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Written Statement of
Georgia Governor Sonny Perdue
On behalf of the Southern Governors' Association

Before the

Senate Committee on Finance
Regarding the
State Children's Health Insurance Program (S-CHIP)

February 1, 2007

Good afternoon, Mr. Chairman, and members of the Committee. Thank you for the opportunity to come before you today as you consider the reauthorization of the State Children's Health Insurance Program, commonly referred to as S-CHIP. I am here today representing the 15 states and two territories of the Southern Governors' Association.

I am pleased to be here on behalf of a state and a region that has been successful in implementing the program Congress created to expand the availability of health insurance to uninsured, low-income children. In fact, Georgia the 9th largest state in the Union has the fourth largest S-CHIP program in the country. Overall, SGA member states have enrolled more than 41% of the current S-CHIP population.

According to the FY2005 S-CHIP Enrollment Report prepared by the Centers for Medicare and Medicaid Services (CMS), the number of enrolled children nationally was more than 6 million. Ten years after S-CHIP was created with strong bipartisan support, it is clear that we have surpassed the original goal of the program—to provide health insurance coverage to 5 million low-income children within 10 years. However, there is still work to be done, and I want you to know that Southern governors are committed to doing all we can to ensure that our low-income children can get access to quality health care.

Without question, states have made dramatic progress in reducing the number of uninsured low-income children through the S-CHIP program. Governors look to the reauthorization of S-CHIP as a primary means of ensuring that we can continue in our partnership with the federal government to provide health insurance to those children already enrolled in our S-CHIP programs and offer coverage to those eligible children not yet enrolled.

The 2007 reauthorization of S-CHIP provides Congress an opportunity to evaluate the current program and update our shared goals. As governors, we are responsible for achieving the goals set forth for this program, and in that role, we have learned some lessons and established some principles that I'd like to pass along to you as you consider the future direction of the program.

Making Children a Priority

First, we believe **children should be the priority population for S-CHIP**. This means that the resources for the program must be focused first on children. This is not necessarily the case in every state right now. CMS has allowed some states to make changes to their programs to include health insurance coverage for pregnant women and adults with children; arguably, these populations are directly connected to the targeted population of children. However, some states also have been allowed to expand coverage to include childless adults under their S-CHIP program. In all of these cases, these states are paying the same 70/30 Federal match rate as those states, like Georgia, that are only covering children.

Respectfully, if we had unlimited funds to put toward this program, this might not be an issue. I recognize though, as a Governor who has a constitutional requirement to balance a budget, that this is simply not the reality. In fact, there are currently 15 states that do not have enough Federal matching fund allocations to cover their projected S-CHIP expenditures for FY2007. Therefore, while some states struggle with shortfalls and are unable to cover even their low income, eligible children, others have so much excess funding that they are covering populations that were never the intended recipients under the program.

Fixing Formula Flaws

Second, there are two primary factors in the S-CHIP funding formula that have a negative effect on southern states: the state "Cost Factor" and the calculation for "Number of Children."

The "State Cost Factor" is a geographic cost factor based on annual wages in the health care industry for each State and is meant to serve as a proxy for health care costs. This factor, however, does not take into account the many variables that reflect actual health care costs. In fact, there is very little correlation between this measure and overall health care costs. Use of this factor serves to reduce the allotments to states with low wages, which is contrary to the interest of directing S-CHIP funds to low-income uninsured children.

The "Number of Children" is calculated as 50 percent of the number of low-income children and 50 percent of the number of *uninsured* low-income children. There are two problems with this aspect of the formula:

1. **Inaccuracy of the Count Reduces Allotments**. The measures used to count uninsured and eligible children have proven ineffective in Southern states, resulting in the most severe funding shortfalls in the country.

Until this fiscal year, CMS has relied on the U.S. Census Bureau's Current Population Survey (CPS) to estimate both the overall number of low-income children and the number of low-income children who are *uninsured*. The CPS survey estimates come from only a sample of the population, and as a result, those estimates can differ widely from the results of a complete census. To compensate for sampling errors, the CMS is then required to use a three-year average of these estimates. But this overall approach still leaves tremendous room for errors. For example:

- In FY2006 original allotments were based on data averaged over the three-year period 2001-2003. In a state like Georgia where the population growth is twice the national average, this kind of lag has significant consequences.

- Sampling errors further complicate an already unmanageable situation. On average, the states' share of S-CHIP allocations has been shown to vary by as much as 30% over a nine-year period. Governors cannot have this kind of unpredictability if they are to properly manage their S-CHIP enrollment.

While it is difficult to pinpoint the best solution for this obviously complex projection model, there can be little doubt that there is a major disconnect between the survey results and the actual number of eligible children. While CMS has begun using a full census data source to address some of these problems, we are not convinced this change alone can correct an annual projection that has proven to be so consistently and dramatically wrong.

2. **Number of "Uninsured Kids" Undermines Goal of Program.** The other 50 percent of the "Number of Children" factor is determined by the number of uninsured children. So as you enroll children, you receive less funding in the following years. The successful implementation of S-CHIP in any state automatically undermines maintaining funding to keep these kids enrolled in the program. Two primary examples of the formula problems are North Carolina and Georgia.

Georgia. In Georgia, we are providing coverage to 273,000 eligible children, and Georgia State University has estimated another 100,000 children are eligible to participate in PeachCare. Yet CMS figures project an eligible population of only 130,000, so Georgia is already covering more than twice the CMS-projected population. Meanwhile, our average monthly enrollment has increased 19% since FY2005. Georgia's successful implementation of this program has left us facing a $131 million Federal funding shortfall in FY2007. Without additional Federal matching funds, the PeachCare program will be depleted of federal funds by March of this year. Georgia stands ready to meet its obligation to this program but we cannot go it alone.

North Carolina. In North Carolina's situation, the S-CHIP allocation methodology understated the number of potential eligibles. As a result, North Carolina's annual S-CHIP Federal funding allocation was insufficient to cover the number of enrolled children, requiring North Carolina to take drastic action. That action included shifting children aged 0 to 5 to Medicaid, reducing S-CHIP payments to providers and limiting S-CHIP enrollment growth for the remaining population to only 3% every six months.

Unfortunately, these measures are not long-term solutions and increase the liability for Federal government expenditures as Medicaid is an entitlement program and allows for fewer options for flexibility and management of the program than does S-CHIP.

Maintaining Flexibility

Finally, Southern governors have recognized that flexibility has been the key to success in implementing S-CHIP, and as such, maintaining the flexibility of how each state meets the health care needs of the program's targeted population should be maintained in reauthorization. Unlike traditional entitlement programs, S-CHIP has allowed states to tailor benefit packages to meet the needs of recipients. This has allowed governors to increase efficiencies resulting in a more sustainable health care delivery program. Additionally, state legislatures have used S-CHIP flexibilities to make decisions that have allowed the program to continue to operate during budget deficits and rebound as fiscal circumstances have allowed. As a result, states have been able to rely on S-CHIP help them meet the most critical needs of its low-income children.

In closing, I'd like to outline some of the basics of Georgia's PeachCare program because I believe it further highlights the challenges that must be addressed within reauthorization.

As I have already noted, Georgia has the fourth largest enrollment in the country, with more than 270,000 eligible children receiving coverage. Georgia only covers children. Ninety-five percent of our PeachCare families have incomes below 200% Federal Poverty Level and we place priority on those families by implementing a sliding scale premium which requires families that make more to pay more. Unlike most states, Georgia does not provide a guarantee of continuous eligibility. Families are obligated to report changes in income or status and we undertake an independent verification of income. Beginning this summer we will have 100% income and citizenship verification. Further, families have a two-week grace period to pay their premiums. Georgia is the **only** state in the country that has a grace period of less than one month. Families who do not pay premiums on time in Georgia are temporarily locked out of the program. Georgia's program is designed to ensure our families have affordable health insurance options for their children while also encouraging personal and financial responsibility.

America is a compassionate nation and we must continue to take care of our most vulnerable citizens. As we focus on new ways to reach the Nation's uninsured, I ask you, distinguished members of Congress, to preserve, secure and improve the State Children's Health Insurance Program because it is already making great strides in meeting the needs of our most vulnerable population. I hope that you find these principles and lessons learned by states to be helpful. On behalf of the members of the Southern Governors' Association, I hope you will use us as a resource as you consider reauthorization.

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