $20,000 more than the family's annual income. "What are we supposed to do?" asked Josephina. "We both work so hard for our family and now we are scared we may lose our home. Not having health insurance has terrorized our family."

- **DEVANTE is a 13-year-old boy from Texas.** Devante has cancer of the kidneys and went without any health coverage for four months while his mother attempted to renew his Medicaid coverage. Although his mother submitted at least three renewal applications beginning in February 2006—one through the financial counselor at Texas Children's Hospital—and called the CHIP/Medicaid hotline dozens of times, there was no record of Devante's case in the system when advocates contacted the call center on his behalf on August 25, 2006. Meanwhile, Devante went without any health insurance at all from May through August. He depended on clinical trials for care, and his tumors continued to grow. Devante's mother wanted to transfer him to the University of Texas M.D. Anderson Cancer Center for care, but without health insurance, was unable to cover the cost of care.

Devante eventually was transferred to M.D. Anderson and the radiation therapy is taking away the pain that he was in, but he suffered needlessly for months while his paperwork was caught up in red tape. It was only through personal intervention and extensive follow-up with the highest levels of the Texas Health and Human Services Commission that his coverage was reinstated. Over 200,000 children like Devante have lost health coverage or benefits for one or another inappropriate bureaucratic reasons and cutbacks in CHIP benefits by the Texas legislature.

- **MARY,** a chronically sick 7-year-old child with a medical chart over 3 inches thick, has a disorder called hereditary spherocytosis, meaning that her red blood cells are not formed correctly. Mary also has asthma. When she gets sick with something as minor as a cold, she could become anemic enough to need to be hospitalized and need a blood transfusion. She requires shots once a month to manage her condition. Mary used to receive health coverage through the Children's Health Insurance Program (CHIP), but her father recently started a new job that put the family income above the CHIP limit by $300. Her father's new employer offers insurance for families, but the cost of $988 a month makes this coverage unaffordable for the family. This is a crisis for Mary, who must see the hematologist and endocrinologist once a month. Mary's father is now borrowing what he can from family members and the bank to cover Mary's health needs until he can find someone or some way to help his child. In the meantime, her chronic condition continues and the emergency room is her only option.

- **One-year-old CARMEL from Minnesota** is the youngest of four children whose parents can't afford health care without help from Minnesota's child health insurance program. All the children face numerous health problems requiring multiple visits to the doctor. Carmel's oldest sister has a bone cyst that has required three surgeries in the past couple of months, and her two brothers' have Attention Deficit Hyperactivity Disorder and need weekly therapy sessions. Carmel has had difficulty gaining weight and suffers chronic ear infections (eighteen over the past year). In a single recent week, Carmel's mother had to schedule three doctor's visits for her brothers and sister. The family income is now too high and they will soon no longer by eligible for Minnesota's child health insurance program. Although health insurance is available through Carmel's father's employer, the monthly premium is almost $300 and each visit to the doctor will cost $40 per child. Carmel's family lives on a very tight budget. With the added insurance cost, the family will only have $100 left over each month for food and necessities. Carmel's parents will soon have to decide if and how they are going to purchase health insurance through her father's employer or go without medical coverage.

- **The BAZILE family** was forced to evacuate from New Orleans during Hurricane Katrina. Louisiana's CHIP 30-day process from start to finish turned into a yearlong nightmare for Texas CHIP processing. The family did not receive any communication for a month and a half after applying and was required to provide

numerous forms of "missing information." Sydney and Paris Bazile remained uninsured one year after the storm because paperwork was mismanaged.

Covering *All* Children in 2007: An Achievable, Smart and Right Goal

WHY ACT NOW? Medicaid and the State Children's Health Insurance Program (SCHIP) have made tremendous progress in improving children's health insurance, currently providing coverage to over 30 million children. **Yet more than 9 million children in America, almost 90% living in working households and a majority in two-parent families, are still uninsured.** Millions more are underinsured. Chronic budget shortfalls, often confusing enrollment processes, and dramatic variation in eligibility and coverage from state to state prevent millions of currently eligible children from living healthy and realizing their full potential in school and life. As Congress considers reauthorization of SCHIP in 2007, there is a special opportunity and responsibility for our nation and leaders in all parties to take the next logical, incremental, smart and just steps to ensure health and mental health coverage for **all** children in America as a significant down payment on health coverage for all.

The Children's Defense Fund (CDF) proposes to ensure affordable access to comprehensive health and mental health care for all children in America. CDF's proposal, which we support, would simplify and consolidate children's health coverage under Medicaid and SCHIP into a single program that guarantees children in all 50 states and the District of Columbia all medically necessary services so that a child's chance to survive and thrive is protected in every state and backed by guaranteed federal funding.

WHO WOULD BE ELIGIBLE?

- **All children with family incomes at or below 300% of the federal poverty level** ($61,950 for a family of four in 2007) would be eligible. Children with family incomes over **300% could buy into the program.**
- **Pregnant women at or below 300% of the federal poverty level** would be eligible for prenatal, delivery and post-partum care for at least 60 days after birth to ensure babies are born healthy and new mothers get the health and mental care they need to care for their child.
- Youth who have transitioned from the **foster care system through age 20, and other special needs children covered by current law, would be eligible.**

WHAT BENEFITS WOULD BE INCLUDED?

- All children enrolled in a new program would receive **comprehensive coverage of all medically necessary care equivalent to current Medicaid benefits.**

WHAT WOULD BE THE COST FOR FAMILIES?

- Children in families with incomes at or below 200% of the federal poverty level ($41,300 for a family of four in 2007) **would pay nothing for coverage or services.**

- Children in families with incomes between 201% and 300% of the federal poverty level would have **no premiums for coverage and nominal co-payments for services.**
- Children in families with incomes over 300% of the federal poverty level who enter the program would **be responsible for paying monthly premiums and co-payments for services provided.**

HOW WOULD A BLENDED CHILDREN'S PROGRAM STREAMLINE ENROLLMENT?

- All children currently enrolled in **Medicaid or SCHIP would be enrolled automatically**.
- All children currently receiving services under **certain means tested federal assistance programs like school lunch and food stamps would be enrolled automatically with opportunity for families to "opt out."**
- All parents would also have the **option to enroll their child at birth, school registration, or issuance of a Social Security card.**
- Applications would be short and **simple to complete; children would be presumed immediately eligible for services;** and **obstacles to enroll and stay enrolled would be eliminated.**

WHAT WOULD THE FEDERAL AND STATE ROLES BE AND WHO WOULD PAY WHAT TO ENSURE EXPANDED COVERAGE AND BENEFITS FOR ALL 9 MILLION UNINSURED CHILDREN?

- There would be **no additional cost to states for child coverage expansion or enhanced benefits.** Funds for coverage expansion and improvements would come from the federal government with states maintaining their level of contribution in children's Medicaid and SCHIP as of the end of 2006.
- All eligible children would be **guaranteed coverage** under this program regardless of their state of residence.
- To improve children's access to health and mental health services, **payment to health care providers would be increased to not less than 80 percent of average private provider payment rates within a state.**

The affordable cost and breakdown of these common sense next steps which a strong majority of Americans of all parties support is attached – calculated by the nonpartisan group Lewin and Associates. The expansion of coverage and improvement of benefits for all children and pregnant women up to 300 percent of the federal poverty level requires an annual investment of $14.8 billion over and above current children's Medicaid and SCHIP funding with cost of living adjustments. The 5 year costs of this coverage expansion and benefit equalization would be $70 billion phased in (see attached table). This increased annual investment of $14. 8 billion in our children's and pregnant women's health is equivalent to...

- less than 2 months of the war in Iraq
- 9 days of military spending in 2007
- 3 months of the tax cuts to the richest 1 percent in 2007

- 2 months of the tax cuts to the richest 1 percent in 2011 if the tax cuts are made permanent
- 3 months of a proposed estate tax repeal
- 14 days of spending on Medicare in 2007
- 8 months of spending on farm subsidies in 2007

Investing $26.1 billion to cover more than 9 million children and pregnant women *and increase payments to health care providers* would cost:

- Less than 3 ½ months of the war in Iraq
- 16 days of military spending in 2007
- 5 months of the 2001-2004 tax cuts to the richest 1 percent in 2007
- 3 months of the 2001-2004 tax cuts to the richest 1 percent in 2011 if the cuts are made permanent
- 5 ½ months of an estate tax repeal
- 25 days of spending on Medicare in 2007

We think our rich nation can take care of its seniors and its children! We have heard much about "pay-go" as a reason we cannot or should not cover all children now. We repeat: children are the cheapest and most cost effective group to cover. Preventing and treating children's conditions early saves money. We support fiscal responsibility by the President and Congress but respectfully submit that ensuring healthy children is not a pay-go issue. It is a values, choices and priorities issue – a core moral issue. If Congress and the President could find the money without "pay-go" to provide tax cuts to millionaires and billionaires and wage a costly war, we believe you can find the money to ensure the health of all of our vulnerable children.

Some have said that CDF's proposal to blend the two separate bureaucracies of children's Medicaid and SCHIP into one single and simpler bureaucracy would threaten Medicaid. We disagree. We seek to expand Medicaid's guaranteed coverage and benefits to all SCHIP and uninsured children and simplify the 50 different state dual eligibility standards and enrollment procedures to make it easier and less costly to reach all children. We fully support the Medicaid guarantee and benefit package for all children and would strenuously resist any efforts to weaken either. Many states are already blending and simplifying their programs and CDF proposes to make the best and sensible state practices and policies national funded policy for all children and pregnant women. We hope the Congress will agree and use SCHIP's funding reauthorization to do the right and sensible thing for all children and for the nation's future.

Enclosures
Lewin cost estimates with phase-ins over 5 years
Who Are America's Uninsured Children
A poll of voter support for children's health coverage
Current state coverage programs

Federal Budget Requirements of CDF's Healthy Children Proposal FY 2008 - FY 2012 (Billions of dollars)

Fiscal Year	Expansion and Improvement of Coverage	Increased Provider Payment Rates	Total Federal Costs of CDF's Healthy Children Proposal
2008	$3.981	$9.891	$13.871
2009	$10.335	$11.873	$22.209
2010	$15.638	$13.576	$29.214
2011	$19.699	$15.112	$34.812
2012	$21.087	$16.178	$37.265
Five-Year Total	**$70.740**	**$66.632**	**$137.371**

Note: This table reflects annual budgetary support requirements, taking into account the estimated pace of phase-in of implementation of the new program over its initial five-years, and related level of coverage of uninsured children. The program would reach 25 percent of its ultimate enrollment level in 2008, 60 percent in 2009, 85 percent in 2010, and 100 percent in 2011 and there-after.
Source: Lewin Group estimates.

Who are America's 9 million uninsured children?

They are White, Hispanic, Black, Asian/Pacific Islander, American Indian. They are rural, urban, and suburban. They live in every family type although a majority live in two parent families and almost 90% of them in a working household playing by the rules.

Of the 9 million uninsured children:

Race/Ethnicity*	Percentage of the uninsured	Uninsured number**
Hispanic	38.3	3.5 million
White	37.8	3.4 million
Black	16.3	1.5 million
Asian/Pacific Islander	4.4	398,000
American Indian	1.6	143,000
Other (multi-racial)	1.6	149,000
Total	100.0	9 million

Age	Percentage of the uninsured	Uninsured number
Birth through age 5	29.0	2.6 million
Age 6 through age 12	31.5	2.8 million
Age 13 through age 18	39.4	3.6 million
Total	99.9	9 million

Income	Percentage of the uninsured	Uninsured number	Upper limit, annual income for family of 4
100% poverty & below	31.8	2.9 million	$20,000
Over 100% through 200%	32.1	2.9 million	$40,000
Over 200% through 300%	18.4	1.7 million	$60,000
Total, 300% and below	82.3	7.4 million	$60,000
Over 300% through 400%	7.2	655,000	$80,000
Over 400%	10.5	946,000	--
Total	100.0	9 million	

Family Structure	Percentage of the uninsured	Uninsured number
Two parents in household	53.3	4.8 million
Single parent household	37.6	3.4 million
Child has no parent in household	9.1	824,000
Total	100.0	9 million

Parental Work Status***	Percentage of the uninsured	Uninsured number
At least one working parent	86.6	7.1 million
No working parent	13.4	1.1 million
Total	100.0	8.2 million ***

Citizenship	Percentage of the uninsured	Uninsured number
Child is a U.S. citizen	87.8	7.9 million
Child is not a U.S. citizen	12.2	1.1 million
Total	100.0	9 million

Note: Children are ages birth through 18.

* Hispanic children are in a separate category and are not included in the White and Black categories.

** Numbers sometimes will not add to total because of rounding.

*** Of children who have at least one parent in the household.

SOURCE: U.S. Census Bureau: 2006 Annual Social and Economic Supplement to the Current Population Survey. Calculations by the Children's Defense Fund, 12/06

Children's Defense Fund

Americans' Perceptions About Children's Health Insurance

Key findings from a July 2006 poll conducted by Peter D. Hart Research Associates for the Children's Defense Fund that surveyed 1,014 registered voters (48% male, 52% female)

In the United States:

- More than 9 million children—one in nine—have no health insurance coverage. Every 46 seconds, another baby is born without health insurance.
- Almost 90 percent of uninsured children live in a home where at least one parent works and a majority of those children live in two-parent households.

The Children's Defense Fund is committed to ensuring that *every* child in America gets the health and mental health care they need to grow and thrive. In July 2006, CDF conducted a poll to find out more about Americans' attitudes about this growing children's health crisis. Here is what our polling discovered.

- An overwhelming majority of Americans think **all children in public health care programs should have access to the same health services**.

- **Americans believe a plan to address uninsured children should include comprehensive benefits** – 89 percent or more of Americans think emergency care, immunizations, services for children with disabilities, preventative visits, mental health coverage, and dental care should be included in a plan to provide health coverage to all uninsured children in America.

- More than three-fourths of Americans think it is "important" or "extremely important" that our elected leaders in Washington **focus on ensuring health insurance coverage and access to health care for all children in America**.

- Asked to choose from a variety of possible reasons to provide health insurance to all children, respondents thought the most important was: **"Children cannot take care of themselves, and it is especially important that they get regular medical care so they grow up healthy."**

- When asked which statement came closest to their view about why it is important to provide insurance to uninsured children, more Americans said it is **"the smart thing to do" than "the right thing to do" or "the fair thing to do."**

- Almost 7 in 10 Americans think the **federal government is doing "too little"** to help children who do not have health insurance coverage.

- Among those who support providing health care coverage for all uninsured children in America, **more support eliminating tax breaks on high earners and increasing cigarette and alcohol taxes** than other proposed trade-offs to pay for the program.

	Income: Poverty Level Eligibility Criteria for Children, State Children's Health Insurance Program				
			Upper income thresholds: income as a percent of FPL		
	State	Type of SCHIP: Medicaid, Separate or Combined	Medicaid expansion	Separate program	# Ever Enrolled in 2005
21 States	Arkansas	Combined	200%	200%	1,214
	California	Combined	100%	250/300%	1,223,475
	Delaware	Combined	200%	200%	10,354
	Florida	Combined	200%	200%	384,801
	Idaho	Combined	134%	185%	21,839
	Illinois	Combined	133%	200%	281,432
	Indiana	Combined	150%	200%	129,544
	Iowa	Combined	200%	200%	46,562
	Kentucky	Combined	150%	200%	63,728
	Maine	Combined	150%	200%	30,654
	Maryland	Combined	200%	300%	120,316
	Massachusetts	Combined	150%	300%	162,679
	Michigan	Combined	150%	200%	89,257
	Minnesota	Combined	280%	275%	5,076
	New Hampshire	Combined	300%	300%	11,892
	New Jersey	Combined	133%	350%	129,591
	North Carolina	Combined	200%	200%	196,181
	North Dakota	Combined	100%	140%	5,725
	Rhode Island	Combined	250%	250%	27,144
	South Dakota	Combined	140%	200%	14,038
	Virginia	Combined	133%	200%	124,055
	approx total				**3,079,557**
12 States	Alaska	Medicaid	175%	-	22,322
	District of Columbia	Medicaid	200%	-	6,631
	Hawaii	Medicaid	300%	-	20,602
	Louisiana	Medicaid	200%	-	109,150
	Missouri	Medicaid	300%	-	115,355
	Nebraska	Medicaid	185%	-	44,706
	New Mexico	Medicaid	235%	-	24,310
	Ohio	Medicaid	200%	-	216,495
	Oklahoma	Medicaid	185%	-	108,100
	South Carolina	Medicaid	150%	-	80,646
	Tennessee	Medicaid	-	-	
	Wisconsin	Medicaid	185%	-	57,165
	approx total				**805,482**
	Alabama	Separate	-	200%	81,856
	Arizona	Separate	-	200%	88,005
	Colorado	Separate	-	200%	59,530
	Connecticut	Separate	185%	300%	22,289
	Georgia	Separate	-	235%	306,733
	Kansas	Separate	-	200%	47,323
	Mississippi	Separate	-	200%	79,352

	Income: Poverty Level Eligibility Criteria for Children, State Children's Health Insurance Program				
			Upper income thresholds: income as a percent of FPL		
	State	Type of SCHIP: Medicaid, Separate or Combined	Medicaid expansion	Separate program	# Ever Enrolled in 2005
18 States	Montana	Separate	-	150%	15,841
	Nevada	Separate	-	200%	39,316
	New York	Separate	-	250%	618,973
	Oregon	Separate	-	185%	52,722
	Pennsylvania	Separate	-	200%	179,807
	Texas	Separate	-	200%	526,406
	Utah	Separate	-	200%	43,931
	Vermont	Separate	-	300%	6,614
	Washington	Separate	-	250%	15,547
	West Virginia	Separate	-	200%	38,614
	Wyoming	Separate	-	200%	6,120
	approx total				**2,228,979**
	National total:				**6,114,018**

Sources: CMS/Center for Medicaid and State Operations, information from SCHIP state plans, as of July 2006.

Testimony Submission for the Record

Senate Finance Committee
Hearing on:
"Improving Health of America's Children"

Jan. 31, 2007, 10 a.m.
215 Dirksen Senate Office Building

Submitted by:

Paul Fronstin
Employee Benefit Research Institute (EBRI)
T-147

"Employment-Based Health Insurance of Children: Why Coverage Decreased Between 2000 and 2005"

Employment-Based Health Insurance of Children: Why Coverage Decreased Between 2000 and 2005

By Paul Fronstin, EBRI[1]

The percentage of children covered by an employment-based health plan decreased every year between 2000 and 2005, from 62.3 percent to 57.7 percent (Figure 1). The decline in employment-based coverage among children followed a strong expansion of coverage that started in 1994. Between 1994 and 2000, the percentage of children covered by an employment-based health plan increased from 58.8 percent to 62.3 percent.

Prior research by the Employee Benefit Research Institute (EBRI) has shown why the likelihood of having employment-based health benefits increased for children during the earlier period (Fronstin, 1999). The EBRI study found that the percentage of children with a working parent increased, the percentage of children in families with incomes below the poverty level decreased, and more children had a working parent employed in a large firm. The increase in employment-based coverage among children during this period was attributed in part to an increase in the number of adult women working. During this period, the percentage of women ages 18–45 in families receiving public assistance or welfare income declined, while employment increased (Figure 2).

While the expansion in employment-based coverage among children during the 1990s was experienced mainly among children, the erosion in coverage since 2000 has affected both children and adults. The percentage of children with employment-based health benefits fell from 62.3 percent to 57.5 percent from 1999 to 2005, and for the first time since 1998, the percentage of uninsured children increased, rising from 10.8 percent to 11.2 percent (Figure 1). As a result of the decrease in the percentage of children with employment-based coverage and shifts in various factors affecting the likelihood of having employment-based coverage, 2.5 million fewer children were covered by an employment-based health plan in 2005, compared with 2000. Fewer children had coverage in 2005 than in 2000 for the following reasons:

- The distribution of children by family income shifted away from higher income levels to the poor.
- The distribution of children by parents' work status shifted toward fewer children in families in which the family head was employed.
- Fewer children were in families in which the family head was working full-year and full-time.
- Working family heads were less likely in 2005 than in 2000 to be employed by large firms and in manufacturing jobs, which are the private-sector firms most likely to offer health insurance.

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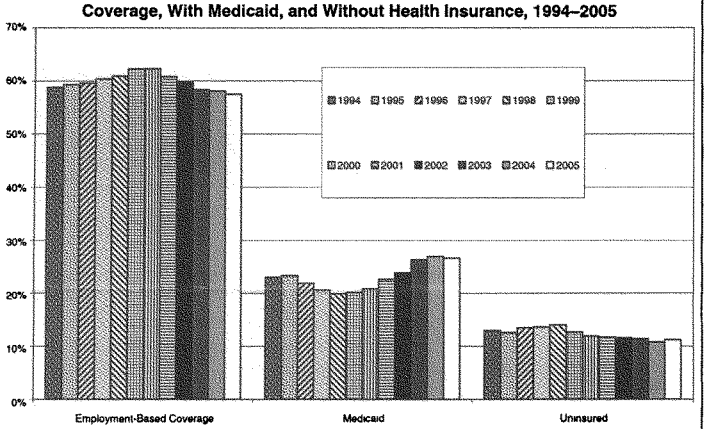
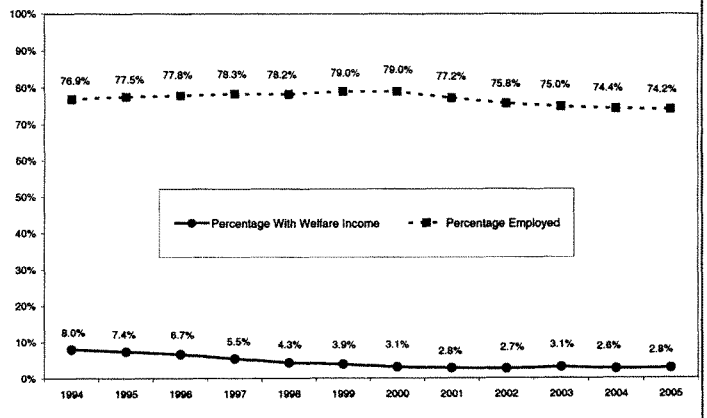
[1] Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan research institute that focuses on health, retirement, and economic security issues. EBRI does not take policy positions and does not lobby. Fronstin can be reached at (202) 775-6352, fronstin@ebri.org

Figure 1
Percentage of Children, Under Age 18, With Employment-Based Coverage, With Medicaid, and Without Health Insurance, 1994–2005



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2006 Supplements

Figure 2
Percentage of Women Ages 18–45 Who Were in Families With Welfare Income or Who Were Employed, 1994–2005



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995-2006 Supplements.

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Statement for the Record

Submitted by Families USA
1201 New York Ave, Washington DC 20005
Before the Senate Finance Committee
February 1, 2007
The Future of CHIP: Improving the Health of America's Children

Since its inception in 1997, the State Children's Health Insurance Program (SCHIP) has made huge strides in covering America's children. Building on the success of Medicaid, SCHIP has reduced the percentage of uninsured children by a third. The program has also been invaluable in reducing racial and ethnic disparities. The SCHIP program will expire in 2007 unless Congress reauthorizes it.

Reauthorization provides an opportunity to review how SCHIP works, examine what has been learned about children's health coverage in the last 10 years, and discuss what Congress must do to continue the progress made in reducing the number of uninsured children. Our statement focuses on how SCHIP and Medicaid have played a critical role in leveling the playing field for minority children.

Most Uninsured Children Are Racial and Ethnic Minorities

In 2005, more than 8 million children went without health insurance, and 60 percent of them belonged to a racial or ethnic minority group.[1] Health insurance is essential for children so that they have timely access to preventive health care services and treatment for conditions that could affect their health later in life. The gaps that persist in children's health coverage remain a major obstacle to eliminating the more pervasive health disparities that confront racial and ethnic minorities of all ages in the United States.

Reducing disparities in children's access to health care is an important and achievable goal. Health insurance is especially important for minority children because when they lack coverage, they are less likely to see a doctor. For example, uninsured African American and Latino children are less likely to have a personal doctor and more likely to forgo needed medical care than other uninsured children.[2] Fortunately, most uninsured children (74.1 percent) are eligible for health coverage through either Medicaid or the State Children's Health Insurance Program (SCHIP).[3] This means that increasing support for these programs will be crucial to reducing health disparities.

Medicaid and SCHIP Play a Crucial Role in Covering Children of Color

Although children receive health coverage through a variety of sources, Medicaid and SCHIP play an especially important role in covering children from communities of color. Today, more than half of all children who receive health insurance through public programs belong to a racial or ethnic minority group. While most insured children (68.1 percent) have coverage through a

parent's employer, slightly more than half of insured African American children (51.3 percent) and insured Latino children (50.3 percent) are covered by Medicaid or SCHIP.[4]

Minority children are more likely to have public coverage for a variety of reasons. For example, even though most children in Medicaid and SCHIP live in working families, children from communities of color are less likely to have employer-based coverage. This is because their parents are disproportionately more likely to work either in positions where health care benefits are not offered or for small companies that cannot afford to pay for employee health insurance.[5] Even when parents are offered coverage through an employer, many cannot afford the premiums.

Together, Medicaid and SCHIP provide a vital safety net for America's low-income children. These children live in households with annual incomes below 200 percent of the federal poverty level ($33,200 for a family of three in 2006).[6] And because minority children are much more likely to live in low-income families, they are more likely to rely on programs like Medicaid and SCHIP for health care coverage.

Disparities in Coverage Have Decreased Since SCHIP Started

After SCHIP was created in 1997, the percent of children who were uninsured steadily declined, from a high of 15.4 percent in 1998 to a low of 10.8 percent in 2004.[7] The decline was even more striking for racial and ethnic minorities. In 1998, roughly 30 percent of Latino children and 20 percent of African American children were uninsured. In 2004, those numbers had dropped to about 21 percent and 12 percent, respectively.[8] While disparities in insurance coverage still exist, SCHIP and Medicaid played an important role in narrowing the coverage gap for minority children.

SCHIP was created at a time when more and more Americans were losing employer-based health insurance. The program expanded health coverage to many low-income children and was crucial to reducing both the number and proportion of children who were uninsured. Together, Medicaid and SCHIP were directly responsible for expanding children's health coverage, even as a growing number of parents lost employer-based coverage and became uninsured. And while many low-income children benefited from the expanded eligibility provided by SCHIP, minority children experienced the greatest gains from increased coverage through public programs.

SCHIP Plays an Important Role in Reducing Disparities in Access to Care

In addition to reducing the coverage gap for minority children, enrollment in SCHIP has also been shown to reduce disparities in access to health care services—an important measure of the program's success. For example, uninsured minority children are more likely than other uninsured children to have unmet health care needs and to lack a usual source of care, but a study of children enrolled in New York's SCHIP program for one year found an almost complete elimination of these disparities.[9] A study of California's SCHIP population confirmed these results: Across racial and ethnic groups (including different language groups), enrollment in SCHIP was associated with a stark reduction in disparities in access to needed care.[10]

SCHIP Reauthorization: A Chance to Level the Playing Field

Together, SCHIP and Medicaid have made tremendous strides toward narrowing the coverage gap that exists for minority children. However, millions of children from communities of color remain uninsured, and more work must be done to ensure that these children receive the health care coverage they need. The good news is that the majority of uninsured children are already eligible for either Medicaid or SCHIP. In fact, more than 80 percent of uninsured African American children, and 70 percent of uninsured Latino children, appear to be eligible for public coverage.[11]

But without additional funding for SCHIP, these children will remain uninsured, and the progress made over the past 10 years will be reversed as states scale back their SCHIP and Medicaid programs. At this point, there is insufficient federal funding for SCHIP to cover the children currently enrolled, let alone to expand coverage to uninsured children who are eligible. To finish the job it started in 1997, Congress should add sufficient money to the federal budget to cover all uninsured, low-income children who are already eligible for Medicaid or SCHIP. This is a critical step for expanding coverage for minority children.

The reauthorization process also provides an opportunity to address the underlying barriers to enrollment in Medicaid and SCHIP that minorities are more likely to face. For example, distrust of the health care system, language and cultural barriers in the application process, and misinformation about eligibility rules are a few of the obstacles that can prevent eligible children from enrolling in public programs. Enrollment strategies targeted to minority communities, including the use of community health workers and promoters to help guide families through the enrollment process, have been shown to increase enrollment and reduce disparities.[12] Congress should take advantage of SCHIP reauthorization to improve outreach efforts and simplify enrollment in order to reach the millions of uninsured children from communities of color who are eligible for Medicaid and SCHIP.

SCHIP reauthorization provides policymakers with a unique opportunity to address racial and ethnic disparities in children's access to health care. By prioritizing children's health care and increasing funding for this important program, Congress can level the playing field for children's health coverage and pave the way for reducing health disparities later in life.

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[1] U.S. Census Bureau, "Table HI08. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children under 18 (All Children): 2005," *Current Population Survey 2005*, available online at http://pubdb3.census.gov/macro/032006/health/h08_000.htm, accessed on December 11, 2006.
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[3] Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* 26 (November 30, 2006): w22-w30.
[4] U.S. Census Bureau, op cit..
[5] E. Richard Brown, Victoria D. Ojeda, Roberta Wyn, et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (Los Angeles: UCLA Center for Health Policy Research and Kaiser Family Foundation, April 2000).
[6] U.S. Department of Health and Human Services, "2006 Federal Poverty Guidelines," *Federal Register* 71, no. 15 (January 24, 2006): 3,848-3,849.

[7] Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington: U.S. Census Bureau, August 2006).
[8] Based on analysis of data from the U.S. Census Bureau's Current Population Survey, 1997-2005 (ages 0-17 years). In the estimates reported here, "African American" includes individuals who identify as "black alone" or "black, Hispanic" according to the terminology used by the U.S. Census Bureau, and "Latino" includes individuals who identify as "white, Hispanic" or "black, Hispanic."
[9] Laura Shone, Andrew Dick, Jonathan Klein, et al., "Reduction in Racial and Ethnic Disparities after Enrollment in the State Children's Health Insurance Program," *Pediatrics* 115 (June 2005): 697-705.
[10] Michael Seid, James W. Varni, Leslie Cummings, and Matthias Schonlau, *Improving Access to Needed Health Care Improves Low-Income Children's Quality of Life* (Santa Monica, CA: RAND Corporation, 2006), available online at http://www.rand.org/pubs/research_briefs/RB9210/.
[11] Urban Institute analysis of data from the U.S. Census Bureau's Current Population Survey, 2004, as reported in *Going Without: America's Uninsured Children* (Washington: Robert Wood Johnson Foundation, August 2005).
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Labor and Business Relations
State Government
Health and Human Services
Appropriations Subcommittee,
Chair

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-203
Dirksen Senate Office Bldg.
Washington, DC 20510-6200b

With the 110th Congress underway, no issue will be more important to Iowa's children than the reauthorization of the State Child Health Insurance Program (SCHIP). SCHIP, known in Iowa as ***hawk-i***, provides health insurance coverage to more than 32,000 Iowa children in families with incomes below 200% of the federal poverty level.

With Medicaid, ***hawk-i*** provides primary and preventive health services to three out of every ten Iowa children. Amidst rising health care costs and declining employer health insurance coverage, these two programs have ensured these Iowa children have access to health services that supports their healthy development. Studies show that comprehensive health services for children are very cost-effective, in identifying and treating health and development issues early, before they become chronic conditions.

Unfortunately, even with these two programs, up to 55,000 Iowa children remain uninsured, and declining employer-sponsored coverage puts other children at risk. While Medicaid and ***hawk-i*** have reduced the number of uninsured children in Iowa during a period where uninsurance among nonelderly adults has risen, nearly 6% of all Iowa children remain uncovered.

Nationally and in Iowa, there is strong public support for governmental action to ensure all children receive comprehensive health services. More than eighty percent of Iowans and Americans believe that government has a major responsible in ensuring children have health care coverage. SCHIP reauthorization provides Congress an opportunity to build upon and strengthen a popular program in doing just that.

This includes:

- Preserve the existing Medicaid and SCHIP programs established in the states (which, for Iowa, means providing supplemental funding of $18 million for the 2006-7 federal fiscal year and nationally means providing an additional $15 billion in funding over the next five years);
- Provide additional financial support for states to expand their current programs, to cover more children and to provide the full coverage children need, based upon recognized American Academy of Pediatrics standards, with additional support for both Medicaid and SCHIP of $45 billion in addition to the $15 billion, enabling states to further reduce the number of uninsured children by approximately two-thirds; and
- Establish performance standards and incentives to ensure that states enroll eligible children and provide effective primary, preventive, and developmental services.

Research is clear that children benefit greatly from well child services that are comprehensive in addressing their medical, behavioral, and developmental health care needs. This includes medical care and it incorporates oral health, vision screening, behavioral health, and guidance to parents on nutrition and exercise, child development, and language and learning. A comprehensive approach is critically important for child health, as children with

undetected vision problems or dental pain not only face adverse health outcomes, they also are less likely to learn and be successful in school. Physician guidance to parents on how to provide infants and toddlers proper nutrition and exercise may be the best, and certainly the most cost-effective, way to address the growing problem of obesity and diabetes in children and adults. As Congress works on SCHIP reauthorization, members need to build upon the growing evidence of the importance of establishing a child health insurance coverage model that promotes primary and preventive care and reflects children's developmental needs, rather than an adult health model that stresses protection from catastrophic health needs.

Through its Assuring Better Child Healthy Development (ABCD II) program under Medicaid, Iowa is a leader in providing such comprehensive and developmental services and improving the healthy development of young children. To continue to be that leader, Iowa needs support from its Congressional delegation in both reauthorizing and strengthening SCHIP and Iowa's ***hawk-i*** program.

Governor Chet Culver and leaders in the Iowa General Assembly are committed to further expanding both the number of children covered in Iowa and the quality of the coverage they receive. This is one of the major goals for the 2007 legislative session, and Iowa plans to commit additional state funding to this end. It is critical, however, for the federal government to remain a partner in providing the continued and expanded funding support presented here, in order for Iowa's actions to be most effective.

Senator Jack Hatch

Representative Ro Foege

Chairs, Joint Human Services Appropriations Subcommittee, Iowa General Assembly

February 1, 2007

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Senators Baucus and Grassley:

As the Senate Finance Committee discusses the State Children's Health Insurance Program (SCHIP) in preparation for the program's reauthorization this year, the Healthcare Leadership Council (HLC) believes it is necessary to fully consider the benefit, both current and potential, this program can offer to American children.

Today, SCHIP, with five million children enrolled, provides an outstanding example of bipartisanship and public-private partnership. By allowing flexibility to states in how best to implement this program, we have seen innovation – such as using SCHIP dollars to augment employer-sponsored coverage – and success. Participation in SCHIP grew faster then many other federal programs.

We know, though, that much work remains to be done. It is estimated that at least nine million children are without health insurance. As the committee discusses the future of the SCHIP program, we would urge consideration of the proposal HLC helped to craft as a member of the Health Coverage Coalition for the Uninsured (HCCU).

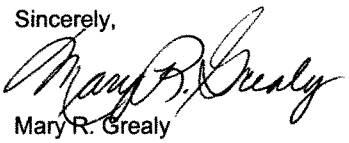
Under this proposal, implementation of the "Kids First Initiative" allows parents to more easily enroll their children in public programs, like SCHIP and Medicaid. It calls for a "one-stop shopping" system whereby low-income families could enroll uninsured children in SCHIP or Medicaid at the same time as they apply for other public programs, like reduced-cost lunches or food stamps. The proposal additionally calls for a new refundable tax credit to cover private health insurance costs, also available to low-income families. A competitive grant program that would enable states to experiment with new approaches to expand coverage has also been proposed by HCCU organizations. The Lewin Group estimates this proposal to cost a modest $40-50 billion over five years and would cover eight million children. More information about the HCCU group and the proposal is attached.

Healthcare Leadership Council
1001 Pennsylvania Avenue, N.W., Suite 550 South
Washington, D.C. 20004
202/452-8700 • 202/296-9561 • www.hlc.org

The Healthcare Leadership Council also launched the *Health Access America* partnership late last year, in part to test and measure the effectiveness of enrollment techniques for both public and private health coverage. We would be happy to share the results of our pilot activities. What we have learned so far, in part, is that it takes public-private partnerships and one-on-one communication with uninsured individuals in order to make progress.

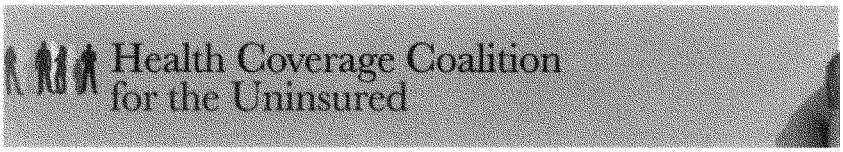
We appreciate your interest in exploring ways to improve the SCHIP program and would welcome the opportunity to discuss these issues with you. The members of the Healthcare Leadership Council stand ready to assist in any way we can to help American children receive the health care coverage for which they are eligible.

Sincerely,



Mary R. Grealy
President

cc: Senate Finance Committee Members
Attachment(s)



» America's Uninsured
» The Historic Agreement
» About the Coalition
» The Organizations Involved
» In the News

About the Coalition

America's health insurance crisis is, without question, one of the most vexing health pc
our time. Over the years, numerous groups have brought forth possible solutions, but t

With so many different views expressed with equal passion, finding solutions for the ur
become a political hot potato, and even finding a common starting point for discussions
elusive. The HCCU's signatory organizations -- most of which developed their own pro
health coverage could and should be expanded -- recognized the importance of findinç
solutions that are both effective and politically feasible.

Together they set aside some of their differences and forged consensus on how to pro
coverage to as many Americans as possible, as quickly as possible.

HCCU signatory organizations include:

-- AARP
-- American Academy of Family Physicians
-- American Hospital Association
-- American Medical Association
-- American Public Health Association
-- America's Health Insurance Plans
-- Blue Cross and Blue Shield Association
-- Catholic Health Association
-- Families USA
-- Federation of American Hospitals
-- Healthcare Leadership Council
-- Johnson & Johnson
-- Kaiser Permanente
-- Pfizer Inc.
-- United Health Foundation
-- U.S. Chamber of Commerce

Click here to read more about the HCCU.

Health Coverage Coalition for the Uninsured
info@coalitionfortheuninsured.org · 202-354-6443

Health Coverage Coalition
for the Uninsured
coalitionfortheuninsured.org

Expanding Health Care Coverage in the United States: A Historic Agreement

A diverse group of 16 major national organizations with an abiding interest in accessibility to quality health care have reached a consensus on policy approaches to expand health coverage to as many people as possible as soon as possible. In formulating the proposal, the participating organizations agreed upon key principles: (1) emphasizing making coverage available to those least able to afford it, (2) relying upon incentives and voluntary approaches, (3) building upon the employer-based system and not weakening incentives for employers to offer coverage, (4) using a combination of public and private approaches to expand coverage, (5) recognizing the budget challenges facing most states, and (6) recognizing the importance of consumer outreach and education on health coverage options.

The Health Coverage Coalition for the Uninsured (HCCU) recognizes that expanding coverage is inextricably linked to reducing the cost and improving the quality of health care. Although it was not the focus of this group, we believe strategies need to be developed to increase price and quality transparency and improve quality through health information technology, chronic care management, patient safety, evidence-based medicine, medical liability reforms, and health delivery efficiencies. We also support the development of model benefits based on the 5 "E's" – epidemiology, economics, ethics, evidence, and ease of use.

The HCCU proposes to expand health coverage to the uninsured in two phases:

Phase I: The "Kids First" Initiative and State Experimentation

To ensure as many of America's 9 million uninsured children receive health coverage as soon as possible, several key steps are proposed to increase public- and private-sector health coverage.

Public Program Enrollment
With respect to expanding public-sector coverage, the proposal would improve enrollment of children who are uninsured but currently eligible for SCHIP (State Children's Health Insurance Program) and Medicaid. Those steps include:

- Giving states the flexibility to deem low-income uninsured children eligible and enroll them in SCHIP or Medicaid when they qualify for other means-tested programs (such as free or reduced-price school lunches; food stamps; or the Women, Infants, and Children program). This would enable low-income working families to enroll in coverage through "one-stop shopping."
- Providing states the additional federal SCHIP funds needed to pay for the resulting increased enrollment of children from lower-income families.

Family Tax Credit
This proposal is also designed to increase children's health coverage in the private sector, including through employer-sponsored health insurance. It creates a new family tax credit for the purchase of children's health coverage that would have the following features:

- Make refundable, advanceable, and assignable tax credits available to families with children with incomes up to 300 percent of the federal poverty level to facilitate the purchase of health coverage. For tax-credit beneficiaries with access to employer-sponsored insurance, credits would be used to purchase coverage from the employer.
- The tax credit would cover a significant percentage of the premium charged for meaningful health coverage. The percentage of premium covered by the tax credit would be graduated on a sliding scale based on family income. Since the tax credit pays a percentage of the premium, it automatically adjusts

to variations in health insurance costs based on such factors as region of the country and, in some states, the child's health status.
- Provide information and outreach on how to obtain and retain health care coverage.

State Demonstration Program
The proposal also establishes a state demonstration program giving states flexibility to experiment with new approaches that expand health coverage. Competitive grants would be provided to the states which, unlike Medicaid waivers, would be new money over and above federal funds currently provided to states for Medicaid and SCHIP. Individuals who currently have public coverage would not lose or have their coverage reduced. The state demonstration program would reward performance toward the achievement of expanded coverage benchmarks.

Phase II: Longer-Term Policy Recommendations

In addition to immediate steps to increase coverage for children, our proposal is also designed to achieve a balance of expanded public- and private-sector coverage for uninsured adults.

Public-Sector Proposals
With respect to expanded access to public coverage, the proposal would allow states to eliminate family status as an eligibility requirement and determine eligibility for Medicaid coverage based exclusively on financial need. The proposed changes include:

- Give states the option to expand Medicaid eligibility to all adults with incomes below the federal poverty level.
- Provide federal funds to states to cover the costs of expanding Medicaid coverage for adults up to 100 percent of the federal poverty level.
- Give states increased flexibility to take advantage of employer-sponsored insurance offered to public program enrollees.
- Give states new options to use more effective means of enrolling Medicaid-eligible adults.

Private-Sector Proposals
This proposal seeks to expand health coverage in the private sector, including employer-sponsored health coverage. It does so through a variety of measures, including:

- Make refundable, advanceable, and assignable tax credits available for individuals and families with incomes between 100 and 300 percent of the federal poverty level for the purchase of health coverage. The credits would be used to purchase employer-sponsored insurance when an employer offers coverage.
- The tax credit would cover a significant percentage of the premium charged for health coverage. The percentage covered by the tax credit would be graduated on a sliding scale based on income. Since the tax credit pays a percentage of the premium, it automatically adjusts to variations in health insurance costs based on such factors as region of the country and, in some states, the enrollee's age and health status.
- Make the tax credit available to those with and without access to employer-sponsored health insurance. States would certify the availability of meaningful coverage that would be affordable for those without access to employer-sponsored insurance.
- Provide federal grants to states in order to provide health coverage for high-risk populations.
- Provide support to public and private safety net providers and establish consumer assistance and outreach programs to improve understanding about health coverage options.

The HCCU's 16 Signatory Organizations Include:

- AARP
- American Academy of Family Physicians
- American Hospital Association
- American Medical Association
- American Public Health Association
- America's Health Insurance Plans
- Blue Cross and Blue Shield Association
- Catholic Health Association
- Families USA
- Federation of American Hospitals
- Healthcare Leadership Council
- Johnson & Johnson
- Kaiser Permanente
- Pfizer Inc.
- United Health Foundation
- U.S. Chamber of Commerce

Testimony Submitted on Behalf of
March of Dimes Foundation
"The Future of CHIP: Improving the Health of America's Children"
United States Senate Committee on Finance
February 1, 2007

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The March of Dimes Foundation is pleased to submit testimony on behalf of its over 3 million volunteers and 1400 staff, and share with you some of the Foundation's priorities for the upcoming reauthorization of the State Children's Health Insurance Program (SCHIP). As you may know, the March of Dimes is a national voluntary health agency founded in 1938 by President Franklin D. Roosevelt to conquer polio. Today, the Foundation works to improve the health of mothers, infants and children by preventing birth defects, prematurity and infant mortality through research, community services, education, and advocacy. The Foundation is a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers affiliated with 52 chapters in every state, the District of Columbia and Puerto Rico.

The March of Dimes is committed to strengthening the SCHIP program to improve the health of pregnant women, infants and children. To achieve this goal, the March of Dimes recommends that the Committee authorize a substantial amount of new funding for SCHIP reauthorization. Our immediate priority is funding sufficient to protect states' 2007 SCHIP programs. As Members of the Committee are aware, the measure enacted at the end of the 109th Congress is projected to provide resources necessary to ensure that no state runs out of SCHIP funding before May 1, 2007. However, at least one state reports that its funding may actually run out sooner. Unless Congress acts soon, additional states may be forced to narrow or eliminate benefits, lower eligibility thresholds, and/or reduce provider payment levels. Any of these actions would weaken a well regarded program and could undermine the availability of affordable health coverage for children.

As Members of this Committee are aware, the concern about adequate funding extends well beyond 2007. In addition to the funding level assumed in the CBO baseline, new resources will be needed to maintain current levels of eligibility. And, if the Committee wishes to see states reach out to eligible but unenrolled children or expand eligibility, a significant investment of new funding will be necessary.

We know that there are millions of uninsured children who are currently eligible for both SCHIP and Medicaid. In fact, the March 2005 Current Population Survey found that forty-nine percent of all uninsured children are eligible for Medicaid and 19 percent are eligible for SCHIP. The March of Dimes believes that states should have the tools and resources necessary to enroll these children.

The March of Dimes also encourages the Members of the Committee to amend the statute so that states can make modest but important improvements to their SCHIP programs. We at the Foundation are working closely with Senators Lincoln, Bingaman and Lugar to craft and reintroduce the "Prevent Prematurity and Improve Child Health Act," (S.710 from the 109th Congress). This bill includes provisions designed to further some of the priorities the Foundation hopes the Committee will consider during its deliberations over the reauthorization of SCHIP. Specifically, the bill calls for giving states the authority to: (1) cover income eligible pregnant women age 19 and older without being required to obtain a federal waiver; (2) provide wraparound coverage for children with special healthcare needs whose private health insurance benefits are limited; and (3) cover legal immigrant children and pregnant women. In addition, the March of Dimes intends to pursue some

quality and accountability initiatives to improve the coverage and care that children enrolled in SCHIP receive. Finally, the Foundation is working with the bill sponsors on a proposal to use telemedicine to provide better access to specialty providers for pregnant women in rural areas at risk of complications of pregnancy or preterm birth.

Coverage for Pregnant Women Over Age 19

Under current SCHIP law, maternity coverage for pregnant women over age 19 who meet the income eligibility requirements is permissible only through a federal waiver — a slow and cumbersome process which all but five states have chosen to avoid. This policy creates an unfortunate separation between pregnant women and infants, which runs contrary to long-standing *Guidelines for Perinatal Care* promulgated jointly by the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP), as well as eligibility standards for federal programs such as Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC program). The March of Dimes view is that reimbursement policies should be aligned with -- and not undermine -- established clinical practice guidelines.

While SCHIP regulations permit states to amend their plans to cover 'unborn children,' thus making reimbursement available for prenatal, labor and delivery services, postpartum care for the mother — a benefit prescribed in the ACOG/AAP *Guidelines for Perinatal Care* — is not reimbursable. Women who do not receive postpartum care are at greater risk for a variety of health complications that make it difficult for a mother to properly care for her new infant.[1] Further, women who do not receive postpartum care are more likely to quickly become pregnant again, and a pregnancy spaced too closely to a previous pregnancy presents a medical risk factor for premature birth.[2]

According to information compiled by the Centers for Medicare and Medicaid Services, only five states (CO, NJ, NV, RI, and VA) use waivers to cover income eligible pregnant women and nine states have amended their plans to cover unborn children (AR, CA, IL, MA, MI, MN, RI, TX, WA). Due in part to the lack of a simple federal mechanism to provide comprehensive coverage to pregnant women in SCHIP, the majority of states do not provide any coverage for pregnant women through their SCHIP programs, leaving many pregnant women uninsured for medical services crucial to their health and that of their child.

According to the 1999 Institute of Medicine Report entitled "*Health Insurance is a Family Matter*," uninsured pregnant women have fewer prenatal care services and more difficulty obtaining the care they need.[3] To maintain the health of a pregnant woman and

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[1] American College of Obstetricians and Gynecologists and American Academy of Pediatrics. *Guidelines for Perinatal Care*. 2002. pp. 156-160.

[2] Basso O, Olsen J, Knudsen LB, Christensen K. Low birthweight and preterm birth after short interpregnancy intervals. *American Journal of Obstetrics and Gynecology* 1998;178(2):259–63.

[3] Burstein, Amy B. 1999. *Insurance Status and Use of Health Services by Pregnant Women*. Washington, DC: March of Dimes. Cited in *Health Insurance is a Family Matter*. 2002. Institute of Medicine (IOM). Washington, DC: National Academies Press.

her unborn child, continuous access to prenatal care is essential. The ACOG/AAP *Guidelines for Perinatal Care* state:

> Women who have early and regular prenatal care have healthier babies. Generally, a woman with an uncomplicated pregnancy should be examined approximately every 4 weeks for the first 28 weeks of pregnancy, every 2-3 weeks until 36 weeks of gestation, and weekly thereafter. Women with medical or obstetric problems may require closer surveillance.[4]

Lack of adequate, regular prenatal care is associated with poor birth outcomes, including prematurity (born before 37 completed weeks of gestation.) or low birthweight (less than 5 ½ pounds). Prematurity is the leading cause of neonatal death. Low birth weight is a factor in 65 percent of infant deaths. Premature and low birth weight babies may face serious health problems as newborns, and are at increased risk of long-term disabilities. Infants born to mothers who did not receive regular prenatal care in 2002 were about twice as likely to be low birth weight as infants born to mothers who received early and adequate prenatal care.[5]

Conversely, women who do receive sufficient prenatal care are more likely to have access to screening and diagnostic tests that can help identify problems early; services to manage developing and existing problems; and education, counseling and referral to reduce risky behaviors like substance abuse and poor nutrition. Such care may thus help improve the health of both mothers and infants, reducing their future healthcare costs.[6]

Neither the cumbersome and time consuming waiver process nor use of the 'unborn child' regulatory option gives states the flexibility they need to provide pregnant women with coverage through SCHIP. Therefore, the March of Dimes recommends that the Committee approve a statutory change granting states the authority to extend SCHIP coverage to income eligible pregnant women age 19 and older. Both the National Governors' Association (NGA) and the National Conference of State Legislatures (NCSL) recommend that this option be made available to states.

Private-Public Partnerships to Stretch SCHIP Dollars Further

Under current law, children must be uninsured to qualify for SCHIP. Some children with significant health problems have limited private insurance that does not meet their medical needs. Other children whose parents have access to employer based coverage, may go without because the parent's employer does not provide coverage for dependents or the family cannot afford the premium costs. In each of these cases,

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[4] American College of Obstetricians and Gynecologists and American Academy of Pediatrics. *Guidelines for Perinatal Care*. 2002. p. 54.

[5] National Center for Health Statistics. 2002 final natality data. Data prepared by March of Dimes Perinatal Data Center, 2005.

[6] "Benefits from and Barriers to Prenatal Care," in McCormick, M.C., and others. 1999. *Prenatal Care: Effectiveness and Implementation*. Cambridge University Press, Cambridge, England.

families face a difficult choice, purchase employer based coverage that does not meet the child's medical needs or forego private health insurance altogether in order to be eligible for SCHIP. By allowing SCHIP and private plans to work together, SCHIP dollars could be stretched further because private plans would cover a portion of healthcare costs. Such public-private partnerships could be structured in several different ways. For example:

1. Wraparound coverage: For pregnant women, infants and children with limited private coverage, SCHIP could cover benefits — such as vision, dental, physical/occupational/speech therapy, etc. — not offered by the private plan. Allowing states to use SCHIP as a secondary payer for children when private insurance is limited would parallel an approach already permitted in the Medicaid program.

2. Single benefit coverage: For pregnant women, infants and children with limited private coverage, SCHIP could cover a specific benefit — such as vision, dental or home care — not offered by the private plan.

3. Premium support: For families satisfied with their private coverage, but unable to afford the full cost of the premium, SCHIP could provide a subsidy to lower the premium cost so that dependents could be covered.

Pregnant women and children receiving this type of assistance should be allowed to switch to traditional SCHIP if they lose their private coverage or the private plan no longer meets their healthcare needs.

The March of Dimes urges the Committee to give states the opportunity to develop alternative types of public-private partnerships to better serve the complex healthcare needs of pregnant women and children.

Quality and Accountability

The March of Dimes strongly recommends that the SCHIP reauthorization bill include provisions designed to strengthen the quality of healthcare that enrollees receive through measuring, monitoring and reporting on quality of care. Such initiatives help ensure that children receive the care they need. Since children are growing and developing, they have different kinds of healthcare needs than adults. To date, however, most national initiatives aimed at improving the quality of care in the U.S. have focused on adults and the March of Dimes believes SCHIP reauthorization is an excellent vehicle through which states can be supported in their efforts to utilize pediatric measures. SCHIP already includes a requirement that states report on quality measures. However, the field has advanced significantly in the past 10 years, and the March of Dimes urges the Committee to revisit the current law provisions and update them as appropriate.

More specifically, the Foundation recommends that the Department of Health and Human Services (HHS) work with health professionals and consumer groups to develop

and disseminate a core set of pediatric quality measures. This effort should be conducted in partnership with the Agency for Healthcare Research and Quality (AHRQ) and other appropriate entities, including the National Quality Forum and health professional certification boards. In addition, HHS should also gather and publicly report state level data on pediatric quality performance measures.

To ensure that states have the resources necessary to implement such measures, the March of Dimes encourages the Members of the Committee to consider an enhanced federal match rate that could be used to gather and report data, and to develop interoperable clinical health-information systems.

Coverage for Legal Immigrants

In 2003, this Committee and the full Senate approved a provision to allow states to cover legal immigrant children through their SCHIP programs. At that time, the Congressional Budget Office (CBO) estimated that about 155,000 children and 60,000 pregnant women would have been eligible for coverage if the provision had been enacted. The provision had broad bipartisan support in the Senate as well as the support of the NGA and NCSL. CBO estimated that this coverage would cost the federal treasury $500 million over three years. Unfortunately, the provision was not included in the conference agreement.

As of 2004, there were an estimated 31 million non-elderly immigrants living in the United States,[7] approximately 74% of whom are here legally.[8] Almost half of non-citizen immigrants are uninsured, largely because they are more likely to work in low wage jobs, service or agriculture industries or small businesses where employers often do not offer health coverage.[9]

The Foundation urges Members of this Committee to allow states to extend SCHIP coverage to income eligible legal immigrant pregnant women and children.

Conclusion

The March of Dimes appreciates the opportunity to submit its comments for the record and looks forward to working with Chairman Baucus and Senator Grassley, as well as Senators Lincoln and Bingaman and other Members of the Committee to reauthorize and strengthen SCHIP — a program central to the health of the nation's pregnant women, infants and children.

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[7] Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of Census Population Survey (Annual Social and Economic Supplement; March 2005)

[8] *The Foreign-Born Population in the United States: March 2002*, (Washington DC: U.S. Census Bureau), February 2003 and Passel, J., Capps, R. and M.Fux *Undocumented Immigrants: Facts and Figures* (Washington DC: Urban Institute), January 12, 2004.

[9] Bureau of Labor Statistics, *National Compensation Survey: Employee Benefits in the Private Industry in the United States*, Table 1, March 2005.

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February 15, 2007

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"The Future of CHIP: Improving the Health of America's Children"

Statement for the Hearing Record
February 1st Hearing by the
Committee on Finance
U.S. Senate
Washington, DC

On behalf of the National Association of Children's Hospitals, I would like to thank the Senate Finance Committee for the opportunity to submit this statement in support of federal efforts to ensure all children have health coverage, beginning with reauthorizing and strengthening the State Children's Health Insurance Program (SCHIP).

N.A.C.H. is the only national, not-for-profit trade association of children's hospitals, including more than 135 independent acute care and specialty children's hospitals and children's hospitals that operate within a larger hospital or health system. While less than five percent of all hospitals, children's hospitals deliver more than 40% of all hospital care for children in the nation as well as the large majority of hospital care for children with complex and serious medical conditions such as cancer or heart defects.

Children's hospitals are also the health care safety net for their communities, devoting on average more than 50 percent of their patient care to uninsured children or children covered by public programs like SCHIP, despite the fact that those programs often pay well below the cost of care. Finally, children's hospitals train most of the nations' pediatric workforce and house the nation's premier pediatric research centers. Directly or indirectly, through clinical care, training, and research, children's hospitals touch the lives of every child in this country.

Recommendations for the Reauthorization of SCHIP

Building on the foundation of Medicaid's coverage of 28 million children – among the nation's poorest and sickest – SCHIP has made it possible for states to cover an

additional six million children of families whose incomes exceed Medicaid eligibility criteria but who cannot afford or are unable to obtain private coverage for their children. At a time when the rising number of uninsured Americans is testimony to the limitations of our system of health coverage, the declining percentage of uninsured children is a measure of the combined success of SCHIP and Medicaid.

Because of this success, N.A.C.H. recommends that Congress commit to achieving the goal of health coverage for all children. The first step should be to build on the foundation of Medicaid and SCHIP. In particular, N.A.C.H. recommends:

- **Reauthorize and Fully Fund SCHIP:** Congress should reauthorize and fully fund SCHIP – at least to fill in all projected shortfalls of federal funds to states and to enable states to cover all eligible but unenrolled children.

- **Improve Outreach and Enrollment:** More than two-thirds of the nation's uninsured children are already eligible for either Medicaid or SCHIP. Reauthorization of SCHIP should include specific measures that help states to improve outreach and enrollment of children who are eligible for Medicaid or SCHIP. They might include financial incentives, simplified and unified application forms, extended continuous eligibility, and others.

- **Protect Medicaid's Safety Net for Children:** SCHIP's success stands on the shoulders of Medicaid. Our ability to sustain this success, as the nation reaches out to cover all children, depends on both programs having the funds to meet their goals.

  Neither Medicaid nor SCHIP is perfect. SCHIP is capped; when funds run short, as 14 states are projected to experience this year, children are left waiting in line for coverage. Medicaid's historically low reimbursement rates – particularly for physicians – too often leave children without access to a community physician or medical home. However, despite these hurdles, together SCHIP and Medicaid have created an essential safety net of coverage for low-income children and children with disabilities or other special needs.

  Children's health care, especially for children with serious illnesses or chronic conditions, is much more concentrated and regionalized than comparable care for adults. Health coverage for all children, including all of the patients of children's hospitals, relies heavily on the strength of our public insurance programs for children of low-income families.

- **Invest in the Development of Quality and Performance Measures for Children:** More and more payers are asking for quality and performance measures for health care providers. Our member hospitals are pursuing quality and performance measurement as well.

  The American Academy of Pediatrics, American Board of Pediatrics, Child Health Corporation of America and N.A.C.H. are working together to identify measures for hospital and physician care for children and for ways to validate those measures.

But we cannot do this alone. Achieving quality and performance measures for children needs federal leadership.

Measures need to be tested, and they need to gain consensus support and wide-acceptance. Private and public investment has made this progress possible for measures for adult health care. The federal government's leading role in public investment has focused largely on adult measures and Medicare. A commensurate investment for children's measures has not been made, even though public coverage through Medicaid and SCHIP is the nation's single largest payer of children's health care.

It's time to make the same investment in quality and performance measures for children's health care that has been made for adults. N.A.C.H. asks that you provide the federal government, including the Centers for Medicare and Medicaid Services, with the authority and resources needed to support the development and advancement of pediatric quality and performance measures. This will greatly enhance the ability of states, providers and consumers to have a portfolio of measures they can use for children.

Ten years ago, Congress faced and met an unprecedented bipartisanchallenge – how to put the federal government on a solid path toward elimination of the federal deficit. That successful effort culminated in the "Balanced Budget Act of 1997" (BBA). And, precisely because it was setting priorities vital to the future of our nation, Congress created SCHIP as part of the BBA to expand health coverage for children. In effect, Congress made children's coverage a priority within a balanced budget.

Ten years later, Congress faces the same challenge – to achieve fiscal control while at the same time taking the next step to cover all children. It should reauthorize and expand SCHIP, while keeping Medicaid coverage for children strong. Ten years of success, broad support throughout the private sector, and bipartisan support in Congress and state capitals all argue for taking that next step.

Medicaid and SCHIP are fundamental to the financial infrastructure of health care for <u>all</u> children, through the work of children's hospitals. The decisions Congress makes on SCHIP and Medicaid will affect the health care of every child in this country.

Thank you again for the opportunity to submit this statement for the record. N.A.C.H. would be pleased to be of assistance to the committee in its efforts advance reauthorization of a fully funded SCHIP program that continues to build on a strong Medicaid foundation.

SCHIP Essential Support for Nation's Families

Introduction
This testimony is submitted on behalf of the Northwest Federation of Community Organizations (NWFCO), the Center for Community Change and the Fair Immigration Reform Movement (FIRM). Together these organizations represent a nationwide coalition of over 60 organizations in thirty-five states composed of low-income and immigrant parents. When the State Children's Health Insurance Program (SCHIP) was created in 1997, we worked to ensure implementation of the program throughout the United States.

SCHIP has been a wise investment in our children and families. Without it, thousands of children around the country would go uninsured, missing the essential health care services they need to develop, grow, and learn. But there is still room for improvement. We offer our stories from families across the nation.

Malvina Gregory - Maine People's Alliance
Malvina Gregory "We represent over 30,000 Mainers who depend on SCHIP for health care for their families. My friend Tiffany May is a single working mother of two young teenagers who wouldn't have health coverage without CHIP. Although they struggle to make ends meet, they don't worry about health care. This simple principle that all families deserve health coverage so that they can be full participants in our communities is a core value of my organization." We are urging and expecting Congress to step up for our communities, our families and our future.

Jesus Torrez - Idaho Community Action Network
I am with the Idaho Community Action Network and my son Moses is one of the 18,639 kids in the state that are insured through the children's health insurance program. The Children's Health Insurance Program ensures that kids are healthy and do well in school. Congress should invest in our children and our future by fully funding CHIP.

Sabrina Morales - Comunidades Unidas- Utah
Increasing the funding for SCHIP is so important for families in our state. The Jones family is just one of many families SCHIP has helped. The Jones family came to us with three children: the oldest daughter was 8 and the youngest was 4. With the exception of routine school check-ups, these children had not seen a doctor since they were babies. The youngest child's teeth were so rotten that she needed emergency care as soon as they signed up. This program was so important to the Jones family that she cried when her children got into the program. There are many more families in Utah who need this program. *

LeeAnn Hall- Montana People Action
The Children's Health Insurance Program is a top priority for our organization. I want to tell you a story about one of our Billings members, a family with two working parents, 3

kids and a grandchild at home. The father has private insurance but can't pay the additional $400 a month to insure the family, say nothing about the deductibles. They could access Indian Health Services but only on Tuesdays and Thursdays. Their three children, thank God, are on CHIP and their grandchild is on Medicaid. They are grateful for the CHIP program because now we can see any doctor on any day and the children get the care they need. It brings a great piece of mind to know your children can be healthy. Their story is common amongst low-income working families in Montana. This is the time for leadership from our representatives in Congress. Invest in our children and families and fully fund CHIP.

Jazmin Arias – Pineros y Campesinos Unidos del Noroeste - Oregon
My name is Jazmin Arias and I worked for the Oregon Health Plan as eligibility work and I saw many families that were working and couldn't get health insurance through their employer. They didn't qualify for the Oregon Health Plan. The only way to access health care for their children was through the Children's Health Insurance Program. These parents were relieved their children had access to the health care they needed. These are the families that are working hard, in low paying jobs and stuck in the middle. Healthcare is a basic human right. I urge you to listen to the experiences of these families and fully fund an important and successful program. Our families are at the heart of our communities – our children are our future.

Pramila Jayapal - Executive Director of Hate Free Zone – Washington
I want to tell you a story about Mayra Martinez. Her husband works in construction and she is at home with their three young children. All the kids are insured through CHIP. These kids have the usual childhood issues, the youngest recently broke her arm but is doing well because she received the medical attention she needed. While this is an every day story it is a story of success, as many families do not have insurance to get the necessary medical attention to avoid a crisis. CHIP is an important program for the families in our communities. We urge Congress to take the lead and fully fund this program so all eligible families get the health care they need.

Dedra Lewis – ADP – Springfield Massachusetts
In 2005, my beautiful 9 year old daughter was diagnosed with a rare eye disorder called Uveitis. Since then, she has been slowly losing her eyesight. Today, she can only see shadows, tomorrow she may go into complete darkness. We go to doctors and specialists at least three times a week- so much that I had to cut back at work from full-time to just twenty-four hours a week in order to keep up with all the appointments. Once I went part-time I lost the health insurance offered by my job. I thank God everyday that the SCHIP program was there. I can't even imagine what would happen to my family without it. This is a critical and hugely successful program. Please listen to our stories and take the leadership necessary to expand CHIP to all the families that need it.

Mary Sanchez – Pilsen Neighbors Community Council – Chicago Illinois
Our CHIP program is called "All Kids". I work in a non-profit medical center in a Mexican neighborhood. I see first hand what the lack of health care can do to a community. A family with three children and no money for any health care couldn't get

the check ups they need to enroll their kid in school. Without CHIP, these children would have been left, literally, outside. With CHIP, they can have the sound bodies they need to pay attention and succeed in school. Health care is a human right. I urge you to remember the children and take leadership for them, because they represent the future.

These are stories that can be heard in neighborhoods across the country. With reauthorization of the program now under discussion, we have the opportunity to renew this commitment to children and move the country closer to the goal of coverage for all our children.

A Program of Success

Thanks to SCHIP, many children have been protected from much of the decline in job-based health coverage in recent years. In the last decade, while the number of uninsured adults grew by six million, SCHIP helped to actually reduce the number of uninsured children by a third. Between 1997 and 2005, the uninsured rate among children dropped from 22.3 percent to 14.9 percent, progress attributable to our country's investment in children's coverage.

The gains in children's health through SCHIP would not have been possible without strong Medicaid programs. SCHIP builds on the basis of Medicaid, so both programs need to be strong in order for them to be effective. Over the past ten years, not only has SCHIP built on the framework of Medicaid, it has been a boost to Medicaid programs. When states created SCHIP and then reached out to inform families about the program, they also informed the public about Medicaid, resulting in increased enrollment in both programs. In 2005, Medicaid and SCHIP combined to cover 34 million children.

However, in the past year, the number of uninsured children rose for the first time since 1998, with a disproportionate share of Hispanic background, or residing in the South or the West. The good news is that as states continue to expand coverage, many of these children are already eligible, or will become eligible for SCHIP or Medicaid. This is dependant, however, on strong federal support.

The flexibility within SCHIP has also allowed some states to expand their programs to cover other groups of people. Coverage of pregnant women obviously promotes healthy babies. Additionally, there is evidence that covering parents increases the likelihood of their children enrolling. Not only that, healthy parents are better able to hold a steady job and to take care of their children. Currently, five states cover pregnant women and nine states cover pregnancy related care. Twelve states have waivers to cover parents; however, most of these programs have not been fully implemented.

Challenges in Reauthorization

Ensuring adequate financing for SCHIP is key to preserving and building on its successes. It is not surprising that at the time of its creation, SCHIP spending was below what was allotted by Congress because state programs were just getting off the ground. As these programs gained traction and children started to enroll, the yearly allotments were quickly surpassed. For a short time, this shortfall was filled by money left over

from early years when programs were smaller. However, as enrollment continues to grow, these surpluses are increasingly not enough to maintain current levels of coverage. In fact, even if states maintain current enrollment levels and current yearly allotments, it has been estimated by the Center on Budget and Policy Priorities that shortfalls will occur in 44 states within three years. This timeline is likely to be much shorter. With growing health care costs across the country, and many states showing increased support for children's coverage at the state level, a significant increase in federal funding is needed.

Two thirds of the nine million uninsured children are eligible for SCHIP (or Medicaid) but are not enrolled due to lack of information and enrollment/retention barriers. Among these barriers are a lack of awareness of the program and its eligibility levels, a lack of funds to support outreach efforts, and the new citizenship and identity documentation requirement that is deterring enrollment or delaying coverage for thousands of children.

States are clearly interested in covering more children across the country, which means expanding SCHIP and Medicaid programs. Some states have already improved coverage levels and removed barriers that were keeping eligible children from enrolling. Other states have adopted coverage expansions or are considering them. These steps to move forward will falter if reauthorization fails to take this into consideration.

Conclusion

We have come to share our belief that health care is the foundation for a successful life. Over the last ten years, SCHIP and Medicaid have combined to bring this goal closer to a reality. Congress now has a chance to bring that goal even closer as they move to reauthorize SCHIP.

While states already have the flexibility in both SCHIP and Medicaid to simplify enrollment and improve retention rates, there is sometimes reluctance to do so because increased enrollment means further strain on limited funding. One study found that almost 90 percent of parents surveyed found that they would enroll their children in SCHIP or Medicaid if they knew about it, and yet there are still millions eligible but not enrolled. In order to continue the success of this program, barriers to enrollment must be removed completely; reauthorization must provide enough funding to maintain current levels of enrollment, support outreach activities and the resulting costs of increased enrollment.

In addition to the millions of children already enrolled in SCHIP or Medicaid, millions more remain uninsured and yet ineligible, even though many are low-income. Some come from families whose income is above eligibility levels but do not have access to employment-based insurance. Others are excluded from SCHIP or Medicaid due solely to complicated and restrictive eligibility requirements related to immigration status. States currently do not have the option of covering these children even though they wish to do so. Reauthorization must also, then, give states greater flexibility to expand eligibility to reach all uninsured children regardless of immigration status.

The only way to continue to build on the successes of SCHIP and Medicaid is through Congressional leadership and action this year. Congress must work hard to make sure the progress in improving children's health continues and give states the tools to continue moving forward in covering all kids. SCHIP reauthorization is an opportunity for our leadership to show they stand for our communities, our families, and our future.

PICO National Network | *Unlocking the Power of People®*

Written Testimony for the Senate Finance Committee Hearing on
"The Future of CHIP: Improving the Health of America's Children"

February 1, 2007

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Bishop Roy Dixon, prelate of the Southern California 4th ecclesiastical jurisdiction of the Church of God in Christ, PICO Board President
Rev. Bill Calhoun, Pastor, Montview Boulevard Presbyterian Church, Denver, Colorado
Rev. Heyward Wiggins, Pastor, Camden Bible Tabernacle Church, Camden, New Jersey

Mr. Chairman and Members of the Committee:

On behalf of PICO's national network of faith leaders we thank you for holding these important hearings and honor the Committee's historical role in finding common ground to expand health coverage for children. And we thank you for recognizing the deep commitment of America's faith leaders to children's health coverage and inviting us to submit testimony for the record.

PICO is a national network of 53 faith-based federations working in 150 cities and 17 states. Our network encompasses 1,000 congregations from 50 different denominations and faith traditions, working together to improve communities and expand opportunities for working families. PICO led a county-based cover-all-kids initiative that has been replicated in more than half of California's counties. PICO is working with faith communities in other states including Colorado, Florida, Louisiana, Missouri, New Jersey, Pennsylvania and Massachusetts to expand coverage to uninsured children.

We urge Congress to complete the job you began 10 years ago by strengthening and expanding the State Children's Health Insurance Program (SCHIP), while protecting Medicaid. This logical and critical next step will put this nation on the path to covering all children by 2012.

The faith communities represented by the PICO National Network understand through our many religious traditions that as a society we are judged by our commitment to our children. Children are a blessing of a loving God. We are charged with the responsibility of providing a sound foundation for their future. Just as we insist that every child has access to quality education, so too should every child have access to quality health care. All children deserve the blessing of good health. There is no reason why any child should go without care or rely on the emergency room for their health care.

Covering all children is an issue that affects the hundreds of thousands of our member families who are unable to obtain affordable health coverage at work. Nationally, just 40 percent of all families with incomes less than 300 percent of the poverty line are able to obtain health coverage through their employers. That is why families in our congregations have joined together through PICO to press local, state and federal government to help make sure that parents have affordable choices to obtain health coverage for their children.

Next week, PICO will be releasing a national clergy letter signed by 200 prominent clergy calling on the Administration and Congress to work together to expand federal financing for children's health to support the growing number of states that are moving forward to cover all children. States are leading on the issue of covering all children, but they cannot succeed without increased federal financing for children's health.

To that end, PICO is submitting a five step **Road Map for Covering All Children by 2012**.

(1) Fill the existing SCHIP shortfalls facing states, so that no one risks losing coverage

Keeping current children enrolled is critical but not enough, given the 9 million children who are still uninsured.

(2) Fund proven outreach initiatives and provide states with the financial incentives and support to reach all eligible but uninsured children

PICO federations have worked closely with school districts and state officials to implement express-lane eligibility programs that enroll eligible children from health coverage at school. These and other community-based outreach programs work because our schools and communities understand that children need to be healthy to succeed in school and life. Our states know how to reach eligible children. What they need is a predictable financing and the financial incentive to reach and retain all eligible children.

Today, under current federal policy, states that move toward covering all children are punished. Instead, we should reward states that approach full coverage, by increasing the Medicaid match rate as a state approaches covering and retaining all Medicaid eligible children and providing bonus SCHIP dollars as a state approached covering and retaining all SCHIP eligible children. If we value covering all children we need to reward states that reach the finish line.

(3) Provide financial support and incentives for state efforts to expand high-quality preventative care and increase eligibility

While reaching eligible but uninsured children must be a priority, we should also be aware that many states are seeking ways to expand eligibility and improve quality. All working families need to the choice of affordable coverage for their children if they cannot obtain it at work. Federal policy needs to support states that are seeking

to expand eligibility and improve the quality of preventive care that children receive through proven state programs.

(4) Allow states the option to cover legal immigrant children and pregnant women

There is no reason why any child needs to go to the emergency room for basic health care needs. No one benefits from overcrowded emergency rooms and the high cost of treating medical problems late in the game. Congress should fix this injustice by giving states the option of covering documented immigrant children in their SCHIP and Medicaid programs. Congress should also allow states to use SCHIP funds to cover pregnant women.

(5) Provide financing in SCHIP and Medicaid to support the cost of covering newly enrolled children

Children's health coverage in the United States is a federal-state partnership. As states move to expand coverage to cover all children, the federal government needs to keep pace. States such as Illinois, Pennsylvania and California have received much attention for their effort to expand children's health coverage, but these state initiatives are not sustainable without new federal financing.

SCHIP stands on the shoulders of the much broader Medicaid program. Together SCHIP and Medicaid work together to provide essential health coverage options for working families. It is critical that as we work to expand coverage we do not harm the Medicaid program, which provides an invaluable safety net to support the health development of 25 million of the poorest children in the United States.

Finding the approximately $50-60 billion over five years in new federal financing to help states cover all children is ultimately a test of our will as a nation. Republican and Democratic governors and legislatures throughout the United States have found that will.

Their success and the health of America's children depends on Congress and the Administration rising to the challenge.

To help build support for expansion of children's health financing as part of SCHIP reauthorization, PICO is announcing a national campaign by faith communities across the country to support covering all children. Faith communities will be holding town hall meetings on children's health during February and March. We will be organizing prayer services and letter writing campaigns and bringing clergy and lay leaders to Washington, DC for a Faith and Families Summit on Children's Health on Capitol Hill on March 7th.

In closing, we pray that Congress sees the opportunity that exists this year to demonstrate real concrete progress on expanding health care for those who need it most. We urge you to carefully consider our Road Map for Covering all Children by 2012.

We invite all members of the Committee to join us for the Faith and Families Summit for Children's Health on March 7th. We look forward to working closely with you to build broad bipartisan support for expanding children's health financing.

On behalf of PICO National Network
Bishop Roy Dixon, prelate of the Southern California 4th ecclesiastical jurisdiction of the Church of God in Christ, PICO Board President
Rev. Bill Calhoun, Pastor, Montview Boulevard Presbyterian Church, Denver, Colorado
Rev. Heyward Wiggins, Pastor, Camden Bible Tabernacle Church, Camden, New Jersey

Testimony to Senate Finance Committee Hearing
The Future of CHIP: Improving the Health of America's Children
Held on February 1, 2007

Susan Salter
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I begin my testimony by stating that although I currently serve as the Chair of the Iowa ***hawk-i*** Board, I do not speak on behalf of the Board. I have been a member of the board for several years and have chaired the ***hawk-i*** Board for the past two years. Prior to that I served on the Covering Kids Task Force. I believe, as a citizen, I have developed some expertise regarding the SCHIP program, and I hope you will accept my testimony as a well-informed citizen of the state of Iowa.

The SCHIP program, known in Iowa as ***hawk-i,*** has been a very popular and critically important program in Iowa. Working in close collaboration with Medicaid, ***hawk-i*** provides private health coverage to children from 133% to 200% of poverty in Iowa, while Medicaid provides coverage for children under 133% of poverty.

Over the last decade, federal SCHIP funding, coupled with state funding, has expanded coverage of Iowa's children in both Medicaid and ***hawk-i***, to over 230,000 Iowa children. Surveys conducted by the University of Iowa of recipients show strong satisfaction with both programs.

At the same time, the experiences over the last decade have pointed to areas where the SCHIP program could be strengthened in providing coverage – some of which require additional federal action. Iowa has a very strong and effective community-based SCHIP outreach program that also has served as the "eyes and ears" of the program in gathering information about limitations in the current program.

As SCHIP is being reauthorized, the following should be considered for inclusion in reauthorization:

1. Allowance for children of state employees, particularly those employed on a part-time basis, to be eligible for SCHIP. Currently, Iowa state employees are covered under a state health insurance plan that provides comprehensive family health insurance coverage (even more comprehensive than SCHIP), without any premium. At the same time, part-time employees (under 20 hours a week) are only eligible for partial coverage and many cannot afford to pay the premiums, yet are categorically excluded from SCHIP. This certainly was not the intent of Congress in establishing an exclusion for state employees and should be corrected.

2. Options for wrap-around SCHIP coverage for persons with employer-sponsored health coverage. If a parent is able to receive some health care coverage for their family, but are left under-insured, SCHIP could fill the gap in benefits available to their family.

3. Pre-existing conditions of children for families on some forms of independently purchased health coverage. These families recognize that if they take advantage of ***hawk-i*** and then become ineligible through increased earnings, they will need to rely upon independently purchased coverage and will have pre-existing condition limitations on needed coverage for their children.

4. Transportation, care coordination, and other issues related to getting to care under ***hawk-i,*** which are available under Medicaid. These services enable families to secure a medical home for their child(ren) as well as assure transportation to medical appointments. The Care Coordinator guides families in the value of preventive health services that include immunization, developmental screenings, and anticipatory guidance to parents. Additionally, when a child has a medical home and accesses regular preventive health services, emergency room visits go down.

5. Lack of coverage for adults in the household. Research shows that when parents are covered with health insurance, children are more likely to be covered. States should have the flexibility to design their SCHIP program to cover parents when it meets the needs in their state.

6. Limitations on actual coverage of services under SCHIP compared with Medicaid. Some services allowed under Medicaid, including the amount of services, are not reimbursed under SCHIP. This not only limits the necessary health care children can receive, but also prevents knowledgeable health care providers from providing the care they deem appropriate.

In some instances, these require additional federal flexibility to states, and in all instances they would require additional federal funding to that already being provided.

I also would like to clear up what may be a misconception regarding any "stigma" the Medicaid program may have that would cause parents to refuse coverage for their children. In fact, ***hawk-i*** has worked closely with Medicaid, and ***hawk-i*** outreach efforts promote the benefits of Medicaid, which provides the more comprehensive health coverage that some children need. Collaborative work has streamlined Medicaid information to parents and has recently resulted in parents receiving a Medicaid card for their children equivalent to private health coverage. While in the beginning of the program in 1997 there may have been several instances where parents enrolling their children in ***hawk-i*** and finding their children enrolled in Medicaid declined that coverage, there is no evidence that this is a significant issue today.

Finally, the biggest recent barrier to covering children in Iowa has been the new citizenship documentation requirements for Medicaid, which have proved to be very difficult for the state to administer and for some families to comply with in securing coverage. Although SCHIP does not have these requirements, they do create a barrier for some families who must prove ineligibility for Medicaid before they can be considered eligible for ***hawk-i***.

Thank you for your consideration of my remarks.

Susan Salter

Susan Salter
February 11, 2007

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