Georgetown University Health Policy Institute

Center for Children and Families

GEORGETOWN UNIVERSITY

"The Future of CHIP: Improving the Health of America's Children"

Testimony Submitted

to the

Senate Committee on Finance

By

Cindy Mann, JD

Executive Director

Georgetown University

Center for Children and Families

February 1, 2007

Chairman Baucus, Senator Grassley, and Members of the Committee:

Thank you for the invitation to participate in this hearing on the State Children's Health Insurance Program. I am Cindy Mann, the Executive Director of the Center for Children and Families, a research and policy center at Georgetown University's Health Policy Institute that focuses on children and family health coverage issues. I am also a Research Professor at Georgetown University and an Associate Commissioner with the Kaiser Commission on Medicaid and the Uninsured. My involvement with SCHIP has been long and varied. Soon after enactment of SCHIP, I served as the Director of the Family and Health Programs Group within the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services). This group oversaw the implementation of SCHIP at the federal level. Since then I have worked with states, foundations, and community organizations as they have attempted to bring the promise of SCHIP to fruition, and I have analyzed how federal and state policies and procedures have affected children's coverage.

A great deal has been accomplished as a result of Congress's action in 1997 to establish SCHIP. When the legislation was first debated, the big questions were, would states take up the opportunity to expand coverage for low-income children and would families enroll their children in the coverage offered to them. We now know the answers to these questions. Every state has a SCHIP program, and SCHIP has been successful not only in covering newly eligible children but also in triggering major improvements in Medicaid that allowed millions of uninsured children who had been eligible for Medicaid but not enrolled to gain coverage and access to care. As a result of these two programs – SCHIP and its larger companion program, Medicaid – the portion of low-income children in America without coverage declined by one-third between 1997 and 2005.

With success come challenges, however. Few would disagree that SCHIP's key challenge has to do with its financing. While there are a number of SCHIP financing issues, the single most important issue is whether sufficient federal funds will be made

available to assure further gains in covering children. The SCHIP funding level for 2007 – $5 billion – was picked ten years ago before Congress had any experience with the program. This level of funding falls far short of what is needed when measured against what states are spending now and particularly in light of the growing interest in covering more children and the compelling need to do so. According to the most recent U.S. Census data, some nine million children in America still lack coverage.

SCHIP reauthorization comes at just the right moment. The substantial coverage gains achieved for children over the past decade demonstrate that the nation is on the right track. The public strongly supports efforts to cover children, and many states across the nation – including most of the states represented by the Senators on this Committee – have recently taken steps to reach more children or are poised to do so. SCHIP reauthorization creates the opportunity for Congress to again take leadership to move the nation closer to the broadly shared goal of assuring that every child in America has coverage.

My testimony this morning will cover three areas: Trends in eligibility and coverage; key SCHIP financing issues; and steps that can be taken to help reach uninsured children. The focus here is not intended to negate the importance of other SCHIP reauthorization issues, including the scope of coverage provided to children, quality care issues, and outreach strategies.

Eligibility and Coverage Trends

In 1997, right before SCHIP was enacted, only three states covered children under age 19 with family incomes up to 200 percent of the federal poverty line. (In 2007, 200 percent of the poverty line is equivalent to $2,862 per month in total earnings for a family of three.) To encourage states to expand coverage, Congress established SCHIP and offered states federal matching payments at a more favorable matching rate as compared to Medicaid. (On average, states pay 30 percent of the cost of SCHIP coverage compared to 43 percent of the cost of Medicaid coverage.) Federal SCHIP funds could be used to

cover children through Medicaid, a separate (non-Medicaid) child health program, or a combination of the two approaches. By 1999, every state had an approved SCHIP plan. Currently, 18 states use their SCHIP funds only in a separate program; 10 states and the District of Columbia use SCHIP funds only to expand Medicaid; and 22 states rely on a combination approach. As shown in Figure 1, as of July 2006, 41 states plus the District of Columbia now cover children with family incomes at or above 200 percent of the federal poverty line.

The variation across states in income eligibility levels reflect individual state choices permitted by the SCHIP law. Indeed, the law is premised on the notion that states should have broad discretion to design their programs guided by federal standards particularly with respect to benefits and cost sharing. The law permits states to set their upper income eligibility level at 200 percent of the federal poverty line or 50 percentage points above their Medicaid income eligibility level prior to SCHIP and also to establish their own rules for how they will calculate income (i.e., whose income will be counted and whether deductions, exclusions or disregards will be permitted). Of the 36 states that had separate SCHIP programs in 2005, 13 considered gross income and 23 took work-related expenses and/or other income exclusions and disregards into account. Each state's income eligibility threshold and income counting rules reflect state-level considerations, including how much funding a state is prepared to commit to SCHIP, state personal incomes and poverty rates, and the cost of living. California covers children at higher income levels than Texas, but a family in San Diego with income at 250 percent of the federal poverty level has the same buying power as a family living in Houston with income equal to only 154 percent of the federal poverty level.

Enrollment grew slowly at first, particularly in states that were starting new child health programs, but it soon took off and has grown every year except for 2003-2004. Nationwide, by 2002, more than two-thirds (68 percent) of children without private coverage whose family incomes made them eligible for SCHIP were enrolled, a significant achievement for a new initiative. Participation rates vary from state to state. The most recent data available show that in 2005, SCHIP covered six million children

during the course of the year and about four million children on the last day of the year. Of the six million children enrolled in 2005, about 1.7 million were covered in SCHIP-funded Medicaid expansions and the remaining 4.4 million through SCHIP-funded separate programs. (Figure 2)

SCHIP's impact, however, extended far beyond the confines of the coverage financed with SCHIP funds. SCHIP was designed to stand on the shoulders of the much larger Medicaid program. As part of the broader effort to cover eligible children and to coordinate enrollment between SCHIP and Medicaid, SCHIP touched off widespread efforts to simplify the process for enrolling and retaining children eligible for Medicaid. In addition, sometimes for the first time in the history of the Medicaid program, a vast array of entities, including states and local community organizations, governors and mayors, schools, churches and synagogues, health centers and hospitals, engaged in outreach efforts to inform families about eligibility for coverage, including Medicaid. As a result of the simplification and outreach initiatives, as many children gained coverage through Medicaid as through SCHIP. In 2005, Medicaid covered about 28 million children. (Figure 2)

These enrollment gains occurred in the context of a particularly challenging health coverage environment. Over the past decade, health care costs rose sharply, and many fewer families had access to employer-based insurance. As a result, according to data collected by the Centers for Disease Control and Prevention, between 1997 and 2005, the number of uninsured adults grew by more than six million. During this same time period, however, SCHIP and Medicaid more than offset the declines in job-based coverage for children, and the portion of low-income children who were uninsured declined by one-third, from 22.3 percent in 1997 to 14.9 percent in 2005. (Figure 3)

For the first time since 1998, U.S. Census Bureau data (the Current Population Survey) showed that the number of uninsured children rose in 2005, with near-poor children (those with incomes between 100 and 200 percent of the poverty line) experiencing the largest increase. Over nine million children under age 19 were uninsured in 2005. Most

(88 percent) are in families with at least one employed parents, and about one-third (35 percent) have incomes below 100 percent of the federal poverty line ($1,431 a month for a family of three). A disproportionate share of uninsured children resides in the South (43 percent) and in the West (29 percent), and a disproportionate share (38 percent) is Hispanic. As explained below, the good news in terms of the potential for achieving significant additional coverage gains for children in the future is that most uninsured children are now eligible for either SCHIP or Medicaid and when informed that their child may be eligible their parents report they are eager to enroll them into coverage.

Financing Challenges

Financing challenges have been at the center of most of the controversies having to do with SCHIP since the enactment of the program. Since 1997, the law has been amended several times to alter the rules for how SCHIP funds are distributed to states and how long states can use SCHIP funds. Formula and distribution questions continue to be important, but the key financing issue facing the Congress today relates to the overall level of funding that will be made available for SCHIP and related Medicaid improvements as part of SCHIP reauthorization. Consistent with the public's strong support for children's coverage, an election-eve poll conducted for the Center for Children and Families last November found that 82 percent of voters supported investing more money in SCHIP. Of these, two thirds want to see Congress provide a funding level that allows states to cover more children in SCHIP.

Enrollment and spending data show that the fiscal year 2007 SCHIP allotment level is well below what is needed to sustain current coverage efforts and move forward. This is not surprising. The fiscal year 2007 commitment of $5 billion was set ten years ago as part of the original legislation that established SCHIP. At the time, there was no experience with the program and little evidence upon which Congress could rely to project what the program might need five or ten years later. Moreover, SCHIP was part of a much larger budget bill, the Balanced Budget Act of 1997 (P.L. 105-33), a 537-page law that affected a large number of programs and areas of federal spending, estimated to

achieve $160 billion in gross federal savings over five years. The five-year commitment of $20 billion for children's health initiatives (SCHIP and Medicaid) was set within a context of a complex bill with many competing demands.

There has long been a mismatch between SCHIP spending and the allocation of funds to states. As might have been expected, SCHIP spending started slow and ramped up as programs got underway and costs rose. The ten-year funding levels, however, did not ramp up. They were set at $4.3 billion in 1998, stayed at that level through 2001, dropped to $3.2 billion in fiscal years 2002 – 2004, and grew to a little over $4 billion in 2005 and 2006. (Figure 4) The 2007 allotment totals $5 billion, but in 2007 states are projected to spend more than $6.3 billion, according to the Congressional Research Service. CRS estimates that 37 states will spend more than their total fiscal 2007 allotment in 2007. The mismatch grows over time; the Center on Budget and Policy Priorities projects that by 2010, spending just to maintain current enrollment will exceed annual allotments in 44 states, assuming a continuation of the $5 billion in total annual SCHIP allotments.

SCHIP's financing structure was built on the assumption that some states might spend more than their current year allotments. Under the law, states have access to their annual allotments for three years, and some states receive funds redistributed from other states that do not spend their full allotments. These carry-over and redistributed funds were intended to help move the dollars to the states with the greatest needs. This worked for a while (with occasional adjustments by Congress), but as enrollment and costs grew carry-over-funds were depleted in many states and the amount of funds available for redistribution declined considerably.

The mismatch between current allocation levels and spending needs is now painfully apparent and growing. As health care costs rise and many states recommit to the goal of covering children, including the uninsured children who are already eligible for SCHIP but not enrolled, a significant increase in the federal financial commitment to this program is needed to keep the progress that has been made intact and to move forward.

In just the past year, a number of states have improved coverage rules and removed barriers that were keeping eligible children from enrolling or retaining coverage. Other states are planning to take similar steps, and some states have adopted or are considering coverage expansions. This movement forward on behalf of children will stall, particularly in those states with fewer resources to fall back on, if the federal commitment of funds falls short of what is needed.

Some changes to the formula for targeting SCHIP funds to states with the greatest needs could address some of the funding problems, but they will do relatively little to reduce the need for additional federal funding over the longer term. Some have suggested that narrowing the groups of people – children and adults – who can be covered with SCHIP funds would also help to address SCHIP funding problems. Currently, there is no federally-imposed cap on the income level of the children who can be covered in SCHIP; indeed, as explained above, the SCHIP law permits states broad flexibility to set income levels and to define and determine the income they will count. A change in this policy would not only result in children losing coverage, but would also require Congress to set detailed new federal rules for a program that has prided itself on the flexibility it accords to states.

In addition to children, according to the Centers for Medicare & Medicaid Services (CMS), five states have waivers to cover pregnant women and nine states provide pregnancy-related care to women through a regulation that allows states to cover unborn children. Twelve states have waivers to cover parents although several have not been implemented or have very limited enrollment. A few states also use SCHIP funds to cover childless adults; the Congress eliminated the Secretary's authority to approve additional SCHIP waivers to cover childless adults as part of the Deficit Reduction Act of 2005. In fiscal year 2005, about 638,789 adults (pregnant women, parents, and childless adults) were covered with SCHIP funds compared to more than 6.1 million children (in these CMS data, pregnant women covered through the unborn child option are counted among the 6.1 million children).

States with parent or pregnant women waivers have relied on and conformed to waiver guidance that dates back to the early days of the program. The waiver authority that has been used to allow states to cover populations other than children was explicitly authorized in the SCHIP legislation (Section 2107(e)). States and the Congress were apprised of the guidelines the Secretary intended to apply in guidance issued in July 2000. Acknowledging the tension of covering populations other than children in the context of a program funded through a block grant, the guidance permitted waivers to cover pregnant women or parents if the state was covering children up to at least 200 percent of the federal poverty line and had taken certain specified steps aimed at promoting enrollment of eligible children. In addition, once a state began using SCHIP funds to cover parents or pregnant women, the funding for parent or pregnant women coverage would stop if the state closed enrollment for children or if it ran short of the funds it needed to cover children. The 2000 waiver guidance explicitly declined to permit states to use SCHIP funds to cover childless adults.

Additional SCHIP waiver guidance was issued in August 2001 as part of the Bush Administration's broader waiver initiative called the Health Insurance Flexibility and Accountability ("HIFA") initiative. HIFA guidelines permitted states to use SCHIP funds to cover childless adults, and, in general, the waivers granted under HIFA did not include specific simplification requirements aimed at improving participation rates for children. The HIFA waivers still require states to keep enrollment for children open as a condition of covering adults and they prioritize funds to be spent for children. As noted above, the DRA stopped further waivers using SCHIP funds to cover childless adults.

The Secretary's waiver authority must, according to statute, be exercised in a way that "furthers the objectives of the (SCHIP) program' (Section 1115 of the Social Security Act). Coverage for pregnant women and parents promotes children's health and well being in a number of different ways. Coverage of pregnant women promotes healthy babies, and several members of Congress, including members of the Finance Committee, have offered legislation to explicitly permit states to use SCHIP funds to cover pregnant women without a waiver (supplementing the current authority for states to cover unborn

children). Parent coverage also benefits children, by helping parents stay or become healthy allowing them to work and take better care of their children. In addition, there is considerable evidence that when states cover families – parents as well as children – eligible children are more likely to enroll. There is also evidence that parent coverage leads to improved utilization of health services for children. In addition, family-based coverage makes it more feasible for states to pursue premium-assistance approaches, where they use SCHIP (or Medicaid) funds to subsidize the purchase of insurance offered to the family through the work place.

The central issue with respect to covering parents or pregnant women seems not to be whether it is improper for states to have received waiver authority to make this coverage possible – the objectives are reasonable within the context of the purposes of SCHIP and the policy is longstanding and transparent –but whether there are sufficient funds to sustain these modest efforts to offer family coverage and premium assistance. Cutting off this source of coverage for low-wage parents who generally lack any other viable insurance options will not resolve the SCHIP funding gap but will deepen the problems so many families face trying to secure coverage.

Getting To The Finish Line

While states have made substantial progress in recent years boosting participation rates in both SCHIP and Medicaid, the single most important step that can be taken to lower the uninsured rate among children is to enroll the children eligible under current program rules. The fact that there are large numbers of eligible but unenrolled children is essentially a “good news” story. Since 1997, states have expanded their programs increasing the size of the eligible population. Therefore, despite the fact that states are considerably more successful than they have been in the past enrolling eligible children, a significant number of uninsured children are eligible but not enrolled. Close to seven out of ten (68 percent) of all uninsured children in 2004 were eligible for either Medicaid or SCHIP, and among low-income children, about 87 percent were eligible but not enrolled.

(Figure 5) Lack of information about program eligibility and barriers to enrollment and retention are the key reasons why eligible children remain uninsured. One study found that nearly 90 percent of parents surveyed responded that they would enroll their child in SCHIP or Medicaid if they knew the child was eligible.

States generally have the flexibility in both SCHIP and Medicaid to simplify enrollment and improve retention rates, and they can draw down federal matching payments to help pay for outreach activities. They are, however, sometimes reluctant to take these steps because of the resulting coverage costs. A survey conducted for the Kaiser Commission on Medicaid and the Uninsured showed that between April 2003 and June 2004, when state budgets were under considerable pressure, nearly half the states (23 states) imposed enrollment barriers that made it more difficult for eligible children and families to enroll or retain coverage in SCHIP or Medicaid. In addition, seven states imposed SCHIP enrollment freezes.

These procedural barriers can lead to significant enrollment declines. Washington's experience is instructive. In 2003, after the state dropped a series of procedural simplifications, enrollment among children dropped by over 40,000. In 2005, when many of these changes were reversed enrollment again began to rise.

The challenge going forward is to consider ways to reduce these policy fluctuations that lead to children gaining and losing coverage notwithstanding their eligibility. One approach may be to provide greater federal assistance with coverage costs if a state adopts and maintains policies aimed at promoting participation of eligible children (e.g., 12-month continuous eligibility, express lane enrollment, simplified renewals) or reaches certain enrollment goals or targets. Since about 70 percent of the uninsured children who are eligible for public coverage but unenrolled are eligible for Medicaid, it will be important to apply such policies to Medicaid as well as SCHIP so that the greatest possible coverage gains are achieved and the lowest income children are not left behind.

If the goal is to reach and enroll eligible children, it will be important in the context of SCHIP reauthorization to address the new citizenship/identity documentation requirement imposed in Medicaid by the Deficit Reduction Act of 2005. The new rules are beginning to cause tens of thousands of children to lose out on coverage or to experience delays in gaining coverage. According to a new report issued by the Center on Budget and Policy Priorities:

- Between August and December 2006, 14,000 people lost or were denied or coverage in Wisconsin as a result of the requirement. Most could prove citizenship but could not establish "identity" under the stringent new rules, indicating that the people losing coverage were citizens.
- Virginia reports a decline of 12,000 children since July 2006 when the new rules went into effect. A recent up-tick in enrollment suggests that after long delays some people are gaining coverage and that lack of documentation, not lack of citizenship, is the problem.
- The Kansas Health Policy Authority reports that between 18,000 and 20,000 individuals—mostly children and parents have experienced delays or denials in coverage. A story of a seven-month old baby shared by the Chief of Ambulatory Pediatrics at the Kansas University Medical Center in an opinion piece appearing in the *Kansas City Star*, shows that these delays are affecting citizen children (the baby's coverage was delayed even though he was born in the same Kansas hospital that was hoping to treat him) and can lead to serious and sometimes permanent health problems.

Of the one-third of uninsured children who are ineligible for SCHIP or Medicaid (13 percent of low-income uninsured children), some have family incomes above the income eligibility levels in their state. Many of these children cannot afford employer-based coverage even if it is offered. Others are income-eligible for the programs but are barred from participating in SCHIP or Medicaid due to restrictions relating to their immigration status. States are prohibited by a federal law that pre-dates SCHIP from using federal SCHIP (or Medicaid) funds to cover legally present immigrant children who have been in

the country for less than five years, regardless of their income or need for medical care. Allowing states the option to cover these children in SCHIP or Medicaid, if otherwise eligible, could provide children with access to needed and timely care and offer states and health care providers federal matching funds for care that they might be providing with limited state, local or charity funds. The experience in localities that cover children in these circumstances (with state or local funds) also shows that the elimination of eligible confusing rules about children's eligibility helps with outreach and promotes enrollment among a broader group of children.

Conclusion

Americans strongly believe that children should have health care coverage. SCHIP, along with its companion program, Medicaid, has brought the nation closer to this broadly held goal. A new wave of activity is moving across the country as Governors and state legislators from both parties commit themselves to cover eligible but unenrolled children and some seek to expand coverage to all children. Further progress for children, however, requires federal leadership and action to assure adequate funding to keep the progress going and to put in place policies that can support and encourage states to move forward. SCHIP reauthorization is the opportunity for this Congress to make children's coverage a priority.