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SCHIP: STATES' PROGRESS IN REDUCING THE NUMBER OF UNINSURED CHILDREN

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A B S T R A C T

The Balanced Budget Refinement Act of 1999 requires that every 3 years the Office of Inspector General assess the progress made by States in reducing the number of uninsured low-income children. This is our second inspection to fulfill this mandate.

As of June 1, 2003, 46 States submitted State Children's Health Insurance Program (SCHIP) 2002 Annual Reports. Of these, 44 provided some response to the Centers for Medicare & Medicaid Services's (CMS) requirement that all States describe their progress in reducing the number of uninsured low-income children in their Annual Reports. However, only 22 of these States directly addressed the CMS regulation to report a change in the number of uninsured children in the State. Of these 22 States, 17 reported a reduction in the number of uninsured children, 3 reported an increase, and 2 reported no change. National data indicate that the rate of uninsured children nationally has declined.

Instead of measuring changes in insurance among children, 19 other States responded to this requirement by reporting on SCHIP enrollment. Three States reported on something other than the number of uninsured children or SCHIP enrollment. Two States submitted Annual Reports that did not address their progress in reducing the number of uninsured low-income children.

We recommend that CMS resolve the inconsistency between the requirement that States report on changes in the number of uninsured children and the practice of accepting enrollment data as a proxy. We also recommend that CMS ensure the integrity, validity, and usefulness of the SCHIP Annual Report and SCHIP enrollment data.

OBJECTIVE

- To fulfill the congressional mandate under the State Children's Health Insurance Program (SCHIP) to assess States' progress in reducing the number of uninsured, low-income children
- To describe States' self-assessment methods
- To review the Centers for Medicare & Medicaid Services's (CMS) oversight of States' assessments

BACKGROUND

Enacted in 1997, SCHIP made approximately $40 billion in Federal matching funds available to States over 10 years to provide coverage to uninsured children below 200 percent of the Federal poverty level.

The Balanced Budget Refinement Act of 1999 requires that every 3 years the Office of Inspector General (OIG) (1) evaluate whether States are enrolling Medicaid eligible children in SCHIP, and (2) assess the progress made by States in reducing the number of uninsured low-income children, including their progress in meeting the strategic objectives and performance goals included in the State child health plan. This report addresses the second mandate. The first mandate will be addressed in a separate report. This is the second time OIG has conducted these inspections to fulfill the mandate.

Congress also mandated and CMS regulated that States annually assess and report on their progress in reducing the number of uninsured low-income children.

To assess States' progress in reducing the number of uninsured low-income children, we reviewed the fiscal year (FY) 2002 Annual Reports submitted by 46 States. We determined that a State directly addressed CMS's regulations if the State reported on a change, or lack of change, in the number and/or rate of uninsured children measured at two or more points in time. In addition, we conducted case studies of six States and consulted national data sources to further inform Congress on national progress in reducing the rate of uninsured children.

FINDINGS

In FY 2002, 22 States described changes in the number of uninsured children, and 17 of these States reported a decline. Forty-six States submitted FY 2002 SCHIP Annual Reports to CMS. These reports are

required to provide assessments of State's progress in reducing the number of uninsured low-income children. However, only 22 of these States directly addressed CMS's requirement to provide an estimate of changes in the number of uninsured low-income children. The other 24 States did not report sufficient information to determine whether the number of uninsured children had changed.

Of the 22 States that provided data on change in the number of uninsured children, 17 States reported a decrease, 3 reported an increase, and 2 reported no change in the number of uninsured children. Several national data sources show a reduction in the national number of uninsured children.

In response to CMS's requirement, States provided Current Population Survey, State survey, and enrollment data. The 22 States that measured changes in the number of uninsured children relied on the Census Bureau's Current Population Survey (CPS) or State survey data.

Instead of providing data on change in the number of uninsured children, 19 States provided enrollment data in response to the requirement to describe their progress in reducing the number of low-income uninsured children. There are several reasons why an increase in enrollment does not directly correspond to a decrease in the number of uninsured. Some children who enroll in SCHIP had a previous source of insurance, and so their SCHIP enrollment does not change the number of uninsured children. For example, some children transition to SCHIP from Medicaid. Likewise, a small percentage of SCHIP enrollees may have had prior private health coverage, despite SCHIP provisions to minimize shifts from private to public insurance. Further, external factors that result in loss of private coverage, such as a rise in unemployment, could cause uninsurance rates for children to increase despite increases in SCHIP enrollment.

Three additional States provided responses that measured something other than insurance or enrollment, and two States submitted Annual Reports that did not provide any response to CMS's requirement.

States' challenges to addressing their progress to reduce the number of low-income uninsured children include limitations associated with CPS estimates and costs of conducting a State survey. CPS limitations include small sample sizes for some States and underestimates of enrollment in public programs. Congress has funded annual improvements to the CPS through FY 2006.

CMS has not ensured that States describe changes in the number of uninsured children. As the Federal administrator of SCHIP, CMS's responsibilities include holding States accountable for directly addressing SCHIP regulations. CMS has not ensured that States report data on changes in the number of uninsured low-income children, as evidenced by the 28 of 50 States that did not directly address this requirement in 2002.

Though CMS regulations require States to provide an annual estimate of changes in the number of uninsured in the State, in practice, CMS accepts enrollment data as a proxy measure of States' progress in reducing the number of uninsured children. CMS recognizes that enrollment data does not measure changes in insurance coverage but reports that it accepts an enrollment proxy because of challenges States face in assessing their progress in reducing the number of uninsured children.

RECOMMENDATIONS

CMS should resolve the inconsistency between the requirement that States report on changes in the number of uninsured children and CMS's practice of accepting enrollment data as a proxy. We present two options for resolving this inconsistency.

Option 1: Enforce exisiting regulations that require States to report changes in the number of uninsured children.

Option 2: Broaden the requirements for States' reporting of progress toward reducing the number of uninsured children to include changes in SCHIP enrollment as an acceptable measure of this progress.

CMS should ensure the integrity, validity, and usefulness of the SCHIP Annual Report and SCHIP enrollment data. Toward this end, regardless of the option chosen above, CMS should work with States in the following three specific areas.

(1) CMS should encourage States to obtain the most precise and reliable State-level estimates of number of children with health insurance.

(2) CMS should improve its oversight to ensure that States submit relevant and timely information on progress toward reducing the number of uninsured children.

(3) CMS should ensure the accuracy of SCHIP enrollment data.

AGENCY COMMENTS

CMS provided comments on the draft report. CMS agreed with several of our recommendations and described steps the agency has implemented to improve the integrity of the States' SCHIP Annual Reports. The complete text of CMS's comments can be found in Appendix B.

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OBJECTIVE

- To fulfill the congressional mandate under the State Children's Health Insurance Program (SCHIP) to assess States' progress in reducing the number of uninsured, low-income children
- To describe States' self-assessment methods
- To review the Centers for Medicare & Medicaid Services' (CMS) oversight of States' assessments

BACKGROUND

Congressional Mandates to Evaluate SCHIP

Office of Inspector General (OIG). Section 703 of the Balanced Budget Refinement Act (BBRA) of 1999 requires that every 3 years OIG (1) evaluate whether States are enrolling Medicaid eligible children in SCHIP, and (2) assess the progress made by States in reducing the number of uninsured low-income children, including their progress in meeting the strategic objectives and performance goals included in the State child health plan (State plan). BBRA requires OIG to conduct the assessment in a sample of States that administer SCHIP separately from their Medicaid programs.

Government Accountability Office (GAO). BBRA also requires GAO to monitor OIG evaluations. In response to OIG's 2001 evaluation, *Assessment of State Evaluations Reports* (OEI-05-00-00240), GAO released a March 2002 report entitled *Inspector General Reviews Should be Expanded to Further Inform Congress*. The GAO report found that increasing the number of States under review and including those that administer Medicaid expansion programs and Medicaid-SCHIP combination programs would better inform Congress. Further, GAO suggested that OIG identify and evaluate States that use more rigorous methods to measure their progress and to review other sources of information that assist States in improving their evaluations.

OIG concurred with GAO's recommendation to expand the scope of future reviews of SCHIP. In addition, OIG agreed to consider other data sources to assess progress, while continuing to focus on what States currently do to measure their program performance.

States. Through section 2108(a) of the Social Security Act (the Act), Congress also requires States to annually assess their own SCHIP progress, including the progress made in reducing the number of uninsured low-income children, and report to the Secretary by

January 1 on the results of their assessment.[1] Section 2107(a) of the Act requires that each SCHIP State plan include a description of the program's strategic objectives and performance goals, including those related to increasing health insurance coverage for low-income children, and methods for assessing progress toward these goals.[2]

CMS also issued regulations implementing this mandate of Section 2108(a) of the Act. Title 42 C.F.R. § 457.750(b)(1) requires that, in their Annual Reports, States must "describe the State's progress in reducing the number of uncovered, low-income children." The regulations also outline States' options for estimating the number of uninsured, low-income children, using the Bureau of the Census's Current Population Survey (CPS), State surveys, or "another appropriate source." Whichever source of data is chosen, according to 42 C.F.R. § 457.750(c)(2), "the State must provide an annual estimate of changes in the number of uninsured in the State."

The State Children's Health Insurance Program: Overview

Enacted in 1997 as Title XXI of the Act, SCHIP legislation made approximately $40 billion in Federal matching funds available to States over a 10-year period to provide coverage to uninsured children below 200 percent of the Federal poverty level.[3] The program's goal is to expand coverage to uninsured children with incomes that exceed the States' Medicaid eligibility levels, but remain too low to purchase private health insurance coverage.[4] Within Federal guidelines, States set eligibility standards for the program; determine the type, amount, duration, and scope of services offered; and set payment rates for providers.[5]

SCHIP is a State and Federal partnership in which all States and the District of Columbia have approved State plans, and 49 States and the District of Columbia have enrolled children (herein referred to as the 50 States).[a] Unlike Medicaid, SCHIP is not an entitlement program, and States have the discretion to cap enrollment, create waiting lists of eligible children, or not offer a SCHIP at all. Title XXI requires States with separate programs to screen SCHIP applicants for Medicaid eligibility before enrolling them in SCHIP.

States have three options for covering uninsured children under Title XXI. They can (1) institute a separate children's health insurance

[a] Tennessee does not have any children enrolled in its Title XXI program.

program, (2) expand Medicaid eligibility, or (3) institute both a separate SCHIP and a Medicaid expansion, known as a combination program.

In fiscal year (FY) 2002, 5,315,229 children were enrolled in SCHIP under Title XXI.[6]

The Current Population Survey

The Current Population Survey (CPS), sponsored by the Bureau of the Census and the Bureau of Labor Statistics, is a primary source of data on the number of uninsured children. CPS's main purpose is to collect labor force statistics, but it also collects data on health insurance coverage through the Annual Demographic Supplement survey conducted each March.

CPS provides a consistent source of longitudinal data on the number and rate of uninsured children each year.[7] CPS is the only source of both national and State-level estimates of the number and rate of uninsured children for all 50 States. The State-level CPS estimates are used to determine each State's annual SCHIP-funding allotment.

Some States have concerns about the precision and reliability of CPS data due to small State sample sizes. In 1999, Congress responded in Public Law 106-113 to these concerns by allocating $10 million annually through FY 2006 to the Bureau of the Census to

> "make appropriate adjustments to the annual Current Population Survey…in order to produce statistically reliable annual State data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsured rates of children can reasonably be detected."[8]

Adjustments include increasing sample sizes to improve estimates of the number of uninsured low-income children.

Other National Data on Insurance Rates for Children

The National Health Interview Survey conducted annually by the Centers for Disease Control and Prevention (CDC) collects national-level data on a broad range of health topics, including the health insurance status for children.

The Behavioral Risk Factor Surveillance System conducted annually by CDC collects State-level health insurance data on adults. States may choose to fund additional State specific questions on the health insurance status of children.

The Urban Institute, a non-profit organization, conducts the National Survey on America's Families to collect information on a variety of

issues, including children's current health insurance status and SCHIP enrollment. This survey provides national data and State-level data for 13 States. Surveys were conducted in 1997, 1999, and 2002.

State Fiscal Constraints and Impact on SCHIP

According to *The Fiscal Survey of States*, conducted by the National Governors Association and the National Association of State Budget Officers, States continue to face budgetary pressures. This report found that "budget gaps are lingering as spending pressures persist, particularly from Medicaid and other health care."[9] States have curtailed spending, and FY 2004 expenditures are expected to rise only by 0.2 percent over FY 2003, representing the smallest nominal increase since 1979.[10] In FY 2004, 13 States enacted decreased budgets.[11]

As States encounter difficulty producing required Federal matching funds for Title XXI programs, some States have elected to cap SCHIP enrollment, increase premiums, increase the rigor of the enrollment process, and lower the upper limit for income eligibility to adjust to the increasing budget deficits.[12] As of November 2003, six States had frozen their SCHIP enrollment.[13]

Related Work by the Office of Inspector General

In February 2001, OIG released two separate reports on SCHIP to fulfill the congressional mandate to OIG. In *Ensuring Medicaid Eligibles are not Enrolled in SCHIP*, (OEI-05-00-00241), OIG found that between 97 and 99 percent of SCHIP participants were correctly enrolled in SCHIP in FY 1999. In *Assessment of State Evaluations Reports*, (OEI-05-00-00240), OIG found that questionable evaluations by the States undermine the reliability of reported success in reducing the number of uninsured children. OIG also found that State evaluations have conceptual and technical weaknesses.

SCOPE

This evaluation addresses the second directive of the BBRA mandate, to assess States' progress in reducing the number of uninsured low-income children. As required by Congress, OIG is concurrently conducting a separate evaluation to determine if Medicaid-eligible children are being incorrectly enrolled in SCHIP.

To assess State progress, this report evaluates States' assessments of their progress toward reducing the number of uninsured children. We also assessed the methods States use to determine this progress, as described in their FY 2002 SCHIP Annual Reports. In addition, we

provide national level data on changes in the rate of uninsured children. We included all States and the District of Columbia (herein referred to as a "State") that submitted FY 2002 Annual Reports by June 1, 2003. Annual Reports were due by January 1, 2003. Connecticut, Hawaii, Minnesota, and Nevada had not submitted reports by June 1, 2003, and Tennessee was exempt from the Annual Report requirement because the State had no children enrolled in its SCHIP program. Therefore, we reviewed Annual Reports from 46 States.

We analyzed States' progress and methods to the extent that sufficient data and information was provided in their Annual Reports. We did not conduct an independent evaluation of the reported outcomes of individual States' performance objectives.

METHODOLOGY

To assess States' progress in reducing the number of uninsured low-income children, we reviewed the FY 2002 Annual Reports submitted by 46 States. From these reports we determined whether States directly addressed CMS's regulations to describe the State's progress toward reducing the number of uninsured low-income children by providing an annual estimate of changes in the number of uninsured in the State. We determined that a State directly addressed CMS's requirement if the State reported on a change, or lack of change, in the number and/or rate of uninsured children measured at two or more points in time. Though Congress and CMS-specified low-income children, we considered States that provided information on progress toward reducing the number of all uninsured children as having addressed CMS's requirement. Data limitations prevented more detailed analyses, including comparisons across States.

We also undertook in-depth analyses and conducted site visits in six case study States: California, Florida, Massachusetts, North Carolina, Rhode Island, and Utah. These States were identified by CMS and SCHIP stakeholders as having notable evaluation expertise or experience. Diversity in size, geography, program administration, and measurement methodologies were additional criteria for selection. These States encompass all three types of SCHIP program design (i.e., separate child health program, SCHIP Medicaid expansion, and combination). These States are not representative of the universe of States.

In addition to their Annual Reports, we further reviewed the methods by which the six case study States evaluated their outcomes through interviews with their SCHIP staff, researchers, and advocates.

We interviewed CMS staff to gain further understanding of how they oversee States' Annual Reports and their role in monitoring SCHIP progress toward reducing the number of uninsured children.

We also obtained information on the national trends in insurance coverage for children from (1) the CPS, (2) the National Health Interview Survey, and (3) the Urban Institute's National Survey of America's Families.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

In FY 2002, 22 States described changes in the number of uninsured children, and 17 of these States reported a decline.

While 44 of the 46 States provided some response to CMS in their 2002 Annual Reports, only 22 of these States directly addressed CMS's regulations requiring States to describe progress in reducing the number of uninsured low-income children by estimating changes in the number of uninsured in the State.[b] We determined that a State directly addressed CMS regulations if the State reported a change, or lack of change, in the number and/or rate of uninsured children measured at two or more points in time. For additional information on States' responses, see Appendix A.

Seventeen of these twenty-two States reported a reduction in the number or rate of uninsured children.

Of the 22 States that directly addressed CMS's requirement to measure insurance coverage changes, 17 reported a decrease in the number of uninsured children. Three States reported an increase in the number of uninsured children and two States measured no change. Table 1 below summarizes these States' results.

Table 1. State-Reported Changes in Insurance for Children

States reporting a decrease in the number of uninsured children	17
States reporting an increase in the number of uninsured children	3
States measuring no change in the number of uninsured children	2
Total State responses	**22**

Source: States' SCHIP Annual Reports to CMS, FY 2002

Of the 17 States measuring a decrease in uninsured children, 5 specifically reported a reduction in the *number* of uninsured children over time; 9 States reported a decrease in the *rate* of uninsured children; and 3 States reported reductions in both the number and rate of uninsured children.

State-reported reductions in the number of uninsured children range from a 5 to 37 percent decline. For example, 1 State's estimate of uninsured children declined from 311,000 to 197,000 children, a decrease of 37 percent. State-reported changes in insurance rates ranged from 1.5 percentage points (representing an 18 percent

[b] Though Congress and CMS specified "low-income" children, we include States that provided information on progress toward reducing the number of all uninsured children.

reduction in the rate of uninsured children) to 6.3 percentage points (representing a 66 percent reduction). For example, one State reported its estimated rate of uninsured children dropped from 9.5 percent in 1996 to 3.2 percent in 2001. This represents a 66 percent reduction in the rate for uninsured children.

State-reported progress in reducing the number of uninsured children is not comparable across these 17 States. States measure change over different periods of time and for different populations. For example, three States reported change over a 1-year period, while other States compared current estimates of the number of uninsured children to estimates from up to 5 years earlier. Some States also provided estimates from more than two points in time.

Further, 12 of the 17 States reported changes in the number of uninsured children overall, while 5 reported specifically on children in certain income ranges (e.g., children up to 200 percent of poverty). Only 2 of the 17 States provided information on the statistical significance of their reported decreases in the number of uninsured children.

Five of the twenty-two States that directly addressed CMS requirements reported an increase or no change in the number of uninsured children. Specifically, three States reported an increase in the number of uninsured children, and two States reported no change. Two of these five States attributed their lack of measurable insurance progress to factors related to their measurement of the number of uninsured children. Specifically, one State's estimate of the number of uninsured children decreased, but this change was not statistically significant, so we categorized this State as measuring no change. Another State reported that their increase in the number of uninsured children was due, in part, to a change in the weighting of its latest CPS estimates.

National data show a decline in the number of uninsured children. To further inform Congress on the national progress toward reducing the number of uninsured children, we consulted several data sources on national insurance coverage trends for children. These estimates are not directly comparable to one another because they provide data on different populations (e.g., all children versus low-income children) or different periods of time. However, all three sources provide evidence that the national rate of uninsured children has declined.

Specifically, CPS data demonstrate a decline in the rate of uninsured children nationally.[14] In 1998, CPS estimated that 15.4 percent of all children under 18 years old lacked health coverage. By 2002, this

estimate dropped to 11.6 percent, which represents a 25 percent reduction[c] in the rate of uninsured children.[15]

The National Health Interview Survey, a survey administered by CDC which collects health data from a random sample of individuals nationwide, shows a statistically significant reduction in the rate of uninsured children from 1997 to the first half of 2003. In 1997, this survey estimated that nationally, 13.9 percent of all children lacked health insurance at the time of the survey. By 2003, this rate had dropped to 9.4 percent.[16]

The Urban Institute found that the rate of uninsured low-income children below 200 percent of the poverty level fell from 22.5 percent in 1999 to 16.8 percent in 2002.[17] This decrease was associated with increased Medicaid and SCHIP coverage.[18]

To Respond to CMS's requirement, States use CPS, State Survey, and Enrollment Data.

The 22 States that directly addressed CMS's requirement relied on the CPS or State survey data to measure a change in the number of uninsured children over time. Instead of measuring SCHIP progress in reducing the number of uninsured children, 19 additional States provided enrollment data in response to CMS's requirement. Three additional States provided responses that measured something other than children's insurance or enrollment progress, and two States submitted Annual Reports that did not provide any response to this requirement. Table 2 summarizes States' responses from their 2002 Annual Reports.

Table 2. States' Annual Report Assessments of Changes in the Number of Uninsured Children

States whose responses measured changes in the number of uninsured children	22
States whose responses measured SCHIP enrollment	19
States whose responses measured something other than children's insurance or enrollment	3
States whose Annual Reports did not provide any response to CMS's requirement	2
Total	**46**

Source: States' SCHIP Annual Reports to CMS, FY 2002

[c] The CPS revised its survey question during this time, which may affect the magnitude of this change.

Of the 22 States that directly addressed CMS's requirement, 12 relied on CPS data.

Twelve States, including one case-study State detailed below, used CPS data to measure the outcome of their efforts to reduce the number or rate of uninsured children in their CMS Annual Report. Annually, CPS provides a free, easily accessible source of longitudinal data on the number and rate of uninsured children. CPS provides State-level insurance estimates for all children and specific estimates for children below 200 percent of the poverty level. For many States, CPS is the only data source available for estimating changes in the number of uninsured children.[19]

All States, as well as Congress, CMS, OIG, and the public, have access to annual, State-level CPS estimates of uninsured low-income children. However, some States face limitations by relying solely on CPS data for State-level estimates of uninsured children.[20] For States with smaller populations, CPS sample sizes are relatively small.[21] The smaller the sample size, the less precise the estimate. These estimates may not detect incremental changes in insurance rates over time. For example, one State noted that its CPS estimates showed a reduction in the number of uninsured children, but this reduction was not statistically significant because the State's CPS sample size was too small. Another State reported that its total CPS-estimated eligible population was less than its current Medicaid and SCHIP enrollment.

Beyond the concerns about sample size, CPS is an employment survey that includes health insurance questions at the end of the survey. Some researchers believe that a survey focused on health issues is more likely to elicit accurate responses about health insurance status.[22] Further, CPS asks respondents in March about their health insurance coverage at any time during the past calendar year, rather than their current insurance status.[23] Researchers expressed concern that CPS respondents may erroneously report on current insurance status.[24] Finally, CPS data tend to underestimate the number of children enrolled in Medicaid, and these children may be incorrectly counted as uninsured.[25] One State noted that its CPS estimate of SCHIP coverage was 83 percent lower than the State's actual SCHIP coverage.

Rhode Island. Rhode Island finds CPS data valuable to track State health insurance trends and progress in reducing the number of uninsured children, despite its limitations. Though State SCHIP staff acknowledged the imprecision of CPS point estimates, they expressed confidence in the overall direction of change indicated by CPS data. The

exact number of uninsured children is less important to the State than knowing whether the rate of uninsured children is declining.

To confirm CPS insurance trends for children, State staff consult several additional data sources. Rhode Island added a question on children's insurance status for its State sample in the CDC-administered Behavioral Risk Factor Surveillance System. The State also collects health insurance status data through a State household survey usually conducted every 5 years. Finally, the State consults private coverage data from BlueCross BlueShield, which accounts for 69 percent of the State's health insurance market, and data on the use of uncompensated care provided by safety net providers.

The other 10 States that directly addressed CMS's requirement used State surveys.

Ten States conducted statewide surveys that enabled them to measure and report on change in the number or rate of uninsured children over time. By developing their own surveys States are able to tailor their questions to overcome some of the limitations associated with CPS insurance rate estimates and address State-specific concerns. Three of these ten States were included in our case studies, and their efforts are detailed below.

Florida. While Florida SCHIP staff expressed confidence in their CPS insurance estimates, the State sought more detailed information on its uninsured population. State staff believed that estimates of the rate of uninsured children for different regions and demographic groups would help Florida better understand and more effectively address uninsured subpopulations. Florida fielded telephone surveys in 1998 and 2002 designed to produce estimates of insurance specific to 17 regions and various demographic groups. The surveys also sought to determine if uninsured children were likely to be eligible for Medicaid or SCHIP.

Massachusetts. According to Massachusetts's staff, their State survey has several advantages over CPS for estimating the State's rate of uninsured children, including a larger sample size which allows a more precise estimate. And, unlike CPS, this survey focuses exclusively on health insurance. Further, Massachusetts tested its survey questions extensively using cognitive interviews and focus groups to ensure that the survey would yield valid and reliable results.

Massachusetts's survey results support its contention that CPS overestimates its number of uninsured children. In 2002 the State survey estimated that 3 percent of all children were uninsured, while

CPS estimated 7.8 percent. Estimates for Massachusetts from the National Survey of America's Families align more closely with the results of the State survey than the CPS for this State.

Utah. From 1986 to 2001 Utah conducted a telephone survey every 5 years to collect comprehensive information on children's health, including their health insurance status. In its FY 2002 Annual Report, Utah compared its estimated rates of uninsured children from 1996 to 2001 and found that the rate for uninsured children decreased from 8.5 percent to 7 percent. However, the State noted a limitation of this comparison. In 2001, Utah changed its health insurance questions. The State cannot determine how much of the change in it's estimated insurance rates since 1996 should be attributed to the change in the survey questions, rather than an actual change in insurance coverage during that time.

In response to CMS's requirement, 19 additional States reported on enrollment instead of progress in reducing uninsured children.

In their Annual Reports 19 additional States responded to CMS by reporting on SCHIP enrollment, without providing information on the changes in the number or rate of uninsured children over time. These States reported a variety of enrollment information, including enrollment at a point in time; changes in enrollment over time; comparisons of SCHIP enrollment to an estimate of uninsured children at a point in time, known as a penetration rate; or some combination of these. Fourteen States reported changes in SCHIP enrollment over time. Of these, 13 States reported enrollment increases, and 1 State reported enrollment had remained stable.

While SCHIP enrollment increases provide one measure of program success, these numbers do not indicate changes in States' rates or number of uninsured children. Some States interpret increases in enrollment, an output, as net gains in health insurance coverage, an outcome. However, enrollment increases are not analogous to insurance increases for several reasons. Some children transition to SCHIP from Medicaid, and so their SCHIP enrollment does not change the number of uninsured children. Likewise, a small percentage of SCHIP enrollees may have had prior private health coverage, despite SCHIP provisions to minimize the shift from private to public sector insurance, which is known as "crowd out."

Further, external factors may affect the insurance rate for low-income children. For example, if a large number of children lose their private health coverage due to a rise in unemployment or a rise in private

insurance premiums, the number of uninsured children may increase despite concurrent increases in SCHIP enrollment.

States offered technical and economic reasons for using enrollment data. Eleven States, including three States that used enrollment data, cited data limitations associated with CPS estimates in their Annual Reports. States expressed concerns that CPS produces unreliable and imprecise estimates for their States. As mentioned above, this is primarily due to small State sample sizes, the fact that CPS is a lengthy labor-related survey with health insurance questions at the end, and historical CPS undercounts of public health insurance participation. For example, one State explained that the CPS estimate of the total number of children under 100 percent of poverty in the State was lower than the actual number of children under 100 percent of poverty that were enrolled in the State's Medicaid program. Further, the State's enrollment in SCHIP is 128 percent of the CPS baseline estimate of all uninsured children in the State. Another State also considered the CPS measurement of insurance coverage at any time during the prior year, rather than at a point in time, a disadvantage.

While a State survey could overcome CPS precision and reliability concerns, a State survey may be cost-prohibitive. In interviews, SCHIP staff from four States pointed to recent economic downturns and fiscal constraints to explain why they did not focus on assessing their progress in reducing the number of uninsured. Respondents explained that their priorities have shifted from reducing the number of uninsured children and increasing program enrollment to maintaining current enrollment levels and preserving SCHIP benefits. One State's SCHIP staff acknowledged their inability to reliably measure their progress in reducing the number of uninsured children but viewed this as a necessary tradeoff, stating that they would "rather spend their money to cover kids than to count them."

North Carolina. North Carolina illustrates these explanations for using enrollment data. Their performance objective related to reducing the number of uninsured children is "to enroll as many children as possible that can be covered within available funds." This State estimates that there are 35,000 more SCHIP-eligible children than the State's target enrollment goal, which is the maximum number of children the budget will cover. According to SCHIP staff, they have insufficient funds to cover all eligible children, in part, because CPS underestimated their number of eligible children, and they have exhausted their Federal SCHIP allotment.

In their Annual Report North Carolina provided CMS with a baseline insurance rate derived from an adjustment of CPS data. However, neither the State staff nor the researchers who calculated this baseline have confidence in the accuracy of this estimate. This lack of confidence in the CPS estimate, combined with a lack of funding for a State survey, has motivated a continuing reliance on enrollment numbers to assess and report success.

In the Annual Report North Carolina specifies its performance goal as its current number of enrollees. In effect, the States' goal is to maintain current enrollment in the program, not to reduce the overall insurance rate. State staff report that State funding availability and the assumption that SCHIP is enrolled to capacity are the factors used to determine their SCHIP goal. State SCHIP staff explain that because they lack reliable data to demonstrate that there are additional eligible but uninsured children, they must set their goals within budgeted funds.

CMS has not ensured that States describe changes in the number of uninsured children.

CMS has not held States accountable for directly addressing the CMS requirement that States describes their changes in the number of uninsured low-income children. As detailed above, 24 of the 46 States that submitted Annual Reports to CMS did not describe their progress in reducing the number of uninsured children. Four additional States had not submitted Annual Reports by June 1, 2003, despite a deadline of January 1, 2003.

CMS accepts enrollment data as a proxy measure of SCHIP progress. Six years after SCHIP enactment, less than half of States report directly on their progress in reducing the number of uninsured as required by CMS. In lieu of this direct assessment, CMS accepts and uses enrollment data from States as an alternative measure of program success. CMS's staff explained that States' enrollment numbers provide a reliable indicator of States' SCHIP progress, as long as States continue to take measures to prevent "crowd out" (i.e., substitution of SCHIP for private health insurance). In addition, CMS consults CPS data available from the Census Bureau to track national health insurance trends for children as well as State-level CPS data for each State.

There is incongruity between CMS's requirement that States describe their progress in reducing the number of uninsured children and CMS's acceptance of enrollment data from States as a substitute for a measure

of change in the number of uninsured children. Title XXI states that the main long-term goal of SCHIP is to expand health assistance to uninsured low-income children.[26] The mandates that States assess and report their progress in reducing the number of uninsured low-income children, and that OIG assess States' progress toward this goal demonstrate Congress's interest in this specific outcome. CMS regulations also require States to provide an annual estimate of changes in the number of uninsured children.[27]

However, CMS sets its SCHIP Government Performance and Results Act (GPRA) goal around increasing enrollment. In its assessment of SCHIP, the Office of Management and Budget (OMB) noted that CMS's GPRA goals do not measure the impact of SCHIP on the rate of uninsured children, and OMB recommended that CMS develop goals to measure this impact.[28]

CMS reported to us that it sets its GPRA goal around increasing SCHIP enrollment because of the difficulties associated with measuring changes in insurance rates, particularly in the context of changes in economic conditions and private insurance markets. CMS also emphasized the limitations of CPS data for State-level insurance estimates, particularly for smaller States, and recognized that many States cannot afford to field their own State insurance coverage surveys. Further, CMS respondents pointed to studies that have shown minimal "crowd out" to demonstrate the link between enrollment and insurance increases.

Accuracy of SCHIP enrollment data raises additional concerns. CMS emphasized limitations of available health insurance data. However, we also found limitations with one of the primary enrollment data elements for SCHIP -- the annual number of children "ever enrolled" by State for each FY. CMS produces an annual summary of the number of children "ever enrolled" in SCHIP by State, based on unverified, State-submitted data. The Annual Report template also asks States for the number of children "ever enrolled" in SCHIP. For 10 States, we found discrepancies between the numbers of "ever enrolled" children reported in the Annual Reports and those reported in the CMS enrollment summary. For instance, between FYs 2001 and 2002, one State's Annual Report showed an increase in enrollment of 7,000 children, while the CMS summary reported a decrease of 15,000 children for the same State. CMS described a new data reporting system that it has implemented since our review that it expects will improve the accuracy of State-reported enrollment data.

In addition, CMS's enrollment summary double counts children who transfer from one SCHIP program to another during the year. This duplicate count occurs for children in the 20 States with both Medicaid expansion and separate programs (combination States) who move from one program to the other within the same State. It also occurs for children who move from one State's to another State's SCHIP. CMS recognized this limitation of its data on "ever enrolled" children. However, CMS pointed out that it collects other types of unpublished enrollment data, such as quarterly point-in-time enrollment counts, that are not subject to this problem.

CMS has not ensured that States submit relevant, clear, and timely information in their Annual Reports.

The law and CMS regulations require States to submit SCHIP Annual Reports to describe their progress toward meeting the strategic objectives and performance goals described in their State plans.[29] CMS regulations for State plans, which reflect Section 2107(a) of the Act, set forth that States must specify one or more performance goals for each strategic objective and must describe how performance will be measured through objective, independently verifiable means and compared against performance goals.[30] SCHIP law specifically requires States to, "assess the operation of the State plan, including the progress made in reducing the number of uncovered low-income children."[31] And CMS regulations require States to provide an annual estimate of changes in the number of uninsured.[32]

CMS reports that its project officers are in contact with the States to provide technical assistance that States need to complete their Annual Reports and to check on States' progress. CMS also reported that it discusses content and deadlines of the Annual Report on monthly SCHIP Technical Advisory Group calls.

Yet, these efforts have not ensured that States establish and report strategic objectives, performance goals, and methodologies that are relevant to measuring change in the number of uninsured children. For example, one State described its performance goal related to reducing the number of uninsured children as expanded capacity of the State's data systems and additional field staff training. Another State described increased administrative and outreach capacity as its performance goals and the hiring of 47 outstationed eligibility workers as its progress related to reducing the number of uninsured children.

While these may be creditable goals for achieving other SCHIP objectives, they are not performance goals that lead to measurement of

changes in the number of uninsured children. In comparison, an example of a relevant, objective, and measurable performance goal related to reducing the number of uninsured children was one State's goal that "the percent of children with creditable coverage for the entire year, whose family income is between 150% and 200% of the Federal Poverty Level, will be increased from 89.7% in 1998 to 95% in 2003."

CMS has not required States to resubmit sections of the Annual Report when they provide unclear information or outdated goals. In their 2002 Annual Reports, seven States submitted outdated goals related to reducing the number of uninsured children. For example, one State continued to cite a performance goal related to reducing the number of uninsured children that the State had already achieved more than 2 years earlier.

CMS has not held States responsible for timely State Annual Report submissions. Twelve States' Annual Reports were submitted after the January 1, 2003 deadline.[d] Late submissions ranged from 2 days to 5 months past this deadline. In addition, four States had not submitted 2002 Annual Reports at the time of our analysis in June 2003. CMS has indicated that those States have since submitted 2002 Annual Reports, but these reports were more than 5 months late.

[d] Eight additional States' reports did not include a submission date.

In response to our congressional mandate, we found that 22 States reported a change in the number or rate of uninsured children in their FY 2002 Annual Report. The remaining 28 States did not report sufficient information to allow us to assess whether they had reduced their numbers of uninsured children.[e] CMS has not ensured that States comply with CMS's requirement that States' describe changes in the number of uninsured children. As such, we offer two options for CMS to select in order to increase States' compliance. In addition, we offer a three-prong approach to assist CMS in working with States to ensure the integrity, validity, and usefulness of all data submitted by States in their Annual Report.

CMS should resolve the inconsistency between the requirement that States report on changes in the number of uninsured children and CMS's practice of accepting enrollment data as a proxy.

Currently, there is inconsistency between CMS's requirement that States report on changes in the number of uninsured and CMS's acceptance of enrollment data as a proxy for progress toward reducing the number of uninsured children. As CMS recognizes, enrollment data does not measure changes in insurance coverage. We present two options for resolving this inconsistency.

Option 1: Enforce exisiting regulations that require States to report changes in the number of uninsured children.

As the agency responsible for overseeing SCHIP, CMS should hold States accountable to directly address its requirement that States describe their progress in reducing the number of uninsured low-income children by providing an annual estimate of changes in the number of uninsured in the State. If a State's response does not demonstrate change in the number of uninsured children, CMS should follow up with that State to provide further clarification and technical assistance as needed.

[e] Tennessee is excluded from this count because the State has no children enrolled in SCHIP.

Option 2: Broaden the requirements for States' reporting of progress toward reducing the number of uninsured children to include changes in SCHIP enrollment as an acceptable measure of this progress.

While CMS acknowledged that enrollment data does not measure changes in insurance coverage, CMS provided justifications for accepting enrollment data as a proxy measure of change in the number of uninsured children. These justifications focused on challenges that some States face estimating changes in the number of uninsured children. However, this practice is not consistent with current requirements for States to report on changes in the number of uninsured children. If CMS decides that the challenges for some States to obtain information on changes in the number of uninsured children outweigh the benefits of the information, then CMS should change the regulations to reflect this decision.

CMS should ensure the integrity, validity, and usefulness of the SCHIP Annual Report and SCHIP enrollment data.

Toward this end, regardless of the option chosen above, CMS should work with States in three specific areas (1) encourage States to obtain the best estimates available of children's insurance coverage, (2) ensure States provide relevant and timely information on SCHIP progress as required, and (3) ensure the accuracy of SCHIP enrollment data.

CMS should encourage States to obtain the most precise and reliable State-level estimates of number of children with health insurance.

Many States face difficulties obtaining precise and reliable health insurance estimates, including concerns about the imprecision and unreliability of State-level estimates derived from CPS and the costliness of State-initiated surveys.

Some States use CPS data in some way but do not directly address CMS's requirement to estimate change in the number of uninsured, e.g., States that compare enrollment data to a CPS estimate of uninsured children at one point in time. For these States, CMS should provide technical assistance to SCHIP staff on how to best use CPS data to measure progress in reducing the number of uninsured children.

On behalf of States that have concerns about the reliability of CPS data, CMS should continue departmental efforts to collaborate with the Bureau of the Census on increasing CPS sample sizes to make this data more useful for each State. CMS should also encourage these States to

revisit CPS data to determine whether ongoing CPS sample size improvements have alleviated their concerns.

Further, CMS should work with States that continue to distrust CPS estimates to identify or develop alternative data sources. CMS could compile and share strategies that other States have used to measure their progress in reducing the number of uninsured children. Recognizing the costs of a new State survey, CMS can encourage States to take advantage of existing surveys and data sources. For example, States can minimize costs by adding questions on children's health insurance status to the existing CDC's Behavioral Risk Factor Surveillance Survey. The Urban Institute's National Survey of America's Families also provides State-level estimates of children's health coverage for 13 States every few years. CMS could encourage these 13 States to use this information to assess their progress toward reducing the number of uninsured children.

CMS should improve its oversight to ensure that States submit relevant and timely information on progress toward reducing the number of uninsured children.
While CMS reported having a process for overseeing the quality and timeliness of States' reporting, this process should be evaluated and improved because it has not fully resolved deficiencies in States' Annual Reports. Similar to the methods we used for this report, CMS should carefully review States' Annual Reports to ensure that States provide clear and timely information on their progress toward reducing the number of uninsured children that meets CMS's requirements. If a State's Annual Report describes performance goals, measures, or outcomes that do not describe progress toward reducing the number of uninsured children, CMS should follow up with that State for further clarification and provide technical assistance as needed. Likewise, CMS should provide guidance to States on updating outdated goals to reflect current program conditions. CMS should also reinforce the importance of submitting the SCHIP Annual Report by the January 1st deadline.

CMS should ensure the accuracy of SCHIP enrollment data.
Even beyond its use as a proxy measure for insurance progress, enrollment data provide its own important measure of program success. CMS should rectify inconsistencies between States' 2002 enrollment data reported in CMS's enrollment report and data reported in States' Annual Reports by reviewing the two numbers to identify and reconcile any discrepancies. CMS has recently implemented a new reporting system for States' enrollment data and anticipates that this system will

alleviate the data concerns cited in our report. CMS should review 2003 data to verify that this new system ensures data accuracy.

In addition, CMS should reconsider its methodology which double counts children that transfer from one SCHIP program to another during the same FY in States with both Medicaid expansion and separate SCHIP programs. CMS should devise criteria for categorizing such children in a way that produces an unduplicated count of "ever enrolled" children, such as counting them in the program in which they were enrolled for the greatest duration. CMS should also publish additional types of data it collects, such as quarterly point-in-time enrollment numbers, to provide a more robust picture of SCHIP enrollment.

CMS provided comments on the draft report. CMS agreed with several of our recommendations and described steps the agency has implemented to improve the integrity of the States' SCHIP Annual Reports. The complete text of CMS's comments can be found in Appendix B. CMS also provided technical comments on the report.

CMS provided responses to each of our recommendations.

Recommendation 1. CMS should resolve the inconsistency between the requirement that States report on changes in the number of uninsured children and CMS's practice of accepting enrollment data as a proxy.

CMS Response. In response to our recommendation to resolve inconsistency, CMS stated that they will work with Congress to clarify how progress should be measured and reported. CMS also noted that their regulations require States to "describe the State's progress in reducing the number of low-income, uncovered children" but do not specify a particular methodology for meeting this requirement.

Further, CMS agreed that they need to work with States to improve State measurement efforts. Consistent with our recommendations, CMS stated that they are taking steps to enhance technical assistance to improve State measurement capabilities, including scheduling a technical assistance session at an upcoming national conference. CMS also highlighted some of the same difficulties States face in measuring changes in the number of uninsured children that we discussed in our report.

Recommendation 2. CMS should ensure the integrity, validity, and usefulness of the SCHIP Annual Report and enrollment data.

CMS Response. CMS stated that, in addition to providing technical assistance to States, they are reviewing all State reports on progress toward covering the uninsured. Also, CMS has been encouraging States to revisit CPS data in light of ongoing improvements to this survey, as we recommended.

Further, CMS has implemented a new, web-based State Annual Report Template System, and CMS highlighted this system's role in implementing this recommendation. CMS expects that this system will

assist the agency to more effectively analyze State reports on progress toward covering the uninsured. Consistent with our recommendations, CMS stated that they are using this new system to more closely review the information States provide and to request that States provide more clear and accurate responses in their SCHIP Annual Reports. CMS also expects the system to help improve CMS's oversight of the SCHIP Annual Report submission process. Additionally, this system will be linked to the SCHIP enrollment data that CMS collects and reports, and CMS stated that this will eliminate the discrepancies we found between enrollment data in the SCHIP Annual Reports and in CMS's enrollment summaries.

In response to our recommendation that CMS reconsider its methodology for "ever enrolled" data which double counts certain children who transfer between SCHIP programs, CMS stated that the number of double-counted children is limited, and that they do not believe this impacts the total enrollment significantly. We suggested that CMS also publish the "point-in-time" enrollment data they collect, which is not duplicative, but CMS noted that this data is not as reliable as "ever enrolled" data. CMS is working with States to improve data reliability.

Throughout their comments, CMS also highlighted national data that show significant reductions in the number of uninsured low-income children since the implementation of SCHIP and indicate CMS's and States' success in achieving SCHIP program goals. As we noted in our report, national data does provide evidence of success in reducing the number of uninsured low-income children, the primary goal of SCHIP. We hope that our recommendations and the steps that CMS has implemented will contribute to continued national progress toward this goal and ensure that each State shows similar success.

States' Responses to CMS's Requirement in their 2002 Annual Reports

States whose responses measured progress in reducing the number of uninsured children

1	Alabama	12	Montana
2	Arizona	13	New Hampshire
3	Delaware	14	New Jersey
4	Florida	15	New York
5	Georgia	16	Ohio
6	Idaho	17	Rhode Island
7	Kansas	18	South Carolina
8	Kentucky	19	Utah
9	Louisiana	20	Washington
10	Massachusetts	21	West Virginia
11	Maryland	22	Wisconsin

Source: States' SCHIP Fiscal Year 2002 Annual Reports

States whose responses measured SCHIP enrollment

1	Alaska	11	North Carolina
2	Arkansas	12	North Dakota
3	California	13	Oklahoma
4	Colorado	14	Pennsylvania
5	Illinois	15	South Dakota
6	Iowa	16	Texas
7	Maine	17	Vermont
8	Michigan	18	Virginia
9	Missouri	19	Wyoming
10	Nebraska		

Source: States' SCHIP Fiscal Year 2002 Annual Reports

States whose responses measured something other than children's insurance or enrollment

1	Indiana	3	Oregon
2	Mississippi		

Source: States' SCHIP Fiscal Year 2002 Annual Reports

States whose Annual Reports did not include any response to CMS's requirement

1	District of Columbia	2	New Mexico

Source: States' SCHIP Fiscal Year 2002 Annual Reports

States that did not submit an Annual Report by June 1, 2003

1	Connecticut	3	Minnesota
2	Hawaii	4	Nevada

Note: Tennessee was not required to submit a 2002 Annual Report because they had no enrolled children in SCHIP.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

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DATE: JUN 29 2004

TO: Dara Corrigan
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D. MM
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "SCHIP: States' Progress in Reducing the Number of Uninsured Children" (OEI-05-03-00280)

Thank you for the opportunity to review the OIG Congressionally mandated report on how states assess progress in reducing the number of uninsured low-income children. We agree with several of the OIG recommendations and have already implemented steps to improve the integrity of the state annual report submissions. As noted in your report, we have provided extensive guidance to states through our Technical Advisory Group, our Regional Offices (RO) and Central Office (CO) Project Officers, that reports must be submitted in a timely manner. In addition, we have created a new web-based system for submission of the annual reports, which has resulted in states submitting more timely, quality reports. Finally, we have improved our internal monitoring of state reports on uninsured and have engaged external experts to provide technical assistance to states on improving their measurement of children's uninsurance rates.

We believe these efforts will lead to continued improvement of states reporting of their progress towards covering the uninsured. As noted in the OIG report, published national data show that significant reductions in uninsurance among low-income children have occurred since the implementation of the State Children's Health Insurance Program (SCHIP). For example, the Current Population Survey (CPS) estimated that 15.4 percent of all children under 18 years old lacked health coverage in 1998, but this estimate dropped to 11.6 percent in 2002. The Centers for Disease Control and Prevention's National Health Interview Survey shows a statistically significant reduction from 23 percent of children below 200 percent of poverty lacking health coverage in 1997 to 14 percent in 2003. These findings indicate that the Centers for Medicare & Medicaid Services (CMS) and the states have effectively addressed the goals of title XXI, and we are very proud of the program's success.

Below you will find detailed responses to the various recommendations in the draft report.

OIG Recommendation

CMS should resolve the inconsistency between the requirement that States report on changes in the number of uninsured children and CMS's practice of accepting enrollment data as a proxy.

- Option 1: Enforce existing regulations that require States to report changes in the number of uninsured children.
- Option 2: Broaden the requirements for States' reporting of progress toward reducing the number of uninsured children to include changes in SCHIP enrollment as an acceptable measure of this progress.

CMS Response

Consistent with the requirements of Title XXI of the Social Security Act, CMS regulations require states to "describe the state's progress in reducing the number of uncovered, low-income children." Our regulations do *not* specify a particular methodology for meeting this requirement. While the OIG describes one approach to measuring the reduction of uninsurance among children, CMS, along with other experts in measuring the uninsured, have recognized the challenges associated with measuring insurance coverage at the state level. With recent improvements in the CPS and improved modeling methods, however, CMS agrees with the OIG that we need to work with states to improve state measurement efforts. To that end, we have taken steps to enhance technical assistance to states to improve their measurement capabilities.

It is also important to note that state-specific data on changes in the number of uninsured children is available publicly and has been analyzed by many groups including CMS and the State Health Access Data Assistance Center (SHADAC). A forthcoming SHADAC analysis comparing the number of uninsured children by state pre- and post-SCHIP implementation indicates that all states have made progress in reducing the number of uninsured children. The CMS is currently working to schedule a technical assistance session at the National Academy for State Health Policy's annual conference for August 2004. In this session, CMS will work with outside experts to emphasize the importance of analyzing data on the uninsured and how states can use and report on CPS.

State enrollment reports, along with national reports on the uninsured, show that SCHIP has made significant progress in reducing the number of uninsured children. In order to form a complete picture of progress towards covering the uninsured, the number and rate of uninsured children needs to be analyzed with enrollment in SCHIP and Medicaid and the extent to which, if any, public coverage is crowding out private coverage. The SCHIP legislation is up for reauthorization in 2007 and CMS will work with Congress to clarify how progress should be measured and reported.

OIG Recommendation
CMS should ensure the integrity, validity, and usefulness of the SCHIP Annual Report and SCHIP enrollment data.

> (1) CMS should encourage States to obtain the most precise and reliable State-level estimates of number of children with health insurance.

CMS Response
The CMS has provided guidance to states since 1998 on the options for producing baseline estimates, recognizing that it would not be possible to rely on a single data source and methodology for all states. Measurement of state progress toward reducing the number of uninsured children is challenging because of the limitations of state-level baseline data on the number of children uninsured prior to SCHIP, as well as lags in obtaining data on the number of uninsured children since SCHIP was implemented. Other barriers include the lack of consistent measures over time (states are free to change their baselines) and inadequate sample sizes to develop reliable measures. The OIG acknowledges that states face significant obstacles in funding and expertise necessary to perform analysis on their progress.

While there are significant data limitations inherent in individual state estimates of the number of low-income children, national data show progress toward reducing the number of low-income uninsured children. Some states have concerns about the precision and reliability of CPS data due to small state sample sizes. States face limitations by relying on CPS data for state-level estimates of uninsured children. For states with smaller populations, the CPS sample sizes are relatively small; the smaller the sample size, the less precise the estimate. In addition, these estimates may not detect incremental changes in insurance rates over time. The OIG discussed the possibility of performing state-specific surveys of the uninsured but we note, as did the OIG, that these surveys may be prohibitively expensive.

As noted above, CMS will continue to provide technical assistance to states and is currently in the process of reviewing all state reports on progress towards covering the uninsured. The CMS will provide more state-specific technical assistance to the states identified as not measuring progress towards covering the uninsured, either as measured through changes in the uninsured or changes in enrollment in SCHIP and Medicaid. However, it should be noted that state-specific CPS information is available going back to 1997. Both CMS and the states review this data.

As OIG discussed in its findings, each new CPS uninsured data release has been an improvement on the last data release. Congress appropriated $10 million to the Census Bureau for fiscal year (FY) 2000 and each subsequent fiscal year to improve the reliability of the CPS estimates of the number of uninsured children. In recent years the Census Bureau has added an insurance verification question to the survey and continued to increase sample sizes in small states. Both of these steps should improve the reliability

and accuracy of the CPS and CMS has been encouraging states to revisit the CPS as a source for state-level uninsured data in light of these improvements.

The CMS has also implemented the State Annual Report Template System (SARTS), which is a web-based system for states to submit their annual reports. The CMS expects that SARTS will help states streamline their submissions to CMS and also help CMS to more effectively analyze state annual reports on progress towards covering the uninsured since all of this information will be available in a central, electronic database. The CMS is also taking advantage of SARTS to more closely review the information provided by states and to request that states provide more clear and accurate responses to the questions included in the state annual report template. The CMS also reviews state annual reports as part of its work in compiling annual summaries of state annual reports. Individual project officers also use the annual reports as part of their review of state plans. The CMS prepared a summary of state annual reports for both FY 2001 and 2002 and will prepare a summary of FY 2003 annual reports.

OIG Recommendation - continued

(2) CMS should improve its oversight to ensure that States submit relevant and timely information on progress toward reducing the number of uninsured children.

CMS Response

The CMS holds states accountable for submitting relevant, clear, and timely annual reports. Each state has both a CMS CO and RO Project Officer. Both the CO and RO Project Officers are in contact with their states to provide technical assistance required to complete the annual report and to check on each state's progress. Since OIG's review of the FY 2002 annual reports, all states, (except Tennessee, which has no program operating at this time) have submitted FY 2002 annual reports. The annual report contents and deadlines are discussed on the monthly SCHIP Technical Advisory Group calls and on the monthly RO/CO conference calls.

As discussed above, CMS has implemented a web-based annual report database, SARTS. The CMS expects that SARTS will help improve its oversight of the state annual report submission process since it will streamline the submission process and collect all the reports in one electronic location.

OIG Recommendation - continued

(3) CMS should ensure the accuracy of SCHIP enrollment data.

CMS Response

The OIG reported that CMS should rectify inconsistencies between states' 2002 enrollment data reported in CMS' enrollment report and data reported in the state annual reports. While it appears that there is a discrepancy in reported enrollment, the issue is that states may take numbers from different periods of time or report a different type of

data in the two reports. States submit a number of SCHIP enrollment data elements to CMS through the Statistical Enrollment Data System (SEDS), the official source of SCHIP data. The CMS is now using SARTS to eliminate any appearance of a discrepancy between the two reports. The enrollment data that states enter and certify in SEDS will automatically feed the enrollment information that appears in the annual report because SEDS and SARTS will now "talk" to one another.

As CMS acknowledges in its annual enrollment releases of the number of children ever enrolled in SCHIP, there may be some double counting in states with combination programs. However, only a third of SCHIP programs are combination programs and CMS collects other types of enrollment data that do not result in double counts. The number of children ever enrolled in SCHIP may be duplicative in combination states because states are required to report unduplicated enrollment by quarter and year for each program type. A limited number of children may switch between a Medicaid expansion program and a separate child health program and will therefore be counted in the enrollment for both program types once CMS totals the enrollment as part of its quarterly and annual enrollment totals. We do not believe that this impacts the total enrollment in a significant way.

States also submit quarterly and annual point-in-time counts of enrolled children. These enrollment data will not be duplicative since they do not track movement between the two program types. Both types of data, ever enrolled and point-in-time, provide valuable insight into SCHIP enrollment trends and help form a more complete picture of SCHIP. The CMS is working with states to improve state-reported point-in-time data but point-in-time data is still not as reliable as ever-enrolled data. The CMS does not think it would be helpful or a wise use of state resources to require states to decide if a child should be considered as having been enrolled in primarily an SCHIP Medicaid expansion program or a separate child health program.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of William Moran, Regional Inspector General for Evaluation and Inspections in the Chicago regional office. Other principal Office of Evaluation and Inspections staff who contributed include:

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END NOTES

[1] Social Security Act, Section 2108(a)

[2] Social Security Act, Section 2108(a) and 42 C.F.R. § 457.750(b)(1)

[3] Title XXI of the Social Security Act (State Children's Health Insurance Program (SCHIP) enabling legislation) was created by the Balanced Budget Act of 1997 (Public Law 105-33).

[4] Social Security Act, Sections 2101(a) and 2110(b)

[5] Social Security Act, Sections 2102 and 2103

[6] SCHIP Preliminary Annual Enrollment Report for Fiscal Year (FY) 2002. Posted January 31, 2003. Available online at http://www.cms.hhs.gov/schip/enrollment/schip02.pdf.

[7] State Health Access Data Assistance Center. "Issue Brief: The Current Population Survey (CPS) and State Health Insurance Coverage Estimates." March 2001. Available online at http://www.shadac.org/publications/issuebriefs/IssueBrief1.pdf

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[9] National Governor's Association and National Association of State Budget Officers. "The Fiscal Survey of the States." December 2003. Available online at www.nga.org/cda/files/FSS1203.PDF

[10] Ibid.

[11] Ibid.

[12] Kaiser Commission on Medicaid and the Uninsured. "Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children." December 2003. Available online at http://www.kff.org/medicaid/4159.cfm

[13] Kaiser Commission on Medicaid and the Uninsured. "Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children." December 2003. Available online at http://www.kff.org/medicaid/4159.cfm. As of November 2003, Alabama, Colorado, Florida, Maryland, Montana, and Utah had frozen their SCHIP enrollment.

[14] Current Population Survey, March 2002. Health Insurance Table H108: "Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children Under 18: 2001." Available online at http://ferret.bls.census.gov/macro/032002/health/h08_000.htm

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[18] Urban Institute, "Children's Insurance Coverage and Service Use Improve." July 31, 2003. Available online at http://www.urban.org/url.cfm?ID=310816

[19] State Health Access Data Assistance Center. "Issue Brief 1: The Current Population Survey (CPS) and State Health Insurance Coverage Estimates." March 2001. Available online at http://www.shadac.org/publications/issuebriefs/IssueBrief1.pdf

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[31] Social Security Act, Section 2108(a)(1)

[32] 42 C.F.R. § 457.750(c)(2)