S. HRG. 110–439

CHILDREN'S HEALTH INSURANCE PROGRAM IN ACTION: A STATE'S PERSPECTIVE ON CHIP

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

(BILLINGS, MT)

APRIL 4, 2007

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

43–021—PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON FINANCE

MAX BAUCUS, Montana, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia	CHUCK GRASSLEY, Iowa
KENT CONRAD, North Dakota	ORRIN G. HATCH, Utah
JEFF BINGAMAN, New Mexico	TRENT LOTT, Mississippi
JOHN F. KERRY, Massachusetts	OLYMPIA J. SNOWE, Maine
BLANCHE L. LINCOLN, Arkansas	JON KYL, Arizona
RON WYDEN, Oregon	CRAIG THOMAS, Wyoming
CHARLES E. SCHUMER, New York	GORDON SMITH, Oregon
DEBBIE STABENOW, Michigan	JIM BUNNING, Kentucky
MARIA CANTWELL, Washington	MIKE CRAPO, Idaho
KEN SALAZAR, Colorado	PAT ROBERTS, Kansas

RUSSELL SULLIVAN, *Staff Director*
KOLAN DAVIS, *Republican Staff Director and Chief Counsel*

CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

CHILDREN'S HEALTH INSURANCE PROGRAM IN ACTION: A STATE'S PERSPECTIVE ON CHIP

WEDNESDAY, APRIL 4, 2007

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

The hearing was convened, pursuant to notice, at 2:10 p.m., in the Student Union Building, Montana State University-Billings, Billings, MT, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senator Cantwell.

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

The CHAIRMAN. Good afternoon, everyone. We are now convening the Senate Finance Committee hearing in Billings. It is not often that we get to have a hearing outside of Washington, DC and come to where the rubber meets the road, where the real decisions are made. We are very honored to be here at MSUB, the Finance Committee is, to have this hearing on the Children's Health Insurance Program.

Also, I want to begin by thanking our Governor, Governor Schweitzer, for joining us here today. [Applause.]

The Governor has been a great friend to Montana's children in lots of different ways, helping them, and having the legislature do the right thing on CHIP, for example.

In addition, we are very honored to have Joan Miles here with us. Joan is the Director of the Department of Public Health and Human Services to represent the technical level of all that is happening in Montana as we improve our outreach for children. Also, a big, big welcome, a big Big Sky welcome, to Senator Maria Cantwell, who has joined us here today. [Applause.]

Senator Cantwell is a member of the Finance Committee, one of our most valuable members. Of course, all members are valuable. She is very active in lots of areas, very effective, not only for the people whom she represents from the State of Washington, but also on national issues. I could just go down the list. One of the issues is energy. She is very forward-looking in trying to figure out how to make sure we become more independent of OPEC. Another is just basic investment decisions and how we have the wherewithal, the economic wherewithal and the capital of our country to invest in areas that help make our country stronger. And, clearly, Seattle as the gateway to Asia is an extremely valuable part of the country in terms of trade with Asian countries and America, and she is a

very, very smart, good, and effective Senator. So we thank you, Senator Cantwell, for all that you do.

Sir Thomas Browne, an English physician and philosopher, once wrote: "There is no road or ready way to virtue."

Well, Sir Thomas Browne wrote this long before we had the Children's Health Insurance Program. In my view, the program has paved the clearest road to improve the lives of our Nation's children in recent years.

It is only fitting that we here today in Montana join to discuss our journey this past decade with the Children's Health Insurance Program. Today's hearing gives the Finance Committee a great opportunity to hear directly about how it has worked at the State level and, again, as I mentioned earlier, where the rubber meets the road.

I am proud of the role that so many of us have played in Montana's journey with CHIP so far. It was in 1997, frankly, that this got off the ground, and it was a great idea. It was championed by Senators on both sides of the political aisle, and Senator Hatch from Utah was extremely active, and the late Senator John Chafee of Rhode Island, another very active Senator. They are the two—and there were a couple more—that were really the major prime movers in 1997. I was there, I was pushing it, but to be honest, it was Senator Hatch and Senator Chafee who really led the effort, and we all owe them a deep debt of gratitude for all that.

I was also at that time, prior to coming to our legislature, back then helping Montana get started with CHIP, testifying at a committee because of its importance. I am very happy that we have moved, and I am very hopeful that the State legislature now will take the next step as it moves coverage beyond the 150 percent up to a higher level.

The number of children in our State who have been helped by low-income programs is at least 13,000, and it has also improved the enrollment of Native Americans, a segment which is often forgotten, and we are not going to let that happen. And I think we can be proud when the legislature finally enacts an increase in coverage.

But we cannot rest on our laurels. There is always much more to be done, and that clearly is the case here.

Too many children who are eligible for the Children's Health Insurance Program and for Medicaid remain uninsured. That is, they just do not get the benefits in the law. Nationwide, three-quarters of the 9 million uninsured children are eligible for either CHIP or Medicaid, but they are not enrolled.

Of our State's 37,000 uninsured children, more than half—that is, 19,000—are eligible for either Medicaid or CHIP. But they remain uninsured. Many of those who remain uninsured live in Indian country. Clearly, that is an area that we have to address. And the number of uninsured children in Montana unfortunately has been rising, even as the number of uninsured children nationwide has been falling. The largest increase in uninsured children is among children under 5 years of age. Those are the kids, clearly, who need access to health care the most. This is simply unacceptable.

Not having health insurance means one accident, one broken leg, or one major life-saving surgery could drive these families into bankruptcy.

Today, we will hear from Melissa Anderson. Melissa will tell us how not having health insurance coverage can mean choosing between making payments to keep her business from sinking and paying for prescriptions to keep her son from having seizures. These are decisions no Montanan or any American should have to face.

And while Montana's recent Children's Health Insurance Program expansions are positive, we still in our State rank second to last in coverage. We need to ensure that Montana, therefore, has the funding that it needs to cover kids at levels provided by most other States. In fact, in my personal view, I think we need to see that Montana can cover kids up to twice the poverty level, even more than we are contemplating in the legislature.

Looking at the road ahead for CHIP, there are at least five principles that I will pursue.

First, we must provide adequate funds to maintain coverage for those already on the program. According to the Congressional Budget Office, we will need at least $13.4 billion over the next 5 years just to maintain coverage.

Second, we must reach the 6 million children who are eligible for coverage either under CHIP or Medicaid but not enrolled.

Third, we must support State efforts to expand coverage to children through the Children's Health Insurance Program.

Fourth, we must improve the quality of health care that children receive. I do not think enough emphasis has been given to quality. Quality is something which we should certainly focus on in reauthorizing legislation.

And, finally, we must not add to the numbers of the uninsured as a result of our legislation. There are some, unfortunately, who would like to see the numbers of uninsured actually rise due to restricting of coverage under the program. I am totally on the opposite side of that one. I think we should expand and not let anybody fall between the cracks. Again, there are some who have a contrary view in Washington, DC.

There will be challenges on the path to passing our bill. First among them is how to finance the cost of renewing the program. It is going to cost about $50 billion over the 5 years.

Let me state right here that this is the major initiative taken by the Congress when we passed the budget resolution just a short while ago: expanding CHIP by this amount. It is by far the most significant new addition that we have passed in the budget resolution, and it is because of its need. We are moving in this country toward universal coverage. [Applause.]

We are the only industrialized country in the world without universal coverage. That is not right. Every American should get health insurance. When I say universal coverage, I mean that we have to find our own unique American solution through a combination of private and public programs that results in universal coverage. Again, it is public and it is private. It is working together. It has to be a uniquely American solution. But we must move ag-

gressively in this to provide universal coverage. And expanding the Children's Health Insurance Program is a step in that direction.

I plan to move on this very quickly and work with the Ranking Republican on the Committee, Chuck Grassley. I would like to move this legislation without delay. After this second hearing this committee is now holding, we will be getting down to brass tacks in the coming months. We will have a committee bill ready for markup I think by late spring of this year. I want to move it, and we will vote on the bill before September 30th, when funds expire.

Again, the program expires September 30th, and I am not going to tempt fate by waiting close to the deadline. Rather, we have to move early, as I said, markup by late spring. The fall schedule depends significantly on the decisions made by the Majority Leader and other extraneous issues that we cannot now foresee. So my view is let us get started, let us move.

This afternoon I very much look forward—and I know I speak for the Governor and for Senator Cantwell—to hearing from people who really know what is going on. It has been a great journey for us, and you can help us so very, very much.

We are honored today to have our Governor. Governor Schweitzer has been moving the ball forward to get health care for Montana's children since he was elected. In the past 2 years, he has led State efforts to expand eligibility and lift enrollment levels. He has improved outreach that is so critical to the program and making progress toward reaching our State's uninsured children.

Thanks for all of you. It is a real honor to have you here. Thanks for taking the time to come from Helena. I expect, though, it is probably a little bit of a respite. It is kind of joyful to leave Helena these days, in all fairness to the legislature. [Laughter.]

This might be an excuse for you to leave Helena and come on over. In any event, we are very honored to have you here and would love to hear your comments. [Applause.]

STATEMENT OF HON. BRIAN SCHWEITZER, GOVERNOR, STATE OF MONTANA, HELENA, MT

Governor SCHWEITZER. Thanks, Max. I do that all the time. It is actually "Senator Baucus." I make that mistake all the time, and I know people all over Montana make that same mistake. And so——

The CHAIRMAN. What do you mean, "mistake?" [Laughter.]

Governor SCHWEITZER. I have decided, you know how sometimes when you try to remember someone's name, it is better to remember what they do and then that triggers your mind to what their name is. So in my mind, I will always think of you as "Senator CHIP" because no one has done more for the Children's Health Insurance Program than Senator Baucus. So from now on it is "Senator CHIP." [Applause.]

The CHAIRMAN. Except for those wonderful children who made those chocolate chips out here.

Governor SCHWEITZER. Those are great.

The CHAIRMAN. They have done more for CHIP than anybody.

Governor SCHWEITZER. And, Senator Cantwell, welcome to Montana, and I know that after you have more of a chance to travel

across Montana, you will be back many times to enjoy the splendor of Montana.

For those of you who do not know, Senator Cantwell really has led on the national scene in energy independence, so I think of her as "Senator Energy." And for those of you who—I have the same problem with Senator Tester. I always think of him as "Jon," like you do. So Jon, Senator Tester, has taken on the cause of veterans, and so I just think of him as "Senator Vet." Now we have this all taken care of.

Healthy communities start with healthy families, and a healthy start is healthy children. Montana has 13,300 of our children enrolled in the CHIP program that gets the families a healthy start. And some people think of the Children's Health Insurance Program as being intended for indigent families. It is not. In Montana, 92 percent of the people who are enrolled in the CHIP program have one or both of the parents working. These are working families, and, "Senator CHIP," there is nothing more important to working families than a healthy child, because all over Montana there are young families who say a prayer with their children as they tuck them into bed, and after they tuck their children in, they go down the hall and they kneel again and they say a prayer. And this time the prayer is that none of their children gets sick because they do not have health insurance.

These are working families. These are members of our community. So thank you for providing the Federal funds so that 13,300 kids have coverage. We have asked the legislature to increase coverage in the CHIP program in Montana to 175 percent of the poverty level, and, Senator, if you can find the resources in Washington, DC, if you could help us, we will take it to 200 percent and above in the future.

The CHAIRMAN. Well, Governor, it is my goal to help make that happen. That would be the right thing to do.

Governor SCHWEITZER. So, again, thank you very much. There is nothing more important than healthy families, healthy communities. It starts with healthy children.

Thank you very much.

The CHAIRMAN. Thank you very much. [Applause.]

Thank you for your time. Go back and straighten them out over there.

Governor SCHWEITZER. Honestly, when I leave Helena while the legislature is in session—Nancy and I have three teenagers—it is like going on vacation and leaving the kids at home. [Laughter.]

Senator CANTWELL. Well, thank you, Chairman Baucus.

The CHAIRMAN. I would like to introduce you first.

I have already introduced Senator Cantwell once, but I always like to do it again. I meant it when I said it. She is just a great person, a super Senator. We are very lucky that she is able to find time to come over and visit us in Billings. Let us give a huge, huge, huge Big Sky welcome to Senator Maria Cantwell. [Applause.]

OPENING STATEMENT OF HON. MARIA CANTWELL, A U.S. SENATOR FROM WASHINGTON

Senator CANTWELL. Thank you, Chairman Baucus. Thank you for the introduction and certainly for that Big Sky welcome. We have

been at several events today already, and I certainly feel welcome every time I hear, "Welcome to Big Sky country."

I am sorry that the Governor left because I have been spending time in Montana, mostly fly fishing, and I will come back for many other activities. I want to thank him for his leadership with the State legislature because part of the challenge for SCHIP is to make sure that the State legislature does its job in matching the Federal program, enrolling children and making SCHIP a priority. I thank the Governor for that and for his leadership on energy policy issues as well.

Max and I had a chance this morning to talk about the common interests of our States in growing canola, and how that might be used for biodiesel in the future. And, I applaud Max for his creation of an Energy Subcommittee on the Finance Committee to explore how we can put the Washington and Montana farmer in the energy business as opposed to the Saudi OPEC cartel. So thank you very much for your work on these issues.

It is my pleasure to tell you what a tireless advocate the chairman of this committee is for your State—for farmers, for trade, for economic development, for jobs, for education, and, as has already been mentioned, for the CHIP program. I also personally want to thank Caden and Ethan Berg. I do not know where they went, but they are the two most darling young people. And I love the way they gave us this cookie, Max. It actually says "60 billion" on it. [Laughter.]

The CHAIRMAN. I like that.

Senator CANTWELL. So the price is being communicated well through these children.

The CHAIRMAN. With the high inflation rate in this case.

Senator CANTWELL. Besides getting to your stomach, they definitely got to my heart, and so I am glad that they were here.

I want to thank Chairman Baucus for visiting Seattle last year and having a similar hearing at Children's Hospital to talk about the SCHIP program in Washington State. We are a State that in 1994 expanded our Medicaid program to cover families that earned too much to qualify for Medicaid but could not afford private insurance. Today, we cover over 140,000 children.

Like you, I believe that we need to use our States' experiences to help inform good Federal policy. That is why we are here today—to hear from you about how we can do that. Without health care coverage, children do not have access to the basic health care services that we all take for granted, including things like well child visits, treatment for asthma—and simply just the security of knowing that you have a physician, a doctor on call.

Health insurance costs are skyrocketing, and many families cannot keep up. Last year, the premiums for employer-sponsored health care coverage rose 7.7 percent. Now, that is twice as fast as workers' wages and twice as fast as inflation. You can see how that is a huge challenge. Family health insurance coverage costs an average of $11,500 a year. When you are talking about family incomes, you are talking about a sizable part of their income going to health insurance.

The average worker is paying about $3,000 a year towards those premiums, which is almost a $1,300 increase from what they paid

in 2000. If you think about that increase and the fact that you have not seen a similar increase in wages, you have to wonder where somebody is going to come up with an extra $1,300 in such a short period of time.

Wages simply cannot keep pace with these increases, and businesses are obviously feeling strained by health care costs. I know that we are going to hear from Dr. Lyons. Her organization, the Kaiser Family Foundation, issued a report analyzing how these changes in employees' health care coverage are impacting the system. They found that in 2000, 66 percent of non-elderly Americans were insured through the workplace, but by 2004 only 61 percent were covered through the workplace.

Part of finding solutions through CHIP is addressing the fact that more and more employers are not able to cover their workforce in the community. Both children and adults experienced the steady declines in job-based health care coverage, and that is something that we have to get serious about.

It is Medicaid and the Children's Health Insurance Program that have provided the backstop, to prevent the number of uninsured children from growing. Unfortunately, I understand from Dr. Lyons's testimony that the number of uninsured children may be on the rise again. That is why it is so important that Senator Baucus is leading this charge in the Senate to reauthorize the CHIP program.

It is reauthorization of this Federal-State partnership that brings us here today. But, it is also to recognize the great strides that have already been made in the program. It has been a key driver in cutting the percentage of low-income children without health care coverage by a third over the past decade. We need to celebrate that as well.

But our work is far from done because 9 million children in the United States remain uninsured, and it will not be news to the people in this room that there are real consequences to lacking insurance. In the *American Journal of Medicine* this month, researchers found that the uninsured receive less care and have poorer outcomes than those who have insurance.

We need to do better, and that is what this hearing is about, to make sure that we continue to focus on giving the resources to all children in America, to make sure that they are covered, not only that they get good health care but that they get a good start in life.

So thank you for being here. It is a pleasure to be in Big Sky country. I hope I get asked back a lot.

The CHAIRMAN. You will.

Senator CANTWELL. Otherwise, I am just going to come on my own. But it is a pleasure to see so many people in Billings turn out, and I want to also thank the MSUB for hosting this forum for us and thank all of those who are testifying.

The CHAIRMAN. Thank you, Senator, very much. Thank you. [Applause.]

We have three panels. The first panel I will introduce, and then, when they are finished, I will introduce the second panel. The third panel is all of you. We have reserved time—not a lot of time, but about 20 minutes—for people who want to speak to go to the microphone. So when we are going through the first two sets of wit-

nesses, and Senator Cantwell and I will ask questions, I would encourage you to think of points you want to make. Maybe somebody said something that needs to be clarified, or maybe somebody said something that maybe is not quite right, or maybe somebody did not say something that needs to be said. So you are all the third panel.

The first panel includes Joan Miles, Director of Montana's Department of Public Health and Human Services, and Joan will talk about how the State has implemented CHIP and the challenges our State faces in reauthorization.

Next is Dr. Barbara Lyons, deputy director of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Dr. Lyons will talk about how Montana's experiences fit with those of other States implementing their programs, and she will give us a lot of new ideas.

Finally, Melissa Anderson, on the first panel, is a single, self-employed mom from Helena. She will talk about how CHIP has helped her family through a very difficult health crisis.

So why don't all three of you come on up here, and, Joan, when you are ready, you can begin.

Again, welcome, Joan, and thanks for all that you do for all of us in our State.

STATEMENT OF JOAN MILES, DIRECTOR, MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, HELENA, MT

Ms. MILES. Thank you, and thank you for having all of us here. This is an honor to be part of the national discussion on CHIP reauthorization, and we really appreciate it.

I would like to introduce Jackie Forba, who is sitting back here. She is the Bureau Chief in Helena for our CHIP program, so if you do have any questions for me, she might be able to help me.

I am going to jump right into the testimony because there is a lot to say, but again, thank you, this is a wonderful opportunity.

Our motto for our CHIP program in our State is "Health insurance for children, peace of mind for parents." And I can tell you from firsthand experience, working 11 years at a local public health department before I became director of this department, that the CHIP program truly does give parents peace of mind.

I was working there when the program started, and we saw year by year the number of people come in, and we would say, "Do you have insurance?" And they would say, "Yes. As a matter of fact, I do have insurance. I just got on the CHIP program." So it really has been not only peace of mind, but I think a source of pride for families in Montana.

Montana has less than 1 million people, and that is approximately 6 people per square mile as compared to 8,800 per square mile in DC. That is why you are feeling a little crowded. The median household income in Montana ranks 48th in the United States. However, Montanans are fiercely independent and very proud, and they do not see themselves, we do not see ourselves as a State that is a relatively poor State. The rate of uninsured children in our State is higher than the national average, and we have

7 reservations in Montana with a disproportionate share of low-income children.

I am giving you some of these statistics not to point out so much the uniqueness of Montana. I think you could have all 50 States here talk about the uniqueness of their own States. What has been the hallmark of the CHIP program is the ability for States to look at their own situations and design the program to meet their needs. And we certainly encourage that in the reauthorization that this is one of the things that we can continue to do, to look at our own situation and design a program to fit our needs.

As a result of that, in Montana we chose to do a stand-alone insurance program, and as the Governor talked about, 92 percent of the CHIP children have parents who are employed. By the way, the single-largest employer is self-employed. It is people who are self-employed. That is the category of employer that is the largest of these families.

We fund a lot of our program through tobacco settlement dollars and the tobacco tax increase. Two years ago, we increased the tax on cigarettes in Montana by $1 a pack and dedicated a lot of those funds to be able to go to the CHIP program. We stand ready to increase our eligibility. We have the funding in the budget if the legislature does approve this bill to expand eligibility up to 175 percent of poverty. We are one of 10 States, however, that has not yet been able to insure children up to 200 percent of poverty.

We have 13,350 kids as of the end of April on our program. However, we do not cover any expanded populations. We are still working on getting our uninsured children covered. We have worked hard in the past year to increase our enrollment, and we have been successful in increasing enrollment among Indian children by 20 percent, statewide by 9 percent, and by the way, Yellowstone County, you have increased your enrollment by 20 percent. You certainly brought up the State average.

In terms of the reauthorization, I think we have four issues that I want to bring up. They are detailed in my testimony because I know I will not be able to get into all of them. A lot of it is based on some equity issues.

We would like to see the priority be to really focus on children, and particularly those States that have not yet been able to get up to that 200 percent of poverty.

We do need dependable, predictable funding. That has been a problem in our State. Our legislature meets every other year. They have been reluctant to do things like CHIP expansion because we do not know what the level of funding is going to be. We do not want to have waiting lists. We do not want to start something and then have to cut kids off. So the ability to have dependable, adequate funding and not be dependent on redistribution funds after the fact is very critical for us.

We would urge, I think, basically a two-pronged approach: that Congress should first designate funding to support State efforts to fully cover all uninsured children up to 200 percent of the Federal poverty level; and then additional funds could be used by the States to cover expanded populations. But we really hope that the priority will be to get kids under 200 percent of poverty, to get enough funding in the States for those children.

I will have probably the more boring testimony here. You are going to hear some wonderful stories from some of the other panelists. You were right. I have the technical comments.

The 10-percent administrative cap has been a problem because things that the State has to consider administrative when we do it are not considered administrative if you have a fully insured program. In other words, things that Blue Cross Blue Shield used to do for the State of Montana were not considered administrative. They were considered benefits. For us they are considered administrative. We did switch to a self-administered program, but we almost were prohibited from doing it because of the 10-percent cap.

We would like to see the prohibition on State and university employees lifted. Right now they are not eligible for CHIP coverage. And yet that same prohibition is not there for Federal employees. It is just as difficult for a low-paid State employee to pay monthly premiums as it is for a low-paid Federal employee. We would encourage that.

It looks like my time is up.

The CHAIRMAN. We will give you an extra minute.

Ms. MILES. An extra minute, thank you. I have two more quick things.

The PERM Project, the Payment Error Rate Measurement, that CMS is having the States do for both CHIP and Medicaid this year, we would encourage that PERM-related costs either be 100-percent federally funded or be excluded from the 10-percent administrative cap so that we could at least obtain some Federal matching funds in order to do those audits.

By the way, we have to do as many audits in our State as some of the larger States have to do, so it will be proportionately very costly for Montana to do this project.

Finally, we would urge you to look at the Child Support Enforcement Program. Right now, if there is a child support enforcement order and a parent is required to provide insurance, they cannot use the CHIP program. They have to do it through private insurance. However, divorced families who are not under the State Child Support Enforcement can access CHIP. So, again, it is an equity issue. We think that children of divorced families should have that same access to CHIP whether they are under an enforcement order or not.

The CHAIRMAN. Thank you very much, Joan. That is very helpful.

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

The CHAIRMAN. Dr. Lyons?

STATEMENT OF DR. BARBARA LYONS, VICE PRESIDENT AND DEPUTY DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUNDATION, WASHINGTON, DC

Dr. LYONS. Thank you, Chairman Baucus, Senator Cantwell. I am pleased to be here today in Billings, MT, to testify on the importance of a State Children's Health Insurance Program. I am going to get right to it.

First and foremost, CHIP is a success story. Today CHIP covers 6 million children nationwide, as you have heard repeatedly today, over 13,000 in Montana. The investment in CHIP has paid off be-

cause children have better access to the care they need. They have improved health. They are performing better at school as a result of this program.

Over the past decade, CHIP and Medicaid have reduced the uninsured rate among low-income children by one-third. That is a fantastic accomplishment given the falling rates of employer-sponsored coverage, the rising health care costs we had during this period, and the fiscal strain that States were under during the economic downturn.

Since the enactment of CHIP a decade ago, the need for the program has grown substantially. Fewer firms today are offering health coverage, and, as Senator Cantwell said, health insurance premiums have skyrocketed in the past couple years.

CHIP is literally a lifeline for low-income, working families who have been hardest hit by these changes. Without CHIP, the overwhelming majority of these children would be uninsured.

Why has CHIP been so successful? I am going to tick off three reasons.

First, all States expanded eligibility. As was noted earlier today, 41 States provide CHIP for children and families at or above 200 percent of the Federal poverty level. A number of States have recently broadened eligibility. Here in Montana, Oklahoma, and Ohio, there are proposals on the table to increase eligibility that would raise these States up as well.

Second, CHIP established a new priority on enrolling eligible children and keeping them covered once they are in the program. Montana has adopted many of the enrollment simplifications in its CHIP program, including no asset test, no required face-to-face interview, permitting self-declaration of income, and using 12-month continuous eligibility to keep kids covered once they are enrolled.

Importantly, many States have carried these improvements in CHIP over into the Medicaid programs as well so that poorer children could also benefit from streamlining activities. Unfortunately, the new citizenship documentation and identity rules in Medicaid that are being implemented by CMS run counter to these simplifications and create barriers to enrollment for eligible children.

The third point that has been very important is outreach. Outreach is an essential tool to inform families about the availability of coverage. It works best when program eligibility is broad and the enrollment procedures are family-friendly and easy for families to navigate.

Children's participation in CHIP and Medicaid is high, reflecting the value that parents place on coverage and their positive experiences with the program. Building on the success of CHIP, more needs to be done to reach the 9 million children nationwide who remain uninsured. These children are missing out on valuable health benefits. Parents of uninsured children do live in constant fear that an accident or medical emergency could just wipe them out financially, and they worry that they are passing this stress onto their children.

Unfortunately, many do not know that their children qualify for CHIP or Medicaid, or they have difficulty applying for coverage.

Outreach and streamlined enrollment are key to overcoming these hurdles.

Successful outreach, however, depends on adequate financing being available to support the coverage when children do enroll, and the biggest challenge in CHIP throughout its history has really been the program's financing. Throughout the program's history, the capped financing has not lined up well with program needs. The distribution of Federal dollars across States has also been problematic.

As Congress prepares to reauthorize CHIP, a number of issues will be discussed, including who can be covered and the level of Federal financing that is available to States. CHIP's experience over the last decade suggests three lessons to keep in mind as these discussions go forward.

First, I will just reiterate that States attribute much of the success of CHIP to the flexibility that they have had over eligibility, benefits, and program design. This flexibility has enabled States to design programs that meet their residents' needs, the local health insurance market, and the political environment in that State.

Second, the level of Federal financing and how these funds are allocated across CHIP will be pivotal to the program's future success. And States are poised to move forward. They really are. There is much enthusiasm to do more to reach uninsured children. It is mounting in States across the country. The outcome of the CHIP reauthorization debate will be a key factor in whether States across the country can go forward.

So I will just close by saying that the health and health coverage of millions of children depend on reauthorization of CHIP. Unless Congress acts, the program will expire in less than 6 months. And without additional Federal financing, more children will become uninsured, jeopardizing a decade of progress that we have made in covering kids.

So thank you for the opportunity to testify, and I look forward to your questions.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Next we have Melissa Anderson.

STATEMENT OF MELISSA ANDERSON, REPRESENTING HER FAMILY, HELENA, MT

Ms. ANDERSON. Thank you, Senator Baucus. My name is Melissa Anderson, and I would just like to say thanks for allowing me to come share my story today about the CHIP program and how it helped my son and me during a crisis period in our lives.

To give you a little bit of background, I have been self-employed for the last 11 years, and I can tell you from experience that it is nearly impossible to find affordable health insurance. I did not think that was a problem until I needed it.

In 2005, our family situation changed, and I got a divorce, and it was during this transition period that my son, Kasey, age 9 at the time, had a grand mal seizure. Now, the news itself was shocking, and he had to undergo extensive testing and was diagnosed with a seizure disorder. But perhaps even more traumatic was

wondering how I was going to pay those bills because, like I said, we had no insurance.

It was about that time that Kasey's neurologist suggested that we apply for the CHIP program, and I said, "Well, I do not think we are going to qualify for that. That is probably for low-income people." And he said, "Well, you never know until you try."

So I filled out the paperwork, and I can tell you honestly right now that that is the best filling out of paperwork I have ever done in my life because, much to our surprise, we did qualify. And I cannot tell you what a relief it was getting to know that we were going to have help for these medical bills.

Kasey had MRIs, EEGs, expensive blood work, and then he had to be placed on seizure medications, which were not cheap, either.

You know, basically what it did for us is it gave us peace of mind knowing that I could go back to work and concentrate on making more money, and he could concentrate on getting well. And that right there made all the difference in the health of our family.

I truly believe there are many others out there just like us who do not realize that they qualify for this program. They probably think it is for low-income people, and I am here to tell you it is for low- to middle-income people.

We received the CHIP program for about 10 months, and then I overqualified because I worked very hard that year to try to get myself back up. And I am here to tell you that it was almost a seamless transition going from the CHIP program to another insurance program, which I was very worried about because they accepted us even though most insurance companies would have said, "Oh, this is a pre-existing condition." We had no problem with that whatsoever, and for that we are very thankful because that is what we call "bridging the gap," so to speak.

I am not embarrassed to have received these benefit. I am a very hard-working person, and I think there is a problem in our society today with American workers, people who are blue-collar workers or people like myself who go out and work hard every day to pay my fair share of taxes and then find out I do not have enough money at the end of the day to buy insurance. And insurance is always at the bottom of the list. I do not care who you are. That is always going to be last. You either put food on the table, pay your mortgage, or buy insurance. Well, what would you do?

So I am not embarrassed to accept the benefits that were there in our time of need because to me it is a "hand up." And I have actually been helping to advocate this program ever since. As a matter of fact, I am a video producer, and I helped to produce the CHIP commercials.

The CHAIRMAN. Good for you.

Ms. ANDERSON. So I am giving back, and I am giving back today by my testimony.

In my opinion, I would just like to say that kids should not have to feel guilty about being sick. And parents should not have to worry about how they are going to make enough money to pay those doctor bills or worry about whether they can afford to take their kids to the doctor. That is just not right. And we have to do the right thing in America to help people like me and other people

to find insurance for our kids. Actually, I think it should go further, because I still do not have health insurance for myself.

So I am just here to say thank you to all of the advocates and supporters of the CHIP program, and I would like to say thank you, and I want to leave you with one last thing. I do believe that prevention is the best medicine, and I can testify for that right now because, as of 3 months ago, my son no longer has to be on his seizure medications. So prayers have been answered, and thanks to the CHIP program and the medication that he received. We are very grateful for that. Thank you very much.

The CHAIRMAN. Thank you very much, Melissa. [Applause.]

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

The CHAIRMAN. I would like to do something a little bit different instead of being so formal. When we have these hearings in Washington, DC, generally each of us on the committee takes 5 minutes, and it goes to the next person, 5 minutes and so forth. It gets to be a little bit formal sometimes, and so what I would like to do, if you do not mind, Maria, is just kind of open it up, and the two of us can talk with all the three of you, and you can talk with us, and we can have a little conversation here as we try to advance the ball. I will ask a couple of questions. You may want to pipe in with something to ask. Or you may want to add on to it or maybe you have something different. We have allotted 15 minutes for us with this panel.

I am going to jump right into what I think is a very vexing problem that we are going to face, and that is financing. Dr. Lyons, you talked about it a little bit. It gets to the allocations among States, maybe some population changes and formula changes as we reauthorize this. It gets a little bit to the coverage that some States have compared with some other States.

I know that New York is looking at 400 percent of poverty, and I think New Jersey is 350 percent, if I am not mistaken, or something like that.

Then it gets a little bit into the shortfalls that we face this year. Some States just ran out of money and came running to Congress for some help, and some other States had some surpluses. They did not use it all.

I would just like some guidance from all of you as to how we get at that in a way that assures predictability and can help States fashion their programs in a way that is fair to them and fair among States. So just your thoughts, please.

Dr. LYONS. I will start and say that the most important issue, I think, facing the reauthorization is making sure that there are adequate funds on the table. The program has been struggling for the past several years.

The CHAIRMAN. Adequate funds for the current coverage?

Dr. LYONS. Well, adequate funds, I would say, beyond current coverage. If we really want to do something about uninsured children in this country, we have to go beyond current coverage.

So there is more money needed to just maintain the coverage that is there. In addition to that, if we are going to do something to reach those kids who are eligible for the program, for CHIP, as well as Medicaid, but not enrolled, more money needs to be put to-

wards that coverage. States could cover those kids now. They are not. They need incentives to go out and bring those kids in, to streamline their enrollment processes so that they can be covered and that they can stay covered. And that is, quite frankly, going to take some financing from the Federal Government to support those efforts.

The Federal Government could also help by providing additional financing so that States can do that in an efficient way, so they can use automatic enrollment procedures, where if a child was eligible for one program and they are likely to be eligible for CHIP or Medicaid as well, the State can get them enrolled easily. States need help with information technology and data-sharing systems. We are in the 21st century, yet some of the computer systems that we are using in these programs do not talk to each other. Those kinds of things would be very helpful for States.

So the bottom line is, I think there needs to be additional Federal money there. The $50 billion that you have included in the budget resolution is a great, great start to help States get there, if we can keep that money in the budget. But when we talk about differences across States, States are in very different places across the Nation, and their decisions on who they cover and what levels they cover I feel really need to be individual State decisions. The cost of living varies dramatically in different places across the country, and so one State's decision to be at 200 percent of poverty may make sense. In another State, like New Jersey, 350 percent of poverty is going to give you the same purchasing power for a family living there.

So I think to set arbitrary limits on a percent of poverty could actually inhibit the work that States are trying to do to cover more uninsured kids.

The CHAIRMAN. Right. Could you explain in a little more detail why dollars are necessary to reach out and find the children who are eligible but not covered?

Dr. LYONS. Because once those kids are covered, it will cost money to provide the coverage for those kids. Most uninsured kids—three-quarters—are actually eligible for CHIP or Medicaid but are not enrolled. Because CHIP is a block grant program, the funds are limited. So if you bring in more kids, under a block grant program you will not necessarily have more money.

The CHAIRMAN. As opposed to Medicaid.

Dr. LYONS. In Medicaid, financing is tied to the individual child. So the more kids a State enrolls—the State gets paid for each one of those kids. You get matching Federal dollars for each one of those kids.

When folks have looked at the formula to distribute CHIP funds to States, one of the options that they are looking at is whether to tie the distribution of funds to actual enrollment, which would get you——

The CHAIRMAN. And your thoughts on that?

Dr. LYONS. I think that makes sense. I think tying it to the number of kids whom you are enrolling in the program is a good way to make sure that the dollars follow the kids who are getting coverage. There are a whole slew of problems with the current CHIP financing formula which we are not going to have time to go into

today, but definitely keeping the dollars tied to the kids makes sense.

The CHAIRMAN. In your view, what is one of the largest problems with the current program? You said a whole slew of them we cannot go into.

Dr. LYONS. Oh, I am talking about the formula. The biggest challenge facing the program is really raising that total level of Federal dollars going into the program. That would help with a lot of the problems with even the distribution of funds across States if there is just more program money there. And I would reiterate that the need for the program has grown so dramatically since CHIP was enacted, while Federal financing has stayed relatively flat over the past 10 years on a year-by-year basis.

The CHAIRMAN. I would just remind everybody we are talking about how it is a matching program.

Dr. LYONS. Right.

The CHAIRMAN. It is Federal-State.

Dr. LYONS. The State spends money to cover children and then the Federal Government matches that.

The CHAIRMAN. Yet it is a block grant, so there is a cap.

Dr. LYONS. It is capped. The original program was capped at $40 billion over the 10 years, and that is different from Medicaid where the spending goes up the more kids you cover.

The CHAIRMAN. Would you say quality is a factor in allocation?

Dr. LYONS. On quality, I would say that we definitely have seen that covering kids with CHIP or Medicaid makes a big improvement in their access to care and their quality of care. During the first 10 years of the program, the focus really was on looking at enrolling those kids and seeing what works to enroll kids. Now that we are 10 years into it, it probably makes sense to look a little harder at the quality standards that are applied to the program. The current standards are voluntary and pretty minimal in terms of what States have to report.

Having said that, if there is going to be more requirements and more standardization of data that States are required to provide, again, I think the Federal Government has to help pay for that and provide money in additional administrative funds so that States are not bearing the burden of that.

Secondly, I would say that it would be good for the Federal Government to provide some technical assistance to States in reporting so that the data that actually is reported is meaningful.

The CHAIRMAN. Senator Cantwell?

Senator CANTWELL. Thank you, Chairman Baucus. I would like to follow on the same line of questioning. It seems like one of our challenges is that various States have different commitments, different economies, different fluctuations. The Washington State economy is very, very cyclical, so a couple years ago we thought we were going to lose our ability to cover about 100,000 children in Washington State because we had a downturn in the economy.

Dr. Lyons or Ms. Miles, how do you think that we standardize? I know you are saying we want flexibility in the program, but if we know how much insurance is going up, and we know what family income is, thereby showing how difficult it is to get access or coverage, why can't we set some national goals of what we would

like to see? And then, it is up to States to decide whether children's health care is a priority. Are there not some things that we should be doing there? I understand what you are saying about New Jersey because it is obviously a much more expensive place to live, but isn't the real equation here that we think at some level of income or some level of buying power, the availability of insurance for Ms. Anderson is not there? It is just not there in the marketplace. And so she would buy it if she could. She cannot.

I am getting at the question of how do we set a Federal standard or goal so that States know how to plan for that? Because I think they have the same dilemma in their fiscal policies and budgets. I am assuming, Ms. Miles, you have this dilemma here. You want to plan probably for 175 percent of the poverty level, but you want to know the Federal dollars are going to be there to match that, or else you will have a shortfall in the next biennium. Well, I do not know if you do it on a biennial basis here.

The CHAIRMAN. We do.

Ms. MILES. I would just comment that you have pointed out, I think, a very difficult problem, and one that we really struggle with in our State. When we start counting the uninsured and the people who have coverage, there is no quality indicator in there or comprehensive—I mean, insurance is not always insurance is not always insurance. I mean, some can be very catastrophic and you count them as covered, and some can be really aiming at the preventive type of insurance that Melissa was talking about.

So we do struggle with that, and I guess it would be interesting to see an analysis of what kind of coverage some of the States have and if there are some goals to get to some minimal floors, not just in terms of who is eligible but what kind of insurance and what kind of coverage does that provide. I think that would be a challenge to try to balance that, but I think that that is probably getting at a very key issue that should probably be of great concern to Congress.

Senator CANTWELL. Well, I would think, too, that a State like Montana or Washington could then plan for what we expect the potential impacted population will be over the next 10 years.

Senator Baucus has been a big leader on health care IT. We hope we make medicine more efficient. We hope we get coverage for many people, for working families like Ms. Anderson, to afford. But at the same time, we know this challenge we are going to be facing for the next 10 years. We are going to see an increase in health care insurance. We are going to see that cost go up.

So it would seem like you could probably pencil out for Montana exactly what that population increase is likely to be, could you not?

The CHAIRMAN. Isn't part of the problem because it is a block grant program? That is the problem, and that sort of begs whether it is worth even considering changing to an entitlement program. I think that is probably not in the cards in Congress given the history of it, but a block grant has its advantages—flexibility and so forth—and it has its disadvantages, too, in terms of budgeting.

Ms. MILES. Right.

The CHAIRMAN. You know, there is churning problem here, too. They are on for a while, then they are off, and that is obviously

a problem. There are immunizations, check-ups, and all those kinds of things.

What changes would you suggest in the authorizing legislation to help discourage churning, kids on and off all the time, so we keep kids covered for a longer period? Any ideas on all that?

Dr. LYONS. Well, I will agree with you totally, you cannot have quality, monitor quality, you cannot improve quality when you have kids popping on and off. You cannot hold anyone accountable.

The 12-month continuous eligibility that you have in the CHIP program in Montana, States have found that to be very, very useful in terms of keeping kids covered. That has not always been employed in the Medicaid program across States. It is much less likely to be used. That is a very important lever to keeping kids covered.

We have found that in most cases, when kids go off the program, it is really not because they are not eligible anymore. It is more because the paperwork did not get completed.

So, again, coming back to some IT help, if there was technology being applied to keeping kids enrolled, kids were enrolled for longer periods of time, that would help a lot with that churning.

The CHAIRMAN. Let me just touch on IT for a second here, information technology, health information technology. There is room for huge, huge improvement in productivity in the health care sector, especially with more dedication to information technology. I remember a couple years ago then-Chairman Alan Greenspan said that the one area that is lagging way behind and that has the greatest potential for productivity increases is health care, and a lot of it is because of all the paperwork and it is just a very inefficient system we have in this country.

The question is: How do we get better information technology? How do we get doctors and hospitals and everybody more electronically hooked up with compatible software, compatible systems and interoperability and so forth? But it does not happen because the doctors do not take it up and invest in it. It is not in their best interest in the short term to do so. Hospitals do not because it is not in their short-term interest to do so. A very small portion of the Medicare budget is dedicated to this. HHS does quite little.

I am just thinking out loud here. Is there a place for a requirement somehow that a certain percentage of these dollars that go to Medicare, Medicaid, CHIP, or something in reimbursement to doctors and hospitals, a certain percentage that they have to dedicate to IT? We have to have something here to kind of move the ball here, because there has been a lot of talk about information technology, but not a lot has been done about it. I am just trying to figure out some way to advance the ball. Your thoughts, any of you?

Dr. LYONS. Again, I think there needs to be some Federal leadership here because you have States at very different places around the country.

There has been some attempt through some of the Medicaid transformation grants in the Medicaid program to try to facilitate IT and electronic medical records. And I think that those demonstration projects will be very helpful in advancing the conversation, but, at the end of the day, I still think there needs to be more

Federal leadership, because there are just so many different parties involved.

Ms. MILES. Senator Baucus, I was going to thank you for the leadership you have shown on this whole health information technology issue, and one of the problems that we have in Montana, I think, is that the technology is changing so much faster than we are able to organize around. And every time we think we have some people talking the same language and looking in one direction, things change.

I think you are right that at some point there needs to be leadership saying that this is what we expect or this is what we want you to start looking at, because it has been very difficult for us to try to—it is a moving target, and we are jumping around, and we are not getting anywhere on it.

The CHAIRMAN. We have been trying, and by "we," I am speaking very generally. There was a fellow named Dr. Brailer at HHS, and this was his job. But he got discouraged, frankly. He was not supported, so he bailed out.

Ms. MILES. I am not surprised.

The CHAIRMAN. But it is our job just to pick up the pieces and get it moving.

Ms. ANDERSON. I would just like to say something. As a working person, you know, I, like she said, would love to go out and get some health insurance if I thought I could afford it and pay my taxes. I think there is a big squeeze that is bigger than this health care issue right now going on in America that is squeezing the working-class families to where they cannot afford to even buy that health insurance.

And so if you have a health insurance program, I know in the past they have had HMOs where you have had copays, but if you offered or extended an insurance similar to this for adults, I bet you would get a lot more takers.

The CHAIRMAN. I think it is clear as we move to universal coverage, probably we are going to expand programs like CHIP and Medicare and Medicaid, and also private incentives, tax incentives for more individual and group market coverage. We do not know exactly what it is going to be, but it is probably going to include some of them.

Ms. ANDERSON. Because right now all I have is accident insurance.

The CHAIRMAN. That is not right.

Ms. ANDERSON. And that is all I can afford, and that is $100 a month. Fortunately, it worked for me. A couple months back I had a shelf fall down, and I broke my nose, and it was 100-percent coverage at the emergency room, and I had to have a CAT scan, which was $775. But I am just telling you it is very expensive. Health insurance is very expensive. And so if we can work on the cost——

The CHAIRMAN. This begs a whole deeper issue, and that is health care costs in this country.

Ms. ANDERSON. They are very high.

The CHAIRMAN. And we have to get a handle on that sooner rather than later, or else this system could possibly collapse. We have to get started.

Senator CANTWELL. Well, Mr. Chairman, I know you want to go to the next panel.

The CHAIRMAN. Okay. Thanks very, very much. We appreciate it. Thank you. [Applause.]

The next panel is Dr. Janis Langohr of the Children's Clinic. Dr. Langohr will talk about her work as a pediatrician and the role that CHIP plays.

Also Representative Jonathan Windy Boy, who is Tribal Council Member of the Chippewa Cree and a Representative over in Helena. He can tell us what is going on over there, give us some guidance.

And Judy Stewart, a nurse, Director of Strategic Partnerships, Yellowstone City-County Health Department.

And Rev. Vernon Wright, from Helena. Rev. Wright is the Minister of Plymouth Congregational Church, and he will talk about his work in the community and also the moral imperative of providing health care for kids.

Let us start out here, and, I guess, Dr. Langohr, you are first.

STATEMENT OF JANIS I. LANGOHR, M.D., PEDIATRICIAN, THE CHILDREN'S CLINIC, BILLINGS, MT

Dr. LANGOHR. Thank you, Chairman Baucus and Senator Cantwell, for the opportunity to testify on a topic that is close to my heart: children and health care. As a pediatrician practicing in Montana, I can give a view from the trenches, so to speak, of the importance of the Children's Health Insurance Program to children and their families. Pediatrics, by its nature, is a profession that is highly reliant on government insurance programs such as CHIP. Our patients and their families are young. They do not have the resources to own expensive private health insurance.

Conservatively, 40 percent of the patients at our clinic in Billings are covered under CHIP or its larger companion program, Medicaid. In some pediatric practices around the State of Montana, the percentage is even higher. On top of that, there are 37,000 children in Montana who have no health insurance at all. Many of these uninsured kids are probably eligible for CHIP or Medicaid, but are not enrolled. In short, there is a very large number of children in Montana who need these programs in order to receive basic medical services. That number will grow as the escalating cost of health care and insurance continues to outpace Americans' income.

If one truly wants to know the value of CHIP, the question must be asked: What is life like for a child who does not receive medical care? Unfortunately, I have a lot of examples from my practice. One is the plight of a toddler with such rotten teeth and infected ears that he went on to develop mastoiditis, an exquisitely painful and life-threatening infection of the bone behind the ear. Or there is the teenage diabetic who shared her insulin with her uninsured diabetic family member to the detriment of them both. Another situation is one of an asthmatic teenager who made annual trips by life flight for about 3 years to a Billings hospital to spend a couple of days on life support before picking up a new supply of asthma medication, which he had depleted long ago. That is an expensive trip to the pharmacy.

All of these cases have common elements. First, loving but economically challenged families were involved. Secondly, all cases represent common childhood maladies that were left unattended and became life-threatening. Third, the cost of these cases to our health care system and our State was staggering. And, finally, the single most important element in all these situations is that they could have been prevented by providing these children with regular access to routine medical surveillance and care. In the decade since its inception, CHIP has been resoundingly successful in providing children with a medical home and improving their access to care. Dollar for dollar, the CHIP program represents one of the best returns on investment our society can make.

Yet access to care for children remains a critical problem in America. Dental services, mental health care, and services for children with special needs are woefully lacking. The parade of children with painfully decayed teeth that marches through our clinic each week is a testament to the crisis in dental care. Repeatedly, we also see children with significant behavioral and mental health problems who have nowhere to turn other than their primary pediatrician. And a recent survey of Montana families of children with chronic developmental and physical impairments, such as autism and cerebral palsy, overwhelmingly revealed that access to health care is their number one concern. These families feel isolated in the day-to-day struggle to care for their child. Poor reimbursement by Medicaid and CHIP to providers is the root of these problems. Providers must make difficult business decisions and limit or even exclude patients on Medicaid and CHIP, leaving families stranded.

Montana, with its small population sprinkled over a vast area, presents yet another unique challenge to providing care. Probably the best example here is of Montana children who are critically ill or injured. Fortunately, children rarely need such extreme care, but when they do, they need very expensive and highly specialized services specific to children. These complex services are difficult to coordinate in a rural State. Pediatric sub-specialists and surgeons generally migrate to well-endowed children's hospitals in large metropolitan areas. Critically ill children and their families must follow them there. Hundreds of Montana children are medically evacuated to larger pediatric medical centers each year at enormous cost to the State.

Senators, children and the problems they face are my personal passion. But, quite frankly, most Americans feel the same way I do. After all, children are our future. A country with such wealth, medical expertise, and advanced information technology has the ability to create a comprehensive health care system for children even in challenging States such as Montana. Ultimately, achieving that goal makes good economic and social sense. Although many challenges remain, CHIP is a model for achieving this worthwhile goal.

Thank you.

The CHAIRMAN. Thank you, Dr. Langohr, very much. That was very good. [Applause.]

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

The CHAIRMAN. Representative Windy Boy?

STATEMENT OF HON. JONATHAN WINDY BOY, COUNCIL MEMBER, CHIPPEWA CREE TRIBE BUSINESS COMMITTEE; AND MONTANA REPRESENTATIVE, HOUSE DISTRICT 32, BOX ELDER, MT

Mr. WINDY BOY. Thank you, Mr. Chairman, Senator Cantwell. I have about 20 pages here.

The CHAIRMAN. Well, if you want, we can put it all in the record. Do you want that?

Mr. WINDY BOY. Actually, I think that I do have this in for the record.

The CHAIRMAN. Well, we will put your whole statement in the record.

Mr. WINDY BOY. Mr. Chairman, one of the things that I would like to focus my testimony on is some of the underfunding that IHS has had. You are aware of how underfunded the IHS has been. The reason why it is so important to keep the funding levels more at a parity level is because right now, using my tribe for an example, I only have enough contract health service dollars to be able to take care of emergency level 12, which is a life-or-death situation.

The CHAIRMAN. And that is all-year-rounders.

Mr. WINDY BOY. That is all-year-rounders, and right now, with the amount of money that we have, it is not even close to where we need to be, because, as you heard earlier, preventive medicine is probably more feasible in mainstream America.

One of the things that I would like to also go into as well is a couple years ago, during the last legislative session, I had the opportunity to put in House Bill 452, which calls for a demonstration project between the tribes, the State, and the Federal Government, which is coming along pretty well right now, and I have a couple staff in Garfield, and the IHS has also been instrumental on that part. And what that did—I always think of wanting to think outside the box on situations and how this would work. Right now some of the Indian children who are under the current CHIP program—and others use hypothetically the number 3,000—and if we had 3,000 Indian kids who were on the CHIP program, what this bill would do is to move them over to the Medicaid program. And the reason why that would be—the advantage of doing that—is that once you move them away from CHIP, put them under the Medicaid program, Medicaid fully reimburses the State 100 percent under the FMAP, and by doing that, that would free up those slots for other people who are eligible for the CHIP program.

So there are some things that I think will be advantageous as far as where we are going with the CHIP program, and I think that we need to be more proactive about things. We can throw billions of dollars into a program like we threw billions of dollars into Iraq, and it is not going to solve the problem. We need to come up with situations and ideas and things that are going to solve the problems, and I think that thinking outside the box is the way to go.

One of the things that I would like to point out, Mr. Chairman, is that we mentioned some of the road blocks, and the last couple of years I have been thinking about the Federal poverty level. I have a graph here, Mr. Chairman, about the current poverty level. In a family size of two, $20,535 is considered poverty level, and at 200 percent it is $27,380, and the Federal poverty level in the for-

mula has been in place since the Eisenhower days, and I think that if we were to take a look at the Federal poverty level and the formula, how it has been, and putting the numbers—nowadays, the cost of living, the cost of health care, and all of these other rising costs that we are faced with today as opposed to what was in place back in the days of Eisenhower—I bet you would probably have a lot more real picture because, you know, $27,000 20 years ago was a lot of money and $27,000 at 200 percent 40 years ago was a lot of money. And if we continue to raise the Federal poverty level, like you mentioned that New York and New Jersey are considering, to 350, 400 percent, you know, that is unreal. And if we are to go that route, I think that with the existing Federal dollars that are coming down for IHS, I think we would probably be at 800 percent. So I think, you know, the difference of the parity of the levels of dollars is coming down. I think that we need to take a look at the whole system of care.

Thank you.

The CHAIRMAN. Thank you very much, Jonathan. Thank you very much. [Applause.]

[The prepared statement of Mr. Windy Boy appears in the appendix.]

The CHAIRMAN. Okay, Judy. You are next.

STATEMENT OF JUDY STEWART, DIRECTOR OF STRATEGIC PARTNERSHIPS, YELLOWSTONE CITY-COUNTY HEALTH DEPARTMENT, BILLINGS, MT

Ms. STEWART. Good afternoon, Senator Baucus and Senator Cantwell. I am sitting here trying to be nonchalant about this, but this is really an honor to be participating in this, and I thank you for the opportunity and the invitation.

The CHAIRMAN. The honor is ours, believe me.

Ms. STEWART. Thank you.

As the Director of Strategic Partnerships for the Yellowstone City-County Health Department, I have the opportunity to collaborate with multiple stakeholders in our community to create and implement viable solutions to problems that are too difficult, if not impossible, to solve individually, and the issue of the uninsured is certainly one of these issues. With the rapidly growing number of uninsured people in our country, this can no longer be considered an individual problem. It is a community, State, and national problem, and has and will continue to require a collaborative, creative, and cooperative approach in solving.

There is a direct cause and effect between not having health insurance and poorer health outcomes, and it has been proven that the uninsured live sicker and die quicker. Without insurance, people avoid preventive health care. Routine illnesses, left untreated, may progress to serious and potentially chronic conditions. An example of this recently made headlines when an 11-year-old boy died of an untreated dental abscess. And this did not happen in a Third World country. This happened in the United States of America, and I think that is unacceptable.

Why is reauthorization so important, especially for the residents of Montana? As compared to the other States, Montana has the 14th-highest uninsured rate in our Nation. Montana's per capita

income ranks 48th in the Nation, with only West Virginia, Arkansas, and Mississippi having lower incomes; 14.2 percent of Montana's population falls below the Federal poverty level, and 19.2 percent of our children do, and that is compared to 12.5 percent nationally. Without CHIP, these children will have very limited options for preventive care, dental services, mental health care, and assistance with prescriptions and vision care.

On March 1st, there were almost 13,300 children enrolled in CHIP. That is a 9-percent increase in the number of children enrolled over this time last year. Even with this increase, there remain an estimated 35,000 uninsured Montana children, many of whom would be eligible for CHIP, and there is currently no waiting list for those who qualify.

I think there are three priority areas that must be addressed in order to utilize and maximize CHIP.

The first is education. Communities need to take a leading role in educating about the availability and the benefits of CHIP while dispelling the misconceptions about CHIP eligibility. For example, one common misconception is that being a working parent automatically disqualifies your child from being eligible for CHIP, or that if you are Native American you are ineligible for CHIP. Providing parents with this correct information is the first step in insuring more children.

The second priority is that communities must work to decrease barriers for families that need to apply for CHIP. Over the past 5 years, Billings Clinic, St. Vincent Healthcare, and the Yellowstone City-County Health Department have worked together to highlight issues of the uninsured during "Cover the Uninsured Week." Recognizing CHIP as one of our most valuable resources in combating the growing number of uninsured, it has been a top priority for this partnership to increase CHIP enrollment over the past 2 years. We identified that the stigma attached to being uninsured continues to be a significant barrier for families. Even now, when one in five Montanans are uninsured, people are embarrassed by the fact that they are unable to provide health insurance for their children.

In response to this, we have hosted two CHIP Champion luncheons where people from a wide variety of organizations come together and they are trained in how to assist families in completing the CHIP application. Our hope is that in our community parents will experience "no wrong door" when they are accessing information on CHIP. People will not be "referred" on. They will be assisted by the first person they talk to about CHIP, someone they already have a trusting relationship with.

We have also promoted CHIP at local enrollment fairs at schools. Our first one was a couple weeks ago at Lockwood School, and our second one is planned for Laurel in April. The intent is to offer the information and assistance in an environment that is safe and familiar to the family. These activities, combined with the traditional access to CHIP enrollment, have resulted in a 20-percent increase in CHIP enrollments in Yellowstone County over the past year.

The third priority needs to be improved access to services for those who have CHIP. Unfortunately, there are providers that do not accept children covered by CHIP, especially in the area of dental care, and improved access to a full complement of health serv-

ices is vital, and I encourage you to support increased funding for the expansion of community health centers that offer access to health care services not only to CHIP recipients, but to everyone, regardless of their inability to pay.

I have a job that falls outside what most people would consider the "conventional" nursing career, in that I do not work in a clinic or a hospital. And at times it has made it very difficult when my children have tried to explain to their friends what I do for a living. So I am always kind of interested to hear what they are telling people, and they have come up with some interesting things.

One day I overheard my 11-year-old talking to a friend of his who had just asked him that question, "What does your mother do?" And so I kind of listened, and he said, "Well, she is a nurse and she helps people who are poor and they cannot go to the doctor because they do not have any money to pay." And, you know, I was pretty impressed. That is fairly close, probably closer than a lot of times what they get to. But it was his next statement that stopped me in my tracks, and this is coming from an 11-year-old. He said, "Can you believe there are kids out there who cannot go to the doctor when they need to because they do not have insurance?"

It is my hope that in the very near future every Montana child will have health insurance and they, like my 11-year-old, will find it incomprehensible that there are children living in our great country who do not have access to health care.

Reauthorization of CHIP is imperative if we are to meet this goal, and I thank you today for allowing me to be a part of this very important discussion, and I very much appreciate you making this a highlight of your work in Washington, DC.

The CHAIRMAN. Thank you, Judy, very, very much. Thank you. [Applause.]

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

The CHAIRMAN. Rev. Wright, that is a good name. [Laughter.]

STATEMENT OF REV. F. VERNON WRIGHT, PLYMOUTH CONGREGATIONAL CHURCH, UNITED CHURCH OF CHRIST, HELENA, MT

Rev. WRIGHT. Thank you, Senator and Chair. It is an honor to be here. I am grateful for your leadership of this country in a difficult epoch.

I want to just tell you I have been brought before you today as an ordained United Church of Christ minister, and I want you to realize that I recognize the legitimacy of other faiths across this great Nation, but it is from my own tradition that I speak as an authority. So I am going to share with you that tradition. I, like many in the United Church of Christ, am a Congregationalist. We founded Plymouth Colony and Massachusetts Bay Colony in the 1600s. Fifteen of us were signers of the Declaration of Independence. Congregationalists defended the slaves on the Amistad slave ship, advocated for more humane living conditions for immigrants at the turn of the century, labored for civil rights in the 1960s, and have continued to be advocates for the poor, the dispossessed, and the disenfranchised in this country. Today, over 35,000 Montana kids and 8.4 million children across this country have no health

care coverage, and this I think constitutes not only an economic crisis but a moral crisis for our Nation. Standing firmly in a deep U.S. religious and civic tradition, I would urge you, along with thousands of UCC churches and other mainline churches and many mosques and synagogues across this country, to not only reauthorize CHIP but to expand it.

Jesus Christ, and the Hebrew prophetic tradition represented in the narrative of Jonah, for instance, had a new vision of humanity in which all human beings—elders, children, women, men, slaves, free, Jews, Gentiles—were one in the eyes of God. I think that is what we recognize when we say that we have one Nation under God. Standing on the tradition of the Torah, where true worship of God is marked by justice and mercy, Christ taught God's reign would become manifest when we serve the last and the least out of loving concern. And children at that time, just as they are today, truly were the last and the least, which is why Christ spends so much time in the narratives welcoming them, healing them, and loving them.

I have a young family, and as a minister I minister to many other young families. I am somewhat acquainted with their needs. Many children my two young sons go to school with are distracted because they are living with horrendous coughs and toothaches festering long enough for trips to emergency rooms. A child for whom the only option when dealing with a toothache or walking pneumonia is the emergency room is a child who lives in constant threat. According to many child psychologists, such as Dr. Bruce Perry, for instance, the brain does not develop well under threat, and the greater the threat, the more severe the handicap of brain development. Each week my church and countless other churches in my community give to families to buy food and medicine so that their futures and the futures of our communities might not be diminished. But what we can afford to give as churches and other religious organizations is just a drop in the bucket, and it does not keep families from sliding down further and further into the pit of dysfunction. That is why we need a society that stands for something more than personal gain, where the common concern is something larger than what hard-working synagogues, mosques, or churches can provide alone.

Fortunately, we do not stand alone in this conviction. It is out of this faithful concern that Jonathan Winthrop wished that this new Commonwealth truly would become a Beacon on a Hill and Light of the Nations. As he prayed to God for deliverance from a storm off that land which would become Boston: "Now the only way to avoid this shipwreck, and to provide for our posterity, is to follow the counsel of Micah, to do justly, to love mercy, to walk humbly with our God. For this end, we must be knit together, in this work, as one man. We must entertain each other in brotherly affection. We must be willing to abridge ourselves of our superfluities, for the supply of other's necessities. We must uphold a familiar commerce together in all meekness, gentleness, patience, and liberality. We must delight in each other; make other's conditions our own; rejoice together, mourn together, labor and suffer together, always having before our eyes our commission and community in the

work, as members of the same body. So shall we keep the unity of the spirit in the bond of peace."

And so we must ask: What kind of light in the world as a Nation are we if our children are without health care?

I see I have reached beyond my 5 minutes here.

The CHAIRMAN. You have a little grace period there.

Rev. WRIGHT. I am almost done.

What kind of future are we providing for our children, the future of our Nation, when we allow for millions of American children to be so vulnerable? Truly as a Nation, are we not headed for shipwreck? I think the moral thing to do is not only reauthorize CHIP, but to act on its expansion, as you stated earlier. In the end, the greatness of our Nation is measured not by our might but by the health and well-being of our peoples and the mercy and compassion of our governance.

Thank you.

The CHAIRMAN. Thank you very much. I appreciate that. Very nice. [Applause.]

[The prepared statement of Rev. Wright appears in the appendix.]

The CHAIRMAN. Judy, as we work to reauthorize, are there certain sorts of institutions that tend to help work better for outreach than others? And a lot of people do not read the newspapers. A lot of people do not even watch the evening news at all. A lot of people, how do they get their news? Sometimes it is just if they have TV, it is the soaps or something else, who knows what. As you mentioned earlier, it is just the decisions that people have to—you mentioned like an appointment earlier today, maybe 6 weeks down the road, that is an eternity in the lives of an awful lot of people.

So is it schools? Is it churches? What is it that tends to work a little bit better than other institutions to reach people whom maybe when we reauthorize this we might be aware of as we try to encourage more outreach? Or is there something else? Because you know a lot more about this.

Ms. STEWART. You know, I think the important thing is to go where the populations are, and I think we need to make more of an effort to bring the information to them.

The CHAIRMAN. How do we do that?

Ms. STEWART. I think, you know, school is the logical choice. You know, they are surrounded by people that they are familiar with. A lot of times the parents will have relationships if with no one else other than the school secretary who they are having to call in to and say your child is sick because they are home with a sore throat, or the school nurses are certainly a logical point as well, school counselors.

I think if we work with the schools to get that information out and accessible to them, that will make them feel comfortable with sitting down and helping people. I think there goes with it a certain amount of training, because a lot of times people feel very uncomfortable talking to people about: Well, how much do you make, or do you have insurance?

I think we need to get past that and realize that, you know, it is such a common problem, we need to do what we can to decrease

that stigma to people. And church is, you know, another great opportunity to reach out and get to people.

I had sign-up information at our Little League sign-ups for people who are coming through.

The CHAIRMAN. Sports, yes, that is one area.

Ms. STEWART. So I think communities really need to work with what works for them, and you need to be able to find out where are the children, where are the low-income folks—or the middle-income people—who may have access to this, because if one in five of us is uninsured—one, two, three, four, five; one, two, three, four, five—you know, there are people everywhere. There are people in the grocery stores, sitting next to you in church, sitting down the aisle from you in school. So any place that children congregate—Head Start, another great opportunity for that.

The CHAIRMAN. That would be one, yes.

Dr. Langohr, on the question of access, you know, particularly with dental care, it is sometimes hard to find doctors, providers, for dental care. How do we kind of get from here to there and sort of connect the dots a little bit? I am just a little bit frustrated on how kids qualify but just the doctor says no, they are not taking them, or if the doctor is not there, or whatnot. What do we do about that?

Dr. LANGOHR. Well, I share your frustration. You know, I think the root of that problem really has to do with reimbursement. Dentists just cannot provide for CHIP or Medicaid because they are not being reimbursed at the level they should. Also, there are so many issues to access to care.

The CHAIRMAN. Should we address reimbursement in legislation?

Dr. LANGOHR. I think absolutely that has to happen. Pediatrics in general is not a very well-reimbursed profession. I am not speaking from the sense of a general pediatrician, but if you compare our services to services for the elderly, the reimbursement is much lower. So it is kind of undermining our profession in many ways, especially for surgeons and sub-specialists and people who do the hardest work, the developmental folks and mental health folks. So the infrastructure is poor because reimbursement is poor.

The other issues of access to care have to do with transportation, poverty, people in transition, people not making appointments. And if you are dentist and you want to work on a child's mouth and you allot an hour for it and they do not show up, you know, eventually you are not going to take that group of patients who do not show up. So what do you do? Dental clinics in the community, do you tie dental clinics with schools? I think there needs to be some rethinking of the infrastructure in terms of providing child care that we could enhance. What is the role of hospitals? What can we do for hospitals? How can we help these clinics? What are the services that are needed? How can we help them in rural States?

Montana is very troubled because we just do not have the infrastructure here for access to care.

The CHAIRMAN. Judy mentioned community health centers. Is that a role here? Is that part of it?

Dr. LANGOHR. I think absolutely that is a role, and certainly there are dentists with the community health centers. But there are just not enough, and those programs have to survive, too, on low reimbursements.

The CHAIRMAN. Maria?

Senator CANTWELL. Dr. Langohr, following up on that, what happens when somebody comes to see you who does not have either CHIP coverage or Medicaid coverage? What happens?

Dr. LANGOHR. You mean the uninsured?

Senator CANTWELL. Yes.

Dr. LANGOHR. We do not deny access to people at all at our clinic. They get billed for our services, and over time, if they cannot pay, that builds up and builds up and builds up, and eventually you have to make a business decision about coverage for people.

It is not a decision we make very easily at the Children's Clinic, and, quite frankly, it is not a decision that we make very well in terms of business sense, because it is very hard to deny people care. But there is a limit at which you cannot survive if you continue to do unreimbursed care.

Senator CANTWELL. Did you want to add to that?

Mr. WINDY BOY. Yes, if I can. You know, we are kind of in a similar situation with the tribes because of what I mentioned about the Level 12 health care that we offer. There are some times we have emergencies, not only under dental, but we also have under emergency health care just in general medicine. And a lot of times when IHS or our Contract Health Service dollars do not cover that, then eventually the providers outside the reservation, like the doctor said, the business decision is made there, and a good majority of people who cannot afford that, get billed for that, and their names end up in the credit bureau and stuff.

Senator CANTWELL. I am sure one of your points is to make sure that there are funds within the Indian Health Service to cover access. But back to this question, one thing that I am curious about is, do you think that we actually have the documentation about who is getting turned away and what those costs are later in the system, because, as you are articulating, at some point in time, it is uneconomical to just keep providing that.

I have found in our State, we find physicians do not really want to say, "I am not serving this population anymore." They do not really want to say that. It is not documented. It is not covered. And so when you want to come back to try to paint the picture of what is really happening, it is hard to do that because we do not have adequate information.

Dr. LANGOHR. I would say that that information is very difficult to divulge. It is not something a clinic wants to divulge.

Senator CANTWELL. How can we encourage that in some non-attributable way that would help us really categorize the problem? Because part of our challenge in Washington, DC is to make these decisions and to allocate resources, by finding out what services are there and are not there. Sometimes because of this reporting issue, it can be very, very challenging. And I am sure those patients who are not seen by your clinic or are not seen by Indian Health Services do show up back in the system at a much higher cost later. There is so much here that is preventive, but putting our finger on the solutions is very hard.

Let us just say, for example, if we found out that, 100 percent of all physicians turn away—I do not know—5 percent, whatever it is, that might better help us in fashioning a solution. But that

information is challenging, so maybe there is a way to get it without having it attributable to specific clinics.

Ms. STEWART. If I may add, one way that I think it is very indicative of the issues is, you look at emergency room visits. We did a recent study here about dental access, and both the local hospitals were very nice to work with me, and we just worked with three basic dental diagnoses. And so those people who entered into the emergency room with those three diagnoses, we looked at the utilization. And I think that is very telling when, you know, the majority of the people would access care in practically the most expensive arena for, you know, a toothache, and saying, you know, well, this is because they could not get to a dentist or, you know, they are accessing emergency rooms for a sore throat. I think that is very indicative of access issues.

Senator CANTWELL. The reason I am bringing this up, Mr. Chairman, is, obviously our overall Medicare reimbursement rate in Washington State is problematic. It is one of the lowest, and we have seen fewer and fewer physicians practicing in certain areas because they want a higher reimbursement rate somewhere else.

We asked CBO to do a report, which then came back and said, there is not really an access problem—partly because the information was not available to document the problem and partly because people can still go to the emergency room. But, obviously, if they go to the emergency room, it is a higher cost of care. So in looking at the CHIP program, I sometimes, particularly as it relates to dental care in whole regions that do not have access, you almost think about some sort of voucher or something that could be presentable to a variety of health care providers, because I know the waiting period at the clinics in our State is just a horrendous length of time to get access to some of the clinics.

The CHAIRMAN. Senator Cantwell makes an excellent point, and that is data. You know, so often we are sitting there, and we are trying to do the right thing. But, boy, I will tell you, our decisions are based on gut, hunches, intuition, experience, and so forth, all of which is valuable, but it would help us a lot if we had a little more data all the way around.

So I encourage the State to try to figure out ways to come up with data, you know, and, Jonathan, your reservation, and others perhaps, maybe the legislature. I was very intrigued with your idea of transferring CHIP over to Medicaid. That is very outside the box. But it is just data. What is happening? Which kids are accessing, which are not, how many turned away? Senator Cantwell's point, because it just helps us so much if we have some data. I encourage all of us to try to—particularly you on the front lines working at this, because you have—you are closer to the data, and it would help us very, very much.

Rev. WRIGHT. I just think, you know, we talk about data, we talk about particular aspects of the health care system itself. But I think we as a Nation really need to be able to rearticulate our neighborhood vision.

The CHAIRMAN. Clearly.

Rev. WRIGHT. And, you know, serving a church that has Republicans and Democrats both in there, I can tell you from experience that they are both compassionate people, and they are both quite

concerned and willing to give vast amounts of money for serving other people. But they have a different way of articulating the role of the State in that. But I think that, you know, as a Nation, if we talk about a neighborhood concern, we can start to approach some of our values that we really do hold in common.

I know that you do a lot of work in a bipartisan way. You have to. But, you know, our own State situation right now is appalling because we are not getting to the real issue of the human being.

The CHAIRMAN. I think the smaller the community, the more the community itself can work it out to find solutions. The trouble is that we are such a big country, and we are talking about Federal legislation. And so lots of Senators and House Members sitting back there in Washington, DC want to do the right thing and get home as much as humanly possible, but still rely more on data, on evidence, whereas the smaller the community, the more that is in a certain sense less necessary because people will do the right thing in most cases.

Rev. WRIGHT. But it is vision that drives it all.

The CHAIRMAN. It is vision.

Rev. WRIGHT. It is your values.

The CHAIRMAN. It is clearly vision, but we also have choices, and it is dollars, unfortunately, and it is allocation of dollars. And so we clearly want to persuade people to allocate dollars in a way that makes sense.

Senator CANTWELL. I would just say, Rev. Wright, that you definitely have a vibrant spirit and a rich soul for someone so young, and we appreciate your testimony. I think it is moving. I hope that Senator Baucus can invite you back to persuade and evangelize for many of our colleagues. But, unfortunately——

The CHAIRMAN. I am not going to touch which side of the aisle that needs to be on. [Laughter.]

Senator CANTWELL. But, unfortunately, since I have been the victim of the very thing he is talking about—take, for example, veterans' health care, another thing that your Senators, Senator Tester and Senator Baucus, and my colleague, Senator Murray, and I, we have all been concerned about. Yet if you go back to the debate, we had these debates on the Senate floor where the response to our concern is: "Well, care is there; care is being provided." And yet this panel just basically talked about the holes in the current network that you all are trying to close.

So what is helpful for us to win the day in the debate is to show exactly how people do fall through the cracks and to show that the population is not getting served. Otherwise, people look at the overall amount of money, or they look at the program, and they say, "Well, you know, this is covered." I wish you the best of luck with the Governor of Montana and persuading the legislature to do the right thing. As I mentioned, Washington State started a program in 1994 prior to any Federal program. But, you have to have the commitment on both levels, and oftentimes when people disagree, the commonality that can get them to agree is common data. And so, hopefully we can have both your spirit in DC on this important issue and the data to make the case.

Rev. WRIGHT. The dysfunction, though, is larger than one issue. The impact of poverty goes far beyond one particular issue. So I

think until we as a Nation can grapple with the many different streams that contribute to poverty and what it is, we are going to be in trouble.

Senator CANTWELL. I do not know if that is applause or somebody wants to come in. [Laughter.]

But I would say, you know, it is one of the reasons why I decided to join this Finance Committee, because I think that Senator Baucus shares a vision of where we need to go in eradicating that. By that I mean an investment in the future. And I think this Finance Committee has a great ability to make some of the decisions that will eradicate poverty by saying, let us make college education more affordable, let us make access to health care a guaranteed benefit for the children of America, let us make sure that we are giving families the opportunities to help themselves.

But when you come back to that budget equation, you really do have to actually count votes, and the challenge that we have is that, again, some people will use a lack of information documenting the problem as a way to basically deter progress. And I think the commitment level for something like the CHIP program is bipartisan, but when you come down to how much money should be spent, I would like everybody to say let us cover 200 to 250—or whatever the adjusted rate is. And I might be more willing to make it an even more aggressive program because we in Washington State have gone further than other States. But I hope that that Federal program could be designed to bring States along that have not been as aggressive.

The CHAIRMAN. That is why the values that you espoused, Reverend, are exactly the goals that we are seeking to achieve. You are a beacon. You are a guiding light here. We are going to do all we can to follow that light.

Mr. WINDY BOY. Mr. Chairman, could I enlighten you on what is going on?

The CHAIRMAN. I would love to be enlightened.

Mr. WINDY BOY. Mr. Chairman, I know I spoke on a tribal level, but if I can give you hopefully a little bright light from Helena as well. There are a couple things.

It is unfortunate what has happened in the legislature, and the citizens of Montana, I am sure they probably have some concerns about some of this, especially these particular issues. There were two bills that have been increased, and you probably heard about them: there is that 200-percent eligibility bill that Representative Mary Caferro out of Helena sponsored, and then that has been sitting in appropriations since January; and the other one that is coming from the Senate side, Senator Weinberg had 175 percent and that is still making its way through. But one of the things that was interesting on the dental, there was—Representative Bill Jones has sponsored a couple bills that included dental, so that is one of the good things to come out of that. But some of the other things that I think probably need to happen on the State level as far as some of the eligibility, and that is one of the things I see as one of the barriers, is determining eligibility. And I think that if we—and if the forms and the applications were shortened up to the point where it is more user-friendly, I think that would really make a difference.

The CHAIRMAN. I was going to ask several questions along that line, but we just do not have the time right now.

Mr. WINDY BOY. And then one more thing, too, you know, as far as eligibility and other things: I think methamphetamine is going to be an issue, and the mental health issue I think probably needs to be addressed at some point.

The CHAIRMAN. Thank you. Thanks for all that you do, Jonathan. You do a good job.

Let us thank our panel. They have been just great. [Applause.]

Now we are going to get to the third panel, and that is all of you. We will have a question-and-answer session here.

Since this is a formal hearing, I would like each of you to identify yourselves. Please give your name and the organization you might represent and where you are from. We need that for the record. Also, if you could be very brief. We do not have an awful lot of time here. We have about 20 minutes. So please get straight to the point, which then means other people have time to make the points that they want to make. You all can stay up here if you want, because then you can see people, listen to them, and so forth.

We have a couple of people with prepared remarks, and I urge them to be very brief as well. Dr. Kevin Rencher is a pediatric dentist from Helena, as well as Clark Sauers, a high school student who is on the Health Insurance Program. Clark is also from Helena.

STATEMENT OF DR. KEVIN RENCHER, PEDIATRIC DENTIST, HELENA, MT

Dr. RENCHER. Good afternoon. My name is Dr. Kevin Rencher. I am a pediatric dentist in Helena, MT. I am in private practice in Helena. I have been there for 2 years. I also volunteer on Wednesday afternoons at the local community health center. The reason I do that is so that kids who cannot afford dental treatment can see a specialist at the community health center.

As you know, a month ago a 12-year-old boy died in Maryland from a dental abscess. He had a toothache that spread into the bone and spread into his brain, and he died.

Two weeks ago, Senator Baucus, I was meeting with some members of your team, and one of them asked me: "Could this happen in Montana?" My answer was that it absolutely could happen in Montana. And they said, "Well, how often do you see it in your practice?" I said, "Well, I do not know. I will have to go back and look."

Well, it has been 2 weeks exactly since I left your office. In the last 2 weeks, I have seen 5 children who have had severe, severe dental decay. When I say "severe," I mean 20 teeth, at least 20 cavities. They show infections, pain, have been on antibiotics for weeks. Out of those 5 children that I have seen in the last 2 weeks, one was from Havre, one was from Box Elder, one was from Great Falls, one was from Butte, and one was from Dillon. Dillon, MT. And those patients have been coming to my office. I am in Helena.

Had their parents waited any longer for them to seek care, they would have become the next dental tragedies. There is a tremendous amount of need in this State, a huge unmet need.

There are four statistics that I think it is important that everybody understands. Dental disease is the most common chronic disease in childhood. For every child with unmet medical needs, there are 3 children with unmet dental needs. More children miss school for dental disease than for any other reason. And, finally, for every family with no medical insurance, there are 2½ families without dental insurance.

For me to come here today, I had to reschedule 40 patients. Out of those 40 patients, a handful of which have been in pain for several weeks and have been on antibiotics, as my office called these families to say, "Listen, we are going to have to reschedule you," I was afraid that they would be frustrated or disappointed that we had to reschedule them. To my surprise, and to my great happiness, they were grateful that the Senate Finance Committee was holding this hearing, because these parents understand how important the dental component is to CHIP.

There are three things that we need from the Federal Government. First, CHIP needs to be reauthorized with a much stronger dental component, and there are three things that we need.

First, we need a Federal guarantee for dental coverage. Too often, when States have to make cuts, they cut out the dental, and that is why we see such a problem from the dental component. There needs to be a Federal guarantee for dental coverage.

Second, we need to allow States to offer dental coverage to those children via a dental wraparound. There needs to be some sort of dental wraparound so that children do not lose their dental benefits when their parents receive medical coverage. Oftentimes, that medical coverage does not cover dental, and those children are being dropped from CHIP.

And, third, we need to require States to report their dental performance so we can look at the data. Right now the data is extremely lacking when it comes to the dental procedures. We need to have that data so that in 10 years we can have a much more educated conversation.

I want to go back to these 5 kids. These 5 kids truly were weeks, maybe months, from being the next dental tragedies. Havre, Great Falls, all over the State, they are having to drive to get their dental treatment completed. We need to do all we can to remove those barriers, and by reauthorizing CHIP with a much stronger dental component, we could remove some of those barriers.

Thank you both for your time and your energy on this very, very important children's oral health issue.

The CHAIRMAN. Doctor, thank you. That is very compelling. Very helpful. [Applause.]

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

The CHAIRMAN. I know we do not have time, but I am going to jump in. Why do States tend to drop dental coverage first? Does anyone want to take a crack at that for about 30 seconds? They do? Why? If they do, we have to find out why and do something about it.

Okay. Yes, next?

STATEMENT OF LORI SIMON, MARCH OF DIMES, BILLINGS, MT

Ms. SIMON. Hi, I am Lori Simon with the March of Dimes, and I would like to thank you, Senator Baucus, for holding this important hearing to discuss CHIP.

The March of Dimes is very concerned with ensuring that pregnant women have access to the full spectrum of maternity care benefits. This gives infants the best chance for a healthy start and protects the mother's health.

Currently, if a State wants to cover pregnant women in CHIP, they have to get a special waiver or go through a regulatory process that does not allow reimbursement of medically necessary postpartum care. Do you support giving States the option to cover pregnant women in CHIP without a waiver? And will you include a provision to grant States this option in your reauthorization bill?

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

Okay, next? Do not forget. Name?

STATEMENT OF CLARK SAUERS, SENIOR, PROJECT FOR ALTERNATIVE LEARNING, HELENA, MT

Mr. SAUERS. My name is Clark Sauers. I am 17 and a senior at the Project for Alternative Learning.

The CHAIRMAN. All right. And from Helena.

Mr. SAUERS. From Helena, yes.

The CHAIRMAN. Thank you.

Mr. SAUERS. I am here today to talk about my experiences with CHIP, and what I have had is—well, let us just start with I am a very accident-prone person. [Laughter.]

The CHAIRMAN. You are a teenager.

Mr. SAUERS. I am a typical guy, 17, I watched the "Jackass" movies and did not heed the "Do not attempt this stunt" warnings.

Well, a laundry basket and a staircase later, I was in the hospital having surgery on my foot, and CHIP helped me a lot with that. When I walked out the door, I had to pay $3. And without CHIP, I do not know how I would have been able to come up with the money.

And not only that, but I am also here today to say that kids—I mean, generally, when these bills are talked about, nobody talks about the kids that CHIP affects. I mean, they are talked about, but no one talks to them. And that is also the fault of the kids because nobody knows that you can come up here and speak. And one of the reasons I came today was to show that I am up here, I can do this, I am talking, just know that your voice can be heard and that more people should be coming up here and talking about things that affect them.

Thank you.

The CHAIRMAN. Good. Good for you, Clark. [Applause.]

STATEMENT OF ERAN THOMPSON, MONTANA PEOPLE'S ACTION, BILLINGS, MT

Mr. THOMPSON. My name is Eran Thompson. I represent Montana People's Action from right here in Billings. We are here today to do two really important things. The first one is to make sure that folks who could not attend, that their voices had an oppor-

tunity to be heard. The second one is to stress two essential points that we feel are important for the reauthorization of CHIP.

So starting with our first point, really quickly, we have spent the last few months organizing our interns to go out door to door, to stand at tables at food banks, to be at Family Services, wherever they could, to find CHIP families and to find people who should be CHIP families.

The CHAIRMAN. Good.

Mr. THOMPSON. And in doing so, we published a storybook that is available. Our interns have it back there. It is also available on our website.

The second thing is we talked to some of our friends in Washington, and so Washington Can, a nonprofit organization there, has sent for you, Senator Cantwell, a letter, a sign-on letter, with several organizations from around the State of Washington to express their concerns about reauthorizing CHIP.

For Senator Baucus, we have also talked to several Catholic churches who wish they could be here today, and I have a sign-on letter for you from several Catholic parishes around the city.

That moves on to our two essential points. You will see the two flags in front of you on those chocolate chip cookies that were given to you by Caden and Ethan, members of the Montana People's Action families.

The first point of those is that $50 billion is great, $60 billion is better. [Laughter.]

The CHAIRMAN. It is. I agree.

Mr. THOMPSON. And we will have plenty of time to talk about that some other time.

The second one is a very important and a not often well known in Montana issue, and we will rise today to ask you to support removal of the 5-year bar for the State Children's Health Insurance Program. Under current Federal law, lawfully residing immigrant children and pregnant mothers are barred from Medicaid and CHIP for over 5 years. This restriction has increased racial and ethnic health disparities among children in the U.S., and despite immigrants' high rate of employment, almost half of low-income immigrant children are uninsured, at a rate three times higher than that of our children from native-born families.

Failing to provide basic preventive health care for immigrant children jeopardizes their health and creates a need for more expensive subsequent care. Similarly, failing to provide prenatal care risks the health of newborn U.S. citizens and increases the need for costly medical interventions after birth.

As a person of color and as a native-born and -raised Montanan, I cannot understand the deliberate intention to leave these children behind. Why are their lives less precious than any other child's? Can they not be our future leaders, innovators, and productive citizens of our Nation? And does not an investment in their well-being now make that more likely?

Thank you.

The CHAIRMAN. Thank you, Eran, very much. Thank you. [Applause.]

STATEMENT OF RUSS BROWN, ON BEHALF OF STATE REPRESENTATIVE ARLENE BECKER, VICE-CHAIR, MONTANA HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES, BILLINGS, MT

Mr. BROWN. Chairman, Senator, my name is Russ Brown. I have been asked to read a brief statement into the record on behalf of State Representative Arlene Becker.

The CHAIRMAN. It will be included.

Mr. BROWN. Thank you.

The CHAIRMAN. You are welcome.

Mr. BROWN [reading]. "For the record, my name is Arlene Becker, and I reside in Billings, MT. I have been a registered nurse for over 20 years, and I am currently a State Representative from Billings who is honored to serve in that capacity as Vice Chair of Montana's House Health and Human Services Committee.

"I am also proud to note that I serve with a group of caring, committed individuals who sought to emulate Senator Baucus' lead in this all so important area of children's health care with the enactment of CHIP-enabling legislation in Montana."

I am going to skip some of this for time.

"For all CHIP's success, not only is it imperative for CHIP to be renewed, but expansion of coverage must take place to ensure that no child is left behind. Reenactment legislation must put kids first. I strongly encourage you to prioritize those States, including Montana, that do not currently operate at the 200 percent of poverty level as the primary focus of the first funding allocation.

"I also urge you to eliminate the State university employee exclusion component of CHIP that does not allow children of State university employees to be eligible for this coverage. Children in need and whose parents fall within the proposed 200-percent level should not be excluded, regardless of whom their employer is. They should be as eligible as the children of Federal employees.

"Senators, like yourself, I am passionate and remain committed to ensuring that all children have access to affordable and adequate health care. The reenactment and expansion of CHIP is a critical building block in that process.

"Thank you, Senators, for holding this hearing in Montana, and I can assure you that there is a strong sense of commitment from our State legislature to work with you in any way possible.

"And, Max"—or excuse me, Senator Baucus—"many of you noted the efforts of the Senators before you, Senator Hatch and others. However, many of us regard you as the godfather, or perhaps the midwife, of the national CHIP program." [Laughter.]

The CHAIRMAN. We are mixing a lot of metaphors here.

Mr. BROWN. Sorry about that. I am just reading.

"Perhaps the midwife of the national CHIP program, and words are truly inadequate to express how proud we are of your efforts.

"Thank you."

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

The CHAIRMAN. Thank you very much. Thanks to Arlene. [Applause.]

I am going to give everybody an offer that they cannot refuse.

Pat?

STATEMENT OF PAT CALLBECK-HARPER, ASSOCIATE STATE DIRECTOR OF AARP, HELENA, MT

Ms. CALLBECK-HARPER. Mr. Chairman, my name is Pat Callbeck-Harper. I am associate state director of AARP Montana in Helena, with 154,000 members. I want to say a word to ask for the inclusion in all of this discussion and the gathering of data of a rather silent and invisible population that are both advocates of the CHIP program, could be beneficiaries of the CHIP program, and thanks to Judy, are also targets of education about the CHIP program.

AARP is the largest supporter of grandparents raising grandchildren in the country. Our Grandparents Information Center on the Internet says that there are 6,000 Montana grandparents currently in custodial care of their children and raising their grandchildren. They also estimate another 10,000 grandparents are parenting their grandchildren with one of their parents in the home as well. So they are the household heads parenting their children and their children's children.

The newspaper a couple weeks ago talked about a 70-year-old woman who adopted her 5 great-grandchildren and expected to be able to raise them on her Social Security income. We in the AARP know that that is a tragedy in the making, and our grandparents raising grandchildren support groups are uneven in their knowledge about CHIP, so we have a responsibility at AARP as advocates on CHIP, which we take very seriously. But when they tell us what their biggest problems are, it is about the cost of medical care. But, in particular, thanks to our dentist from Helena, dental care is the most tragic reality for these grandparents in trying to raise thousands of grandchildren, the average being 3 to 5 grandchildren whom they raise at a time on very, very diminishing incomes.

So whatever we can do in MMA, Max, or Medicare or anything else to get this universal health care coming, it is going to be a multigenerational benefit that an expanded CHIP brings to Montana grandparents.

Thank you. [Applause.]

The CHAIRMAN. Thank you, Pat.

Before you go next, I want to ask Dr. Rencher, could you please tell each of those children that your message was received loud and clear by this committee?

Dr. RENCHER. Thank you.

The CHAIRMAN. And we very much appreciate their rescheduling their time to make way for you to come here and explain to us just how terrible a problem kids have with respect to insufficient dental care. I just want to thank you. If you could just send that message back to those kids and the families, that would make a big difference to all of us. Thank you.

STATEMENT OF OLIVIA RIUTTA, REPRESENTATIVE OF WEEL, HELENA, MT

Ms. RIUTTA. Good afternoon, Chairman Baucus, Senator Cantwell, and members of the panel. I have been in Helena too long. You can tell.

My name is Olivia Riutta. I am here as a representative of WEEL. We are a statewide nonprofit organization made up of low-

income Montana families, and I first just want to say what an honor it was to drive over with Clark this morning. Such a poised advocate for youth on the CHIP program.

I want to start out by saying that at WEEL we believe health care is a human right, and it is a necessary investment in our Montana families, in our communities, and really in our State economy. You came to Helena in February and challenged the State legislature to push for CHIP expansion in Montana, saying that you would do the same in Washington, and we are still working on it. We are not quite there yet, but do not worry, we have not given up.

And with that, as I was leaving yesterday, the Montana Democratic Women's Legislative Caucus asked me to read a brief statement because they are busy taking care of business in Helena today. They cannot be on vacation like the rest of us.

"Senator Baucus and members of the committee, the Montana Democratic Women's Legislative Caucus would like to go on the record as enthusiastically endorsing the proposed renewal and extension of CHIP. Early in the legislative session, we identified expanding coverage of CHIP in Montana as one of its top priorities. We thank you for your leadership on this innovative health care program and believe that its continuation in Montana is critical to the well-being of thousands of Montana's children who otherwise would not have access to adequate health care."

The letter goes on to specifically address the issue of supporting further funding for outreach, especially in rural Montana communities, where there are only 8 people per mile. I believe that was the statistic.

This letter is signed by Senator Carol Williams, which is very exciting, because she is serving as the first majority speaker of the Montana State Senate ever.

So, with that, I just want to add that we reiterate the feelings of the caucus that outreach is a serious issue and that there needs to be an any-door policy in Montana. Wherever children are accessing benefits, accessing programs, going to school, we need to figure out how we can get them on CHIP and how we can have this information disseminated through means that families are already used to, that do not carry stigma, and that they are more assured to sign up for the program on.

Thank you very much.

The CHAIRMAN. Super. Thank you very much. [Applause.]

STATEMENT OF DOLLY ROCKROADS, NORTHERN CHEYENNE TRIBE, CO-FOUNDER OF THE NATIONAL INDIAN CHILD DEVELOPMENT INSTITUTE

Ms. ROCKROADS. My name is Dolly Rockroads. I am from the Northern Cheyenne Tribe. I am the co-founder of the National Indian Child Development Institute.

Forty years ago, when John Kennedy was the President, he sent emissaries to different parts of the country. These emissaries came back with the concerns and issues of the American people, and one of the highest priorities was children's issues, child care, and they set up the National Child Development Institute.

Ten years later, the African American women organized. They are known as the National Black Child Development Institute. They have a chapter in every major city in America. The Latino women have organized. These organizations impact education, medical issues concerning their children. The Native American women have never organized. This is what we have done.

Two years ago, when I was at MSU here, through my early childhood classes I was introduced to these organizations. What we are doing is we are projecting back the customs and the culture to the young in taking care of their children, and this young man over here spoke so eloquently. Our child care practices are universal quality health care practices. And I am going to share just one with you. The cradle board, for my tribe in its primitive form, it was a piece of buckskin and a piece of rawhide. Our ancestors swaddled their newborn to a backboard. You know what a backboard is. EMTs carry backboards when someone breaks their neck, their back, they package them. Well, that is what our ancestors did.

Then they became modern. With the introduction of the beads, they beaded the outside, but the back was still the rawhide. Today we are even more contemporary. We just take a piece of cardboard the width and length of the newborn. We tuck it into a corner of a blanket, and we swaddle our newborn to the backboard.

When you look at the physiology and the anatomy of that little one, when you are in the womb, you are curled up, your spinal column is wide open. When you are born, you straighten up. Your spinal column comes together and is only starting to fuse together.

That is a universal quality health care practice. They do not know what causes this. I suspect that has something to do with that.

I read a book 2 weeks ago on Hilary Clinton. They were at a big old gathering and such, and she whispered to the old President Bush, "Do you know that the majority of our infants do not live to be a year old?" That is what we are up against.

I commend all of you, the leaders, for bringing awareness and focus to the medical side of America and how we take care of our children.

Thank you.

The CHAIRMAN. Thank you, Dolly, very much. Thank you. [Applause.]

We have to wrap up after you. You are our wrap-up person.

STATEMENT OF CAROLE LANKFORD, VICE CHAIR OF THE SALISH-KOOTENAI TRIBE

Ms. LANKFORD. Good afternoon. My name is Carole Lankford. I am Vice Chair of the Salish-Kootenai Tribe, and I want to thank you, Chairman Baucus and Senator Cantwell, for coming here, and all the panel that was here today. It was really nice to have you come in and hear our stories in Montana.

The Salish-Kootenai has testimony that we have drafted, and we will forward that to you, because I know there is no time.

Two points I would like to see. I would like to see the enrollment process a little bit easier, and I like the idea of including pregnant women. I think that is very important. I see that all the time, In-

dian women and women across the State of Montana, you know, having difficulty having access to care.

So I just want to thank you very much for this opportunity.

The CHAIRMAN. Thank you, Carole, very, very much. [Applause.]

Some of you have prepared remarks, and I would appreciate it if you could leave it with our clerk over here, with Carla. While I am mentioning Carla, I would like all of the people who came out from Washington, DC, who are part of the Finance Committee staff who helped make all this possible, to be recognized.

First is Carla Martin over here, and Jewel Harper from the clerk's office, Lisa Dennis, Erin Shields, and Catherine Dratz. Also chief counsel for the Finance Committee and Health staff is Michelle Easton, and, of course, Alice Weiss behind me. Could all of you please stand? And Carol Hill Johnson from Senator Cantwell's office. All of you please stand. [Applause.]

Give them a round of applause. They work hard.

I would also like to recognize my staff, which is Melody Haynes—a lot of you know Melody here in Billings—Jim Corson, Fred Kaiser, Julie Morgan, and Bob Grayson. Could you all please stand, everybody? Raise your hands if you are already standing. [Applause.]

They do all the work.

This has been just great. I have learned a lot. It was very helpful. And I thank Senator Cantwell. I could speak for her and say the same. And I thank all of you who took the time to come here.

This is an ongoing process. We have only begun to start now. So I would urge you to keep talking to us and we will with you.

I am going to do two things. I would like to give you my personal telephone number as well as my personal private e-mail address. You really cannot do this in Washington. There are so many people in the State of Washington. But here is my personal private e-mail address. It is maxbaucus@earthlink.net. And my private telephone number is (202) 224–4375.

There are a lot of ideas that this hearing is going to spawn, and I urge you follow up on it, and we will with you, and just thank you very, very much for all that you do.

Thank you. The hearing is adjourned.

[Whereupon, at 4:21 p.m., the committee was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Melissa Anderson

Testimony before the Senate Committee on Finance

My name is Melissa Anderson…I'm self employed business owner from Helena, Montana. This is my son Kasey, who's eleven. We're here to share our story about the CHIP program.

I've been self employed for the past 11 years and speaking from experience I can tell you it's nearly impossible to find good affordable health insurance. I didn't think that was a problem until we needed it.

In 2005, our family situation changed, and it was during this transition that Kasey had a grand mal seizure! The news itself was shocking…After undergoing extensive tests, Kasey was diagnosed with a seizure disorder. Perhaps even more traumatic, however, was the financial aspect of all this. We had NO insurance!

It was then that Kasey's neurologist suggested that we apply for the CHIP program…or Children's Health Insurance Plan. I didn't think to ask for assistance because I didn't think we would qualify. But, I can honestly say, it was the best filling out of paperwork I've ever done! I was quite surprised to find out we qualified!

It was a relief to know that we would be getting some help with his medical bills. Kasey underwent expensive medical tests, such as MRI's, EEG's, bloodwork and was placed on anti-seizure medication all of which were paid by the CHIP program. I can't tell you what a relief this was to us. It gave me peace of mind to know that the bills would be covered and I could concentrate on work again and Kasey would have the proper medical care to get better.

I truly believe there are many others out there like us that don't know about the CHIP. It is a program that fills the gap,…for children of low to middle income families like ours that can't afford health insurance. I would encourage parents to apply for this program, even if you don't think you qualify, as you might be surprised like we were. It's easy to enroll… All you have to do is call 1-877-Kids-Now.!

We received the CHIP benefits for about 10 months before seamlessly being enrolled into another health insurance plan. The benefits here were even more tremendous, as we didn't have to worry about Kasey's illness being a "pre-existing" condition. For that we are truly grateful!

I'm not embarrassed that we received benefits from this program because I believe it was there for us in a time of "need" and I believe that more kids ought to be able to benefit from this program like Kasey did.

In my opinion, kid's shouldn't have to feel guilty about being sick. Parents shouldn't have to worry about how they are going to pay those bills to help them get better.
It seems like there is a big "squeeze" happening right now among average working families in America struggling over how to pay the bills...like paying the mortgage, or putting food on the table ,...and that puts health care at the bottom of the list. It shouldn't have to be that way.
Right now there are millions of uninsured kids in America, like Kasey who don't have health insurance and if you met them you would know that they just need a "hand-up".

I'm here to tell you the CHIP program does just that! The CHIP program was the safety net for us when we needed it,...and for that we are grateful!

I'd like to say thanks to the CHIP Program and all it's supporters! I believe that prevention is the best medicine and in our case this holds true. Thanks to CHIP and the many prayers that went out, Kasey is now seizure free and no longer needs the medication.
And for that he is thankful!

Let's continue to do the right thing for America's Famlies and Children!

Thank you!

Senate Finance Committee Field Hearing regarding
Children's Health Insurance Program (CHIP)
Testimony presented on behalf of
State Representative Arlene Becker
Vice-Chair, Montana House Committee on Health and Human Services
and a 20 year RN

Dear Senators (Max) Baucus and (Maria) Cantwell:

For the record, my name is Arlene Becker and I reside in Billings Montana. I have been a Registered Nurse for over 20 years and I currently am a State Representative from Billings who is honored in that capacity to serve as Vice Chair of the Montana House Committee on Health and Human Services.

I am also proud to note I served with a group of caring and committed individuals who sought to emulate Senator Baucus' lead in this all so important area of Children's Health Care with the enactment of CHIP enabling legislation in Montana in 1999.

Senators: You already know of and have had reinforced this afternoon, how critical the CHIP program is to Montana families. As champions of the national effort to ensure health care availability for all children, you don't have to be persuaded on this issue. This statement is presented to reinforce your efforts and to commend you on the direction you are taking the program.

Because, for all of CHIPS success, not only is it imperative for CHIP to be renewed, but expansion of coverage must take place to ensure "no child is left behind."

Re-enactment legislation must put kids first. I strongly encourage you to prioritize those states, including Montana, that do not currently operate at the 200% level of poverty, as the primary focus of the first funding allocation.

I also urge you to eliminate the State and University employee exclusion component of CHIP that does not allow children of State and University employees to be eligible for coverage. Children in need and whose parents fall within the proposed 200% level should not be excluded regardless of who the employer is. They should be as eligible as the children of federal employees.

Senators, like yourselves I am passionate and remain committed to ensuring that all children have access to affordable and adequate health care. The re-enactment and expansion of CHIP is the critical building block in that process.

Thank you for holding this hearing in Montana and I can assure you there is a strong sense of commitment from our state legislature to work with you in any way possible.

And Max, many of us regard you as the godfather or mid-wife of the National CHIP Program, and words are inadequate to express how proud we are of your efforts.

Respectfully submitted,

Representative Arlene Becker
House District 52
Billings, Montana

Vice-Chair Montana Health and
Human Services Committee

Statement by Janis Langohr, MD, FAAP
Hearing on the Children's Health Insurance Program

Senate Finance Committee, April 4, 2007. Billings, Montana

Thank you Senator Baucus and members of the Senate Finance Committee for the opportunity to testify on a topic that is close to my heart, children and healthcare. As a pediatrician practicing in Montana, I can give a view from the trenches, so to speak, of the importance of the Children's Health Insurance Program to children and their families. Pediatrics, by its nature is a profession that is highly reliant on government subsidized insurance programs such as CHIP. Our patients and their families are young. They do not have the resources to own an expensive private health insurance policy. Conservatively, 40 per cent of our patients at our clinic in Billings are covered under CHIP or its larger companion program, Medicaid. In some pediatric practices around the state of Montana, the percentage is much higher. On top of that 37,000 children in Montana have no health insurance coverage at all. Many of these uninsured kids are probably eligible for CHIP or Medicaid but are not enrolled. In short, there are a very large number of children in Montana who need these programs in order to receive basic medical services. The numbers will grow as the escalating cost of healthcare and insurance continues to outpace Americans' income.

If one truly wants to know the value of CHIP, the question must be asked: What is life like for a child who does not receive basic medical services? Unfortunately, I have plenty of examples from my practice. One is the plight of a toddler with such rotten teeth and infected ears, that he went on to develop mastoiditis, an exquisitely painful, and life threatening infection of the bone behind the ear. Or there is the teenage diabetic who shared her insulin with her uninsured diabetic family member to the detriment of both of them. Yet another situation is one of an asthmatic youngster who made annual trips by life flight to a Billings hospital to spend a couple days on life support before picking up a new supply of asthma medications which he had depleted long ago.

All of these cases have common elements. First, loving, but economically disadvantaged families were involved. Secondly, all cases represent common childhood maladies that were left unattended and became life threatening. Third, the cost of these cases to our healthcare system and our state was staggering. And finally, the single most important element in all these situations is that they could have been prevented by providing these children with regular access to routine medical surveillance and care. In the decade since its inception, CHIP has been resoundingly successful in providing children with a medical home and improving their access to medical care. Dollar for dollar, the CHIP program represents one of the best returns on investment our society can make.

Yet access to care for children remains a critical problem in America. Dental services, mental healthcare and services for children with special needs are woefully lacking. The parade of children with painfully rotten teeth that marches through our clinic each week is a testament to the crisis in dental care. Children with significant behavioral and mental health problems frequently have no where to turn other than their primary pediatrician. And,

a recent survey of Montana families of children with chronic developmental and physical impairments, overwhelming revealed that access to the health care is their number one concern. These families feel isolated in the day to day struggle to care for their child. Poor reimbursement by Medicaid and CHIP to providers is the root of these problems. Providers must make difficult business decisions and limit or even exclude patients on Medicaid and CHIP.

Montana, with its small population spread over vast distances, presents yet another unique challenge to providing care. Probably, the best example here is for those children who are critically ill. Fortunately children rarely need such extreme care, but when they are critically ill, they need very expensive and highly specialized services specific to children. Due to the vast distances between such patients and poor reimbursement for such services, pediatric sub-specialists and surgeons are defeated in their attempt to serve young Montanans. They instead must migrate to well-endowed Children's Hospital in large metropolitan areas. Critically ill children and their families in Montana must follow them there. Hundreds of Montana children are medically evacuated to larger pediatric medical centers each year at enormous cost to the State of Montana.

Senators, the problems I present today are my passion. But quite frankly, I feel most Americans feel the same way as I do about children. After all, children are our future. A country with such wealth, medical expertise and communications technology has the ability to create a comprehensive healthcare system for children even in challenging states such as Montana. Ultimately achieving that goal makes good economic and social sense. Although there are many challenges remain, CHIP is model program for achieving this worthwhile goal. Thank you.

THE KAISER COMMISSION ON
Medicaid and the Uninsured

The State Children's Health Insurance Program: Lessons and Outlook

Testimony by Barbara Lyons, Ph.D.
Vice President and Deputy Director
The Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

Before the
Committee on Finance
United States Senate

Billings, Montana
April 4, 2007

The State Children's Health Insurance Program
Summary of Testimony by Barbara Lyons, Ph.D., Vice President and Deputy Director
The Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation
Submitted to the Senate Committee on Finance
April 4, 2007

SCHIP has successfully worked together with Medicaid to provide health coverage to millions of low-income children.

- SCHIP covers 6 million children today, building on Medicaid's coverage of 28 million children.
- Over the past decade, SCHIP and Medicaid together have reduced the uninsured rate among low-income children by one-third.
- Without SCHIP, millions more children in low-income working families would be uninsured.

Effective outreach, expanded eligibility, and streamlined enrollment and renewal are key elements of SCHIP's success.

- SCHIP established a new paradigm in which priority is given to finding and enrolling eligible children in SCHIP and Medicaid.
- Experience has shown that increasing eligibility, simplifying the enrollment process, and providing 12 months of continuous eligibility boosts coverage of eligible children.
- Continuous outreach and broad messaging about the availability of health coverage create enthusiasm and spur enrollment in SCHIP.

Because of SCHIP, millions of children have better access to the care they need.

- SCHIP and Medicaid increase the likelihood that children will have a medical home and lead to improvements in children's health, yielding benefits in school as well.
- Utilization of preventive and primary care services increases with SCHIP and Medicaid coverage to a level on par with private insurance.
- SCHIP and Medicaid have helped to narrow racial and ethnic disparities in access to health care.

Children's participation in SCHIP and Medicaid is high, but many uninsured children are missing out on the programs' important health benefits.

- Children's participation in SCHIP and Medicaid is high, reflecting the value parents place on coverage and their positive experiences with the programs.
- Low-income parents are emphatic about the need for health insurance for their children, but many cannot afford to pay for it on their own.

- Parents of uninsured children often do not know that their children qualify for SCHIP or Medicaid, do not know how to apply, or have faced enrollment barriers.

Financing issues have presented the biggest challenges for SCHIP.

- The capped financing for SCHIP, set 10 years in advance, often has not aligned with program needs.
- As state programs have matured, state spending for SCHIP has exceeded federal allotments.
- The distribution of federal SCHIP dollars across states has left some states with inadequate funds to keep up with enrollment and spending, while other states have had more funds than they could spend.

Decisions regarding the level and allocation of federal financing in SCHIP reauthorization will be pivotal to SCHIP's future success.

- SCHIP works effectively when state and federal funds are available at the level necessary to finance coverage.
- The Congressional Budget Office estimates that SCHIP enrollment will fall significantly if there is not additional federal financing for the program.
- The level of federal funding and its allocation across the states will determine whether states are able to address their 2007 funding shortfalls, maintain current eligibility levels, cover those children who are eligible but not enrolled, or expand coverage to more children or other groups.

The health and health coverage of millions of children depends on the reauthorization of SCHIP.

- The SCHIP program will expire and no federal funds will be available to support the program if SCHIP is not reauthorized by the Congress by September 30, 2007.
- Without additional financing for SCHIP, more children will likely become uninsured, jeopardizing a decade of progress in covering children and improving their access to care.
- To build on SCHIP's success, more needs to be done to reach the 9 million uninsured children who are missing out on the important benefits of coverage.

Thank you for the opportunity to offer testimony this afternoon on the State Children's Health Insurance Program (SCHIP). I am Barbara Lyons, Vice President of the Henry J. Kaiser Family Foundation and Deputy Director of the Kaiser Commission on Medicaid and the Uninsured. The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

SCHIP was created nearly a decade ago as part of the Balanced Budget Act of 1997 (BBA). Together with Medicaid, SCHIP has helped to dramatically reduce the uninsured rate of low-income children by expanding eligibility and simplifying enrollment procedures. The gains in coverage have helped to increase access to health services for millions of children and provided greater financial security and peace of mind for their families. SCHIP must be reauthorized by the Congress for funding to continue beyond FY 2007. My statement today will highlight the lessons on covering children that have emerged from nearly 10 years of experience in the SCHIP program and lay out the major issues for SCHIP reauthorization.

Lessons from 10 Years of SCHIP

SCHIP has successfully worked together with Medicaid to provide health coverage to millions of low-income children.

Together, SCHIP and Medicaid provide health coverage for one in four of our nation's children. Medicaid provides a base of coverage for 28 million poor and near-poor children in America. SCHIP targets low-income children who do not qualify for Medicaid and covers an additional 6 million low-income children (Figure 1). Annual growth in SCHIP enrollment averaged 10.4% from June 2000 to June 2006 nationally and by 14.6% in Montana. SCHIP and Medicaid have successfully reduced the rate of low-income uninsured children by one-third over the past decade (Figure 2). This decline is particularly noteworthy given the falling rates of employer-sponsored coverage over the period and the fiscal stress that states experienced during the economic downturn from 2001 to 2004.

SCHIP has been a critical source of health coverage for low-income children who do not qualify for Medicaid but whose families cannot obtain or afford private coverage. As health insurance premiums rose and the percent of firms offering health coverage declined between 2000 and 2005, the number of uninsured Americans rose by 6 million, with adults accounting for almost all of the growth. During this period, public coverage through SCHIP and Medicaid played a significant role in stemming increases in the rate of uninsured children. In contrast, the number of uninsured adults climbed steadily upward, reflecting their more limited access to public coverage. In 2005, SCHIP and Medicaid did not fully offset the loss of employer-sponsored coverage among children, and the uninsured rate for children increased for the first time since 1998.

Low-income families have been the hardest hit by the deteriorating employer-based health insurance market. The percentage of firms offering health coverage has been on a long-term steady decline and, today, fewer than half of firms that employ a large number of lower-wage workers offer coverage to their employees. Three-quarters of low-income uninsured working parents do not have access to employer-sponsored coverage.

Even when firms offer health insurance, low-income workers often have difficulty affording it. Since 2000, the average premium for family health coverage has risen more than four times faster than wages. The average family premium now exceeds the earnings of a full-time minimum wage worker. In addition, deductibles and cost-sharing have also increased, placing families at greater risk for high out-of-pocket expenses. The average low-income family spends 70% of its income on housing, food, and transportation, leaving little room for other important expenses, such as education, clothing, child care, and health care. SCHIP, because it is affordable, helps many low-income working families obtain health coverage for their children. Few children enrolled in SCHIP have access to affordable private coverage. Without SCHIP, millions more children would be uninsured.

A hallmark of SCHIP's success in covering low-income children has been the flexibility provided to states to determine the structure of and eligibility for their programs. States currently administer their SCHIP programs as Medicaid expansions, separate programs, or a combination of the two. SCHIP coverage levels vary by state, in part based on states' Medicaid eligibility levels prior to SCHIP's enactment. However, all states are prohibited from providing SCHIP to legal immigrants who have been here for less than 5 years, undocumented children, children of state employees, children over age 18, and children who have private coverage.

Effective outreach, expanded eligibility, and streamlined enrollment and renewal are key elements of SCHIP's success.

SCHIP established a new paradigm in which priority is given to finding eligible children and enrolling them in SCHIP and Medicaid. States have taken steps to improve outreach, expand eligibility, and streamline enrollment and renewal processes. Experience has shown that all these actions boost the enrollment of eligible children.

Expanded Eligibility

SCHIP provided an impetus for states to broaden eligibility to reach more low-income children. As of July 2006, 41 states including the District of Columbia had income eligibility levels in Medicaid and/or SCHIP at or above 200% of the federal poverty level ($40,000 for a family of four) (Figure 3). The federal poverty level is uniform nationwide; however, the cost-of-living varies substantially across the country. For example, a family living in San Jose, California has about half the purchasing power of a family with the same income living in Durham, North Carolina. States with lower eligibility levels tend to be rural states where the cost-of-living is lower.

Simplified Enrollment and Renewal

The implementation of SCHIP spurred states to adopt a variety of strategies designed to simplify enrollment and renewal procedures to bring children into coverage and keep them covered. Many of the simplification measures adopted by SCHIP programs have been carried over into Medicaid, facilitating coverage for low-income children more broadly. Nearly all states have now eliminated asset tests and face-to-face interview requirements for children covered under either SCHIP or Medicaid. States have also reduced verification requirements and provided for presumptive eligibility and self-declaration of income. Twenty-five states have adopted 12-month continuous eligibility in SCHIP, modeled on private insurance practice, to prevent kids from churning on and off of coverage. Montana has implemented many of these simplifications in their separate SCHIP program, including no asset test or face-to-face interview requirement, permitting self-declaration of income, and using 12-month continuous eligibility.

One recent development runs counter to the many simplification efforts that have promoted enrollment. The Deficit Reduction Act of 2005 (DRA) included a provision that requires Medicaid applicants and beneficiaries to provide proof of citizenship and identity to obtain or retain coverage. While the DRA provision does not apply to SCHIP generally, it does apply in states that have used Medicaid expansions for SCHIP. The new requirements are creating barriers for Medicaid enrollees, and some states are already reporting significant negative impacts on enrollment, including both declines in enrollment and delays due to backlogs in processing applications.

Family Coverage

Research shows increased enrollment and improved access and utilization of health services among children when parents are also covered. Unfortunately, in most states, eligibility levels for parents are substantially lower than those for children, precluding family enrollment in all but the very poorest families. While coverage for children is typically at 200% of the federal poverty level, eligibility for parents is set at or below 65% of the federal poverty level in half the states (Figure 4). Under federal waivers, some states are permitted to use SCHIP funds to cover parents. As of January 2007, 11 states were using SCHIP waivers to cover parents, although some have very limited enrollment. As a condition of covering parents, the waivers require that states keep children's enrollment open and prioritize funds for children. In 2005, about 600,000 adults were enrolled in SCHIP, compared to 6.1 million children on the program.

Continuous Outreach and Broad Messaging

Outreach is an essential tool to find and enroll eligible children. SCHIP and Medicaid enrollment are supported by continuous outreach and broad messaging about the availability of health coverage. A number of states have initiated broader coverage strategies for children building on Medicaid and SCHIP. Illinois, Massachusetts, Pennsylvania, Tennessee and Washington have enacted plans to provide universal coverage for all children. The message that all children are eligible for coverage is simple

and powerful and, in Illinois, this message attracted a substantial number of children who qualified for existing programs, in addition to newly eligible children. Conveying this message can help to overcome misperceptions among eligible families that their children do not qualify for coverage. Coordination between SCHIP and Medicaid is also critical for conducting effective outreach campaigns, for successfully enrolling children in the appropriate program, and for maintaining health coverage of children. Information technology and data sharing across public programs hold considerable promise for improving outreach to families with uninsured children, getting them enrolled in Medicaid and SCHIP, and keeping them covered.

Because of SCHIP, millions of children have better access to the care they need.

Improved Access to Care

The benefits of health coverage are widely known. Children enrolled in SCHIP and Medicaid have much better access to preventive and primary health care than uninsured children (Figure 5). Compared with uninsured children, children with public coverage are much more likely to have a usual source of care--an essential building block of continuity and quality of care. They are also significantly more likely than uninsured children to have seen a doctor or other health professional, to have had at least one well-child visit, and to have received dental care in the last 6 to 12 months.

Consistent with their better access, children with public coverage report lower rates of unmet needs for doctor and/or specialist care, prescription drugs, dental care, and hospital care than children who are uninsured. Findings that unmet needs decreased significantly in the year following the enrollment of uninsured children in Medicaid or SCHIP provide additional evidence of gains in access and care associated with these two public programs.

Children in Medicaid and SCHIP have access to preventive and primary care that is comparable to that of privately insured children; some research indicates that, among low-income children, those with public coverage fare better on key measures of access than those covered by private insurance. Although their coverage is financed publicly, children in Medicaid and SCHIP are often enrolled in the same managed care plans that serve the privately insured population.

Reduced Racial and Ethnic Disparities

SCHIP and Medicaid are responsible for gains in both coverage and access for children in all racial and ethnic groups. Further, the two programs have helped to narrow racial/ethnic disparities in access to care among low-income children. The Congressionally mandated evaluation of SCHIP found that SCHIP reduced racial/ethnic disparities in numerous access measures, including having a usual source of care, unmet need, and continuity of care. In New York, following the enrollment of previously uninsured children in SCHIP, the rates of unmet needs fell among the children overall, and previously observed racial/ethnic disparities in unmet needs disappeared (Figure 6).

Improved Quality of Care

Evidence that children enrolled in public coverage experience improved quality of care has also emerged. For example, a study of one state's SCHIP program found that after enrollment in SCHIP, children received a greater proportion of their health care visits at their usual source of care. Also, improvements in the quality of asthma care have been shown for children following their enrollment in SCHIP, with the greatest improvements for children who were previously uninsured. The parents of these children benefited too, as fewer worried about their child's health after enrollment. Adding to findings of improved quality of asthma care, other research shows improved health outcomes for children with asthma associated with coverage under Medicaid and SCHIP. These improvements include marked reductions in the average number of asthma visits and in the rate of asthma-related hospitalizations for children.

Improved Health Outcomes and School Performance

Significant declines in infant mortality and childhood deaths, as well as a reduction in low birth weights, have been attributed directly to expansions in eligibility for Medicaid and SCHIP. State and national surveys of parents and caretakers indicate that after one year of enrollment in Medicaid or SCHIP, children are in better health. An important test of the impact of coverage is the experience of the children with the greatest health needs. A study of children enrolled in California's SCHIP program for two years found that those with the poorest health status had dramatic improvements after the first year, especially in physical and social health outcomes, and these improvements were sustained over time. Chronically ill children also showed gains in physical and social functioning after more than one year in the program.

Enrollment in public coverage also has been associated with improved school performance. Researchers have found increased school attendance, greater ability to pay attention in class, and increased ability to participate in school and normal childhood activities following enrollment.

Children's participation in SCHIP and Medicaid is high, but many uninsured children are missing out on the programs' important health benefits.

Children's participation rates in SCHIP and Medicaid are high (about 75%) reflecting the value that parents place on the coverage and their positive experiences with the programs. Building on the success of SCHIP, more needs to be done to reach the 9 million children who remain uninsured. The uninsured rate among children varies dramatically across the country, ranging from 5.5% in Massachusetts to 20% in Texas (Figure 7). Generally, the south and the west have higher rates of uninsured children than other areas of the country. In Montana, the uninsured rate for children is 15%, somewhat higher than the national average of 11%.

About three-quarters of uninsured children are eligible for SCHIP or Medicaid (Figure 8). As states have expanded eligibility for low-income children, a larger pool of children

have become eligible for these programs. Almost all eligible but uninsured children live in families with income below 200% of the federal poverty level. These children typically live in working households that often have little contact with government assistance programs. The overwhelming majority (85%) are native citizens. Forty percent are Hispanic, reflecting the high uninsured rate in the nation's growing Hispanic population. An additional 900,000 uninsured children are not eligible for Medicaid or SCHIP, but live in families with income below 300% of the federal poverty level, where access to employer-sponsored coverage can be limited.

Low-income parents are emphatic about the need for health insurance for their children, but many cannot afford to pay for it on their own. Most parents of low-income uninsured children have positive perceptions of SCHIP and Medicaid, but do not think their children qualify, do not know how to apply, or have faced barriers in the enrollment process. Fiscal constraints resulting from the recent economic downturn led many states to curtail outreach and limit enrollment by freezing enrollment, increasing premiums in SCHIP, and reversing simplifications in enrollment procedures. These types of program changes are confusing to parents and complicate efforts to conduct outreach and enroll eligible children.

As national economic and state fiscal situations have improved, states have begun to invest once again in statewide and community-based outreach activities that target children who are eligible but not enrolled. However, outreach efforts can be undertaken only if state and federal financing is available to support actual coverage. The level of federal funding and allocations to states will determine whether children who are now enrolled do not lose coverage and whether additional uninsured children can be covered.

Financing issues have presented the biggest challenges for SCHIP.

While SCHIP is widely hailed for its successes, financing issues present some of the biggest challenges for the program. The primary issues are the total amount of federal financing available and the distribution of the funds across states.

Under SCHIP, state spending for eligible beneficiaries and services is matched by the federal government. To encourage participation among the states, the federal government assumed a larger share of SCHIP financing by making enhanced (relative to Medicaid) matching payments. On average, the federal government's share of SCHIP spending is 70 percent, compared with 57 percent in Medicaid. However, federal funds for SCHIP are capped nationwide and allocated to the states according to a statutory formula. Thus, each state operates under an individual funding cap. This financing structure contrasts with Medicaid, where federal matching funds are guaranteed to the states, with no pre-set limits.

SCHIP was established as part of the Balanced Budget Act of 1997 and the legislation provided a total of $40 billion for the program over 10 years. The use of a capped financing structure in SCHIP helped meet some of the larger spending targets in that bill and generate the political support needed for passage, but the funding levels that were set

for 10 years never matched program needs. In the early years of the program, as states were getting their programs off the ground, SCHIP spending was below total allotment levels. However, as the SCHIP programs matured and the statutorily set annual allotment levels fell from $4.2 billion to $3.1 billion in 2002, SCHIP spending began exceeding the annual allotment levels and has done so every year since (Figure 9).

In addition to the level of total funding, the distribution of funding across the states has been problematic. The distribution formula has left some states with more funds than they could spend and other states needing additional funds to keep up with program enrollment and costs. For some states that had already expanded Medicaid coverage for children prior to SCHIP's enactment, it was difficult to spend their SCHIP allotments, but other states with high numbers of uninsured left large amounts of federal money on the table, despite the enhanced matching rate.

Concerns also have been raised about the SCHIP distribution formula. The formula directs funds based on a states' relative share of the nation's low-income children and its share of low-income uninsured children. Some argue that by including a factor for uninsured children, the formula penalizes states that increase enrollment in SCHIP. Finally, the provisions in SCHIP law to "redistribute" SCHIP funds from states unable to spend their full allotments to states that exhaust their allotments have created complexity and unpredictability in the program's financing that have led to numerous legislative changes to redistribute unspent funds.

Looking Toward SCHIP Reauthorization

As Congress prepares to reauthorize SCHIP, a number of issues will be discussed, including who can be covered and the level and distribution of federal financing. States attribute much of SCHIP's success to the flexibility they have had over eligibility, benefit design, and program structure. The primary challenges for SCHIP have related to the program's financing. SCHIP works effectively when state and federal financing is available to support coverage.

Decisions regarding the level of federal and allocation of federal financing in SCHIP reauthorization will be pivotal to SCHIP's future success.

If the SCHIP program is not reauthorized by the Congress by September 30, 2007, no federal funds will be available and the program will expire. The program is currently financed at $5 billion in federal funds annually. However, the Congressional Budget Office assumes that, due to increases in underlying health inflation, SCHIP enrollment will fall significantly, from 6.9 million in 2007 to 5.3 million in 2012, if federal funds available for the program do not increase (Figure 10). During the past decade of relatively flat (and even declining) federal SCHIP funding, per capita health spending nationally rose by roughly 85%.

As Congress engages in discussions over reauthorizing the SCHIP program, 14 states are facing federal financing shortfalls in FY 2007. Further, 37 states are spending more in

2007 than their allotments for that year (Figure 11). They are supporting their programs with carry-over funding from prior year allotments. Because these carry-over or "reserve" funds are increasingly scarce as health costs more generally continue to rise, even more states will face funding shortfalls if federal funding is not increased. The level of federal financing included in SCHIP reauthorization will determine whether states can address their funding shortfalls in FY 2007, maintain current eligibility levels, expand coverage to those who are eligible but not enrolled, or expand coverage to more children or other groups.

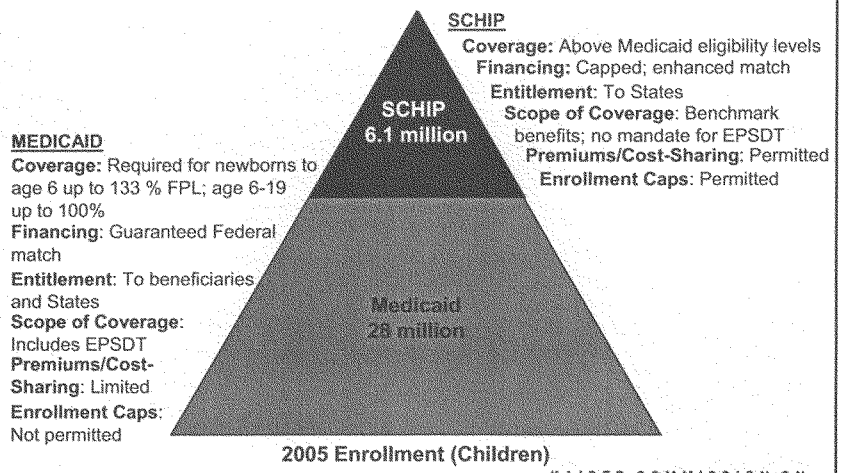
The health and health coverage of millions of children depends on the reauthorization of SCHIP.

Together with Medicaid, SCHIP has been regarded as a huge success in expanding coverage and reducing the uninsured rate among children. Low-income children who are enrolled in SCHIP and Medicaid have increased access to needed care and obtain more appropriate care. Evidence indicates that these children have better health quality and outcomes as a result. Without additional federal financing for SCHIP, progress will be reversed as more children, parents, and pregnant women will likely become uninsured.

As Congress debates SCHIP reauthorization, many states are moving forward with plans to expand health insurance coverage for children and more broadly. Montana is currently considering increasing the eligibility limit for its SCHIP program from 150% to 175% of the federal poverty level. States like Washington and Illinois are moving forward to cover all children and Massachusetts and Maine are implementing more comprehensive reform plans. A fundamental component of these plans is their reliance on SCHIP and Medicaid as building blocks to achieve broader coverage. Since most children who are eligible for publicly financed coverage are covered by Medicaid, the foundation upon which SCHIP is built, sustaining that program will also be of utmost importance. The outcome of the SCHIP reauthorization debate will be a key factor in determining the ability of states to move forward in their efforts to cover more of the uninsured.

Figure 1

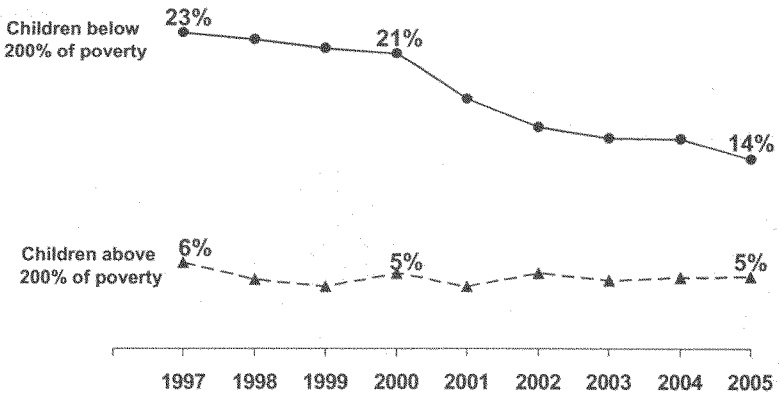
SCHIP Builds on Medicaid for Children's Coverage



KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 2

Percentage of Children Without Health Insurance, By Poverty Level, 1997-2005

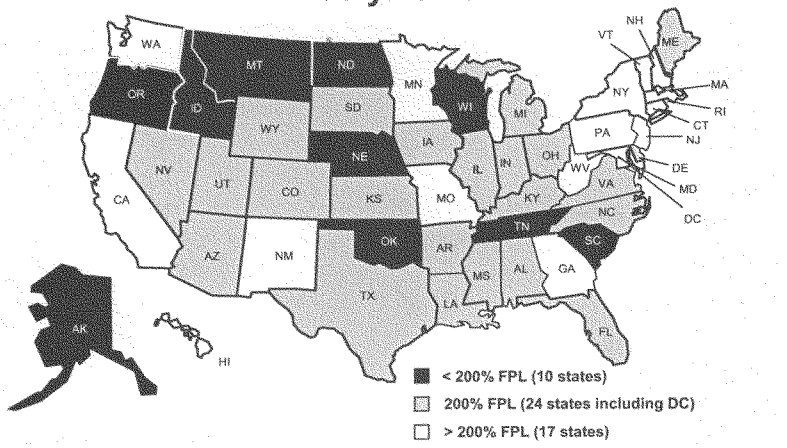


Source: L. Ku, "Medicaid: Improving Health, Saving Lives," Center on Budget and Policy Priorities analysis of National Health Interview Survey data, August 2005.

KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 3

Children's Eligibility for Medicaid/SCHIP by Income, July 2006

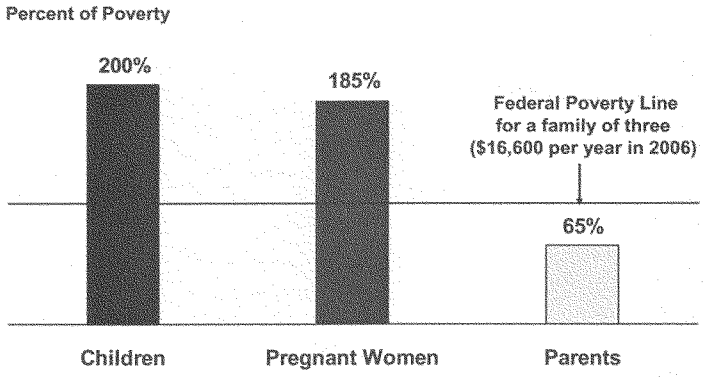


*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
**IL uses state only funds to cover children above 200% FPL
***PA and WV expanded coverage in 2007
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 4

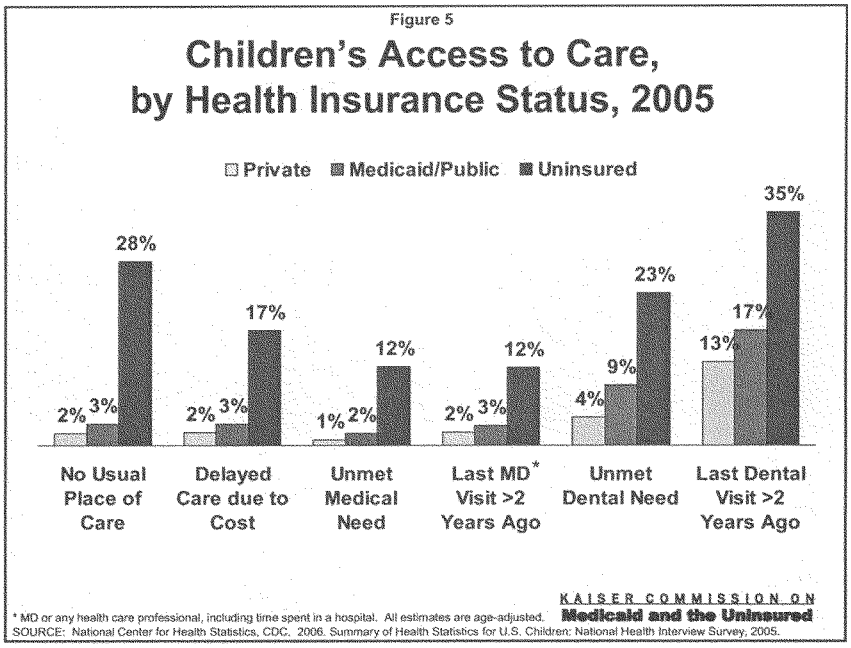
Median Medicaid/SCHIP Income Eligibility Threshold for Children, Pregnant Women, and Working Parents, July 2006



Note: Eligibility levels for parents based on the income threshold applied to a working parent in a family of three.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

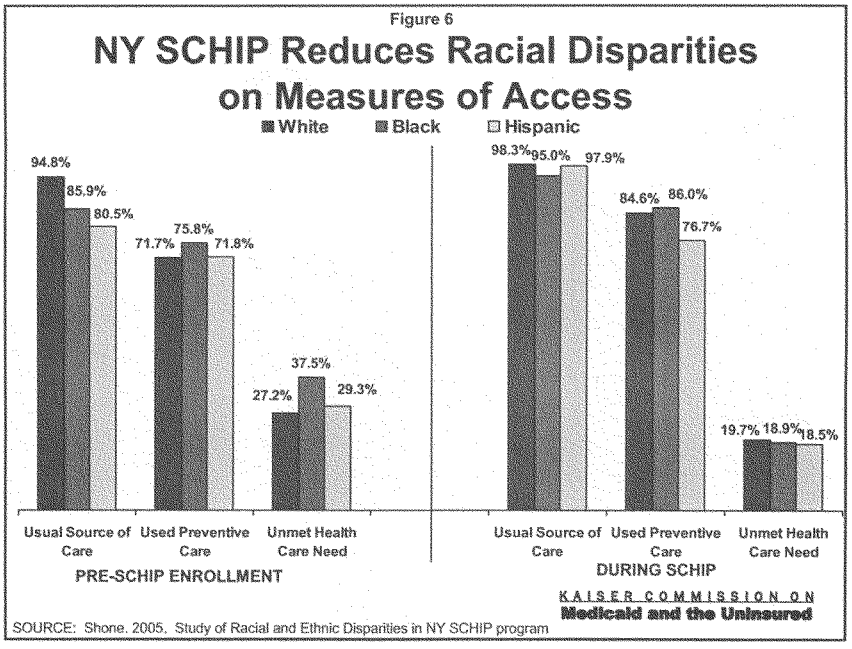
KAISER COMMISSION ON Medicaid and the Uninsured

Figure 5



* MD or any health care professional, including time spent in a hospital. All estimates are age-adjusted.
SOURCE: National Center for Health Statistics, CDC. 2006. Summary of Health Statistics for U.S. Children: National Health Interview Survey, 2005.

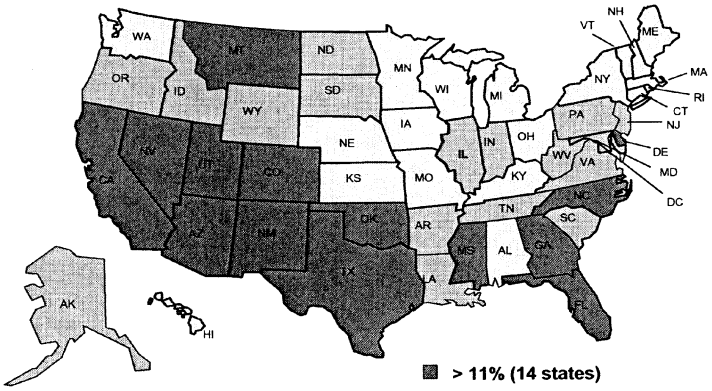
Figure 6



SOURCE: Shone. 2005. Study of Racial and Ethnic Disparities in NY SCHIP program

Figure 7

Uninsured Rates for Children under 19, by State, 2004-2005



US Average = 11%

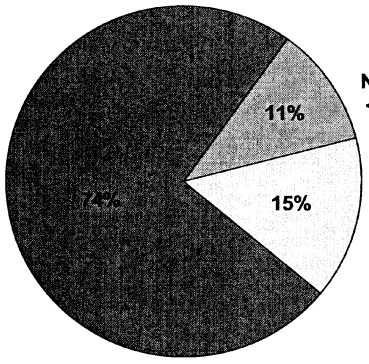
- > 11% (14 states)
- 9-11% (17 states)
- < 9% (20 states including DC)

SOURCE: Urban Institute and KCMU analysis of the March 2006 Current Population Survey. Two-year pooled estimates for states and the US (2004-2005).

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 8

Distribution of Uninsured Children by Eligibility for Medicaid/SCHIP, 2004



Eligible for Medicaid or SCHIP

Not Eligible, <300% FPL

Not Eligible, > 300% FPL

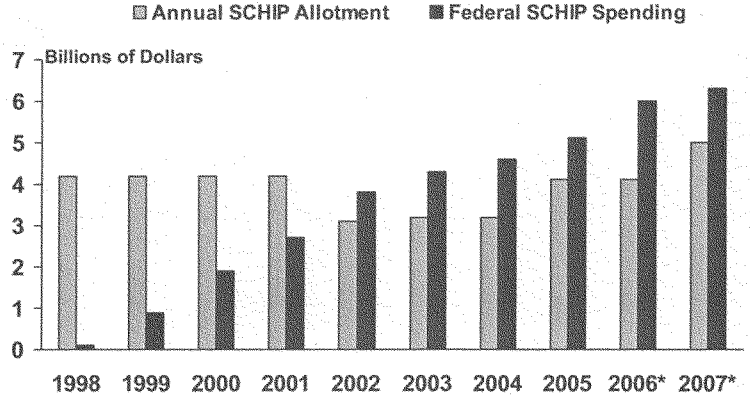
8 Million Uninsured

*The Federal Poverty Level (FPL) for a family of three in 2004 if $15,067 per year
SOURCE: Urban Institute analysis of the 2005 Annual and Social Economic Supplements to the CPS for KCMU. Data has been adjusted for the Medicaid undercount. CPS does not fully account for immigration status so estimates in the eligible category potentially include some undocumented children.

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 9

Spending for SCHIP first outpaced SCHIP allotments in 2002

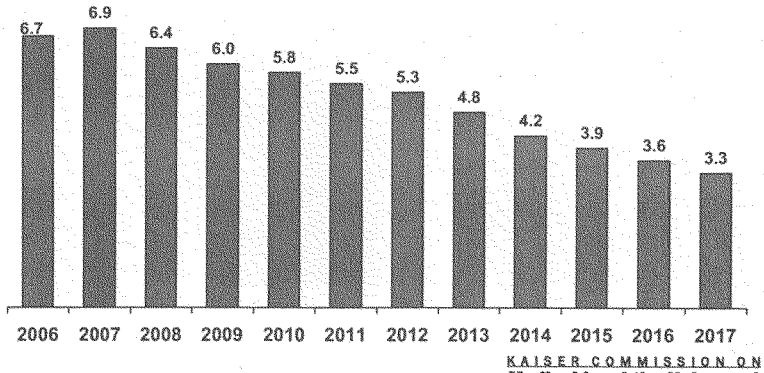


* Projected spending
SOURCE: "SCHIP Original Allotments: Funding Formula Issues and Options, October 2006. Congressional Research Service.

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 10

SCHIP Enrollment Projections for Children if Federal Financing is Held Constant at $5 Billion Annually

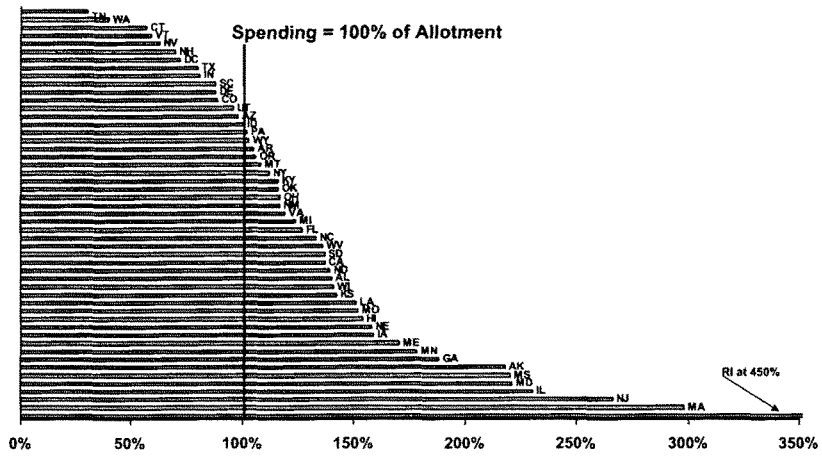


KAISER COMMISSION ON Medicaid and the Uninsured

SOURCE: CBO March 2001 Baseline: SCHIP Fact Sheet, February 23, 2007

Figure 11

Spending Expected to Exceed Allotments in 37 States in FY 2007



SOURCE: Data on allotments and spending from CRS, State Children's Health Insurance Program: A Brief Overview 10/12/2006 National average is 130%

KAISER COMMISSION ON Medicaid and the Uninsured

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

JOAN MILES
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO Box 4210
HELENA, MT 59604-4210

TESTIMONY OF THE MONTANA DEPARTMENT OF PUBLIC HEALTH

AND HUMAN SERVICES AS PRESENTED BY DIRECTOR JOAN MILES

BEFORE THE SENATE COMMITTEE ON FINANCE REGARDING

THE CHILDREN'S HEALTH INSURANCE PROGRAM IN ACTION:

A STATE'S PERSPECTIVE ON CHIP

APRIL 4, 2007

Good Afternoon. I'd like to thank Senator Baucus and the Senate Finance Committee for conducting this hearing in Billings. I'd especially like to thank Senator Baucus' staff and the Committee staff for all their work to make this happen.

I must make special note regarding Senate Finance Committee Health Counsel, Alice Weiss. Alice is a knowledgeable resource who provides updates and insight regarding CHIP reauthorization and works tirelessly to make sure Montana's unique voice is heard.

This hearing is a great opportunity for Montanans to be part of the discussion and decision making process on the federal reauthorization of CHIP. I'd like to provide you with some information about our state, our CHIP Program and our perspective on reauthorization of CHIP.

Montana Facts

- Less than one million people live in Montana and there are approximately 6 people per square mile. (In Washington, DC there are approximately 8,841 people per square mile.)
- Montana's median household income ($36,200) ranks 48th in the US.
- The rate of uninsured children in the US is 11.5%. Our rate in Montana is 17% and represents approximately 37,000 uninsured children.
- Approximately 24,000 uninsured children live in families earning less than 200% FPL ($41,300 for a family of four).

Montana's CHIP Program

- The program is a separate ("stand alone") program, not a Medicaid expansion. There is widespread public support for our CHIP program because it is for children of working families and is not considered a government entitlement program. Ninety-two (92%) of CHIP children have one or more employed adults in their family.
- A large number of CHIP parents are self-employed or work for small businesses so employer-sponsored insurance is unavailable or cost prohibitive.
- The source of state funds for the program has been tobacco tax and tobacco settlement funds in addition to state general funds.
- The benefits are based on the state employee plan and families pay co-payments based on their income.
- The financial eligibility level is 150% FPL ($30,975/year for a family of four). Montana is one of ten states with an eligibility level less than 200% FPL. (See attached Coverage Levels map).

- We provide no coverage for expansion populations (pregnant women, parents and childless adults).

- Our statewide CHIP provider network has more than 4,000 medical providers, 290 dentists and all 59 Montana hospitals. (See attached Provider Network map). This assures access to care for CHIP children living in urban and rural areas throughout Montana.

- Montana CHIP provided insurance for 13,291 children in March 2007.

- Currently there is no cap on enrollment – eligible children are enrolled the first day of the following month.

- CHIP enrollment has steadily increased since removal of the enrollment cap in July 2005.

- Outreach efforts by CHIP staff (see attached list), community advocates and Indian Health Service/Tribal Health staff contributed to a 9% increase in the number of children enrolled this year. The increase was even greater for Native American children and children living in Yellowstone County. Enrollment for each of those groups increased by 20%.

- Outreach to Native American families is especially important because Indian Health Services (IHS) does not provide a comprehensive package of benefits. Historically IHS is under funded. Inconsistent health care services are the result. CHIP provides an additional source of revenue for IHS and also expands the network of providers from whom a child can receive care.

Montana's Perspective on CHIP Reauthorization

Montana fully supports the FY 2008 Senate and House Budget Resolutions to provide up to an additional $50 billion over the next five years to fund CHIP nationwide. We believe these funds will allow states to continue covering all children currently enrolled and to expand coverage to uninsured children.

Montana CHIP provides health insurance for kids and peace of mind for parents. CHIP is a successful, cost-effective program in Montana and we need to build on its strengths to expand coverage to more uninsured children in our state.

We urge Congress to reauthorize the program as soon as possible and to avoid the need for a continuing budget resolution.

There are four issues related to federal reauthorization of the program that I'd like to address. Those issues are:

1) Federal funding and Allocation of Funds to States;
2) Coverage for Children of State and University System Employees;
3) Payment Error Rate Measurement (PERM) Project; and
4) Coverage for Children Receiving Services from the Child Support Enforcement (CSE) Program

1) Federal Funding and Allocation of Funds to States

- Reauthorization decisions and allocation of funds should be based on the purpose of CHIP which is the provision of child health assistance to uninsured, low-income children.

- Federal funding should be equitable, stable and sufficient.

- There are a number of bills currently being considered by the Montana legislature. (See attached list.) Dependable federal funding is often critical in determining whether proposed bills are passed.

- States need an ***adequate annual*** federal allocation in order to ensure sustainable enrollment. Montana is not able to enroll additional children if federal funding fluctuates. Redistribution funds are too unpredictable for a state to depend upon. For example, if the Montana legislature increases the CHIP eligibility level and the federal grant remains the same, Montana will have a budget shortfall in 2009.

- The allocation formula should be revised to assure an equitable distribution of funds.
  - An accurate estimate of the number of low-income uninsured children in each state is essential.
  - The formula should reflect the number of children currently enrolled as well as the uninsured and low-income children in the state.
  - Children covered by Indian Health Services and or Tribal Health Services should continue to be eligible for CHIP.
  - Montana would like to suggest a two-pronged approach: Congress should first designate funding to support state efforts to fully cover all uninsured children up to 200% FPL ($41,300 for a family of four). Congress should then designate additional funds that can be used at the state's discretion to expand coverage to higher income children and families to the maximum extent possible.

- Lastly, the 10% cap on administrative costs has some inherent flaws which should be corrected. In particular, administrative services which an insurance company provides as part of a fully insured plan are considered benefit costs. If a state provides those same services as part of a self-insured plan, they are considered administrative costs and subjected to the 10% cap. This difference in how costs are "counted" almost made it impossible for our state to self insure even though we knew we could reduce overall administration and use those funds to purchase needed medical care for Montana children.

2) Coverage for Children of State and University System Employees

- Currently there is a federal regulation against insuring children of State and University System employees. It needs to be eliminated. There is no similar prohibition against insuring children of federal employees or other employers. Our understanding is it does not apply to all states in the country. A limited number of states with separate CHIP programs are the only ones adversely

affected. The regulation does not impact states with Medicaid expansion CHIP programs. (See attached map of CHIP program types.)

- Some states with separate CHIP programs have indicated to us this prohibition against covering state employees' children affects the ability of "Welfare to Work" participants or temporary employees to accept permanent positions because those individuals cannot afford to purchase dependent coverage through the state insurance plans.

- There is widespread support from CHIP programs (separate, Medicaid expansion and combination CHIP programs) across the country to have this regulation removed by Congress during SCHIP Reauthorization.

3) Payment Error Rate Measurement (PERM) Project

- The Centers for Medicare and Medicaid Services (CMS) estimates it will cost Montana approximately $500,000 for an audit of CHIP and $500,000 for an audit of Medicaid. Montana's PERM audits are scheduled to begin next fall (FFY 2008).

- The current PERM guidelines instruct states with significantly diverse CHIP enrollments to sample the same number of cases. For example, New York, California, and Texas will sample the same number of cases as Montana, despite the obvious difference in CHIP enrollments among those high and lower population states. Even within the state of Montana, PERM mandates the identical number of cases to be reviewed by CHIP and by Medicaid even though Medicaid covers nine times the number of people.

- PERM-related costs are a significant fiscal burden on states and will detract from the ability of our CHIP program to provide coverage to low income children. (We estimate we could insure approximately 250 children for one year with the money that will be spent on PERM.)

- CHIP funds are better used to strengthen program efficiency and quality, and focus on outreach strategies designed to reduce the number of uninsured low income children and families in our state.

- PERM guidelines don't follow Montana's already established and CMS approved state plan for CHIP eligibility determination, e.g. self-reporting of income. PERM reverses CHIP's ten year commitment of reducing barriers for lower income families to access health care.

- If this program continues, all PERM-related costs should be 100% federally funded or exempt from the 10% administrative cap.

4) Coverage for Children Receiving Services from the Child Support Enforcement (CSE) Program

- Parents of children who are enrolled in CHIP and have a medical support order through CSE are unable to remain insured by CHIP because the parent who is responsible for providing health insurance must provide employer

sponsored or individual coverage. Oftentimes the coverage the parent is able to purchase is costly and the benefits are limited. For example, prescriptions, mental health, preventive health and dental services may not be part of the benefit package and/or the number of visits may be capped.

- As a condition of an approved CSE State Plan, Montana must include medical support in all child support orders enforced under Title IV-D of the Social Security Act.

- Since children can be adversely affected by this regulation (e.g. increased barriers and decreased access to health care services) the federal government should examine the impact on children and repeal or revise this regulation.

- Children whose families do not receive services from CSE do not have similar restrictions on their CHIP eligibility.

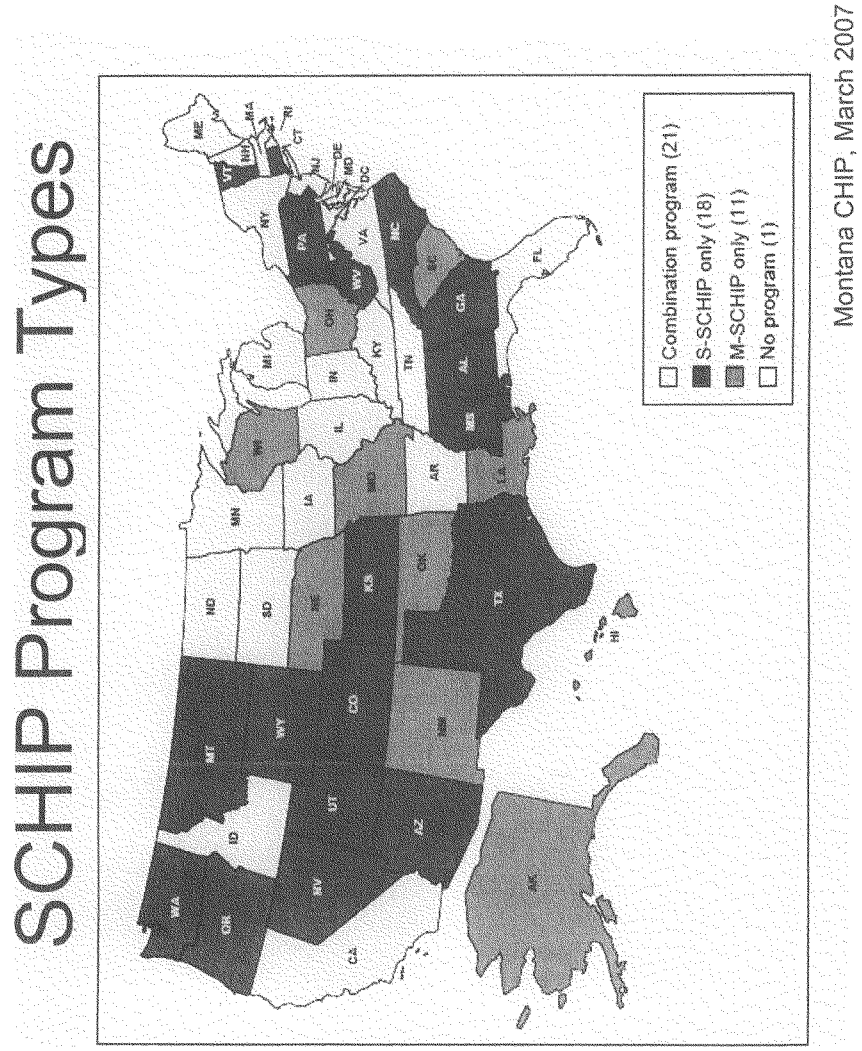
In closing, I'd like to again thank Senator Baucus and the Senate Finance Committee for the opportunity to share Montana's perspective on CHIP Reauthorization with you today. I provided written testimony which includes additional details which I hope you will find helpful.

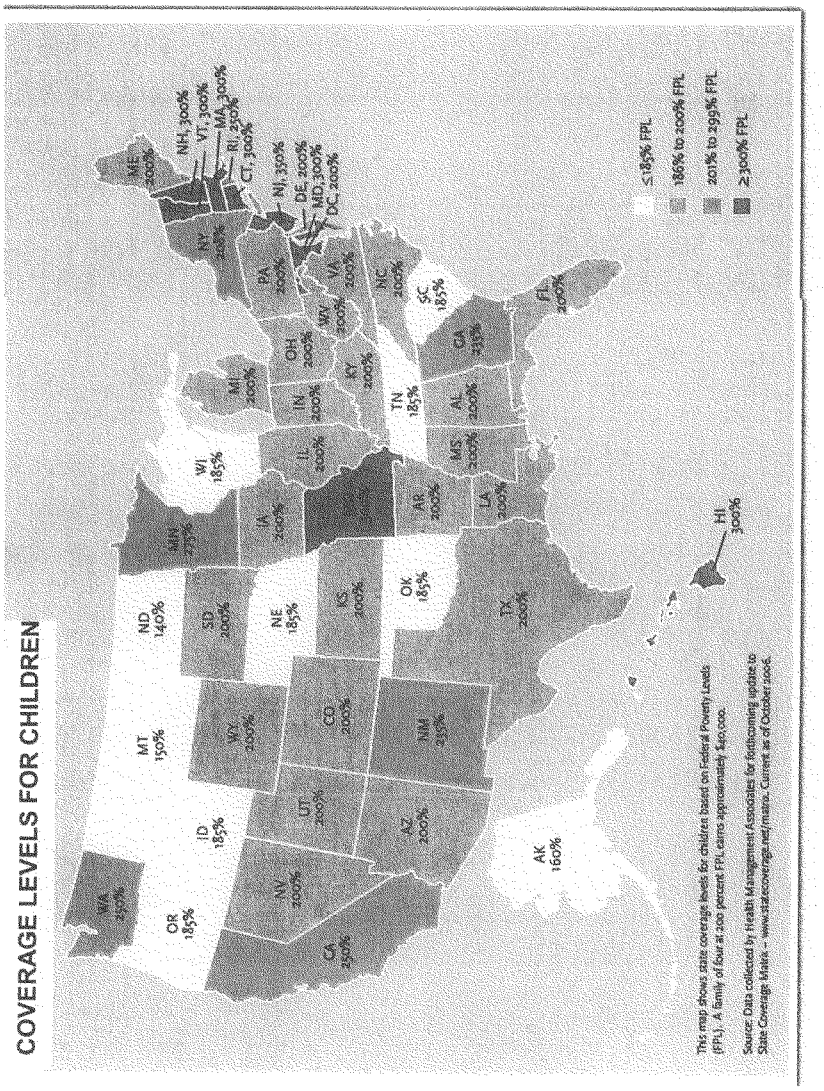
Our CHIP Bureau Chief, Jackie Forba, is here today with me and we are both available to answer any CHIP-related questions you may have.

ATTACHMENTS TO WRITTEN TESTIMONY

The Montana legislature is currently considering the following bills related to CHIP:

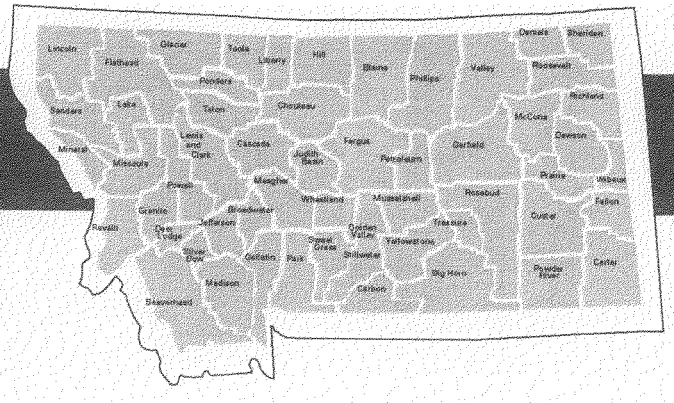
- SB0022 sponsored by Sen. Dan Weinberg to expand CHIP coverage to more Montana children by increasing the eligibility level from 150% to 175% FPL
- SB560 sponsored by Sen. Christine Kaufmann and HB839 sponsored by Rep. Mary Caferro to create the Montana KIDS Care Program to provide health care to all Montana children
- HB157 sponsored by Rep. Mary Caferro to revise exceptions to the limit on CHIP administrative expense
- HB198 sponsored by Rep. Bill Jones to expand the CHIP dental care benefits
- HJ30 sponsored by Rep, Kevin Furey to study the methodology for expanding CHIP and for managing an expanded program
- HJR44 sponsored by Rep. Dave Gallik recognizing the importance of Montana CHIP and urging the timely Congressional reauthorization of federal funds for the program


SCHIP Program Types
Combination program (21)
S-SCHIP only (18)
M-SCHIP only (11)
No program (1)
Montana CHIP, March 2007



Montana CHIP, March 2007

Provider Network



March 2007
4,065 Total Providers

Physician / Allied / Hospital
1,757 / 2,282 / 59

Montana CHIP
Children's Health Insurance Plan

BlueCross BlueShield of Montana

Beaverhead	14 / 25 / 1	Granite	1 / 1 / 1	Powell	7 / 13 / 1
Bighorn	5 / 10 / 1	Hill	25 / 40 / 1	Prairie	0 / 1 / 1
Blaine	2 / 7 / 0	Jefferson	7 / 10 / 0	Ravalli	53 / 90 / 1
Broadwater	3 / 6 / 1	Judith Basin	2 / 3 / 0	Richland	19 / 12 / 1
Carbon	8 / 12 / 1	Lake	38 / 55 / 2	Roosevelt	5 / 12 / 3
Carter	1 / 1 / 1	Lewis & Clark	104 / 175 / 2	Rosebud	10 / 13 / 1
Cascade	215 / 200 / 2	Liberty	3 / 3 / 1	Sanders	10 / 18 / 1
Choteau	4 / 9 / 2	Lincoln	20 / 38 / 1	Sheridan	3 / 6 / 1
Custer	12 / 48 / 1	Madison	3 / 10 / 2	Silver Bow	85 / 122 / 1
Daniels	1 / 3 / 1	McCone	0 / 3 / 1	Stillwater	6 / 10 / 1
Dawson	9 / 16 / 1	Meagher	4 / 2 / 1	Sweet Grass	2 / 6 / 1
Deer Lodge	18 / 29 / 1	Mineral	7 / 11 / 1	Teton	2 / 9 / 1
Fallon	1 / 3 / 1	Missoula	291 / 376 / 2	Toole	6 / 8 / 1
Fergus	17 / 27 / 1	Musselshell	3 / 6 / 1	Treasure	1 / 0 / 0
Flathead	188 / 236 / 3	Park	30 / 49 / 1	Valley	8 / 12 / 1
Gallatin	147 / 271 / 1	Petroleum	0 / 0 / 0	Wheatland	6 / 4 / 1
Garfield	0 / 0 / 1	Phillips	1 / 5 / 1	Wibaux	0 / 1 / 0
Glacier	11 / 17 / 1	Pondera	5 / 17 / 1	Yellowstone	448 / 381 / 2
Golden Valley	0 / 1 / 0	Powder River	0 / 2 / 0		

Children's Health Insurance Plan - Community Outreach Activities
January 2006 – March 2007

CHIP Media Campaign - "Health Insurance for Kids - Peace of Mind for Parents"

- CHIP conducted a statewide media campaign February 13, 2006 through March 10, 2006 including television, radio, and print advertising. CHIP and Department staff produced all of the campaign materials in-house. By working directly with media outlets and avoiding advertising agency fees and commissions, the Department saved approximately $20,000.

- Two 30-second television commercials, one of which featured Governor Schweitzer and Nancy Schweitzer, aired statewide on broadcast TV stations from February 13 to March 10.

- Two 30-second radio commercials aired February 13 to March 10.

- The campaign placed print advertising in all Montana markets, including rural, weekly newspapers and tribal newspapers beginning the week of February 6, 2006 and running through the end of March.

- CHIP evaluated results in March and April 2006 and is prepared to follow-up with additional media placements, if warranted.

- CHIP conducted a summer print advertising campaign in follow-up to last spring's statewide media campaign. Ads placed in all Montana markets, including daily, rural, weekly newspapers and tribal newspapers, running June through August 2006.

- Covering Kids & Families, a program sponsored by the Robert Wood Johnson Foundation, conducted a television campaign promoting CHIP in the greater Helena area from mid-August to mid-September, as part of its annual back-to-school initiative.

- CHIP conducted a statewide print media campaign supporting the release of the 2007 income guidelines (February-March 2007). Ads placed in all Montana markets, including daily, rural, weekly newspapers and tribal newspapers.

Community Partnerships

- CHIP continues to develop its statewide network of health care associations, individual health care providers, and related agencies to increase CHIP awareness by distributing CHIP materials in their communities. To date, over 300 new distribution points have been established across the state.

- Conducted the following CHIP train-the-trainer workshops:

    - April 3, Billings, St. Vincent's Healthcare
    - May 23, Missoula, St. Patrick's Hospital
    - July 23, Libby, St. John's Lutheran Hospital
    - July 26, Sidney, Sidney Health Center

- Developed a "CHIP Champion" award plaque to recognize community partners who go "above and beyond" in promoting CHIP in their communities. Award presented to

two individuals thus far: Renita Watson of Rocky Boy Tribal Health and JoHanna Spang of Northern Cheyenne Tribal Health.

Native American Outreach Activities

- Upon request of IHS and tribal health directors, CHIP conducted informational/outreach meetings with all seven reservation tribal health/IHS departments emphasizing how CHIP works in conjunction with Indian Health Services/tribal health, incorporating hands-on training to help families apply for CHIP.
    - April 26 – Confederated Salish & Kootenai, St. Ignatius
    - June 6 – Crow Reservation, Crow Agency
    - June 6 – Northern Cheyenne Reservation, Lame Deer
    - June 13 – Ft. Belknap Reservation, Harlem
    - June 14 – Rocky Boy Reservation, Box Elder
    - July 26 – Ft. Peck Reservation, Poplar
    - August 23 – Blackfeet Reservation, Browning

- Developed and distributed a brochure insert and poster addressing advantages of Native American participation in CHIP.

Direct Mail Outreach

- In late December 2006, CHIP sent a direct mailing to 2,748 households who had received Food Stamp benefits within the last several months. The mailing list included only FS households with children 0-19 years old who did not already have Medicaid or CHIP coverage. CHIP received 120 returned applications—a 7 percent response.

- On February 20, 2007, CHIP sent a direct mailing to 204 families who had been denied CHIP benefits in the last 12 months for over-income, but would likely be eligible for CHIP under the new 2007 income guidelines. CHIP is currently tallying the response rate.

Other Outreach Activities

- A series of statewide press releases beginning in early December 2005, announcing increased CHIP enrollment, the CHIP media campaign, new income guidelines, and the CHIP self-administration contract were covered by several major Montana newspapers, including the Billings Gazette, Great Falls Tribune, Montana Standard, and the Helena Independent Record.

- In February 2007, DPHHS issued a press release announcing the 2007 CHIP income guidelines, garnering coverage in Montana's major daily newspapers.

- Incorporated printed application into brochure to create a single, easy-to-distribute, marketing tool.

- Redesigned CHIP website to be more user-friendly and consistent with other DPHHS sites.

- Developed web-based interactive application allowing parents to complete application on their computer.

- Distributed CHIP information packets to all state legislators (May 2006).
- Mailed CHIP brochure kits to all Offices of Public Assistance (May 2006).
- CHIP materials sent to all businesses participating in the Insure Montana program (state program providing affordable health insurance for small businesses).

Trainings, Workshops and Community Events

2006 Events

- Capital Hill Mall Health Fair (March 4th) Helena
- Montana School Nurse Association meeting (March 17) Helena
- Medicaid Provider Fair (March 22-23) Helena
- Blackfeet Nation Federal Benefits Workshop (March 28-29) Browning
- CHIP Champions Train-the-trainer Workshop (April 3) Billings
- MSU American Indian Council Pow Wow (April 14-15) Bozeman
- Spring Public Health Conference (April 18-19) Billings
- University of Montana Kyi-Yo Pow Wow (April 21-22) Missoula
- Blackfeet Health Conference (April 24-25) Browning
- The Confederated Salish & Kootenai Tribes Federal Benefits Workshop (April 26-27) Pablo
- Grandparents Raising Grandchildren Conference (June 10) Great Falls
- Grandparents Raising Grandchildren Conference (June 17) Billings
- CHIP Train-the-trainer workshop (July 21) Libby
- CHIP Train-the-trainer workshop (July 26) Sidney
- Covering Kids & Families Press Conference (August 9) Helena
- Rocky Boy Federal Benefits Workshop (August 9-10) Box Elder
- CKF-sponsored Back-to-School Expo (August 12) Helena
- St. Regis Family Fair (August 15) St. Regis
- MT Public Health Association Conference (September 12-14) Billings
- MT Parent Teacher Association Convention (September 15-16) Missoula
- MT American Indian Women's Health Conference (October 6) Billings
- Lions Club meeting (October 17) Helena
- MEA-MFT Conference (October 18-20) Billings
- Altacare Annual Training Conference (October 19) Butte
- St. John's Ministries Employee Benefits Fair (October 20) Billings
- Indian Child & Family Conference (October 24-26) Great Falls
- Montana Eligibility Workers Conference (October 25) Great Falls
- NAMI Conference (October 25-27) Helena
- Early Childhood Services Fair (November 4) Ronan

2007 Events

- Helena Health & Wellness Fair (January 23) Helena
- Bozeman-Deaconess Health Fair (February 24) Bozeman
- Kids Care Fair (March 3) Helena
- MT People's Action & Head Start CHIP Registration Night (March 14) Missoula
- Crow Federal Benefits Workshop (March 20 & 21) Crow Agency

Upcoming Events

- St. John's Lutheran Hospital Health Fair (March 31) Libby

- MT Public Health Conference (April 17-19) Great Falls
- Northern Cheyenne Federal Benefits Workshop (April 18 & 19) Lame Deer
- Glendive Health Fair (April 26) Glendive
- Child Abuse Conference (May 8-10) Missoula
- Grandparents Raising Grandchildren Conference (June 2) Billings
- Grandparents Raising Grandchildren Conference (June 23) Great Falls

Upcoming Outreach Activities

- In March 2007, CHIP will conduct a direct mail outreach campaign to households participating in the Low Income Energy Assistance Program (LIEAP), who have uninsured children in the household.

- In Summer 2007, CHIP will distribute materials to all Montana school districts to include in their back-to-school information packets.

- Continue to conduct ongoing surveying to track/gauge enrollee retention, customer satisfaction, and outreach efforts.

- Continue building community partnership network, focusing next on pharmacies and dental offices.

- Schedule and conduct "CHIP Champion" train-the-trainer workshops in Great Falls, Helena, Bozeman, Kalispell, and other cities.

- Schedule and conduct CHIP informational/outreach meetings with Urban Indian Health Clinics in Helena, Butte, Missoula, Billings, and Great Falls.

- Schedule and conduct CHIP informational/outreach meetings with all seven reservation Indian Health Service (IHS) and Tribal Health facilities, annually.

- Evaluate the cost effectiveness of contracting with community-based organizations to distribute CHIP information and assist with the completion of applications.

Statement of

DR. KEVIN RENCHER

to the

COMMITTEE ON FINANCE

U.S. SENATE

on

DENTAL ISSUES IN REAUTHORIZATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Field Hearing on
The Children's Health Insurance Program in Action:
A State's Perspective on CHIP

April 4, 2007
Billings, Montana

I am a pediatric dentist, practicing in Helena, Montana for the past two years. I still consider myself a new "dentist," but a veteran of providing oral health care to children under both the SCHIP and Medicaid programs. I greatly appreciate the opportunity to appear before the Committee today to talk about reauthorization of the SCHIP program and its importance for children's oral health. My testimony is also endorsed by and represents the position of the American Academy of Pediatric Dentistry.

Let me note a few facts about oral health care access to put things in perspective:

Unmet dental needs among children are three times that of unmet medical needs—and parents cite dental care as the number one unmet health need of their children. For every child in the U.S. who lacks medical insurance, 2.6 lack dental insurance.

Dental decay is the most common chronic childhood disease found in children in the United States today—5 times more common than asthma. It remains a hidden crisis to some extent because children from low-income families experience a high disease burden—80% of all the dental problems in children are found in those 25% from lower income groups.

A 2005 CDC report on oral health trends in America shows that dental disease for young children increased by 15 percent, meaning that more than a quarter of all U.S. preschoolers have tooth decay.

Early intervention prevents dental disease and reduces costs, avoiding more costly restorative care or even hospitalization in many cases of early childhood caries. An age one visit is so important because there is a strong emphasis on prevention, with parents given counseling in infant oral hygiene, home- and office-based fluoride therapies, dietary counseling, and oral health habits and dental injury.

The recent tragedy of a the twelve-year-old Maryland boy whose family did not have Medicaid access and who died after bacteria from an abscessed tooth spread to his brain has generated attention to the often-overlooked issue of access to dental care for all children. Oral health is central to overall health. The mouth, as a part of the body, has long been ignored. Indeed, when dental problems go untreated, innocent victims suffer the unfortunate consequences. This exemplifies the importance of every child having a dental home by age one and the proper infrastructure in place to prevent and treat dental decay.

The tragedy in Maryland could have easily happened in Montana. In the last week I have seen patients from Havre, Great Falls, Helena, and Butte with extremely severe dental disease. Had these children waited any longer to receive dental care, the results could have been disastrous. This amount of decay causes serious health problems and can lead to death—even in Montana.

SCHIP has now served children for 10 years and is up for reauthorization. This provides a terrific opportunity for Congress to refine the dental component of the program in ways that stabilize and improve dental coverage at little to no cost. Dental care for children is (1) essential; (2) preventive; and (3) cost effective.

On behalf of the American Academy of Pediatric Dentistry and a coalition consisting of the entire dental community including the American Dental Association and the Children's Dental Health Project, I urge you to do three things for children in SCHIP:

(1) Recognize that the mouth is an integral part of our bodies and that treatment of mouth diseases can no longer be considered "optional" healthcare. Despite the magnitude of need, dental coverage remains an optional benefit in SCHIP. All states have recognized that poor oral health affects children's general health and have opted to provide dental coverage.

However, dental coverage is often the first benefit cut when states seek budgetary savings. Congress can stabilize access to dental care for children by establishing a federal guarantee for dental coverage in SCHIP.

(2) Allow states to offer dental coverage to those children via a dental wrap-around. This will allow working-poor families to keep their private medical coverage—thereby saving state and federal dollars—while obtaining dental coverage for their children. Children who receive medical benefits through their parent's employer-sponsored plan are not

eligible for dental coverage through SCHIP, even if they meet the income and other eligibility standards.

(3) Require states to report on their SCHIP dental program performance. After 10 years we are unable to say how well or poorly SCHIP dental programs perform because states are not required to report on dental performance.

It is recommended that information be reported using the CMS Form 416 used for Medicaid, which will allow reporting of care by age group, including dental visits occurring by age one. This is especially important as the AAPD and the ADA both recommend that a dental home be established for each child by age one. Growing evidence shows that early intervention reduces disease and improves oral health care.

With these SCHIP dental provisions, the benefits of cost-effective prevention can bring savings to government and better health to children. This outcome is truly attainable because preventive dental care works.

I understand that several SCHIP reauthorization bills have been introduced in Congress, as well as children's oral health legislation, and many of these bills include the dental provisions I have discussed this morning. I sincerely thank those members such as Senators Rockefeller, Clinton, Bingaman, Cardin, and Snowe for their leadership.

Note that in the last federal fiscal year 17,000 Montana children were eligible for SCHIP benefits. Of those 17,000 children, 7,600 received some type of dental care. By comparison, there were 59,100 children enrolled in Medicaid in the state in FY 2003. So, SCHIP is obviously a much smaller program. But it is important to note that SCHIP holds promise to overcome some of the historical problems in the Medicaid program, and can lead to improvements in the Medicaid dental program. In 2001, the Urban Institute wrote an early assessment of SCHIP and concluded that ". . . different delivery systems supported by competitive payments appear to be contributing to improved provider participation and better access to dental care in some state SCHIP programs." Most important, the study noted what it called a "spillover" effect on the Medicaid programs in two states—Alabama and Michigan. The authors stated that the Alabama and Michigan officials reported that the early success of their dental SCHIP programs had expedited reform of their dental Medicaid programs and that data suggested that improvements in access may be occurring under Medicaid programs that are paying dentists at market rates.

In fact, a very recent study of the first five years of Michigan's "Healthy Kids Dental" Medicaid program concludes that an increasing proportion of children received dental care each year from local providers close to home; the number of dentists continues to increase; and many of the children in the program appear to have a dental home and are entering regular recall patterns. Meanwhile, the Michigan Department of Community Health expanded the program to 59 of Michigan's 83 counties, effective May 1, 2006.

Let me add a final comment about community health centers and their role in oral health care. Please keep in mind that the dental service delivery system IS the practicing dental community. Medicaid or SCHIP cannot succeed in delivering services to children unless the dental practice community is fully engaged. While expansion of dental services at community health centers helps, it can actually be done most cost-effectively, quickly, and efficiently by contracting between centers and private practice dentists as is done by health centers with obstetricians. In fact there is a step-by-step guide available to assist centers with just such dental contracting.

Since the inception of the SCHIP program in Montana, the SCHIP dental benefit has been carved out of the CHIP medical program and has been a direct-reimbursement style, fee-for-service model which Montana dentists strongly support.

I want to thank Senator Baucus and the Finance Committee for the opportunity to present this testimony. While I had to reschedule the appointments of over 40 children from all over western Montana to be here this afternoon, I explained to their parents how important it was for me to be here today and for the Finance Committee to hold this hearing on such a critical issue for the future of America's children.

Please feel free to contact me if you have any questions regarding this or any other children's oral health issue.

Thank you,

Kevin L. Rencher.

Testimony of:
Judy Stewart, RN, BSN
Director of Strategic Partnerships
Yellowstone City-County Health Department

Good afternoon, Senator Baucus and distinguished members of the United States Senate Committee on Finance. My name is Judy Stewart, the Director of Strategic Partnerships with the Yellowstone City-County Health Department. I appreciate the opportunity to appear before you today to discuss the issue of the uninsured in Montana and the importance of the Children's Health Insurance Program to Montana's children.

As the Director of Strategic Partnerships I have the opportunity to collaborate with multiple stakeholders in our community to create and implement viable solutions to problems that are too difficult if not impossible to solve as individual organizations. The issue of the uninsured is one such issue. With the rapidly growing number of uninsured people in our country, this can no longer be considered an individual problem. It's a community, state and national problem that has and will continue to require a collaborative, creative and cooperative approach in solving.

Through my work at the Yellowstone City-County Health Department, I have encountered parents who knew their children were doing poorly in school because they couldn't see the board but had no money to pay for an eye exam or glasses. I have encountered parents who knew their kids were very ill but couldn't afford the cost to take them in to see a Doctor. I have encountered parents who knew their kids were experiencing severe dental pain on a daily basis, yet wouldn't take them to a dentist because they didn't have the money upfront. As a parent, I can only imagine how difficult is must be to limit access to basic health care services for your child, because of an inability to pay.

There is a direct cause and effect between not having health insurance and poorer health outcomes and it has been proven that ***the uninsured live sicker and die quicker.*** Without insurance, people often avoid accessing preventive healthcare. Routine illnesses, left untreated may progress to more serious and potentially chronic conditions. An example of this recently made national headlines when an 11 year old boy died of an untreated dental abscess. This didn't happen in a third world country. It happened in the United States of America. I think that is unacceptable.

10 years ago, Congress created the State Children's Health Insurance Program. This brought health and hope to thousands of uninsured children whose parents incomes

exceeded the financial guidelines for Medicaid. Today, our country's leaders are considering the merits of reauthorizing this valuable program. On behalf of the nearly 13,300 Montana children who receive the benefits from CHIP, I thank Senator Baucus for making CHIP reauthorization one of his top priorities.

Why is reauthorization so critical for our nation and specifically for Montanans? As compared to other states, Montana has the 14th highest uninsured rate in the nation with nearly 160,000 uninsured people. Montana's per capita income ranks 48th in the nation- with only West Virginia, Arkansas, and Mississippi having lower incomes. 14.2% of Montana's population falls below the Federal Poverty level- and 19.2% of our children falls below the FPL (compared to 12.5% nationally). Without CHIP, these children will have very limited options for preventive care, dental services, and assistance with mental health costs, prescriptions and vision care.

On March 1, 2007 there were 13,291 Montana children were enrolled in CHIP. That's a 9% increase in the number of children enrolled in CHIP since this time last year. Even with this increase there remains an estimated 35,000 uninsured Montanan children who may meet the eligibility criteria for CHIP and there is currently no waiting list for those who qualify.

There are 3 priority areas that must be addressed in order to maximize utilization of CHIP.

The first priority is education. Communities need to take a leading role in educating about the availability and benefits of CHIP while dispelling the misconceptions about CHIP eligibility. For example, one common misconception is that being a working parent automatically disqualifies your child from being CHIP eligible. Providing parents with correct information is the first step in insuring more children.

The second priority is that communities must work to decrease barriers to families applying for CHIP. Over the past 4 years, Billings Clinic, St. Vincent Healthcare and Yellowstone City-County Health Department have worked together to highlight the issues of the uninsured during the nationally recognized "Cover The Uninsured Week". Recognizing CHIP as one of our most valuable assets in combating the growing number of uninsured, it has been a top priority for this partnership to increase CHIP enrollment for the past 2 years. We identified that the stigma attached to being uninsured continues to be a significant barrier for families. Even now, when 1 in 5 Montana's are uninsured, people are embarrassed by the fact that they don't have health insurance. In response to this, Billings has hosted 2 CHIP Champion luncheons where people from a wide variety of organizations received training to assist families in completing the CHIP application. Our hope is that in our community, parents will experience "no wrong door" when

accessing information on CHIP and/or assistance with the application. People won't be "referred" on- they will be assisted by the first person they talk to about CHIP, someone they already have a trusting relationship with.

We've also promoted CHIP enrollment fairs at local schools. Our first was at Lockwood school in early March and a second is planned for the Laurel school district in April. The intent is to offer the information and assistance in an environment that's safe and familiar to the family. These activities, combined with the traditional access to CHIP enrollment, have resulted in a 21% increase in CHIP enrollments in Yellowstone County over the past year.

The third priority needs to be improved access to services for those who have CHIP. Unfortunately, there are many providers that don't accept children covered by CHIP- especially in the area of dental care. This can make accessing services very difficult. Improved access to a full compliment of health services is vital.

Conclusion

I have a job that falls outside what most people consider the "conventional" nursing career, in that I don't work in a hospital or clinic. This has made it challenging for my children when they try to explain what I do. So I'm always interested in the explanations they give to that question. One day I overheard my 11 year old son talking to his friend who had asked the question. My son started his explanation, pausing to think of just the right way to explain what I did. He finally said "She's a nurse who helps people who are poor and can't go to the Doctor because they don't have the money to pay." I was impressed with his fairly accurate explanation. He continued, and it was his next statement that stopped me in my tracks. He said "Can you believe that there are kids out there who can't go to the Doctor when they need to because they don't have insurance?"

It is my hope that in the very near future every Montana child will have health insurance and they, like my 11 year son, will find it incomprehensible that there are children living in our great country who don't have health insurance.

Reauthorization of CHIP is imperative if we are to meet this goal.

Thank you for the opportunity to be part of this important discussion today about the Children's Health Insurance Program, as well as for the opportunity to highlight some Montana specific information about our uninsured children.

Testimony of
The Honorable Jonathan Windy Boy
Council Member, Chippewa Cree Tribe Business Committee.
Montana Representative, House District 32

For
"The Children's Health Insurance Program in Action:
A State's Perspective of CHIP"
Before
The Senate Finance Committee
April 4, 2007 – 2:00 PM
Ballroom, Montana State University-Billings, Student Union Building

---

Good afternoon, Chairman Baucus, and members of the committee. My name is Jonathan Windy Boy. I am a Tribal member of the Chippewa Cree Tribe of Rocky Boy's Reservation and a citizen of the beautiful State of Montana. I serve as a council member for the Chippewa Cree Tribe Business Committee and I also serve as a Representative in the Montana State Legislature, House District 32. I serve as the Chairman of the Rocky Boy Health Board, the governing body for the Chippewa Cree Health Center. I represent the Montana/Wyoming Tribes on the Centers for Medicaid/Medicare Services' Tribal Technical Advisory Workgroup (TTAG) and I also serve as the chair of the Montana Wyoming Tribal Leaders Council - Subcommittee on Health. I appreciate this opportunity to address the issues of the people I represent in our fair state. I would like to thank the committee for the opportunity to testify on "The Children's Health Insurance Program in Action: A State's Perspective on CHIP".

I want to thank Senator Baucus for his recent "Honoring Promises" presentation. Before I begin this address I would like to reaffirm the foundation of those "promises" regarding Tribes and our sovereign status.

Tribal Sovereignty and American Indian/Alaska Native Health Disparities

The overarching principle of Tribal sovereignty is that Tribes are and have always been sovereign nations, Tribes pre-existed the federal Union and draw our right from our original status as sovereigns before European arrival.

The provision of health services to Tribes is a direct result of treaties and executive orders entered into between the United States and Tribes. This federal trust responsibility forms the basis of providing health care to Tribal people. This relationship has been reaffirmed by numerous court decisions, Presidential proclamations, and Congressional laws.

Given the significant health disparities that Tribal people have, funding for Indian healthcare should be given the highest priority within the federal government. Many of the diseases that Tribal people suffer from are completely preventable and/or treatable with adequate resources and funding. As the federal government develops models that aim to reduce or eliminate racial and ethnic disparities (i.e. "Closing the Gap") a balance needs to be made between the federal deficit model (comparison to All U.S. Races) and a positive development model. Otherwise health policy (and the subsequent allocation of funding toward healthcare) will be determined on the basis of Tribes being a marginalized minority and not as sovereign nations with distinct treaty rights, which have been negotiated with the ***"full faith and honor of the United States".***

Underfunding of Indian Healthcare

For some time now, the United States has not funded the true need of health services for AI/AN people. The medical inflationary rate over the past ten years has averaged 11 percent. The average increase for the IHS health services accounts over this same period has been only 4 percent. This means that IHS/Tribal/Urban Indian (I/T/U) health programs are forced to absorb the mandatory costs of inflation, population growth, and pay cost increases by cutting health care services. There simply is no other way for the I/T/U to absorb these costs. The basis for calculating inflation used by government agencies is not consistent with that used by the private sector. OMB uses an increase ranging

from 2–4 percent each year to compensate for inflation, when the medical inflationary rates range between 7-13 percent. This discrepancy has seriously diminished the purchasing power of Tribal health programs because medical salaries, pharmaceuticals, medical equipment, and facilities maintenance cost Tribes the same as they do the private sector.

In FY 1984, the IHS health services account received $777 million. In FY 1993, the budget totaled $1.5 billion. Still, thirteen years later, in FY 2006 the budget for health services is $2.7 billion, when, to keep pace with inflation and population growth, this figure should be more than $7.2 billion. This short fall has compounded year after year resulting in a chronically under-funded health system that cannot meet the needs of its people.

Access to Medicaid

The IHS budget cannot provide the health services needed thus Tribes must depend upon alternative resources, such as, Medicaid for critically needed healthcare for our people. Understanding this, accessing Medicaid is an important health issue.

The barriers to accessing Medicaid have been identified by Tribes through out the years. Though there has been some positive movement, many of those identified barriers still remain. The most critical of those identified is the application and eligibility determination process. This is the first gate and if a Tribal member cannot get through the first gate – access to needed healthcare is denied. The application and eligibility determination barriers are often protocols developed to "cost contain" or manage the Medicaid budget. Unfortunately, Tribal people often cannot afford to jump through the "hoops" of a budget management protocol and the denial of access to care can be disastrous for the individual Tribal member and their family.

In FY 2004, the Chippewa Cree Tribe and the Confederated Salish & Kootenai Tribes partnered with the State of Montana and CMS/Region VIII to begin discussion on how to alleviate the barriers to accessing Medicaid for the Montana Tribes. From, this initial meeting, today, the Chippewa Cree Tribe is in final negotiations with the State of Montana to contract Medicaid Eligibility

Determination. Having the ability to assist Tribal applications by determining Medicaid eligibility on site at our Tribal healthcare center will facilitate access to care for eligible Indian users that are eligible Medicaid users. Getting access to healthcare through Medicaid to those eligible Montana citizens (whether Indian or non-Indian) as soon as possible benefits the recipient and the State of Montana. A healthy state community is one where its citizens can fully participate in education, employment and economic development.

The Children's Health Insurance Program

Montana has a healthcare crisis and the expansion of CHIP is a crucial piece of the solution. Montana has 37,000 uninsured children. How many children is that?

Montana's uninsured children could:

- Stretch 28 miles if they held hands,
- Fill 673 school buses, and
- Form 4,111 little league teams.

Montana has one of the highest rates of uninsured kids in the nation and the second lowest eligibility level for CHIP. While the uninsured rate for children nationally has remained constant, Montana's uninsured rate for kids has actually increased in the last three years (14%-16%).

This is a working class poor issue; over 90% of uninsured children in Montana come from homes where at least one parent is working full time. While employer sponsored insurance may be working in other areas, in Montana this model is failing our children.

In the last three years workers have seen an increase of 77% in the cost of their premiums for family coverage, for an average cost of $677.00/month. With Montana's median annual income being approximately $28,000.00 family insurance is unaffordable resulting in many parents being forced to drop coverage thus increasing the uninsured roles of our children.

Where is the smartest place to invest our healthcare dollars? The smartest place to invest is in preventive care and what we know is when children are uninsured they are not getting into see a doctor at the time when the care does the most good and is the least costly.

According to a recent study looking at access patterns of uninsured children, over 50% of uninsured kids had no well-child visit in the past year, 1/3 of uninsured kids had no usual source of care, 10% had not been into see a dentist, ¼ had unmet vision needs, and over a third had not been into see a doc at all.

In addition, CHIP is great for our economy. For every dollar that the state invests in CHIP we draw down four federal dollars in federal match.

Let's support children getting into see the doctor at a time when care is the most effective and the least costly, lets support working families for whom insurance is too expensive, give the public what they want while improving the health of our economy and most importantly, the health of one of our most precious resources, our children.

Emerging Diseases: Methamphetamine Abuse

"Methamphetamines is the scourge of my reservation," was a statement made by my colleague, Richard Brannan, Chairman of the Northern Arapaho Tribe of Wyoming in his testimony before the Senate Indian Affairs Committee recently. He spoke of the heartbreak of losing 2 young children in the fight against meth. He spoke of his concern that no more children are sacrificed by this epidemic. His testimony reflected the concern of every Tribe in Montana and Wyoming.

We know that to begin the foundation process to healing, we need to have the mental health resources that are available from the feds and the state. We need to have the ability to bill Medicaid for services in our alcohol and substance abuse programs in order to insure their sustainability and capacity to serve an increasing need. Without the ability to bill Medicaid, Tribes are reliant upon a rapidly decreasing Indian Health Service budget that does not meet the needs of our people.

We as Tribes know that a comprehensive approach to addressing meth is needed. For Tribes, resources and funding from the U.S. Department of Justice, Department of Health and Human Services – SAMHSA, Indian Health Service, and CMS, to name a few will be needed to effectively eliminate meth abuse. We will need to partner with the State of Montana's Department of Public Health and Human Services to access the resources designated for Tribes.

The Senator's plan for expanding CHIP so that more children will be able to access the program is to be commended. Today in a political climate where Tribes can expect budget cuts that mean less health services for their Tribes and less access to health insurance for the working class rural Montana citizens. The Senator's plan to expand CHIP is timely. With the increased meth abuse in the Nation, an epidemic that is destroying families and putting more children at risk, we will need more resources to help those children and families that are affected and cannot afford healthcare.

It will take the commitment of the Administration, the State, the citizens of Montana and the Montana Tribes to build the healthy Tribal and Montana communities where healthcare is more than a promise but a reality for every man, women and child. I thank you for this opportunity to provide testimony.

Rev. F. Vernon Wright
UCC Minister
Helena, MT
ruachwrights@msn.com

Moral Foundation for the Re-Authorization of CHIP

Senators, and Chair, thank you for providing me the opportunity to speak before you today. I am grateful that you have done so much to provide for the welfare and freedom of the citizens of this nation in the post 9-11 epoch.

I have been brought before you as an ordained United Church of Christ religious leader from Helena, MT. Today I wish to speak on the moral foundation of the country and its implications for children's health insurance. I, like many in the UCC, am a Congregationalist. We founded Plymouth Colony and Massachusetts Bay Colony in the 1600's. Fifteen of us were signers of the Declaration of Independence. Congregationalists defended the slaves on the Amistad, advocated for more human living conditions for immigrants in the turn of the century, labored for Civil rights in the 60's, and have continued to be advocates for the poor, the dispossessed and the disenfranchised. Today 37,000 Montana kids and 8.4 million US children have no health care coverage and this constitutes a moral crisis. Standing firmly in a deep US religious and civic tradition, I would urge you to fully re-authorized CHIP and expand it.

Jesus Christ, and the Hebrew prophetic tradition represented in the narrative of Jonah for instance, had a new vision of humanity in which all human beings, elders, children, men, women, slaves, free, Jews, gentiles, were one in the eyes of God. Standing on the tradition of the Torah, where true

worship of God is marked by justice and mercy, Christ taught that God's reign would become manifest when we serve the last and least out of loving concern. And children at that time, just as they are today, truly were the last and the least, which is why Christ spends so much time welcoming them, healing them and loving them.

I have a young family and minister to many young families, so I am somewhat acquainted with their needs. Many children my two young sons go to school with are distracted because they are living with horrendous coughs and toothaches festering long enough to warrant a trip to the emergency room. A child for whom the only option when dealing with a toothache or walking pneumonia is the emergency room, is a child who lives in constant threat. According to many child psychologists, the brain does not develop well under threat and the greater the threat the more severe the handicap. Each week my church and countless others give to families to buy food and medicine so that their futures and the future of our communities might not be diminished. But what we can afford is simply a drop in the bucket- it does not keep families from sliding down further and further into the pit of dysfunction. That is why we need a society that stands for something more than personal gain, where the common concern is something larger than what hard-working synagogues, mosques or churches can provide alone.

Fortunately we do not stand alone in this conviction. It is out of this faithful concern that Jonathan Winthrop wished that this new Commonwealth truly would become a Beacon on a Hill and Light of the Nations. As he prayed to God for deliverance from a storm off that land which would become Boston,

> Now the only way to avoid this shipwreck, and to provide for our posterity, is to follow the counsel of Micah, *to do justly, to love mercy, to walk humbly with our God.* For this end, we must be knit together, in this work, as one man. We must entertain each other in brotherly affection. We must be willing to abridge ourselves of our superfluities, for the supply of other's necessities. We must uphold a familiar commerce together in all meekness, gentleness, patience and liberality. We must delight in each other; make other's conditions our own; rejoice together, mourn together, labor and suffer together, always having before our eyes our commission and community in the work, as members of the same body. So shall we *keep the unity of the spirit in the bond of peace.*

And so we must ask, what kind of light in the world as a nation are we if our children are without health care? What kind of future are we providing for our children - the future of our nation - when we allow for millions of American children to be so vulnerable. Truly as a nation, are we not headed for shipwreck? I think the moral thing to do is not only re-authorize CHIP, but act on its expansion. In the end, the greatness our nation is measured not by our might but by the health and well-being of our peoples and the mercy and compassion of our governance.

COMMUNICATIONS

3,000 Police Chiefs, Sheriffs, Prosecutors, other Law Enforcement Leaders, and Violence Survivors Preventing Crime and Violence

United States Senate
Committee on Finance

Field Hearing:
"The Children's Health Insurance Program in Action:
A State Perspective on CHIP"

April 4, 2007

Written Testimony of David S. Kass
President

FIGHT CRIME: INVEST IN KIDS
1212 New York Ave, NW Suite 300
Washington, DC 20005
(202) 776-0027 (phone)
(202) 776-0110 (fax)

Submitted for the Record
April 18, 2007

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to submit this written testimony. My name is David Kass. I am president of FIGHT CRIME: INVEST IN KIDS, an anti-crime group of more than 3,000 police chiefs, sheriffs, prosecutors, and victims of violence from across the country who have come together to take a hard-nosed look at the research about what really works to keep kids from becoming criminals.

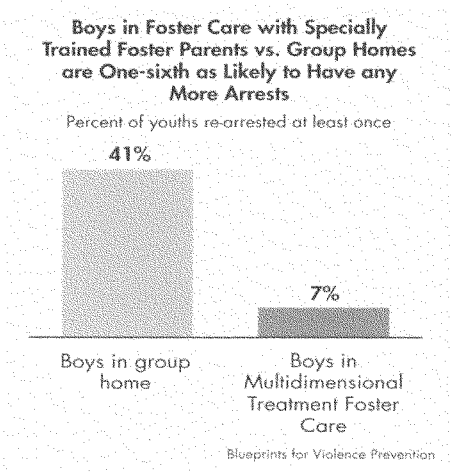
There is no substitute for tough law enforcement. Dangerous criminals must be prosecuted and put behind bars. However, at the point a juvenile or young adult is arrested, it is sometimes too late. No prison can bring back a murdered wife, mother or child, and no punishment can undo a crime victim's anguish. We could be saving thousands of lives and preventing thousands of crimes by investing more in cost-effective, proven programs that give kids the right start in life. One such program is the State Children's Health Insurance Program (SCHIP). The State Children's Health Insurance Program can provide funding for many effective interventions that are proven to help treat kids with behavioral or emotional problems—preventing later violence and saving taxpayers money.

Current data regarding children and mental health presents an alarming picture: at least one-tenth of children suffer from a serious mental health problem, but 75% to 80% of children and youth in need of mental health services do not receive them. In particular, children and youth from low-income families are at-risk for mental health problems: 21% of low-income children and youth ages 6 through 17 have mental health problems. Fortunately, the State Children's Health Insurance Program is in a position to address this problem. However, in order to ensure that more children have access to mental health services, SCHIP reauthorization must address two issues. Reauthorization of SCHIP should ensure adequate funding for states to both maintain their existing SCHIP caseloads and for states to cover all children and pregnant woman up to 200% of the federal poverty line. In addition, current law regarding mental health coverage should be strengthened to ensure that mental health benefits are equivalent in scope to benefits for other physician and health services.

Mental health is inexorably linked to the safety of our communities. Although not all youth with untreated mental health problems become criminals, research shows that youth with untreated mental health needs are more likely to get in trouble and jeopardize public safety. For example, an estimated 7% or more of preschoolers have levels of disruptive, aggressive behaviors severe enough to qualify for mental health diagnosis and approximately 60% of these children will later manifest high levels of antisocial and delinquent behavior. Treating behavioral and emotional problems and mental illness while children are young is critical to preventing more serious later problems. A scientifically designed and tested evidenced-based early screening and treatment approach for those children is called The Incredible Years. The Incredible Years is a comprehensive program with three components (parents, teachers, and children) aimed at increasing social and emotional competence and reducing juvenile antisocial behavior. A study of the approach found that when both the children and their parents receive help, 95 percent of the children experience significant reductions in problem behaviors. The benefits of early intervention depend on early detection. Fortunately, SCHIP coverage can

help ensure that behavioral and emotional problems and mental illness are identified and treated early in life, preventing more serious problems later.

SCHIP can also help fund evidenced-based, intensive individual and family therapy programs for troubled youth who have begun to commit criminal offenses. Such programs include Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), and Multidimensional Treatment Foster Care (MTFC). These interventions work individually with kids to change their behavior, with parents to equip them to better manage their children's behavior and with communities to move kids back into classrooms. For example, MTFC provides specially trained foster parents and ongoing supervision by a program case manager, as well as frequent contact and coordination of services with a youth's parole or probation officer, teachers, work supervisors and other involved adults during and after a youth's out of home placement. Compared to similar juveniles placed in non-secure group facilities, the MTFC approach cuts the average number of repeat arrests for seriously delinquent juveniles in half, and six times as many of the boys in MTFC as boys in a group home successfully avoided any new arrest. MTFC is also cost-effective. MTFC saves the public an average of over $77,000 for every juvenile treated.



Functional Family Therapy (FFT) works to engage and motivate youth and their families to change behaviors that often result in criminal activity. In one evaluation from Salt Lake City, families with troubled youths were randomly assigned to either a group that received FFT or one that did not. The youths whose families received FFT were half as likely to be re-arrested as the youth whose families did not receive the family therapy. By reducing recidivism among juvenile offenders, FFT saves the public an average of $32,000 per youth treated.

Similarly, the Multi-Systemic Therapy (MST) program targets kids who are serious juvenile offenders by addressing the multiple factors – in peer, school, neighborhood and family environments – known to be related to delinquency. One MST study followed juvenile offenders until they were, on average, 29-years-old. Individuals who had *not* received MST were 62 percent more likely to have been arrested for an offense, and more than twice as likely to be arrested for a violent offense. It is also less expensive than other mental health and juvenile justice services like residential treatment and incarceration, saving the public $4.27 for every dollar invested.

What reduces crime saves money[103]	Savings or costs per participant				
	Costs avoided by crime victims[104]	Savings to taxpayers from crime reduction only[105]	Program Costs	Net savings to taxpayers	Net savings to taxpayers and victims
Functional Family Therapy for youth on probation (FFT)	$19,529	$14,617	$2,325	$12,292	$31,821
Multi-Systemic Therapy (MST)	$12,855	$9,622	$4,264	$5,358	$18,213
Multidimensional Treatment Foster Care (v. regular group care) (MTFC)[106]	$51,828	$32,915	$6,945	$25,970	$77,798
Aggression Replacement Training (ART)	$8,897	$6,659	$897	$5,762	$14,660

Washington State Institute for Public Policy 10/06

Currently, the State Children's Health Insurance Program provides health coverage to over six million low-income children with incomes just above the eligibility threshold of Medicaid enrollment. But federal funding for SCHIP is limited and 9 million children are without health coverage. Reauthorization of SCHIP should ensure adequate funding for states to both maintain their existing SCHIP caseloads and for states to cover all children and pregnant woman up to 200% of the federal poverty line.

Another problem that should be addressed during reauthorization of SCHIP are benefit limits on mental health services. In contrast to Medicaid, which requires comprehensive coverage for mental health services, many state CHIP programs have limits on mental health treatment. State limitations on mental health services include limits on diagnostic services, inpatient care, outpatient visits, and annual cost. Consequently, many children have access to only minimal mental health benefits—benefits based on arbitrary limitations, not medical necessity. For example, one study found that children with complex mental health or developmental problems would only have access to full coverage for their recommended services in not more than 40% of the 36 states with separate SCHIP plans. Typically, outpatient coverage is limited to 20 or 30 visits with inpatient coverage limited to 30 days. Partial hospitalization and residential treatment services benefits are also frequently subject to limits (between 30 to 60 days), and in roughly a quarter of states these benefits are not covered at all. In the state of Montana, with the exception of major mental health conditions such as schizophrenia and

bipolar disorder, outpatient mental health services are limited to up to 20 visits per year, and inpatient mental health services are limited to 21 days per year. Similarly, in Iowa, outpatient mental health services are not only limited to 30 visits per year, but services exclude coverage for developmental and learning disorders. In MTFC, adolescents are placed in a therapeutic foster home setting for six to nine months. The typical duration of home-based MST services is approximately four months, with multiple therapist-family contacts occurring each week for several hours of treatment. Thus, in states like Iowa and Montana, coverage would be insufficient for troubled youth who could potentially benefit from MTFC or MST.

Since timely and effective access to mental health care can prevent future crime, access to mental health services is not just a public health issue, it is also a public safety issue. Mental health benefits under SCHIP can be strengthened by ensuring that mental health benefits are equivalent in scope to benefits for other physician and health services, and by eliminating the current authority to reduce mental health benefits below actuarial equivalence to the benchmark plan. We look forward to working with you both to expand the State Children's Health Insurance Program so that more children have access to these critical services, as well as to eliminate the mental health disparities within the program.

Thank you for this opportunity to present our views on how your committee can help to reduce crime and make us all safer.

April 4, 2007

Max Baucus
United States Senator
Billings Office

Attached is a two page summary on CHIPS and comments by a Medical Social Worker with the Fort Peck Tribal Health Department. I requested Dale Four Bear, MSW, submit a brief response to be presented at the Field hearing in Billings today. I do feel that children's mental health access Issues need to be addressed. Mr. Four Bear refers to this.

Thank you.

Gary James Melbourne'
Director, Tribal Health
Fort Peck Tribes

Cc: file

Preview

Up to this point in my practice as a Licensed Clinical Social Worker, I have to say that my practice did not include referrals to the CHIPS Program. Therefore, I had to research this respective program to educate myself on the program and its benefits. Perhaps, this is a glimpse into the amount of education needed for our area health providers and most importantly our clientele in regards to CHIPS. As I began to research the CHIPS program, I believe that the program could be of help to those who could qualify. On the Fort Peck Indian Reservation, the key once again would be education and awareness.

With the help of hard research, i.e. internet and pamphlets, and provider interviews, I was able to ascertain information regarding the accessibility of our clientele to the CHIPS Program.

CHIPS and the Fort Peck Indian Reservation

The Montana Children's Health Insurance Plan was established to provide low-income earning families with access to health care which they wouldn't regularly be able to afford. In essence, it is designed to be a private insurance program for working parents. Among the criteria for establishing eligibility is as follows: the family needs to meet certain income criteria, not be eligible for Medicaid, and be under the age of 19.

In consultation with various case workers and health benefit coordinators providing services to those clients on the Fort Peck Indian Reservation, accessibility to CHIPS is primarily hindered by the lack of awareness and knowledge of the program by potential clients. Accompanied by the fact that the Indian Health Services is considered by many to be the primary health facility for reservation people, it appears that most people identify the Indian Health Services as the only option for health care. Perhaps, this creates a sense of comfort and promotes stagnation whereby most are unwilling to pursue other avenues to meet their health care needs.

With the lack of understanding and knowledge of CHIPS comes hesitation and misunderstanding. Because there is an enrollment process to access CHIPS, it has been noted that many reservation residents do not want to go through all the "red tape" to establish eligibility. To put it bluntly, many consider the "red tape" to be too intrusive and accordingly do not want the state involved in their "personal business". The Indian Health Services, with its own limitations, is accepted by all to be the primary health care sources.

How can CHIPS help the Indian Health Services? Like Medicaid, CHIPS would provide the opportunity for I.H.S. health care providers to enter into third party billing. Like the Medicaid third party billing process, the revenue generated by CHIPS third party billing would be collected by the I.H.S. and be available for continued funding of health care. It seems that every year the I.H.S. faces the reality that funding may be cut and respective health care is jeopardized. CHIPS may not be the answer to all I.H.S. funding concerns,

however it does create the opportunity for monies to be returned to the respective I.H.S. programs.

What kind of mental health services are covered by CHIPS? According to the established guidelines, individual mental health care is offered on a limited basis to include individual therapy, therapeutic group home placements, and partial acute care hospitalizations, among others. It appears that family counseling and therapy is covered by CHIPS on a limited exceptional basis, such limitations require the respective child to receive a diagnoses of Serious Emotional Disturbance (SED) to access the respective coverage. Perhaps, a case can be made for many children to be diagnosed with SED, but this whole diagnostic process corrals our overall efforts to be provide services to all families in need.

It has been my experience that families should be treated as a unit, after all our children are products of their environments. Time and again, our children receive quality individual care but are returned to the same home environments where there may not be any support or understanding of the child's need for continued care. Rather than receive the needed support, their growth and healing is stymied again by a lack of support. This phenomena is witnessed repeatedly and accordingly supports our observations that families need to be treated as unique units.

Summing it up, residents from the Fort Peck Indian Reservation need more education about and awareness of the eligibility requirements and benefits of the Montana Children's Health Insurance Plan. Once enlightened, I believe many may begin to view the program as possibly being beneficial to their families. It also remains our responsibility as case workers to make our clients aware of CHIPS, perhaps in the process creating a sense of empowerment and freedom within our clients.

THE URBAN INSTITUTE 2100 M STREET, N.W. / WASHINGTON D.C. 20037

Statement of Genevieve Kenney, PhD
Principal Research Associate
The Urban Institute

Submitted for the Record of the Hearing,
"The Children's Health Insurance Program in Action: A State's Perspective on CHIP"

Before the Committee on Finance
United States Senate

April 4, 2007

I appreciate the opportunity to provide a statement on the State Children's Health Insurance Program (SCHIP). A principal research associate and health economist at The Urban Institute, I have been at the Urban Institute for over 20 years, where I have been a lead researcher on numerous evaluations, including two major evaluations of SCHIP: a congressionally-mandated evaluation for the U.S. Department of Health and Human Services and an evaluation supported by a number of private foundations. The views expressed here are my own and do not necessarily reflect the views of the Urban Institute or its sponsors.

Background. The State Children's Health Insurance Program (SCHIP) is up for reauthorization this year. SCHIP was created in 1997 to increase insurance coverage of children whose families earn too much to qualify for Medicaid, but still cannot afford private health insurance. It was funded as a capped block grant to states, providing $40 billion in federal funds over a ten-year period that were matched by state funds. Numerous studies have assessed SCHIP along a number of different objective standards, and the evidence strongly indicates that SCHIP has been a success[1]:

- SCHIP resulted in coverage expansions for children in all states despite being an optional program.
- SCHIP prompted enrollment- and renewal-simplification efforts and new investments in outreach, many of which were adopted by Medicaid programs as well.[2]
- SCHIP, though smaller than Medicaid, has become an important part of the coverage patchwork for children, providing coverage to over 4 million children on any given day and to more than 6 million children over the course of the year.
- SCHIP, together with Medicaid, contributed to coverage gains for poor and near-poor children over the last decade.[3]
- SCHIP achieved coverage gains for children without inducing large-scale crowd out of employer coverage.[4]

---

[1] G. Kenney and J. Yee, "SCHIP at a Crossroads: Experiences to Date and Challenges Ahead," *Health Affairs* 26, no. 2 (2007): 356-369.

[2] G. Kenney and D. Chang, "The State Children's Health Insurance Program: Successes, Shortcomings, and Challenges," *Health Affairs* 23, no. 5 (2004): 51–62; T. Selden, J. Hudson, J. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs* 23, no. 5 (2004): 39-50.

[3] L. Dubay and G. Kenney, "Gains in Children's Health Insurance Coverage but Additional Progress Needed," *Pediatrics* 114, no. 5 (2004): 1338-1340; L. Dubay, I. Hill, and G. Kenney, "Five Things Everyone Should Know about SCHIP," *Assessing the New Federalism* Policy Brief A-55 (Washington: Urban Institute, 2002); J.S. Schiller, M. Martinez, and P. Barnes, "Early Release of Selected Estimates Based on Data from the 2005 National Health Interview Survey," June 2006, www.cdc.gov/nchs/data/nhis/earlyrelease/insur200606.pdf (accessed 16 April 2007); T.M. Selden, J.L. Hudson, and J.S. Banthin, "Tracking Changes in Eligibility and Coverage among Children, 1996–2002," *Health Affairs* 23, no. 5 (2004): 39–50; J.P. Vistnes and J.A. Rhoades, "Changes in Children's Health Insurance Status, 1996-2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Statistical Brief #141 (Rockville, MD: Agency for Healthcare Research and Quality, 2006).

[4] C. Bansak and S. Raphael, "The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program," *Journal of Policy Analysis and Management* 26, no. 1 (2006): 149-175; P. Cunningham, J. Hadley, and J. Reschovsky, "The Effects of SCHIP on Children's Health Insurance Coverage:

- SCHIP led to improvements in children's access to needed health care and produced access improvements for children in different types of programs and circumstances (e.g., age, race/ethnicity, health status etc.).[5]

- SCHIP helped narrow, but did not eliminate racial and ethnic gaps in coverage and access to care among children.[6]

While SCHIP faces many important programmatic challenges related to its funding level and formula, the close to two million uninsured children who are eligible for SCHIP but are not yet enrolled, and quality monitoring and improvement,[7] I focus on three issues—crowd out, the coverage of children with family incomes above 200 percent of the federal poverty level (FPL), and the coverage of parents. My main points are the following:

- First, the weight of the evidence on crowd out indicates that it has been a smaller problem than was feared when SCHIP was enacted. Moreover, most children currently covered under SCHIP do not have parents with employer-sponsored insurance coverage. Thus, funding shortfalls under SCHIP would produce higher uninsurance rates among children, since so few enrollees have access to affordable private coverage.

- Second, relatively few SCHIP enrollees have family incomes above 200 percent of the FPL, and most of these pay premiums for SCHIP coverage and do not have parents with employer-sponsored coverage. Thus, restricting SCHIP eligibility to children with family incomes below 200 percent of the FPL would raise uninsurance rates among children.

- Third, while relatively few parents are covered under SCHIP, reducing coverage for parents under SCHIP would lower their access to needed health care and have adverse effects on the health, well-being, and insurance coverage of their children. Given that more than 7 million low-income parents are uninsured and given that they have very little

---

Early Evidence from the Community Tracking Survey," *Medical Care Research and* Review 59, no. 4 (2002): 359-383; A. Davidoff, G. Kenney, and L. Dubay, "Effects of the State Children's Health Insurance Program Expansions on Children with Chronic Health Conditions," *Pediatrics* 116, no. 1 (2005): e34-e42; L. Dubay and G. Kenney, "The Impact of SCHIP on Insurance Coverage," Draft Manuscript; J. Gruber and K. Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" NBER Working Paper 12858 (Cambridge, MA: National Bureau of Economic Research, 2007); J. Hudson, T. Selden, and J. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry* 42, no. 3 (2005): 232-254; A. Lo Sasso and T. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics* 23, no. 5 (2004): 1059-1082.

[5] Davidoff, Kenney, and Dubay, op cit.; G. Kenney, "The Impacts of SCHIP on Children Who Enroll: Findings from Ten States," *Health Services Research*, in press; P. Szilagyi et al., "Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York," *Pediatrics* 117, no. 2 (2006): 486-496; see Kenney and Yee (2007) for additional literature on access and use improvements under SCHIP.

[6] For example, see A.W. Dick et al., "SCHIP's Impact in Three States: How Do the Most Vulnerable Children Fare?" *Health Affairs* 23, no. 5 (2004): 63-75; L.P. Shone et al., "Reduction in Racial and Ethnic Disparities after Enrollment in the State Children's Health Insurance Program," *Pediatrics* 115, no. 6 (2005): e697–e705.

[7] See Kenney and Yee (2007), cited in Footnote 1 above, for a discussion of these other important issues facing the program at reauthorization.

access to employer-sponsored insurance, serious consideration should be given to expanding such coverage instead of restricting SCHIP coverage for parents.

Crowd Out Under SCHIP. When SCHIP was created, there was concern that many families would drop employer coverage in order to enroll their children in the new program[8], a phenomenon known as "crowd out." As a consequence, the SCHIP statute included anti-crowd out provisions and the Congressional Budget Office (CBO) baseline for SCHIP assumed a crowd out rate of 40 percent. In response, most states required waiting periods for children with employer-sponsored coverage to avoid crowd out.[9] The difficulty with assessing the extent of crowd out is that it is impossible to know what would have happened to children's coverage in the absence of SCHIP, given the other changes that were going on in the economy and the private insurance market, such as the shift of jobs toward smaller employers and the service sector, which are less likely to offer employer coverage, and the high growth in the cost of family health insurance premiums in absolute terms and relative to income. In the absence of any public policy changes, such employment shifts and the premium growth that has outstripped wage growth since the late 1990s would have led to continued declines in private insurance coverage.[10] Therefore, separating the effects of policy changes implemented coincidently with these trends is methodologically challenging.

Numerous econometric studies have attempted to examine the extent to which eligibility expansions to children under SCHIP have substituted for employer coverage on a national level, by controlling for potentially confounding changes occurring over the same time period.[11] These studies have produced estimates that range from 0 to 70 percent, demonstrating how sensitive the estimates are to the data and methodological approach and how imprecise the estimates are. The only longitudinal study that has examined crowd out under SCHIP at a national level found estimates in a much lower band, between 0 and 25 percent.[12] In addition, the one study that examined crowd out at the employer-level found that SCHIP expansions had no effect on offers of family coverage and only a small effect on the employer's contribution toward family coverage.[13]

---

[8] United States House of Representatives, Committee on Ways and Means, Subcommittee on Health, Hearing on "Children's Access to Health Coverage," 8 April 1997.

[9] A.W. Lutzky and I. Hill, *Has the Jury Reached a Verdict? States Early Experiences with Crowd Out under SCHIP.* Occasional Paper No. 47 (Washington, DC: The Urban Institute, 2001).

[10] G. Claxton et al., "Health Benefits In 2006: Premium Increases Moderate, Enrollment In Consumer-Directed Health Plans Remains Modest," *Health Affairs* 25, no. 6 (2006): w476-w485; J. Gabel et al., "Health Benefits In 2005: Premium Increases Slow Down, Coverage Continues To Erode," *Health Affairs* 24, no. 5 (2005): 1273-1280; J. Gabel et al., "Health Benefits In 2003: Premiums Reach Thirteen-Year High As Employers Adopt New Forms Of Cost Sharing," *Health Affairs* 22, no. 5 (2003): 117-126; J. Holahan, "Changes in Employer-Sponsored Health Insurance Coverage," *Snapshots of America's Families III*, No. 9 (Washington, DC: The Urban Institute, 2003); S. Zuckerman, "Gains in Public Health Insurance Coverage Offset Reductions in Employer Coverage among Adults." *Snapshots of America's Families III*, No. 8 (Washington, DC: The Urban Institute, 2003).

[11] See references in Footnote 4.

[12] L. Dubay and L. Blumberg, "The National Impact of the SCHIP on Insurance Coverage of Children: A Longitudinal Analysis," Working Paper (Washington, DC: The Urban Institute, 2007).

[13] T. Buchmueller et al., "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry* 42, no. 3 (2005): 218-231.

Moreover, very few SCHIP enrollees drop employer-sponsored coverage in order to enroll in the program.[14] Estimates from a congressionally-mandated evaluation of 10 states that account for over 62 percent of all SCHIP enrollees in the nation conducted for The Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services indicate that only 28 percent of children newly enrolling in SCHIP had had employer-sponsored coverage in the preceding six months and that only half of them, or 14 percent overall, could have retained that coverage (Figure 1).

Employer-sponsored insurance (ESI) is not a viable alternative for many SCHIP enrollees, since most do not have parents with employer-sponsored insurance coverage.[15] An estimated 37 percent of all SCHIP enrollees in the nation live in families where at least one parent has employer-sponsored coverage and only 25 percent of all SCHIP enrollees live in families where all parents present (i.e., one parent in single-parent families and both parents in two-parent families) have employer coverage (Figure 2). In addition, no information is available to assess the affordability or quality (i.e., in terms of benefits) of the ESI coverage that is available.

Uninsurance rates among low-income children are much lower than those among other low-income populations that are less likely to be eligible for Medicaid and SCHIP coverage (Figure 3). In particular, low-income parents are nearly twice as likely as low-income children to be without health insurance coverage. Likewise, the uninsured rate for low-income people age 19 through 21 is more than two times as high as the uninsured rate for low-income children under age 18. In addition, the uninsured rate for low-income non-citizen children, another group with very limited access to public insurance programs, is more than 2.5 times as high as for low-income citizen children (Figure 3). The higher rates of uninsurance among these groups are suggestive of what uninsurance rates might have been for low-income citizen children, had SCHIP and Medicaid not been available to them.

In summary, the weight of the evidence on crowd out indicates that it has been a smaller problem than was feared when SCHIP was enacted. While crowd out is an inevitable by-product of any effort to expand coverage, it is likely that alternative policy approaches, which do not include anti-crowd out measures such as those implemented under SCHIP, would lead to more crowd out than was observed under SCHIP.[16] Although econometric studies have not produced a definitive crowd out estimate, very few SCHIP enrollees drop employer coverage to enroll in SCHIP and most children currently covered under SCHIP do not have parents with employer-sponsored

---

[14] A. Sommers et al., "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs* 26, no. 2 (2007): 529-537; J. Nogle and E. Shenkman, *Florida KidCare Program Evaluation Report, 2003,* January 2004, http://www.ichp.ufl.edu/documents/KidCareReportYear5Final.pdf (accessed 16 April 2007); D. Hughes, J. Angeles, and E. Stilling, *Crowd-Out in the Health Families Program: Does it Exist?* (San Francisco: Institute for Health Policy Studies, University of California, August 2002).

[15] A. Sommers, S. Zuckerman, and L. Dubay, "The Relationship Between SCHIP and Private Coverage Among SCHIP Enrollees." In G. Kenney, C. Trenholm, et al., "The Experiences of SCHIP Enrollees and Disenrollees in Ten States: Findings from the Congressionally Mandated SCHIP Evaluation," report prepared for the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services (Princeton, N.J.: Mathematica Policy Research and the Urban Institute, 2005); G. Kenney and A. Cook, "Coverage Patterns Among SCHIP-Eligible Children and Their Parents," Health Policy Online No. 15 (Washington, DC: The Urban Institute, 2007); R.A. Allison et al., "Do Children Enrolling in Public Health Insurance Have Other Options?" Kansas Health Institute Research Brief 03-2 (Topeka, KS: KHI, 2003).

[16] J. Gruber, Letter to U.S. Representative John Dingell, 28 February 2007.

insurance. Thus, funding shortfalls under SCHIP would produce higher uninsurance among children since so few SCHIP enrollees have access to affordable private coverage. Key policy questions going forward will be whether the provision of wrap-around benefits (e.g., dental and mental health services), which is not currently permitted under the SCHIP statute, and greater reliance on premium assistance programs could give states even more effective tools to limit crowd out.

Coverage of Children above 200 percent of the FPL under SCHIP. While the majority of uninsured children are low-income, a sizeable number of uninsured children have incomes above 200 percent of the FPL, and most of these higher-income children are not eligible for public coverage.[17] Overall, an estimated 2.5 million uninsured children live in families with incomes above 200 percent of the Federal Poverty Level (Figure 4). About half of the uninsured children with incomes above 200 percent of the FPL have family incomes between 200 and 300 percent of the FPL. The risk of uninsurance declines with family income—nearly 10 percent of children with incomes between 200 and 300 percent of the FPL lack health insurance coverage compared with five percent of those with incomes between 300 and 400 percent of the FPL, and three percent of the children with incomes above 400 percent of the FPL. Most uninsured children with incomes between 200 and 300 percent of the FPL do not have parents with employer-sponsored insurance coverage.[18] Moreover, in most states, private non-group insurers are not required to issue insurance policies to individuals with health problems, further limiting coverage options for children losing SCHIP eligibility.

As of July 2006, 16 states had income thresholds above 200 percent of the FPL for children under SCHIP.[19] According to the Congressional Research Service, about 9 percent of all children enrolled in SCHIP in FY 2006 had family incomes above 200 percent of the FPL.[20] Recent evidence suggests that most SCHIP enrollees with incomes above 200 percent of the FPL do not have parents with employer-sponsored insurance coverage.[21] Almost all SCHIP enrollees with incomes above 200 percent of the FPL pay premiums for SCHIP coverage, as most states use sliding-scale premium schedules that require families with higher incomes to contribute more toward their child's coverage compared to families with incomes below 200 percent of the FPL. The level of premiums varies across states, reflecting differences in the cost of living and other factors.[22]

---

[17] J. Holahan, A. Cook and L. Dubay, *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?* (Washington, DC: Kaiser Family Foundation, 2007).

[18] Estimates based on Urban Institute Tabulations of the 2006 Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) indicate that only 13.5 percent of uninsured children in this income group have a parent with employer-sponsored coverage, although tabulations of the February Contingent Work Supplement and March ASEC Supplement to the 2005 CPS indicate that 49 percent of uninsured children with incomes between 200 and 299 percent of the FPL live in families where there is an offer of employer-sponsored insurance coverage.

[19] Most states report their eligibility thresholds net of disregards. When disregards are taken into account, it appears that 37 states have gross income thresholds that are above 200 percent of the FPL.

[20] C. Peterson and E. Herz, *Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees* (Washington, DC: Congressional Research Service, 13 March 2007).

[21] An estimated 30 percent of SCHIP enrollees with incomes between 200 and 300 percent of the FPL live in families where all parents who are present have employer coverage [based on methodology in Kenney and Cook (2007)].

[22] G. Kenney, J. Hadley, and F. Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43, no. 4 (2007): 345-361.

In summary, restricting SCHIP eligibility to children in families with incomes below 200 percent of the FPL would lead to higher uninsurance rates among children, since many of the families with incomes between 200 and 300 percent of the FPL who have children enrolled in SCHIP would find it difficult, if not impossible, to obtain affordable private coverage that meets their child's health care needs. Adopting broader Medicaid/SCHIP eligibility policies that encompass higher income children may also raise enrollment among the millions of low-income uninsured children who are eligible for Medicaid and SCHIP but not yet enrolled.[23] A key policy challenge for states will be to determine a premium schedule that minimizes the public subsidies that go to higher-income families, while at the same time maximizing take-up among the higher-income children who are uninsured.

Coverage of Parents Under SCHIP. Of the over 10 million parents who are uninsured, more than two-thirds have incomes below 200 percent of the FPL.[24] The risk of being uninsured is much higher for low-income parents than for higher-income parents—fully 42 percent of poor parents and 33 percent of near-poor parents lack coverage compared to 16 percent of parents with incomes between 200 and 300 percent of the FPL and 5 percent of those with incomes that are above 300 percent of the FPL.[25]

SCHIP funds are used to cover parents in nine states, with parents constituting 6.8 percent of all SCHIP enrollees in 2006 (0.5 million enrolled at any time in FY2006).[26] Without the higher federal matching rate available under SCHIP compared to Medicaid, it is not clear how many of these states would continue to provide expanded coverage for parents. While public coverage has grown for parents over the last decade, coverage is still very limited, with the median eligibility level under Medicaid/SCHIP at just 65 percent of the FPL for parents, compared with 200 percent of the FPL for children.[27] Only about a third of all low-income uninsured parents appear to be eligible for Medicaid or SCHIP coverage.[28]

While most low-income uninsured parents are from working families, only a quarter live in a family that has an offer of employer-sponsored coverage. Poor uninsured parents are much less likely than those in families with incomes between 100 and 200 percent of the FPL to have such an offer in their family—just 15 percent of poor parents live in families that have an offer of employer-based coverage (Figure 5).

A substantial number of low-income uninsured parents have one or more health problems—29 percent indicate that they are in poor or fair physical or mental health or that they have a

---

[23] Selden, Hudson, and Banthin, op cit.
[24] Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America 2005 Data Update* (Washington, DC: Kaiser Family Foundation, 2006).
[25] Ibid.
[26] Peterson and Herz, op cit.
[27] D. Cohen Ross, L. Cox, and C. Marks, *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,* (Washington, DC: Kaiser Family Foundation, 2007).
[28] Urban Institute tabulations of the 2005 Current Population Survey which adjust for underreporting of public coverage and take into account immigration status among income-eligible parents.

functional limitation.[29] Since many uninsured parents have chronic health care problems, finding non-group health insurance coverage that addresses their health care needs may be very difficult. Not having insurance introduces real access barriers for many uninsured parents. Low-income uninsured parents go without care at high rates—two-thirds did not see a doctor in the past year, almost 90 percent received no dental care, and over half did not have a usual source for health care.[30]

In addition, there are many connections among the insurance coverage, health status, and use of services of parents and their children. First, covering parents increases receipt of primary health care among their children.[31] When parents have health insurance for themselves, they may be more effective at obtaining health care services on behalf of their children. Second, expanding eligibility for public programs to parents has been shown to increase public coverage and to reduce uninsurance among children.[32] Third, a parent's health status affects the child's health status, health care use and well-being.[33] For example, children with depressed parents are less likely to receive preventive care and more likely to have unmet health needs and to have increased mental health problems.[34]

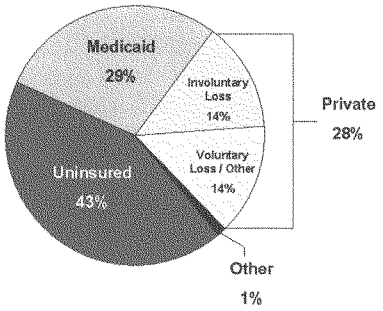
While relatively few parents are covered under SCHIP, reducing coverage for parents under SCHIP would lower their access to needed health care and also have adverse effects on the health, well being, and insurance coverage of their children. Given that such a large share of low-income parents are uninsured and do not have access to employer-sponsored insurance, instead of restricting SCHIP coverage for parents, serious consideration should be given to expanding such coverage.

In summary, the research evidence strongly indicates that SCHIP has been a success, leading to improvements in insurance coverage and access to care among low-income children, without crowding out employer coverage on a large scale. The research also clearly indicates that reductions in program funding or eligibility, either to children or their parents, would have adverse effects on the health and well-being of children.

---

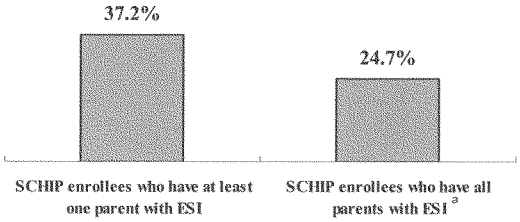
[29] Urban Institute analysis of the 2004 Medical Expenditure Panel Survey.
[30] Ibid.
[31] A. Davidoff et al., "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry* 40, no. 3 (2003): 254-268; Committee on the Consequences of Uninsurance, Institute of Medicine, *Health Insurance Is a Family Matter* (Washington, DC: National Academy Press, 2002); L. Ku and M. Broaddus, *Coverage of Parents Helps Children, Too* (Washington: Center on Budget and Policy Priorities, 2006).
[32] B. Wolfe et al., "SCHIP Expansion and Parental Coverage: An Evaluation of Wisconsin's BadgerCare," *Journal of Health Economics* 25, no. 6 (2006): 1170-1192; B.D. 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* 25, no. 6 (2006): 1154-1169; A. Aizer and J. Grogger, "Parental Medicaid Expansions and Health Insurance Coverage," NBER Working Paper 9907, August 2003; L. Dubay and G. Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid," *Health Services Research* 38, no. 5 (2003): 1283-1301.
[33] Committee on the Consequences of Uninsurance, Institute of Medicine, op cit.
[34] Ibid; G. Fairbrother et al., "How do Stressful Family Environments Relate to Reported Access and Use of Health Care by Low-income Children?" *Medical Care Research and Review* 62, no. 2 (2005): 205-230; M. Olfson et al., "Parental Depression, Child Mental Health Problems, and Health Care Utilization," *Medical Care* 41, no. 6 (2003): 716-721.

Figure 1: Coverage of Recent Enrollees in the State Children's Health Insurance Program (SCHIP) during the Six Months before Enrollment, Ten States, 2002



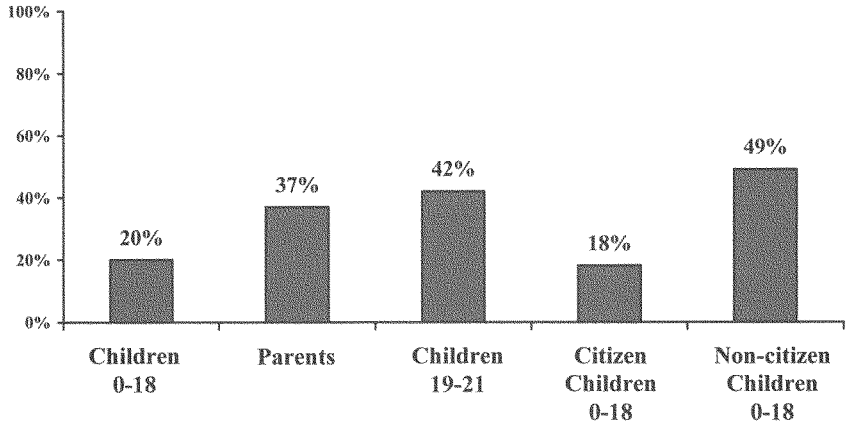
Source: A. Sommers et al., "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in 10 States." *Health Affairs* 2007, 26(2): 529-537.

Figure 2. Employer-Sponsored Insurance (ESI) among Parents of SCHIP Enrollees



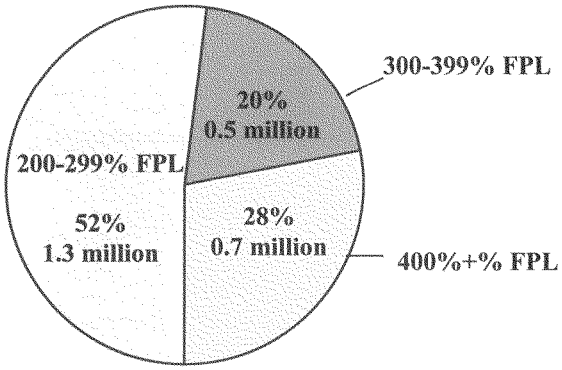
Source: Urban Institute tabulations of the 2005 Annual Social and Economic Supplement to the Current Population Survey.
[a] Where both parents have ESI in two-parent families and where one parent has ESI in single-parent families.

Figure 3. Uninsurance Rates for Low-Income Children and Parents



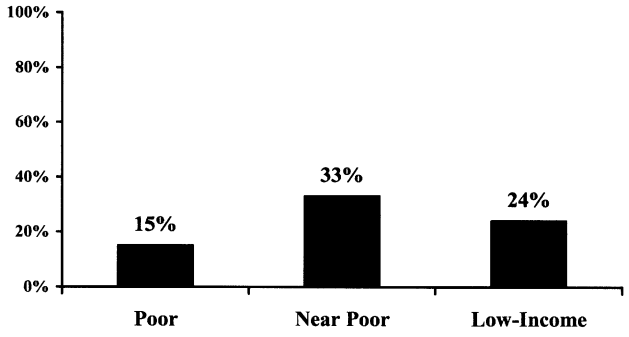
Source: Urban Institute tabulations of the 2006 Annual Social and Economic Supplement to the CPS.

Figure 4. Composition of Uninsured Children Above 200 Percent of Poverty



Source: Urban Institute tabulations of the 2006 Annual Social and Economic Supplement to the CPS.
Note: Data may not sum to 100 percent due to rounding.

Figure 5. Share of Low-Income Uninsured Parents in Health Insurance Units that Have an Offer of Employer Coverage



Source: Urban Institute analysis of the February 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2005 Annual Social and Economic (ASEC) Supplement of the CPS

○