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CHIP PROGRAM FROM THE STATES' PERSPECTIVE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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CHIP PROGRAM FROM THE STATES' PERSPECTIVE

THURSDAY, NOVEMBER 16, 2006

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:35 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the subcommittee) presiding.

Present: Senators Rockefeller and Lincoln.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator HATCH. Welcome to everybody. We are grateful to have you all here.

I am going to put my opening remarks in the record. I will just say a few things. We are going to have three votes, and then they tell me there is going to be a closed session, so you may be stuck here all afternoon, and I do not want to do that to you if I can help it.

This year, we are going to be responsible for reauthorizing and financing one of the most important programs, in my opinion, in the government, and that is the State Children's Health Insurance Program.

Now, let me make one thing clear: CHIP must be reauthorized. It is an important program. It was the only way we could help the kids who are really left out of the health care system, and that is the children of the working poor.

I want to be able to do that. There are literally millions of American children insured through CHIP, 6.2 million to be exact. That being said, it must be acknowledged that the reauthorization poses many challenges.

That is why my friend Senator Rockefeller and I have worked closely together on this program from the beginning, and I feel it imperative that this subcommittee devote a second day of hearings to CHIP this year.

So with that, I am going to quit talking and put the rest of my statement in the record. It is a wonderful statement. I think you would have all enjoyed it. [Laughter.] As you know, we love to make statements around here.

[The prepared statement of Senator Hatch appears in the appendix.]

Senator HATCH. But I am going to turn to my colleague, Senator Rockefeller, and then we are going to go to these witnesses as quickly as we can.

Senator ROCKEFELLER. All right. Will you instruct our colleague, Senator Lincoln from Arkansas, to come sit over here and not be so modest?

Senator HATCH. Senator Lincoln, you can come sit even on my right. [Laughter.]

Senator ROCKEFELLER. You have to instruct her, Mr. Chairman.

Senator LINCOLN. Just keep going, Jay.

Senator HATCH. We are really glad to have you.

Senator LINCOLN. If Senator Jeffords comes, I will move quickly.

Senator HATCH. By the way, I did not mention Senator Lincoln and what she meant to this issue as well, and so many others. But this was a miracle that we were able to get the CHIP program through.

The CHIP program became the glue that really brought about the first balanced budget. Democrats wanted CHIP, and some of us Republicans; Republicans wanted the balanced budget, and some of the Democrats. But this actually became the glue that brought about the first balanced budget in over 40 years. The reason it was is, it is an important, good program. So, Senator Rockefeller, we turn to you.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. All right. Actually, I am going to put my statement in the record, too.

You have heard this reminiscence from me before, but I do not care because I love telling it so much. [Laughter.]

We had a meeting—and you will remember this. Unfortunately, this was pre-Senator Lincoln—but we were wandering all over the place on this, John Chaffee, Orrin Hatch, a whole lot of people on both sides of the aisle. And we happened to have a rectangular table in the middle of the room. Not this. We were seated at a rectangular table.

Senator HATCH. Right in this room.

Senator ROCKEFELLER. In this room. And there was staff behind us, and we were not getting anywhere. Somebody, probably you, came up with the brilliant idea of saying, let us get everybody out of here but members of the Senate. That is what happened.

I think probably some fairly surly comments emitted from various parts of the room, but nevertheless, an amazing thing happened, which is the Senate at its best, which you do not often see. That is that, there we were, around a table.

Senator Hatch actually was the first to speak. We were all within about 10 feet of him, but he felt so strongly about getting the Children's Health Insurance Program started that he stood up to make his remarks, which was totally inappropriate physically, but psychologically, emotionally, and in terms of commitment, it was just devastating. It was just devastatingly effective.

Then Al D'Amato, who had been not very vocal on these matters, I do not remember if he stood up or not, but he just let it rip: "You can't do this to children. They've got to be insured." And then

Frank Murkowski, who usually does energy things, just started talking about the importance of giving health care to children. It went right on around.

Virtually, by the end of whatever it was, a couple of hours, there was going to be a CHIP program. It was not written, but the commitment was so fully there. I have always been intrigued by the fact that we were cautious in the public setting and we were true to ourselves in the private setting. That is my statement.

[The prepared statement of Senator Rockefeller appears in the appendix.]

Senator HATCH. Well, thank you, Senator. I will add to that that it was written the way I originally said it would be written, and it has worked amazingly well. I hope that all of you feel that way. If you do not, you have to tell us where we have to change it.

Senator Lincoln, we will put your statement in the record. Is that all right?

Senator LINCOLN. Absolutely. Yes.

[The prepared statement of Senator Lincoln appears in the appendix.]

Senator HATCH. We are very pleased today to have the witnesses before this committee. I am just going to read you off from left to right.

I am really proud to have Mr. Nate Checketts here, the director of Bureau of Access, Utah Department of Health in Salt Lake City; Ms. Sharon Carte, who is the executive director of the West Virginia CHIP State Capitol Complex in Charleston; Ms. Ann C. Kohler, director of the Division of Medical Assistance & Health Services, Department of Human Services in Trenton, NJ; Mrs. Tobi Drabczyk. Is that how it is pronounced?

Mrs. DRABCZYK. Drabczyk.

Senator HATCH. All right. I am sorry. I was, at one time, living in Pennsylvania, and we pronounced it Drabczyk. But Drabczyk. All right. I stand corrected. Mrs. Drabczyk represents her family from Walkersville, MD.

Ms. Nina Owcharenko.

Ms. OWCHARENKO. Very good.

Senator HATCH. I got one! [Laughter.] She is from The Heritage Foundation, a senior health care policy analyst, Center for Health Policy Studies. We get so many good ideas from The Heritage Foundation in these areas, and many other areas as well, so we are proud to have you here.

Dr. Lisa C. Dubay. We are proud to have you here. She is an associate, Bloomberg School of Public Health at Johns Hopkins University.

I do not think we could have a better group of people who could help us to know what we should do about reauthorization of CHIP.

So we will start with you, Mr. Checketts, and we will go right across. If you could limit your statements, we might be able to get through this hearing. If you do not, we are going to be gone for a long time and you will just have to wait. So if you could summarize, that would be even better.

Mr. Checketts, we will turn to you.

STATEMENT OF NATE CHECKETTS, DIRECTOR, BUREAU OF ACCESS, UTAH DEPARTMENT OF HEALTH, SALT LAKE CITY, UT

Mr. CHECKETTS. Members of the Subcommittee on Health Care, my name is Nathan Checketts and I am the Director of the Utah CHIP program. Thank you for this opportunity to speak about CHIP in Utah.

I appreciate the invitation of Senator Hatch and this committee to come and speak. Senator Hatch has put a lot of effort and leadership into bringing CHIP into existence, and it has really benefitted millions of children around this country.

I also want to acknowledge the role that Secretary Leavitt played in the development of CHIP in Utah. As governor, he helped determine what flavor of CHIP we were going to implement in our State.

In my remarks, I am going to provide a brief sketch of how CHIP looks in Utah, what factors have contributed to CHIP's success in my State, what is still left to be done, and how CHIP can still be improved.

CHIP has been a tremendous success in Utah. Since 1999, over 110,000 children in Utah have been on CHIP. Currently, we have 36,000 children enrolled. CHIP in Utah covers children up to 200 percent of the Federal poverty level. Most families pay a small premium and have some co-payments for services. Services are provided through private networks that are contracted with CHIP.

So what has made CHIP so successful in Utah? CHIP is not a mandate. Expansions in enrollment levels have been funded at the State's discretion. In contrast, decision makers in Utah have been uncomfortable with Medicaid growth, because much of Medicaid is an entitlement and they feel like they have no choice but to fund that growth.

CHIP does not feel like a welfare program. CHIP has been able to sell itself with TV and radio marketing. Reduced eligibility requirements and an online application allow a more streamlined eligibility process; in many cases, applicants can complete the entire process without setting foot in an eligibility office.

Benefits are structured like private benefits: premiums, co-pays, provider panels, and market-rate reimbursements for providers. Better reimbursement rates translate into more physicians and dentists accepting CHIP, which translates into more access to health care for children.

Given CHIP's success to date, can we say "mission accomplished?" Not yet. Despite great strides in enrollment, the number of uninsured children continues to grow. The need for CHIP today is as great as it has ever been. In 2001, 11.9 percent of Utah children under 200 percent of Federal poverty level were uninsured; by 2005, this percentage increased to 16.8 percent, or 52,400 children.

If the State enrolled all uninsured children thought to be eligible for CHIP, which would be an additional 25,000 children, the percentage of low-income children who are uninsured would drop to 8.9 percent. Yet, this increase in enrollment would cost $8.3 million in State funds and an additional $30.8 million in Federal funds on an ongoing basis.

So how can CHIP be improved for Utah? Current Federal funding for CHIP is not adequate if we hope to reduce the number of uninsured children. Do Utah's expenditures exceed its CHIP allocations? Not today. The Federal share of Utah's current annual CHIP spending, about $40 million, is approximately equal to its annual allocation, and Utah has some unspent allocations from prior years.

However, Governor Huntsman is looking to insure additional children in our State. CHIP will likely be one of the vehicles for that coverage. If Utah enrolls more children on CHIP, the State will quickly spend down its prior unspent allocations and will also acquire additional Federal funding.

Besides increased funding, States can use additional flexibility to create a better CHIP program. As dictated by Federal requirements, children on CHIP receive very good health insurance and have limited cost sharing. Yet, discussions for options for families at higher income levels are stymied because the entire host of CHIP requirements follows an expansion of eligibility.

Most requirements should stay in place for children at the lower income levels. However, for children with higher family income, States should be given additional flexibility, especially in benefit design and cost sharing when coverage is expanded to these groups.

Last month, CMS approved a premium assistance option for CHIP in Utah. Our new program is called Utah's Premium Partnership for Health Insurance, or UPP. We are excited to have the opportunity to partner with employees and employers to serve our clients through their employer's health plan.

However, enrollment in this option will be limited because we are required to allow children to elect direct CHIP coverage at any time. Most families will choose direct CHIP coverage because it is a generous program.

If the election requirement were lifted for children with higher family incomes, additional options could be considered, including only offering a tiered premium assistance option for higher-income families. A gradual reduction of benefits would eliminate the benefit cliff that families currently face in Utah at 200 percent of the Federal poverty level.

Another concern for Utah is how the Federal Payment Error Rate Measurement, or PERM, program is being implemented for CHIP. We support reviews of claims and eligibility. However, PERM has imposed a uniform sample size across all States regardless of the number of children covered in the State.

We have been told that the cost will be approximately $500,000 for each State, and that the cost will count against the 10 percent administrative cap for CHIP. For smaller States like Utah, this PERM expenditure will have a disproportionate impact on the dollars that we are spending to currently run the program. PERM sample size and administrative cost requirements need to be reconsidered so that CHIP in small States is not harmed by the effort to improve accuracy.

Thank you for this opportunity to discuss the CHIP program with you. CHIP has been a great partnership between the State and Federal Government, and we look forward to continue working with you on this.

Senator HATCH. Thank you, Mr. Checketts. We will certainly look into the matters that you have raised.

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

Senator HATCH. We have just had the first vote and it's halfway through, so I asked Senator Rockefeller and Senator Lincoln to go over and vote and see if they can come back. We have three votes in a row. I am going to stay for you, Ms. Carte, and then hopefully they will come back and keep going, and then I will come back and we will just kind of keep rotating.

Ms. Carte, we will turn to you.

STATEMENT OF SHARON CARTE, EXECUTIVE DIRECTOR, WEST VIRGINIA CHIP STATE CAPITOL COMPLEX, CHARLESTON, WV

Ms. CARTE. Thank you, Mr. Chairman. I do have my written statement. Considering that time is limited, I will try to hit on the high points.

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

Senator HATCH. We will put all the statements in the record as though fully delivered.

Ms. CARTE. Thank you.

I would like to focus on some of the high points. West Virginia is a stand-alone CHIP, very much a program like that of Utah. It covers up to the 200 percent Federal poverty level, children between birth through age 18. It has a comprehensive package of benefits, very much like a commercial standard plan. It was benchmarked on West Virginia's Public Employees' Insurance Program.

It has grown in phases. I submitted a number of exhibits to help illustrate that for the committee. Early on in the first 2 years of CHIP, it was a Medicaid expansion, briefly. But then, later, the State plan was amended to make it a separate stand-alone program. For those first 2 years, it was operated at below 150 percent of poverty income levels.

But when you look at West Virginia CHIP and West Virginia Medicaid together, as you see in the exhibit I submitted, I am sure it is similar to most States that in effect you have a stair-step approach where the eligibility levels are much higher for younger ages for Medicaid.

For example, in West Virginia they go up to 150 percent of poverty for those children under one, and they go to 133 percent for children in the preschool years. So it was really only later, when West Virginia was able to expand its program to the 200 percent level, that we were really able to get more coverage for adolescents and older children, so we saw this phased-in growth.

Then I have an exhibit that shows the steady enrollment growth of West Virginia CHIP. The earliest years, of course, when we went to 200 percent were the most dramatic growth, but we have continued to enjoy a very steady increase in enrollment.

You have detailed there for you the difference between the enrollment in average active enrollment numbers, but also the numbers of unduplicated children who flow through the program in a year's time. I think that is important to point out, because CHIP is continuously enrolling and disenrolling children.

Sometimes I am asked, as I was this week before our legislature when I reported, how many children are left who are uninsured in West Virginia, and it is not an easy thing to answer.

Currently, I think all the CHIP programs are asked by CMS to report how many children are uninsured through point of time, or data, or on any given day how many children, and we use current population estimates for that.

However, when you look at the unduplicated numbers, you see that, in fact, there is a much higher number of children served. I am hoping that, in the future, CHIP and Medicaid can be more seamless together and that we can work within each State to eliminate gaps in coverage, because, even though in West Virginia we have 12 months of continuous coverage both for CHIP and Medicaid, in fact, you still see Medicaid children, probably because of coverage or non-coverage as parents' income changes, that they go in and out of the program more frequently. So what I am alluding to is, there are coverage gaps there that could be closed by closer coordination.

I addressed the fiscal changes and the fiscal management that the program has in West Virginia. We started out with a program of about $11.8 million in expenditures in 2000, and it has now grown to $41.6 million. That is an increase of over 250 percent.

During this same period, however, the annualized cost per child increased from approximately $924 to $1,600 in those fiscal years, an increase of 26 percent. It is a substantial increase, but I suggest to you that that increase is not nearly as great as those that were experienced by commercial plans.

West Virginia has always had a certain amount of cost sharing. It was something that our board felt strongly about, that there should be opportunities for families to cost share, to the extent possible, within the program.

Since we were benchmarked along the lines of our Public Employees' program, we made sure that there was a lifetime coverage limit of $1 million, just like our Public Employees' Insurance Program has. The State plan was also amended to have an annual limit of $200,000 per child, per year of coverage, and that limit has posed very few problems for us.

So we have been mindful of trying to be prudent with taxpayer funds. We constantly review utilization with a third-party administrator in order to manage escalating trends, and we think that that is our responsibility in order to serve the greatest number of West Virginia's children with a health plan of strong value.

Outreach has changed somewhat since the early years. In the earliest 2 years, there was very little public/private expenditure that went for program outreach when it was a Medicaid expansion, but subsequently we were able to form a truly great public and private effort through the West Virginia Healthy Kids and Families Coalition.

That coalition had received support from local foundations in West Virginia, such as the Sisters of St. Joseph, the Claude Worthington Benedum Foundation, a major West Virginia foundation, and of course, the Robert Wood Johnson Covering Kids Project. This allowed CHIP to be a key player with these foundations and coordinate a lot of outreach throughout the State.

We also received some Medicaid funding for outreach that came through our primary care clinics, our primary care association, which includes a number of FQHCs, or Federally Qualified Health Centers, as well as some other nonprofit and profit clinics.

After the busiest years of outreach, and after a few years when we felt we had done the business of getting the word out and boosting enrollment, we changed our outreach into a form where it now takes health prevention and promotion messages, such as the one in the exhibit with my testimony, that talks about the most important school supply being a healthy pair of eyes, and this is distributed through a nonprofit as a publicly published document for child care providers throughout the State of West Virginia.

Senator HATCH. Ms. Carte, I am going to have to interrupt you because I am late for this vote.

Ms. CARTE. Sure.

Senator HATCH. I will try to get back as soon as I can. I will probably have to vote this time and then vote the next one. So I can have the 15 minutes, and then we will try to get back to the rest of you as soon as we can.

Ms. CARTE. All right.

Senator HATCH. So with that, we will just hold the meeting up until we can get back.

[Whereupon, at 3 p.m., the meeting was recessed and reconvened at 3:14 p.m.]

Senator LINCOLN. Thank you all. I apologize for the confusion. But for the sake of time, and with Senator Rockefeller and Chairman Hatch, they will probably vote the next vote and then come back. I will get started, so then I can leave and go and take that second vote. So I will resume the committee.

Ms. Kohler, I believe it is your opportunity to offer your ideas to us.

STATEMENT OF ANN CLEMENCY KOHLER, DIRECTOR, DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES, DEPARTMENT OF HUMAN SERVICES, TRENTON, NJ

Ms. KOHLER. Thank you. I would like to thank you, the Chairman, and Senator Rockefeller for the opportunity to be here today and talk to you about the importance of the CHIP program. I am Ann Kohler, and I am responsible for both the Medicaid and the CHIP program in the State of New Jersey.

As chairman of the National Governor Association's Health and Human Services Committee, Governor Corzine considers the reauthorization of the CHIP program his top priority for the committee and looks forward to working with NGA and with you on this important issue.

New Jersey implemented our CHIP program in 1998. It started as the KidCare Program. While it was very successful, we found quickly that we could expand the program through the enrollment of parents, and we did. In 2000, we decided to open the program up to parents in families with incomes below 200 percent of the Federal poverty level, and we renamed the program the FamilyCare Program.

Within a few years, the program was so successful that we had to close enrollment to the adults in the program. But I am happy

to say, in 2005, we were able to reopen it, and we now again offer coverage to the parents of our low-income children, both in Medicaid and in FamilyCare.

We currently are providing health insurance to over 125,000 children through our SCHIP program and over 70,000 adults through the same program, and at the same time we cover over 450,000 children in our Medicaid program and 350,000 adults. We have almost a million people—that is 1 in every 8 people—in the State covered under this important program.

While we use a higher percentage of eligibility for our CHIP program than many other States, it is important to note that we have one of the highest costs of living in the entire Nation.

So in New Jersey, it costs a lot more to be poor than it does in some other States. We wanted our program to reflect that and to have eligibility levels that enabled us to reach the working poor and provide health insurance to their children.

New Jersey greatly appreciates the opportunity that this program has provided to us. We have been able to provide health insurance to our most vulnerable population, our children.

New Jersey has made a strong commitment to our SCHIP program, thus evident in the benefit package that we offer and our attention to simplifying the application. We recently went from an 18-page to a 1-page mail-in application, and you can also apply online through the Internet. We have a website, *njhelps.org,* and you can come right in and apply for a program online.

The prospect of eliminating or limiting this program is of significant concern to us. New Jersey has spent its entire CHIP allotment over the past few years, and we have received redistributed dollars from other States.

As you know, these dollars have been diminishing over time, and now there is an urgent need for Congress to increase the allocations that we receive and to allow the States to meet an ever-growing need for health insurance among the working poor.

We recognize that there are long-term CHIP financing and policy issues to consider as we move towards reauthorization, but we feel that action is needed now to prevent any kind of shortfalls during fiscal year 2007.

With your permission, I would like to include with my testimony for the record a letter from the NGA on behalf of all the Nation's governors urging action to address these shortfalls before the end of the 109th Congress. Failure to fund these shortfalls could cause some States to reduce or cease coverage for children, and we cannot allow that to happen.

Both Medicaid and SCHIP have been extremely successful in expanding coverage to children. By promoting the continued success of these programs, we can ensure that children and their families get the needed health insurance they need.

Thank you again for your interest in our program. Providing health care to our children and their families is a top priority for New Jersey and, we hope, for the Nation. I hope that my remarks here today will help you fashion a plan to continue the support for the SCHIP program.

Thank you.

Senator LINCOLN. Thank you, Ms. Kohler. I appreciate it.

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

Senator LINCOLN. I have just been notified that they have shortened the votes to 10 minutes now, and they have already started the second one, so I may have to excuse myself. What I will do is adjourn the committee and allow one of the other guys to come back and reopen you all when there is time.

I feel frustrated, because this is a very, very important issue. I wanted to ask, Ms. Kohler, about your waiver on covering pregnant mothers, and the prematurity issue. Hopefully, we will have the opportunity to do this.

We apologize for the confusion on the floor, but without a doubt, I think you heard both Senator Rockefeller and Chairman Hatch say that it is definitely our desire here to ensure that we continue and improve on such a valuable program for our States, and for the Nation's children.

So if you all do not mind, I am going to recess the committee, then we will reconvene when they come back. Thank you.

Ms. KOHLER. Thank you.

[Whereupon, at 3:20 p.m., the hearing was recessed to reconvene at 3:22 p.m.]

Senator HATCH. All right. Enough frivolity around here. [Laughter.]

I understand, Mrs. Drabczyk, we are to you now. So, if you can keep them short, we have one more vote. These are 10-minute votes, so I will have maybe 7 or 8 minutes. I would like to finish this panel. What you have to say is very important to us.

So, we will turn to you.

STATEMENT OF TOBI DRABCZYK, REPRESENTING HER FAMILY, WALKERSVILLE, MD

Mrs. DRABCZYK. It is an honor to be here.

Senator HATCH. By the way, I want to thank Senator Lincoln for filling in. It meant a lot to me. Go ahead.

Mrs. DRABCZYK. My name is Tobi Drabczyk. I am from Walkersville, in Frederick County, Maryland, about an hour from here. My husband Kevin and I have been married for 18 years. We have four children: a daughter, Severa, is 14; a son, Mitchell, 12; daughter, Jocelyn is 3; and a daughter, Arwen, who is 16 months.

I would like to tell you a little bit about why the CHIP program has been so important to my family. Kevin has had a full-time job ever since I have known him. Sometimes his job had health insurance, sometimes it did not. The health insurance he gets right now covers him only. To cover me and the children, it would cost us over $500 a month. He only makes $36,000 a year. We cannot afford that.

When I became pregnant with my 3-year-old, Jocelyn, I read about the Maryland CHIP program and I called the Health Department. They helped me sign up and told me that my older children would also qualify. For me, that coverage became incredibly important when I was diagnosed with gestational diabetes.

I had to monitor my blood sugar several times a day, and just the cost of the test strips alone would have been more than I could afford. Because of the CHIP program, I was able to get the care

I needed, and Jocelyn, and subsequently Arwen, were both born healthy, because I ended up having it with her, too.

Kevin and I are very fortunate that our children are generally healthy, but we have to deal with routine illnesses, like all parents do. Thanks to the CHIP program, our babies have been able to get their vaccinations on time, and when the older ones have things like ear infections, we have been able to get the antibiotics that the doctor prescribes.

On $36,000 a year, we often find ourselves living paycheck to paycheck. There are truly times when we are short on the gas money my husband needs to get to work, and there are times when money for food is even tight.

But because of the CHIP program, we have never had to choose between those things and our children's health. I can get the medicine the children need when they need it, as opposed to when we can figure out how to budget for it.

We are not parents who take our children to the doctor for every little sniffle. We do not abuse the program. But about a year ago, we found ourselves in a scary situation with our son, Mitchell. Mitchell had been having arm tics since he was about 6 years old. They came and went, but it started to get worse.

Senator HATCH. What were they, again? I missed it.

Mrs. DRABCZYK. Arm tics.

Senator HATCH. Oh. Tics. All right.

Mrs. DRABCZYK. He also started to have other symptoms, vocal tics, sharp movements of his neck. One day, the next movements became so disturbing that we were afraid he had a brain tumor or something, so we took him to the emergency room.

Due to the CHIP program, we were able to do that. After some exams, we were referred to a pediatric neurologist, something we definitely could not have afforded without the CHIP program. He was eventually diagnosed with Tourette's Syndrome.

Again, we are very lucky. Without the CHIP, we would never have been able to afford the specialists and all the tests. We would still be wondering what was wrong with our son. The CHIP program helped allay our terrible fears.

Mitchell is doing just fine now. He has a very mild case of Tourette's. With CHIP, we know we can take him for the check-ups he needs and any help he might need in the future.

I hope that this has explained how important the CHIP program has been to our family. We are a family that works hard. We do not use any other form of government assistance. We pay our taxes, which help to fund this program. We just need a little bit of help once in a while to keep our children healthy.

I would like to thank you and the other Senators for bringing us the CHIP program, and for all the work you have done so far. Please keep it going. Our children need it.

Thank you.

Senator HATCH. Well, I want to thank you for this wonderful testimony, because there are millions of people out there—children, anyway—who have parents just like you who need the help. This is a wealthy country. We should do this.

I am going to do everything in my power to make sure this is reauthorized and strengthened. The testimonies we are getting

here today are very, very important. I just want you to know that. I am very grateful for you being here and for the wonderful testimony you have given.

Mrs. DRABCZYK. Thank you very much.

[The prepared statement of Mrs. Drabczyk appears in the appendix.]

Senator HATCH. Ms. Owcharenko, we are going to turn to you. I hope I am not messing up your name too badly.

Ms. OWCHARENKO. No, perfect.

STATEMENT OF NINA OWCHARENKO, THE HERITAGE FOUNDATION, SENIOR HEALTH CARE POLICY ANALYST, CENTER FOR HEALTH POLICY STUDIES, WASHINGTON, DC

Ms. OWCHARENKO. Thank you for having me. I look forward to addressing the committee today.

SCHIP is unique. Although often discussed in conjunction with Medicaid, it is a distinctly different program with a different scope, focus, and approach. First of all, it is not an entitlement program, but a capped spending program.

Second, unlike Medicaid, which provides health care services to a very broad and diverse population with multiple eligibility standards, SCHIP has a simpler, more targeted purpose: low-income uninsured children.

Finally, SCHIP gives States greater flexibility than Medicaid in structuring the benefits to more closely reflect private coverage. Unlike federally administered programs, the very nature of a joint Federal/State program results in State variations.

While variations support the principles of federalism, they can also make it difficult to evaluate and assess the performance of a program. Thus, it is equally as important for Federal policy makers to establish clear Federal policy objectives to measure the effectiveness of the program and ensure that it remains focused on its purpose.

Three specific areas come to mind. First, funding in the reallocation process. The current reallocation process is based on whether or not a State has spent their Federal allotment. The number of States that have exhausted their Federal allotments has climbed. In 2001, 12 States exhausted their allotments. By 2005, the number had increased to 27 States.

This raises the question of whether the reallocation process discourages some States from being fiscally prudent, knowing that any unused funds will be distributed to other States. Also, of the 18 States projected to face funding shortfalls in 2007, 7 of the 18 States have eligibility above 200 percent of poverty, and 4 of the 18 have eligibility below 200 percent of the Federal poverty.

Federal policy makers should consider restructuring the reallocation process to ensure that it is focused on meeting certain Federal goals and objectives. Specifically, priorities should be given to those States facing funding shortfalls that have not yet reached federally established benchmarks.

Second, eligibility. While the law defines the intended population as targeted low-income children whose families' incomes are at or below 200 percent of the Federal poverty line, this definition has lost clarity. Today, there are 15 States with eligibility above 200,

and 9 of those 15 States have eligibility at or above 300 percent Federal poverty.

Furthermore, eligibility levels are not an accurate measure of success. A State with eligibility at 300 percent of poverty may only have a 40-percent enrollment, while a State with eligibility at 185 percent may have an 80-percent enrollment.

Federal policy makers should reaffirm the existing Federal poverty and population eligibility standard and establish enrollment targets to measure the effectiveness of the program.

Third, benefit design. The SCHIP benefit package, specifically the separate SCHIP option, references in its fashion to reflect private coverage. However, recent administrative changes by some States have softened this distinction, for example, reducing or eliminating any cost-sharing requirements.

Moreover, burdensome regulations and rules discourage approaches, such as the premium assistance model that was previously discussed by Utah. Federal policy makers should bolster the private coverage model in SCHIP and include a more flexible premium assistance model.

In conclusion, undoubtedly Federal funding will dominate the upcoming SCHIP reauthorization debate. However, Federal lawmakers have the responsibility to look beyond funding and evaluate the effectiveness of the program and the policies impacting its implementation.

Thank you. I look forward to the discussion.

Senator HATCH. Well, thank you. We appreciate it. We appreciate the advice that you are giving us. We will certainly take it into consideration.

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

Senator HATCH. Now, Dr. Dubay. Is it Dubay?

Dr. DUBAY. Dubay.

Senator HATCH. They just told me it was Dubay. So, Dr. Dubay, we are honored to have you with us, and we look forward to hearing you.

STATEMENT OF LISA C. DUBAY, PhD, ASSOCIATE, BLOOMBERG SCHOOL OF PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD

Dr. DUBAY. Thank you. It is an honor to be here.

As you all know, the SCHIP program triggered a major expansion in eligibility for public health insurance coverage for children that built on the groundwork that Congress had laid a decade earlier with the Medicaid expansions for children.

It was designed to sit specifically on top of the Medicaid program and provide States with resources and incentives to cover uninsured children whose family incomes are too high to qualify for Medicaid, but too low to be able to afford private coverage.

So, what have we accomplished with SCHIP? Well, in fiscal year 2005, there were 6.1 million children already enrolled in the SCHIP program, and 3.9 million enrolled on the last day of that fiscal year. Coverage under the Medicaid program has also increased as a result of SCHIP implementation. Medicaid participa-

tion rates for children increased from 74 percent in 1997 to 82 percent in 2002.

Moreover, the number of uninsured children at a point in time has fallen from 10 million in 1997 to 7.5 million in 2005. When we focus on low-income children particularly, we can highlight the achievements of SCHIP. Among low-income children, the uninsurance rate fell from 22 percent in 1997 to 15 percent in 2005. Unfortunately, these figures also illustrate that more progress could be made towards eliminating uninsurance among children.

So who are the children that remain uninsured? Evidence from the National Survey of America's Families shows that in 2002, 49 percent of all uninsured children were eligible for Medicaid and 23 percent were eligible for SCHIP.

Consequently, solving the problem of uninsured children is, in large part, an issue of increasing and maintaining rates of enrollment and retention in the Medicaid and SCHIP programs.

I think it is important to ask why there are so many children who are eligible, but uninsured. The first explanation lies, I think, in a good news story. States have recently expanded eligibilities for coverage, so, despite the fact that States are far more successful than they used to be in enrolling eligible children, a significant share of uninsured children remain eligible for coverage.

While the facts on the eligible but uninsured are disconcerting, we must keep in mind that the total number of uninsured children that this is based on has fallen since CHIP's implementation.

Second, budgetary constraints keep some States from fully embracing or maintaining all of the strategies that are known to be effective at increasing children's health insurance coverage.

The reality is that when States enroll more children, they face higher costs. This makes States particularly reluctant to engage in aggressive enrollment efforts when either facing economic difficulties or uncertainty about Federal contributions.

Third, some families continue to be unaware that they could secure coverage for their uninsured children through Medicaid or SCHIP. At the same time, when low-income parents of uninsured children are asked whether they would enroll their child in these programs if told their child was eligible, 82 percent of children had a parent who responded that, yes, they would enroll their child. These results suggest that parents need more information about the potential eligibility of their children.

So how can we get to the finish line? Congress has at its disposal several tools for moving forward. First, a threshold issue is whether the SCHIP program will be fully funded in 2007 and beyond. To address this issue, Federal matching funds in excess of the amount set aside for SCHIP under Congressional budget rules for this fiscal year and for future fiscal years will be needed.

There is little doubt that children will lose coverage and the country will be unable to make progress unless the Federal Government provides the funds needed to be a full partner with the States.

Second, it will be vital to identify strategies for reaching the more than two-thirds of uninsured children who already are eligible for Medicaid and SCHIP. Congress should support and encour-

age State interest in reaching eligible unenrolled children by offering performance-based assistance with coverage costs.

In addition, it could support efforts to provide families with information about their children's eligibility for coverage through community-based and other types of outreach efforts.

Third, one of the most effective methods for increasing participation of eligible, but uninsured, children is to cover their parents. While family-based coverage has costs that accompany it, it is also associated with a 14 percentage point increase in participation of children in health insurance programs, and with greater use of curative and preventive care among children.

With the 10-year anniversary of the SCHIP creation rapidly approaching, we are at a crossroads in children's coverage. The evidence is clear. This program and its partner, Medicaid, have together worked to significantly lower the number and percent of uninsured children.

We should fully fund the SCHIP program to continue this progress and move forward in finding ways to ensure that all uninsured children secure coverage that provides access to high-quality care. Our children are our future, and their health is critical to the Nation as a whole.

Senator HATCH. Well, thank you so much, Dr. Dubay.

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

Senator HATCH. Let me start with you, Mr. Checketts. We only have a few minutes to go here, but I would like to get a few questions in.

According to our information, Utah is projected to spend $39 million in Federal CHIP funds in fiscal year 2007. Am I pretty close there?

Mr. CHECKETTS. Yes.

Senator HATCH. And your fiscal year 2007 allotment of Federal CHIP funds is just over $40 million, so you are spending in accordance with your allotment level, 1 of only 14 States poised to do that in fiscal year 2007.

What have you done in Utah, and are doing about this, to make it happen this way?

Mr. CHECKETTS. Well, one of the things we have used in the State is, we have open enrollment periods where we allow individuals to come in and do that. In order to get individuals to apply during those periods, we have extensive outreach efforts and we have used radio ads, TV ads. We have our website, which allows individuals to come in and apply online, and also to be able to get all the information there through the web.

Senator HATCH. Utah has been pretty effective in getting kids to be part of CHIP, and families to be part of CHIP, and I think you have been pretty innovative. I think some of your outreach has been pretty creative, too.

I remember when CHIP was first implemented, the State advertised for CHIP on city buses. It even went that far. Could you please talk about the methodologies that you are using to make outreach successful in our home State of Utah?

Mr. CHECKETTS. Sure. As I mentioned, one of the things that we found extremely successful is being able to put our applications online. In our last open enrollment period, 50 percent of the families

filled out an application online. We have also been able to expand our outreach through other groups that we partner with.

In our new program, our Premium Assistance Program, we have partnered with health insurance underwriters, the health insurance brokers in the State, and they will be going out. As they make contacts with employers, they will be sharing our program materials with them and encouraging them to enroll in our programs.

Senator HATCH. Both you and Ms. Carte mentioned the administrative burdens that the Payment Error Rate Measurement, sometimes referred to as the PERM, would present to smaller States like Utah and West Virginia.

Has there been an opportunity for State CHIP directors to have a dialogue with CMS regarding these specific concerns? If so, what has CMS told you? Do you want to take a crack at that, Ms. Carte?

Ms. CARTE. Yes, Senator. West Virginia was a State that participated in the PERM project, which led to the development of the regulations. It seemed that there was a major break in the process. When we participated, we had eligibility samples of 50 or 100. We had very low error rates that came out of these reviews.

We provided feedback to Federal officials, but when the final regulations came out in September and we had an opportunity to provide comment, I was really startled when I saw the final regulations.

The CHIP programs were being asked to have a sample now of 500 eligibility cases. For example, much of my program's operations are carried out by third-party administrators, and I just have a small staff of eight. So, we will have to retrieve 500 files over the course of a year.

The cost of doing that and of coordinating work with the Federal contractors who are doing the payment error review part is going to be considerable. We are not even clear. CMS has said that States that have a Medicaid error quality assurance program could perhaps use that, if it is independent of the CHIP program, for review.

But even looking at that, with Medicaid and CHIP together, each having eligibility samples of 500 active cases each and then 200 inactive cases, it is going to pose considerable expense. In West Virginia, we have estimated right now—and without some future answers from CMS it is unclear—that that could take as much as 15 percent of our administrative costs in a program that already has an administrative cap. It has serious implications for us, sir.

Senator HATCH. All right.

Mr. Checketts, do you have anything you would care to add to that?

Mr. CHECKETTS. PERM was implemented last year for some Medicaid States. One of our concerns is that they have taken that methodology and just applied it directly to CHIP this year. The size of the programs are vastly different. What would be in Utah a $1.8 billion program on Medicaid, that same methodology is being applied to a $50 million program on CHIP. The scale just is not appropriate.

Senator HATCH. Dr. Dubay, I read your written testimony with a great deal of interest. I felt like you did have some interesting

insights, especially about the funding shortfalls of the CHIP program.

Let me make one thing perfectly clear: I agree with you. I do not want the children who are currently eligible for CHIP to lose their coverage.

Now, in your testimony, you note that if the budget challenges of the CHIP program are not addressed, 1.9 million children could lose their coverage by the year 2016. I think that is your figure.

Dr. DUBAY. Right. Correct.

Senator HATCH. Now, would some adults still be covered through CHIP under the scenario that you described in your testimony?

Dr. DUBAY. Would some adults still be covered?

Senator HATCH. Yes.

Dr. DUBAY. I believe they would be.

Senator HATCH. You do? All right. I would be interested if you can submit any further information on that, I would appreciate it. I think we would all appreciate it. I should not just speak for me.

Mrs. Drabczyk, I want to thank you for testifying before this committee. You did an excellent job. Your family's experience with the MCHIP program was quite compelling, especially your son Mitchell's diagnosis.

Many years ago, I was the one who came up with the orphan drug bill to try to find therapies for population groups of less than 200,000, and Tourette's Syndrome was one of those. We do have some pharmaceuticals that have been developed through the orphan drug program that hopefully are helping your son. I am glad that Mitchell is doing well.

But I am interested in hearing more details on how your family found out about the CHIP program. Was it difficult for your children to apply, or for you or your husband to apply on their behalf? How long did it take to have this coverage take effect?

Mrs. DRABCZYK. I found out about it by a print ad in a Frederick's Child Magazine. It's a magazine they put out in Frederick County for parents. They just had a print ad with a chart: if your income is this and your family size is this, you may qualify.

So when I became pregnant, I called and we qualified. I went to the health department. They signed me up. But it is very easy to sign up in Maryland. You do not even have to go in. You can have them mail the application to you. You mail it back in. I do not know if it is law or not, but they say 3 weeks is all it is supposed to take for you to get to know if you have coverage or not.

Senator HATCH. That is pretty good.

Mrs. DRABCZYK. And I knew within about 2 weeks. It is very easy.

Senator HATCH. That is good.

Let me go to you, Ms. Kohler. I am not trying to embarrass you with this question, please know that, but I do want to ask this question because I think it's important.

Over the past 5 years, New Jersey has received over $600 million, as I understand it, from other States' unspent CHIP funds, plus $50 million last year from the Deficit Reduction Act.

Now, your CHIP program covers adults and it covers children up to 350 percent of poverty, if I have that right.

Ms. KOHLER. That is correct.

Senator HATCH. That is the highest level in the country. I have noted your point in your testimony that New Jersey has a higher cost of living than in many other States. That being said, however, your projected fiscal year 2007 spending is 2½ times what you know to be your allotment. That is your projected spending, if I have that right, and I think I do.

What is the responsibility of other States, as under the President's proposal, or the Federal Government under Senator Rockefeller's proposal, to pay for the shortfalls resulting from the choices made in your State? Now, that is a tough question. Again, I am not trying to embarrass you, but I would like to hear what you have to say about it.

Ms. KOHLER. All right. Senator, New Jersey has long made a commitment to insure children. As I said, New Jersey has one of the highest costs of living in the Nation. As a result, what may appear to be an extremely high percent of the Federal poverty level is a very low cost of living in New Jersey.

The cost is so high to live in the State, that many of the people living there, even though they have incomes below 350 percent of the Federal poverty level, they are in the lower economic status. New Jersey has made a commitment that our children and our pregnant women are not going to go without health insurance.

As a result, they have made the commitment on the State side to appropriate additional State dollars needed to bring in the Federal dollars. We have done that both for our SCHIP program, as well as our Medicaid program. Most of our administrative simplifications have been designed to increase coverage of both Medicaid, as well as our CHIP population.

I think my fellow panelists testified about mail-in applications. You mentioned a mail-in in Maryland being very efficient. We have also done that. We have both mail-in applications, as well as an online application which we have found has been very successful.

We are now, for our Medicaid population, starting to experience a decline in the number of people who have applied because of the new citizenship requirements. This is of great concern to us, because we want to continue to assure that anyone eligible for our program can easily come into our program. We are looking for ways to reduce that burden on the population.

We are very concerned about the citizenship requirements recently promulgated by CMS for newborns, because we think it is a barrier to these newborns getting their well baby care and needed immunizations, that they have to wait until they have a birth certificate.

So, we certainly hope Congress, as part of the reauthorization, takes that into account and does not create another barrier for the CHIP population.

Senator HATCH. Yes. Well, the question, really, I was asking is, we are getting some complaints from other States that you are getting more than you should get out of this program. I am not sure that is accurate. But I just wanted to hear, how do we even this up? How do we get States to feel like they are being treated equally when you are getting so much from other States' allotments?

Ms. KOHLER. I think it is important to note that the reason that we were able to benefit from the redistribution is because States

have not expanded their programs or encouraged as many people to apply for their program. It is unspent dollars that we receive, not dollars that they are using to cover children. It is dollars that are unspent that we receive.

Senator HATCH. I understand. All right.

Well, I personally believe this panel has been excellent. You have helped us quite a bit.

Senator Rockefeller would like to have me ask a question for him, and I am happy to do it.

You are the lucky one, Ms. Carte, I will tell you.

Ms. CARTE. Really?

Senator HATCH. Yes. You are really lucky here. [Laughter.]

Ms. CARTE. All right.

Senator HATCH. I am sure this question is very fair. [Laughter.] And if it is not, I will withdraw it. I am only kidding. [Laughter.]

Senator Rockefeller's question is this: "With over 8.4 million uninsured children in this country, I believe we should make it a priority to provide access to comprehensive coverage for more children.

"West Virginia is currently a national leader in health insurance coverage for children, with 92 percent of the State's children currently insured either through Medicaid, which is the largest public insurer, CHIP, or private coverage.

"When fully implemented, I believe," Senator Rockefeller says here, "the expansion of CHIP is projected to increase the percentage of West Virginia children who currently have health insurance to 97 percent from that 92-percent level. This near-universal health insurance coverage would be among the highest percentage of any State in the country."

Now, Senator Rockefeller goes on to say, "This is something I am very proud of. Can you talk a little bit about how West Virginia has been able to achieve such high levels of health insurance coverage among children?"

I am interested in that, too, so I am going to compliment my colleague for having asked that question through me.

Ms. CARTE. Well, I think some of that I alluded to earlier in talking about, really, the tremendous outreach that we had. There was such interest in CHIP coming up in the public generally.

I also had mentioned, I think when you were in the room, that we had somewhat phased-in growth, and initially the first 2 years of the program were somewhat slow as things like benefit levels were determined, and that we just had a very restricted group of children that were coming in at that point.

But once it took off, there is such strong public support. I am sure you have seen that when you are back home in your home State, the recognition by people of the needs, and parents like Mrs. Drabczyk, having those needs met.

I think it is the expectation that we need to do the right thing in order to allow all children to access coverage, and that having coverage and not just accessing the health care system also makes a difference.

If I might just refer a little bit to your question to Ms. Kohler a little bit, I think something that happened in that regard, when

legislation is passed, sometimes there are unintended consequences.

I think one of the consequences of the Federal funding formula and having the 3 years out there, because of this slow, phased-in growth, initially West Virginia was one of the States that had a lot of public criticism in the early years because we were not growing fast enough.

Then we did grow fast and we dramatically expanded to 200 percent, and you saw this major growth where lots of children came in. Then we came to a level where we were spending all of our allotment, and now we have exceeded it.

When I look at the Congressional Research Service reports, West Virginia is about mid-level in how we have used our allotment. I think as you heard me say earlier, we are very mindful that this is a block-granted program. We have tried to be careful stewards fiscally. But when you have that public expectation driving things, it is hard to stop.

I think you are probably well-aware of some States that found themselves in a position where they had to close enrollment. They later reversed that or found ways to support their programs and grow them nonetheless.

Senator HATCH. Now, Ms. Owcharenko, I do not want you to think that you are being ignored here, so I am going to ask you a question, too, all right?

Shortfall States with Medicaid expansion programs have a fall-back to use Medicaid funds for their shortfall, although at a reduced matching rate. Now, shortfall States with a separate CHIP program have no medical fall-back, that is, except for Rhode Island, I believe, which had such an arrangement written into the terms and conditions of their waiver agreement.

Now, should States with separate CHIP programs also be able to draw down Medicaid funds for their shortfalls? From the other perspective, should States with Medicaid expansion CHIP programs not be permitted to draw down Medicaid funds through their shortfalls?

Ms. OWCHARENKO. I think it is one of the problems with how SCHIP has been implemented, because it is very confusing between having a separate SCHIP program—there are separate rules for how that program functions, whether it is cost-sharing requirements, the benefit package. If a State simply did a Medicaid expansion, then all the Medicaid rules apply.

So I actually believe that probably the best approach is to make a clearer separation between SCHIP, regardless of if it is a Medicaid expansion or stand-alone, from traditional Medicaid. I think that the funding source should stay within the SCHIP funding source, because those are the intended populations and the intention of Congress of targeting the low-income children who are uninsured.

Senator HATCH. Well, thank you. I think this has been an excellent panel. You have helped us to understand these things a little bit better.

What I would like to do is ask each of you to consider what we have talked about here today. We naturally have not covered every

aspect of concern with regard to the CHIP program, and we would like you to write to us and give us your best ideas.

If you think of things you have not been able to discuss today, we would particularly like to hear from you. Mr. Checketts, I expect to hear from you. How is that? But I would love to hear from the rest of you, too, and so would others.

Again, I am very grateful to Senator Rockefeller, Senator Kennedy, and Senator Lincoln. We are grateful—very, very grateful—to them for the work that they have all done, and many people on my side of the table as well. I could mention them all, but I will not take the time to do that today.

But I am grateful that you folks would take the time to come, in this lame duck session, and be willing to help us to understand how we can make this program better during the next year.

We are going to need all of your support to be able to reauthorize this program, because there are some who still do not like it. But my experience is, every State in the Union likes it. There are some who do not, but I think they are in a distinct minority.

What we are doing here is taking care of families like yours, Mrs. Drabczyk, clearly wonderful people who would love to be able to do more for their kids but just cannot do it.

One of the ways this got started is, two couples from Provo, Utah came to me, and both the husbands and the wives worked, but in neither case did they make—this is back when we did this program—more than $20,000 combined income. So, they clearly could not take care of the health care needs of their children.

They were working as hard as they could, doing everything they possibly could. They were contributing. I do not know that they were paying taxes at the $20,000 level, but they were willing to do that. But they just were, frankly, tremendously concerned about their children because they were left out of the system. That is how this began, really.

Frankly, this great country should do this. So we need your help. We need the best advice we can get, because there is always some bureaucratic ensnarlements or entanglements that make the program more costly than it should be, or more difficult to administer, or more difficult to apply for, and we would like to have the best advice you can all give us. That is why you are here, is to help us to understand, and we have particularly chosen you six folks to give us a better understanding of this.

So with that, I want to again congratulate you all for your splendid testimonies and tell you we are very grateful to have you here.

We will just adjourn the committee until further notice.

[Whereupon, at 3:58 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

TESTIMONY OF SHARON L. CARTE
EXECUTIVE DIRECTOR OF WVCHIP
BEFORE THE UNITED STATES SENATE FINANCE SUBCOMMITTEE
NOVEMBER 16, 2006

Senator Hatch, Chairman, Senator Rockefeller, Ranking Member, Honorable Members of the Subcommittee:

Good afternoon, I am Sharon L. Carte, Executive Director of the West Virginia Children's Health Insurance Agency.

Thank you for the privilege of sharing with you today West Virginia's experience with the State Children's Health Insurance Program.

ELIGIBILITY

The West Virginia Children's Health Insurance Program (WVCHIP) is a separate stand-alone program now serving nearly 40,000 children from birth through age 18 each year. Currently, children in households up to 200% of federal poverty level (FPL) are eligible, although West Virginia is modifying its State Plan to cover children in households up to 220% FPL through premium participation effective January 2007.

BENEFITS

WVCHIP benefits were developed using West Virginia's Public Employees Insurance plan as its benchmark and it has a comprehensive plan of coverage for doctor visits and checkups, vision and dental checkups, immunizations, hospital stays, mental health services, and prescription drugs. Benefits are administered and claims paid through two major third party contracts: one for medical and dental, and one for pharmacy benefits.

STATE LEGISLATIVE ENACTMENT AND PHASED PROGRAM

The West Virginia Legislature enacted state statute to create WVCHIP in April 1998. This legislation also created an advisory board made of citizen members, legislators, and state agency directors that meet at least quarterly. As a program with phased growth, WVCHIP spent its first year and a half as a Medicaid expansion program before amending its State Plan in late 2000 to become a separate stand alone program – a change strongly endorsed by the West Virginia Legislature. To reach its current eligibility income level, West Virginia has amended its State Plan three times between 1998 and 2000 ***(See Exhibit A: Health Coverage of West Virginia Children By WVCHIP and WV Medicaid, June 30, 2006)***.

ENROLLMENT CHANGES

After the more dramatic growth increase that ended in 2002 when the Program had expanded to 200% FPL from 150% in late 2000, enrollment has had continued steady growth from an average enrollment of 20,701 to 24,693 – a nearly 20% growth ***(See Exhibit B: WVCHIP's Unduplicated and Active Enrollment, Fiscal Years 2000 to 2006)***.

FISCAL CHANGES AND FISCAL MANAGEMENT

Over the course of the past eight years, expenditures growth has come from a level of $11.8 million in total expenditures in FY2000 to $41.6 million in 2006, an increase of 253%. During this same period, the annualized cost per child has increased from approximately $924 to $1,605 between fiscal years 2000 and 2006, an increase of 26%.

Along with cost sharing, WVCHIP has a lifetime coverage limit of $1 million and in 2002 the State Plan was changed to include an annual coverage limit of $200,000 per child. Like most commercial plans, we constantly review utilization with a third party administrator in order to manage escalating trends. We believe we have provided prudent management of state and federal taxpayer funds in order to serve the greatest number of West Virginia's children with a health plan of strong value.

OUTREACH CHANGES

In the first two years, very little public/private expenditures went for program outreach. After expansion to 200% FPL, WVCHIP launched into full outreach mode in a campaign of highly diverse media approaches and local community activity with various community partners.

This tremendous outreach effort was made possible by a truly great public/private effort with much of the private effort being coordinated with CHIP funding by the WV Healthy Kids and Families Coalition. The Coalition had actively advocated for WVCHIP's startup and it received support from local foundations such as the Sister of Saint Joseph, the Claude Worthington Benedum Foundation, and of course, significant contribution on the national level from Robert Wood Johnson's Covering Kids Project. Another key partner was support from WV Medicaid for outreach through the WV Primary Care Association, which includes many Federally Qualified Health Centers as well as non-profit clinics. After the busiest outreach years of 2003 to 2005, local activity has decreased significantly as the public/private partnership achieved its goal of "getting the word out" and boosting enrollment. Outreach efforts now come through the standard operations funded through the program such as CHIP's Call Center when distributing applications on request or informing applicants or assisting them about how to apply online through CHIP's website www.wvchip.org or direct electronic application through www.wvinroads.org. In addition, we now promote visibility to the general public through efforts aimed at health prevention or health promotion such as health messages promoting the importance of prevention checkups in early childhood ***(See Exhibit C: Most Important School Supply? – A Healthy Pair of Eyes)***. Last year we distributed messages such as these through "WV Child Care Quarterly" which is distributed to child care providers throughout the state.

MEASURING QUALITY

Once enrollment and access are assured, the question becomes what have we done for the health of the children served, or what must we do better. To answer this, WVCHIP has established measures that tell us about access to primary care, access to preventive dental and vision services, and well child checkups. In addition, we have measures for two of the chronic conditions children or youth are

more likely to experience in our state – proper use of asthma medications and diabetes care ***(See Exhibit D: WVCHIP Quality Indicators by HEDIS Measures, 2005)***.

In addition to health quality measures such as those already mentioned, WVCHIP administers a state designed customer satisfaction survey every other year. In 2005, survey response rate was at 50.7%. WVCHIP customers indicated that they were "very satisfied" (73.7%) or "satisfied" with the program overall, with less than 1% reporting dissatisfaction. More importantly, 51.9% felt the quality of care received improved after enrolling in the program (more details are available in WVCHIP's 2005 Annual Report at www.wvchip.org).

CHALLENGES IN WVCHIP'S FUTURE

To assure our continued success, WVCHIP's foremost challenge is to have stabilized funding. Many things were "unknowns" at the enactment of this program – how many children were really uninsured; could we find and enroll them, once enrolled will they have access and can we make a difference in their health status? We have come a long way to answer most if not all of these questions. Fortunately, West Virginia is not one of the states with insufficient federal funding this year, but in two or three more, we will also join their ranks if the funding mechanism stays as it is presently. Last year, we were one of the states eligible to receive redistributed funds, but we did not, because they went to other states that had exceeded their allocations. Clearly, a rebasing of the federal formula needs to occur to sustain the gains achieved so far.

In this past year's regular Legislative session in West Virginia, the Legislature passed a statute allowing WVCHIP to expand to 300% FPL, but after considerable discussion with our advisory board, we concluded that with the uncertainty of future federal funding we would cautiously expand only to the 220% FPL level.

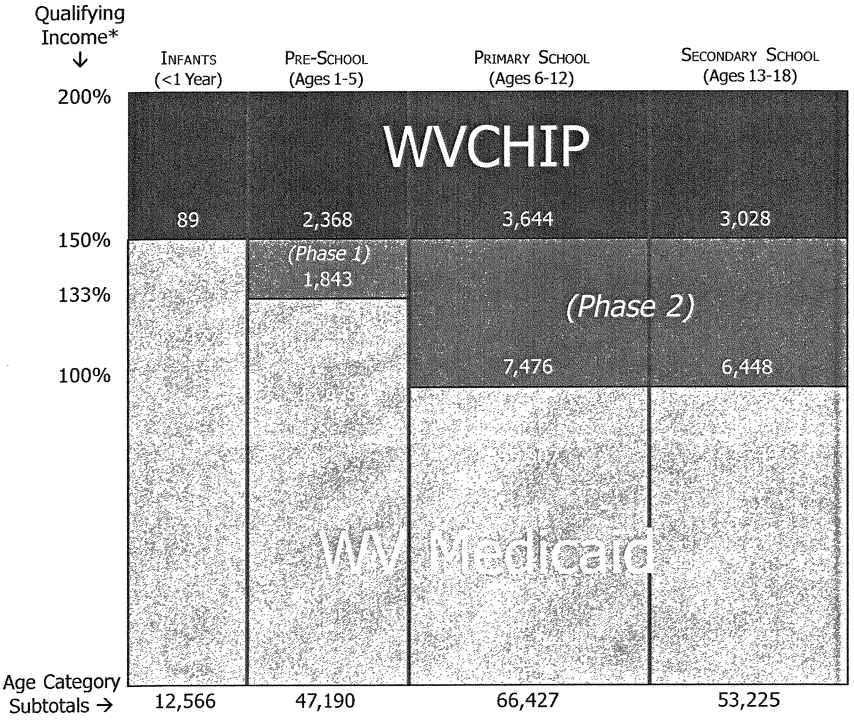
Another recent change that deserves mention is the recently released regulations on Payment Error Rate Measurement and the administrative burden they pose, especially for small stand alone programs such as WVCHIP, but we are still awaiting response from the Centers for Medicare and Medicaid on this issue.

I hope this has been information of some use to the honorable members, and it is my expectation that we will go forward together to assure all our children have the health care coverage they deserve.

Thank you for your time and again for the privilege of sharing this information with you today.

Exhibit A

HEALTH COVERAGE OF WEST VIRGINIA CHILDREN BY WVCHIP AND MEDICAID - JUNE 30, 2006 -



Household incomes through 200% of the Federal Poverty Level (FPL)

Total WVCHIP Enrollment **24,896** ***Total WV Medicaid Enrollment*** **154,512**

Total # of Children Covered by WVCHIP and Medicaid - **179,408**

Exhibit B

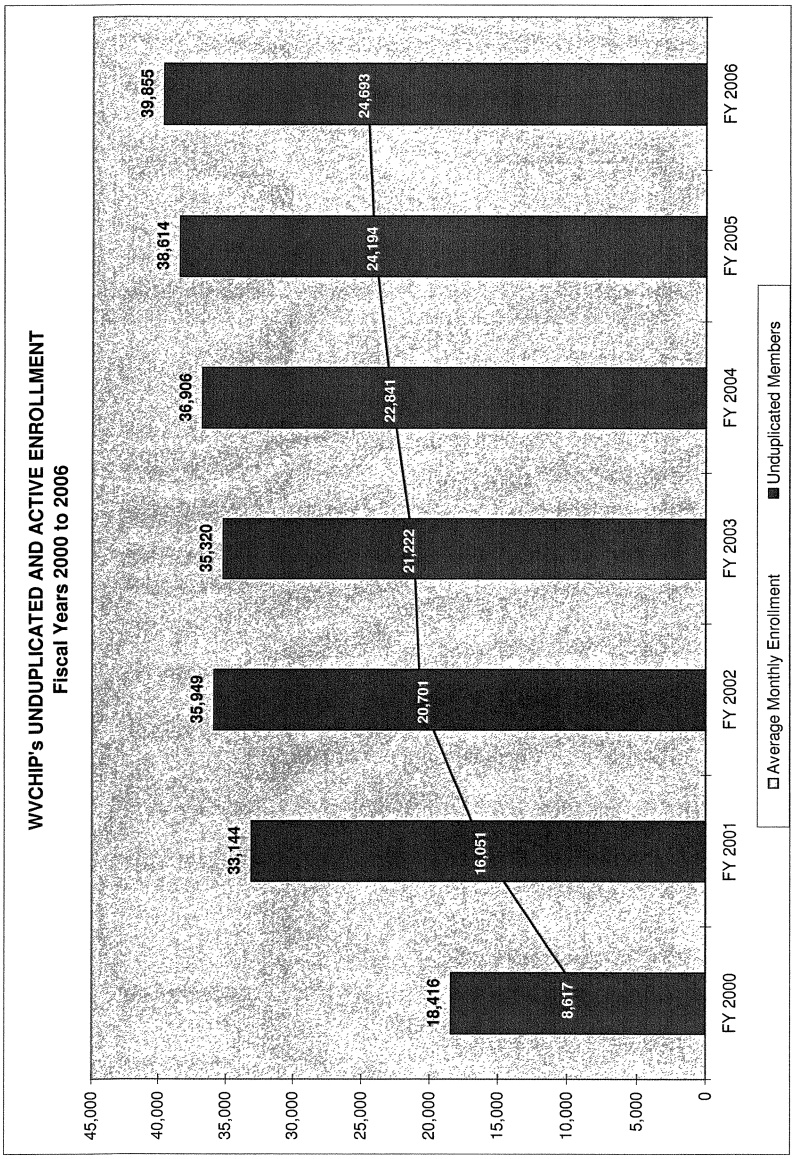
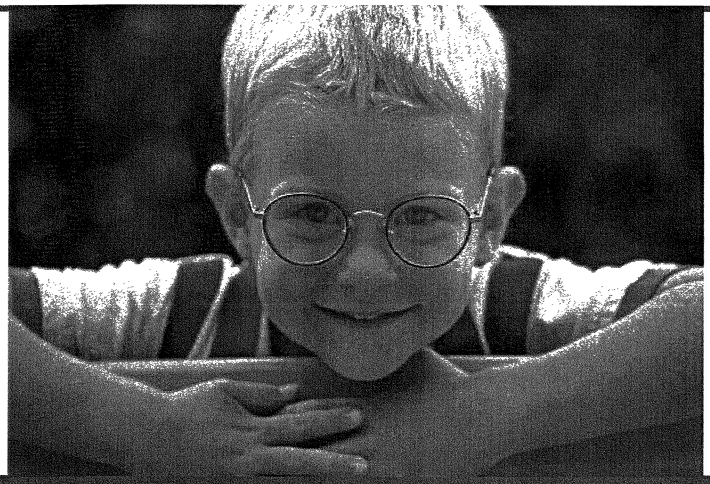

WVCHIP's UNDUPLICATED AND ACTIVE ENROLLMENT
Fiscal Years 2000 to 2006
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
18,416
8,617
33,144
16,051
35,949
20,701
35,320
21,222
36,906
22,841
38,614
24,194
39,855
24,693
FY 2000
FY 2001
FY 2002
FY 2003
FY 2004
FY 2005
FY 2006
Average Monthly Enrollment
Unduplicated Members

Exhibit C



Most important school supply? --

A Healthy Pair of Eyes

Make sure your child's vision is "school-ready" with

- ☑ **Early vision screening** by age 30 months or before age 3 as recommended by the American Academy of Pediatrics
- ☑ **Getting a full eye exam** by the Optometrist as recommended by your child's doctor
- ☑ **Yearly HealthCheck exams**: a complete well-child check-up with vision, hearing, dental screens and other developmental checks right for his age and stage by his pediatrician or family doctor

Helping your child be school-ready!

West Virginia CHIP Children's Health Insurance Program

www.wvchip.org
www.wvdhhr.org/mcfh/ICAH/healthcheck

Exhibit D

WVCHIP Quality Indicators by HEDIS® Measures, 2005

DENTAL VISITS*	**95.81%**
♦The number of children enrolled for the entire year, Ages 4 - 18, who had a dental checkup.	
VISION VISITS*	**30.43%**
♦The number of children enrolled for the entire year, Ages <11 - 18, who received preventive vision services.	
ACCESS TO PRIMARY CARE*	**90.05%**
♦The number of children enrolled for the entire year, Ages 1 - 11, who received primary care services.	
WELL CHILD VISITS*	**94.53%**
♦The number of children enrolled for the entire year, Ages 1 - 6, who had a well child visit with prevention or screening services only.	
ADOLESCENT WELL VISITS*	**82.85%**
♦The number of children enrolled for the entire year, Ages 12 - 18, who had a well child visit with prevention or screening services only.	
PROPER USE OF ASTHMA MEDICATIONS*	**90.48%**
♦The number of children with persistent asthma enrolled for the entire year and prior year who were prescribed appropriate medication.	
DIABETIC CARE* with	
H1BC (hemoglobin test)	**77.27%**
EYE EXAM	**90.91%**
LDLC TESTS (cholesterol level)	**29.55%**
♦The number of children enrolled for the entire year with Type 1 or Type 2 diabetes shown to have had a hemoglobin test (HbA1c); an Eye Exam; and a serum cholesterol level (LDL-C) screening.	

**HEDIS® is a commonly used standardized set of performance measures designed to allow purchasers and consumers to compare the performance of health care plans, usually managed health plans. HEDIS® is sponsored, supported, and maintained by the National Committee for Quality Assurance. WVCHIP extracts these measures from claims data only for those children of designated ages who were enrolled for an entire calendar year.*

SHARON CARTE
RESPONSES TO QUESTIONS SUBMITTED FOR THE RECORD
FROM THE SUBCOMMITTEE ON HEALTH FROM THE SENATE FINANCE COMMITTEE HEARING
NOVEMBER 16, 2006

Senator Hatch

Q. What are the biggest successes of CHIP program? What are the biggest obstacles facing the states as far as the CHIP program is concerned?

R. In West Virginia, it has meant assuring that 94.2% of all children below 200% FPL have some form of health coverage, whether public or commercial.

Q. What recommendations and suggestions do you have for the Senate Finance Committee as we reauthorize the CHIP program next year?

R. Mostly, improvement/overhaul of the allotment formula in order to have stable predictable funding for the future and sustain the gains made so far.

Q. What has your state done to ensure that all CHIP eligible children are covered by the program?

R. As noted in my opening statement and in our State Plan, we had tremendous outreach through public and private partnerships that resulted in strong efforts statewide at the local community level.

Q. Do you think the major focus of reauthorization next year should be on finding a solution to state shortfalls and the problems with the allotment formula?

R. Yes, I believe this is the foremost issue for all states.

Q. What three changes would you like to see made to the CHIP program that would help you to run your programs more effectively?

R.
1. Allow separate CHIP's the ability to cover children of state or other local governmental employees as they do in Medicaid.
2. Assist all states in a budget neutral way of removing the "stair step" income eligibility levels described in my testimony.
3. Help change ERISA law to facilitate employer sponsored insurance so that CHIP funding can be used as to subsidize employer insurance participation.

Q. Do you anticipate that your state will pursue a DRA state plan amendment? Do you have any concerns regarding how the new DRA flexibility might impact your CHIP programs?

R. West Virginia has already modified its State Plan under Medicaid in a manner that would allow it to provide a more insurance-like plan similar to CHIP's, so we do not expect any adverse impact.

Q. Is it your opinion, then, that the federal government should provide whatever federal CHIP funds are necessary to cover states' expansions? In other words, should CHIP be an open-ended entitlement to states?

R. No. I believe one of the reasons CHIP was embraced in West Virginia was because of the added flexibility of benefit design and because it was not open-ended.

Q. Some states treat it as a true capped allotment, but others spend well beyond their federal funds, in anticipation that someone will step in with additional money, or maybe because they have Medicaid funding as a fallback. How do you describe to legislators and the governor the structure of CHIP and the policy choices from its capped-grant nature?

R. I have always described the structure of CHIP to West Virginia's Governor, Legislature, and public as a block granted program that ultimately must be capped. I must respond to Senator Hatch's surprise about why some states have treated SCHIP as a "true allotment" versus an "open entitlement" program. I believe West Virginia's experience points out two factors:

First, a tension or conflict exists between what the SCHIP law purports to do, and the vagaries of the federal funding formula. Section 2101 in the 1998 statute says the purpose of SCHIP is "to provide funds to States that enable them to initiate and expand the provision of child health assistance to uninsured, low income children...." Later, Section 2110 defines low income children as "those children whose family income exceeds the Medicaid applicable income....but does not exceed 50 percentage points above it." In federal code, a low targeted income child was defined as having a family income at or below 200% FPL (§457.310b(1)). As noted, WVCHIP's initial program was cautiously set at the 150% FPL income level. Due to the "stair step" eligibility levels in Medicaid (as shown in Exhibit A), this limited participation for infant and preschool children – a life stage when preventive care is very important. Since the 150% FPL level was below the maximum allowed under the code, this resulted in tens of millions of federal funding dollars being returned to the overall SCHIP funding pool (and ultimately those unspent federal funds unused by West Virginia from 1998 through 2001 were returned to the U.S. Treasury). Had West Virginia remained at this level in order to just stay within its annual allotment, over 36% of children covered by WVCHIP today would have been without coverage (those numbers shown in darker blue above the 150% income level). How rational is that? I believe the 37 states that have overspent their allotments have faced this same dilemma, but have also come down in favor of meeting the needs of low income uninsured children as allowed for under the law. In West Virginia, the decision to cover children with family incomes up to 200% FPL was made prior to my directorship. Two years later in 2002, WVCHIP expenditures already began to exceed its annual allotment. This brings us to another quirk of the current formula: as a state covers more uninsured children, the amount of the annual allotment is reduced! So, the choices for West Virginia to remain within its allotment would have been: remaining at 150% FPL and not covering an estimated 11,229 children each year on average since 2000, or closing enrollment after 2002 and not covering an estimated 12,432 each year for the next four years – all the while when federal funds allocated by Congress for this purpose would sit there unused.

This brings us to the second factor making it difficult for states to remain within the artificial construct of the allotment – public understanding and expectation. After West Virginia developed its separate CHIP program at the 150% FPL and many children remained outside program eligibility, there was mounting advocacy and public criticism for not expanding to the extent allowed by law, particularly as millions in unspent funds were lost to the state. Finally, it became a major issue in the gubernatorial race of 2000, and was said to have contributed to the loss of the incumbent governor who had not aggressively developed the program.

Q. Was one goal to align the benefits offered to eligible Medicaid and SCHIP children? How does the DRA benefit package for Medicaid children compare to the benefits in your separate SCHIP program?

R. Since our program is in a different department, I am not aware of all of West Virginia Medicaid goals as part of DRA. We believe it will be quite similar and ultimately be aligned completely.

Q. Is there a difference in the amount, duration, and scope of such benefits between the DRA benefit package for children and the state's separate SCHIP program?

R. I am not able to answer this completely at this time, since we are in a separate division, but there are some differences, yes.

Senator Rockefeller

Q. Talk a little bit about West Virginia's decision to expand CHIP to children between 200% and 300% of poverty. How will this new expansion work? Why did the state decide to phase-in the expansion instead of expanding all at once?

R. The decision to expand CHIP this year was not a result of program initiatives, but came as a result of State legislation that allows the program to expand to 300% FPL through a premium participation approach. The legislation was extensive and was concerned with many issues related to a comprehensive look at the State's health care situation. The part concerning CHIP expansion was put forth as one way in which the State could most expeditiously reduce more uninsured lives. After the bill's signing and as CHIP began to work on an implementation plan with its board, concerns were raised about to what extent could support be expected for continued funding past 2007 when reauthorization is supposed to occur. This looming question and the possibility of an unfunded liability caused the board to vote in favor of a slowly phased in approach starting with an increase to 220% FPL.

Q. How has West Virginia been able to expand CHIP to cover more children? How many children in West Virginia will have access to health insurance coverage?

R. We have estimated that if we were to expand to 300% FPL, this would allow West Virginia to cover nearly 97% of all children.

Q. How has West Virginia been able to achieve such high levels of health insurance coverage among children?

R. As noted earlier, West Virginia was fortunate to have great public and private partnerships with charitable foundations at the both the national and state levels with great assistance from the RW Foundation's Covering Kids Project, the Claude Worthington Benedum, and the Sisters of Saint Joseph Foundation. Because of these partnerships, we could both take CHIP to the local level statewide with back-to-school pool parties, CHIPPY the CHIPmumk, health fairs, Christmas parades, the State Fair, as well as on-going meetings with out community partners for over a three year period to let us know what was working and what needed improvement. This also meant we could still afford a strong multi-media effort of paid print, radio, and television advertising for a period.

Senator Lincoln

Q. Such as allowing SCHIP to provide wraparound coverage for children with special healthcare needs and limited private insurance or premium subsidies to help children remain in the private health insurance system?

R. The flexibility allowed under SCHIP for premium subsidy for employer sponsored insurance should be examined, some of the barriers such as ERISA law need to be assessed if the Congress wants to go above 200% in the most efficient way.

State of Utah
JON M. HUNTSMAN, JR.
Governor
GARY R. HERBERT
Lieutenant Governor

Utah Department of Health
David N. Sundwall, M.D.
Executive Director
A. Richard Melton, Dr. P.H.
Deputy Director
Allen Korhonen
Deputy Director
Health Care Financing
Michael T. Hales
Division Director
Bureau of Access
Nathan Checketts
Bureau Director

November 16, 2006
The CHIP Program From the States' Perspective

Nathan Checketts
Director, Bureau of Access
Utah Department of Health
288 North 1460 West
Salt Lake City, Utah 84114

Members of the Subcommittee on Health Care:

CHIP has been a tremendous success in Utah.

How Does CHIP Impact Utah's Children?

- Since 1999, 111,601 children in Utah have been served by CHIP.
- Currently we have 35,803 children enrolled.
- Out of 788,452 children in the state last year, CHIP served 5.9 percent.

Why has CHIP been successful in Utah?

- CHIP is not a mandate. Expansions in enrollment levels have been funded at the State's discretion. The State feels more of a gun to its head regarding Medicaid growth because Medicaid is an entitlement.
- CHIP does not feel like a welfare program. CHIP has been able to sell itself with TV and radio marketing. Reduced eligibility requirements allow less bureaucratic application forms and streamlined eligibility determination procedures. The ability to file applications online has reduced contacts with traditional eligibility offices. In many cases, applicants can complete the entire eligibility process without setting foot in an eligibility office. Benefits are structured like private benefits – premiums, copays, provider panels, and market rate reimbursement for providers. Better reimbursement rates translate into more physicians and dentists accepting CHIP children. Because of the public's perception of CHIP, eligibility

staff repeatedly get requests from families to enroll children on CHIP rather than Medicaid despite the fact that Medicaid has a greater range of benefits.

- CHIP provides great coverage. The benefits are the same as those of the Governor's and legislators' children. CHIP scores well against private plans and Medicaid in HEDIS and CAHPS reviews.
- CHIP has strong support from Utah's advocates for children. CHIP also ties into a broader national campaign to cover children. National back-to-school events and advertising help get the word out in Utah also.

Mission Accomplished? Not Yet

Despite great strides in enrollment, the number of uninsured children in Utah continues to grow and the need for CHIP today is as great as it has ever been. In 2001, 11.9 percent of Utah children under 200% FPL were uninsured. By 2005, this percentage increased to 16.8 percent, or 52,400 children. If the State enrolled all uninsured children thought to be eligible for CHIP (24,600 children), the percentage of children under 200% FPL who are uninsured would drop to 8.9 percent. Yet, this increase in enrollment would require $8.3 million in state funds and an additional $30.8 million in federal funds on an ongoing basis.

The federal portion of Utah's current annual CHIP spending ($40.0 million) is approximately equal to its annual allocation. Although Utah has unspent CHIP allocation from prior years, Governor Huntsman is looking to insure additional children in the State. CHIP will likely be one of the vehicles to increase coverage. If this effort receives full funding, Utah will quickly spend down its prior allocations and also require additional funding above its current CHIP allocation level in the following years.

Many states are facing expenditures that exceed their CHIP allocations. However, despite the need in other states, the needs created by the number of children and the number of uninsured children in Utah have not lessened. Utah has developed its program within the original intent of CHIP. All funds to date have been expended on children under 200% FPL – no funding has gone to adults. Although the State's methodical expansion of CHIP has left some unspent allocations up to this point, the State still faces the needs of many uninsured children.

How Could CHIP Be Improved for Utah?

States can use additional flexibility to create a more rational CHIP program. In Utah, we cover children up to 200% FPL. These children receive very good health insurance with limited cost sharing as dictated by federal requirements. Discussions of options for families at higher income levels are stymied because the entire host of CHIP requirements follows an expansion of eligibility.

Because the core of CHIP is children at 200% FPL and under, most restrictions should stay in place at that level. However, for children over 200% FPL, states should be given additional flexibility – especially in benefit design and cost sharing.

Last month, CMS approved a premium assistance option for CHIP in Utah. Our new program is called Utah's Premium Partnership for Health Insurance (UPP). We are excited to have the opportunity to serve our clients through their employer's health plan. Through UPP, we hope to allow families to receive services through a single source and to reach people who had been hesitant to enroll in a government managed plan.

However, enrollment in this option will be limited because we are required to allow children elect direct CHIP coverage at any time. Most families will chose direct CHIP coverage because of the good coverage and its low copays and premiums. If the election requirement were lifted for children over 200% FPL, additional options could be considered – including only offering a premium assistance option for those above 200% FPL. This option combined with benefits and cost sharing flexibility could be used to create a tiered reduction of benefits as income increased, rather than the cliff families currently face in Utah at 200% FPL. Although this tiered option could currently be developed with state-only funding, the loss of an approximately 80 percent federal match makes it unlikely.

Another concern for Utah is how the Payment Error Rate Measurement (PERM) program is being implemented for CHIP. We support reviews of claims and eligibility in order to help ensure that CHIP funds are only being used for appropriate service for eligible children. However, PERM has imposed a uniform sample size (500 approved/200 denied) across all states regardless of the number of children covered. We have been told that the cost will be approximately $500,000 for each state and that the cost will count against the 10 percent administrative cap for CHIP. For smaller states like Utah, this PERM expenditure will have a proportionally large impact on the dollars we are currently using to run the program, including eligibility determinations. We ask that PERM sample size and administrative cost requirements be reconsidered so that CHIP in small states is not harmed by this effort to improve accuracy.

Thank you for this opportunity to discuss Utah's CHIP program with you. CHIP has been a great partnership between the State and the federal government. We look forward to many more years working together to provide health care options for children.

Sincerely,

Nathan Checketts

Nathan Checketts
Director, Bureau of Access
Utah Department of Health

Utah Children's Health Insurance Program (CHIP)
2006 Annual Evaluation
October 2006

The Utah Department of Health (Department) operates the Utah Children's Health Insurance Program (CHIP). CHIP is a state-sponsored, health insurance plan for uninsured children whose parents' income is under 200% of the federal poverty level (FPL). CHIP was initiated on August 1, 1998; and since its inception, CHIP has served 110,600 children. The CHIP benefit plan was modeled after traditional commercial health insurance plans and utilized the Public Employee's Health Plan as the benchmark of coverage. CHIP currently contracts with two HMO plans to provide medical services.

The following is a brief outline of the efforts and accomplishments for the CHIP program.

Financial

CHIP receives approximately 80 percent of its funding from the federal government. Since FY 2001, state funds have come from the proceeds of the Master Settlement Agreement between the State and tobacco companies.

- For FY 2001, the Legislature appropriated $5.5 million for the required State match.
- For FY 2004, the Legislature increased the funding to $7.0 million to cover more children on CHIP and to restore dental services to the program.
- For FY 2006, the Legislature increased CHIP funding to $10.3 million to cover more children on the program.

For FY 2006, CHIP spent $48.2 million on health plan premiums and $3.6 million on administration. The majority of the administrative costs came from eligibility determination. With an average enrollment of 35,257 for FY 2006, the average cost per child was $1,471 per year, or $123 per month.

Cost Sharing

Families pay quarterly premiums of up to $25 per quarter for enrollment in CHIP. The amount of premium varies depending upon family income. In FY 2006, CHIP collected $790,535 in quarterly premiums.

Families pay small co-payments in addition to quarterly premiums. As established in federal guidelines, no family on CHIP is required to spend more than five percent of their family's income on premiums, co-payments, and other covered services over the course of a plan year.

Benefits

Federal guidelines allow states to select from several options in creating a benchmark for CHIP coverage. Utah has elected to benchmark its program to state employee benefits. CHIP has not rebenchmarked its coverage since the program started.

Many CHIP clients will not be affected by an effort to rebenchmark benefits, because federal guidelines limit the co-payments that can be charged to some income groups. Of the approximately 36,000 children currently on CHIP, the greatest impact would be on approximately 12,000 children whose families have higher incomes (between $30,000 and $40,000 for a family of four).

The Department is working with an actuarial firm to rebenchmark CHIP benefits to the current state employee benefits. Once this project has been completed, CHIP will begin the state and federal approval process to change benefits and co-payments. This process will help reduce CHIP expenditures and help offset the rate of growth in expenditures.

Utah's Premium Partnership for Health Insurance (UPP)

In an effort to create private health insurance opportunities for individuals that qualify for CHIP, the Department sought federal approval to offer families the ability to purchase their employer-sponsored health insurance rather than enroll their children in CHIP. The Department received notification on October 25, 2006 that the federal government approved this proposal. Beginning November 1, qualified families will be able to receive a rebate of $100 per month per child when they purchase health coverage through their work.

In addition, qualified families can also receive an additional rebate of $20 per month per child if they purchase dental coverage through their work. If the family does not purchase dental coverage for their children through their work, the children can be enrolled in CHIP dental coverage, which is provided through the Public Employee's Dental Plan.

Eligibility

Individuals can only apply for CHIP during periodic open enrollment periods. CHIP is now closed for new applications based on available funding. The Department will review enrollment and funding in the spring of 2007 to determine when the next open enrollment can be held. Applications for UPP are currently being accepted.

When CHIP is open, applications can be submitted through the mail or in-person using a simple two-page application form. Applicants may also apply online. A simplified renewal form and process has been implemented to reduce unnecessary barriers for the families being served.

Basic Eligibility Criteria

1. Gross family income cannot be higher than 200% FPL (e.g., for a family of four, 200% FPL is $40,000).
2. The child must be a resident of the state of Utah, and a U.S. citizen or legal alien.
3. The child must be 18 years of age or younger.
4. The child must be uninsured and not eligible for Medicaid.

CHIP children are enrolled in the program for twelve-month periods.

CHIP has contracted with two private health plans to provide medical services for enrollees:

1. Molina Healthy Kids

2. Public Employee's Health Plan

CHIP has contracted with the Public Employee's Dental Plan to provide dental services for all enrollees.

Enrollment

In 2005, House Bill 114, Children's Health Care Coverage Amendments (Rep. Hogue), provided an additional $3.3 million in tobacco settlement funds to expand enrollment. With this increase, CHIP remained open from July 1, 2005 to September 1, 2006. During that period, CHIP received 29,457 applications and enrolled 28,315 children. For September 2006, there were 35,706 children enrolled in the program.

Of the current enrollees, the ethnicity, race, age, and income breakdown are as follows:

Ethnicity (as of September 2006)		
Hispanic	4,258	(11.9%)
Non-Hispanic	31,448	(88.1%)
Race (as of September 2006)		
Asian	501	(1.4%)
Native Hawaiian/Pacific Islander	101	(0.3%)
Black	271	(0.8%)
Native American/Alaska Native	870	(2.4%)
White	33,932	(95.0%)
Multiple Races	31	(0.1%)
Age (as of September 2006)		
Less than 10	20,285	(56.8%)
10 to 19	15,401	(43.1%)
Income (as of September 2006)		
Less than 100% FPL	8,449	(23.7%)
101% to 150% FPL	14,460	(40.5%)
151% to 200% FPL	12,797	(35.8%)

64% of CHIP children are residents of Davis, Salt Lake, Weber, and Utah counties.
36% are residents of other counties.

Where are CHIP Kids Going After CHIP?

The most recent monthly eligibility data (September 2006) shows that of the CHIP cases that closed:

- 40% enrolled in another insurance plan
- 5% gained access to employer-sponsored health insurance coverage
- 9% could not be located or had moved out of state
- 29% were enrolled in Medicaid

Strategic Objectives and Performance Goals

The 2006 Consumer Assessment of Health Plans Survey (CAHPS) measured what parents thought about the care and services their children received from their CHIP health plan in the past year. A survey was mailed to CHIP parents in February 2006 and follow-up telephone surveys were conducted in May 2006. A total of 1,323 parents responded to the survey.

Goal #1: Improve access to health care services for children enrolled in CHIP.

- 87.5% of children ages 1 to 11 had a visit with a primary care practitioner in 2005
- 84.0% of parents said that getting necessary care for their child was "Not a Problem"

Goal #2: Insure CHIP enrolled children receive high quality health care services.

- 83.2% of parents rated their child's health plan as an 8, 9, or 10
- 87.4% rated their health care received as an 8, 9, or 10
- 86.8% rated their personal doctor or nurse as 8, 9, or 10
- 79.3% rated their specialist as an 8, 9, or 10

Note: Above ratings were done on a scale of 0 to 10, with 10 being the highest rating and 0 being the lowest.

Goal #3: Insure that children enrolled in CHIP receive timely and comprehensive preventive health care services.

- 84.0% of parents surveyed said that they "Always" or "Usually" got timely care.

Note: In all the above goals except the rating of their health plan, CHIP scored well above national benchmarks.

Core Performance Measures

The 2006 Health Plan Employer Data and Information Set (HEDIS) measurements are a core subset of the full HEDIS dataset reported by Utah's CHIP HMOs to the Department based on information from patient visits in 2005. HEDIS consists of a set of performance measures that compare how well health plans perform in key areas: quality of care, access to care and member satisfaction with the health plan and doctors.

Measure #1: Well Child visits in the first 15 months of life.

- 73.1% of CHIP enrolled children who turned 15 months old during 2005 and had been continuously enrolled from 31 days of age, received at least 5 well child visits.

Measure #2: Well child visits in children the 3rd, 4th, 5th, and 6th years of life.

- 45.9% of the CHIP enrollees ages 3-6 had one or more well-child visits with a primary care practitioner in 2005.

Measure #3: Children's access to primary care practitioners.

- 86.3% of CHIP enrollees had a visit with a primary care practitioner in 2005.

CHIP Client Feedback

The following quotes were taken from actual parents of CHIP enrollees:

"We have definitely benefited from CHIP. Not that we've had to use it much, but it's nice to know that that security is there in case we need it. We were more concerned about the kids. We had a son playing baseball at the time, and worried about the accidents that can happen with sports. You never know, you could have a broken arm or leg, whatever, and it would be expensive. But things have worked out well, no big catastrophes. And it's nice to have the coverage."

"All of a sudden we were without insurance and expecting our second child. CHIP has provided us with advice to enable us to move through this difficult period. Our son was born with a bone abnormality and needed prompt, expensive medical care. Without CHIP, our family would have had to make the difficult decision to postpone Preston's treatment until we could cover the procedure ourselves."

Senate Finance Committee Hearing
Subcommittee on Health
Questions Submitted for the Record
Mr. Nate Checketts
The CHIP Program from a States Perspective
November 16, 2006

Senator Hatch

What are the biggest successes of the CHIP program? What are the biggest obstacles facing the states as far as the CHIP program is concerned?

One of our biggest successes in Utah is the number of children we have served since the inception of CHIP. Over 110,000 Utah children have received CHIP services since 1998. This coverage translates into better health for those children, fewer missed days of school, and a better peace of mind for their parents.

Another of our accomplishments is in the way we continue to build on the success of our open enrollment periods. Each open enrollment campaign focuses on delivering a clear, consistent message. These campaigns have motivated more and more families to apply, and ultimately be enrolled in CHIP. The timing of each open enrollment period is coordinated as much as possible with the media in order to offer a new story each time and maximize the CHIP message.

A big obstacle for CHIP in Utah has been limited state funding. This limitation has caused the State to hold limited open enrollment periods for CHIP. These periods can cause workload issues during periods when we accept applications and, in some situations, families can experience breaks in coverage if they lose Medicaid or private coverage during a period that CHIP is closed.

While the availability of state funding has limited Utah's CHIP program in the past, Governor Huntsman has proposed a 40 percent increase in CHIP state funding for FY 2008. If the Legislature approves an increase of similar size, the State will quickly spend all available federal allocations.

Another obstacle for CHIP is the rapidly rising cost of health care. The State struggles to maintain current enrollment levels when CHIP expenditures rise faster than the average rate of state revenue growth or federal allocations.

What recommendations and suggestions do you have for the Senate Finance Committee as we reauthorize the CHIP program next year?

Current CHIP funding is not sufficient to cover all uninsured children in Utah under 200% FPL. Utah already uses its entire annual federal allotment to cover 35,000

children. Yet, the State believes an additional 24,600 uninsured children are CHIP eligible. As the State considers proposals to enroll more children, Utah will need additional federal allotment if the State is to reduce its number of uninsured children. The committee should consider increasing the funds available to cover children.

Although the State is grateful that CHIP already provides states more flexibility than Medicaid, more flexibility in CHIP would still be appreciated. The committee should consider additional options, including allowing states to offer a premium assistance only program to families with higher incomes.

PERM requirements have been implemented equally on CHIP and Medicaid despite the fact that Medicaid in Utah is a $1.8 billion program while CHIP is a $51 million program. The committee should reconsider the language authorizing PERM so that it is CHIP-friendly, especially in smaller states.

What has your state done to ensure that all CHIP eligible children are covered by the program?

Within the limits of available state funding, Utah has taken the following actions to help families enroll in CHIP. Utah provides multiple avenues to submit an application – at an eligibility office, by mail, by fax, or on the Internet. Families don't ever need to set foot in an office if they chose because verifications can be handled on the phone and by mail. Utah also outstations workers in areas where they are likely to have contact with families in need (including school districts). Utah has simplified its eligibility and review processes to reduce the paperwork that families complete to be on the program. Utah also conducts extensive outreach efforts including TV and radio ads during an open enrollment period.

The CHIP program and the flexibility it provides states has been extremely successful in providing coverage to children and families. Given the success of the program, do you think the major focus of reauthorization next year is on finding a solution to state shortfalls and the problems with the allotment formula?

In most aspects, CHIP is working extremely well. Providing states with sufficient funds to cover children should be the major focus of reauthorization. Although other factors may need to be considered, the major factor in the allocation formula should be the number of children under 200% FPL in the state.

Beyond CHIP financing issues (e.g., asking for more federal matching dollars), what three changes would you like to see made to the CHIP program that would help you to run your programs more effectively?

The process to make changes to CHIP is too cumbersome. Although CMS worked well with us as we implemented a premium assistance option within CHIP, the discussions and approval still took 11 months. It was frustrating for implementation of this option to take this long since the option was a priority of the administration, the application was submitted on a CMS template, and other states had already been approved to implement similar options.

As mentioned previously, Utah would like to consider the option of a premium assistance only option for higher income families but has been required to offer a direct coverage CHIP option to all qualified families.

As mentioned previously, PERM places a disproportionate review on CHIP in comparison to Medicaid. The emphasis in federal oversight should reflect the size of the programs.

The Deficit Reduction Act of 2005 (DRA) give states the option to amend their state plans to increase enrollee cost sharing, and provide Medicaid to specified groups through enrollment in benchmark and benchmark-equivalent coverage without regard to certain traditional Medicaid program requirements including freedom of choice, state wideness, and comparability. States operating CHIP Medicaid expansion programs may target their CHIP enrollees as a part of their DRA state plan amendments. Some have argued that states may use the new DRA flexibility to align their CHIP and Medicaid programs both in terms of the cost sharing requirements and the benefit coverage, and that these changes could make CHIP and Medicaid coverage seamless to enrollees particularly in the case where individuals in a given family access coverage through both programs concurrently. Do you anticipate that your state will pursue a DRA state plan amendment? If so, do you have any concerns regarding how the new DRA flexibility might impact your CHIP programs?

Utah does not plan to pursue a DRA state plan amendment for children. The requirement to provide wrap around coverage to benchmark plans limits the flexibility a plan amendment would provide.

You cover children in your CHIP program up to 200% of poverty. Your annual allotments of federal CHIP funds are roughly equal to your need. However, CRS projects there are eight states (Alaska, Iowa, Louisiana, Maine, Mississippi, Nebraska, North Carolina, South Dakota) facing shortfalls in FY2007 that cover children up to 200% of poverty or less and that do not cover adults. How is it that these states are facing shortfalls even though their eligibility levels are the same as yours? Is the allotment formula not targeting funds correctly, or are these states spending money differently somehow?

Utah has used limited open enrollment periods to keep spending within available state funds. When CHIP is closed for new applications, enrollment declines and it lessens the draw on our federal CHIP allotment.

Senator Rockefeller

Mr. Checketts, in your testimony, you estimate what it would cost in federal CHIP dollars to cover all children in the state: an additional $30 million. However, if CHIP is reauthorized and annual funding is frozen at current levels of $5 billion per year, won't Utah have insufficient federal funding over time to sustain such an expansion, particularly as health care costs rise and population growth increases annually, while funding remains static?

If Utah remains flat funded for the future at its current federal CHIP allotment of approximately $40 million per year, then the State could cover no more than the current 35,000 enrolled. In addition, the number on CHIP would likely fall as rising health care costs would force us to reduce the number of covered children to stay within the $40 million allotment.

Shouldn't the baseline funding levels be adjusted to reflect actual state need for current programs and what state need could be, if states like Utah did more to cover more uninsured children?

The need in Utah exceeds the currently available allotment. If the State is to address the issue of the remaining uninsured children under 200% FPL, Utah will need more CHIP funding.

Mr. Checketts, one of things I think many of the members of this Committee have wondered about is why states have unspent federal CHIP funds from year-to-year, particularly those states with high numbers of uninsured children. From your experience in Utah, can you tell me what causes states to have unspent CHIP funds? Is it because of program cutbacks, lack of state matching dollars or a combination of several different factors?

Utah has unspent CHIP funds because of limited state matching dollars. The Legislature has increased state funds in two of its last four sessions and Governor Huntsman has requested a significant increase in state funds this year.

Some have argued that perhaps Congress should consider capping CHIP eligibility at 200% of poverty. Wouldn't you agree that there is significant variation in median and per capita income among the states and in health care costs? For example, the cost of

living in New Jersey is very different from the cost of living in West Virginia or Utah. Do you think 200% of the poverty level is the same in one state as it is in another state?

The federal poverty level is a rough measure of need that doesn't fully account for local conditions. Even in Utah, an income of $40,000 for a family of four means something very different in Park City than it does in little Harper Ward. Likewise, I am sure even states with larger populations, like New York, see large differences between the cost of living in New York City versus that in Buffalo.

Senator Lincoln

How could your states benefit by greater opportunities for private-public partnerships in SCHIP, such as allowing SCHIP to provide wraparound coverage for children with special healthcare needs and limited private insurance or premium subsidies to help children remain in the private health insurance system?

Utah has recently implemented a premium assistance option for CHIP. We are excited about this opportunity to partner with employees and employers to cover children in our state. As mentioned previously, Utah would like to consider a premium assistance only program for higher income families.

Written Testimony of Tobi Drabczyk
Senate Finance Subcommittee Hearing on Children's Health Care
Thursday, November 16, 2006

Good afternoon. My name is Tobi Drabczyk and I am from Walkersville, which is in Frederick County, Maryland. My husband, Kevin, and I have been married for 18 years and we are the parents of four children: Our oldest daughter, Severa, is 14. Our son, Mitchell is 12. And we have two younger daughters: Jocelyn, who is 3 and Arwen, who is 16 months.

Kevin has had a job ever since I have known him – he has always worked. Sometimes his job came with health insurance, but sometimes we haven't been so lucky. Right now, Kevin is the Maintenance Supervisor for an apartment complex. He earns $36,000 a year. The health insurance he gets through his job covers only him — it would cost our family about $500 per month to cover the children and me, and that's just too expensive for us.

When I became pregnant with Jocelyn, I read about Maryland's medical assistance program and I called the Health Department. They helped me sign up and also told me that both Severa and Mitchell would qualify for the children's health insurance program, MCHP. For me, the coverage was incredibly important. It turned out that I had gestational diabetes. I had to monitor my blood sugar several times a day – and just the cost of the test strips was more than I could afford. Because of the insurance, I was able to get the care I needed and Jocelyn was born a healthy baby.

Kevin and I are very fortunate that our children are generally healthy – but we have to deal with routine illnesses just like all parents. Thanks to MCHP, our babies have been able to get their vaccinations and when the older ones have had ear infections — which are so painful — we've been able to get the antibiotics the doctor prescribes. On $36,000 a year, we often find ourselves living paycheck to paycheck. There are times when we are short on the gas money my husband needs to drive to work and there are times when money for food is tight. But, we have never had to choose between those things and our children's health. Because of MCHP, I can get the medicine the children need when they need it as opposed to when I can figure out how to budget for it.

We're not parents who take our children to the doctor for every little sniffle — but about a year ago, we found ourselves in a scary situation with our son. Mitchell had been having arm tics since he was about six years old. They came and went, but then they began getting worse. He also started to have other symptoms – vocal tics and sharp movements of his neck. We were seriously worried that he might have a brain tumor. One day it was clear that something was really wrong and my husband took Mitchell to the emergency room. After some preliminary exams, we were referred to a pediatric neurologist who tested our son's motor skills and did

blood tests, ruling out many possibilities. Eventually, Mitchell was diagnosed with Tourette's Syndrome. Again, we are very lucky. Without MCHP, we would never have been able to afford the specialists and all the tests. We'd still be wondering what was happening to our child. MCHP helped allay our terrible fears.

Mitchell is doing just fine. His case is very mild so he does not need any medication and we learned that Tourette's Syndrome slows down as children get older. With MCHP, we know we can take him for the check-ups he needs.

I hope I have explained how important MCHP is to our family. We are a family that works hard, we pay our taxes — but we just need a little bit of help. With MCHP we can be sure that our children stay healthy. That's what all parents want for their children. Thank you for the opportunity to talk with you today.

Senate Finance Committee Hearing
Subcommittee on Health
Answers to Questions Submitted for the Record
Mrs. Tobi Drabczyk
The CHIP Program From the States' Perspective
November 16, 2006

Question: Mrs. Drabcyzk, before your children were enrolled in the Maryland Children's Health Program (MCHP), where did you receive health care? If your kids were not covered, how hard do you believe it would be today to find doctors who would care for your family at reduced rates, or offer flexible payment options?

Answer: Before my children were enrolled in the Maryland Children's Health Program there were about 6–7 years when we had no health care coverage for them. They were covered by private health insurance through my husband's work during my pregnancy and as newborns, infants, and until my son was around 3 or 4 years old. After that until about 4 years ago we had no coverage, they did not have regular checkups, and we did not take them to the doctor for any illness. We were lucky, and they did not have any serious health concerns during this time. If they had or if we needed care for them we would go to the emergency room of our local hospital.

If my children were not covered by MCHP today I know that it would be very difficult to find doctors who would care for them at reduced rates or with flexible payment plans. I had tried this approach during the years when we did not have coverage and at times for myself when I wasn't covered, and the doctors I talked with all wanted the cost of care covered up front before they would see any of us. With the high prices of health care and the high cost of malpractice insurance that doctors have to pay, very few can or will give care without being sure of full payment. When I was pregnant with my daughter Jocelyn, before I knew of MCHP, I talked to several doctors, and they would not even see me unless I had paid a full ⅓ to ½ the total cost of my prenatal care. I know that it would be all but impossible to find a doctor to care for my children if they weren't covered by MCHP.

Question: If your children were not covered by MCHP, do you think you would be able to afford routine preventive care visits for your children? You mentioned that MCHP coverage has helped to ensure that your kids have received timely immunizations; without coverage, what types of services might your kids have to go without?

Answer: If my children were not covered by MCHP I know that I would not be able to afford routine preventive care visits for them. My son, Mitchell, was not covered by health insurance from the time he was around 2 years old and until he was around 8 years old, and we tried to keep up with his immunizations, paying as we went, but we couldn't

keep up, and he did indeed miss a lot of the immunizations he needed as a preschooler/grade-schooler. He was able to catch up after we got enrolled in MCHP. Without any health insurance coverage my children would most likely go without regular checkups, simple health issue visits (like bad colds, flu, ear infections). We would have to take them to the emergency room and would only do so for emergency situations or very serious health concerns.

Question: You mentioned that you read about Maryland's coverage options. Was it easy to access the program once you learned about it? Do you need to go to the MCHP office regularly to renew coverage for your children?

Answer: Once I learned about MCHP it was very easy to access the program. All I had to do was call or e-mail or mail the local health department and request an application. It was sent in the mail, and I filled it out and mailed it back in the postage-paid envelope. In Maryland you have to get a determination of coverage within three weeks, and I got my letter in two weeks' time. Then I was sent a package of information and insurance cards. It was very easy to access initially and to renew coverage is just as easy. Each year the health department sends me a notice that it is time to re-enroll. If all of my family information is the same, I just send back the notice; if there are changes I write them in on the form and send it back.

Testimony of
Lisa Dubay, Ph.D., Sc.M.
Research Scientist
Johns Hopkins Bloomberg School of Public Health

Prepared for
The Senate Finance Committee
Subcommittee on Health
Hearings on
The CHIP Program: From the States' Perspective

November 16, 2006

Senator Hatch, Senator Rockefeller, and distinguished members of the Senate Finance Committee, Sub-Committee on Health, I am pleased to have the opportunity to speak with you today about the State Children's Health Insurance Program. My name is Lisa Dubay and I am a Research Scientist at the Johns Hopkins Bloomberg School of Public Health, as well as the Research and Policy Advisor at Georgetown University's Center for Children and Families. Prior to joining the public health school at Hopkins, I was a Principal Research Associate at the Urban Institute where I participated in the Congressionally mandated evaluation of SCHIP. Over the course of 19 years at the Urban Institute, I led other evaluations of the SCHIP program and evaluations of the Medicaid expansions for children and pregnant women. Importantly, the views that I will express today are my own.

My testimony will focus on two issues: what have been the major accomplishments of the SCHIP program; and what are the opportunities to use SCHIP reauthorization to move towards the goal of assuring that all children have health insurance coverage that provides access to high quality health care. Our children are our future and their health is critical to the nation as a whole.

Background on SCHIP

As you all know, the SCHIP program triggered a major expansion in eligibility for public health insurance coverage for children, following the important groundwork laid a decade earlier when Congress delinked Medicaid eligibility from welfare eligibility for children and set a national floor for children's eligibility for coverage under the Medicaid program. Designed to sit on the shoulders of Medicaid, SCHIP provides states with resources and incentives to cover uninsured children whose family incomes are too high

to qualify for Medicaid but too low to afford private insurance. Crafters of the SCHIP legislation, including members of this Committee, offered states the choice to use their SCHIP funds either to expand Medicaid or cover children through a separate child health program and granted states considerable flexibility to set the eligibility rules for their SCHIP programs.

Currently 18 states use their SCHIP funds to cover children in a separate program only; 11 states and the District of Columbia use their SCHIP funds only to expand Medicaid; and 22 states employ a combination approach.[1] As of July 2006, 26 states cover children up to 200 percent of the federal poverty line ($33,200 in annual earnings for a family of three), while 15 states have adopted income eligibility limits above that level and 10 have income eligibility thresholds below that level.[2] Consistent with the choices accorded states in the SCHIP law, some states apply these eligibility limits to gross income while others consider work-related expenses that reduce families' ability to afford coverage, such as taxes and child care costs. The various choices states have made reflect differences in state preferences and political inclinations, as well as differences in fiscal capacity, local economies, and family incomes. Perhaps most important to families, this flexibility allows states to account for the geographic variation in the cost of living. For example, it allows states to recognize that a family living in San Diego at 250 percent of the federal poverty line has same buying power as a family living in Houston at 154 percent of the federal poverty line.[3]

SCHIP has also had an important impact on Medicaid. Mindful of Medicaid's role in covering children, Congress included key provisions in the law to assure that states with separate programs coordinated their new programs with Medicaid so no children fell through the cracks. The Congress also adopted new Medicaid options in other parts of the Balanced Budget Act of 1997 to allow states to implement continuous and presumptive eligibility for children eligible for Medicaid. These changes, along with the outreach and simplification efforts that states adopted and that carried over to Medicaid as well as SCHIP, have proved to be key components of the SCHIP success story.

The enactment of SCHIP was followed by unprecedented levels of activity aimed at reducing the rate of uninsurance among children. By 1999, every state had enacted SCHIP in one form or another, and states, as well as community organizations, schools, national foundations, and others concerned about children's health undertook efforts to inform families about the availability of coverage. The level of outreach was unprecedented, but the change in the paradigm went well beyond outreach. The focus on covering children prompted a close examination of the systems for enrolling children into public coverage programs. The new SCHIP programs were designed in ways that would promote participation, and, just as significantly in terms of the number of children affected, is that SCHIP triggered a re-examination of state Medicaid application and renewal procedures. Complex forms and unnecessary and burdensome procedures for

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[1] FY 2005 Annual SCHIP Enrollment Report, CMS (http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1184785).

[2] Ibid.

[3] Author's calculation based on 2006 cost of living data from ACCRA – the Council for Community and Economic Research.

enrolling and renewing coverage for children in Medicaid were replaced in most states by simplified and more family-friendly systems.

In many respects, SCHIP has been a model program, garnering widespread, bi-partisan support from state and federal officials, as well as the families it serves. The most consistent set of concerns affecting the program relate to its financing. In the early years of SCHIP, as states were getting their child coverage initiatives underway, significant numbers of states were unable to use the SCHIP funds made available to them under the timeframe outlined in the original SCHIP statute. Congress repeatedly had to take action to extend the life of SCHIP funds to ensure that the resources would be available in future years for states when they were needed.

More recently, however, the picture has shifted dramatically. In fiscal year 2006, nearly all states – 38 out of 50 – used more federal SCHIP matching funds than they received in their annual allotments. In total, states spent some $6.3 billion in federal matching funds in 2006 compared to the $5 billion they received in their SCHIP allotments. States addressed much of this mismatch by drawing on unspent funds from earlier years and resources reallocated from other states. But, these options are rapidly disappearing as the size of the fundamental mismatch between the need for federal funds and the amount being made newly available continues to grow rapidly.

What Have We Achieved?

According to the Center for Medicaid and Medicare, there were 6.1 million children ever enrolled in the SCHIP program in FY 2005, 4.3 million ever enrolled in the last quarter of FY 2005, and 3.9 million enrolled on the last day of FY 2005.[4,5] In addition to increases in coverage under the SCHIP program, coverage under the Medicaid program has also increased since SCHIP implementation. As can bee seen in Table 1, Medicaid participation rates increased from 74 percent in 1997 to 82 percent in 2002 for children. And participation in SCHIP increased from 48 percent to 68 percent between 1999 and 2002.

Since SCHIP was implemented, the number of children 18 years old and younger uninsured at a point in time has fallen from 10.0 in 1997 to 7.5 million in 2005 according to the National Health Insurance Survey and the percentage of all children uninsured has fallen from 13.5 percent to 9.7 percent (See Table 2 and Table 3). When you consider only children in families with incomes below 200 percent of the federal poverty level, you see large and significant reductions in both the number and the rate of uninsurance. Among low-income children the uninsurance rate declined from 22.3 percent in 1997 to 14.9 percent in 2005.

In many respects, these declines in the uninsurance rate understate the impact of the SCHIP program on public coverage as secular declines in employer-sponsored coverage due to both economic and inflationary forces would have resulted in higher rates of uninsurance were it not for the safety net of Medicaid and SCHIP for children. Because

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[4] Ibid.

[5] FY 2005 4th Quarter Enrollment Report (CMS)
http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS056615

of these two programs, low-income children were protected from increases in the rate of uninsurance experienced by low-income adults between 1997 and 2005 and actually experienced reductions in uninsurance.

Who are the Uninsured Children?

Uninsured children are of all ages and races and live in all regions of the country. According to the March 2005 Current Population Survey, 68 percent of uninsured children live in families with one or more full time workers and another 9 percent live in families with part-time workers. Moreover, their parents work in firms of all sizes. It is well known that the vast majority of uninsured children are eligible for Medicaid or SCHIP. Table 4 shows data from the National Survey of America's Families in 2002 for all uninsured children and for low-income children. Forty-nine percent of all uninsured children are eligible for Medicaid and 23 percent are eligible for SCHIP. When we focus on low-income uninsured children, you can see that 58 percent are eligible for Medicaid and 22 percent are eligible for SCHIP. Importantly, most low-income uninsured children who are not eligible for Medicaid or SCHIP are not eligible due primarily to their immigration status. Only 5 percent of low-income uninsured children are not eligible because the state they live in does not cover children with family incomes up to 200 percent of the federal poverty line.[6] Consequently, solving the problem of uninsured children is in large part an issue of increasing and maintaining rates of enrollment and retention in the Medicaid and SCHIP programs.

Why Are So Many Children Eligible but Not Enrolled?

This problem is particularly puzzling given that states have been quite successful over the past decade in increasing the rate at which eligible children participate in public programs. First, much of the explanation lies in a "good news" story. Since 1997, states have expanded eligibility for coverage, greatly increasing the size of the eligible but not enrolled population. As a result, despite the fact that states are far more successful than they used to be in enrolling eligible children, they still have significant numbers of uninsured children who are eligible for coverage. In effect, they have made their own jobs far more challenging by extending eligibility for coverage to millions more of America's uninsured children. In addition, when the economy turned down, families lost economic ground and more became eligible for public coverage.

Second, although the state response to SCHIP has been impressive and Governors from both sides of the aisle have shown a strong commitment to covering children, budgetary constraints keep some states from fully embracing or maintaining all of the strategies that are known to be effective in increasing children's participation. The reality is that when states enroll more eligible children, they face higher coverage costs, which may be difficult for them to afford. Particularly if they are facing economic difficulties or fierce competition for state resources, they may be reluctant to aggressively pursue the enrollment of eligible uninsured children. Indeed, in the aftermath of the last economic

[6] More current data using the Current Population Survey, but not yet releasable, indicates that while the number of uninsured children has changed, the vast majority of uninsured children remain are eligible for Medicaid or SCHIP

downturn, when faced with slow or negative revenue growth and growing numbers of families in need of coverage for their children, nearly half of all states (23 states) reinstated or adopted new procedural barriers to enrollment and retention of coverage, making it harder for eligible uninsured children to secure the coverage that they need.[7] Even when not faced with downturns, some states may be hard-pressed to absorb the coverage costs generated by successful enrollment initiatives. The issue is particularly acute with regard to Medicaid-eligible children because the federal government covers a smaller share of coverage costs for children covered by Medicaid than for children covered by SCHIP.

Third, some families continue to be unaware that they could secure coverage for their uninsured children through Medicaid or SCHIP. In many cases, these families are under the erroneous impression that you must be on welfare in order to secure health care coverage for your children. For example, data from the 2002 round of the National Survey of American Families indicates that for uninsured children whose parents had heard of Medicaid or SCHIP, only 56.7 percent understood that welfare receipt is not a prerequisite for enrollment in health coverage.[8] With the further passage of years since these data were collected, that percentage may well be much lower today. However, it is important to note that, when informed that they can enroll their children in Medicaid or SCHIP, the vast majority of families are eager to do so. In the NSAF, we asked low-income parents of uninsured children who had heard of the Medicaid or SCHIP programs whether they would enroll their child in these programs if told that the child was eligible. Eighty-seven percent of children had a parent who responded that that, yes, they would enroll their child if they knew they were eligible, 12.6 percent had parents who said no, and 5.7 percent had parents who were undecided.[9]

Finally, a new, but growing issue is the federal mandate included in the Deficit Reduction Act of 2005 requiring states to secure documentation of the citizenship status of citizens seeking Medicaid coverage. States are given little discretion in how they implement the requirement and some are reporting that it creates unnecessary barriers to eligible children enrolling in coverage. For example, states must require families to provide hard copies of their children's birth certificates and proof of their identities even in circumstances when the state paid the hospital bill for the birth of the child and, thus, there is no dispute that the child is a citizen.

How Can We Get to the Finish Line?

In light of the success of SCHIP and Medicaid in covering children, as well as the shape of the remaining population of uninsured children, Congress has at its disposal several tools for moving forward.

First, a threshold issue is whether the SCHIP program will be fully funded in 2007 and beyond, allowing states to sustain and build on their successful implementation of

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[7] Donna Cohen Ross et al, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2004.

[8] Kenney G, J Haley, A Tebay. "Familiarity with Medicaid and SCHIP Programs grows and Interest in Enrolling Children is High " *Assessing the New Federalism, Snapshots III.* Washington, DC: The Urban Institute, July 2003.

[9] Ibid.

SCHIP. The vast majority of states now find themselves facing the prospect of running out of federal SCHIP funding in the years ahead, with some 17 states slated to run short of funds as early as this year (fiscal year 2007).[10] Administration estimates suggest that these budget challenges, if left unaddressed, will translate into some 1.9 million children losing SCHIP coverage by 2016. To address this issue, federal matching funds in excess of the amount set aside for SCHIP under congressional budget rules – $5 billion a year – will be needed. This amount falls short of what states currently spend using the dwindling supply of unspent funds from earlier years and is not slated to be indexed for health care inflation or expected growth in the number of eligible uninsured children. It also provides no room for states to experiment with further expansions of coverage or initiatives to reach eligible, uninsured children. The state and federal financial partnership behind SCHIP has been a critical component of its success and there is little doubt that children will lose coverage and the country will be unable to make further progress unless the federal government provides the funds necessary to continue playing a full role in this partnership.

Second, it will be vital to identify strategies for reaching the more than two-thirds of uninsured children who already are eligible for Medicaid or SCHIP. To this end, it will be important to 1) support and strengthen state interest in reaching eligible uninsured children, such as by offering performance-based assistance with coverage costs to states that successful cover more uninsured children; 2) provide families with information about their children's eligibility for coverage and assistance in applying for and retaining coverage, such as through community-based outreach efforts; 3) give states the flexibility and tools needed to reduce the paperwork burden associated with enrolling and keeping children in coverage, including, to decide the best way to ascertain a child's citizenship status.

Third, we know that one of the most effective methods for increasing participation of eligible but uninsured children is to cover their parents. As we move forward with SCHIP reauthorization it is critical to do the most that we can to ensure full participation of all eligible children. While family based coverage has coverage costs that accompany it, it is also associated a 14 percentage point increase in participation of children in health insurance programs and with greater use of preventive care visits among children. [11,12]

Fourth, states will need new tools for reaching uninsured children who are ineligible for publicly-financed coverage, including some legal immigrant children and children in somewhat more moderate-income families who nevertheless are unable to afford coverage.

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[10] Broaddus M, E Park "Freezing SCHIP Funding in SCHIP Reauthorization Would Threaten Recent Gains in Health Coverage." Washington DC: Center on Budget and Policy Priorities, July 2006.

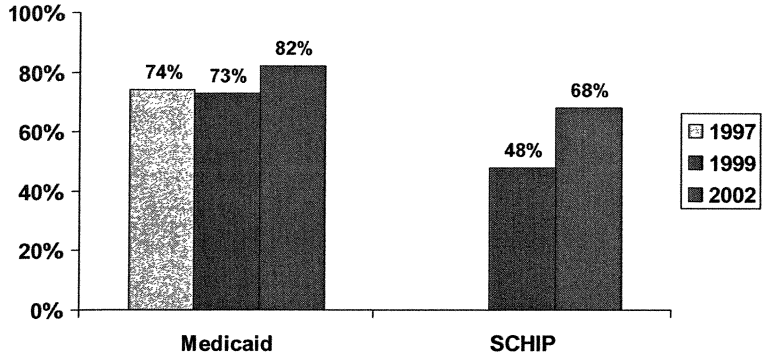
[11] Dubay, Lisa and Genevieve Kenney. "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid." Health Services Research, 38 (5): Oct 2003.

[12] Davidoff, Amy, Lisa Dubay, Genevieve Kenney, Alshedye Yemane. "The Effect of Parent's Insurance Coverage on Access to Care for Low Income Children." Inquiry, 40(3): Fall 2003.

Conclusion

With the 10-year anniversary of SCHIP creation rapidly approaching, we are at a crossroads in children's coverage and the evidence is clear: This program and its partner, Medicaid, have together worked to significantly lower the number and percent of uninsured children. We should fully fund the SCHIP program to continue this progress and move forward in finding ways to ensure that all uninsured children secure coverage that assures high quality access to care.

Table 1
Medicaid and SCHIP Participation
1997, 1999, 2002



Source: 1997,1999,2002 National Survey of America's Families

Note: Excludes children with private coverage and defined for citizen children ages 0 to 17.

1

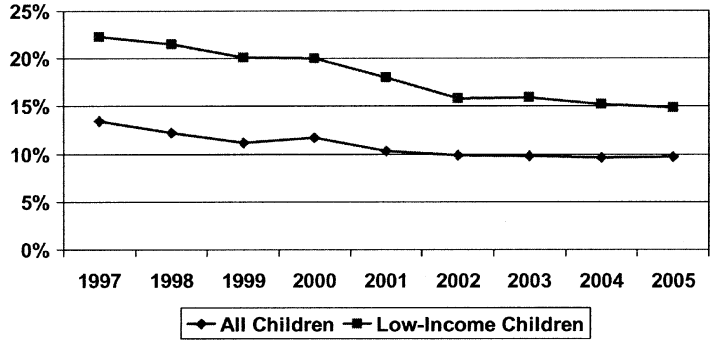
Table 2
Uninsured Children in 1997 and 2005

	1997	2005
Number of Uninsured Children	10.0 million	7.5 million
Percentage of All Children Uninsured	13.5%	9.7%
Percentage of Low Income Uninsured	22.3%	14.9%

Source: Authors tabulations of 1997 and 2005 National Health Interview Survey

2

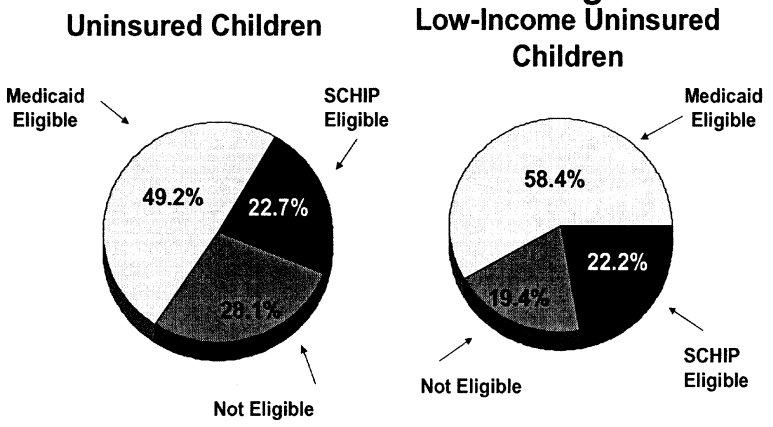
Table 3
Trends in the Percentage of Uninsured Children 1997 – 2005, All Children and Low-Income Children



Source: Authors tabulations of 1997-2005 National Health Interview Survey.

3

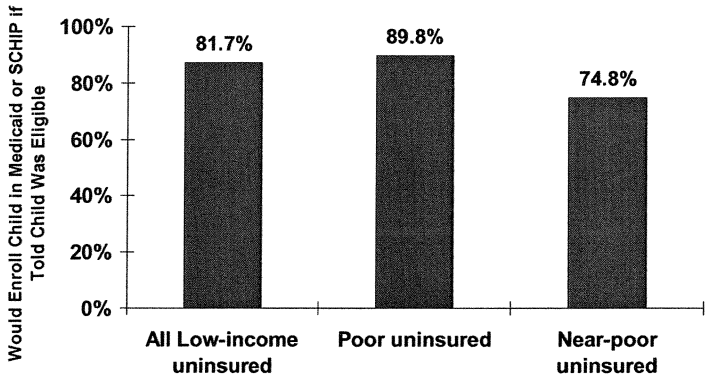
Table 4
Most Uninsured Children are Eligible for Public Insurance Coverage



Source: 2002 National Survey of America's Families using July 2002 eligibility rules.

4

Table 5
Interest in Enrolling in Medicaid and SCHIP is High, 2002



Source: Kenney, Haley and Tebay (2003)

5

Senate Finance Committee Hearing
Subcommittee on Health
Questions Submitted for the Record
Dr. Lisa C. Dubay
The CHIP Program from a States Perspective
November 16, 2006

Senator Hatch:

What are the biggest successes of the CHIP program?

Certainly, one of the biggest successes of the State Children's Health Insurance Program is that all 50 states and the District of Columbia embraced the options provided by Congress and each state now has a SCHIP program. As a result of efforts by states, 3.9 million children were covered by SCHIP on the last day of fiscal year 2005 and 6.1 million children were ever enrolled in FY 2005, according to the most recent data available from the Center on Medicare and Medicaid Services (CMS).

Moreover, with the implementation of the SCHIP ever-on enrollment in **Medicaid** increased by 6.8 million children between 1997 and 2004. This increase in Medicaid coverage was likely in large part due to outreach efforts that occurred with SCHIP implementation and to eligibility simplification efforts that were allowed under the Medicaid program as part of the Balanced Budget Act of 1997. As a result of increased enrollment in Medicaid and SCHIP, the number and rate of low-income uninsured children has declined by close to a third.

Not only have millions of children enrolled in SCHIP, numerous studies have demonstrated that program improves access to care and increases the use of health care services for those who enroll. Standing on the shoulders of Medicaid, SCHIP now is a critical part of the landscape of children's coverage

What are the biggest obstacles facing the states as far as the CHIP program is concerned?

States currently face two major obstacles regarding the SCHIP program that are intertwined. First, until recently, 17 states were facing SCHIP shortfalls for fiscal year 2007. Moreover, it is estimated that if SCHIP allocations remain frozen at the budget baseline of $5 million, 24 states will face shortfalls that are equivalent to covering 1 million children in 2008 and 36 states will face shortfalls that are equivalent to covering 2.1 million children by 2012.

Second, participation in the SCHIP among children without insurance coverage is much lower than under the Medicaid program. In particular, 66 percent of such children were enrolled in the SCHIP in 2004 compared to 75 percent of Medicaid eligible children. As a result, 17 percent of uninsured children are eligible for SCHIP. There is considerable evidence that the low participation rates are due to a range of problems including lack of

knowledge and understanding on the part of parents of uninsured children, churning in and out of the program, the magnitude of the premium faced by families, and, for a small share of parents, lack of interest in insurance programs.

When states either face shortfalls or expect to face shortfalls, they are reluctant to conduct outreach and education efforts and make all of the eligibility determination and re-determination simplifications needed to enroll all of the eligible children. Rather states likely to exhaust their SCHIP allotments are faced with the prospect of capping enrollment or reducing eligibility, shouldering the federal share of costs of covering these children and crowding out other state programs, or reducing provider payments. For many of the states facing shortfalls, shouldering the federal share of the costs associated with SCHIP enrollment is infeasible; consequently, the options remaining are likely to lead to children loosing coverage and/or reductions in access.

Full funding of SCHIP with re-authorization is necessary to maintain the progress the nation has made in reducing the number of uninsured low-income children. Additional federal dollars will be needed to address the problem of eligible but uninsured children.

Shortfall states with Medicaid expansion programs have a fallback, to use Medicaid funds for their shortfall (although at a reduced matching rate). Shortfall states with a separate CHIP program have no Medicaid fallback (except for Rhode Island, which had such an arrangement written into the Terms and Conditions of their waiver agreement). Should states with separate CHIP programs also be able to draw down Medicaid funds for their shortfalls? From the other perspective, should states with Medicaid-expansion CHIP programs NOT be permitted to draw down Medicaid funds for their shortfalls?

There are a number of issues embedded in these questions. To me the real question boils down to: how serious is Congress about ensuring that we meet our national goals of protecting low-income children from uninsurance? For many years prior to implementation of the SCHIP program, states could cover children up to virtually any income threshold under their Medicaid program as did states such as Minnesota and Washington. In designing the SCHIP program, Congress tried to address a number of issues perceived to have deterred most states from expanding coverage for children under Medicaid. Specifically, Congress allowed states to create a separate SCHIP program under which benefits were not required to be as broad as under Medicaid and provided states with a higher federal match on SCHIP covered children in order reduce the burden born by states in covering children. These issues underlying these incentives have real implications for how go forward in the future.

I believe that Medicaid expansion states should be allowed to receive the Medicaid match on children beyond the allotments. States were allowed to cover such children prior to SCHIP with a Medicaid match and should continue to be able to do this after implementation of SCHIP. In addition, states have been allowed to use a combination approach under SCHIP which offers them the same protection for children eligible for the Medicaid expansion portion of the program. I also believe these states should be able to

obtain the Medicaid matching rate for these children when SCHIP allocations are depleted.

But what about shortfall states with separate SCHIP programs -- should they be allowed to get obtain the Medicaid match on SCHIP and under what circumstances should this occur? Clearly states can change eligibility rules so that more children are covered either under the Medicaid program or under a Medicaid SCHIP expansion in order to have the protection of the Medicaid match. From an equity perspective, I am comfortable with providing states a wrap around Medicaid match when they go beyond their SCHIP allotment. At the same time, we know that part of the reason states were eager to take up SCHIP was the option of a separate state program and the enhanced federal match. As we chip away at these incentives, we risk tipping the balance of what states are willing to do to cover low-income children.

Ultimately, I believe strongly that we need to align our national objectives of ensuring that low-income children are protected from uninsurance and the incentives and financial supports we give to states to encourage them to make this happen. Were SCHIP to be re-authorized with sufficient federal funding to allow states to continue to provide coverage to those children already enrolled and to enroll those eligible but uninsured, the issue of drawing down the lower Medicaid match would not be relevant.

Should adults, including childless adults, be covered in the Children's Health Insurance Program? (As you know, the Deficit Reduction Act prohibits CHIP funds being used to pay for health coverage of childless adults.)

As you have mentioned, the DRA prohibits states from obtaining waivers to use SCHIP funds to pay for the health coverage of childless adults. I agree that that this particular restriction should be maintained. However, I strongly believe that we ought not to go backwards in terms of covering pregnant women and parents in low-income families. The option given to states by the federal government to cover pregnant women and parents of Medicaid and SCHIP eligible children and to receive a SCHIP match for these individuals should be continued for a number of reasons.

First, we all know that prenatal care is associated with improved maternal and child birth outcomes. By investing in low-income children in the prenatal period, we not only better serve our nation's children, but it is the right thing to do.

Second, there are clear benefits to children of having parents who are insured. In particular, public health insurance programs that cover parents have been shown to increase participation among children by about 20 percentage points. Moreover, having an insured parent is associated with a 5 percentage point increase in the probability that a child has a well child visit of about 5 percentage points beyond the effect of the child having insurance coverage.

Finally, we should ensure that parents have health coverage that provides them with access to the care they need to be both physically and emotionally healthy if we care

about the wellbeing of the nation's children.. Healthy parents are more likely to be able to work, to raise healthy children, and to more successfully promote their children's health and wellbeing. Consequently, I strongly support the use of SCHIP funds to finance care for parents.

What do you see as the federal government's responsibility to step in when states are facing shortfalls of federal CHIP funds? And should that responsibility vary according to who in the state is eligible for CHIP (e.g., children in higher-income families, adults)?

A large part of SCHIP's success is the strong partnership between the federal government and the states. Another clear reason for SCHIP's success is the flexibility offered to states to set eligibility thresholds and to design programs that meet state specific needs and to obtain federal matching funds for these choices.

I have argued previously that parents should be covered so I won't belabor the point much here. However, we need to recognize that covering parents is a strategy that states have used not only to provide coverage to parents of Medicaid and SCHIP eligible children, but also to increase enrollment of eligible children. States that covered parents under SCHIP did so under waiver authority that was approved only if certain conditions were met. The success of the SCHIP program in the future, no doubt, rests on continued state flexibility. Consequently, I believe that states should continue to receive federal matching funds for parents covered under waiver authority and approved by the federal government.

I do want to spend some time here on the issue of higher income children. As I mentioned in my testimony, a family living in San Diego at 250 percent of the federal poverty line has same buying power as a family living in Houston at 154 percent of the federal poverty line. When you examine which states have eligibility thresholds for children above 200 percent of the FPL, you see that, for the most part, they are states in which the cost of living is high. By allowing states to cover children above 200 percent of the FPL, we implicitly allow them to adjust for variation in the cost of living. This type of allowance is consistent with other federal policies. For example, under the Medicare program physician and hospital payments are adjusted to account for geographic variation in the cost of practicing medicine. It seems to me that we ought not to penalize high cost states, and consequently the children who live in such states, by limiting the federal SCHIP contribution if such states face a shortfall.

Finally when designing the SCHIP program Congress could neither predict the economic declines and rapid increases in medical care spending that occurred over the past ten years nor make accurate allocations to states based on need due to shortcomings with available data. Consequently, there is mismatch between both the total amount of dollars Congress made available for allocation and the distribution of these funds across states on the one hand, and what state need to cover eligible children on the other hand. Given these circumstances, the federal government should continue to honor its commitment to match state spending with federal funds when states make choices allowed under the law,

including covering both parents of Medicaid and SCHIP eligible children and higher-income children.

Senator Rockefeller

Dr. Dubay, according to your data, 7 in 10 uninsured children are already eligible for Medicaid/CHIP. Why are they still uninsured and what can we do to get them enrolled in coverage?

Yes, my research indicates that about 7 in 10 uninsured children are already eligible for Medicaid or SCHIP. The problem of uninsured but eligible children is complex and due to a number of factors that would need to be addressed in order to get them enrolled in coverage. It is clear from research using data from 2002 that there is considerable confusion on the part of parents of uninsured children about how the Medicaid and SCHIP programs work and who is eligible to participate. While 92 percent of low-income parents with uninsured children have heard of Medicaid and SCHIP, only 50 percent have both heard of the program and understand that their family doesn't have to also be receiving welfare. At the same time, over 80 percent of these parents said that they would enroll their child in Medicaid or SCHIP if they were told that the child was eligible. So efforts that reach parents of uninsured children are clearly needed.

Despite the willingness of parents to enroll, knowledge barriers are not the only barriers to enrollment facing parents of uninsured children. Data from the Congressionally Mandated SCHIP Evaluation indicate that knowledge barriers (25 percent), barriers due to perceptions regarding how difficult it is to enroll (20 percent), and having both of these types of barriers (20 percent) account for 55 percent of the responses given my low-income parents of uninsured children when asked about why they did not enroll their child in Medicaid or SCHIP. Another 16 percent cite barriers considered to reflect a lack of interest in enrolling in the program and another 19 percent did not report any barriers to enrolling their children. In addition, data from the National Survey of America's Families in 2002 indicates that as many as 20 percent of low-income children uninsured on the day of the survey were enrolled in Medicaid or SCHIP in the past year. Moreover, about 22 percent have parents who have inquired about Medicaid or SCHIP and applied for the programs. Other parents of uninsured children may also not be able to afford the premiums required under SCHIP.

These patterns suggest the need for a multifaceted approach to the problem of eligible but uninsured children. First, outreach efforts clearly need to be developed and implemented. Many communities have successfully used community based outreach workers to identify eligible children and help their parents with the enrollment process. Second, we need to strengthen states' interest in enrolling eligible but uninsured children, potentially through performance based incentives and certainly by fully funding the SCHIP program. Third, we need to make sure that states have the flexibility to implement strategies that are known to promote enrollment including reducing the paperwork burdens for data that the state can otherwise verify. Among other options this would allow states the flexibility in

the mechanisms they chose for verifying the citizenship of children and express lane eligibility.

Along with CHIP, what role has Medicaid played in reducing the number of uninsured children? How many uninsured children are eligible for either Medicaid or CHIP?

Together Medicaid and SCHIP have reduced the number of uninsured children from about 10.0 million to 7.5 million according to data from the National Health Interview Survey (NHIS). Importantly, this estimate understates the role that Medicaid and SCHIP have had in reducing uninsurance rates because it does not account for the secular declines in coverage that occurred for other populations, in particular for parents and other adults, and that would have also occurred among children were it not for the SCHIP program.

Increased participation in Medicaid was clearly a driving force behind coverage improvements and reductions in uninsurance since the SCHIP began. Between 1997 and 2004, the number of ever enrolled children increased by 6.8 million, which is a greater than the number of children covered by SCHIP during this period. In fact, estimates from the NHIS suggest that more than 50 percent of the decrease in uninsurance rates among low-income children can be attributed to increased participation in Medicaid.

The latest estimate of the number of uninsured children who are eligible for Medicaid and SCHIP are based on the March 2005 Current Population Survey. These data indicate that approximately, 4.4 million uninsured children are eligible for Medicaid and 1.7 million uninsured children are eligible for SCHIP.

Dr. Dubay, if CHIP is reauthorized but funding remains frozen at current levels, as is assumed under the budget baseline, what is the projected shortfall among the states and what is the likely effect on children's enrollment?

It has been estimated that if funding remains frozen at current levels when SCHIP is reauthorized that states will face a shortfall of about 14.6 billion dollars over the course of fiscal years 2008 to 2012. This shortfall would have a number of implications for children's enrollment. First, it has been estimated that under this scenario 2.1 million children would lose their coverage under the SCHIP program by 2012. Even if Congress were to eliminate coverage of pregnant women and adults under the SCHIP program it is likely that at least 1.5 million children would lose coverage by 2012 given that the most recent data on the number of adults covered under the program is small. Second, if Congress reauthorizes SCHIP but funding remains frozen at current levels, children will lose coverage and states will not be able to enroll those children who are currently eligible but remain uninsured.

In short, reauthorization using the budget baseline would stop in its tracks the progress we have made as a nation in reducing uninsurance among children and would certainly

prevent us from getting to the finish line on this issue. Not only should Congress commit the funds needed to maintain current levels of coverage under SCHIP, it should provide the funding necessary to enroll those eligible for the program but who are currently uninsured.

Dr. Dubay, one of things I think many of the members of this Committee have wondered about is why states have unspent federal CHIP funds from year-to-year, particularly those states with high numbers of uninsured children. Based on your research, what causes states to have unspent CHIP funds? Is it because of program cutbacks, lack of state matching dollars or a combination of several different factors?

As always, the real answer to this question having unspent federal SCHIP dollars from year-to-year is likely the result of a number of factors and that the importance of these factors varies by state. Why do states have unspent SCHIP dollars? First of all, the methodology used to allocate funds across the states did not perfectly match dollars with potential eligibility under SCHIP program in each state. Second, some of the states with unspent SCHIP funds implemented their large expansions under SCHIP later than other states and as a result currently have unspent SCHIP dollars. Importantly, this is not the case for all late starting states. For example, Mississippi was one of the last states to broadly expand coverage and was facing a shortfall in 2007. Third, some states with unspent SCHIP dollars do have large numbers of uninsured children. These states tend to have low rates of participation in the Medicaid and SCHIP programs. Fourth, there are a number of states who have unspent SCHIP dollars because they have not always had state matching dollars available to draw down their federal match.

While I would not argue for a redesign of the SCHIP allocation formula during the reauthorization process, I might argue for providing incentives for states to increase participation and use their unspent federal dollars on covering children. In particular, providing incentive payments to encourage states to increase participation in Medicaid and SCHIP and reducing the length of time in which state can hold onto unspent federal dollars from 3 years to two years would both likely provide incentives to states to use their dollars.

Statement of the Honorable Orrin G. Hatch
Senate Finance Committee's Subcommittee on Health Care
Hearing on
The CHIP Program From the States' Perspective
November 16, 2006

The Chair will call this hearing to order.

Next year, this Committee will be responsible for reauthorizing and financing one of the most important programs in the government, the State Child Health Insurance Program.

Let me make one thing clear: CHIP *must* be reauthorized. It is an important program that is providing needed health care services to literally millions of American children, 6.2 million to be exact.

That being said, it must be acknowledged that the reauthorization poses many challenges.

That is why Senator Rockefeller and I felt it imperative that the Subcommittee devote a second day of hearings to CHIP this year.

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, better known as CHIP, through the new title XXI of the Social Security Act. CHIP provides states with federal matching funds to cover uninsured children of families with incomes that are above Medicaid eligibility levels.

When designing their CHIP programs, states may expand their state Medicaid programs, create separate state programs, or have a combination approach. All 50 states and the District of Columbia have CHIP programs.

The CHIP program is financed through both the federal and state governments and is overseen by the states. States receive an enhanced federal match for the CHIP program – this federal match is significantly higher than the federal match that states receive through the Medicaid program.

The Balanced Budget Act of 1997 provided approximately $40 billion in federal funding for the CHIP program. Collectively, states have spent $10 billion of their own funds on CHIP and $23 billion in federal funds for CHIP through the end of FY 2005.

As CHIP has evolved and matured, a number of key issues have become defined, issues the Committee must address in the reauthorization.

The first priority facing us is how to ensure that all eligible children are covered. Hand in hand, is the need to improve outreach efforts.

Another issue that has been in the forefront of any CHIP discussion is how to deal with states that have experienced shortfalls in their federal allotments.

One important focus of the Committee will be a re-examination of what populations should most appropriately be covered by CHIP.

When Senator Rockefeller, Senator Kennedy, Senator Chafee and I worked on the original legislation in 1997, our goal was to cover the several million children who had no health insurance. While we have gone a long way toward achieving that goal, we still have a long way to go. In that light, coverage of uninsured children must be our top priority, even though there are pressures to include other vulnerable and needy populations.

The State perspective in addressing all these issues will be helpful to the Subcommittee.

We have assembled an impressive panel of witnesses to discuss these pressing issues.

Testifying before the Subcommittee today is the state CHIP Directors from my home state of Utah, West Virginia and New Jersey. In addition, we have the Drabczyk family, Nina Owcharenko of the Heritage Foundation and Lisa C. Dubay of the Bloomberg School of Public Health, Johns Hopkins University.

I know that I speak for both Senator Rockefeller and myself when I say that we are looking forward to working with our current Chairman, Senator Chuck Grassley and our new Chairman, Senator Max Baucus on legislation to reauthorize this program. It is a high priority for me and it is a high priority for Senator Rockefeller.

Senator Rockefeller, soon to be my Chairman, I have enjoyed working with you so much this Congress. We have put together some interesting hearings this year and I look forward to continuing to work with you next Congress.

I want to thank all of our witnesses for taking time out of their busy schedules to testify before the Subcommittee today.

Senator Rockefeller?

Statement of
Ann Clemency Kohler

Director
New Jersey Division of Medical Assistance and Health Services,
New Jersey Department of Human Services

The United States Senate Committee on Finance
Subcommittee on Health

"The CHIP Program: From the States' Perspective"

November 16, 2006

Good Afternoon, I am Ann Clemency Kohler, the Director of New Jersey's Division of Medical Assistance and Health Services. It is this Division that administers New Jersey's Medicaid and SCHIP programs for the New Jersey Department of Human Services.

I want to thank Chairman Hatch, Ranking Member Rockefeller, and the members of the subcommittee for the opportunity to talk to you about the importance of the SCHIP program across the nation and in New Jersey in providing much needed health care coverage to children and families. As Chairman of the National Governors Association's (NGA) Health and Human Services Committee, Governor Corzine considers SCHIP reauthorization to be his highest priority for the Committee and looks forward to working through the

NGA with Congress and the Administration on a bipartisan basis to expand this program's impressive list of successes into the future.

New Jersey implemented its SCHIP program in January 1998 and called it NJ KidCare. The program was met with great anticipation and excitement over the prospect of providing health insurance to thousands of uninsured children in New Jersey.

The KidCare program was successful and through it we learned more about the uninsured population in New Jersey and how great the need was to provide health care to children and their parents. We learned that there is increased participation among eligible children when parents are made eligible for health care coverage. We know that providing health care coverage to pregnant women leads to healthier babies and moms.

And so in September 2000, a decision was made to cover parents and adults up to 200% of the federal poverty level and the program was re-named NJ FamilyCare.

Within a few years, budgetary constraints caused New Jersey to close the program to single adults and parents. In September 2005, we were able to again make FamilyCare available to uninsured low-income parents and guardians with children who are 18 or younger.

We now provide health insurance coverage to over 125,000 New Jersey children and over 70,000 adults through our SCHIP program.

In addition, we cover over 450,000 children and close to 350,000 adults through our "Medicaid" program. As a result, New Jersey provides health insurance coverage to over one million adults and children.

While New Jersey uses a higher percentage of the federal poverty level for eligibility for its SCHIP program than all other states, we also have one of the highest costs of living in the nation. Simply put, it costs far more to be poor in New Jersey than in almost all other states. We have no choice but to use a generous eligibility income level in order to reach those truly needy children and families with low median income levels.

New Jersey greatly appreciates the opportunities that the SCHIP program provides states. Through our SCHIP program, we have been able to provide health insurance to the most vulnerable population in our state.....our children.

New Jersey has made a strong commitment to the SCHIP program. This commitment is evident in the generous benefits package that we offer, our attention to simplifying the application process and the intense outreach efforts we have undertaken. The prospect of limiting or, at worse, eliminating our SCHIP program is of serious concern to us.

New Jersey has historically spent its entire annual SCHIP allotment and has been eligible for SCHIP funds not used by other states. As

you know, these reallocated funds have been diminishing over the years and now there is an urgent need for Congress to increase annual allocations to states to meet the ever-growing national need for health care insurance.

While we recognize there are long-term SCHIP financing and policy issues to consider as we move toward reauthorization of the program, action is needed now to prevent funding shortfalls in fiscal year 2007. I would like to include with my testimony for the record a letter from NGA on behalf of all the nation's governors urging action to address these shortfalls before the end of the 109th Congress. Failure to fund these shortfalls will cause some states to reduce or cease health care coverage for children. We cannot allow that to happen. Both Medicaid and SCHIP have been successful and efficient in expanding coverage to children. By promoting the continued success of these programs, we can help to ensure that children and families get the health care that they need.

Thank you, again, for your interest in this urgent issue. Providing health care to our children and their families is something that is a priority in New Jersey and must be a priority for the nation. I hope that my remarks here today will help fashion an action plan to provide continued support for our nation's SCHIP program.

Senate Finance Committee Hearing
Subcommittee on Health
Questions Submitted for the Record
Ms. Ann C. Kohler
The CHIP Program from a States Perspective
November 16, 2006

Senator Hatch

What are the biggest successes of the CHIP program? What are the biggest obstacles facing the states as far as the CHIP program is concerned?

Successes

New Jersey's biggest successes include insuring hundreds of thousands of children and reducing New Jersey's Charity Care payments.

In addition, New Jersey experienced the following successes:

- **Re-opening of the program to parents at or below 100% FPL on September 1, 2005. As of September 1, 2006, the income limit for parents has increased to 115% FPL;**
- **Success of the online application. New jersey is in the process of testing a Spanish online application to further accommodate potential applicants;**
- **New Jersey now has one year's experience of using a combination application – Presumptive Eligibility (up to 350%), NJ FamilyCare and Medicaid. Federally Qualified Health Centers (FQHCs) and hospitals are becoming acclimated to completing applications for uninsured children when they present for care at their facility, and;**
- **The electronic database of all New Jersey schools, (NJ Smart) has added a question to capture the health insurance status of every child enrolled in a New Jersey school. This will enable New Jersey to outreach and enroll these children.**

Obstacles

New Jersey has experienced the following challenges with the CHIP program:

- **New Federal Deficit Reduction Act (DRA) requirement that increases citizenship and identification documentation for Medicaid applicants may reduce the number of children who apply for benefits.**
- **New Jersey has a joint application for both groups.**

Senator Hatch continued

What recommendations and suggestions do you have for the Senate Finance Committee as we reauthorize the CHIP program next year?

Part of the original allotment was based on the number of low-income and low-income uninsured of each state. The formula considers low-income to be at or below 200% of the federal poverty level which is a disadvantage to those states that have a higher cost of living as compared to the national average. New Jersey believes, upon reauthorization, a more equitable distribution of available federal funding should be based on program expenditures of the individual states current programs and be re-evaluated in each subsequent year based on projected spending. In doing so, it would help ensure that those already enrolled children and parents do not risk losing coverage for lack of available funding. Failure to do so may require significant program changes to those states that, through successful enrollment and outreach efforts, continuously outspend their annual allotments and have relied on redistributions from other states in prior years.

What has your state done to ensure that all CHIP eligible children are covered by the program?

In an effort to conduct smart and targeted outreach to eligible children, New Jersey has redirected our efforts toward "inreach" within our own Department and in the other Departments of state government. This involves us working with other Departments, such as the Department of Education, to identify uninsured children.

As a result of New Jersey inreach activities, we have simplified the enrollment of children who are already receiving other state benefits, such as Food Stamps, by using the same information supplied on those applications.

Currently, New Jersey is conducting outreach and inreach with the following governmental partners:

- **Department of Labor – Weekly referrals, staff training and dissemination of Program materials.**
- **Department of Health and Senior Services – Enrollment coordination with the Women, Infants and Children program and New Jersey FQHCs.**
- **Department of the Treasury, Division of Taxation – Referrals, information dissemination and training materials to staff and web-site linkage.**
- **Department of Education and New Jersey Schools – Statewide database coordination, school nurse outreach program, Free and Reduced Priced Lunch program outreach campaign, K – 8 health curriculum, information dissemination and web-site linkages.**

Senator Hatch continued

- **Department of State, Office of Faith Based Initiatives – Requires all grantees to receive training and conduct outreach and enrollment.**
- **Motor Vehicle Commission - Information dissemination.**
- **Commission for the Blind and Visually Impaired – Referrals.**
- **Division of Family Development – Coordination with the Office of Child Support and Paternity, information dissemination.**
- **Department of Banking and Insurance – Information dissemination.**

In addition, New Jersey has engaged strong media campaigns, conducted hospital outreach, developed successful community, faith based and business partnerships conducted training programs for interested parties and developed a presence on the World Wide Web through a dedicated web-site and linkages with other social service assistance portals.

The CHIP program and the flexibility it provides states has been extremely successful in providing coverage to children and families. Given the success of the program, do you think the major focus of reauthorization next year is on finding a solution to state shortfalls and the problems with the allotment formula?

Yes. Please see our response as to what recommendations and suggestions we have for the Senate Finance Committee for the reauthorization of the CHIP program.

Beyond CHIP financing issues (e.g., asking for more federal matching dollars), what three changes would you like to see made to the CHIP program that would help you to run your programs more effectively?

1. **Allow SCHIP dollars for qualified immigrants regardless of date of entry.**
2. **Repeal Medicaid documentation requirements for citizenship and identity.**

The Deficit Reduction Act of 2005 (DRA) give states the option to amend their state plans to increase enrollee cost sharing, and provide Medicaid to specified groups through enrollment in benchmark and benchmark-equivalent coverage without regard to certain traditional Medicaid program requirements including freedom of choice, state wideness, and comparability. States operating CHIP Medicaid expansion programs may target their CHIP enrollees as a part of their DRA state plan amendments. Some have argued that states may use the new DRA flexibility to align their CHIP and Medicaid programs both in terms of the cost sharing requirements and the benefit coverage, and that these changes could make CHIP and Medicaid coverage seamless to enrollees particularly in the case where individuals in a given family access coverage through both programs concurrently. Do you anticipate that your state will pursue a DRA state plan

Senator Hatch continued

amendment? If so, do you have any concerns regarding how the new DRA flexibility might impact your CHIP programs?

New Jersey is closely reviewing the option.

Various organizations (CRS, Center on Budget and Policy Priorities) project your FY2007 shortfall at around $150 million in federal CHIP funds. However, if no additional federal funds are provided, you will be able to claim a portion of that shortfall under regular Medicaid. What is your own projection of your total federal CHIP shortfalls in FY2007, and what portion of that can be covered with Medicaid funds?

New Jersey's federal CHIP shortfall in FY 2007 is $195.4 million. This shortfall would be reduced by $118.7 million, to a $76.7 million shortfall, if New Jersey were to claim parents <134% FPL as Medicaid rather than CHIP.

The premiums you charge range from $18 to $121 per family per month (no premium below 150% of poverty). There has been debate as to whether premiums should be required; if so, what their amount should be; and whether the cost of collecting them is worth what is received. What are your thoughts?
Senator Hatch continued

New Jersey charges a premium, not only to help offset the cost of the program, but to encourage family responsibility. Focus groups conducted in New Jersey have shown that families appreciate the opportunity to help pay lower premiums.

According to one source, you are one of nine states that have a premium assistance program, where CHIP helps pay premiums for children who qualify for CHIP but also have access to employer coverage. Of your more than 100,000 child enrollees, only 441 are enrolled in this program. What do you think about the premium assistance concept in CHIP and what has been your experience?

It is extremely difficult to obtain information on Employee Retirement Income Security Act (ERISA) plans. This is the most significant barrier to increasing enrollment in the program.

Senator Rockefeller

Ms. Kohler, can you explain how your state's CHIP program works; specifically, how it functions hand-in-hand with Medicaid? What do we need to do to make this two-tier system work better and to make progress in covering more uninsured children?
Senator Rockefeller continued

- **On July 1, 2005 a one page application was available to families. Medicaid and CHIP use the same application.**

- **In New Jersey, families applying for Medicaid or CHIP can apply online or use the application. A face-to-face interview is not required.**

- **The online application was made available in September 2005, with an electronic verification.**

- **A preprinted renewal application is now available to help increase retention of our children. Families can also phone the state to have the renewal application completed over the telephone.**

- **Presumptive Eligibility (PE) sites use the same CHIP/Medicaid one page application instead of the prior two-step process. This has helped simplify and ease the PE process used by the hospitals and FQHCs. Providers also have access to applying online on behalf of uninsured children.**
- **Both Medicaid and lower income CHIP children have the same benefits, access to the same HMOs and providers.**

- **Prior to the DRA requirements most families needed to supply:**

  <u>Proof of Income:</u>
  One pay stub for each job for the most recent month available, award letters, or some proof of each kind of income received;

  <u>Proof of Qualified Immigrant status (if applicable):</u>
  A copy of the front and back of the Resident Alien Card
  The Temporary I-551 stamp on a passport or Form I-94,

  <u>Proof of other Insurance (if applicable):</u>
  A copy of the front and back of the insurance card, or
  Letter stating the insurance ended.

As of July 1, 2006 all families applying for Medicaid must also send in proof of citizenship and identity documents.

New Jersey is working to use existing databases to verify citizenship and identity, when necessary.

Senator Rockefeller continued

Ms. Kohler, it is my understanding that, in addition to children, New Jersey also covers parents (of CHIP-eligible children) and pregnant women through CHIP. Some have argued that CHIP dollars should not be used to cover parents and pregnant women. What has been your experience in New Jersey? Isn't it true that covering parents and pregnant women increases the likelihood that CHIP-eligible children will be covered?

New Jersey found that covering parents was the most effective way to enroll children in our program.

What more can we do to help states enroll more children? What tools or resources do states need? In talking with your colleagues from other states, is it your sense that the new Medicaid citizenship documentation requirement has undermined progress that states have made by threatening mail-in applications and the use of the internet to streamline enrollment for citizen children?

Yes, the new citizenship documentation undermines our ability to enroll eligible children in Medicaid.

Some have argued that perhaps Congress should consider capping CHIP eligibility at 200% of poverty. Wouldn't you agree that there is significant variation in median and per capita income among the states and in health care costs? For example, the cost of living in New Jersey is very different from the cost of living in West Virginia or Utah. Do you think 200% of the poverty level is the same in one state as it is in another state?

Yes, we agree that there is a significant difference between median and per capita income among states as well as health care costs and the cost of living.

The program should be modeled to reflect the high cost of living in some states.

Senator Lincoln

New Jersey is one of only two states that have chosen to provide comprehensive coverage for pregnant women (including prenatal care, labor and delivery, and postpartum care) through an SCHIP waiver. Having gone through the waiver process, do you believe that more states would provide SCHIP coverage for pregnant women over age 19 if states did not have to seek a federal waiver?

As you know, providing quality prenatal care significantly increases the likelihood of having a healthy baby. Removing the need to obtain a federal waiver could increase SHIP coverage of pregnant women.

Senator Lincoln continued

How could your states benefit by greater opportunities for private-public partnerships in SCHIP, such as allowing SCHIP to provide wraparound coverage for children with special healthcare needs and limited private insurance or premium subsidies to help children remain in the private health insurance system?

New Jersey's PSP and Payment of Premium programs, both providing a form of premium assistance and support, would benefit by expansion to provide wrap-around services to special needs children. This would ensure that children have access to all necessary services, i.e. durable medical equipment and medical supplies.

Senator Blanche Lincoln Statement
Finance – Subcommittee on Health Care Hearing (11/16/06):
"The CHIP Program From the States' Perspective"

I want to thank Chairman Hatch and Ranking Member Rockefeller for allowing us to come together and discuss this important issue once again. As we all know, in conjunction with Medicaid, the State Children's Health Insurance Program has been a great success in reducing the number of uninsured children in my state of Arkansas and across the country.

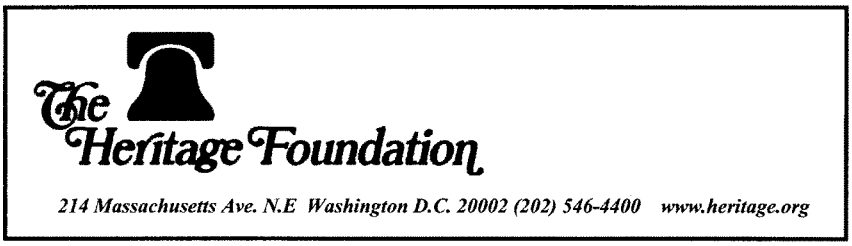
Much of that success can be contributed to the flexibility provided each state under the program. That flexibility has allowed states to determine how best to cover their populations most in need.

I am grateful to each of the witnesses for being here today and look forward to learning more about the lessons you have learned. As we look toward reauthorization of SCHIP next year, I am hopeful that we can apply those lessons and work together in a bipartisan manner for these children. They deserve nothing less.

Thank you all for being here, and thank you Mr. Chairman.

Of particular interest to me is the issue of reducing the incidence of premature births and improving the health of women of childbearing age and children by expanding their access to health care. By doing so, we can improve the health of hundreds of thousands of infants born each and every year.

That is why I've reintroduced the 'Prevent Prematurity and Improve Child Health Act' with Senators Lugar and Bingaman. This legislation seeks to reduce the incidence of prematurity by giving states new options to cover pregnant women and children under SCHIP.



CONGRESSIONAL TESTIMONY

Keeping SCHIP Focused on Federal Objectives

Testimony before
Committee on Finance,
Subcommittee on Health
United States Senate

November 16, 2006

Nina Owcharenko
Senior Health Care Policy Analyst
Center for Health Policy Studies
The Heritage Foundation

My name is Nina Owcharenko. I am Senior Health Care Policy Analyst at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

For the first time in ten years, the State Children's Health Insurance Program (SCHIP) is due for congressional reauthorization. Reauthorization provides an opportunity for policymakers to review and assess the program's goals and objectives and make whatever adjustments and reforms may be necessary to improve it.

The Unique Characteristics of SCHIP

It is important to recognize the unique characteristics of the SCHIP program. Although often discussed in conjunction with Medicaid, SCHIP is a distinctly different program with a different scope, focus, and approach. First, it is not an entitlement program, as Medicaid is, but a capped spending program. Second, unlike Medicaid, which provides health care services to a very broad and diverse population with multiple eligibility standards, SCHIP has a simpler, more targeted purpose: to address the needs of uninsured *children* whose families earn too much to qualify for Medicaid but not enough to purchase private health care coverage on their own. Finally, the benefit structure and options under SCHIP are more flexible than Medicaid and more closely reflect the structure of private coverage.

Unlike federally administered programs, the very nature of a joint federal-state program results in state variations. There are funding variations, eligibility variations, and even structural and administrative variations. While variations support the principles of federalism, they also can make it difficult to evaluate SCHIP's performance. Thus, it is equally as important that federal policymakers establish clear federal policy objectives to measure the effectiveness of the program and ensure that it remains focused on its purpose.

Setting Federal Policy Objectives

There are three key policy areas that federal lawmakers should evaluate with a view to strengthening federal guidelines and objectives.

> ***Funding.*** As mentioned, SCHIP is a capped spending program. Each state receives an annual fixed federal contribution that is based on a variety of factors, such as the number of uninsured children in the state. States have three years to spend their allocation. At the end of three years, any unused federal allotments are subject to a reallocation process. The process divides states into two categories: states that have exhausted their original allocations (referred to as "redistribution" states) or states that have not done so (referred to as "retention" states), and unused funds are distributed to the states based on these categories.[1]

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[1]Elicia J. Herz, Bernadette Fernandez, and Chris L. Peterson, "State Children's Health Insurance Program (SCHIP): A Brief Overview," Congressional Research Service *Report for Congress*, August 4, 2005, p. 5.

Original state allotments give states a predictable but fixed federal funding source that forces states to decide the best and most efficient way to use those funds to reach the targeted populations in a fiscally prudent manner. However, the SCHIP reallocation process focuses solely on state spending and actually rewards states for overspending by giving them additional funds through the reallocation process. In FY 2001, 12 states were considered "redistribution states"; by FY 2005, the number had increased to 28 states.[2] This raises the question of whether the reallocation process discourages states from being fiscally prudent, as states realize that unused federal funds will be taken from their states and redistributed, even to those states that outspend their allotments.

Recommendation: Federal policymakers should restructure the reallocation process to ensure that it is focused on meeting certain federal goals and objectives. Specifically, priority should be given to states facing funding shortfalls but have not yet reached federally established benchmarks. The reallocation process should not be based on whether a state has outspent its federal allotment.

Eligibility. As previously mentioned, SCHIP is intended to target children whose family incomes are too high for traditional Medicaid but not high enough to afford private coverage on their own. The legislative language itself defines "targeted low-income children" as children whose family income is at or below 200 percent of the poverty line.[3] For states with Medicaid eligibility at or above 200 percent FPL prior to enactment of SCHIP, the law enables them to target children 50 percent above the Medicaid level.[4]

These basic thresholds are important in evaluating whether the program remains focused on its specific federal target. Prior to enactment of SCHIP, there were only four states with Medicaid eligibility at or above 200 percent FPL.[5] Today, there are 15 states with SCHIP eligibility above 200 percent FPL, and nine of these 15 states have eligibility at or above 300 percent FPL.[6] Twenty-six states maintain SCHIP eligibility at the 200 percent FPL threshold, and eligibility in nine states is below 200 percent FPL.[7]

Seven of the 18 states projected to face a funding shortfall in FY 2007 have set SCHIP eligibility above 200 percent FPL.[8] Furthermore, the four states that face funding shortfalls in FY 2006 are states that also cover adults.[9] Both of these

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[2]*Ibid.*, p. 20.
[3]42 U.S. Code 1397jj.
[4]*Ibid.*
[5]Data provided by U.S Department of Health and Human Services, Centers for Medicare and Medicaid, Centers for Medicaid and State Operations, October 5, 2006.
[6]*Ibid.*
[7]*Ibid.*
[8]Chris L. Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," Congressional Research Service *Report for Congress*, May 8, 2006, p. 11, and data provided by U.S Department of Health and Human Services.
[9]Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," p. 8.

examples raise the question of whether these states are expanding beyond the scope of the program and beyond their means. Finally, eligibility levels are not an accurate measure of success. A state with eligibility at 300 percent FPL may only have 40 percent enrollment, while a state with eligibility at 185 percent FPL may have 80 percent enrollment.

Recommendation: Federal policymakers should enforce the existing federal poverty and population eligibility standard. Moreover, lawmakers should establish enrollment targets to measure the effectiveness of the program.

Benefit Structure. States have the ability to select the type of benefit structure for their respective SCHIP programs. States have three options: expand traditional Medicaid, create a separate SCHIP plan, or a combination of the two.[10] Twelve states have set up a Medicaid expansion, 18 states have set up a separate SCHIP plan, and 21 states have chosen a combination approach.[11]

The SCHIP benefit package, specifically for the separate SCHIP option, references and is fashioned after private coverage. However, administrative changes by some states have softened this private coverage model.[12] Administrative changes, such as limiting or eliminating premiums and co-pays, diminish the correlation between SCHIP and private coverage and, at the same time, reduce the distinction between SCHIP and traditional Medicaid. Furthermore, although states are expected to minimize the "crowding out" effect, some states have adopted administrative changes that nullify such provisions: for example, removing the "uninsured" waiting periods before children can enroll in SCHIP.[13]

On the other hand, administratively burdensome rules and regulations discourage states from taking full advantage of premium support models where states use SCHIP funds to enroll children in existing private coverage options, typically by signing the child up for dependent coverage through a parent's place of work.[14]

Recommendation: Federal policymakers should augment the private coverage model in SCHIP, including a more flexible premium assistance option. SCHIP should be a program that helps mainstream children in working families into private health care coverage, not a program that supplants it.

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[10]States choosing to set up a separate SCHIP plan can select a benchmark benefit package option, a benchmark equivalent option, a Secretary-approved coverage option, or designate an existing comprehensive state-based coverage option (specifically selected states only).

[11]Data provided by U.S. Department of Health and Human Services.

[12]Donna Cohen Ross and Laura Cox, "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families," Henry J. Kaiser Family Foundation October 2005, pp. 57 and 61, at *www.kff.org/medicaid/upload/In-a-Time-of-Growing-Need-State-Choices-Influence-Health-Coverage-Access-for-Children-and-Families-Report.pdf* (November 14, 2006).

[13]*Ibid.*, p. 33.

[14]Cynthia Shirk and Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards," National Health Policy Forum *Issue Brief* No. 812, July 17, 2006, at *www.nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf* (November 14, 2006).

Conclusion

Undoubtedly, funding will dominate the upcoming SCHIP reauthorization debate. However, federal lawmakers have the responsibility to look beyond funding and evaluate the effectiveness of the funding and the policies impacting its implementation. In its reauthorization, federal policymakers should consider setting clear federal goals and measures for the program. These additions would be useful and would ensure that the program is meeting federal objectives effectively.

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Senate Finance Committee Hearing
Subcommittee on Health
Questions Submitted for the Record
Ms. Nina Owcharenko
The CHIP Program From the States' Perspective
November 16, 2006

Senator Hatch

What are the biggest successes of the CHIP program? What are the biggest obstacles facing the states as far as the CHIP program is concerned?

The biggest success of the CHIP program has been in the reducing the number of low-income uninsured children. The ability for states to identify uninsured children through outreach efforts is another success of the program. This experience can be a valuable tool to educate and facilitate coverage for families and other uninsured Americans beyond CHIP.

The biggest obstacles facing the program is keeping the program fiscally sustainable at both a state and federal level, preventing the program from diminishing its private coverage model, which distinguishes it from Medicaid, and most importantly, stopping the crowd-out effect of private coverage.

What recommendations and suggestions do you have for the Senate Finance Committee as we reauthorize the CHIP program next year?

There are three main areas the Senate Finance Committee should focus on as you reauthorize the CHIP program. First, prioritize funding allocations, especially for shortfall redistribution by distinguishing between those states at or below 200 percent FPL from those above 200 percent FPL. Second, reinforce the private coverage model for CHIP so that CHIP looks more like private coverage rather than Medicaid, including giving enrollees a choice of competing CHIP plans. Finally, the rules and regulations guiding integration of existing private coverage options should be reviewed to make premium assistance models more flexible and accessible to working families with CHIP eligible children. Moving to a premium assistance model could also help to prevent further crowd-out effect as well as help families transition into private coverage for the long term.

Shortfall states with Medicaid expansion programs have a fallback, to use Medicaid funds for their shortfall (although at a reduced matching rate). Shortfall states with a separate CHIP program have no Medicaid fallback (except for Rhode Island, which had such an arrangement written into the Terms and Conditions of their waiver agreement). Should states with separate CHIP programs also be able to draw down

Medicaid funds for their shortfalls? From the other perspective, should states with Medicaid-expansion CHIP programs NOT be permitted to draw down Medicaid funds for their shortfalls?

The concern of a Medicaid "draw down" option for either a separate CHIP program or Medicaid expansion CHIP program is that it creates a default entitlement program. Unlike Medicaid, CHIP is not an entitlement, but a block grant style program. Meaning, each state must fund the program within a specific federal allocation. Under a Medicaid "draw down" option, the block grant concept is meaningless as states would no longer have to live within the federal allocation. Moreover, it would simply add to the already unsustainable fiscal future of the Medicaid entitlement.

Should adults, including childless adults, be covered in the Children's Health Insurance Program? (As you know, the Deficit Reduction Act prohibits CHIP funds being used to pay for health coverage of childless adults.)

States should continue to have flexibility to administer and test innovative approaches provided the state can show that it can successfully meet federal objectives of the program, including reaching uninsured children below 200 percent FPL. In addition, states could be required to demonstrate a more aggressive integration of private coverage options and models. Moreover, these experiments should not increase the cost the federal government (taxpayer) or jeopardize the balance of allocations between other states.

What do you see as the federal government's responsibility to step in when states are facing shortfalls of federal CHIP funds? And should that responsibility vary according to who in the state is eligible for CHIP (e.g., children in higher-income families, adults)?

The concern with the federal government stepping in where states face shortfalls is that it defeats the purpose of the block grant approach. The block grant approach expects states to administer the CHIP program with a clear and consistent federal fiscal appropriation. Unfortunately, the redistribution process, under which shortfalls have been addressed, discourages fiscal prudence. Instead, fiscally prudent states loose funding to states that spend beyond their federal allocation. Certainly, a good case could be made that the federal government could differentiate between those states which have gone beyond the original purpose of targeting low income children below 200 percent FPL, or other populations, and than those states at or below 200 percent FPL focused on the targeted population.

Senator Rockefeller

The Congressional Research Service projects a total shortfall of $12.7 billion over a five-year period (2008-2012) and the Center on Budget and Policy Priorities has an estimated range of $12.7 to $14.6 billion. The actuaries at CMS project that CHIP enrollment will

decline by 1.5 million children between 2006 and 2012, presumably because of these shortfalls.

Not once in your testimony do you discuss what will happen to millions of children if CHIP is reauthorized but only at current artificial baseline levels of $5.0 billion annually in perpetuity. How do you propose to ensure that we don't have a loss in children's health insurance coverage and increases in the ranks of uninsured kids? It doesn't seem like your recommendations even address this fundamental financing issue. Please explain.

The issue of funding CHIP is an important issue but in my opinion should be a decision for Congress to debate in the context of the overall budget, taking into consideration other competing spending demands and priorities for the country.

Ms. Owcharenko, in your testimony, you discuss how reallocation of CHIP funds has distorted state spending patterns and it should be modified. But it seems that tinkering with redistribution is almost irrelevant if you don't add more funding to the program above baseline levels.
The amounts available for redistribution will be less than $200 million annually assuming CHIP is reauthorized but funding remains frozen under the baseline levels. How would an adjusted redistribution system even come close to addressing the looming shortfalls states will face under a reauthorized CHIP program?

My testimony was not intended to address the overall funding levels of the CHIP program, but to stress that whatever the level of funding, those funds should be used in the most effective and efficient way. Prioritizing funding, for example, is one way to effectively and efficiently distribute funds between shortfall states in an equitably manner.

Also in your written testimony, you state the following, "Seven of the 18 states projected to face a funding shortfall in FY 2007 have set [CHIP] eligibility above 200 percent FPL. Furthermore, the four states that face funding shortfalls in FY 2006 are states that also cover adults." However, I think this statement is somewhat oversimplified, and I would like to ask you to clarify.

a. First, it seems that this statement refers to shortfall states from both fiscal year 2006 as well as fiscal year 2007. The data I have indicates that only 17 states are projected to have federal CHIP funding shortfalls in fiscal year 2007 - Alaska, Georgia, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Rhode Island, South Dakota, and Wisconsin. Does your data suggest something different? If so, what is the source of that data?

The data referenced in my testimony was based on Congressional Research Service shortfall estimates. [See "Table 2, Projected Final Distribution of DRA Funds and Projected Shortfalls of Federal SCHIP Funds, 2006 and 2007."

SCHIP Financing: Funding Projections and State Redistribution Issues, Congressional Research Service, May 8, 2006, p. 11.]

b. Second, of the 17 states which are expected to have fiscal year 2007 federal CHIP funding shortfalls, I would characterize their coverage as follows (please let me know if you have data which suggests something different):

- Eight of the 17 FY2007 shortfall states cover only children under 200% of FPL (Alaska, Iowa, Louisiana, Maine, Mississippi, Nebraska, North Carolina, South Dakota);
- Four of the 17 FY2007 shortfall states cover only higher income children in addition to covering children under 200% of FPL (Georgia, Maryland, Massachusetts, Missouri)
- Two of the 17 FY2007 shortfall states cover only adults in addition to covering children under 200% of FPL (Illinois, Wisconsin); and
- Three of the 17 FY2007 shortfall states cover both higher income children and adults in addition to covering children under 200% of FPL (Minnesota, New Jersey, Rhode Island).

Wouldn't it be just as accurate to say that "Twelve of the 17 states projected to face a federal CHIP funding shortfall in FY 2007 cover children only? Furthermore, three of the five other shortfall states cover both higher income children and adults in addition to covering children below 200% of poverty"?

There are a variety of ways to describe the states facing shortfalls. The goal of my testimony was to illustrate that there are distinctions between the shortfall states based on eligibility and covered populations. These distinctions should be considered when determining the most effective and efficient use of CHIP funds.

None of the data in the above question takes into account the fact that some states effectively cover children at higher income levels through earnings disregards. Some have argued that perhaps Congress should consider capping CHIP eligibility at 200% of poverty. Don't you agree that states should have the continued flexibility to use earnings disregards to determine CHIP eligibility?

In principle, states should continue to maintain flexibility to administer their CHIP program. However, I believe states should also be required to meet certain federal objectives. For example, before expanding beyond 200 percent FPL (including using earnings disregard), a state could be required to show it has reached capacity at or below 200 percent FPL. A state could also be required to fund expansions with existing allocations, not depend on redistributed funds. Finally, a major concern with expansions beyond 200 percent FPL is its impact on crowd out of existing private coverage options.

Further erosion of private coverage is bound to occur as states expand above 200 percent FPL. Therefore, greater integration of premium assistance for private coverage could also be a key component.

Wouldn't you agree that there is significant variation in median and per capita income among the states and in health care costs? For example, the cost of living in New Jersey is very different from the cost of living in West Virginia or Utah. Do you think 200% of the poverty level is the same in one state as it is in another state?

Unfortunately, I am not an expert on state poverty variations. However, I would refer to the statute itself which does not differentiate between states but uses the federal standard as it defines targeted low income children as those in families who earn at or below 200 percent FPL.

Statement by Senator John D. Rockefeller IV
Ranking Member, Senate Finance Health Care Subcommittee
"The CHIP Program From the States' Perspective"
November 16, 2006

Thank you, Chairman Hatch. I am pleased that we are having our second Subcommittee hearing on the Children's Health Insurance Program, and I am proud to be working with you on this important issue. I look forward to holding additional hearings on CHIP next year as we prepare for reauthorization.

I would like to extend a warm welcome to all the witnesses who are here today to give us insight from the states, and I look forward to your testimony. I am especially happy that West Virginia's CHIP Director, Ms. Sharon Carte, is here to talk about our efforts to cover additional children in West Virginia. Thank you for being here, Sharon.

Mrs. Drabcyzk, I am also honored to have you here today. I understand that, in addition to your older children, you have two little ones at home. Thank you so much for being here to share your story.

In 1997, when we created the Children's Health Insurance Program, 10 million children were uninsured. These children did not have a regular source of medical care. They did not have access to basic preventive care and immunizations. The common cold could turn into bronchitis or pneumonia, or the flu. Hospitalizations were likely.

Congress passed CHIP in order to give children a fighting chance to become healthy, happy, and productive members of society. We directed states to cover as many children as possible through this new insurance program. In fact, when we thought the program was moving too slowly in the early years, Congress pressured states to implement their programs faster in order to find and enroll additional uninsured children.

Well, I am happy to report that states met the challenge. They did what Congress asked them to do. To date, more than six million children have been covered through CHIP. That is a significant achievement, and I applaud the efforts of the states represented here as well as the efforts of all states to cover children.

Today, however, we find ourselves in a situation strikingly similar to the dilemma we faced in 1997 – more than 8.4 million children are currently without health insurance in this country. In fact, in 2005, the number of uninsured children increased for the first time since CHIP was enacted. This means that, despite our best efforts, we have taken a step backwards in terms of covering children.

We cannot allow this trend to continue. Instead, we must make covering children a top priority – just like we did in 1997.

Our first order of business should be to address the federal CHIP funding shortfalls that 17 states are facing this year. These shortfalls total approximately $920 million. If they are not addressed immediately, as many as 630,000 children could lose their health insurance coverage.

In my judgment, Congress should not go home until these shortfalls are filled. Families should not have to spend the holidays wondering if their children will have health insurance come January.

Families should not have to rob their children of time outdoors or playing sports for fear of an injury they may not have health insurance to cover. We should not subject moms and dads to this genuine worry when we can fix these shortfalls right now.

As we turn our attention to CHIP reauthorization, there are three main issues that I believe are key: expanding coverage, improving financing and continuing state flexibility. States should receive the funding necessary to cover the families currently enrolled in their programs. And, we should provide states incentives to reach children who are eligible for CHIP, but currently unenrolled.

States should also be allowed to continue their ability to expand benefits as long as they have adequate funds to match federal contributions, while not jeopardizing any of the services guaranteed to children.

Our reaching agreement on a CHIP financing structure for the next ten years will undoubtedly be a challenge. But, we must develop a bipartisan approach to funding the program that will respond to the individual spending needs of states and provide program stability from year-to-year.

Of all of next year's challenges, this is one of the most important and one I believe we will come together to address. Children have always been a common ground – and I hope we can all join together to put their health and welfare at the top of the Congressional agenda,

I look forward to hearing from the panelists on all of these topics and more. I thank the Chair.

STATEMENT FOR THE
FINANCE COMMITTEE HEARING:
THE CHIP PROGRAM FROM THE STATES' PERSPECTIVE
Senator Olympia J. Snowe
November 16th, 2006

Good afternoon. I'd like to thank Chairman Hatch and Ranking Member Rockefeller for holding this hearing today. More and more, educators, parents, and lawmakers are concerned about children coming to school ready to learn. Yet one of the most overlooked components to school readiness is good health. Without proper physical and mental health care as they grow and develop, children are at risk of not reaching their full potential. **That's why I have been a stalwart supporter of the State Children's Health Insurance Program (S-CHIP) since it's inception.**

Unfortunately, with the cost of health insurance for a family of four now exceeding $11,000 a year, the ability of many families to obtain health care *is simply out of reach*. In four of the past five years, health insurance premiums have actually increased at double-digit percentage levels. As costs escalate, more and more employers are dropping coverage – it is unaffordable and unsustainable. In fact, today ***less than half*** of our smallest employers offer health coverage of any kind. According to the United States Census Bureau, there are now **46.6 million uninsured Americans**. This number has risen dramatically this decade, increasing 800,000 since 2003 and over 4 million since 2001.

At a time when the overall picture for access to health insurance has been discouraging, S-CHIP stands out as one of the few bright spots. Without a doubt, had it not been for the enactment of S-CHIP, our country would have seen the uninsured rate of children jump as it has for all other groups of Americans, leaving millions

more children uninsured. State leadership has been integral to this effort and my state of Maine has a clear record of achievement in reducing the number of uninsured children over the past ten years. In fact, since the implementation of S-CHIP, Maine has experienced the second largest decline in uninsured children in the country. However, according to the 2006 Kids Count analysis, there are still approximately 19,000 children uninsured in Maine, with 58% of those kids eligible for MaineCare.

So where do we go from here? My immediate concern is the anticipated shortfall 17 states will experience next year in funding for SCHIP – including Maine. That's why I've cosponsored S. 3913, Senator Rockefeller's ***Keep Children Covered Act,*** to make up for the shortfall. Maine faces a projected federal shortfall of $6.5 million, putting as many as 3,250 Maine children in jeopardy. We cannot afford to lose ground on coverage for children and I hope we can achieve a consensus on this issue before we adjourn for the end of the year.

Going forward, states not only need sufficient federal funding to ensure that children currently enrolled in S-CHIP do not lose coverage and become uninsured; *they need additional funding to enroll more uninsured children.* We have heard that some states are not enrolling more children in S-CHIP programs because they do want to take on the additional costs of covering more children. Incentives to encourage states to enroll more children into Medicaid and S-CHIP would go a long way to cover many of the currently uninsured children in this country. At the same time, states should be provided with the resources they need to develop stronger administrative capacity to help S-CHIP -eligible children enroll in *employer-based* health insurance plans.

While I am aware that there is disagreement on this issue, I also strongly believe that in order to insure more kids, we need to insure their parents. That's why I

have partnered with Senator Kennedy in the past on the ***FamilyCare Act,*** which would allow states the option of providing coverage to the parents of the children covered by S-CHIP. Several states have found that coverage of parents will lead to *additional* coverage of children and I am looking forward to hearing the experience our witness from the State of New Jersey has in this area.

Without question, the S-CHIP program has made remarkable progress over the past ten years – it had reduced the number of low-income children without health insurance by one-fourth. At the same time, with ***9 million children still uninsured*** next year's S-CHIP reauthorization needs to be about more than preserving the status quo. We know that *70 percent* of these children are already eligible but un-enrolled. Next year's reauthorization is a golden opportunity to close the enrollment gap and make real progress on ensuring that every child has access to health insurance. What can be a greater priority for our nation than the health and well-being of our children?

Thank you.

Senate Finance Health Subcommittee Hearing: The CHIP Program from the States' Perspective

Statement of Senator Craig Thomas

Chairman Hatch and Ranking Member Rockefeller, thank you for holding today's hearing so that we can continue our discussions regarding the State Children's Health Insurance Program (CHIP). I applaud your efforts to bring folks on all sides of this issue together, and I am sorry that I cannot be there with you today.

We all want to ensure that our most vulnerable children have access to the health care services they need. Undoubtedly, there will be competing ideas on how to accomplish this goal. Working together toward reauthorization in 2007, I do believe we can find reasonable, commonsense solutions that improve CHIP financing – making the program more effective and efficient in the future.

As you all know, CHIP is an entitlement with a capped federal allotment. It does not, however, have an unlimited draw on the federal treasury like Medicare and Medicaid do. The States know how much federal money they will have to spend each year. Although the federal dollars are set annually, there is no limit on the amount of money individual states can use if they chose to create a more generous CHIP program than current law allows. In fact, many states have used waivers to cover one or more categories of adults with children as well as alter benefit packages. There is no question that States are working hard to improve outreach and enrollment efforts so that all eligible children are covered. Unfortunately, some states have overspent their yearly federal allotments in the process.

Other states, like Wyoming, have budgeted appropriately. My state implemented Kid Care CHIP in 1999, and at that time covered children only up to 133% of the federal poverty level (FPL). I am proud that the Wyoming program operates on a public-private model using Wyoming insurance carriers to deliver their CHIP benefit. Because my state runs a modest program utilizing the private market, they returned over $33 million dollars to the federal government.

Wyoming officials then decided to update Kid Care in an effort to cover more children. The state steadily, and responsibly, increased its FPL to 185% in 2003 and finally to 200% in 2005. Wyoming's Kid Care CHIP program director tells me that they have spent all of their 2003 federal allotment, and have budgeted to spend all of their 2004, 2005, 2006, and 2007 allotments.

States that have used all their federal money now find themselves in a financial bind. Legislation has been introduced to address the problem they face. I appreciate the effort underway to try to find a solution by utilizing money currently in the program rather than by simply appropriating new money. I, too, do not believe that states should be allowed to keep significant federal CHIP cash reserves that they will never be able to spend. However, I have concerns that states like Wyoming that have budgeted to spend their allotments within the timeframe allowed by current law will be penalized for another state's overspending. It seems to me that we would be encouraging states to assume the federal government will always put more money into their capped allotments when they have reached their limit.

Mr. Chairman, I appreciate the opportunity to hear from the panel of experts testifying before the Committee today. We have many issues to discuss in preparation for the CHIP reauthorization next year, and I look forward to participating in the debate.

COMMUNICATIONS

Testimony Submitted on Behalf of
March of Dimes
"The CHIP Program from the States' Perspective"
United States Senate Committee on Finance
November 16, 2006

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The March of Dimes is pleased to submit testimony on behalf of its over 3 million volunteers and 1400 staff, and share with you some of the Foundation's priorities for the upcoming reauthorization of the State Children's Health Insurance Program (SCHIP). As you may know, the March of Dimes is a national voluntary health agency founded in 1938 by President Franklin D. Roosevelt to conquer polio. Today, the Foundation works to improve the health of mothers, infants and children by preventing birth defects, prematurity and infant mortality through research, community services, education, and advocacy. The Foundation is a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers affiliated with 52 chapters in every state, the District of Columbia and Puerto Rico.

The March of Dimes is committed to strengthening the SCHIP program to improve the health of pregnant women, infants and children. We have worked closely with Senators Lincoln, Lugar and Bingaman to craft the "Prevent Prematurity and Improve Child Health Act of 2006," S.710, which is pending before this Committee. This bill includes provisions designed to further some of the priorities the Foundation intends to pursue in the upcoming deliberations. Specifically, the bill calls for giving states the authority to: (1) cover income eligible pregnant women age 19 and older without being required to obtain a federal waiver; (2) provide wraparound coverage for underinsured children; and (3) cover legal immigrant children and pregnant women. In addition, the March of Dimes intends to pursue some quality and accountability initiatives to improve the coverage and care that children enrolled in SCHIP receive.

But, before the Committee begins its deliberations over reauthorization of the program, the March of Dimes urges Members to address the more immediate threat that certain states require additional funding in order to maintain their current levels of coverage. According to a recent report prepared by the Congressional Research Service, as many as 17 states are projected to experience an FY 2007 federal funding shortfall that could amount to as much as $927 million. Unless this Committee acts in the near future, states could be forced to narrow or eliminate benefits, lower eligibility thresholds, and/or reduce provider payment levels. Any of these actions would weaken a well regarded program and could undermine the availability of affordable health coverage for children.

Coverage for Pregnant Women Over Age 19

Under current SCHIP law, maternity coverage for pregnant women over age 19 who meet the income eligibility requirements is permissible only through a federal waiver — a slow and cumbersome process which all but two states have chosen to avoid. This policy creates an unfortunate separation between pregnant women and infants, which runs contrary to long-standing clinical care guidelines promulgated jointly by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) as well as eligibility standards for federal programs such as

Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC program).

While SCHIP regulations permit states to amend their plans to cover 'unborn children,' thus making reimbursement available for prenatal, labor and delivery services, postpartum care for the mother — a benefit prescribed in the AAP/ACOG clinical standards of care — is not reimbursable. Women who do not receive postpartum care are at greater risk for a variety of health complications that make it difficult for a mother to properly care for her new infant.[1] Further, women who do not receive postpartum care are more likely to quickly become pregnant again, and a pregnancy spaced too closely to a previous pregnancy presents a medical risk factor for premature birth.[2]

According to information compiled by the National Conference of State Legislatures, only two states (CO and NJ) use waivers to cover income eligible pregnant women and eight states have amended their plans to cover unborn children (AR, IL, MA, MI, MN, PA, RI, WA). Due in part to the lack of a simple federal mechanism to provide comprehensive coverage to pregnant women in SCHIP, the majority of states do not provide any coverage for pregnant women through their SCHIP programs, leaving many pregnant women uninsured for medical services crucial to their health and that of their child.

According to the 1999 Institute of Medicine Report entitled "*Health Insurance is a Family Matter*," uninsured pregnant women have fewer prenatal care services and more difficulty obtaining the care they need.[3] To maintain the health of a pregnant woman and her unborn child, continuous access to prenatal care is essential. "*Guidelines for Perinatal Care*," the clinical standard for care of pregnant women developed jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics states:

> Women who have early and regular prenatal care have healthier babies. Generally, a woman with an uncomplicated pregnancy should be examined approximately every 4 weeks for the first 28 weeks of pregnancy, every 2-3 weeks until 36 weeks of gestation, and weekly thereafter. Women with medical or obstetric problems may require closer surveillance.[4]

Lack of adequate, regular prenatal care is associated with poor birth outcomes, including prematurity (born before 37 completed weeks of gestation.) or low birthweight

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[1] American College of Obstetricians and Gynecologists and American Academy of Pediatrics. *Guidelines for Perinatal Care*. 2002. pp. 156-160.

[2] Basso O, Olsen J, Knudsen LB, Christensen K. Low birthweight and preterm birth after short interpregnancy intervals. American Journal of Obstetrics and Gynecology 1998;178(2):259–63.

[3] Burstein, Amy B. 1999. *Insurance Status and Use of Health Services by Pregnant Women*. Washington, DC: March of Dimes. Cited in *Health Insurance is a Family Matter*. 2002. Institute of Medicine (IOM). Washington, DC: National Academies Press.

[4] American College of Obstetricians and Gynecologists and American Academy of Pediatrics. *Guidelines for Perinatal Care*. 2002. p. 54.

(less than 5 ½ pounds). Prematurity is the leading cause of neonatal death. Low birth weight is a factor in 65 percent of infant deaths. Premature and low birth weight babies may face serious health problems as newborns, and are at increased risk of long-term disabilities. Infants born to mothers who did not receive regular prenatal care in 2002 were about twice as likely to be low birth weight as infants born to mothers who received early and adequate prenatal care.[5]

Conversely, women who do receive sufficient prenatal care are more likely to have access to screening and diagnostic tests that can help identify problems early; services to manage developing and existing problems; and education, counseling and referral to reduce risky behaviors like substance abuse and poor nutrition. Such care may thus help improve the health of both mothers and infants, reducing their future healthcare costs.[6]

Neither the cumbersome and time consuming waiver process nor use of the 'unborn child' regulatory option gives states the flexibility they need to provide pregnant women with coverage through SCHIP. Therefore, the March of Dimes recommends that the Committee approve a statutory change granting states the authority to extend SCHIP coverage to income eligible pregnant women age 19 and older.

Private-Public Partnerships to Stretch SCHIP Dollars Further

Under current law, children must be uninsured to qualify for SCHIP. Some children with significant health problems have limited private insurance that does not meet their medical needs. Other children whose parents have access to employer based coverage, may go without because the parent's employer does not provide coverage for dependents or the family cannot afford the premium costs. In each of these cases, families face a difficult choice, purchase employer based coverage that does not meet the child's medical needs or forego private health insurance altogether in order to be eligible for SCHIP. By allowing SCHIP and private plans to work together, SCHIP dollars could be stretched further because private plans would cover a portion of healthcare costs. Such public-private partnerships could be structured in several different ways. For example:

1. Wraparound coverage: For pregnant women, infants and children with limited private coverage, SCHIP could cover benefits — such as vision, dental, physical/occupational/speech therapy, etc. — not offered by the private plan. Allowing states to use SCHIP as a secondary payer for children when private insurance is limited would parallel an approach already permitted in the Medicaid program.

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[5] National Center for Health Statistics. 2002 final natality data. Data prepared by March of Dimes Perinatal Data Center, 2005.

[6] "Benefits from and Barriers to Prenatal Care," in McCormick, M.C., and others. 1999. *Prenatal Care: Effectiveness and Implementation*. Cambridge University Press, Cambridge, England.

2. Single benefit coverage: For pregnant women, infants and children with limited private coverage, SCHIP could cover a specific benefit – such as vision, dental or home care -- not offered by the private plan.

3. Premium support: For families satisfied with their private coverage, but unable to afford the full cost of the premium, SCHIP could provide a subsidy to lower the premium cost so that dependents could be covered.

Pregnant women and children receiving this type of assistance should be allowed to switch to traditional SCHIP if they lose their private coverage or the private plan no longer meets their healthcare needs.

The March of Dimes urges the Committee to give states the opportunity to develop alternative types of public-private partnerships to better serve the complex healthcare needs of pregnant women and children.

Quality and Accountability

The March of Dimes strongly recommends that the SCHIP reauthorization bill include provisions designed to strengthen the quality of healthcare that enrollees receive through measuring, monitoring and reporting on quality of care. Such initiatives help ensure that children receive the care they need. Since children are growing and developing, they have different kinds of healthcare needs than adults. To date, however, most national initiatives aimed at improving the quality of care in the U.S. have focused on adults and the March of Dimes believes SCHIP reauthorization is an excellent vehicle through which states can be supported in their efforts to utilize pediatric measures. SCHIP already includes a requirement that states report on quality measures. However, the field has advanced significantly in the past 10 years, and the March of Dimes urges the Committee to revisit the current law provisions and update them as appropriate.

More specifically, the Foundation recommends that the Department of Health and Human Services (HHS) work with health professionals and consumer groups to develop and disseminate a core set of pediatric quality measures. This effort should be conducted in partnership with the Agency for Healthcare Research and Quality (AHRQ) and other appropriate entities, including the National Quality Forum and health professional certification boards. In addition, HHS should also gather and publicly report state level data on pediatric quality performance measures.

To ensure that states have the resources necessary to implement such measures, the March of Dimes encourages the Members of this Committee to consider an enhanced federal match rate that could be used to gather and report data, and to develop interoperable clinical health-information systems.

Coverage for Legal Immigrants

In 2003, this Committee and the full Senate approved a provision to allow states to cover legal immigrant children through their SCHIP programs. At that time, the Congressional Budget Office (CBO) estimated that about 155,000 children and 60,000 pregnant women would have been eligible for coverage if the provision had been enacted. The provision had broad bipartisan support in the Senate as well as the support of the National Governor's Association and the National Council of State Legislators. CBO estimated that this coverage would cost the federal treasury $500 million over three years Unfortunately, the provision was not included in the conference agreement.

As of 2004, there were an estimated 31 million non-elderly immigrants living in the United States,[7] approximately 74% of whom are here legally.[8] Almost half of non-citizen immigrants are uninsured, largely because they are more likely to work in low wage jobs, service or agriculture industries or small businesses where employers often do not offer health coverage.[9]

The March of Dimes urges Members of this Committee to allow states to extend SCHIP coverage to income eligible legal immigrant pregnant women and children.

Conclusion

The March of Dimes appreciates the opportunity to submit its comments for the record and looks forward to working with the Chairman and Ranking Member, Senators Lincoln and Bingaman, and other Members of the Committee to reauthorize and strengthen SCHIP — a program central to the health of the nation's pregnant women, infants and children.

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[7] Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of Census Population Survey (Annual Social and Economic Supplement; March 2005)

[8] *The Foreign-Born Population in the United States: March 2002*, (Washington DC: U.S. Census Bureau), February 2003 and Passel, J., Capps, R. and M.Fux *Undocumented Immigrants: Facts and Figures* (Washington DC: Urban Institute), January 12, 2004.

[9] Bureau of Labor Statistics, *National Compensation Survey: Employee Benefits in the Private Industry in the United States*, Table 1, March 2005.

FOR AMERICA'S CHILDREN

TESTIMONY SUBMITTED FOR THE HEARING
"The CHIP Program From the States' Perspective"

UNITED STATES SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH CARE

November 16, 2006

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Voices for America's Children (Voices) appreciates the opportunity to offer testimony to the Senate Committee on Finance Subcommittee on Health Care on the successful federal state partnership developed over the past 10 years in support of the State Children's Health Insurance Program (SCHIP). Over 6 million children across the nation currently benefit from this successful partnership and Voices, a national, nonpartisan, nonprofit, membership-based child advocacy organization believes that children in America deserve access to affordable, comprehensive, health care coverage to support their healthy growth and development.

On behalf of our member advocates in nearly every state, Voices recognizes the vital role SCHIP and Medicaid has played in creating a better future for our country's children. Over the past decade, SCHIP-funded programs across the country have succeeded in providing millions of kids with access to affordable health care coverage. Since the inception of SCHIP, the number of low-income uninsured children has decreased by one-third.[1] Meanwhile, Medicaid remains the backbone of our nation's public health care system for children, providing services to over 26 million children. The federal government and states have worked together to build a public health program for kids that has been resoundingly successful and effective in providing access to and securing coverage for children. However, over 11 percent, or 9 million children, still lack health insurance in the United States.[2]

To better address the health care needs of our children, particularly low- and moderate-income underinsured and/or uninsured children, Voices strongly urges Congress to reauthorize the State Children's Health Insurance Program in 2007 and to continue to work with states to improve, expand and enhance children's health care services across the country. Congress must ensure that states are given the necessary funding to continue to improve their SCHIP programs and allow more children to receive quality health care coverage.

In the coming months, Voices will release its policy recommendations to secure and improve children's health care services through the upcoming SCHIP reauthorization process. Voices' members are currently convening key stakeholders in individual states (including community leaders, state advocates and social service providers) to gather information, discuss the health care needs of children, gauge the current level of children's needs and address how both SCHIP and Medicaid are working to address these needs. Thus, Voices will base its policy recommendations on the experiences of people in the states who are working directly to improve the lives of children in their communities.

Success of SCHIP Partnership: Supporting Evidence

Over the past ten years, SCHIP has made a significant impact in improving children's access to affordable, comprehensive, and quality health care. The program increases

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[1] Georgetown University Health Policy Institute's Center for Children and Families

[2] DeNavas-Walt, C., Proctor, B., and Lee, C. "Income Poverty and Health Insurance Coverage in the United States, 2004" *Current Population Reports.* August 2005.

access to routine, acute and specialty care, as well as utilization of preventative care. In 2005, over 6 million children relied on SCHIP for access to health care services.[3]

States can expand eligibility beyond children to include parents, unborn children, childless adults, and pregnant women.[4] States that want to expand coverage to higher incomes have the freedom to do so by implementing cost-sharing and limiting benefits. Latitude to design their own programs allows states to tailor their program to their populations. Currently:

- 30 states have set eligibility at 200 percent of Federal Poverty Level (FPL), 13 states have set SCHIP eligibility above 200 percent of the FPL, and 8 states have set eligibility below 200 percent of the FPL.[5]
- 7 states cover unborn children, 6 states offer coverage for parents, 5 states offer coverage for childless adults, and 2 states offer coverage for pregnant women.[6]

State flexibility in program operations has also led to innovations in enrollment, outreach, and program design, many of which carried over to the Medicaid program. Efforts to improve enrollment strategies include establishing continuous eligibility, adopting short, joint applications for Medicaid and SCHIP, eliminating face-to-face interviews and resources tests, allowing self-declaration of income and electronic submissions and using passage renewal systems. Outreach strategies include mass media campaigns and providing direct financial support for local application assistance.[7] Many of these outreach efforts have identified and enrolled children who were eligible but not enrolled in Medicaid.

Recent success in Illinois and Pennsylvania demonstrate how SCHIP programs have served to extend coverage to all children residing in these two states.

Illinois' *All Kids* program was the first in the nation to expand upon its SCHIP program to ensure that every Illinois child under age 18 has access to affordable health insurance. Immunizations, doctor visits, hospital stays, prescription drugs, vision care, dental care, as well as speech and physical therapy, are among the benefits covered by the program. There are no costs to families making under 200 percent of FPL, approximately $40,000 for a family of four. For families earning more than $40,000, monthly premiums and co-payments are based on a sliding scale. However, there are no copayments for preventative care visits. Since the enactment of the program nearly one year ago, nearly 100,000 children have enrolled in *All Kids*.

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[3] FY 2005 Second Quarter Ever Enrolled Data by State – Total SCHIP, http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/list.asp#TopOfPage

[4] "Income eligibility levels and cost sharing for children in Medicaid and SCHIP and other populations covered with SCHIP funds." *National Academy for State Health Policy*. July 2005

[5] "Income eligibility levels and cost sharing for children in Medicaid and SCHIP and other populations covered with SCHIP funds." *National Academy for State Health Policy*. July 2005.

[6] Guyer, J. *SCHIP Reauthroization: The Road Ahead.* Georgetown University Health Policy Institute, Center for Children and Families, Washington, D.C. July, 21, 2006.

[7] Kenny, G. and Chang, D. (2004) "The State Children's Health Insurance Program: Successes, Shortcomings, and Challenges" *Health Affairs*. 23, 5, 51-62

Through the Pennsylvania *Cover All Kids* initiative 133,000 uninsured children in this state now will have access to affordable health care coverage. The Pennsylvania initiative expands upon the state's Children's Health Insurance Program (CHIP) to guarantee coverage for all the state's uninsured children under the age of 19. CHIP coverage will be available at no cost to families making under 200 percent of the FPL and will be based on a sliding scale for families making above $40,000. Families making over $60,000 who cannot find or afford private insurance coverage will be able to buy into CHIP at the state's cost for coverage if certain conditions are met. To discourage families from dropping private coverage, the new law sets a waiting period of six months for families with incomes above 200 percent of the FPL. However, this "go-bare" period is not applicable if a child is under two years age or if coverage was lost due to a parent's loss of employment. As recognized by Joan Benso, CEO of Pennsylvania Partnerships for Children and Voices member, passage of children's health legislation "...Is a testament to the good that can be done when [lawmakers] come together and put partisan politics aside for the benefit of our most vulnerable populations."

A review of New York's SCHIP program found significant improvements in health care utilization pre and post enrollment. One year post-SCHIP enrollment, 97 percent of enrollees surveyed had a consistent source of care, an 11 percent increase. Continuity of care also increased from 47 percent to 89 percent of enrollees using their primary care physician for most or all visits. Children with unmet health care needs dropped from 31 percent prior to enrollment to 19 percent one year following enrollment. The percentage of enrollees surveyed with a preventative care visit increased from 74 percent prior to enrollment to 82 percent following enrollment.[8]

A study of Colorado SCHIP enrollees found an increase in the perceived quality of care following SCHIP enrollment. Parents were asked, "How would you rate your child's health care in the previous months?" 35 percent reported the best ranking prior to SCHIP enrollment and 42 percent reported the best ranking following one year of SCHIP enrollment.[9]

These are just some of the examples that indicate that this federal-state partnership has been very successful in increasing access, continuity, and quality of health care for enrollees.

Future Opportunities and Challenges

Congress has opportunities in 2007 to make advancements in meeting the health care needs of children through the reauthorization of SCHIP. Voices' top federal legislative priority is to inform and impact those decisions so that federal supports available to children through SCHIP and Medicaid not only continue, but are strengthened. Voices will release its state-informed policy recommendations to Congress regarding the

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[8] Szilagyi, P., Dick, A., Klein, J., Shone, L., Zwanziger, J., McInerny, T. (2004) "Improved Access and Quality of Care After Enrollment in the New Your State Children's Health Insurance Program (SCHIP)" *Pediatrics.* 113, 5, 395-404

[9] Kemp, A., Beaty, B., Crane, L., Stokstat, J., Barrow, J., Belman, S., Steinter, J. (2005) "Changes in Access, Utilization and Quality of Care After Enrollment Into A State Child Health Insurance Plan" *Pediatrics.* 115, 2, 364-371

SCHIP reauthorization in the upcoming months. Congress must secure the funding necessary to better address the needs of children with no health insurance coverage.

As health care costs continue to rise and more children lack employer sponsored health care, the cost of maintaining coverage at current SCHIP eligibility levels increases. Estimates indicate that if SCHIP funding remains flat over the next five years, states will face a funding shortfall of $10-$12 billion for the 2008-2012 period. If funding were to remain flat, 23 states would face a shortfall in 2008 equivalent to the cost of covering 700,000 children, and up to 36 states would face a shortfall in 2012, equivalent to the cost of covering up to 1.8 million children.[10]

The financial stability of SCHIP is critical to states. If states continue to face impending funding shortfalls, they may be forced to impose enrollment freezes, increase-cost sharing, and place greater restrictions on eligibility requirements. Limiting the program only to a "core" group of eligible children would deny states the flexibility to expand the program to higher income levels or other populations. Such a policy would also increase the number of uninsured children and hinder states' efforts to provide affordable, comprehensive, and quality health care to their citizens.

Conclusion

Voices for America's Children commends the Senate Finance Health Subcommittee for focusing on the role states play to provide children with access to comprehensive and quality health care. It is critical that Congress reauthorizes SCHIP with adequate funding for the program so states can continue to expand child health assistance to uninsured low- and moderate-income families. As Congress takes action to strengthen the SCHIP program, we again urge Congress to protect and maintain Medicaid.

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[10] Broaddus, M. and Park, E., "Freezing SCHIP Funding in SCHIP Reauthorization Would Threaten Recent Gains in Health Coverage." *Center on Budget and Policy Priorities*. June 5, 2006.