

COVERING THE UNINSURED THROUGH THE EYES OF A CHILD

HEARINGS BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED TENTH CONGRESS FIRST SESSION

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COVERING THE UNINSURED THROUGH THE EYES OF A CHILD

WEDNESDAY, FEBRUARY 14, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 2:08 p.m., in room 2322 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman of the subcommittee) presiding.

Members present: Representatives Waxman, Deal, Eshoo, Green, DeGette, Capps, Allen, Baldwin, Engel, Schakowsky, Solis, Hooley, Matheson, Dingell [ex officio], Ferguson, Myrick, Sullivan, Murphy, Burgess, Barton [ex officio], and Wilson.

Staff present: Jonathan Cordone, Bridgett Taylor, Amy Hall, Purvee Kempf, Christie Houlihan, Elizabeth Ertel, Ryan Long, Katherine Morton, Brenda Clark, and Chad Grant.

Mr. PALLONE. I will call this meeting to order. And I wanted to mention that today we have a hearing on covering the uninsured through the eyes of a child. But before we begin, I just did want to mention there was originally a second hearing tomorrow focusing more specifically on SCHIP and the reauthorization. That was postponed due to the death of our colleague, Charlie Norwood. That hearing most likely will take place on Thursday, March 1, 2 weeks from today. But before we proceed if I could, I just wanted to ask if we could have a moment of silence for our colleague. Needless to say, he was a great American and someone who cared deeply and contributed so much to the healthcare debate and if we could just now have a minute silence.

[Moment of silence observed.]

Thank you very much. I understand that the funeral is tomorrow, Mr. Deal?

Mr. DEAL. Yes, Mr. Chairman. If I could maybe just briefly give the outline of the details. My understanding is that the Sergeant at Arms will be coordinating an airplane for those who wish to attend the funeral that will leave the horseshoe at about 10:30 tomorrow morning. The funeral is at 2:00. The plane will fly directly into Augusta which is where the funeral will be held and then we will return tomorrow evening about 6:30 is the anticipated return time.

Thank you.

Mr. PALLONE. Thank you very much.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I now recognize myself for an opening statement. Today, the subcommittee will examine the problem of the uninsured and how it specifically impacts children. We will also explore the program Congress established nearly 10 years ago to help alleviate this problem, the State Children's Health Insurance Program or SCHIP which must be reauthorized this year.

As a father of three young children, I realize how important it is for children to have access to quality healthcare. My wife and I are fortunate that we have the means to provide health insurance coverage to our three children through the Federal Employees Health Benefits Plan, the same program that many of my colleagues use to provide health insurance to their families. But not every family is quite as lucky. For too many American families they are simply struggling day to day to afford the cost of health insurance. And as healthcare costs continue to rise, employer sponsored insurance is eroding. Employers are shifting more cost to workers or they are dropping coverage all together. Nor has the individual market been a viable source of insurance coverage for most Americans and the result has been a steady increase in the number of uninsured Americans since 2001.

Today, there are nearly 47 million Americans who do not have health insurance. Millions more are underinsured. And what is even more appalling is that approximately 9 million of those who are uninsured are children. Now I am going to repeat that again because I think it is worth emphasizing: 9 million children in this country do not have health insurance. I think that is a national disgrace in a country as wealthy and compassionate as ours. No child should be left behind without health insurance, let alone 9 million children.

Now this disturbing statistic would undoubtedly be worse if were not for the State Children's Health Insurance Program or SCHIP. Since this was established by Congress 10 years ago, SCHIP has helped reduce the number of uninsured children in our Nation. Thanks to SCHIP, the percentage of low income children in the U.S. without health insurance has fallen by one-fourth since it was created in 1997. And more than 6 million low income children, most of who would otherwise be uninsured are enrolled in SCHIP.

While the program has largely been a success, it is now being threatened. Last year for the first time since 1998, the number of uninsured children in the country actually increased. And I think we have to stop this alarming trend. Part of our effort must include strengthening SCHIP so it can continue to serve those in need. The most immediate and glaring problem is the lack of funding for the program. Simply stated more money is needed in order to ensure the viability of SCHIP. Various healthcare experts have estimated that we need additional funding over the next 5 years simply to help maintain the program for those who are already enrolled. And if we are going to find the funds, I should say find the approximately 6 million children who are eligible for SCHIP or Medicaid but who are not enrolled. We would need at least a total of \$50 billion over the next 5 years. Now some people may say that this fig-

ure is unreasonable or unrealistic and will be difficult to fund given the budget constraints. But I say how can we afford not to spend this money on this country's most vital asset, our children? It is simply a sound investment in our Nation's future. Republicans had no problem spending \$534 billion on the Medicare prescription drug benefit. And aren't our children worth even a fraction of what it costs us just to get seniors prescription drugs?

I have to say and I have already said when we had our hearing with Secretary Leavitt that I strongly disagree with President Bush who has come up with his own plan for SCHIP reauthorization. In his recent budget, the President proposed a meager \$4.8 billion for SCHIP over the next 5 years and would limit eligibility to 200 percent of the Federal poverty level. His plan shortchanges America's children and will do nothing to solve the problems we current face with SCHIP. In fact, it will make matters worse. I have little doubt that if enacted, the President's proposal would result in fewer children with health insurance coverage than there are today. What is worse is that the administration knows this. They have to know it. Common sense tells us that restricted funding and limited eligibility is going to result in fewer insured children. Yet the administration and Republicans in Congress try to shift the debate by arguing about returning to the original objective of SCHIP by leaving out the parents that are covered today.

The time has come to cut through all the smoke and mirrors. The truth of the matter is that a mere 10 percent of those covered under SCHIP are adults including pregnant women. And once you start to talk about reducing eligibility levels, cutting people from the roles and under-funding the program, then that is when you are moving away from SCHIP's original purpose. We have a unique opportunity before us this year. Finally we have the chance to really do something about the uninsured. It is no longer good enough to simply say that we cannot do this because it costs us too much money. We as a Nation must choices about how we allocate our resources and I would submit that there are fewer needs more important than those of our children and we should be willing to spend the money necessary to ensure every child has access to meaningful healthcare. Ten years ago, we were able to come together in a bipartisan spirit and work together to establish SCHIP. Ten years later let us work together again to strengthen it. I am committed to that effort and I hope that my colleagues on both sides of the aisle will join with me. And I want to thank again our witnesses for attending today. And with that, I would now recognize the ranking member of the subcommittee, Mr. Deal for an opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. I want to thank the chairman for calling this hearing today and to thank our panel of expert witnesses for attendance at the hearing. We look forward to your testimony and I am sure that it will enlighten us as we approach this subject.

I think it is certainly appropriate the committee take this opportunity to examine the characteristics of uninsured children in our country. This is something we need to understand before we at-

tempt to reauthorize SCHIP. As we all know, the health of a child without coverage is put at risk by having no health insurance coverage. And we also know that lack of health coverage impacts the broader society by increasing the cost of healthcare and the cost of insurance to other people.

One of the biggest barriers preventing the uninsured from receiving coverage is the cost of insurance in this country today. I am certain that these prices continue to escalate more and more and more and more families face the difficult decision or the choice of whether to buy insurance or not. I would hope that on another day the committee might take an opportunity to evaluate the mechanisms that would lower the cost of coverage not only for children but for adults as well.

States such as mine have taken some steps to try to make health insurance more affordable for everyone. They have removed and repealed some of the mandates that they had built up over the years. And one of the impediments to people buying health insurance we are told is that State mandates for what the coverage must look like has driven the price and the cost up. I have seen however firsthand in my State the success of the SCHIP which we call Peach Care. You would think we would in Georgia in covering low income children. For instance, almost 70 percent of the children covered by the program in my State are between the 100 and 150 percent of poverty. Ninety-five percent of them are less than 200 percent of poverty, although our eligibility is currently at 235 percent of poverty.

Nevertheless, the variety of different SCHIP Programs across the country have made it apparent to me that in some States the program has lost its focus; that is to cover low income children. I am also very concerned about Federal dollars intended for children being spent on childless adults. Specifically, I look to the four States where adult enrollment exceeds child enrollment under SCHIP. While I believe continued flexibility for States is important as we designed the program to fit their needs. I think this flexibility should have some limits so that the primary focus remains on low income, uninsured children. Current income eligibility requirements also must be addressed. Coming from a State where the median household income is around \$42,000, some of the income levels covered by SCHIP Programs in other States would to us seem excessive.

I believe the funding allocation formula also deserves attention through the course of this hearing and I know that Chairman Pallone and I both come from shortfall States where our block grant money has not been adequate to see us through this current fiscal year and we are in a shortfall as is the State of New Jersey. One of the complaints, a legitimate complaint that my State and others have voiced is that the funding formula allocation is not appropriate. For example, once you enroll a child in SCHIP, you therefore lose the ability to count that child in your uninsured population calculations. That seems to me to be contradictory in the way the formula currently works. I am concerned that it does focus too much on giving money to States with higher uninsured populations and penalize those States which have done a good job and they are successful enrolling their SCHIP population.

Ultimately though, I fear that SCHIP that if it is expanded it could have the possibility of crowding out individuals in the private insurance market. For instance, a family with private coverage may drop that coverage and put their children on the Government program. In doing this, the parents may decide to continue without any coverage. So rather than decreasing the uninsured population, we would simply shift that into a Government program and might leave the adults in the family who previously had coverage without any.

I am sure the committee will closely examine each of these and other issues as we consider the reauthorization of SCHIP and I think the chairman for the time.

Mr. PALLONE. Thank you. Thank you, Mr. Deal.

I now recognize the gentlewoman from California, Ms. Eshoo for an opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Mr. Chairman and welcome to the witnesses that are here today.

I think it is really fitting that in your first hearing as chairman of this subcommittee that you speak on the issue of insuring children. I think it is a fitting tribute to you and what you have cared about for so many years.

The fact is that there are nearly 9 million children without guaranteed healthcare in our country. And I do not think that statistic is synonymous with the word America, so we have work to do. In the short-term, we are going to have to obviously reauthorize SCHIP because it does provide coverage for approximately 5.5 million children in our country today. We also have to make sure that there is appropriate funding that goes along with the policy so that we cover all children, all eligible children under the law.

I think we also have to look at how we can better enroll those who are eligible. There are children in my congressional district and I think in every member's congressional district that are eligible but for one reason or another have not stepped up to be enrolled and I hope that our witnesses will speak to that. I think it is encouraging that there is so many groups and entities that are looking to tackle the program of the uninsured. In California, Governor Schwarzenegger has put out his proposal to cover all the uninsured. That is not just children but adults. His Health and Human Services director, Kim Belshey, met with some members of the California Democratic delegation today. So we welcome all comers to this debate. In the county that I live in, the county is working to put together a program for insuring all of its residents as well so this is good news.

But we have a responsibility when it comes to SCHIP. There are many obstacles. We are not creating a new program. I think the reauthorization of SCHIP gives us the opportunity to cast some very important light on it and how we can build on this very important block that is part of the healthcare system, most importantly for our kids.

So thank you for having the hearing. Again, I think it is fitting, Mr. Chairman, that you are starting with children and I look forward to hearing the testimony and then being able to ask some questions. And we will be able to submit questions to our witnesses if we cannot stay for the entire hearing, Mr. Chairman?

Mr. PALLONE. Absolutely.

Ms. ESHOO. All right, thank you very much.

I yield back.

Mr. PALLONE. And thank you. Thank you for those comments, I appreciate it.

I now recognize the ranking member of the full committee, Mr. Barton of Texas.

**OPENING STATEMENT OF HON. JOE BARTON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BARTON. Thank you, Chairman Pallone.

I have a nine page statement. I am just going to submit that for the record to save us all the grief of listening to that.

I do want to say a few things. I think it is very appropriate that you have held this hearing on the reauthorization of SCHIP. This is one of our newer programs. It was created, I believe in 1997 or 1998. And I think people on both sides of the aisle obviously want to reauthorize it. There will be some differences of opinions about what we do as we do that reauthorization. I would hope that we can have a consensus that we should maintain its status a block grant program that is a State-Federal partnership. I do hope that we can refocus that it is a children's health insurance program and really was not intended to be for adults. I think it is going to be obvious that we are going to have to take a look at the formula and how the moneys are allocated between the various States. And we may want to set some criteria above what percent of the Federal poverty level do we expect the States to pick up the funds as opposed to the Federal dollars going above a certain level.

There are broader health issues that impinge on this as we look at our children's programs. And some of the areas that some of our friends on the Democrat side may want to bring into the SCHIP, I think will oppose it within SCHIP but in the broader context we will not oppose at all. I support additional funding for community health centers. I support State high risk insurance pools. I think the President's idea in terms of using some Medicaid funds for health insurance and giving a tax credit to the individual for health insurance as opposed to giving that tax credit to the business is a good idea. And I think small business health insurance pools are a good idea. I hope we can look at Medicaid reform and in the context of that create some sort of a permanent long-term healthcare program for our adults and senior citizens. It would take a lot of pressure off of Medicaid.

So this subcommittee is going to have many, many issues. I have not even enumerated half the ones that need to be discussed but for today we look forward to listening to our witnesses on SCHIP and we want to thank you. I have not received any complaints about the lack of minority witnesses so you have obviously worked well with the minority staff and Mr. Deal and I commend you for that.

On a personal note, I think everybody knows this but Congressman Norwood's funeral is tomorrow afternoon at 2 o'clock in Georgia. There is a congressional delegation if anyone wants to go, they need to alert the Speaker's office and I think we are leaving from the steps of the Capitol at 10:30 tomorrow morning. Charlie Norwood was a member of this committee. He was a member of this subcommittee. I have a letter on my desk dated February 8 from him asking about some issues and his positions. As he was going home to Georgia, he dictated a letter and said that he wanted some things done and it is dated February 8 which is the day he left to go home so we are going to miss him and I yield back.

Mr. PALLONE. Thank you.

Earlier, we had a moment of silence for Congressman Norwood and we expressed our feelings about him but I do appreciate your mentioning that letter and all that he has done for the issue of healthcare and for the Congress in general. Thank you.

I wanted now we will ask the chairman of the full committee, Mr. Dingell for an opening statement. Thank you.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

The CHAIRMAN. Mr. Chairman, thank you and congratulations on your first hearing as chairman of this subcommittee and you have chosen an admirable subject on which to bring to bear your very fine and able talents.

First of all, this hearing is about a critical and straightforward subject, one in which there is a great national need, healthcare for kids. It has been 8 years since this matter was addressed in the committee and it is time that we should take a careful look at it.

The fact is we know how to provide healthcare for children in a cost effective way. Medicaid and SCHIP or the State Children's Health Insurance Program have been remarkably successful programs in this regard. Today more than one in every four children receives healthcare through these programs. This year, the State Children's Health Insurance Program will mark a decade since its enactment. Its success story is that 6 million children are no longer without health insurance but more needs to be done. Today, seven out of 10 uninsured children eligible for Medicaid or SCHIP are not enrolled. We need to give the States the tools and the financial incentives to reach these children. In so doing, we can make significant headway towards ensuring healthcare for children in low and moderate income families.

Now is the time to reauthorize the program and to build on the success which we have seen so far. Many may question whether we can afford to do so, however, the real question is can our country afford not to do it? The President has provided us with a roadmap leading us regrettably in exactly the wrong direction. His fiscal year 2008 budget proposal only preserves one-fifth of the half million children who are expected to lose coverage over the next 5 years. Coverage for pregnant women, parents, and other adults is at risk under his budget as well. The evidence is clear. Covering parents helps increase the coverage of children. We know that providing healthcare for pregnant women improves birth outcomes

and the health and the wellbeing of the child. Providing healthcare now will provide greater benefits down the road and prevent greater costs at the same time.

I look forward to the testimony of the witnesses. They will not only report on what SCHIP has done well but also what can be done better and how we can improve the program. This is important as we focus on ensuring the youngest amongst us will receive the healthcare they need.

I would like to just say a word at this point in the time remaining to me. Charlie Norwood was a very valuable member of this committee. And like his colleagues all across the committee on both sides of the aisle, I was very fond of him. I greatly regret his loss and grieve that we will not have him with us to work with us on important health matters. He was a wise and a good and a decent man and we will pray to God for his soul and for the comfort of his family.

And I thank you, Mr. Chairman. You will note I have concluded in 2 minutes and 5 seconds.

Mr. PALLONE. The gentleman from New Jersey, Mr. Ferguson.

OPENING STATEMENT OF HON. MIKE FERGUSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. FERGUSON. Thank you, Mr. Chairman.

Congratulations on your first hearing as chairman of the subcommittee and thank you also for recognizing the passing of Charlie Norwood who was a dear friend to many of us and a committed public servant and we certainly offer our prayers to his family and friends today.

Thank you also for holding this hearing. I appreciate the opportunity to speak today on an issue that I think many of us can agree on. Certainly all of us can agree that taking care of our vulnerable children in our home States is a huge priority. My home State of New Jersey and one that I share with our chairman has had a SCHIP Program up and running since 1998. And the program currently provides health insurance to some 200,000 individuals. I support New Jersey's program and believe that our work in this committee is vital to ensure that SCHIP services are there for the people who rely upon them.

SCHIP is nearing the end of its authorization. There are many issues we will face as we work to reauthorize the program. The hallmark of the program, the flexibility offered to States to provide a targeted approach to covering children must be maintained, I believe. Proper funding is also vital for State programs to execute their mission. New Jersey has faced a shortfall in funding each of the last 3 years and I want to work hard with others on this committee to ensure that my home State receives the money that it needs to provide this coverage. But most importantly, it remains clear SCHIP is a good program and it must be funded adequately.

I look forward to hearing from our panelists today. I look forward to hearing further panelists in future hearings. Their commentary on what SCHIP is doing right and what can be done to improve the program is vital as we begin this conversation.

Thank you again, Mr. Chairman, I yield back.

Mr. PALLONE. Thank you.

Now we will have an opening statement from the gentlewoman from Colorado, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you so much, Mr. Chairman and I add my congratulations on your chairmanship.

I also want to thank my constituent, Susan Molina for coming out from my hometown of Denver. I apologize we have snow here as well as in Denver. We had hoped to give you some dry weather. But she is a compelling witness and she is the chairman of the board of the Metro Organization for People, MOP, in Denver which is a fantastic faith based community organization. Any time they tell me to show up wherever it is I always do because they do wonderful work.

Mr. Chairman, I think there are three primary issues that need to be addressed in the SCHIP Program; first, ensuring the stability of the program to continue coverage for those already receiving benefits; second, improving outreach to those who are already eligible for coverage but who are not yet enrolled; and third, expanding coverage to those who despite being ineligible for the current program still find access to health insurance difficult if not impossible to attain.

Since SCHIP's creation, millions of children have benefited from the program and many children in some States—adults too, through waivers from the Bush administration, have access to primary care that catches illnesses early and keeps them out of the emergency room. The access to care has a profound positive impact on their health and I think in the end it will save money. But despite the best efforts of States, many children who are eligible for SCHIP are not enrolled. There are several things we can do to fix that. First, I think we need to allow verification for eligibility for one income based safety net program to count for SCHIP as well. That will simplify the process for recipients and also it will be cut down on a significant administrative burden to States and make it easier for children to enroll in SCHIP. We also need to work with States to limit roadblocks to SCHIP coverage.

Something else that I think we need to look at is how we figure out a way to score SCHIP so that we understand the significant savings that preventative care for children can have on our health system. In my district for example, our public safety net system Denver Health provides millions of dollars of care to the uninsured that is covered partially with disproportionate share hospital dish funds through Medicaid. If we could give more kids coverage through SCHIP, then we could take the dish money and focus it on providing care for other serious patients in the hospitals.

So Mr. Chairman, I think that reauthorization of this program will be one of the two or three most important issues that the Energy and Commerce Committee attacks this year. I look forward to starting the process today and I hope that we do reauthorize the program, that we do authorize adequate funding for the program,

and that we do it without delay so that everybody can have the assurance that this program will be there for them and will work.

Thank you.

Mr. PALLONE. Thank you.

Mr. Burgess of Texas.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

And like so many of my colleagues up here, I too will miss Charlie Norwood. He was a friend long before I came to this Congress. He was a mentor on healthcare policy when I was but a simple country doctor and I too will miss him.

Mr. Chairman, I too, will congratulate you for holding this hearing today. The part of me that studies irony cannot help but notice that our hearing on global climate change was closed on account of ice but children are clearly more important and you pressed ahead and had this hearing so I am grateful that you have done that.

And I am encouraged to hear the gentle lady from Colorado talk about what I would call dynamic scoring from a CBO. I agree. I think that is something that we do need to consider. We all know that a dollar spent early in the course of a disease is much more valuable to the dollar spent at the end stage of disease and certainly a dollar spent at the early part of life is going to deliver more value over time.

I agree with our ranking member, Mr. Barton that there is broad support for the reauthorization for this program. And the issue of providing health insurance for uninsured children is indeed critical, particularly in my home State of Texas. And I am eager to hear from the witnesses about ways that we can ensure that SCHIP continues to grow and improve. Overall, I believe the program has been a resounding success but as Chairman Dingell alluded to there is always more that can be done. So I get 7 minutes, great.

SCHIP was created in 1997 to provide health insurance for children from low income families who made too much money to qualify for Medicaid. When SCHIP was created, each State was given three options for program funds: No. 1, enroll more children in Medicaid, No. 2 create a separate SCHIP Program, or No. 3, devise a hybrid program. Both Medicaid and SCHIP are Federal State matching programs but rather than being an automatically funded entitlement program, SCHIP is funded through a block grant with a fixed annual allotment. This means that SCHIP funding does not automatically keep up with rising healthcare costs but it also means that we are not giving anyone a blank check to spend taxpayer dollars and I appreciate that concept as well. No one has ever solved a problem for the Federal Government by simply throwing money at it. We have seen multiple examples of that over the past several years and I certainly hope that we will not be doing that here. We may choose to expand SCHIP but we should also be looking for ways to utilize our existing resources more wisely.

I am particularly interested in how private health insurance may interact with SCHIP. I noticed that Mr. Peterson's testimony indi-

cates that “private health insurance among children has declined, while public coverage has increased.” And that is something that does concern me, Mr. Chairman that we may tend to crowd out or drive out the private sector and I believe the private sector does still have something to offer in the coverage of children with insurance. Also, Mrs. Mingledorff with the March of Dimes recommends that SCHIP be allowed to provide supplemental funds for private insurance and this concept of premium support sounds like an excellent way to help families help themselves and I am sure we all agree that having health insurance is a good thing. And I agree with ranking member Deal that if there were more ways to allow insurance companies to provide an affordable package to more people that that indeed would help with coverage.

With the capped entitlement nature of SCHIP, States must prioritize coverage of the neediest children that Medicaid does not cover. Unfortunately, some States have extended coverage to adults under SCHIP taking limited dollars away from the needs of children to meet—

Mr. PALLONE. Mr. Burgess, I do not know what is going on with the clock.

Mr. BURGESS. You are in charge, sir.

Mr. PALLONE. But I think you have gone over 3 minutes so if you could wrap it up, I would appreciate it.

Mr. BURGESS. I will be happy to wrap it up. I would only say the inequitable development needs to be stopped even one dollar spent on an adult is a dollar not spent on a child. And in my initial remarks, we know that those dollars can go farther. To this end, I have introduced H.R. 1013, the SCHIP Equity Act. This bill would ensure that every SCHIP dollar is spent on needy children and pregnant women. It is only a starting point for these discussions but I believe a necessary one.

Thank you for your indulgence, Mr. Chairman, I will yield back.

Mr. PALLONE. All right, thank you.

I want to apologize. We are trying to work this clock here and hopefully we will do a better job.

So our next member for an opening statement is Mr. Green of Texas. And we are going to start the clock at 3 minutes so hopefully it works.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman.

Before I start, I want to say all of us regret the loss of our friend who served on our Health Subcommittee for many years, Charlie Norwood. And of course, our ranking member, Nathan Deal’s best friend in Georgia and I had the opportunity to get to know Charlie not only on the Education Committee but here on the Energy and Commerce Committee for a number of years. We may have disagreed on some things philosophically but we worked together on so many other issues dealing with healthcare.

Mr. Chairman, it is fitting our Health Subcommittee begin this Congress with analysis of children’s healthcare issue. This is one of the first items on our agenda and the reauthorization of the CHIP Program is set to expire. The SCHIP is critical of our health

safety network providing comprehensive health insurance for more than 4 million low income children who do not qualify for Medicaid. As a part of the reauthorization process, it is clear that we need to provide more funding for SCHIP. In fact, the estimates show that States need between \$12 and \$15 billion in additional funding over the next 5 years to make sure that children currently enrolled receiving coverage from SCHIP will remain on those rolls. That figure does not include or count the children who are currently eligible for the program but not enrolled. And unfortunately, the administration's budget proposes a virtual freeze in SCHIP funding which the administration estimates will need to enrollment decline of 500,000 children.

Mr. Chairman, I have a full statement I would like to put into the record. But during the debate, we need to take a hard look at the actions of States. And SCHIP is important in my own home State of Texas but I would be remiss if not noting that SCHIP enrollment fell by more than 500,000 in 2003 to 300,000 in 2006, while uninsured rates continue to creep up. Too many children are falling through the cracks with two-thirds of Texas children currently in families earning less than 200 percent of the Federal poverty level. There is no excuse for this dramatic decline in enrollment. We should be adding not cutting kids in the SCHIP roles. At the same time, Texas and other State cut CHIP from SCHIP. We unfortunately let SCHIP funds sit in the bank until they are redistributed to other States and reverted back to the Treasury. Texas alone is allowed more than \$850 billion in SCHIP funds be diverted to other States over the last 7 years. I am all for State flexibility but when States use that flexibility to erect burdensome barriers to enrollment at the same time we leave Federal dollars on the table, something has to be done. Since this hearing is a broad overview of the children's health insurance, we should recognize the access problems faced by newborn children. Thanks to CMS's interpretation of the deficit reduction, citizenship documentation requirements. We all know the intent was to ensure that U.S. citizens only receive Medicaid. But the 14th amendment to the Constitution is a right of citizenship, it is a right for children who are born and there is no question and I will repeat, there is no question a child who is born in a hospital in the United States is a citizen of our country. To force families of newborns to produce a birth certificate before they can receive Medicaid coverage only serves to deny those babies the care they need in the early stages of their life. If their births are paid for by Medicaid in a U.S. hospital the Medicaid statute guarantees them automatic Medicaid coverage for the first year of life and Congress should not stand idly by and let CMS administratively dismantle the statutory benefit.

And again, my son had a child, our second grandchild in south Texas in Brownsville, right after Thanksgiving and I can tell you it took 2 weeks to get his certified birth certificate for our grandson. And at the same time in that hospital there were children who were born who maybe their parents were not citizens but those children are citizens because they were born in Brownsville, TX in the United States and I hope our committee will take a hard look at CMS's interpretation of that and I yield back my time.

Mr. PALLONE. Thank you.

And next is Mrs. Capps of California for an opening statement.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you.

I also will dearly miss our colleague, Charlie Norwood. He and I introduced legislation on children's general health not unrelated to the topic before us so this hearing in my mind is in memory of our colleague.

I am so proud that this is our first hearing of this subcommittee in this Congress. I know it is the first step in what is sure to be a challenging process to figure out how we can ensure access to healthcare for every child in this country which after all should be our goal and it is the goal as I know of the legendary Marian Wright Edelman, founder of the Children's Defense Fund. I was also encouraged that during the first days of this new Congress, Speaker Pelosi emphasized that the agenda of the 110th will have as its primary focus legislation which has a positive affect on children. Covering all children is not partisan but too often it is not on the forefront of political debate. After all children do not vote, it is a harder for them to have a voice in Congress, and that is why it is so important that we have this hearing today to set the tone for the work of this subcommittee and affirming our commitment to reauthorizing SCHIP and ensuring that it is fully funded.

I am please to represent the county of Santa Barbara often noted for the soap opera of the same name and wealthy families therein portrayed but the reality is that this county has the highest percentage of uninsured children in California. California offers SCHIP health coverage to working families and their children through the Innovative Healthy Families Program. While Healthy Families has made great strides, the fact remains that 14 percent of all the children in California still are uninsured which is over a million, almost a 1.5 million children. One million of those children live in families with incomes below the 200 percent of poverty level. As a former school nurse, I can tell you that translates into a million children not receiving proper primary care, not receiving dental care, being sent to school sick, suffering from preventable illnesses, unable to learn. Unfortunately, the President's recently released budget proposal will not address this huge challenge. Rather than expand coverage for these vulnerable children, the majority of whom are in working families working hard every day, the President's Budget would result in approximately 285,000 children in California alone losing access to SCHIP at a time when we ought to be expanding it. Curtailing coverage for the adults in those families will only serve to further reduce the number of children who receive proper healthcare coverage and ultimately proper healthcare because if the parents do not have coverage, it is less likely that the children will actually get the care that they may be eligible for.

I am confident that today's witnesses will well explain the need for expanding SCHIP. I am counting on you to do that. I hope you will. And ensuring its viability rather than taking the President's

cues and breaking the program apart. And I thank each of the witnesses for your testimony here today.

And I yield back 13 seconds, Mr. Chairman.

Mr. PALLONE. Thank you.

I now recognize the gentlewoman from New Mexico, Mrs. Wilson.

Ms. WILSON. Thank you, Mr. Chairman.

I ask unanimous consent to participate in this hearing.

Mr. PALLONE. So moved, so ordered.

OPENING STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mrs. WILSON. Thank you, Mr. Chairman.

Like my colleagues, I wanted to recognize Charlie Norwood and not only for his work on healthcare but he was such a good humored guy. Charlie was also a very passionate guy and would speak very strongly on things that he felt strongly about. And more than once I would lean over to him after one of his passionate speeches and say, Charlie, just do not sugarcoat everything. You cannot tell where you are coming from. You could always tell where Charlie was coming from and he will be very much missed on this committee and in this Congress.

I would like to thank you, Mr. Chairman for having this hearing today. SCHIP has been very important for the children of New Mexico. And I was actually the cabinet secretary for Children Youth and Families in New Mexico when the program was put in place by the Congress. And in New Mexico about 20,000 more low income children have healthcare now and health coverage that they did not have before because of SCHIP. I recently joined a colleague of mine, Marion Barry from Arkansas in organizing a bipartisan letter to the House Budget Committee asking for full funding for SCHIP in this year's budget and also urging the reauthorization of the program. It was a joint effort, one of the first joint efforts in this Congress between a Republican mainstream partnership and the so called Blue Dog Democrats. Those were kind of the unofficial groups of moderate Democrats and Republicans and I think it reflects the broad consensus that exists about this program. There were 76 House Members that signed that letter and many members of this committee signed that letter as well and I wanted to thank my colleagues for their support.

These health insurance issues particularly for children should be a bipartisan issue and I think it will be as we move forward here. When we are talking about insurance and particularly preventive care, children should come first. One of the problems with SCHIP from a New Mexican's point of view is that because New Mexico had a very high percentage of children, we had just expanded our Medicaid Program and eligibility for Medicaid just before the law was passed and as a result, we have large numbers of children who are uninsured who were not eligible for SCHIP because of the way the program was written. And we have carried over a large amount of funds from one year to the other in spite of the fact that we have a large percentage of children who are uninsured in New Mexico.

Today I have introduced legislation that parallels legislation introduced by Senator Domenici and Senator Bingaman to allow per-

manently to carryover these funds so that they can be used. This legislation will also help States of Kentucky, Hawaii, Maryland, and Minnesota, New Hampshire, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. I believe we also in SCHIP need to find methods to reach out and get eligible children enrolled because reaching children early, particularly with preventative care makes such a tremendous difference.

And finally, we need to better integrate SCHIP with private health insurance and employer coverage so that there is a seamless transition for children and their families.

I look forward to hearing the testimony here today and Mr. Chairman, thank you again for allowing me to participate.

Mr. PALLONE. Thank you.

Next I would recognize the gentleman from Maine, Mr. Allen.

**OPENING STATEMENT OF HON. TOM ALLEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE**

Mr. ALLEN. Thank you, Mr. Chairman.

I will give an abbreviated opening statement and submit the balance for the record. Like others, I too, will miss Charlie Norwood and all that he contributed to this committee. I want to welcome the witnesses including of course Jeanne Lambrew who is Maine's contribution to sensible rational healthcare policy making in this city.

I just wanted to say a few things about the status in Maine. Thirty-four percent of children in Maine are covered by Medicaid or SCHIP. That is about 15,000 children. Together those programs ensure that otherwise uninsured children have access to regular health exams, preventative screenings, and other essential healthcare services. SCHIP and Medicaid provide a vital lifeline to hired working Maine families who do not have employer provided coverage or are unable to afford the skyrocketing cost of private insurance. Maine is one of the States with the lowest percentage of uninsured children, just 7 percent of children in Maine are uninsured, half the national rate of 15 percent. But that is 19,000 children without health insurance in our State.

As we go forward, we have to find ways to build on the success of this program and ensure that all children have access to health insurance. I think that is going to be impossible if we do not deal directly and quickly with the looming funding shortfalls in SCHIP that will affect 14 States this year, including Maine. We face a Federal shortfall in SCHIP funding of \$6.5 million and that could mean 3,200 children losing coverage this year. Our goal, of course, has to be to move in the opposite direction to cover everyone. And as we think about this issue in the context of all the challenges we face in Congress, it seems to me we have to set our priorities right. And for me, providing America's children with health insurance, healthcare coverage should be at the top of our agenda.

I thank you and I thank the panel for being here.

Mr. PALLONE. I thank the gentleman.

And I now recognize the gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman.

I really appreciate the fact that you are holding your first hearing on this very important topic.

As we discuss and debate healthcare issues, we all too often focus on the problems with healthcare and certainly there are many. But today we are here to talk about a healthcare success story, SCHIP. Simply put, SCHIP is working. It has been effective in providing healthcare for millions of children and families and I am delighted that we are beginning a conversation on how to make this a stronger and even more effective program.

I would like to take a moment to focus on the Wisconsin Program. When creating our SCHIP Program, which we call Badger Care, Wisconsin strongly believed that family based coverage would be more effective than child only coverage in providing health insurance to uninsured children. Recognizing that children are parts of families and recognizing that making the family unit stronger and healthier is a good thing, we chose to include parents in Badger Care from its inception and this approach has worked. Studies show that children are more likely to become enrolled in programs that ensure their parents also. And that has been Wisconsin's experience.

One of the many benefits of SCHIP is the comparative affordability to the Federal Government of covering this population. And I believe that we will hear from one of our witnesses, Dr. Lambrew that it costs the Federal Government about \$1,000 a year to provide healthcare for the average child. Therefore, in reauthorizing this program, I believe we should look for opportunities to expand and improve SCHIP. The status quo is not good enough. It is great that SCHIP is providing healthcare to 6 million children but there are another 9 million who are uninsured. And of course there are another 38 million adults who are uninsured.

I believe that we should also have a thorough discussion about covering young adults. Those groups, that group has one of the highest uninsured rates among all age cohorts. Thirty percent of Americans between 18 and 24 are uninsured. And these young Americans just graduating from high school, leaving home for entry level jobs that often do not provide healthcare or starting up their college careers too often go without healthcare coverage, yet they share many of the characteristics of their younger counterparts and we should consider and thoroughly debate their inclusion in SCHIP.

We have a unique opportunity to make real coverage, real progress in covering the uninsured starting with children and expanding to other populations and I believe we must cease this opportunity.

Thank you again, Mr. Chairman.

Mr. PALLONE. Thank you.

Mr. Murphy of Pennsylvania recognized for an opening statement.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman.

I appreciate that and thank you for holding this hearing.

As a healthcare provider who has worked with children for 25 plus years, these issues of making sure that we are here to help children are extremely important. Every child deserves to have affordable and accessible healthcare and we need to take all the steps necessary to enroll the children who are eligible but not enrolled in the State's Children's Health Insurance Plan or SCHIP.

As the Congressional Research Service will testify, researchers estimate that 62 percent to 75 percent of uninsured children are eligible for public healthcare coverage. Almost half of low income parents believe that their children are eligible for affordable healthcare coverage and 80 percent stated that if they would, they would enroll if they were told so.

SCHIP is a program that has a great deal of success and it can be even more successful. We need to take the steps necessary to cover all those children that are not yet enrolled in the program. For example, States could use information technology to link Medicaid and SCHIP eligibility enrollment data, the school lunch enrollment data, and other databases to increase enrollment, or we can simply be doing a lot more with providing public information to get kids signed up.

With limited available Federal funds, the priority and congressional reauthorization, SCHIP should focus on America's children caught in between the eligibility for Medicaid coverage and those whose families cannot privately pay for health insurance or afford coverage through their employer. Our priority must be to identify the uninsured children by age and income so we can target healthcare coverage programs to lower the number of children without health insurance.

Thank you, Mr. Chairman for holding this important hearing and I look forward to hearing from the various people testifying today and here about the potential for helping our Nation's children.

Mr. PALLONE. Thank you.

Now is Mr. Matheson of Utah.

OPENING STATEMENT OF HON. JIM MATHESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. MATHESON. Well thank you, Mr. Chairman for holding this hearing.

My wife is a pediatrician. She has had patients who are covered by CHIP and so when I am at the family dinner table, I have had many conversations that have talked about the value of this program. And it is easy to focus on numbers and numbers are important and we have talked about a lot of numbers during these opening statements. But I do not think we should lose sight of the fact of what it means to every individual child who has access to healthcare and what it means to them in terms of their quality of life and their opportunity to succeed in so many ways in life. The title of this hearing is through the eyes of a child and I think that is appropriate that the chairman chose that.

I also think it is appropriate for us after this program has been around for a few years, this is a good time for us to take a look at it and to really scrub it and look through and see what works because it has been a success in so many ways and ways we can all try to make it work better. I think we all share that even in a bipartisan way.

I am glad we have kicked off the first hearing of this Congress for this subcommittee on this issue and I look forward to being actively engaged in it today and look forward to hearing the testimony today.

I yield back the balance of my time.

Mr. PALLONE. I thank the gentleman.

I now recognize Ms. Solis of California for an opening statement.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman and congratulations on holding this first hearing on the uninsured through the eyes of the child.

And today on Valentine's Day, I think we should remember our children and ensuring that they lead happy and healthy lives. And we can start by the discussion on SCHIP by the reauthorization.

One of the issues that I care most about is the healthcare and wellbeing of children in my own district. About a third of that population in my district is uninsured. Many of them for the first time benefit or have benefited from SCHIP. Many, however, do not. I would say one-third of the population there in my district have no form of healthcare insurance; a large proportion are from families of low income working class and speak predominately one language, Spanish. Many of them have barriers before them in terms of accessing healthcare.

I hope that the discussion on SCHIP will help advance opportunities for expansion of the program making it available to people in culturally and linguistically competent manner and by using non-traditional methods such as programs known as Aformatoras which is existent now. These are I do not want to say social workers but advocates in our community that are not paid very much and many do this on a volunteer basis but provide information, preventative information, education, and assistance in enrollment in SCHIP and in other programs so vitally needed and necessary for these at risk populations. I hope that that discussion will take place as we look at reauthorizing SCHIP.

Within the State of California, we have seen many successes where this program has really helped to go very far for a working family of maybe four where the average costs on a monthly basis to cover four children is \$27. That is a bargain. We need to continue to expand the program and we need to encourage our Governors from our various States to look at this program in a different way and to draw down this money and to be forward looking and thinking about how we can cover and expand the program not just for the children but also as my colleague, Congresswoman Tammy Baldwin spoke about those individuals that are working as well 18 to 24 years of age. Many of them in my district are emanci-

pated minors in the foster care program. Many are low income, underrepresented students and children that are also looking for a way, not a handout but assistance. And I think that SCHIP can do that.

Los Angeles County has had its problems with administering healthcare and access to many. It is a community and count that continues to grow. We are somewhat viewed as a magnet because so many people come there and it is hard to turn away folks but we know that there is an obligation there on the part of our leaders there to provide assistance. And SCHIP is one of those solutions. So I hope again that the discussion will continue and that we could see expansive and new opportunities, innovative opportunities to bring in more services for those that are currently not enrolled in the program through non-traditional methods.

So I yield back the balance of my time.

Mr. PALLONE. Thank you.

Ms. Schakowsky from Illinois.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

This is my first hearing on the Healthcare Subcommittee. I am happy to be here and I congratulate you on your role.

I wanted to extend my welcome to Ms. Paz Mingledorff and Ms. Molina for their willingness to come before us today to talk about their personal experiences, the problems that they have had with their children. Putting a face on these issues is always very, very effective and most important.

We are going to hear from some who argue today for limits for drawing lines between children and families as we authorize SCHIP. Some will say that we should cut off eligibility at the 200 percent of poverty level but I think that would set an arbitrary line. Families with income on one side of that line would get assistance but those with incomes even one dollar above it would not. Families above 200 percent of poverty would be on their own even if a basic insurance policy would take about 30 percent of their income or more if one of their family members happens to have an ongoing health need. And there are some who will argue that we cannot afford to cover adults, despite the ample evidence we have that not covering parents results in reduced coverage of children and lowers their use of healthcare services. They would draw their line down the middle of a family.

And there are some who argue that we should distinguish between children, immigrant children on one side of the line and citizen children on the other. Even immigrant children born in U.S. hospitals who are automatically citizens under our Constitution as Mr. Green pointed out are now being subjected to documentation requirements and yet all of these children will grow up in America and represent our future.

Many of those who argue that we cannot afford to expand SCHIP point to the budget constraints. And I agree that we have to restore fiscal responsibility to the Federal Government. And I ask how is it responsible to pass tax cuts, to provide the wealthiest 1 percent of Americans with an average annual tax cut of \$146,000 while de-

nying SCHIP to a family with \$34,500 in income. Our country has the resources to provide healthcare to our children. It is only question of priorities.

And Mr. Chairman, I look forward to this, to our witnesses today. Thank you.

Mr. PALLONE. Thank you.

Ms. Hooley of Oregon recognized for an opening statement. Thank you.

OPENING STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Ms. HOOLEY. Thank you, Mr. Chairman for holding this hearing.

The SCHIP reauthorization is one of the most important pieces of business Congress will take up this year. I am very excited to work on this because the creation of SCHIP was one of my first big bills I worked on as a Member of Congress 10 years ago.

By any measure, SCHIP has been a success. Since its inception in 1997, it has provided health insurance coverage to millions of children. In addition, it has led to improvements and increased participation in Medicaid. These two programs together have reduced the uninsured rate of low income children by one-third. If a program can produce those results in just 10 years, imagine what it can accomplish in the next 10 years.

I think we can credit the success of SCHIP to strong relationships between the Federal Government and States generous matching rates, flexibility for State programs, and strong support by Congress to provide health insurance to our children.

On Friday and yet today I met with a group of healthcare providers and we talked about SCHIP and they all agreed on four points. One was to reauthorize the program, it had been successful. Two, that we would save money if we simplified enrollment. Three, that we continue to give States the flexibility, and four, that we fully funded or funded as high a level as possible.

But when I talk about an issue, I like to talk about a face because that is what I see in any policy is a face. So I want to talk to you about the face I see and that is Caitlyn. She is a 6-year-old from Corvallis. If you visit her home on any of her bad days and listen to her try to breathe, you will understand that Caitlyn suffers from a chronic respiratory ailment. She is one of State's 1,117 children without healthcare coverage. Her hardworking parents make a little too much to qualify the family for our State's Oregon Health Plan which is funded by Medicaid dollars. But far too little to enable her dad to afford the \$520 a month it would cost for the insurance his employer offers. Caitlyn has been ill for several days with asthma-like symptoms that have plagued her since birth. Finally after a night of trying to help her stop coughing, Nicole and Alan, her parents considered their choices. Without insurance, the couple had no doctor, no advice nurse they could call, no emergency room they could afford but they knew that every Monday the Benton County Health Department offers pediatric services for low income families and for the family the fee would be \$30. So that became the plan. They would take Caitlyn to the county clinic Monday, 3 days away, by Sunday though Caitlyn was worse. Through tears she complained her sides hurt. Her parents went through

some rough worrisome hours trying everything they could to think of to relieve her misery. When Monday finally arrived, it did not take the pediatrician long to diagnose Caitlyn's illness pneumonia. She had probably had it for a week or longer the doctor said and urgently needed antibiotics. The diagnosis rocked her mother and dad. They felt guilt over their limited access to healthcare for their children and they felt bitterness over the fact that if they had been able to afford insurance, Caitlyn would have been spared hours of suffering and needless risk to her health.

This story answered my question about how important expanding access to SCHIPS is. The CHIP Program is currently the most efficient way to provide critical healthcare to our children who do not qualify for Medicaid.

And again, Mr. Chairman, I am thankful that we had this hearing today and that this was my first one about SCHIP. Thank you.

Mr. PALLONE. Thank you.

I want to recognize next the gentleman from California but if I could just mention that he was the last Democratic chairman of the subcommittee and I just want to recognize that fact if you will. The gentleman from California, Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman, I appreciate that acknowledgement of my historic role and I must say how pleased I am to see you as Chair of this committee. And also to acknowledge the fact that our very first hearing of this subcommittee is on children's health. It reflects the kind of priorities that I think are important for this committee.

And as I listen to colleagues on both sides of the aisle, I hear a sense of bipartisan support for a program that has done a lot of wonderful things for children in this country. There can be no doubt that we made important strides in providing healthcare coverage through Medicaid for the children below the poverty line and under SCHIP for those who have modest means. And between these two programs, we have provided coverage for more than 30 million children. Well that is good for the children. It is good for this country. They are all going to be benefiting from this expenditure throughout their lives and it is just the right thing to do.

But the sad fact is that we really are not doing enough and I hope that we can keep that in mind when we start passing legislation. We have over 9 million uninsured children in America. And the fact is that two-thirds of them are eligible for either Medicaid or SCHIP but we are not providing sufficient funds for the States to find and cover all the eligible children.

Well making sure that we have a strong SCHIP and Medicaid Program is a no brainer. And I am just stunned when the President proposes a budget provides significantly less than half the funds that would be necessary to keep the kids we already have covered in the program. Secretary Leavitt tried to defend this with the incredible statement that program coverage would only drop about 400,000 people or so. Well I think that is unacceptable when

we know we can be covering more children, we ought not to be talking about covering less.

I also find it amazing to hear people talking about a ceiling of 200 percent of poverty on the income level for eligibility for SCHIP. And it is also amazing to hear people say it is terrible that some of these SCHIP Programs run at the State level decided to devote some of their funds to covering the parents. How do you think we are going to ever reach these kids if we do not also cover the parents? And those parents are part of the 47 million uninsured in this country. They are not going to fix what is wrong with SCHIP by dropping income eligibility levels, cutting off coverage of parents, or any other uninsured people.

We need to devote the money for this effort. It is one I hope we can do together on a bipartisan basis and I am so pleased that this is your very first hearing and I salute you in selecting this issue for reflecting the priorities that I hope are to come out of this Congress.

Mr. PALLONE. Thank you, Mr. Waxman.

And last but not least we have Mr. Engel of New York recognized for an opening statement.

OPENING STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. ENGEL. Thank you, Mr. Chairman.

When it gets down to me, I think of the old adage where that everything that has needed to be said has already been said but not everyone has said it but I will try to say a few things that are important to me.

I want to first of all start by as my colleagues did by saying how much we will miss Charlie Norwood and what a good member of this subcommittee and committee he was. And he certainly has a legacy that we will remember him for the Patient's Bill of Rights and other things that he passionately fought for. And I am privileged to have been his colleague.

Mr. Chairman, thank you for convening this important hearing on expanding children's health coverage. The reauthorization for the State Children's Health Insurance Program is unquestionably in my opinion one of the most important bills we will pass this year.

I am proud that my home State of New York has been one of the true success stories in getting more children covered through the State Children's Health Insurance Program. New York operates a separate stand alone program under SCHIP called Child Health Plus and as of December 2006, nearly 400,000 children were enrolled and receiving comprehensive healthcare coverage in the program. As the third largest SCHIP Program in the Nation, New York reduced the number of uninsured children in the State by 40 percent and we are only one of seven States to achieve a decline of that magnitude. Our SCHIP Program has increased enrollment by over a quarter of a million children since the start of SCHIP which is 150 percent increase. And New York State's aggressive SCHIP outreach has contributed to a nearly 30 percent increase in children enrolled in Medicaid.

Nationwide, Medicaid covers over 28.3 million children and SCHIP covers an additional 6.1 million kids. Despite this coverage, 9 million children, 60 percent of whom live in a household with at least one adult working full-time remain uninsured. It simply makes economic sense to cover the uninsured. When we fail to provide our children with primary and preventative care, routine health problems compound into emergency conditions. Improving coverage reduces racial disparities, unmet needs, and the continuity of care gained is particularly important for managing chronic conditions. The need to appropriately monitor and treat chronic conditions is something I am all too familiar with. Pediatric asthma is the most common chronic illness and unfortunately children living in the Bronx where I am from, have an extremely high prevalence of asthma. Ensuring asthmatic children have comprehensive healthcare makes an unimaginable difference in the number of emergency, hospital visits, missed school days, and basic quality of life. It is money re-spent, well spent.

Reauthorizing the State Children's Health Insurance Program provides us with a great opportunity to strengthen and reform it to cover even more children. As has been mentioned by many of my colleagues, sadly the President's budget released this month prevents this goal from becoming a reality. The proposals within the budget strike at the foundation of patient care, assaulting it in my opinion from every possible angle. The Children's Health Insurance Program will see its funding cut from last year and worse the amount allocated for its reauthorization is less than one half of the amount required to maintain coverage for current beneficiaries.

Let me conclude by saying that I look forward to the testimony today.

And I commend you, Mr. Chairman for focusing on this important program.

Mr. PALLONE. Thank you, Mr. Engel.

Now that concludes the opening statements by members of the subcommittee. I would ask the panel to come forward and take your seats there at the table.

On the first panel we have Dr. Jeanne Lambrew who is associate professor at George Washington University; Ms. Kathy Paz Mingledorff who is a mission volunteer with the March of Dimes; Mr. Chris Peterson who is a specialist in social legislation with the CRS; Ms. Susan Molina, community leader with PICO of Colorado; Ms. Nina Owcharenko, senior policy analyst with the Center for Health Policy Studies at the Heritage Foundation; and finally Jay Berkelhamer who is the President of the American Academy of Pediatrics.

We have 5-minute opening statements from the witnesses. Those statements will be made part of the hearing record. Each of you may in the discretion of the committee submit additional briefs and pertinent statements in writing for inclusion in the record. And I am going to start with Ms. Molina from PICO of Colorado for an opening statement.

**STATEMENT OF SUSAN MOLINA, COMMUNITY LEADER, PICO,
DENVER, CO**

Ms. MOLINA. As you heard, my name is Susan Molina. I am the Board Chair for the Metro Organizations for People in Denver, Colorado. MOP is also a part of the PICO National Network. We are a faith driven I like to say community organization. We work to empower people on real issues that affect our families, our communities every day.

Oddly enough I am not nervous about this because I am here today not to speak to you as a Board Chair, but really as a mother. And I want to just give you a face to my pain. I married very young, at 17, to a very abusive man. He walked out on us when my children were 5 and 3. And I was working in a dead end job cleaning. No one ever grows up saying I want to be a cleaning lady but that was the reality of my life. I was stuck. And when I met MOP and began to work with PICO, my life started to change. I learned that it was OK to face the reality of where I was but knew that I had to better myself and could do that. I got my GED. I have also taken classes at the university and I am now taking a new job. I went from cleaning the building to managing it and I think that is important to say because I feel like somehow I feel like my family is now punished because I have worked hard and I have done better for the family and now my children are not eligible for SCHIP. We are between the 200 and 300 percent of poverty level.

And I want to say that when I was preparing to come here, this became all too real when my children got sick last week and they had the flu and I had wait to see if they needed to go the doctor or not because they do not have insurance. I cannot just take them to the doctor and waive a card and say my kids need to be seen, I have to wait and see if they were going to get worse. And I want to say that we work. We are working families, the ones that are on SCHIP and that is important to say because we want to be able to pay our premiums. We want to be able to take our children to the doctor.

When we talk about 9 million uninsured children, these are real children that have accidents, that get sick, whose parents cannot afford to take them to the hospital. It is hard. I am asking you as a parent to please reauthorize SCHIP and also fully fund it because we are going to lose so many children if we do not fully fund this program.

Through MOP and the work at PICO I have realized that my experience is not unusual. Throughout our network we have surveyed thousands of families and have heard such sad real pain around this issue. In my State, there are 176,000 children that are uninsured. Our State has one of the highest uninsured rates in the country. But for the first time, things are starting to change in Colorado. In 2005, Colorado spent their full allocation of SCHIP money. And MOP in PICO Colorado we are working hard with other healthcare organizations to change State policy to enroll eligible children and expand coverage. And I am happy to say that God has given me the boldness to be here today and the courage because again this is a very hard issue.

PICO is advocating a roadmap to cover all children by 2012. This roadmap has five steps to cover all children. One is to fill the exist-

ing SCHIP shortfalls that face our States; two, fund proof an outreach program to provide States with financial incentives to cover all eligible children; three, to provide financial support and incentives for States to expand the eligibility; four, to allow States the option to cover legal immigrant children and pregnant women; and five, to provide approximately \$50 to \$60 billion in SCHIP and Medicaid financing to support the costs of covering newly enrolled children.

I really just want to point out and again thank my own Congresswoman DeGette for her leadership in working hard to cover all children. On March 7, we will be back on Capitol Hill with 400 other parents and clergy members for a PICO Faith and Family Summit. We would love to have all of you there and that will be at 8:00 to 9:00 a.m. And we will definitely have some information. I come here with my children on my mind. It breaks my heart to know that so many other families need to make hard decisions every day on whether to put food on the table or buy healthcare coverage. It would take me \$200 to \$300 to insure my children with private insurance. I do not have that. That would take away from other things. That is 2 weeks worth of groceries. How can we not work hard to cover our children? We work hard. We are hard working parents. I am a single mother and I am proud of that. And because I am so proud that is why it makes it so difficult but we must, we must work together to reauthorize SCHIP and we must find those funds to be able to expand this program because there are going to be so many other families that have to make hard decisions.

[The prepared statement of Ms. Molina appears at the conclusion of the record.]

Mr. PALLONE. Thank you so much. Thank you really for being here and for sharing all of your concerns. I appreciate it.

Dr. Lambrew.

STATEMENT OF JEANNE M. LAMBREW, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH POLICY, THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND SERVICES, WASHINGTON, DC

Ms. LAMBREW. Thank you very much for having me here today.

My role at this hearing is going to be to try to summarize what we know about the value of public investments in children's health. I am sorry, and to that end, I would like to make three points. First, health coverage for children does improve access of care, health outcomes, and the prospects for children and their families; second, the short run budget costs of covering more children is worth it in the long run for our Nation; and third, the design of the Federal investment in children's health coverage matters. Specifically, some of the block grant features of SCHIP have limited the program's success and should be modified in reauthorization.

But to begin, health coverage is the portal to our healthcare system. It removes financial barriers, the seeking, obtaining, and adhering to healthcare. It prevents the cost of essential healthcare from bankrupting individuals and families. And it ensures that access to the finest healthcare in the world irrespective of income. As such, children who do not have health coverage are at risk. They

are five times as likely to have unmet health needs compared to children in Medicaid and with SCHIP. Uninsured children are 40 percent less likely to receive medical attention for serious injuries. And children without coverage are less likely to receive immunizations against preventable childhood diseases.

Access to healthcare matters because it contributes to the health of children. Sadly, the wealthiest Nation in the world is not the healthiest especially when it comes to its children. In 2004, the United States ranked 35th for mortality behind Korea and Cuba. Our immunization rates while high are below those of Thailand and Poland among others. But programs like Medicaid and CHIP can improve children's health. Increases in Medicaid eligibility have contributed to reductions in child mortality after the first year of life. Insured children with congenital heart problems are one-tenth as likely to die in their first year of life as children who are uninsured. Uninsured children with asthma have about half as many attacks that are severe as children in Medicaid and CHIP.

The benefits for families go beyond though this health impact. It improves the peace of mind and financial security of families. One hospital stay for a child with pneumonia can cost \$8,000. The total healthcare cost of childhood asthma in the U.S. is about \$6 billion. It also improves children's ability to learn. Unaddressed health problems result in lower school attendance. In 2004, asthma alone accounted for an estimated 14 million lost school days among children. Failure to address recurrent ear infections among children reduces their ability to communicate, their school readiness, and their performance. And the unmet mental health needs among adolescents can have lifelong consequences.

In summary, health coverage is as essential to nutrition and education in the development of children. So given these benefits, the next question is how much does it cost? Well, based on Government projections, the estimated average spending per child next year will be about \$2,900. That is about 40 percent below what we pay for our young adults, about one-seventh of what we pay for seniors. Of this, about 35 percent is publicly financed. This is nearly half the proportion of the health spending for seniors that is publicly financed. There is also the lower than the share of education as publicly financed. In dollar terms this translates into about \$1,000 per child for healthcare costs less for the Federal Government because States kick in some money, too.

So is this public investment worth it? No cost benefit analysis exists to put the value of children's coverage into dollar terms. However, some comparisons can help put this into perspective. This \$1,000 per child is less than the cost of a day in the hospital or less than the cost of year's worth of medication for chronic illness. It is a fraction of what we spend per person in the last year of life. And the long-term benefit could far exceed the short-term costs of investing in children's health. One of the most distressing studies in recent years found that for the first time in over a century our children's life expectancy may be less than our own. This is primarily because our children are not as healthy, the obesity epidemic is taking its toll, and not surprisingly poor child health now could drive major Medicare costs later. This suggest that not only

is the current investment in children's health coverage worth, but it may not be enough for our long run needs.

As we look at the proposals in front of this Congress, some would suggest a real reduction in the public investment in children's health coverage. As some of the members have mentioned, the President's budget proposes to spend only about a billion dollars more per year for coverage of children. This amount according to some experts is not enough to maintain coverage. In other words, the programs may have to be scaled back, the uninsured could increase. Now this clearly will reduce the Federal costs for children but doing so is not necessarily free. It would mean increased costs to States that cannot morally scale back on their coverage for children. It would increase private health insurance costs as costs are shifted from uninsured kids to privately insured families. Families themselves would pay the cost of the care for their uninsured children and that cost may be higher because delayed care often is more expensive care and ultimately the children themselves would bear the greatest cost in the form of preventable suffering and limitations of their lifelong prospects.

So I will close by saying that I urge you to think broadly about the value of coverage when you are looking at these budget numbers not just the dollars and cents and the CRS score.

Thank you.

[The prepared statement of Ms. Lambrew appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Dr. Lambrew.

Mr. Peterson.

**STATEMENT OF CHRIS L. PETERSON, SPECIALIST, SOCIAL
LEGISLATION, CONGRESSIONAL RESEARCH SERVICE**

Mr. PETERSON. Chairman Pallone, Mr. Deal, and members of the subcommittee, thank you for the opportunity to testify about characteristics of uninsured children.

I will begin with current estimates some of which has been cited already of children's health insurance and how they have changed over time. Despite the potential benefits of coverage, millions of uninsured children are eligible for public and private coverage. I will conclude with some reasons why this might be the case and what options might be available. The latest estimates from 2005 indicate that there are 47 million uninsured people in the U.S., 9 million of who are children. More than half uninsured children are in a two parent family and most had a parent who worked full-time all year. Between 1996 and 2005, the percentage of children who were uninsured has fallen by 30 percent, in spite of declining enrollment in private coverage. Children's uninsurance has fallen because the drop in private coverage was more than offset by increases in public coverage. However, some of the detail gets lost in these national numbers. As presented in my written testimony for some of the largest groups of children, private coverage did not decline significantly between 1996 and 2005, but among each of these groups public coverage increased and uninsurance dropped.

The overall simultaneous decline in private coverage and increase in public coverage raises questions about the extent to which these changes are linked, particularly as eligibility was extended

up the income scale through SCHIP. Researchers' estimates of this effect vary widely. Moreover, even for children enrolled in public coverage with access to private, it is unclear whether in the absence of public coverage these children will be insured or not. Among currently uninsured children, 42 percent have access to coverage through their parents' employer. Researchers also estimate that 62 percent to 75 percent of uninsured children are eligible for public coverage. Since employer sponsored and public coverage both tend to be heavily subsidized, why would so many children eligible for coverage not be getting it? Some suggest there may be a lack of awareness, particularly for public coverage or that parents have perceptions of public coverage and the enrollment process that prevent them from seeking it. Among parents of low income uninsured children half believe their children are eligible for public coverage yet their kids remain uninsured.

There is still the cost of coverage in private as well as, public coverage. Public coverage is not always free in terms of enrollees' obligations. About 30 States have premiums or enrollment fees in their CHIP Programs for example. And in private health insurance, the cost of family coverage can be quite large. The latest estimates are that the total premium for family coverage through one's job is \$11,500 with workers paying \$3,000 of that. This employee contribution is nearly five times the amount required for single coverage.

Research by the California Healthcare Foundation looked into why higher income uninsured individuals were uninsured. Only 16 percent were considered "cost constrained". That is the individuals believe health insurance is very important but say they would not buy existing products at their current prices. For most of the higher income uninsured, this research found that "health insurance did not rank high as a spending priority". But in terms of children's health insurance, research as Dr. Lambrew has noted has found that health insurance is important. Not only as a bill paying mechanism for when the kids get sick but also because it helps establish a regular source of healthcare such as a physician who knows the child's healthcare needs.

Children with health insurance are more likely to have a regular source of care and therefore have better health outcomes than those without health insurance. This might suggest a need for outreach that goes beyond informing parents of the availability of coverage but also educates them about the benefits of coverage.

In light of the number of uninsured who are eligible for coverage besides the multitude of existing carrots to entice people to enroll, States are beginning to seriously consider sticks as well. For example, Massachusetts residents who are not enrolled in coverage may be subject to financial penalties from the State. But some of these efforts raise questions about the role of States versus the Federal Government in terms of the regulation and financing of public and private health insurance. In addition, the estimates of the uninsured will also depend on the length of uninsurance one is talking about. Although 9 million children are estimated to be uninsured at a given point in time, a smaller number 6 million are estimated to be insured for the entire year. And if you look at the numbers who were ever uninsured during the year even for a day, the estimate

is much larger 15 million. The options that emerge will then depend on how policymakers decide how to reconcile these competing issues and interests.

[The prepared statement of Mr. Peterson appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Mr. Peterson.
Dr. Berkelhamer.

**STATEMENT OF JAY E. BERKELHAMER, M.D., PRESIDENT,
AMERICAN ACADEMY OF PEDIATRICS**

Dr. BERKELHAMER. Yes, thank you Chairman Pallone for the opportunity and Mr. Deal and other members of the committee.

I am a pediatrician from Georgia, Mr. Deal and I know there have been many comments made already but the citizens of Georgia have lost a great child advocate and we just would join you in your remembering and being very fond of his contributions and thank you.

I am the president of the American Academy of Pediatrics. I am a general pediatrician and I have devoted the last 40 years of my career to the practice of caring for children. And I am pleased to comment on behalf of the American Academy of Pediatrics about the future for the Children's Health Insurance Program. It is a program that has been a resounding success. It has been a spillover as well in terms of identifying additional children who are qualified for the Medicaid Program and they have also been enrolled. The eligibility determination processes have been simplified and coordinated between SCHIP and Medicaid and it has become increasingly ineffective as a two part program. Despite the program's widely acknowledged success and popularity, several outstanding challenges have been identified by participating pediatricians and these challenges pertain to funding, ease of enrollment and benefits related under the program. And I want to just make a couple comments about each of those.

In terms of the funding, SCHIP is a block grant which creates some inherent problems. Because the funding is capped, children have been denied services, waiting lists have developed, and predictability of care is compromised. My own State of Georgia is struggling with that issue right now. Congress should strengthen its commitment to the Federal State partnership that has lead SCHIP and Medicaid success over the last decade. There should be a minimum of \$12 billion a year more over the next 5 years in the new SCHIP reauthorization providing SCHIP and Medicaid funding to be able to assure that the children who are eligible for this program can be included. And as was mentioned in some of the opening statements, we have the potential with existing eligibility to cover 6 million of the 9 million children who are currently uninsured. We are almost there. All children have to have health insurance. We have got to get there as a Nation but this would be an extraordinary positive step to include 6 million of the 9 million children who are not insured.

In terms of payment, one of the things that is an important problem with both the Medicaid and SCHIP is the low rate of payment. The low rates of payment seriously impede access to quality care for many children. Pediatricians are forced in many parts of the

country to limit the number of patients they see and some cannot even pay their office overhead when the number of children coming to their office are in SCHIP and in the Medicaid Program. On average across the Nation, Medicaid reimburses at only 69 percent, roughly two-thirds of what Medicare reimburses at. And only 56 percent of what the rates are for commercial insurance. The Academy requests that payment rates for pediatric services be at least at the same level as Medicare giving children the access to the program on an equal footing that they deserve with all other children.

In terms of extending eligibility and enrollment, beyond the payment rates, it is also important to raise the issue of enrollment barriers. And the implementation of SCHIP has had the added benefit as I mentioned of encouraging Medicaid enrollment and I just want to make comment though about the unintended consequences of the Deficit Reduction Act. And I am sorry, Mr. Green left because when he made his statement I wanted to say yes, we have seen that problem. And in my own State of Georgia, it has been documented now that over 100,000 eligible children have been dropped from the roles since these regulations were put in place. And there is similar situations I understand in Kansas, Wisconsin, and Virginia. And these children are not illegal, but they are citizens in poor families who are simply finding it too difficult to meet these requirements in a timely manner. And this state of affairs needs to be corrected and it is really unacceptable.

In terms of benefits, the need for vision, dental, mental health services do not disappear with economic changes and economic circumstances. Children in States with stand alone SCHIP Programs are not guaranteed these services and they should be. Every child needs comprehensive health insurance, age appropriate benefits. The benefits for children really need to be programmed to children. Only one out of every hundred children throughout their entire childhood ever requires catastrophic care. They all create preventative care. They all require preventative care.

So in conclusion, there is a proud history over the past 10 years. We can build on it. We can cover 6 million of the 9 remaining million children and that the AAP stands ready to work with you and supports fully this program.

Thank you.

[The prepared statement of Dr. Berkelhamer appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Doctor.

Now we have Ms. Owcharenko.

STATEMENT OF NINA OWCHARENKO, SENIOR POLICY ANALYST, HEALTH POLICY SYSTEMS, THE HERITAGE FOUNDATION

Ms. OWCHARENKO. Good afternoon, Chairman Pallone, Ranking Member Deal, and members of the subcommittee. I am senior policy analyst at the Heritage Foundation and I appreciate the opportunity to testify before you today on the subject of uninsured children.

Healthcare coverage for children is critical. Without it, children suffer and society pays. Children without coverage often seek care in an inefficient and costly manner. Today's healthcare system has

it shortfalls and policymakers should consider ways to improve coverage options for children and their families.

Like adults, the vast majority over 60 percent of children obtain coverage through the employer based system. Twenty-seven percent receive care through the Medicaid and SCHIP Programs and an estimated 11 percent of children are considered uninsured. However, it is important to note as was already discussed there are a variety of ways of counting the uninsured. The most common figure used is based on a specific point in time however, other calculations include measuring uninsurance for the entire year and uninsurance at any point during the year. In considering duration of uninsurance, children typically have shorter periods of uninsurance than adults. Interestingly, by age group and was also noted in opening statements, children have the lowest rate of uninsurance than most all other age groups except those 65 and older. And adults between the ages of 18 and 24 have the highest with about 31 percent.

By family income, the majority of uninsured children are among lower income families. But the largest growing segment of the uninsured is among middle and upper income families. By family work status, the majority about 68 percent of uninsured children are in families with a full-time full year worker. Only 17 percent of the uninsured children have no family member working.

There are obstacles to existing coverage. The current patchwork system of public and private coverage does not work for everyone including children. In the private sector, not all workers or their dependents have employer based coverage. Some are not offered coverage. Some may not qualify for employer coverage and others simply choose not to participate. Moreover, coverage outside the place of work can be expensive depending on the State. Some well intentioned but costly State regulations can make coverage unaffordable to many families, especially lower income families.

In the public sector, while there are significant numbers of children who qualify for public programs, a good number still do not participate. First access to quality care is a concern. Fewer pediatricians are accepting new Medicaid patients. Second, these programs are fiscally draining State and Federal budgets. The entitlement financing structure of Medicaid for example is the largest State budget item consuming more than education, transportation, and other State priorities. Finally, public program expansions crowd out private coverage for families. Recent analysis estimates that the crowded affect of these public program expansions to be about 60 percent.

Strategies for addressing the shortfalls of the current system should consider children but should also improve the system as a whole. For the private sector; one, fix the tax treatment of health insurance to ensure everyone gets a tax break for purchasing health insurance; two, promote private sector alternatives for those without employer based coverage. For the public sector; first add greater choice for enrollees including enabling them to use public funds as a way to mainstream them into private family insurance. This is especially important in SCHIP; second, adopting more patients that are model that expands personal control in the healthcare decisions for those enrolled in the public programs.

Finally, a solid case can be made to encourage States with Federal guidance and assistance to tackle these issues on their own. There is great diversity among the States. A federalism approach may be the best way suited, best suited way to address these variations.

Thank you for your time and I look forward to the discussion.

[The prepared statement of Ms. Owcharenko appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you.

Next we have Ms. Mingleorff. Now I understand those are your children over there?

Ms. MINGLEDORFF. Yes, they are.

Mr. PALLONE. They have been so well behaved. I was thinking about when mine were that age they would never sit there. In fact, I think there was one time when I brought them to a Whip meeting and I served them a muffin and my son threw the muffin at Congressman Bonior who was conducting the Whip meeting.

Ms. MINGLEDORFF. I have had great help with the March of Dimes staff there.

Mr. PALLONE. Well thank you.

**STATEMENT OF KATHY PAZ MINGLEDORFF, MARCH OF DIMES
FOUNDATION**

Ms. MINGLEDORFF. And good afternoon, Mr. Pallone, Congressmen and Congresswomen.

My name is Kathy Mingleorff and I am pleased to be here to testify as a mother and volunteer of the March of Dimes Foundation. I understand in a very person way the importance of health insurance for women and children and thank the members of the committee for making access to coverage the focus of the hearing. A longer and more complex statement will be submitted for the formal record.

Let me begin today by telling you my family story and specifically why Medicaid and FAMIS, Virginia's State Children's Health Insurance Program SCHIP, have been so important to us. In 2001, I became pregnant while in college and was covered by my parents' private health insurance. But after my son was born, I was no longer a student and I lost my coverage because I was no longer a dependent. My son, Alex who is here with us today was born prematurely at 25 weeks and suffered many complications due to his early delivery. Fortunately, Medicaid was there to provide health insurance for the first 3 years of Alex's life. We had help through Medicaid with Alex's enormous medical bills over \$800,000 in the first 2 years alone. And I have attached to my testimony a handout listing some of my son's medical expenses.

Had it not been for the support, I am not sure how we would have survived. By the time Alex was 2, complications associated with his pre-term birth required a feeding tube, special formulas, and multiple medications. We took Alex to the emergency room many times and he was hospitalized on over three occasions. In January 2005, Alex had surgery to stabilize his reflux condition. I cannot imagine what life would have been without Medicaid.

In 2005, I married and found an employer who was eager to hire me. Unfortunately, the employer did not offer health insurance. I

attempted to enroll Alex in FAMIS but our income was too high for him to qualify with my husband's income of only \$32,000 for our family. At that time, eligibility for the program in Virginia was limited to children whose family incomes were below 133 percent of the poverty level, less than \$22,000 a year for a family of three so my only option was to turn down a position I really wanted in order to keep my son insured through Medicaid. I want to emphasize how difficult that was for me.

In July 2006, the State of Virginia changed its eligibility rules for FAMIS allowing families with incomes up to 200 percent of the poverty guidelines, a little over \$34,000 for a family of three to qualify making it possible for me to enroll my son. Once Alex had health insurance through FAMIS, I was able to accept a full-time position at SCIC, a Government contractor in Virginia. Today, Alex and I have health insurance through my employer and I work full-time as a design consultant at Thomasville Furniture and am taking graduate courses at Marymount University for interior design.

The help that my family received at a time when we needed it most because I was able to work, it was great to have a program like FAMIS. I know from my experience that other families with premature babies, that my story is not unique. In fact, it is not uncommon for a family just getting started to face a problem of not having enough health coverage to meet the needs of a fragile infant.

Given my family's experience, I am sure you can understand why I am so committed to the March of Dimes' goal of using this year's bill as an opportunity to strengthen FAMIS and other State children's health insurance programs. Let me summarize for you the Foundation's recommendations.

Using the information provided by the U.S. Census Bureau, researchers have estimated that nearly half of the 9 million uninsured children in the U.S. are eligible for Medicaid and almost 20 percent are eligible for SCHIP. In other words, with adequate funding and more attention to enrollment of those who are already eligible, more than 6 million uninsured children would have health insurance through these two programs. So for our first recommendation, the March of Dimes urges members of this committee to give States the resources they need. The Foundation is also calling for changes in law to help States make modest but important improvements in their SCHIP Programs.

First, States would be allowed to cover pregnant women age 19 and older who meet SCHIP income guidelines. As many as 24 States have used Federal waivers or special regulatory means to provide such coverage through SCHIP but waivers are administratively burdensome for States and the regulatory approach does not allow for payment of the full scope of maternity benefits recommended by the American College of Obstetrics and Gynecologists and the American Academy of Pediatrics. Both the National Governor's Association and the National Conference of State Legislatures support this proposal. Providing access to maternity coverage will help reduce the number of infants like Alex who are born with significant medical needs.

The March of Dimes also recommends that members of the committee allow SCHIP to supplement limited private health insur-

ance for children with special healthcare needs allowing for a combination of public and private coverage would help families like mine, parents who want to work, are willing to purchase private insurance, but need a little help to be sure that their policy covers their child's serious medical conditions.

Finally, the Foundation urges members to strengthen performance measures that will improve State accountability and quality of care for individuals who rely on SCHIP for their health insurance.

Thank you again, Mr. Chairman for holding this important hearing and for allowing me to testify on behalf of the March of Dimes. Children and their families across the Nation are looking for you and members of this committee to maintain and strengthen SCHIP, a program central to the health of the Nation's pregnant women, infant, and children.

Thank you.

[The prepared statement of Ms. Mingledorff appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you.

And thank all the witnesses for your insight into SCHIP and the whole problem of covering the uninsured for kids in particular.

We are done with the statements but now we will start with questions and I will just recognize myself initially for 5 minutes.

I wanted to ask Ms. Mingledorff both you and Ms. Molina. You have obviously talked about your personal situation of being in the position of having to force to choose between a chance to improve your financial situation or keeping your children's health coverage. And I know, well I should not say I know, I really cannot imagine what a tough decision that has to be but your stories illustrate why it is so important that Congress provide access to affordable health insurance for children and not restrict in my opinion the available funding for kids above 200 percent of poverty. The 200 percent is about \$34,000 a year for a family of three. It may seem if you are making \$34,000 a year you should be able to pay for health insurance but both of you have indicated that is not the case. I just wanted you to comment again maybe dispel the notion that might be out there that somehow if you are making \$34,000 a year you are going to be able to afford health insurance, if you would comment on that?

Ms. MOLINA. Well yes, \$34,000 may sound like it is a good amount of money but when you have to pay for like myself I just finished paying \$5,500 for braces for my first child and now Joseph also needs them and so that is going to cost me another \$5,500. School lunches, I pay \$70 a month for school lunches. And I will tell you what, there is so much more that we are paying out. Not to mention our every day costs, bills. And then too, I want to say something that I did not say is that SCHIP works. It is a great program. We cannot afford private health insurance. This program works.

Mr. PALLONE. Mrs. Mingledorff?

Ms. MINGLEDORFF. I have thought about it on several occasions as to my difficulty in applying for Medicaid, SCHIP, and everything throughout our time period getting State support health insurance. There are so many things that are involved in calculating what

your poverty level is and why you do or do not qualify. For instance in my family, we have a car. We pay \$250 a month as our car payment. That is \$250 that is coming out of my family's income but it is not taken into account as to my family's income. All sorts of things like that, rent, everything else that goes into what you pay every month just to survive is not taken into account. They look at your income. And if your income is \$34,000, then it does not matter if every month you are paying \$7,000 of bills, you still do not qualify.

Mr. PALLONE. All right, thank you, I appreciate your comments.

Now one of the things I am also concerned about is the adequacy of the health insurance coverage that children receive. For example, a family's employer sponsored coverage might not be the best place for a child if it does not cover the benefits the child needs or imposes unaffordable cost sharing or deductibles. We know that is often the case. So I was going to ask Dr. Lambrew if you could please comment on Medicaid and SCHIP and the adequacy and affordability of benefits in those programs.

Ms. LAMBREW. Sure. And I think I need to start with Medicaid because Medicaid is the older program and the program that frankly covers most of the children that we have. And I think that the statistics are about four times as many children are enrolled, insured by Medicaid.

Mr. PALLONE. Good point.

Ms. LAMBREW. And since the program began there was basically a provision that said that for children who get screened and diagnosed with a disease they get the care that they need, that is medically necessary. This has been proven over time through evaluation after evaluation as effective and insuring that low income children have the types of benefits they need.

With SCHIP which is for higher income population, there are benefit standards and these standards are linked to things like the Federal Employees Health Benefit Package, the State Employees Health Benefit Package which are relatively generous in employer's scheme of things. Studies have shown that special needs children do not really work well or, excuse me, do not necessarily get what they need through SCHIP, through these benefit packages. There is a secretarial approved package which has been used by some States for fairly high cost sharing plans and with the Deficit Reduction Act a few years ago there are question marks about exactly what the strength is in terms of our Medicaid benefit package as well.

So the short answer is that the programs do well, they strive to do well but in recent years we have seen erosion in the types of benefits that these children have. And we do know that for any low income families, you have heard these ladies talk about the cost sharing associated with illness could be a barrier even if they are covered by these programs.

Mr. PALLONE. OK. Just quickly, a comment on the fact that children are more likely to have coverage when their parents also have coverage because I know this is a big issue.

Ms. LAMBREW. The statistics are interesting because what we know is that if a child, the parent is insured, the child is more likely to be insured and vice versa. We know that families come to-

gether so there is a real pattern to that. We also know that children whose parents are insured are more likely to get access to care. The parents are more in tune with the healthcare system. But I think some of the statistics that have come out recently are pretty shocking. I think that we know that of the children who are insured through the CHIP, Children's Health Insurance Program, the vast majority of them do not have parents who themselves are insured. It is not like we are seeing lots of families who have the parents in employer based coverage and their children SCHIP. In fact, a study that came out from the Urban Institute just last week found that of the children in SCHIP, two-thirds of their parents, two-thirds of those children's parents do not have employer based coverage. So only one-third of the parents of these SCHIP children have employer based coverage. And when you look at Medicaid, it is basically only 10 percent. So we really do not see kind of the splitting of families which means the best way to get these children may be getting their parents because then you really can get the full family deal.

Mr. PALLONE. Thank you.

I yield to the gentleman from Georgia, the ranking member.

Mr. DEAL. Thank you, Mr. Chairman.

Let me follow up on that because I think we just heard two conflicting statistical statements about the uninsured children and their availability of insurance through the private sector because I wrote down that Mr. Peterson said that 42 percent of uninsured children have access to private insurance. Was that what you said? Does that conflict with what Dr. Lambrew just said?

Mr. PETERSON. I think she was talking about something different. She was talking about SCHIP enrollees and their parents and I was talking about uninsured children all together.

Mr. DEAL. I see the total picture?

Mr. PETERSON. Yes. But it is still the case. Really it depends on one's perspective is this one-third of SCHIP kids who have a parent who is enrolled in coverage she said it is not a lot. I bet Nina would say it is so, it is just kind of a definitional issue at that point.

Mr. DEAL. And back to the point that you made early in your testimony, Mr. Peterson is that as we have seen the number of uninsured children drop, we have likewise seen the number of insured children under private plans likewise drop. Is that right?

Mr. PETERSON. That is correct.

Mr. DEAL. What do you make of that correlation?

Mr. PETERSON. Again, it is very hard to say because you do not know what would occur in the absence of that public coverage and so the most recent estimates I think Nina talked about said that for every 10 percent increase in public coverage there is a 60 percent decline in private coverage. But that assumes that those are linked all the way and it is just not clear from our perspective that you can make that link. The estimates vary widely as I say. Some say there is no link. As the private coverages drop and public has expanded, there is no link from that and that those kids would likely have lost coverage anyway.

Mr. DEAL. Ms. Owcharenko that is what you were talking about when you said the 60 percent crowd out factor. Elaborate on what you mean by the crowd out factor just a little more.

Ms. OWCHARENKO. Well as was discussed, the idea that as public programs have expanded, eligibility up the income scale, the private, the number of individuals, families actually not just individuals, it is actually the families is what the study looked at, not the individual but the impact it had on the family had seen a decline of about 60 percent. So I think that one of the issues is looking at the number between when we are looking at individuals between 200 percent of poverty, 300 where this becomes far more critical. I think that we need to look at alternatives instead of either or is there some way of kind of blending the two together. So you do not have the cliff effects that I think was described earlier where it is one dollar more and you are no longer part of the program, to find ways of somehow blending this, to try to create a more seamless system between the public and private sector.

Mr. DEAL. And one of your suggestions I believe was that we allow some of the say SCHIP funding to be used to buy into a privately available employer plan. Is that right?

Ms. OWCHARENKO. Yes. And I would like to elaborate on that because many times the term premium assistance is used. I would actually take it further because as was noted, a premium does not take into consideration cost sharing requirements. And so having a simple stipend given for the child for dependent coverage could I think also cover things besides the premium. If you have an employer with a higher deductible, then the additional dollars that they are not spending on the premium could be used to help with cost sharing requirements with meeting the deductible, et cetera.

Mr. DEAL. One of the problems I think we have with the way State's regulate insurance at the State level is that some States have huge mandates of what an insurance policy must cover and it drives the cost of that insurance up in that State. Many have proposed and we have in fact voted on during the last Congress a proposal in this committee that dealt with the ability of a person or an employer to buy a policy from another State if it provided a benefit that was acceptable but at a cheaper price and it was affordable to them.

Now we have great inequity in your comment about the tax issues relating to health insurance is certainly an appropriate one. Many of the proposals are that if employers, large employers are going to be able to deduct their cost of health insurance in a group plan, then the same benefits should be extended to the private family et cetera because in effect we are squeezing the balloon and it is coming out in the pricing for the small policy units. Another proposal of course is the ability that we pass in this House a couple of times I think and that is of small businesses to be able to pool together so that they could buy more affordable private insurance plans.

Very quickly, Ms. Owcharenko, would you comment briefly about those kinds of proposals?

Ms. OWCHARENKO. Sure. I do think that tax equity is very important. I think that it was noted there are people that do not have employer based coverage and do not qualify for the public programs who get no tax benefit, no assistance whatsoever. So fixing the Tax Code to allow individuals to receive a benefit, a tax benefit for purchasing private insurance I think is critical. However, it is not ex-

clusive. I think ideas as you mentioned allowing individuals themselves to decide the type of policy and where they want to buy their health insurance from, I think teams up very nicely with changing the Tax Code. So that if you are in a State where you find it unaffordable but you can find coverage in a State, a neighboring State would make a lot of sense to say well gosh there is a policy there that I could afford at least to have catastrophic coverage. It is critical to make sure that we are trying to provide more options that are more affordable for in some cases with these families to simply protect them from a catastrophic illness when they are hit with cancer, or some sort of an illness that costs them a lot of money. At least then there is some sort of a catastrophic backdrop. And it gives the individual the choice. It is not a mandate on the individual one way or the other. If they are happy in the State that they have the coverage, they can keep it.

Mr. DEAL. Thank you.

Mr. PALLONE. Thank you.

Mr. Green for questions.

Mr. GREEN. Thank you, Mr. Chairman.

It is not on my line of questions but I would love to have the debate on mandated benefits. I have served in the legislative body for many years in the State legislature. In 1973, the first mandated benefit we voted on was newborn infant coverage. The insurance policy did not cover newborn infants for the first seven to 21 days depending on the State. Now we can list all sorts of crazy things on mandated benefits but there is also a reason for having State regulations. And that is why going from if I am at Houston, Texas and want to buy a policy in Louisiana the State Insurance Commission that regulates health insurance in Texas has no authority over that insurance policy. So it is great to talk about it in Washington but until we, if we want to take over health insurance even what the State does and I do not think either Republicans or Democrats want to do that yet, but to overrule State mandates, let us fight that battle at the State because that is where they are the ones that are responsible for it.

Mr. Peterson, in your testimony you talked about on page 3 for example the private coverage has not changed significantly between predominately white children or black children because of SCHIPS but it did change among Hispanics, decline in private coverage was large in 1996 and 2006. Did you find any reason for that in your work?

Mr. PETERSON. Yes, I have to talk to the folks at the Agency for Healthcare Research and Quality who had put all that information together to see because there are other—I do not want to use a statistical term, there are other factors that are going on such as the jobs that are available that those folks may have access to so there are a number of things that could be at play here and I can ask them to follow up with you.

Mr. GREEN. I know in person experience in our district because we have a 65 percent Hispanic population and of course the children's population is probably 80 percent is that often times employer based coverage, they may cover the employee but they do not cover the family. And they do not make enough to pay for the

family even though have an option to do that. At least SCHIPS they can afford it.

You said in your statement and I want to reiterate it on page 6, importance that you have the children's healthcare coverage but it is also the relationship with a physician that is so important and that is what SCHIPS brings to the table. And I will give you an example. I have a somewhat suburban district but it is actually urban. And in the late 1990's we were so happy getting a public health clinic in our area because my school superintendent said in a study in their schools that 80 percent of the children their predominate healthcare provider was the school nurse, so that relationship has to be there somehow and the public health system through Medicaid or but also through the SCHIPS Program.

And I also like your statement about the need for outreach. I know often times individual States do not do the outreach and I think the testimony from a lot of the panel today was that the reason we need the coverage, we can cover more children and we have to do that outreach to parents so they know this is available to them.

But now let me get to my other questions. I am concerned about the increasing barriers to enrollment in CHIPS and I will give an example. In Texas, you heard my statement about we lost a number of children after 2003 because of enrollment barriers and I know the sixth month coverage period is overly burdensome and I think contributed like 200,000 loss of children under CHIPS in Texas. And I understand Texas was one of nine States that have the sixth month renewal requirement whereas other States have 12 months. Doctor Lambrew, can you speak to the benefit of the 12 months coverage for continued enrollment in general?

Ms. LAMBREW. Sure. There is lots of good evidence that there are two reasons why it helps. Number 1 is that it is a reduced burden both on families and States to have the child come in, only every once every year rather than every 6 months to do this. It is clearly easier. We also know from—

Mr. GREEN. And excuse me for interrupting but that also means they do not have to stand in line but once a year in the huge lines at some of these agencies.

Ms. LAMBREW. Exactly, if there is a required in-person interview. Some States have moved to a mail in application which is a little bit harder with some of the citizenship documentation rules that have come into effect but that is another way to simplify things. But that is right we did do a Federal evaluation of SCHIP and what we found was that when children leave the program they are not generally going to private health insurance. Only about 14 percent gain private coverage, about 34 percent return to Medicaid, and then 48 percent become uninsured. So we know if we can keep these children on for a longer period of time, then we are keeping these children insured for a longer period of time.

Mr. GREEN. OK. Mr. Chairman, one last question in my 10 seconds I have.

Dr. Berkelhamer, the Deficit Reduction Act and I had mentioned this in my opening statement, the number of changes in Medicaid and I am concerned about the citizenship documentation and my example a child born in our country in a hospital in the United

States is considered a citizen and for them not to be immediately established for Medicaid coverage when they are born here, to wait for their documentation for their certified copy of their birth certificate, does the American Pediatric Society have—

Dr. BERKELHAMER. Penny wise and dollar foolish and you are setting up a situation where children will end up not getting enrolled in a timely manner. It will show up when a disease is further along. It will end up in an emergency room or a hospital. Before the Deficit Reduction Act, mothers who went into labor who were the economic eligibility level were entitled to emergency Medicaid. When their babies were born, they were automatically as you pointed out in your statement enrolled for the first year of their life. That does not happen anymore. The way it is being implemented now, the family has to provide documentation and go through an enrollment process. And it really is putting an impediment in front of people in terms of getting them enrolled in a timely fashion. It is really a problem in the Deficit Reduction Act that needs to be addressed and needs to be corrected. And I would urge all of you to do it.

And if I have just a moment, there has been some discussion here about private versus public but I also think it is extraordinarily important when you think about the interface between the two that every child as I mentioned needs a comprehensive benefit package. The benefits the children need are different than the benefits that adults need. And being protected against catastrophic loss is extraordinarily important but it is not as important in the long run as an isolated thing without looking at immunizations, preventative care, well-child care, and all of the things it is going to take for us to assure that we have a group of children that are growing up and are healthy. And it is a good investment. You may think this program is expensive, it is cheap in the long run, it really is. And every dollar you spend on this program is going to come back in multiples by having a healthy workforce 15, 20 years from now.

Mr. GREEN. Mr. Chairman, I know that is something I found from our community based clinics. They get those children on those immunization schedules and thank you.

Mr. PALLONE. Thank you.

Mr. Sullivan?

Mr. SULLIVAN. Thank you, Mr. Chairman.

I have got a couple of questions I wrote down by listening. I guess my first one would be to Ms. Owcharenko. You were talking earlier about the segment, this large segment of uninsured children are from the middle and upper class and what do you think the best way, what is the best way to get them insurance? What would change their behavior or whatever.

Ms. OWCHARENKO. Well it is the largest growing portion of the uninsured. Meaning it is not necessarily the largest portion, it is still the largest portion our lower income families but the largest growing is in the middle income. And to those I think that the concepts that I have talked about such as reforming the tax treatment of health insurance to give families, middle and upper income families who may not have employer based coverage maybe they are self-employed and they just cover themselves or they just decide

that they would rather deal with that. And I think that there is an importance of stressing to families that coverage is important to have. And I think that is something the entire panel agrees that going without healthcare coverage is really rolling the dice and so providing incentives and tax incentives work very well in a lot of these income groups to encourage them to purchase coverage for themselves, as well as, for their children.

Mr. SULLIVAN. And you also hear people talk about these catastrophic policies and I talked to some people that tried to get some of those and they are pretty expensive really. They are not as cheap as one might think. Why do you think that is?

Ms. OWCHARENKO. Well catastrophic, I would like to point that catastrophic policies, the high deductible options are just one type of health insurance options that are out there. They are certainly seen as kind of the extreme of coverage options. In some faces it is not as comprehensive and up front first dollar coverage as others. And what we see and that is a common factor that we have seen in some individuals facing just as equally as high of cost for a high deductible as they would for a traditional PPO, et cetera.

Mr. SULLIVAN. Right.

Ms. OWCHARENKO. And that tends to relate to State regulation as was earlier discussed. State regulation really does, is an interesting piece that plays a role in the affordability of coverage for individuals.

Mr. SULLIVAN. Well also that made me think of something else on the mandates. Now Congressman Green mentioned some mandates and I agree. Well he mentioned I think it should be mandated but what do you see as mandates that should not be in place? Maybe New Jersey for example, I guess that is the reason why it is high there.

Ms. OWCHARENKO. Well mandates themselves alone are not the biggest problem.

Mr. SULLIVAN. What mandate would you say you have seen in a policy at a State that is not, you do not think should be there?

Ms. OWCHARENKO. Off the benefit mandate, probably the largest cost driver would be the combination of guarantee issue and community rating. Pure community rating which means if you are 18 and you are 64, you pay the same price for health insurance. That really crowds out a lot of the market for younger and healthier individuals. So I think the combination of that guarantee issue with community rating is probably the largest State regulation cost factor for the cost of health insurance.

Mr. SULLIVAN. What do you think of mental health parity?

Ms. OWCHARENKO. I think some States have added it. It certainly is one of the largest cost drivers in the mandate benefit analysis that has been done. It is larger than other additional benefits one on top of the other. It is one of the larger ones.

Mr. SULLIVAN. Do you think mental health benefit is a very expensive benefit?

Ms. OWCHARENKO. It does add to the cost of the premium compared to other benefits that are added.

Mr. SULLIVAN. Because I have actually seen studies where it saved money because—

Ms. OWCHARENKO. Well yes, if you looked at a more dynamic system I guess you could look at all benefits. In the larger term does it help people keep them from going to the hospitals, et cetera. So in the long—

Mr. SULLIVAN. I am also the coauthor of it so I am supportive of mental health parity.

Ms. OWCHARENKO. Yes.

Mr. SULLIVAN. Mr. Peterson you might be able to answer this the best. What is the differential between insuring a child and an adult and can you explain that, the costs? You were mentioning a little bit of that at the wellness, all that, the cost—

Mr. PETERSON. Well I will just say first that we have done analyses of—for some of our CHIP projections and on average adults are 60 percent more expensive than children so I will just say that. If you would not mind, I could comment on the mandated benefits.

Mr. SULLIVAN. OK.

Mr. PETERSON. Maryland is recognized as having the most mandated benefits and they themselves have estimated that that adds 15 percent to the premium.

Mr. SULLIVAN. But what benefits would that be? What mandated benefits—

Mr. PETERSON. Well there is mental health parity. They have others as well that—

Mr. SULLIVAN. Why do you say mental parity? Why does that cost so much? If you look at a dynamic effect of it.

Mr. PETERSON. Well that is true. And that is actually one of the points that the Maryland Healthcare Commissioners made regarding their own mandated benefits. They said look, the total cost of these benefits including maternal care all of that, if you look at that portion it is 15 percent. But most of these plans just looking at the issue in a slightly different light, most of these plans would cover these benefits anyway. So if you actually look at the additional impact it is 2 percent. So again, it is one of these issues of you can take into account different things and come up with different numbers in terms of the real impact of these mandated benefits.

Mr. SULLIVAN. Do these have drug and alcohol in them?

Mr. PETERSON. That is part of the mental health parity often.

Mr. SULLIVAN. OK, Doctor?

Dr. BERKELHAMER. I would want to comment that in the Medicaid Program were half of the enrollees in the Medicaid Program nationally are children. They represent 25 percent of the cost of the total program. They are inexpensive. Even with comprehensive benefit plans like the Medicaid Program, they are very inexpensive to cover. I would also point out to you that mental health is a major problem that needs to be addressed and approximately a third of all the visits to a doctor's office, a pediatrician's office is related to a problem relating to mental health.

Mr. SULLIVAN. That is good, I agree.

Well thank you very much.

Mr. PALLONE. Thank you.

Ms. DeGette?

Ms. DEGETTE. Thank you, Mr. Chairman.

Ms. Mingledorff, I wanted to ask you, Ms. Owcharenko talked about these catastrophic healthcare policies that could be low cost. This was a legislative proposal in the last Congress so people could go to other States and buy these low cost catastrophic policies and they would be low cost because they would not have a lot of mandatory coverages and a lot of other reasons. My question to you is once if you took that job and you had lost your SCHIP eligibility for your kid, would one of those type of policies have helped you with coverage for your son's myriad of disabilities?

Ms. MINGLEDORFF. I do not necessarily know all that is involved in catastrophic coverage but I can just speak from everything that we have experience with him. It has gone from the range of just basic visits and for him a routine, our routine visits do not just include immunizations, well-child visits, they include occupational therapy, speech therapy, follows up with neurology and—

Ms. DEGETTE. Did you investigate how much it would have cost you to purchase a health insurance policy that would have covered all of those things for him?

Ms. MINGLEDORFF. On a few different occasions we did and—

Ms. DEGETTE. And what was the range?

Ms. MINGLEDORFF. The range privately I think was between \$500 and \$700 a month.

Ms. DEGETTE. And what would your income have been if you would have taken that job?

Ms. MINGLEDORFF. It was a part-time position at the time I think it would have been maybe \$1,500 a month.

Ms. DEGETTE. So at least a third of your income. Ms. Molina, if you had been able to purchase a catastrophic insurance policy, do you have any idea whether that would have covered your kids well-child visits or like last week when they had the flu if they had to go to the doctor?

Ms. MOLINA. I do not know.

Ms. DEGETTE. OK. Did you investigate purchasing a health insurance policy?

Ms. MOLINA. Yes.

Ms. DEGETTE. And how much would that have cost you?

Ms. MOLINA. It would cost between \$100 and \$150 per child per month.

Ms. DEGETTE. So that would be roughly \$200 to \$300 a month.

Ms. MOLINA. Yes, \$200 to \$300.

Ms. DEGETTE. If you do not mind if I ask, what was your income at that time per month?

Ms. MOLINA. It was slightly above the 200 percent.

Ms. DEGETTE. So that still would have been what percentage of your income then?

Ms. MOLINA. I would say probably—you are making me do math.

Ms. DEGETTE. It would have been too much for you to afford, I guess.

Ms. MOLINA. Absolutely.

Ms. DEGETTE. OK. Dr. Lambrew, I wanted to ask you a couple of questions. One of them is that we heard some testimony earlier about middle and upper income families who do not purchase health insurance for their children. Is that the largest reason why children are not insured in this country is because higher income

folks are not purchasing insurance for their kids or is the problem of the lower middle class and the working poor not being able to afford insurance?

Ms. LAMBREW. Nina did say this in her testimony. It is clearly a low and middle income problem. Two-thirds of the uninsured have income below this 200 percent of poverty threshold and it really is that concentration. But I do want to go back to this larger point which is the reason why we have a fast growing group among middle and high income people is because we are talking about this program in the context of an eroding employer based coverage systems.

Ms. DEGETTE. Right.

Ms. LAMBREW. The percentage of firms offering coverage has dropped from 69 percent to 61 percent last year. We have uninsured adults growing very rapidly. So I think that we have to really be thinking of the big picture here because at the same time as CHIP has stabilized and reduced coverage for children and Medicaid but we also have this kind of larger problem going on.

Ms. DEGETTE. Do you have any ideas of how we could address that larger problem as it respects children?

Ms. LAMBREW. It is actually quite hard to think through. We could certainly do what the State of Illinois has discussed which is try to open up the program. I guess CHIP to have higher income families buy into it. You could consider a larger health reform proposal because as we said earlier children come in families and typically their parents are also uninsured when they are uninsured. The truth of the matter is I think we need to be talking about covering all Americans at some point because trying to solve the problem through kind of programs like SCHIP presents a challenge. There is a bigger problem going on out there.

Ms. DEGETTE. Right. Well in fact, I just said to Mr. Green listening to the testimony one thing that Mr. Chairman this committee might think about is the idea of establishing the SCHIP guidelines but then also allowing parents with incomes higher than that level to purchase, to buy into SCHIP. It has been so successful so that is something I think we should consider as we look at reauthorizing this.

Mr. PALLONE. If I could just comment. I did not want to use up your time. We are, we will have additional hearings. As I said, we are going to have another one most likely March 1, the second half of this SCHIP hearing. But we also will have other hearings on the issue of the uninsured not just for kids but the larger population as well as the employer based system and what needs to be done there.

I yield to the gentlewoman from California, Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

And I want to use my short time to focus on our two star witnesses, our moms. But I first want to say thank you to Dr. Berkelhamer because we could give you the whole time, this is your subject and I thought you were so concise in your response to my colleague, Mr. Green on talking about how we get paid back as a society in spades by healthy employers if we cover them as kids. This is just so important that we learn this lesson and also your comments to the minority ranking member on comprehensive cov-

erage including mental health. Pediatricians are psychiatrists most of the time, I believe in my practice as a school nurse. And also I wanted to refute or not refute but add to Mr. Green's saying that too many kids get their primary care from school nurses. Having been one, I know that it is an endangered species in a lot of school districts and woe to those who think they are going to get really professional help in the school health office and I wish it were not so.

I did want to before I get to the moms, Dr. Lambrew, our chairman asked you about the importance of covering adults and you said and there is a growing amount of material of having family members covered in order to ensure that the kids get good coverage. And without going on there because I do want to get to the moms, would you just mention briefly the importance of waivers and should we be dealing with this and letting States waive into that kind of coverage.

Ms. LAMBREW. Sure. In Medicaid already even without SCHIP there was an option to cover low income parents and the sad truth is that right now I think the percentage of poverty that we cover parents at nationwide is about 63, 65 percent of the poverty level. So we have options today that some States have not used. What SCHIP has gone and proven is that if the Federal Government comes in with a higher matching rate, States will follow. And the truth is I think waivers help States get access to that higher enhanced matching rate in SCHIP but we do not have to have SCHIP waivers to basically change the law and allow States the kind of financial incentives to cover parents. The truth is it is just a matter of priorities.

Mrs. CAPPS. OK, thank you.

Now I really am impressed that both of you moms would take the time to come here. It is not easy because you have day jobs, you have big responsibilities we can see with the little ones but your teenagers are every bit as challenging as the two little ones all of us who have had teenagers in our families know that. And just in the remaining time, and my question was you did not choose the private sector, maybe you could not but you did not have time to examine all the policies out there. Maybe just each of you take a minute and tell us again what we have not heard yet. Why you think it was so important for you to come and tell us about the importance of SCHIP or what the program meant for you. I will start with you, Ms Molina.

Ms. MOLINA. Well again, I want to say that when my children were on this program, my son and I actually before I came out, we sat on the bed and we made a list of all the times that I took them to the emergency room. Both of my kids really sprained their ankles, they both had to be on crutches. My son broke his arm by falling off the slide at school.

Mrs. CAPPS. Very common childhood things.

Ms. MOLINA. And my daughter had a huge third degree burn on her leg and every time that we would go to the hospital they got excellent care being on SCHIP.

Mrs. CAPPS. Yes.

Ms. MOLINA. And, yes, it is heartbreaking for me to know that my kids are not enrolled now but I am here because I think I rep-

resent the tens of thousands of parents whose children are either not insured or are insured with the new SCHIP and it is just so important for me to come and say this program works. We need to reauthorize it. We need to fully fund it so we know that all the children are covered and we are not going to lose children as the years go by.

Mrs. CAPPS. That was beautiful. And Ms. Mingledorff to you as well if you want to add anything?

Ms. MINGLEDORFF. Yes, absolutely. For me and my family it has been just imperative to be able to have Medicaid and SCHIP to support my family's health needs. As a volunteer and Ambassador Family for the March of Dimes, they know well of our situations that we have gone through in the last 4 and 5 years. And they have not been the common ailments of a 5-year-old child. He was admitted to the hospital when he was 9 months old after spending 76 days in the NICU after he was born. After that when he was 2-years-old he stopped eating and had to be admitted to the pediatric unit at our hospital for over a month and went home on a feeding tube. After that he had every type of equipment that we needed to just support his living. And probably seven different medications, occupational therapy, speech therapy, every specialist under the sun to just follow him and make sure he was doing OK. My whole life was consumed by his every day need and every day his medication and therapies were required to keep him living. And the only way that we were able to do that and provide him with the optimal care was through Medicaid and SCHIP. And if we did not have that, I am positive that he would not be here today.

Mrs. CAPPS. Thank you. You have both, all of you have helped us as we begin to reauthorize.

Thank you.

Mr. PALLONE. Thank you, Mrs. Capps.

Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Let me just talk a minute since it came up about the dynamic budgeting, thinking about the kind of long-term savings that we will have that when we talk about insuring our children we should be thinking not so much about consuming but investing. And if there were only a way to figure out how we could calculate those costs in a much more realistic and sensible way about how it would actually save money down the road. I think we might take another look at our priorities and make some different decisions about what we do.

We have heard about the issue of crowd out and the perhaps causal relationship and perhaps coincidence of the relationship of public and private health insurance coverage. But what I am wondering is if there is any evidence base, I want to ask Dr. Lambrew over the past 10 years of SCHIP and Medicaid have we found a crowd out problem? For example, employer sponsored insurance coverage has it disappeared in New Jersey where up to 350 percent of poverty children are covered? What has been the actual history?

Ms. LAMBREW. Well the good news is that you all in your wisdom funded an evaluation of SCHIP that was completed a couple of years ago. And in that evaluation they certainly looked at this question because it is a critical question as you think about public

program expansions. And what they found was that of the recently enrolled children in the program, 43 percent had been previously uninsured, 29 percent had been coming into the program from Medicaid, a family who again the mother went back to work or for some other reason had too much income for Medicaid, and about 28 percent had previously had private coverage. Of that 28 percent, a quarter of those parents said they could not afford that coverage, it was straining their family income so this is an important move for their economic security. So only a small fraction of the children in the program are coming from some insured situation and as the Federal evaluators say in their own words, the program did not lead to widespread substitution of SCHIP for employer coverage, even though almost all families enrolling their children had at least one working parent. So I think that we have to separate out the larger context of the eroding employer based system from what is actually happening with SCHIP and for low income families they are also experiencing the erosion in private coverage but the evaluators are not finding that a significant percentage of those kids coming into the program are coming in from private coverage.

Ms. SCHAKOWSKY. And you wanted to say something, Mr. Peterson?

Mr. PETERSON. You just mentioned New Jersey and I happen to be looking at their numbers when I was sitting back there and I was thinking about that same issue well what is there rate of public coverage among children. And actually the rate of public children, public coverage in New Jersey is the lowest in the country for children and they have one of the highest employer sponsored coverage in the country so again there are other factors at play. New Jersey has a very high income as a State so one needs to control for all of that and take all that into consideration but just in specific answer to your question that is what the numbers were.

Ms. SCHAKOWSKY. And I wanted to ask Nina if I could so I do not even try it. When you talk about employer based coverage, I wonder what that means anymore because so many of the costs have actually shifted to the—maybe the employer offers it but the employee has to pay the bulk of that. And in fact, Dr. Lambrew you had in your testimony in 2006 the average premium for an employer based family insurance policy \$11,480 was more than the full-time full year earnings of a minimum wage worker. So when we talk about employer based coverages did you take into consideration that it is not realistic for people who make relatively low incomes to actually purchase those employer based, employer offered insurance. Did you consider that when you talked about crowd out and all those—

Ms. OWCHARENKO. Well the study was not mine on crowd out. I will be happy to share it with the committee. It was, I was just using it as an illustration. But when looking at employer based coverage, there are a variety of ways as I mentioned of leveraging those SCHIP dollars to help with the dependent coverage share of the employer premiums and cost sharing requirements. So the concept is how do we pull the existing resources together and allow the family to decide whether they would rather have their child in SCHIP and they remain uninsured or they remain on the employer based policy or say well I would rather take my SCHIP funds and

enroll the child in my family policy through the place of work. At least then we are giving the families some greater choices and flexibility. We talk about State flexibility and that is great but there needs to be some I think attention to also giving families some greater flexibility in making the choices of where they get their coverage and just leveraging the existing sources of funding better there to help them, help those families who find coverage unaffordable.

Ms. SCHAKOWSKY. Let me just ask another question. Dr. Lambrew, you noted that an estimated 18,000 adults die each year because they lack health insurance. Is there any estimated rate for children?

Ms. LAMBREW. The Institute of Medicine who did that review a few years ago just focused on adults. We do not have that for children. But I think it is partly what are friend the doctor here has said which it is not necessarily mortality is lifelong disability that often is the consequence of children not having health insurance. It is the sick child having some sort of disability at school, learning problem, growing into a less productive adult. That is kind of the long-term chronic problem. And especially in this century where chronic illnesses are new, a new problem in health system. It is especially important that we get to children early with wellness and preventative care.

Ms. SCHAKOWSKY. Mr. Chairman, could I ask one short question?

Mr. PALLONE. If you do not mind, we are going to do a second round so we will get back to you.

Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I apologize for having been out of the room for so much of the hearing and bear with me if I cover ground that has been covered before but I am sure that the country will benefit from hearing it again.

Mr. Peterson, if I could ask you is there a difference in the cost of insuring a child versus insuring an adult?

Mr. PETERSON. Yes. As I said just among SCHIP, out analysis was 60 percent, adults are 60 percent more expensive than children on average. There is huge variation by State as well so, that is just the average overall but other States might differ. But, the other thing to take into account which we could provide you with numbers is how that varies for adults and children overall. As the doctor had said children are much less expensive to cover.

Mr. BURGESS. What, if you do not mind and I do not mean to ask you to name names, but can you give us an example of a State that is higher in cost and a State that is, what would be an example of lower in cost?

Mr. PETERSON. In terms of the SCHIP?

Mr. BURGESS. Yes.

Mr. PETERSON. That has not been broken down.

Mr. BURGESS. But in general for insurance coverage is does it cost more to insure someone who lives in the Northeast than it does in the Midwest?

Mr. PETERSON. In SCHIP or overall?

Mr. BURGESS. Overall.

Mr. PETERSON. Yes, that is the case.

Mr. BURGESS. And what is the reason for that discrepancy?

Mr. PETERSON. There is the underlying cost of care and there are different patterns of utilization in terms of how much care people use. And there was an analysis done by the Agency for Healthcare Research and Quality that they found lower holding insurance constant in all these other things utilization was lower in a State like Texas than in the New England area. And so that is controlling for insurance and the different characteristics so fundamentally there are just different uses of healthcare across the country. So utilization and price are both of those factors that then feed into the premiums.

Mr. BURGESS. Does that concept pose any barriers for if someone wanted to discuss a single payer national system, would that in itself be problematic, the different patterns of utilization across the country?

Mr. PETERSON. Well I do not know about that in particular but essentially and I had raised this in my written testimony this does provide tensions even with SCHIP and Medicaid in terms of the different ways that States are doing things with private health insurance as well.

Mr. BURGESS. And would those tensions be magnified if there were say a payroll tax that provided coverage for a single payer system throughout the country? Would my constituents in Texas be covering Mr. Pallone's constituents up in New Jersey?

Mr. PETERSON. Yes, I do not know.

Mr. BURGESS. I do not know either. I have a suspicion. What about we always hear about mandates? We had a hearing in this committee last year or 2 years ago that went on into the wee hours of the morning discussing mandates. What, to what extent do mandates play a role in the cost of insurance?

Mr. PETERSON. I think Nina had mentioned before that mandates are a relatively small portion of some of the State level variation and a lot of it may be more attributable to other practices such as rating requirements whereas New Jersey has people of all ages pay the same rate and those are in response to different priorities. It could be the case that in New Jersey their focus is on people who are regular users of healthcare and so the priority is to try to make sure that they can get access to health insurance but that necessarily means that premiums are going to be higher in a case like that. And so these are State level decisions that have been made depending on the priorities.

Mr. BURGESS. Anyone feel free to offer an opinion on this. I think the statement was made when Ms. Schakowsky was asking the question about the average cost of insurance premiums would be over \$11,000 a year. When you look at products that are available on the Internet such as HSA products, high deductible products, the last time I looked which albeit has been a couple of weeks ago but I think the price is probably still fairly in the ballpark of being current for a male 25 years of age, State of Texas, non-smoker a \$2,000 deductible, PPO policy with Blue Cross, Blue Shield would be between the ranges of \$55 to \$66 a month, significantly less than an \$11,000 a year outlay. What is the reason there? Is it all the high deductible or are there other factors that come into play? Does the competition from being up on the Internet does that help drive the price down?

Mr. PETERSON. Well the \$11,000 number was for family coverage. You are referring to single coverage so that is apples and oranges there.

Mr. BURGESS. Give me a figure if anyone has it of what is a single coverage for that same male 25, non-smoker?

Mr. PETERSON. That is what I would say is \$4,000.

Ms. LAMBREW. If I could just jump in for a second. I think that we have to have, we need to think about three different types of insurance, group employer insurance in which case this whole issue of community rating and guarantee issue is not there because every worker has access to the same plan for the same premium and basically those plans are fairly generous and the benefit mandates normally apply to most self insured firms. There are small businesses that are competing in the small group market in which case some of these rules do play out. And then there is the non-group individual market which is probably what you were looking at. And I think that what we know is in the vast majority of the States there is underwriting in that market. So that rate is probably good if you have a medical screen and a good health history. It probably is not good if you have any sort of family history or health issue. And so I think that we have to make sure that we are comparing apples to apples so that same person might be paying a higher premium in an employer base coverage but they are also getting different benefits. They are just different systems.

Mr. PETERSON. And the other thing regarding catastrophic coverage and the gentleman from Oklahoma who is here was noting that he found that catastrophic coverage was not as inexpensive as he expected it would be. And the reason for that generally that has been found among analysts is that most of the healthcare costs that are in the premium are for catastrophic coverage naturally and it is for ladies like her that drive up the overall premium. Now when you have people in a group and you have that spread out that is fine. The issue is when you start doing in the non-group market and if one then targets where a premium reflects ones own health those become different. And so all of this begins to break down and it is tough issues different States do it differently and it is just really hard. But those are some of the issues at play.

Mr. PALLONE. We better—

Mr. BURGESS. Yes, Mr. Chairman, you have been indulging.

Mr. PALLONE. I was going to let you go on if you wanted to talk about that single payroll tax proposal but—

Mr. BURGESS. I am merely giving you an opening.

Mr. PALLONE. Oh, I see, OK. Dr. Berkelhamer if you would like to—

Dr. BERKELHAMER. I just have to respond to the line of questioning by saying there is I think a futility in going down the path of a catastrophic insurance program for children and that the thing that I have seen in my career and every pediatrician has seen in their career is delay in treatment resulting in catastrophic lifelong disability to a child. A child who has simple diarrhea that can be managed in the doctor's office that waits too many days and comes to the emergency room profoundly dehydrated has brain damage, never recovers again. The child whose had an earache whose mother has waited to take him to have the ears examined to get anti-

biotics who shows up with meningitis on the fifth or the sixth day of illness because she has been fretting about spending the \$100 for the doctor's office visit.

I think that when you look at this program, you have got to look at what is the benefit package that is going to promote good child health. And a catastrophic only approach in SCHIP or for children is just not right. It is not going to get us where we need to go in terms of assuring that kids get the services they need.

Mr. BURGESS. If I may, Mr. Chairman?

I think we have an obligation on this subcommittee to ask these questions. And certainly in countries that have done, had a movement more toward the medical savings account, catastrophic coverage like South Africa, the experience has been just the opposite of what you would suggest that there has not been that delay in coverage so we are charged with yes, trying to extend a very valuable healthcare system to children but we are also required to be good stewards of the taxpayer dollar and it simply in that spirit that the line of questioning occurred.

Mr. PALLONE. Thank you, thank you both.

Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman.

Before I ask my questions, I want to just say to Dr. Lambrew that in my opening statement I mentioned asthma and talked about my area, my district in Bronx, NY has one of the highest prevalent rates of pediatric asthma nationwide and I just want to say that I was very pleased in your testimony that you focused on the importance of comprehensive care to children with chronic illnesses. So I want to just say that if I had more time I would ask you a specific question on it.

And I want to thank Ms. Molina for illustrating how frightening the lack of healthcare coverage can be. Parents obviously want to care for their children as best as possible and should not have to worry that a small raise might make their kids ineligible for coverage or that if their kids are unlucky enough to get sick their family's scarce finances may be turned upside down. Ironically, we find that with children's healthcare and we find that with senior citizens as well when they qualify for a program they get a very small cost of living increase following January and that cost of living increase knocks them out a program and they wind up paying much more than their little increase was so I want to thank you for pointing that out.

But Dr. Lambrew, I want to ask you, could you please comment on the earlier discussion on premium assistance. Would this be helpful for children on Medicaid and SCHIP?

Ms. LAMBREW. Sure. I am actually glad to have an opportunity to answer this because we actually do have this option in SCHIP today. It was built into the program a decade ago because I think there was a lot of reflection on we want to make sure that this is an option for families as Nina mentioned earlier. And if it is cost effective for a State to purchase the premium and wrap around the coverage in an employer based plan States can do so. We have had a few very small number of States that have called this a success, Rhode Island for example because this is a fairly small State has been able to develop relationships with firms to make this happen.

But it is the exception rather than the rule. The States that have tried to do this have found it very challenging to coordinate with employers whose workers are coming in and out of the workforce by definition because this is a low, more a transient workforce at this income bracket trying to coordinate the benefits when those benefits change every year has been quite of a challenge. So some States like say Maine have actually tried to say can we figure out how to have those small business buy into a group product in the same way that the Medicaid people buy into Medicaid managed care. So rather than trying to coordinate with hundreds of different plans, try to figure out some pulling mechanism to allow the small business to buy in and the State to supplement.

Mr. ENGEL. Thank you.

Let me ask you another question. I believe that tax credits will not be very useful in reaching the uninsured children because most of these children are in families of very modest means. So let me ask you this. Medicaid and SCHIP have done a great job in reaching uninsured children. The statistics I have is more than one in every four children in the U.S. is covered through one of these programs. But some organizations have put forward tax credit proposal as a way to reach uninsured children rather than I believe on building up programs that we already know work. So I want to hear your opinion about that. Do you think such proposals are an effective way to reach this population? I happen to think not but I would like to hear what you have to say.

Ms. LAMBREW. I like to say my colleagues agree with me. I think most experts would agree that for a poor population, for a very low income families tax credits are not an effective way to get people covered. These are people who have little to no tax liability. They cannot put up the premium and wait for a tax refund the next year. We have some experience now with advanceable tax credits but it does not work very smoothly. So I think for the low income people who are the majority of our uninsured, a tax credit approach will likely not be as effective as a Medicaid or an SCHIP expansion.

Mr. ENGEL. Thank you.

Following that, the President in his State of the Union suggested a radical proposal which is eliminating the current tax deduction for employer sponsored health coverage and replacing it with a standard deduction for all families. Now obviously this is a bold proposal but my concern is that its net effect will be to cause families who today have decent coverage through their employers to lose that coverage and potentially not be able to replace it with coverage in the individual insurance market which we have problem with. It is obviously a terribly flawed market. I would like you to comment on that, too, Dr. Lambrew.

Ms. LAMBREW. Sure. I will do this briefly. For the first reason that I just said, low income people are uninsured, have little tax liability. They are not going to benefit that much from this proposal. Even the administration has admitted that. Second, the idea of moving people to a non-group market without the types of regulation that ensure that they have access to an affordable product means that there may be some or older workers or sicker people who do not have the option even though they may have that tax voucher. And third, I think there is this whole question mark about

what happens to the employer based system. It is eroding now. Will this accelerate the reduction in employer coverage? I think a fair amount of experts will say yes, that there is no longer a tax break associated with the employer contributing to coverage, why would employers do it? In which case, we are taking apart the main source of health insurance for most Americans today. And then there are economists like John Gruber of MIT who thinks that this actually could cause an increase in the number of uninsured Americans rather than a decrease which is what the administration projects.

Mr. ENGEL. Well thank you very much, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Engel.

And Mr. Waxman is next.

Mr. WAXMAN. Thank you, Mr. Chairman.

Dr. Berkelhamer, I was interested in your views about the impact of Medicaid on low income children because of the EPSDT Program. If these children receive all medically necessary services as prescribed by their doctor, the EPSDT is very important to be able to identify what their needs may be whether it is birth defects, chronic illness, well-child care. Could you talk about what EPSTD guarantees for low income children?

Dr. BERKELHAMER. Early Periodic Screening Diagnosis and Treatment. The *T* is extraordinarily important. It does not do any good to recognize something unless you are going to do something about it. Congressman, thank you for asking that question. One of the big concerns in the Deficit Reduction Act was the language that said that EPSTD would be wrapped around in the Medicaid Program and now we have created great confusion. That is a bedrock component that every child needs. Every child needs to be looked at periodically, the diagnosed diseases early, and to do what we can about them before they become more problems. I would remind all of you that the EPSTD Program was created in the late 1960's, I think it was 1967. Karen is that right, 1967. Did you invent it? No, OK. That it was created in 1967 and it was after the bad experiences we were having during the Vietnam Era where so many young men could not pass their physical and they had chronic life-long disabilities that would have been identified and corrected if there was a program like EPSDT. And that was the major breakthrough idea that came up with this whole concept for EPSDT. And I would say that quite frankly every child deserves EPSDT whether it be in the private sector or in the public sector that this is when I keep talking about the benefit package designed for children, EPSDT is at the core of that benefit package.

Mr. WAXMAN. And what would we expect in that regard in the private insurance plans?

Dr. BERKELHAMER. I think that there needs to be just like I heard Congressman Green talk about mandating newborn coverage, I think that we should not allow children to be in a situation where the parents have an economic disincentive to find out what is wrong with their kid early and that they make the corrected measures that are necessary to care for them. Children need comprehensive care.

Mr. WAXMAN. SCHIP does not have that requirement. Would you think that we ought to be requiring it under the—

Dr. BERKELHAMER. Well certainly those SCHIP Programs that are leaning on the Medicaid Program and there should not be any problem moving from Medicaid to SCHIP as you move up the economic ladder and you should not lose EPSDT as you move up in those programs. I would also say I think it would be very reasonable quite frankly from my perspective if you would require of all insurance programs for children that they have EPSDT benefits.

Mr. WAXMAN. But we are dealing now with the SCHIP and would you recommend Congress consider adding EPSDT to SCHIP for children to ensure that all their benefits packages are appropriately—

Dr. BERKELHAMER. I think that would be a very good idea, thank you for asking me that.

Mr. WAXMAN. One of the aspects of the welfare reform legislation passed in the 1990's was to delay Medicaid coverage for legal immigrant children. I think few people realized we have got policies in place that keep them from coverage for 5 years. Frequently because of burdensome requirements it is extended even longer. There is no logic for delaying health benefits to legal immigrant kids for 5 years except to punish them for their immigrant status. I wonder if some of the panelists might like to comment, Dr. Berkelhamer, would you comment on the effect on a child's health of banning coverage? Does this make any sense?

Dr. BERKELHAMER. It just seems Draconian to me to do that to a child. And I cannot understand why if a child is not physically within our borders that we do not recognize the value in giving that child medical care. And we have to wait 5 years and they have a disability that could have been treated earlier and could have mitigated some of the lifelong problems, I am absolutely certain we are saving money by doing the right thing from the get go. And I just think that we are much too hung up on holding children responsible for whatever the problems are that their parents have. We have to recognize that these children are all of our responsibility and we have to do the right thing for them.

Mr. WAXMAN. Dr. Lambrew, do you have any comment on that?

Ms. LAMBREW. I would just add two things from a cold heartless researcher's perspective which is you know there is a public health argument to be made here which is to the extent that we have children lacking immunizations, lacking health, basic health care and a society where we are more worried about Avian flu and other infectious diseases. It is a public health threat. We have evidence that areas we have high undocumented people have problems with public health and lack of healthcare. And it is an economic issue. These children may get care in the emergency rooms but we are paying more for them there and they are sicker as we talked about earlier and creating a bigger burden on society.

Mr. WAXMAN. OK, thank you.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I just wanted to thank all of you for being here today. I thought this was very worthwhile and answering our questions really in a very concise and effective way.

As I mentioned, we are going to have the second panel which was supposed to be tomorrow but for the unfortunate death of Congressman Norwood and we will most likely have that second panel

on March 1. I would also remind the members that you may submit additional questions for the record to be answered by the relevant witnesses so you may get some written questions. And the questions should be submitted to the committee clerk within the next 10 days and then the clerk will notify Members' offices about the procedures. And without objection, the meeting of the subcommittee is adjourned.

Thank you all.

[Whereupon, at 5:00 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

TESTIMONY OF SUSAN MOLINA

Good afternoon. My name is Susan Molina and I am a working mother whose two children understand exactly how important reliable health coverage is.

I am also committed to improving my community and serve as the Board Chair for Metro Organization for People in Denver, Colorado. MOP is a grassroots, faith-driven organization that works to empower people around real issues that affect our families and communities. MOP is part of the PICO National Network, which spans 1,000 religious congregations in 150 cities in 17 states.

I am here as a mother to speak on behalf of my two children Bernadette (age 14) and Joseph (age 10). I am also speaking for the tens of thousands of parents in the PICO network who lack coverage for their children.

Almost all uninsured children (83 percent) live in families where at least one parent works. I am a single mom who works. I am uninsured. In September my children lost their SCHIP coverage because my new job paid slightly more than 200 percent of poverty and that made my children ineligible.

It is an honor to be here and not something I would have ever expected. I was married at the age of 17 and I had two children. My husband was a very abusive man who walked out on us when my oldest was five. I worked very hard so that I would not become a burden to my parents. Sometimes I worked two jobs.

When I became involved with the MOP organization, my life began to change. I began to see that it's OK to realize where you are and what you've been through as long as you want to change where you're going. MOP and PICO helped me to earn my GED and I even took an accounting class at the university. Now I help mentor others who are in similar situations I was in.

I say all that to say this: as a single mother who has worked to be where I am now it's hard to know that my kids don't have health care. Somehow we are punished for bettering our lives.

When my daughter was 4 she needed a lot of dental work. I was working two part-time jobs that paid \$8-9 an hour and none of us had health coverage. I remember going to the welfare department and asking to enroll in Medicaid. I told them I did not need welfare or food stamps or anything else, just help with the dental work that my daughter needed. After I did the paper work the caseworker told me I didn't qualify unless I quit one of my jobs or had another baby.

When SCHIP became available, I was able to enroll my children in the Colorado Child Health Plus Plan and get my children health coverage. And like most kids, they needed it. While they were on SCHIP both my children sprained their ankles, my son broke his arm and my daughter had a bad burn. Both received good care that kept them from any permanent harm and allowed them to go back to school and allowed me to go back to work.

I was not worried about how much these accidents were going to put us in debt. I just knew they were going to get the care they needed.

All that changed when we lost our coverage in September, because my new job paid slightly above the 200 percent cut off to qualify for SCHIP in Colorado.

We talk about 9 million uninsured children. Behind these numbers are real children who go to school, have accidents and get sick. And real parents like me, who work hard to meet their families' needs.

When insurance prices are outrageously high, as a parent I have to decide whether to put food on the table or buy health insurance. I cannot afford to pay the hundreds of dollars each month that it would cost me to buy health insurance for my children.

I worry that when my children, God forbid, have an accident or get sick I will not have the means to pay for the medical attention they need.

I too am in danger of having a very serious eye disease. Four years ago when I was being tested for Glaucoma I was told that I had to be tested every year to track the condition. I have not been tested for the last 3 years, since I lost my health coverage. It scares me to think that I could eventually have serious problems as a result of not being treated.

Thank God that neither of my children has had a major injury since September. But they have been sick, and not having insurance changes the care you can give them.

Both of my kids were home sick last week for a number of days. The first night I felt very sad that I couldn't just take my son to the doctor because we don't have health insurance anymore. He was running a fever, and as I drove to the store to buy him some medicine, I began to cry. I felt like a failure. My kids needed something I couldn't provide. As a parent you work to make sure they have what they need. I went into the store and picked up the generic brand of chest rub and some Motrin for the fever. As I got back into the car I felt the need to tell someone that of course I would take my children to the doctor if I felt it was an emergency. I wouldn't care if I had to pay hundreds of dollars later.

I called my friend and told her. She just heard me cry for a while, and she said that it was important that I tell this in my story so that you would know that parents go through this helpless feeling everyday. She was right, and I hope you do.

Through MOP and PICO I've learned that my experience is not unusual. In MOP and throughout the PICO network we have surveyed thousands of people in our churches and schools around healthcare. We have heard many sad stories like mine. We have also learned that this is hard for people to talk about because it's so private.

My state, Colorado, has a long way to go in covering all children, but it cannot get there without help from Congress.

- In Colorado there are 176,000 uninsured children.
- Our state has one of the highest uninsured rates in the country: 29 percent of low-income children are uninsured.

But things are changing.

- For the first time in 2005 Colorado spent its full allocation of SCHIP funds.
 - Now MOP and PICO Colorado are working with health care organizations to change state policy to enroll eligible children and expand coverage.
 - I'm happy to say that legislation is about to be introduced to expand coverage.
- But Colorado cannot move forward to help working families like mine without more Federal funding for children's health.

That's why Metro Organizations for People in Denver, PICO Colorado and the PICO National Network, are working with child health organizations to see that Congress fully funds the SCHIP program.

PICO is advocating a Road Map to Covering all Children by 2012. This Road Map has five steps to cover all children:

- (1) Fill the existing SCHIP shortfalls facing states, so that no one risks losing coverage
- (2) Fund proven outreach programs and provide states with the financial incentives to cover all eligible but uninsured children
- (3) Provide financial support and incentives for states to expand eligibility
- (4) Allow states the option to cover legal immigrant children and pregnant women
- (5) Provide the approximately \$60 billion in SCHIP and Medicaid financing to support the cost of covering newly enrolled children

[Attached to my testimony is a letter from more than 200 prominent clergy supporting the PICO Road Map.]

This road map is realistic, responsible, and for millions of children in working American families like mine, it is the highest possible priority.

Working parents need to know that if our jobs don't offer affordable family coverage we have another option for our children.

PICO is working closely with many other state and national organization to win health coverage for all children. This week we joined 55 other national organizations in adopting a consensus plan for SCHIP reauthorization.

I want to thank my own representative, Congresswoman Diana DeGette for her leadership on children's health in Colorado and nationally.

On March 7 I will be back on Capitol Hill with 400 other parents and clergy for PICO's Faith and Families Summit on Children's Health.

We invite all members of the House Energy and Commerce Committee to join us for a Summit kick-off event from 8-9:00am and a 1:00pm Rally. As part of PICO thousands of parents like me are finding our voices.

Chairman Pallone, Congressman Deal, I know you are both parents—and many other members of this subcommittee are too.

I don't need to tell you about how hard we parents will fight for what our children need. And my faith tells me I have a responsibility to join with other parents to make sure that all children have the blessing of good health.

Thank you for the opportunity to tell you one parent's story, on behalf of millions of parents throughout our country.

PICO NATIONAL NETWORK

ALL CHILDREN DESERVE THE BLESSING OF GOOD HEALTH.

This year Congress is reauthorizing the successful State Children's Health Insurance Program (SCHIP) which provides affordable coverage to six million children. Despite progress in expanding health coverage there are still 9 million uninsured children in the United States. This is the right moment for Congress to expand financing for children's health, so that no child goes without treatment or relies on an emergency room for their health care.

A ROAD MAP FOR COVERING ALL CHILDREN

PICO is advocating a five-step road map to help States cover all children by 2012

- (1) Fill the existing SCHIP shortfalls facing States, so that no one risks losing coverage
- (2) Fund proven outreach initiatives and provide States with the financial incentives and support to reach all eligible but uninsured children
- (3) Provide financial support and incentives for State efforts to expand high-quality preventative care and increase eligibility
- (4) Allow States the option to cover legal immigrant children and pregnant women
- (5) Provide financing in SCHIP and Medicaid to support the cost of covering newly enrolled children

Estimated cost is \$60 billion over 5 years

WHY WE CAN'T AFFORD NOT TO COVER ALL CHILDREN

- Leaving children without coverage imperils their development and costs society more than the \$100-\$120 per month needed to provide health coverage to a child
- Covering all children as part of SCHIP reauthorization is the best chance our country has to move the ball forward on health care this year
- States across the country are moving ahead to cover all children, but they cannot succeed without Federal support to expand financing for children's health.
- SCHIP is a highly successful program that has bipartisan support

ORGANIZING FAMILIES AND FAITH COMMUNITIES

PICO is a national network of 53 faith-based federations and 1,000 congregations. PICO led a county-based cover-all-kids initiative that has been replicated in more than half of California's counties. In 17 States and 100 Congressional Districts, PICO is partnering with health and children's advocacy groups at the local, State and national level to expand health coverage for children and families.

Join us for a Faith and Families Summit for Children's Health on Capitol Hill on March 7

For more information visit www.piconetwork.org/schip.html

PICO NATIONAL NETWORK

DECEMBER 20, 2006

The Honorable Harry Reid
United States Senate
Washington, DC 20510

The Honorable Kent Conrad
United States Senate
Washington, DC 20510

The Honorable Max Baucus
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
U.S. House of Representatives

Washington, DC 20515
 The Honorable John M. Spratt, Jr.
 U.S. House of Representatives
 Washington, DC 20515
 Honorable John D. Dingell
 U.S. House of Representatives
 Washington, DC 20515

Dear Majority Leader Reid, Speaker-elect Pelosi, Senator Conrad, Representative Spratt, Senator Baucus and Representative Dingell:

As you prepare to lead the 110th Congress, we urge you to include adequate funding in the Federal budget to sustain and expand the highly successful State Children's Health Insurance Program, so that our Nation approaches the day when every child in the United States has access to affordable health coverage.

As congregations from more than 50 religious traditions, representing over 1 million families, PICO sees children's health as a core moral issue. We take as our example the prophet Jeremiah who lamented for his people of Judah. Grieving over their condition, he cried out: "Is there no balm in Gilead? Is there no physician there? Why then has the health of my poor people not been restored?" We ask these same questions of our elected leaders. Is there no balm in Washington, DC? Is there no solution there? Why has the health of our children not been restored?

In November, Americans voted for change. Many Democrats ran on a health care agenda. Providing access to affordable health insurance for every child is the right place to start. There are 9 million uninsured children in this country; more than 6 million are already eligible for public coverage. If we do what is right as a nation, we can take care of all our children and raise the healthiest generation in American history.

Reauthorization of the State Children's Health Insurance Program (SCHIP) next year provides a golden opportunity to take concrete steps toward covering all children. But progress is only possible if the budget includes adequate funding to sustain and expand the SCHIP program. We urge you to support funding for the following steps:

- Provide adequate Federal funding to cover the 2007 shortfalls in SCHIP funding which put over 600,000 children at risk of losing their health coverage.
- Fill the estimated \$12–14 billion shortfall in funding over 5 years so that no one loses coverage in SCHIP.
- Include substantial additional funding to support States that are moving toward covering all uninsured children, including those expanding coverage to 300 percent of poverty.
- Create financial incentives and support for States to reach out to and retain coverage for the majority of uninsured children—those who are already eligible for SCHIP and Medicaid.
- Give States more ability to simplify the enrollment and renewal process, including using express lane eligibility programs.
- Give States the option and funding to cover legal immigrant children and pregnant women.

In the effort to expand health coverage for children we urge that Congress do no harm to the broader Medicaid program, which provides essential health care services to the poorest children in the Nation. The fate of our children and families is interconnected; we must not pit children from low-income families against those with even lower incomes.

Many local communities and State governments have already taken action toward covering all uninsured children and expanding coverage for low-income families. These initiatives reflect strong grassroots public support for efforts to improve children's health. But without leadership and additional Federal financing, our counties and States run the risk of losing rather than gaining ground on covering all children.

Over the coming months our faith communities will be organizing to make our voices heard in our State capitals and in Washington, DC. We will continue to educate and agitate so that Congress adopts a budget that is faithful to the needs of working families. We urge you to take a first step in restoring American domestic priorities by budgeting sufficient funds to strengthen the State Children's Health Insurance Program.

With more than 1,000 religious congregations representing 50 denominations and 1 million families in 150 cities and 18 States, PICO National Network is one of the largest community-improvement efforts in the United States.

We look forward to an opportunity to meet with you at your earliest convenience to discuss funding for children's health in next year's Federal budget.

Sincerely,

Fr. John Baumann
Executive Director,
PICO National Network, et al.

TESTIMONY OF KATHY PAZ MINGELDORFF

My name is Kathy Paz Mingeldorff and I am pleased to submit this statement on behalf of the March of Dimes Foundation. As a mother, I understand in a very personal way the importance of health insurance for women and children, and I thank Members of the Committee for making access to coverage the focus of this hearing.

Let me begin by telling you my family's story, and specifically why Medicaid and FAMIS—Virginia's State Children's Health Insurance Program (SCHIP) have been so important to us. In 2001, I became pregnant while in college and was covered by my parents' private health insurance policy. But after my son Alex was born, I lost my health insurance because I could no longer be considered a dependent. My son Alex was born prematurely at 25 weeks and suffered many complications due to his early delivery. Fortunately Medicaid was there to provide health insurance for the first 3 years of Alex's life. Without help from Medicaid with Alex's enormous medical bills—more than \$800,000 in the first two years alone—I am not sure how we would have survived.

By the time Alex was 2, complications associated with his premature birth required a feeding tube, special formulas and multiple medications. We took Alex to the emergency room many times, and he was hospitalized on 3 separate occasions. In January of 2004, Alex had surgery to stabilize his severe reflux condition. I cannot imagine what life would have been like for us without health insurance through Medicaid.

In 2005, I married and found an employer who was eager to hire me. Unfortunately, the employer did not offer health insurance. I attempted to enroll Alex in FAMIS but our income was too high for him to qualify. At that time, eligibility for the program in Virginia was limited to children with family incomes below 133 percent of the Federal poverty level—less than \$22,000 a year for a family of 3. So, my only option was to turn down a position I really wanted in order to keep my son insured through Medicaid. I want to emphasize how hard that was for me.

In July of last year, the State of Virginia changed its eligibility rules for FAMIS, allowing families with incomes up to 200 percent of the Federal poverty level (a little over \$34,000 for a family of 3) to qualify, and making it possible for me to enroll my son.

Once Alex had health insurance through FAMIS, I was able to accept full time employment at SAIC, a government contractor in northern Virginia. Today, Alex and I have health insurance through my husband Adam's employer, and I work part time as an administrative assistant for a national furniture corporation and am taking graduate courses at Marymount University.

The help that my family received came at a time when we needed it most. Because I wanted and was able to work, it was great to have a program like FAMIS. I know from my experience and that of other families with premature babies that my story is not unique, in fact it's not uncommon for a family just getting started to face the problem of not having enough health coverage to meet the needs of a fragile infant.

Given my family's experience, I am sure you can understand why I am so committed to the March of Dimes' goal of using this year's SCHIP reauthorization as an opportunity to strengthen the program to improve the health of pregnant women, infants and children. To achieve this goal, the March of Dimes recommends that the Committee authorize a substantial amount of new funding for SCHIP reauthorization. The Foundation's immediate priority is funding sufficient to protect states' 2007 SCHIP enrollment levels. As Members of the Committee are aware, the National Institutes of Health (NIH) Reform Act, P.L. 109-482, enacted at the end of the 109th Congress, included a redistribution of unspent FY2004 funds to states experiencing FY2007 shortfalls, and a January 30, 2007 Congressional Research Service (CRS) report projects that this measure will ensure that no state runs out of SCHIP funding before May 1, 2007. However, officials in at least one state report that its program may experience a funding shortfall prior to May 1. Unless Con-

gress acts soon, additional states may 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 pregnant women and children.

As members of this committee are aware, the concern about adequate funding extends well beyond 2007. In addition to the funding level assumed in the CBO baseline, new resources will be needed to maintain current levels of eligibility. And, if the Committee wishes to see states reach out to eligible but unenrolled children or expand eligibility, a significant investment of new funding will be necessary.

Using information provided by the U.S. Census Bureau, researchers have estimated that nearly half of the 9 million uninsured children in the U.S. are eligible for Medicaid and almost 20 percent are eligible for S-CHIP. In other words, with adequate funding and more attention to enrollment of those who are already eligible, more than 6 million uninsured children could have health insurance through these two programs. The March of Dimes recommends that the committee provide states with the tools and resources necessary to enroll these children.

The March of Dimes also encourages the members of the committee to use this reauthorization as an opportunity to amend the law so that states can make modest but important improvements to their SCHIP programs. The priorities the Foundation hopes the Committee will consider during its deliberations include 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 children with special healthcare needs whose private health insurance benefits are limited; (3) cover legal immigrant children and pregnant women. Finally the Committee should strengthen the law's current requirements to monitor and report on the quality of care provided. Consumers, health professionals and policy makers need to know how well SCHIP is doing on measures such as immunization rates, delivery of services in neonatal intensive care units, well-child visits and other inpatient and outpatient services.

COVERAGE FOR PREGNANT WOMEN OVER AGE 19

Under current law, maternity coverage for pregnant women over age 19 who meet the SCHIP income eligibility requirements is permissible only through a Federal waiver—a slow and cumbersome process which most states have chosen to avoid. This policy creates an unfortunate separation between pregnant women and infants, which runs contrary to long-standing Guidelines for Perinatal Care promulgated jointly by the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP). The March of Dimes view is that reimbursement policies should be aligned with—and not undermine—established clinical practice guidelines.

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 ACOG/AAP Guidelines for Perinatal Care—is not reimbursable with Federal funds. 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 infant. 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.

The Centers for Medicare and Medicaid Services reports that five states (CO, NJ, NV, RI, and VA) use waivers to cover income eligible pregnant women and nine states have amended their plans to cover unborn children (AR, CA, IL, MA, MI, MN, RI, TX, WA). However, a survey conducted by the National Governors Association found an additional eight states where program officials indicate maternity care is being provided to income eligible women age 19 and older through SCHIP. A simple Federal mechanism is needed so that states can, at their option, provide the full spectrum of clinically indicated services to pregnant women who meet the SCHIP income guidelines. As Members know, early and continuous maternity care is crucial to the health of the mother as well as to that of her infant.

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. To maintain the health of a pregnant woman and her unborn child, continuous access to prenatal care is essential. The ACOG/AAP Guidelines for Perinatal Care state:

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.

Lack of adequate, regular prenatal care is associated with poor birth outcomes, including prematurity (born before 37 completed weeks of gestation.) or low birth-weight (less than 5½ 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.

Conversely, women who do receive appropriate levels of 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.

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 the full spectrum of recommended maternity care 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. Both the NGA and the National Conference of State Legislatures (NCSL) recommend that this option be made available to states.

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 premiums. 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:

Wraparound coverage: For pregnant women, infants and children with limited private coverage, SCHIP could cover benefits—such as vision, dental, physical/occupational/speech therapy, et cetera—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.

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.

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. While title XXI has included a quality reporting requirement since the program was created, the field of performance measurement has advanced significantly in the past 10 years. Therefore, the March of Dimes urges the Committee to revisit this section of the law and to provide states the tools they need to update and expand the scope of reporting on the quality of care provided enrollees.

More specifically, the Foundation recommends that the Department of Health and Human Services (HHS) collaborate 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.

The March of Dimes urges members of the committee to ensure that states have the resources necessary to gather and report data as well as to develop interoperable clinical health-information systems.

COVERAGE FOR LEGAL IMMIGRANTS

In 2003, the Senate approved a provision to allow states to cover legal immigrant children through their SCHIP programs, which was ultimately excluded from the larger Medicare Modernization Act negotiated by the House and Senate Conference Committee and signed into law. 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 NGA and NCSL. CBO estimated that this coverage would cost the Federal treasury \$500 million over three years.

In 2004, there were an estimated 31 million non-elderly immigrants living in the United States, approximately 74 percent of whom were here legally. It has also been estimated that nearly 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.

The Foundation urges Members of this Committee to add to SCHIP an option for states to extend SCHIP coverage to income eligible legal immigrant pregnant women and children.

The March of Dimes appreciates the opportunity to submit its comments for the record and looks forward to working with Chairmen Dingell and Pallone and Representatives Barton and Deal, as well as 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.

STATEMENT OF AMERICA'S HEALTH INSURANCE PLANS

America's Health Insurance Plans (AHIP) strongly support the State Children's Health Insurance Program (SCHIP), and we applaud the House Energy and Commerce Committee for focusing on the reauthorization of this vitally important program.

Over the past decade, SCHIP has proven to be highly successful in meeting the health care needs of millions of low-income children. By providing the states with the resources and flexibility to design innovative programs, SCHIP has demonstrated its value as an effective model for extending health coverage to a vulnerable population. As Congress prepares for the coming debate on reauthorization of SCHIP, we see an opportunity to build upon the program's past success with improvements that would enable the states to maintain their existing programs, while also offering coverage to a larger number of uninsured children and making coverage more affordable for their parents.

AHIP ACCESS PROPOSAL CALLS FOR SCHIP EXPANSION

In November 2006, AHIP's Board of Directors announced a proposal for expanding access to health insurance coverage for all Americans. Our proposal includes a comprehensive set of policy initiatives that would expand eligibility for SCHIP and Medicaid, enable all consumers to purchase health insurance with pre-tax dollars, provide financial assistance to help working families afford coverage, and encourage states to develop and implement access proposals.

A major element of AHIP's access proposal calls for expanding SCHIP to ensure that all states can, at a minimum, fully cover all uninsured children in families with incomes under 200 percent of the Federal poverty level. To further address the health care needs of children, we also propose that a health tax credit of up to \$500 be established for low-income families who secure health insurance for their children. These steps are designed to expand access to health insurance coverage to all

children within three years. Other components of AHIP's access proposal seek to cover 95 percent of adults within 10 years.

AHIP also is an active member of the Health Coverage Coalition for the Uninsured (HCCU), which released a proposal in January 2007 for expanding health coverage to the uninsured. The membership of this diverse coalition also includes Families USA, the Chamber of Commerce, AARP, the American Medical Association, and the American Hospital Association. Much like the AHIP proposal, the HCCU proposal builds on the strengths of the existing private-public system and includes key improvements to SCHIP and Medicaid, as well as a broader tax credit. The HCCU proposal shares AHIP's phased approach, beginning with a Kids First initiative followed by a longer-term proposal for adults and families.

As Congress considers SCHIP reauthorization legislation, AHIP urges the committee to consider three priorities discussed in the following sections: (1) increasing Federal funding to help states cover existing SCHIP caseloads and expand coverage to more uninsured children;

(2) establishing performance standards, tied to funding bonuses, to promote quality throughout the program; and (3) authorizing demonstration programs to help states coordinate SCHIP eligibility with private health insurance.

INCREASED FUNDING TO COVER SHORTFALLS AND EXPAND COVERAGE

A top priority in the SCHIP reauthorization process is ensuring that the states receive adequate funding to provide coverage for eligible children. Currently, a number of states are facing funding shortfalls that are threatening their ability to provide quality coverage to children already enrolled in their programs. These shortfalls also may discourage the outreach efforts that are needed to identify eligible children who are not yet signed up for SCHIP.

In addition to stabilizing existing SCHIP coverage, Congress should devote new funding to help states expand coverage to children who currently do not qualify for SCHIP assistance. An infusion of new funding would ensure that states could maintain existing enrollment, while also having greater flexibility to innovate and possibly expand enrollment in conjunction with broader innovations that leverage SCHIP dollars. By providing additional funding for this priority and promoting strategies that do not "crowd out" existing coverage, Congress could target assistance to a segment of the uninsured population—the "near poor"—that have seen a gradual decline in their access to coverage over the past decade.

PERFORMANCE INCENTIVES TO IMPROVE QUALITY

Congress should establish performance standards to measure the extent to which states are achieving demonstrable improvements in child health. Such standards could focus on immunization rates for children, the percentage of infants receiving periodic screenings, the percentage of eligible children who remain continuously covered by SCHIP, and other measures for which data can be easily obtained and compared.

Moreover, these standards would help to promote accountability throughout the program if Congress provided a financial bonus to states that demonstrate strong success, based on the performance standards, in improving the health of their SCHIP populations. These incentives should be supported with new funding—on top of existing allotments—to allow states with highly successful SCHIP programs to take additional steps in developing initiatives that can serve as models for the entire nation.

DEMONSTRATION PROGRAMS TO COORDINATE WITH PRIVATE COVERAGE

Recognizing the need for greater innovation throughout the health care system, we believe Congress should authorize new demonstration programs that allow states to use streamlined procedures in coordinating SCHIP eligibility with private health insurance. These demonstrations could build upon SCHIP's existing premium assistance program, allowing states to assist the parents of eligible children in purchasing family coverage through their employers or other sources. Addressing the coverage needs of the entire family is beneficial to children as well as parents, as indicated by the findings of a 2002 Institute of Medicine (IOM) report which concluded that children are more likely to be taken to the doctor for regular checkups if their parents also have coverage.

Significantly, Massachusetts is one of the few states that has used the current premium assistance option to maximize the value of its SCHIP and Medicaid funding. By pursuing this public-private partnership, Massachusetts was able to position itself for the broader reforms that its state legislature enacted last year. To open

the door for more states to pursue innovative strategies that meet the unique needs and circumstances of their own populations, Congress should encourage greater coordination between SCHIP and private health insurance.

AHIP members are strongly committed to the long-term success of SCHIP and we stand ready to work with the House Energy and Commerce Committee and other members of Congress to strengthen the program.

Jay Berkelhammer

The American Academy of Pediatrics (the Academy) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of children, adolescents and young adults receiving health care in the United States.

The Academy is pleased to provide comments about the future of the State Children's Health Insurance Program, (SCHIP), a program which has been a resounding success. SCHIP also has had positive spillover effects on the Medicaid program. As a result of SCHIP outreach, millions of potentially eligible but uninsured children have been enrolled in Medicaid. Eligibility determination processes have been simplified, and coordination between SCHIP and Medicaid has become increasingly effective.

Despite the program's widely acknowledged success and popularity, several outstanding challenges have been identified by participating pediatricians. These challenges pertain to (1) Payment and Funding; (2) Ease of Enrollment; (3) Benefits available under the program. Recommended strategies in each of these three areas are outlined below. If these changes to the program are incorporated into this year's reauthorization, SCHIP's success will continue through its next decade.

Funding

The SCHIP program is a block grant, which creates inherent difficulties. Because funding is capped, children have been denied services, waiting lists have developed and predictability in care is compromised. If it is not feasible to convert the program to an entitlement such as Medicaid, Congress should set the budget baseline for SCHIP at a rate significantly higher than the level set in law for the final year of SCHIP's initial authorization to avoid future budget shortfalls. Congress must also provide enough funding so that states are not encouraged to limit enrollment or benefits. Congress should strengthen its commitment to the federal-state partnership that has led to SCHIP and Medicaid's success over the past decade. With \$60 billion in new SCHIP and Medicaid funding over five years, states will be able to maintain their existing SCHIP programs, and avoid the tragedy of children losing health care coverage because the federal government did not maintain the commitment made in 1997 when SCHIP was created. This level of funding also will allow the country to move forward by enrolling most of the uninsured children already eligible for Medicaid and SCHIP and providing support to those states seeking to further expand coverage for children.

Payment

One of the important problems with both the Medicaid and SCHIP programs is the rate of payment under each. On average, Medicaid reimburses pediatricians at only 69% of the rate that would be paid under Medicare, and only 56% of commercial rates for an office visit. In some states, Medicaid payment is even lower. While payment rates under Medicaid have been monitored by the Academy, the SCHIP program makes it much more difficult to deduce rates of payment because some states have tied SCHIP payment to Medicaid while others have not.

Low rates of payment seriously impede access to quality health care for children. While a

number of states have taken steps to increase Medicaid and SCHIP payment rates to match those of Medicare, most have not. Low Medicaid and SCHIP payments do not cover costs, and increasingly force pediatricians to make difficult business decisions of continuing to treat patients at a financial loss, or limiting their participation in the Medicaid program altogether. The resulting lack of access for patients may then drive them to seek emergency room care that is significantly more expensive.

To address this problem, the Academy recommends that payment rates for pediatric services be set at least at 100% of Medicare rates. The risk of Medicare is that some states have low pay even under the system, but in general, Medicare payments are much higher than Medicaid and what can be discerned of SCHIP rates. Additionally, adequate payment must be ensured when new vaccines and other new technologies are introduced. Under capitated arrangements, states should ensure that provisions are made to reimburse physicians for the cost of the new vaccines until new contracts are negotiated. In addition, physicians should receive payment for the expenses associated with the administration of each vaccine. Congress should also adopt financial incentives for medical homes, especially in the care of children with special needs, including chronic care management, child and family education, and coordination and consultation with pediatric specialists and other support services. Recognizing the dearth of pediatric subspecialists nationwide, Congress should encourage the inclusion of pediatric subspecialists and the academic medical centers where they practice in managed care plan networks, and encourage coordination and communication between pediatric subspecialists and primary care practitioners. Congress should also identify new mechanisms to designate and support safety net providers, including office-based pediatric practices and hospitals specializing in the care of children, who serve a certain proportion of publicly insured children. Finally, Congress should ensure that financing structures encourage medical home and pediatric subspecialty network continuity in SCHIP and Medicaid when children switch managed care plans and when children switch between the two sources of coverage.

Extending Eligibility and Enrollment

Beyond payment rates, it is also important to raise the issue of enrollment barriers. The evolution of the SCHIP program has spurred the Medicaid program to encourage enrollment. Nevertheless, passage and implementation of the Deficit Reduction Act (DRA) took this success in the wrong direction by erecting virtual barriers to access. One of the most significant changes brought about by the DRA was the requirement that enrollees document citizenship and identity. After a harsh interpretation by the Centers for Medicare and Medicaid Services, a bad law was made worse. We are starting to see the results. As one example, in Georgia, it has been documented that over 100,000 children have been cut from the rolls after the implementation of the regulations called for by the DRA. These children are not illegal, but are citizens in poor families who are simply unable to meet the stringent documentary burden required by the CMS implementation of the DRA. This state of affairs is unacceptable and must be reversed.

Congress should also take the following steps specific to the SCHIP program during reauthorization. Congress should establish a performance-based outreach fund to encourage enrollment of all uninsured children who are eligible for public coverage. Administrative simplification should also be improved upon so that enrollment and reenrollment can reach the

most possible children. States should be encouraged to adopt shortened forms, streamlined verification requirements, online enrollment, and renewal assistance. In addition, states should receive the authority to automatically enroll children into SCHIP (and Medicaid) on the basis of findings of other means-tested programs, such as the National School Lunch Program or the Food Stamp Program. Similarly, presumptive eligibility should be encouraged for all children, allowing health care professionals and designated agencies to grant eligibility for up to 60 days while a child goes through the enrollment process. Additionally, states should be encouraged to adopt 12-month continuous eligibility for SCHIP-enrolled (and Medicaid-enrolled) children.

Beyond these steps, households with children in both Medicaid and SCHIP should be allowed to enroll in the program with the best coverage to ensure continuity among siblings with their pediatric medical home. SCHIP should also be expanded to include adolescents 19 through 21 years of age and allow emancipated minors to be eligible for SCHIP on the basis of their own income. In addition, eligibility restrictions for dependents of state employees should be eliminated if they qualify on the basis of income. Higher income families (>200% of the FPL) should also become eligible for the benefit where they are currently not eligible and asset testing should be discontinued to extend eligibility to more uninsured children.

To provide better services to children, SCHIP programs should not be barred from providing buy-in options for children whose family incomes are above their state's SCHIP eligibility level but who do not have access to or cannot afford comprehensive private health insurance. States should also be granted the authority to cover legal immigrant children. Finally, the program should allow states to draw down Medicaid/SCHIP matching funds when employers pay for a share of the cost of coverage for children enrolled in Medicaid or SCHIP.

Benefits

The interplay between benefits for SCHIP and Medicaid populations should also be addressed by Congress in this year's reauthorization. Specifically, churning between the programs, into private insurance, and back again has become a documented reality for children throughout the United States as their family's economic situations change. It makes no sense from a clinical viewpoint for children in states without Medicaid expansion programs to be denied services guaranteed under Medicaid when they enter the SCHIP program. The need for vision, dental and mental health services does not disappear with changing economic circumstances.

Thus, the Academy recommends that Medicaid benefit coverage in states with Medicaid SCHIP programs must be preserved. Additionally, states should be encouraged to adopt SCHIP benefit packages that are consistent with the AAP policy statement "Scope of Health Care Benefits for Children From Birth Through Age 21," including dental services and the full range of mental health services, including substance abuse treatment. Preventive care, immunization standards, and periodicity schedules also should be consistent with current AAP requirements. Eligibility for the Vaccines for Children Program should also be extended to all children enrolled in non-Medicaid SCHIP programs. Finally, the prohibition against partial benefit packages to allow states with non-Medicaid SCHIP programs to provide additional wrap-around coverage to children who have inadequate private health insurance should be eliminated.

Conclusion

SCHIP has a proud history on which to build. To achieve continued success in reducing uninsurance among children and ensuring access to high-quality pediatric care, the AAP recommends that Congress and state policymakers adopt these important recommendations. In closing, the American Academy of Pediatrics seeks to ensure that Congress keeps in mind the children we care for as it considers reauthorizing SCHIP. The Academy would welcome the opportunity to provide further information and input to the Committee as it engages in the SCHIP reauthorization debate.

Testimony of Jeanne M. Lambrew, PhD
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Services, and Senior Fellow, Center for American Progress

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today at the hearing entitled, "Covering the Uninsured through the Eyes of a Child." I am an associate professor at the George Washington University School of Public Health and Health Services and senior fellow at the Center for American Progress. My role today is to summarize what we know about the value of public investments in children's health.

I am especially excited to be a witness at this first House hearing on the topic this year. 2007 will be a momentous year for children. It marks the 10-year anniversary of the State Children's Health Insurance Program, known as SCHIP. The program, along with Medicaid, has made significant inroads in reducing the number of low-income, uninsured children. Yet, 2007 will be the last for SCHIP if Congress does not act to renew and re-fund it. Congress could, as the President proposes, maintain current levels of funding which would reduce the reach of SCHIP. It could focus on outreach to eligible but uninsured low-income children. Or, it could set policy ensure coverage for all children in America. Each option would have dramatically different effects on children and spending, underscoring the value of hearings like this.

In addition, I had the privilege of working in the Clinton White House a decade ago when SCHIP was created. I watched the President, First Lady, and entire Administration roll up their sleeves to enact and implement this program. I worked with state officials, private foundations, and the corporate community to connect children with existing programs. And I witnessed how compassion for children dissolved hardened partisan positions in Congress. This gives me hope that, a year from now, you will be holding hearings on how to make the most of legislation passed in 2007 that improves coverage for children in this nation.

In my testimony today, I would like to make three points.

- Health coverage for children improves access to care, health outcomes, and the prospects of children and their families;
- The short-run budget cost of covering more children is worth the long-run value to our nation; and
- The design of the federal investment in children's health coverage matters – specifically, the block-grant features of SCHIP have limited the program's success and should be modified in reauthorization.

The Impact of Coverage on Children's Access to Care, Health, and Prospects

Health coverage is the portal to the health care system. It removes financial barriers to seeking, obtaining, and adhering to needed health care. It prevents the cost of essential health care from bankrupting individuals and families. It ensures access to the finest care irrespective of actual income. Yet, the U.S. lacks a system that ensures health coverage for all, despite having the most expensive system in the world. In 2005, national health spending reached 16 percent of the gross domestic product, and spending per capita was 50 percent higher than the next most expensive nation. Health spending per person equaled nearly 15 percent of the median income in the U.S.¹ In 2006, the average premium for an employer-based, family insurance policy (\$11,480) was more than the full-time, full-year earnings of a minimum-wage worker.² This affects businesses' competitiveness; health costs could exceed profits in Fortune 500 companies next year.³ And, it affects the health of our nation. A comprehensive review by the Institute of Medicine concluded that lacking health coverage can have negative effects on health. An estimated 18,000 adults die each year because they lack health insurance.⁴

Access to Care

The problems associated with lacking health insurance coverage extend to children. Studies that compare insured to uninsured children document worse access to care for uninsured children.⁵ One study found that uninsured children were significantly less likely to visit a physician for conditions like acute earaches, recurrent asthma or other conditions for which medical attention is usually considered necessary.⁶ Relative to children enrolled in Medicaid or SCHIP, uninsured children were more likely to report unmet health care needs (11% vs. 2%).⁷ The likelihood of not seeing a doctor within a

year is twice as high for uninsured children compared to children eligible for Medicaid.⁸ Adolescents have special health issues, with increased need for mental and reproductive health care, as well as emergency care due to accidents and risky behavior. Adolescents who are uninsured are four times as likely to report an unmet health need as those who are insured (24% versus 6%).⁹

In recent years, we have been able to study the impact on children of gaining coverage. In Pennsylvania, unmet need among children who gained coverage through a state insurance program fell from 57 percent to 16 percent after 12 months.¹⁰ In New York, the expansion of public programs for children contributed to a rise in the immunization rate among children ages 1 to 5 from 83 to 88 percent.¹¹ According to the federal evaluation of SCHIP, uninsured children who gained coverage through the program received more preventive care, and their parents reported better access to providers and improved communications with their children's doctors.¹² Coverage also matters for vulnerable children. Unmet need among chronically ill low-income children who were uninsured and gained Medicaid or SCHIP coverage decreased by eight percentage points—exceeding the reduction among newly insured children without chronic illness.¹³ Racial disparities in access were also reduced (although not eliminated) for children who were uninsured and subsequently enrolled in SCHIP.¹⁴

Impact on Health and Quality of Life

Access to health care matters to the extent that it improves the health of children. Sadly, the wealthiest nation in the world is not the healthiest, especially when it comes to its children. In 2004, according to the World Health Organization, the United States ranked 35th on infant mortality, behind Korea and Cuba.¹⁵ Our immunization rates, while

high, are below those of Thailand and Poland among others. About two-thirds of nations have lower rates of children dying from injuries than does the U.S.

While health coverage is only one factor in improving health, it does play a role. It helps prevent health problems from worsening. For example, Medicaid expansions from 1983 to 1996 were associated with a population-wide reduction of 22 percent in avoidable hospitalization among children.¹⁶ It helps with the healing of injuries. One study found that, compared to insured children, uninsured children were 40 percent less likely to receive medical attention for serious injuries.¹⁷ Health coverage can help in the control of chronic diseases. One evaluation found that children who were uninsured and gained coverage through Medicaid or SCHIP had fewer asthma-related attacks after enrollment (3.8 vs. 9.5 attacks), with significant improvements in quality of care.¹⁸ And, it contributes to child survival. Increase Medicaid eligibility at the state level has been associated with reductions in child mortality after the first year of life.¹⁹ Uninsured infants with a congenital heart problem (coarctation of the aorta) were nearly 10 times more likely to die than insured infants (33% versus 3.8%) due to delayed diagnosis and care.²⁰

For families, the benefits of health coverage for children extend beyond its impact on health. It improves their quality of life. One study found that the improvement in quality of life resulting from enrollment in SCHIP was equivalent to the benefits of treatment for a child newly diagnosed with cancer.²¹ It also increases financial security. Medical bankruptcy is a large and growing problem in the U.S., and some of it results from childhood illness. This is not surprising given the cost of some illnesses. In 2000, the average charge for the hospitalization of a child with a cardiac or circulatory birth defect was \$59,000 and for a child with pneumonia was \$8,000.²² The total health care

cost of childhood asthma in the U.S. in 2002 was \$6 billion, most of it for home health care and prescription drugs.²³

The cost of unmet health needs among children extends beyond the measurable health costs. Problems that could be managed or cured with health care result in lower school attendance. In 2004, asthma alone accounted for an estimated 14 million lost school days among children.²⁴ This limits children's educational attainment. Recurrent ear infections – which could be addressed through persistent health care – reduce children's ability to communicate and thus school readiness and performance.²⁵ Parents are less likely to let uninsured children participate in school sports, potentially lowering their self-esteem. And, unmet mental health needs among adolescents can have lifelong consequences. In summary, health coverage is as essential as nutrition and education in the development of children.

The Value of the Investment in Coverage for Children

Given the benefits of children's coverage, the question becomes how much does it cost and is it worth it? According to government projections, personal health spending per person in the U.S. will average nearly \$6,700 in 2008. Assuming that historical patterns hold, this means that the estimated average health spending per child next year will be \$2,875.²⁶ This is about 40 percent below the per-capita cost of people ages 19 to 44, and one-seventh of the estimated health spending for seniors (\$19,370). Compared to other age groups, health spending for children tends to be more skewed, meaning that most health spending is concentrated among a few high-cost cases, typically among infants. In addition, children have a greater need for prevention and primary care than do most adults.

Of the nation's health spending for children, about 35 percent is publicly financed. This is nearly half the proportion of health spending on seniors financed by the public (65.5%, calculated before the implementation of the Medicare drug benefit). The U.S. government also finances a lower share of health care than of education for children. In dollar terms, next year, the government will finance roughly \$1,000 per child for health care costs. Since most of that spending is through Medicaid and SCHIP which are matching programs, the federal share of this is below \$1,000 per child.

Is this investment worth it? No cost-benefit analysis exists to put the value of children's coverage into dollar terms. However, some comparisons can help put the investment into perspective. This \$1,000 per child is less than cost of a day in the hospital or a year's worth of medications for chronic conditions. It is a fraction of what we spend per person in the last year of life. We spend more to protect children from the threat of terrorism than disease or disability which statistically are more probable and equally devastating. And, the long-term benefit could far exceed the short-term cost of investing in children's health. One of the most distressing studies in recent years concluded that, for the first time in a century, our children's life expectancy could be shorter than our own, largely due to the obesity epidemic.²⁷ Not surprisingly, experts suggest that poor child health now could be the major cost driver in Medicare in the future. This suggests that not only is the current investment in children's coverage worth it, but more is needed to prevent long-run disability and cost.

Yet, as we look at the proposals in front of this Congress, some would suggest a real reduction in the public investment in children's health coverage. The President's budget proposes to spend about a \$1 billion more per year for children's coverage. This amount, according to most experts, is not enough to maintain the current level of

coverage provided to children, given population and health spending growth trends. This would result in a decline in real terms of the federal investment in children's health insurance coverage. Since low-income families often have no alternative source of affordable coverage, the number of uninsured children could rise as well.

Even if Congress were to fund the program at the amount needed to maintain current services, this would not be enough to reach uninsured children eligible for Medicaid and SCHIP. About 9 million children in the U.S. remain uninsured, and about 6 million of them are, today, eligible for Medicaid or SCHIP. To use simple math, if the federal cost per child were \$1,000, then \$6 billion more per year would be needed to fulfill these programs' promise. This estimate is low since some states would need assistance in financing this coverage. For example, the federal matching rate might need to be increased to help states with low resources afford their share of increased enrollment due to outreach.

And, if policy makers decide to do what was done over 40 years ago for seniors – guarantee coverage for all children –, new options as well as assistance would be needed. In the last decade, the proportion of middle-income children who lack health insurance has grown with the erosion of employer-based coverage for them and their parents. Providing insurance options for such children that is comprehensive and affordable would require additional, shared financial responsibility.

Calculating the federal cost of the options before Congress on children's health insurance is relatively easy and will be done by the Congressional Budget Office and others. But the benefits of the federal investment in children's health coverage are difficult to tabulate in dollar terms or within a five-year budget window. This does not mean that they are any less real: the research is conclusive that covering children

improves access to care, health, and the lifelong prospects of children. This value for the investment is high, which is why leaders in medicine, business, and, increasingly, government are calling for covering all Americans as well as all children.

The Importance of the Structure of Funding for Children's Coverage

The last point in this testimony is that the structure as well as the level of federal funding matters when it comes to children's coverage. We know from experience that Medicaid's funding structure allows it to adapt to unexpected trends. Federal Medicaid funding growth slowed to 3 percent in 1996 as health costs and enrollment dropped due to the strong economy. And it surged by 14 percent in 2002 as a recession caused layoffs, increasing the number of families eligible for the program. In addition, Medicaid funding offers a level of predictability to both families and states that has contributed to the program's high participation rate. In 2002, an estimated 82 percent of children eligible for Medicaid participated in it.²⁸

SCHIP has a different financing structure. Unlike Medicaid, SCHIP matching payments are subject to annual, state-based caps. The SCHIP legislation allows \$5 billion to be allocated to states in FY 2007. The amount is divided into state allotments. The formula for allotments is based on two factors: each state's "number of children" and "state cost factor." The number of children is an equal blend of the number of uninsured children with the overall number of low-income children in the state. The state cost factor takes into account geographic variation in wages. Allotments may be used for the current fiscal year and two subsequent years if unspent. Unspent allotments after that are redistributed to others that may need the funds.

This recycling meant that, prior to FY 2006, states generally had sufficient funds to continue coverage even though some states' annual allotments were less than their annual spending. However, because program spending growth has outstripped that of the total federal allotment, the amount available for redistribution has dropped. In FY 2007, an estimated 17 states face shortfalls, some of which were filled by changes in the redistribution formula in legislation passed by Congress in December's lame-duck session (P.L. 109-432).²⁹ Georgia reports that it will close enrollment in its program, PeachCare, on March 11 due to a shortage of federal funds. A study of one state's experience with waiting lists found that nearly all families reported economic hardship as a trade-off for securing health care for their children.³⁰

When it reauthorizes SCHIP, Congress could work within the program's current structure to mitigate the allocation problems that have emerged. Raising the overall level of federal funding—by increasing the total allotment to keep pace with medical inflation, projected enrollment growth, and/or national health expenditure growth—is one way to do this. Adjustments must also be made to the base-year funding, recognizing that federal spending on SCHIP now exceeds the \$5 billion federal allotment on the books.

In addition, several proposals have emerged on different ways of allocating the aggregate level of funding. Some involve technical changes, for example, switching to more stable data sources. Others have policy significance. For example, the current formula blends states' low-income uninsured children and already-insured children. If SCHIP went back to allocating funds based only on the number of uninsured children, states would get less funds as they insure more children—a potential disincentive for aggressive enrollment policies. Rhode Island, for example, has one of the lowest uninsured rates in the country but spends the most relative to its allotment. An allotment

formula weighted toward states with large numbers of uninsured would lower Rhode Island's federal SCHIP funding and make it difficult to sustain its level of children's coverage. Alternatively, given the budget deficit and fiscally tight environment, some experts argue that all available funding should be targeted toward those that need it most.³¹ Other ideas include basing part of the allocation on historical spending and dropping the state health cost factor.³²

However, the fact is that health care is notoriously unpredictable and, in my opinion, a "perfect block grant" for children's health coverage cannot be designed. In a study of the predictability of Medicaid spending, I found that the Congressional Budget Office's forecast of Medicaid spending only three years into the future was, once, 28 percent too high and, in another year, 31 percent too low.³³ Actual enrollment growth and medical inflation explained only about 30 percent of spending growth over a 30-year period. Beyond the challenges of predicting health cost trends in the aggregate, the federal cost of coverage for low-income children is sensitive to state policy and trends. In any given year, some states expand and others contract coverage, and changes occur in enrollment processes, outreach, and access to private coverage, all of which affect enrollment and costs. This makes accurate allocation of funding to states next to impossible.

So, beyond intricate formulas aimed to target funding, Congress might consider two other options. One is allowing actual enrollment to play a roll in allocating funding for children's coverage. State allotments could be adjusted for their performance in enrolling eligible children (e.g., using a "reinsurance" approach or increased federal matching payments if performance targets are met). States would still face limits on federal

matching payments in SCHIP, but allowing adjustments for enrollment would reduce states' incentives to use waiting lists and lower eligibility limits in the face of such limits.

Second, policymakers might consider eliminating the cap on federal matching payments altogether. This would align SCHIP's financing structure with Medicaid's. The current higher matching rate for SCHIP children's coverage could continue, or it could be blended with the rate for Medicaid children. Eliminating allotments would probably also mean eliminating higher matching rates for adults through SCHIP waivers, as there would no longer be extra allotments used for other populations. This option would remove the contradiction of the federal government promoting outreach while limiting its own financial liability for resulting costs. It shares in the cost of covering all children in states that decide to do so. While a departure from current program structure, lifting the SCHIP allotments might better enable states to meet the program goals.

Conclusion

The most notable health policy accomplishment of this Congress may be its legislation on children's health insurance coverage. The year 2007 marks the 10th anniversary of SCHIP: a successful, bipartisan, federal-state collaboration that improved the nation's health coverage. SCHIP and Medicaid contributed to a one-third reduction in the rate of low-income, uninsured children between 1997 and 2005.³⁴ Yet, SCHIP's expiration in 2007 will force policymakers to revisit its investment in children's health insurance coverage. Much of this debate will be couched in budget terms, focusing on the amount of the increase in federal spending on health insurance for children. However, other costs should be considered as well. Inadequate federal support could mean increased costs to states that do not consider scaling back on children's coverage an

option. Private health insurance costs could increase from the cost shifting of uncompensated care and, eventually, Medicare costs could rise as children with unattended health problems become seniors with chronic disease. Families could pay for the cost of care for their uninsured children and, for those that delay it, higher costs associated with worsened problems. And, ultimately, children themselves would bear the greatest cost in the form of preventable suffering and limitations on their lifelong prospects.

That said, I am optimistic that the leadership of this Committee that succeeded in expanding coverage for children a decade ago will do so again. This nation is ready for change and, I believe, will support efforts to make high-quality health insurance affordable and available to all children, as well as all Americans.

NOTES

¹ Based on Centers for Medicare and Medicaid Services' National Health Accounts, estimated national health spending per capita in 2005 (\$6,697) divided by the Census Bureau's median income for all households in 2005 of \$46,326.

² Kaiser Family Foundation / Health Research and Educational Trust, *Employer Health Benefits 2006* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2006).

³ McKinsey analysis. 2004.

⁴ Institute of Medicine. *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: National Academy of Sciences, 2002).

⁵ See Institute of Medicine, *Health Insurance is a Family Matter*. (Washington, D.C.: National Academy of Science, 2002) for a review of the literature on access and health insurance for children.

⁶ J.J. Stoddard, R.F. St. Peter, and P.W. Newacheck, "Health Insurance Status and Ambulatory Care for Children," *New England Journal of Medicine* 330(2): 1421-25, 1994.

⁷ B. Bloom and A.N. Dey. "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2004," *Vital Health Statistics* 10(227), 2006.

⁸ J. Curry and J. Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics* 111(2): 431-66, 1996.

⁹ P.W. Newacheck, C. D. Brindis, C.U. Cart, K. Marchi, et al., "Adolescent Health Insurance Coverage: Recent Changes and Access to Care," *Pediatrics* 104(2): 195-202, 1999.

¹⁰ J.R. Lave, C.R. Keane, C.J. Lin, E.M. Ricci, et al., "Impact of a Children's Health Insurance Program on Newly Enrolled Children," *Journal of the American Medical Association* 279(22): 1820-25, 1998.

¹¹ L.E. Rodewald, P.G. Szilagyi, J. Holl, L. Stone, et al., "Health Insurance for Low-Income Working Families: Effect of the Provision of Immunizations to Pre-School Age Children," *Archives of Pediatrics & Adolescent Medicine* 151(8): 798-803, 1997.

¹² J. Woolridge, G. Kenney, C. Trenholm et al., *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress* (Washington, D.C.: Mathematica Policy Research, Urban Institute, 2005).

- ¹³ A. Davidoff, G. Kenney, and L. Dubay, "Effects of State Children's Health Insurance Program Expansions on Children with Chronic Illness," *Pediatrics* July 2005 116(1): e34-e42.
- ¹⁴ L.P. Shone, A.W. Dick, J.D. Klein et al., "Reduction in Racial and Ethnic Disparities After Enrollment in the State Children's Health Insurance Program," *Pediatrics*, 2005 115:697-705.
- ¹⁵ World Health Organization. *World Health Statistics 2006*. Geneva: WHO.
- ¹⁶ L. Dafny and J. Gruber, "Does Public Insurance Improve the Efficiency of Medical Care?" in *Medicaid Expansions and Child Hospitalization* (Cambridge, MA: National Bureau of Economic Research, 2000)/
- ¹⁷ Overpeck and Lotch 1995.
- ¹⁸ P.G. Szilagyi, A.W. Dick, J.D. Klein et al., "Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York," *Pediatrics*, 2005 117(2):486-96.
- ¹⁹ J. Curry and J. Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics* 111(2): 431-66, 1996.
- ²⁰ K.S. Kuehl, J.M. Baffa, and G.A. Chase, "Insurance and Education Determine Survival in Infantile Coarctation of the Aorta," *Journal of Health Care for the Poor and Underserved* 11(4): 400-11, 2000.
- ²¹ M. Seid, J.W. Varni, L. Cummings et al., "The Impact of Realized Access to Care on Health-Related Quality of Life: A Two-Year Prospective Cohort Study of Children in the California State Children's Health Insurance Program," *Journal of Pediatrics* 2006 149(3):354-61.
- ²² P.L. Owens, J. Thompson, A. Elixhauser, and K. Ryan, *Care of Children and Adolescents in U.S. Hospitals* (Rockville, MD: Agency for Healthcare Research and Quality; 2003).
- ²³ P.H. Wise, "The Transformation of Child Health in the United States," *Health Affairs* 23(5): September/October 2004.
- ²⁴ American Academy of Allergy, Asthma and Immunology, Allergy and Advocate: Fall 2004
- ²⁵ See Institute of Medicine, *Health Insurance is a Family Matter*. (Washington, D.C.: National Academy of Science, 2002) for a review of the literature on common childhood health problems and the potential implications of coverage.
- ²⁶ This is calculated applying the ratios of children's spending in 1999 to the projected personal health spending. All data from the Centers for Medicare and Medicaid Services, national health accounts, available at: http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage
- ²⁷ S.J. Olshansky, D.J. Passaro, R.C. Hershow, J. Layden, B.A. Carnes, J. Brody, L. Hayflick, R.N. Butler, D.B. Allison, and D.S. Ludwig, "A potential decline in life expectancy in the United States in the 21st Century," *New England Journal of Medicine* 352(11): 1138-1145, 2005.
- ²⁸ L. Dubay, *Testimony Before the Senate Finance Subcommittee on Healthcare, Hearing on the State Children's Health Insurance Program from the States' Perspective*, (Baltimore, Md.: Johns Hopkins Bloomberg School of Public Health, November 16, 2006).
- ²⁹ M. Broadus and E. Park. "SCHIP Financing Update: In 2007, 17 States Will Face Federal Funding Shortfalls of \$800 Million in Their SCHIP Programs." Center on Budget and Policy Priorities, September 21, 2006, available at <http://www.cbpp.org/6-5-06health2.htm> (accessed November 19, 2006).
- ³⁰ P. Silberman, J. Walsh, R. Slifkin et al., *The North Carolina Choice Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families* (Chapel Hill, N.C.: Cecil B. Sheps Center for Health Services Research, January 2003).
- ³¹ C.L. Peterson, "SCHIP Original Allotments: Funding Formula Issues and Options," *CRS Report for Congress* (Washington, D.C.: Congressional Research Service, April 18, 2006).
- ³² C.L. Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," *CRS Report for Congress* (Washington, D.C.: Congressional Research Service, May 8, 2006); Governor S. Perdue, "Written Statement on Behalf of the Southern Governors' Association," Senate Committee on Finance, February 1, 2007.
- ³³ J.M. Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals," *The Milbank Quarterly* 83(1): 41-63, 2005.
- ³⁴ Analysis of the National Health Interview Survey as conducted by Lisa Dubay for the Georgetown Center for Children and Families.

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Children’s Health Insurance Coverage

Health care coverage for children is important. Without it, children suffer and society pays. One study reports that 54 percent of children without coverage have not received any well-child visits and 31 percent have not seen a doctor in the past year, compared to only 9 percent and 26 percent for children with insurance coverage.¹ When an uninsured child does access the health care system, it is usually in a very inefficient and costly manner. The cost of uncompensated care—treating those without coverage— cost taxpayers an estimated \$34.6 billion in federal, state, and local spending in 2004.² Thus, this phenomenon does not just harm children, but impacts society as a whole.

Defining Uninsured

Today’s health care system is a mix of private and public coverage. According to the most recent U.S. Census data, 68 percent of the population receives their health insurance through the private sector—predominately through the place of work—and 27 percent

¹Campaign for Children’s Health Care, “No Shelter from the Storm: America’s Uninsured Children,” September 2006, p. 9, at www.childrenshealthcampaign.org/tools/reports/Uninsured-Kids-report.pdf.

²Jack Hadley and John Holahan, “The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?” Kaiser Commission on Medicaid and the Uninsured *Issue Update*, May 10, 2004, p. 3, at www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf.

receive their care through the public sector.⁵ This leaves an estimated 15 percent of people without health care coverage.⁴

The results for children are similar. Over 60 percent obtain coverage through the private sector employer-based system and 5 percent obtain coverage directly through the private market.⁵ 29.7 percent obtain care through the public sector, of which the overwhelming portion (27 percent) receives care through Medicaid and SCHIP.⁶ The remaining 11 percent of children are considered uninsured.⁷

While significant, it is important to note that there are a variety of ways of counting the uninsured. The commonly referenced Census figures reflect an individual's coverage status at a specific point in time. However, there are other ways of counting the uninsured. For example, besides measuring coverage at a specific point in time, other typical and useful measures include the number of people uninsured for the entire year and the number uninsured at any time during the year. According to a Congressional Budget Office analysis of the uninsured, 26.8 percent of children were uninsured "at any time" in 1998, but only 7.3 percent were uninsured "all year."⁸ Moreover, children are more likely to have shorter periods of uninsurance than adults.⁹

³Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," U.S. Department of Commerce, U.S. Census Bureau, August 2006, p. 21, at www.census.gov/prod/2006pubs/p60-231.pdf.

⁴*Ibid.*

⁵*Ibid.*, p. 69.

⁶*Ibid.*

⁷*Ibid.*

⁸Congressional Budget Office, "How Many People Lack Health Insurance and for How Long," May 2003, p. 7, at www.cbo.gov/ftpdocs/42xx/doc4210/05-12-Uninsured.pdf.

⁹*Ibid.*, p. 9.

Uninsured Children

By Age

Interestingly, by age group, uninsured children actually had lower uninsurance rates than other age group. Adults between the ages of 18 and 24 ranked the highest with 31 percent uninsured, followed by those between 25 and 34 with 26 percent uninsured, those between 35 and 44 with 19 percent, and finally those between 45 and 64 percent with 15 percent.¹⁰ As mentioned, 11 percent of children (below 18 years of age) are uninsured.¹¹

By Family Income

According to estimates by Paul Fronstin at the Employer Benefit Research Institute, an estimated 32 percent of uninsured children are in families with income below federal poverty; 33 percent in families with incomes between 100 and 200 percent federal poverty; 19 percent between 200 and 300 percent federal poverty; and 17 percent above 300 percent federal poverty.¹² Of note, the largest growing segments of uninsured are among middle and upper income families.¹³

By Family Work Status

Fronstin analysis also found that of children without coverage, 68 percent were in families with a full-time, full-year worker; 5 percent of uninsured children were in families with a part-time, full-year worker; 6 percent were in families with a full-time,

¹⁰DeNavas-Walt *et al.*, p. 22.

¹¹*Ibid.*

¹²Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey," Employee Benefit Research Institute Issue Brief No. 298, October 2006, p. 23, at www.cbri.org/pdf/briefspdf/EBRI_IB_10a-20061.pdf.

¹³ Devon Herrick, "Crisis of the Uninsured: 2006 Update," National Center for Policy Analysis Brief Analysis No. 568, September 6, 2006, www.ncpa.org/pub/ba/ba568.

part-year worker; and 4 percent were in families with a part-time, part-year worker.¹⁴

Only 17 percent of uninsured children were in a family with no worker.¹⁵

Obstacles to Existing Coverage

Obviously, the current patchwork system of public and private health insurance does not work for everyone, including children.

Private Sector Shortfalls

As noted, an overwhelming percent of uninsured children are part of a working household where at least one family member has a job. However, having a job does not guarantee coverage for workers or dependents. An employer may not offer coverage, as is common in the small business sector. A worker may not be eligible for employer coverage due to waiting periods or work status. Finally some workers simply choose not to participate in employer coverage. 64 percent of workers who did not participate in employer coverage cited cost as reason.¹⁶

Obtaining family coverage outside the place of work can also be difficult. The federal tax code discriminates against those who do not obtain coverage through their places of work. Unlike under the employer-based system, where the full value of the health benefit is excluded from a workers' taxable income, individuals purchasing coverage on their own do not receive such a tax break and must use after-tax dollars to buy coverage.

¹⁴Fronstin, p. 24.

¹⁵*Ibid.*

¹⁶*Ibid.*, p. 16.

Moreover, states regulate the individual market, which directly impacts those purchasing coverage in their own. Well-intentioned but costly one-size-fits-all state regulations can make coverage unaffordable, especially for those with limited incomes. The Council of Affordable Health Insurance estimates that mandates, for example, can increase the cost of health insurance by 20 to 50 percent, depending on the mandate and state.¹⁷

Public Sector Shortfalls

The public sector also has its share of shortfalls in reaching uninsured children, as illustrated by the number of children eligible for but not enrolled in Medicaid and SCHIP. The Kaiser Family Foundation estimates that 74 percent of uninsured children are eligible for Medicaid or SCHIP.¹⁸

It is common knowledge that access troubles these public programs. The number of doctors who will see new Medicaid patients continues to decline. In a recent analysis of Medicaid physicians, 15 percent of pediatric physicians were not accepting any new Medicaid patients, an increase from the previous year.¹⁹ Moreover, the implications of limited access to care results in more Medicaid and SCHIP enrollees showing up at the emergency room. Research has found that Medicaid and SCHIP ER visits account for over 80 percent of hospital admissions.²⁰

¹⁷Victoria Craig Bunce, JP Wieske, and Vlasta Prikazsky, "Health Insurance Mandates in the States 2006," Council for Affordable Health Insurance, March 2006, www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf.

¹⁸John Holahan, Allison Cook, and Lisa Dubay, "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage," Kaiser Commission on Medicaid and the Uninsured, February 2007, p. 4, at www.kff.org/uninsured/upload/7613.pdf.

¹⁹Peter Cunningham and Jessica May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health System Change *Tracking Report* No. 16, August 2006, p. 3, at hschange.org/CONTENT/866/866.pdf.

²⁰John S. O'Shea, MD, "The Crisis in Hospital Emergency Departments: The Burden of Federal Regulation," The Heritage Foundation *Background*, forthcoming.

Cost is another factor. Federal and state spending on public programs, such as Medicaid, are consuming a greater share of the budget. According to the National Governors Association, Medicaid is now the largest state budget item, surpassing educational, transportation and other key state functions.²¹ At the federal level, federal spending on health care is also increasing at an unmanageable pace. By 2015, health care spending will consume 20 percent GDP, and the government's share will be one-half.²²

Finally, public program expansions also impact the stability of private coverage. Research has shown a direct correlation between the expansion of government public programs and the decline in private health insurance. Most recently, Jonathan Gruber and Kosali Simon found that “the number of privately insured falls by about 60 percent as much as the number of publicly insured rises.”²³ Gruber and Simon also concluded that the “crowd out” phenomenon is far more dramatic when considering the entire family. Thus, expansions reduce private insurance options for family members more rapidly.²⁴

Strategies for Addressing the Shortfalls of the Current System

Policymakers should focus on solutions to improve the function of the private and public sectors that will help families obtain coverage and control their health care decisions.

²¹National Governors Association and National Association of State Budget Officers, “The Fiscal Survey of States,” December 2006, p. 1, at www.nasbo.org/Publications/PDFs/Fall%202006%20Fiscal%20Survey%20of%20States.pdf

²²Christine Boger *et al.*, “Health Spending Projections Through 2015: Changes on the Horizon,” *Health Affairs Web Exclusive*, March–April 2006, exhibit 3, p. W-64, at content.healthaffairs.org/cgi/reprint/25/2/w61 (subscription required).

²³Jonathan Gruber and Kosali Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” National Bureau of Economic Research *Working Paper* No. 12858, January 2007, p. 2, at www.nber.org/papers/w12858.

²⁴*Ibid.*, p. 28.

Private Sector

- **Fix the tax treatment of health insurance.** One of the primary roles of the federal government is the federal tax code. President Bush has recently put forth a bold policy initiative to remove the distortion of the tax code with regard to the tax treatment of health insurance. Federal policymakers should seize this unique opportunity and build on the President's proposal by adopting refundable, advanceable tax credits. These tax credits could be designed to assist families in enrolling their children in dependent coverage through the place of work or the non-employer market.

- **Promote an alternative to employer-based coverage.** As noted, not all families fit into the employer-based system. Although insurance reform is primarily the responsibility of state policymakers, there are some federal tools that can expand individual access to affordable coverage. Federal policymakers should look for ways to encourage individuals to obtain health care coverage of their own choice and help to facilitate a more robust non-employer marketplace. Such policies could encourage innovative approaches that preserve the benefits of pooling, but promote more personal and portable coverage.

Public Sector

- **Add greater choice for enrollees.** The traditional public health care design depends on a one-size-fits-all approach. Balancing financing and design can be difficult and undoubtedly results in coverage that does not meet everyone's

needs. The Deficit Reduction Act increased flexibility for states to tailor health care services to enrollees. Federal policymakers should build on this first step by giving enrollees more choices from competing networks and insurers for the delivery of their care. Moreover, individual enrollees should have the freedom to use their existing public program allocation and purchase private coverage through the marketplace, which would help many low-income children mainstream into the private market with their families.

- **Adopt more patient-centered models.** Due to the bureaucratic structure of the public programs, enrollees have little say in the type or way services are delivered, and many are promised a set of benefits but do not always receive them. The Cash and Counseling initiative in Medicaid is a successful example of creating a more patient-centered approach to care in Medicaid. Federal policymakers should use this model to give enrollees greater control in determining the care and services they receive and from whom.

Federalism

- **Support state-based innovations.** In light of the federal gridlock on health care policy, many states have begun to take the lead on health care reform. In some respects, this makes sense. There is great diversity at the state level, and blanket federal policies can have varying impacts and outcomes depending on the state.²⁵ Thus, federal policymakers should encourage state innovation and

²⁵Sherry Glied and Douglas Gould, "Variations in the Impact of Health Coverage Expansion Proposal Across States," *Health Affairs Web Exclusive*, June 7, 2005, at content.healthaffairs.org/cgi/reprint/hlthaff.w5.259v1 (subscription required).

consider providing federal tools to assist states in addressing the unique needs of their states.

Conclusion

Addressing the lack of health insurance among children is important. One of the best ways to begin to tackle the solution is to address the shortfalls in the overall health care system. Policy initiatives should focus on changes to the private and public health care system that increase coverage options and personal control. Such policy solutions will not only address the needs of children, but improve the health of the system for all Americans.

Chairman Pallone, Mr. Deal, and other members of the Subcommittee, my name is Chris Peterson, and I am a Specialist in Social Legislation with the Congressional Research Service (CRS). Thank you for the opportunity to testify about the characteristics of children in the U.S. without health insurance.

I would like to begin by describing current estimates of children's health insurance coverage and how they have changed in the past 10 years. Over that period, private health insurance among children has declined, but public coverage has increased — in fact, more than offsetting the declines in private health insurance. I will present some estimates on the extent to which the declines in private health insurance are related to public health insurance expansions. I will also point to research that shows, particularly for children, that health insurance is beneficial not only because it provides financial coverage but also because it can help to establish a usual source of care for children — something that is considered critical for children's health outcomes. Despite these potential benefits, millions of uninsured children who are eligible for public and/or private coverage remain uninsured. I conclude with some of the reasons why this might be the case and what options might be available to address this.

Estimates of Children's Health Insurance Coverage

The latest estimates from 2005 indicate that there are 47 million uninsured people in the United States, 9 million of whom are children (under age 19).¹ More than half of uninsured children were in a two-parent family, and 60% of uninsured children were in a

¹CRS Report 96-891, "Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2005," by Chris L. Peterson, August 30, 2006, based on Current Population Survey data.

family where a parent worked full-time for the entire year (**Figure 1** at the end of the written testimony).

Table 1. Health Insurance Coverage of Children (Under Age 18), 1996 and 2005

All children (<18)			
	1996	2005	Percentage-point Change
Private	63%	58%	-5
Public	21%	31%	+10
Uninsured	16%	11%	-5
Non-Hispanic white children			
	1996	2005	Percentage-point Change
Private	74%	72%	-2
Public	14%	21%	+7
Uninsured	13%	8%	-5
Non-Hispanic black children			
	1996	2005	Percentage-point Change
Private	42%	41%	-1
Public	41%	50%	+9
Uninsured	18%	11%	-6
Hispanic children			
	1996	2005	Percentage-point Change
Private	39%	31%	-9
Public	33%	48%	+16
Uninsured	28%	20%	-8

Source: Jeffrey A. Rhoades, "Health Insurance Status of Children in America, First Half 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #131, June 2006. Jessica P. Vistnes and Jeffrey A. Rhoades, "Changes in Children's Health Insurance Status, 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #141, September 2006.

Between 1996 and 2005, the percentage of children who are uninsured has fallen from 16% to 11% (**Table 1**). This 5 percentage point drop occurred in spite of the fact that employer-sponsored coverage rates among children also fell by 5 percentage points

(from 63% in 1996 to 58% in 2005). This overall decline in the uninsured is due to an increase in the prevalence of public health insurance (from 21% of children covered in 1996 to 31% in 2005).²

The changes in children's sources of health insurance vary dramatically by race/ethnicity. For example, among (non-Hispanic) white and black children, private coverage did not change significantly between 1996 and 2005. However, significant increases in public health insurance among white and black children significantly reduced their rate of uninsurance. Among Hispanics, the decline in private coverage was large between 1996 and 2005. However, because the increases in public coverage were even larger, the percentage of uninsured Hispanic children also dropped.³

A decade ago, in 36% of married working families (with children) without an employer offer of health insurance, all family members were uninsured. That percentage dropped to 23% by 2005, and families with partial coverage (some family members without health insurance, some with) rose from 29% in 1997 to 40% in 2005, according to new research by the Agency for Healthcare Research and Quality (AHRQ). The same trend is true among *single*-parent working families without an employer offer. In 1997, 24% of these families had the entire family uninsured. The percentage has dropped to 17%, with partial coverage rising from 32% in 1997 to 41% in 2005.⁴

²Jeffrey A. Rhoades, "Health Insurance Status of Children in America, First Half 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #131, June 2006.

³Jessica P. Vistnes and Jeffrey A. Rhoades, "Changes in Children's Health Insurance Status, 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #141, September 2006.

⁴Jessica P. Vistnes and Barbara Schone, "Pathways to Health Insurance Coverage: The Changing Role of Public and Private Sources," working paper, 2007.

Estimates of the Relationship Between Declining Private Coverage and Increasing Public Coverage

The State Children's Health Insurance Program (SCHIP), which was created by the Balanced Budget Act of 1997 (BBA 97), receives much of the credit for the increases in public coverage among children over the past decade. Before SCHIP, the states' most common upper-income eligibility level for children 1 to 5 years old was 133% of poverty through Medicaid. For 15-year-olds, states' most common upper-income eligibility level for public coverage was 100% of poverty.⁵ Now, the most common upper-income eligibility level for states' public coverage of children of all ages is 200% of poverty through SCHIP (approximately \$35,000 for a family of three).

One of the questions this raises — and one that was raised as SCHIP was being developed a decade ago — is the extent to which expanded public coverage might lead to an erosion of private coverage, particularly as eligibility is extended up the income scale. Even today, researchers produce SCHIP-related estimates of “crowd-out” that vary widely and are highly dependent on the analytic assumptions made.⁶

Congress mandated an evaluation to look into this issue, among others. The evaluation found that 28% of recent SCHIP enrollees had private health insurance at some point during the six months before enrolling in SCHIP. One-half of these enrollees

⁵Thomas Buchmueller et al., “The Effect of SCHIP Expansions on Health Insurance Decisions by Employers,” *Inquiry*, volume 42, number 3, Fall 2005, p. 220.

⁶ See analysis of the literature in Table 1 of Jonathan Gruber and Kosali Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” National Bureau of Economic Research Working Paper 12858.

(14% of the total) lost that private coverage involuntarily during that period.⁷ The study also examined what percentage of Medicaid and SCHIP child enrollees had parents with employer-sponsored insurance for which the employer paid some or all of the premium. In California, for example, 10% of Medicaid-enrolled children had a parent in such an employer plan, compared to 40% of SCHIP-enrolled children.⁸ It is unclear whether, in the absence of public coverage, these children would have been enrolled in private coverage or would have been uninsured.

The research by AHRQ mentioned earlier also looked at changes in coverage among working families (with children) with an offer of employer-sponsored health insurance. Among working *married* families with an offer of employer-sponsored coverage, virtually none had parents enrolled in private coverage with their children in public coverage in 1997. The current percentage is still a relatively small 1.5%. Among working *single-parent* families with children where there was an offer of employer-sponsored coverage, the percentage of families where the adults have private coverage and the children have public coverage rose from 5% in 1997 to 16% in 2005. Again, without additional analysis, one cannot say, in the absence of public coverage, whether these children would have been enrolled in private coverage or would have been uninsured.⁹

⁷ "Congressionally Mandated Evaluation of the State Children's Health Insurance Program," Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. xv.

⁸ "Congressionally Mandated Evaluation of the State Children's Health Insurance Program," Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. 31. Not counting in the "substitution estimate" those children with elevated health care needs reduces the estimates to 8% of child Medicaid enrollees and 11% of SCHIP enrollees.

⁹ Jessica P. Vistnes and Barbara Schone, "Pathways to Health Insurance Coverage: The Changing Role of Public and Private Sources," working paper, 2007. Researchers at AHRQ have also found that if one accounts for all of the various forms of public spending on uninsured children, privately insured children, and SCHIP, then the net cost of SCHIP is substantially less than one might conclude by simply examining SCHIP budgetary outlays. See Thomas M. Selden and Julie L. Hudson, "How Much Can Really Be Saved

Effects of Health Insurance on Children's Health

Health insurance as a bill-paying mechanism by itself is not enough to guarantee high-quality care. Research has shown that, for children, lacking a regular health care provider (for example, a physician who knows the child's health care needs) has a greater negative effect on primary care quality than not having insurance. In fact, when a child needed care, lack of a regular provider was found to be as detrimental as not receiving care at all.¹⁰ Thus, a key impact of health insurance on children's health is not merely paying the bills but ensuring access to or establishing a relationship with a health care provider.

A comparison of children's access to primary care physicians found similar rates of access among those enrolled in Medicaid, SCHIP and commercial plans,¹¹ indicating that both public and private health insurance may be effective in this regard (although there are differences depending on the studies and the measures¹²).

By Rolling Back SCHIP?" *Inquiry*, volume 42, Spring 2005, p. 16.

¹⁰M. Seid and G. D. Stevens, "Access to Care and Children's Primary Care Experiences: Results from a Prospective Cohort Study," *HSR: Health Services Research*, volume 40, number 6, December 2005, pp. 1758-1780.

¹¹ "State Accomplishments: Access and Quality," Margo Rosenbach, presentation at the National Academy for State Health Policy conference "SCHIP At 10," February 22, 2006. The percentage of 12-24-month-olds with a primary care physician (PCP) visit was 94% in SCHIP, 95% in Medicaid, and 97% in commercial plans. The percentage of 25-month-olds to 6-year-olds with a PCP visit was 87% in SCHIP, 85% in Medicaid, and 89% in commercial plans. The percentage of 7-11-year-olds with a PCP visit was 86% in SCHIP, 83% in Medicaid, and 89% in commercial plans.

¹²See, for example, the review of the literature by insurance type in Aimee E. Jeffrey and Paul W. Newacheck, "Role of Insurance for Children With Special Health Care Needs: A Synthesis of the Evidence," *Pediatrics*, volume 118, number 4, October 2006, p. 1030.

Children Eligible But Not Enrolled in Coverage

Eligibility for public coverage. Researchers estimate that 62% to 75% of uninsured children are eligible for public coverage.¹³ Among the parents of low-income uninsured children, nearly half believe their children are eligible.¹⁴ Yet they do not enroll. Among the parents of low-income uninsured children, 84% said they would enroll if told the child is eligible; 16% would not.¹⁵ This suggests a need for outreach that not only informs parents about availability, but also educates them about the benefits of coverage.

Eligibility for private coverage. Tepid responses to offers of health insurance are also observed among those with potential access to private coverage. Research by the California Health Care Foundation found that among higher-income individuals (above 200% of poverty) who were uninsured, only 16% were considered “cost-constrained” — that is, they “attach high importance to having health insurance but say that they would not buy existing products at their current prices. ... (M)ore than one-third have children.” Another 26% were considered “prime prospects” — that is, they “place high importance on having health insurance and indicate a willingness to pay amounts that are near — and often substantially above — the actual cost of health insurance premiums. ... More than one-third have children.” The remaining 58% of higher-income uninsured individuals (who were less likely to have children than the

¹³ Thomas M. Selden et al., “Tracking Changes in Eligibility and Coverage Among Children, 1996-2002,” *Health Affairs*, volume 23, number 5, September/October 2004, p. 39. Lisa Dubay et al., “The Uninsured and the Affordability of Health Insurance Coverage,” *Health Affairs* Web exclusive, November 30, 2006, p. W22.

¹⁴ “Congressionally Mandated Evaluation of the State Children’s Health Insurance Program,” Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. xx.

¹⁵ “Congressionally Mandated Evaluation of the State Children’s Health Insurance Program,” Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. xx.

other groups) “indicated that health insurance did not rank high as a spending priority,” although many “said they would pay the price when presented with actual health insurance premiums.”¹⁶

According to AHRQ, approximately 42% of uninsured children have employment-sponsored health insurance available to them, generally through a parent’s employer. Among uninsured people of all ages, approximately 27% have access to health insurance through an employer.¹⁷ However, recent research has found that workers with a weak interest in health insurance tend to choose jobs that do not offer health insurance, ostensibly in return for higher wages relative to similar jobs that offer health insurance.¹⁸ Thus, the estimates presented in this paragraph may understate uninsured individuals’ true access to employer-sponsored health insurance.

Overall, 86.7% of private-sector employees work in a firm that offers health insurance (2004), which is not significantly different than the offer rate in 1996 of 86.5%.¹⁹ However, over the same period, the percentage of employees enrolling in the coverage for which they are eligible has fallen significantly, from 69.5% in 1996 to 62.6% in 2004.²⁰ This may be because of increasing premiums and cost-sharing for

¹⁶ “To Buy or Not To Buy: A Profile of California’s Non-Poor Uninsured,” California HealthCare Foundation and the Field Research Corporation, 1999.

¹⁷ Preliminary analyses by Tom Selden of the Agency for Healthcare Research and Quality (AHRQ) in response to CRS request, February 12, 2007.

¹⁸ Alan C. Monheit and Jessica Primoff Vistnes, “Health Insurance Enrollment Decisions: Preferences for Coverage, Worker Sorting, and Insurance Take-Up,” National Bureau of Economic Research Working Paper 12429, August 2006.

¹⁹ Agency for Healthcare Research and Quality. Percent of private-sector employees in establishments that offer health insurance by firm size and selected characteristics (Table I.B.2), years 1996-2004: 1996 (Revised March 2000) and 2004 (July 2006). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC [<http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp>], February 12, 2007. The rates were not significantly different for workers in large firms, comparing 1996 offers rates to 2004 offer rates, or in small firms.

²⁰ Agency for Healthcare Research and Quality. Percent of private-sector employees that are enrolled in health insurance at establishments that offer health insurance by firm size and selected characteristics (Table I.B.2.b), years 1996-2004: 1996 (Revised March 2000) and 2004 (July 2006). Medical Expenditure

employer-sponsored health insurance. Although employers are paying roughly the same percentage of the premiums they did a decade ago, the growth in total premiums has been well in excess of wage growth or inflation. Moreover, cost-sharing in employer-sponsored plans (for example, deductibles and copayments) has also increased substantially. Not only is the total premium higher for families than for single coverage, but employers generally pay a smaller percentage of the premium for family coverage than for single coverage.²¹

Options to increase enrollment among uninsured children eligible for coverage. Across the income spectrum, there are individuals who are eligible for health coverage (some public, some private) who do not enroll. Some research, especially with respect to children's health, suggests that increasing awareness of health insurance and its impact on health might lead to additional enrollment. Others have suggested making the process of enrollment easier.

In public as well as employer-sponsored coverage, individuals usually receive substantial financial subsidies. Individuals who are eligible and sometimes able to pay for coverage may find themselves taking up that coverage in states that levy financial penalties on individuals who do not enroll in coverage. For example, for tax year 2007, Massachusetts will deny individuals their state income tax exemption(s) — worth up to \$189 for a single person or \$379 for a couple — if they do not enroll in affordable health

Panel Survey Insurance Component Tables. Generated using MEPSnet/IC [<http://www.meeps.ahrq.gov/meepsnet/IC/MEPSnetIC.jsp>], February 12, 2007. The rates *were* significantly different for workers in large firms, comparing 1996 take-up rates to 2004 take-up rates, as well as in small firms.

²¹ One group of researchers found that in states where SCHIP eligibility was expanded, employers were not more likely to drop coverage but were more likely to charge more for family coverage. Thomas Buchmueller et al., "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry*, volume 42, number 3, Fall 2005, p. 220.

insurance. Beginning with tax year 2008, an additional penalty will be levied for each month an individual is without insurance, equal to 50% of the lowest premium for which he or she would have qualified.²² In short, besides the multitude of existing “carrots” to entice people to enroll in health insurance, states are beginning to seriously consider “sticks” as well.

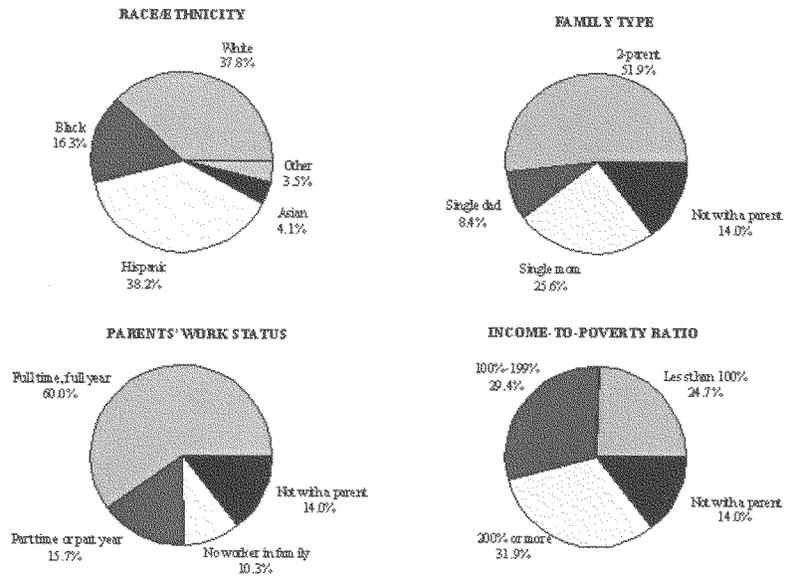
One issue with the future of the Massachusetts health reform, and an issue policymakers deal with nationwide, is defining “affordability.” How does one separate the uninsured into (1) those who don’t have the means to pay for health insurance, and (2) those who might have the means but don’t want to pay? It is a very difficult question to answer — but looking at the situation on the ground, it would seem that the states and the federal government use the federal poverty level as a primary yardstick for determining the appropriate role for providing health insurance.

As I mentioned, the most common upper-income eligibility level for children in SCHIP is 200% of poverty. That is about \$35,000 for a family of three. Coverage for parents in public programs is tied to lower income standards than for children. However, even for children, SCHIP’s upper-income eligibility levels vary substantially by state — from 140% of poverty in North Dakota to 350% of poverty in New Jersey. That is \$24,000 for a family of three in North Dakota and \$60,000 for a family of three in New Jersey. Of course, the cost of living varies dramatically across states, and states vary along other dimensions as well. One way Medicaid and SCHIP may address these variations is through existing flexibility to expand eligibility up the income scale.

²² For additional information, see CRS Report RS22447, “The Massachusetts Health Reform Plan: A Brief Overview,” by April Grady, May 26, 2006.

However, because Medicaid and SCHIP are financed mostly by the federal government, the disparate upper-income thresholds raise questions about the collective obligation to pay for various states' higher-income populations and about how to define equitable federal financing among the states. Similar issues also emerge over the role of the states versus the federal government with respect to private health insurance, in terms of what should be required by insurers, individuals and employers with respect to health insurance.

Figure 1. Characteristics of Uninsured Children Under 19, 2005



Source: CRS Report 97-975, "Health Insurance Coverage of Children, 2005," by Chris L. Peterson.

COVERING THE UNINSURED THROUGH THE EYES OF A CHILD

THURSDAY, MARCH 1, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 2:05 p.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman of the subcommittee) presiding.

Members present: Representatives Green, Capps, Baldwin, Engel, Schakowsky, Matheson, Deal, Hall, Buyer, Ferguson, Rogers, Burgess, Barton [ex officio], and Wilson.

Staff present: Jonathan Brater, Robert Clark, Peter Goodloe, Christie Houlihan, Purvee Kempf, Bridgett Taylor, Brin Frazier, Ryan Long, Katherine Morton, Brenda Clark, and Chad Grant.

OPENING STATEMENT OF HON. FRANK PALLONE, JR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I am going to ask that we get started because we are expecting to have votes in about 15 or 20 minutes so I would like to at least try to get thorough all of not most of the witnesses. Today we have part 2 of our hearing on "Covering the Uninsured Through the Eyes of a Child." We had opening statements at the previous hearing so we will not have them today. We are simply going to turn to our witnesses, and I would ask them to come up and take a seat there with your names.

Welcome and thank you for being here today and let me just introduce the panel before we begin. We have first Dr. Lolita McDavid, who is the medical director for the Child Advocacy and Protection Program in Cleveland, Ohio; and then we have my friend and colleague, Senator Joseph Vitale from New Jersey, from Woodbridge, New Jersey, who is the chairman of the New Jersey Senate Health, Human Services and Senior Citizens Committee, so glad to see him here today; and then we have Alan Weil, who is the executive director for the National Academy for State Health Policy; and Phyllis Sloyer, who is a nurse and Ph.D. and division director of the Children's Medical Services Department of Health, I guess that is for the State of Florida in Tallahassee; and last is Ms. Kathryn Allen, who is the director of health care for the U.S. Government Accountability Office, so welcome all of you.

We are going to have each of you give us a 5-minute opening statement. I should say these statements will be made part of the

hearing record. Each witness may in the discretion of the committee submit additional briefs and pertinent statements in writing for inclusion in the record. I am simply going to through the list here and I will start with Dr. Lolita McDavid for an opening statement.

STATEMENT OF LOLITA M. MCDAVID, M.D., M.P.H., MEDICAL DIRECTOR, CHILD ADVOCACY AND PROTECTION, RAINBOW BABIES AND CHILDREN'S HOSPITAL

Dr. McDAVID. Mr. Chairman and members of the committee, thank you for the opportunity to testify for the National Association of Children's Hospitals. I am Dr. Lolita M. McDavid. As a pediatrician, I have devoted my medical career to children. Currently, I am medical director of child advocacy and protection at Rainbow Babies and Children's Hospital in Cleveland. I submit my written statement for the record.

I have been asked on behalf of the National Association of Children's Hospitals to draw from my professional experience to describe the importance of health coverage for children. I would like to try to do that by giving you two stories.

The first story is about the difference health coverage can make in the life of a child and the child's family. Eugene and Rhonesha are brother and sister who are both patients in my practice. They live with their mom and dad and their family income qualifies them for SCHIP. Gene is 10 years old, the same age as SCHIP. He is a great kid and a great student, and with the exception of needing glasses, he has only had routine health needs.

But Rhonesha, who is 6 years old, has a diagnosis commonly seen in our patient population, asthma. I became Rhonesha's doctor when she was 2 months old. She had required well-child visits like all children but by the time she was 17 months old she was showing signs of reactive airway disease which often is a precursor of asthma. By the time Rhonesha was 22 months old, it was clear she was asthmatic with mild persistent asthma. In many cases like this, I could tell you about emergency room visits, hospitalizations and missed days of work but that has not happened with Rhonesha. Her asthma has been controlled by medications. When she has an occasional flare-up because she has a cold or there is a climate change, her mother manages her illness. Dr. John Carl, a pediatric pulmonologist at our hospital, sees her every 6 months for evaluation. We are now at the point where I only see her for annual routine visits. She is an outstanding first grade student whose favorite subject is math.

Because Rhonesha has coverage through SCHIP, her mother has a relationship with Dr. Carl and me. She can access regular care and not use costly emergency care. Her asthma is controlled. She doesn't need to be hospitalized and she doesn't miss school and her mom doesn't miss work. That is the wonderful promise of health coverage. It not only directly promotes health, it also indirectly promotes learning and employment.

My second story is about a child who is eligible for public coverage but who was not enrolled until after he was admitted to our hospital. Nick's parents brought him to our emergency room on New Year's Day. He was 5 weeks old with respiratory symptoms, vomiting and diarrhea. Although Nick's mother had insurance

through her job, Nick was uninsured. He was admitted to our hospital with pneumonia, and while in the hospital we found out his family was qualified for SCHIP. Happily, Nick went home after 3 days. He was well and now had health insurance through SCHIP that will cover his immunizations and doctor's visits and hopefully keep him out of the emergency room.

As these stories demonstrate, having health coverage makes a real difference, not only in a child's health but also in the cost of the child's health care and in their ability to be ready to learn and grow up healthy and productive.

Building on the foundation of Medicaid, SCHIP has been a great success. Together they have reduced the number of uninsured children by a third. At the same time the overall number of uninsured Americans continues to grow. SCHIP enjoys broad support in State capitals, in Washington and in the private sector. Because of the success, Children's Hospital recommend that Congress commit to achieving the goal of health coverage for all children. The first step should be to build on the foundation of SCHIP and Medicaid. We offer four recommendations.

First, Congress should reauthorize and fully fund SCHIP, at least to fill in all State shortfalls and to enable States to cover all eligible but unenrolled children. Second, the reauthorization of SCHIP should help States to improve outreach and enrollment of children who are eligible for Medicaid or SCHIP. This might include financial incentives, simply their unified application forms, extended continuous eligibility and other methods. Third, reauthorization of SCHIP should not come at the expense of Medicaid. Our ability to sustain the success of SCHIP as the Nation reaches out to cover all children depends greatly on both programs having the funds to meet their goals. To be sure, neither Medicaid nor SCHIP is perfect. SCHIP is capped. When funds run short, as 14 States are projected to experience this year, children are left waiting in line for coverage. Medicaid's historically low payment rates, particularly for doctors, too often leave children without a medical home. Nonetheless, together SCHIP and Medicaid have created an essential safety net of coverage for low-income children and children with disabilities. They are also the foundation for health care for all children. Finally, the reauthorization of SCHIP should include Federal leadership and investment in the measurement of quality and performance of children's health care. The Federal Government is investing in quality measurement for adults' health care through Medicare. It is not doing that for children. It is time to make the same investment in quality and performance measures for children that have been made for adults.

We ask that you provide DHHS with the authority and resources needed to support the development and advancement of pediatric quality and performance measures. This will greatly enhance our ability for States, providers and consumers to have a portfolio of measures they can use for children.

Ten years ago Congress faced and met an unprecedented bipartisan challenge: how to put the Federal Government on a solid path toward the elimination of the Federal deficit. That successful effort culminated in the Balanced Budget Act of 1997 and precisely because it was setting priorities vital to the future of our Nation,

Congress created SCHIP as part of the Balanced Budget Act to expand health coverage for children. In effect, Congress made children's coverage a priority within a balanced budget. Ten years later, Congress faces the same challenge: to achieve fiscal control while at the same time taking the next step to cover all children. They should reauthorize and expand SCHIP while keeping Medicaid coverage for children strong. Ten years of success, broad support through the private sector and bipartisan support in Congress and State capitals all argue for taking that next step.

As a spokesman for Children's Hospital, I can tell you that Medicaid and SCHIP are fundamental to the financial infrastructure of health care for all children. Through the work of Children's Hospital—thank you. I was finished. The decisions Congress makes on SCHIP and Medicaid will affect the health care of every child in this country. Thank you.

[The prepared statement of Dr. McDavid appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you. I am trying to keep it to 5 minutes, if I can, and not go over too much.

Our next witness is Senator Vitale, and I should mention that not only is he from New Jersey but most of his State's Senate district is within my congressional district, and not only is he the chairman of the Senate Health Committee but he also has been an outstanding spokesman on the SCHIP program, so thank you for being with us here today.

STATEMENT OF HON. JOSEPH F. VITALE, NEW JERSEY STATE SENATOR

Mr. VITALE. Thank you again. I am blessed to have actually three Congressmen that represent my district: Congressman Ferguson and yourself and now Congressman Sires.

I wanted to come here today, and I appreciate the opportunity to discuss the importance of the SCHIP program not just across the Nation but in particular to the many children and parents in New Jersey.

New Jersey implemented the SCHIP program in March 1998 by covering children of families whose annual income up to 200 percent of the Federal Poverty Level and called it New Jersey KidCare. An example of 200 percent of the poverty level is a family of three whose annual income does not exceed \$33,200. The program was met with great anticipation and excitement over the prospect of providing health insurance to thousands of uninsured children.

As enrollment grew steadily, we recognized how many more children needed help and health care coverage and in July 1999 expanded eligibility to children whose family's income did not exceed 350 percent of the Federal Poverty Level. An example of that is a family of three with income that does not exceed \$58,100.

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, and we learned that there an increased participation among eligible children when parents are made eligible for health care coverage.

We also know that providing health care coverage to pregnant women leads to healthier babies and moms and so in September 2000 New Jersey made a decision to cover parents up to 200 percent of the Federal Poverty Level and the program was renamed New Jersey FamilyCare. Unfortunately, due to consecutive budget crises, New Jersey had to close the program to parents in June 2002, leaving only those already enrolled to continue participating.

In September 2005, I sponsored new FamilyCare legislation that in addition to streamlining the application process again made FamilyCare available to low-income parents and guardians up to 115 percent of poverty, \$19,000 a year for a family of three, and in 2006 up to 133 percent of the Federal Poverty Level, next year for a family of three whose income would not exceed \$22,000.

We now provide health insurance coverage to 125,000 New Jersey children and over 79,000 adults through our SCHIP program. In addition, we cover 450,000 children and close to 350,000 adults through our Medicaid program. As a result, in partnership with the Federal Government, New Jersey provides health insurance coverage to over 1 million parents 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 more generous eligibility income level in order to reach those truly needy families and children with low income levels. Through SCHIP and Medicaid, it is also a much more economically responsible way to spend health care dollars. In New Jersey, where we have 1.4 million uninsured, access to all levels of care for that population is typically provided by our State's hospitals. In fiscal year 2007, the State has budgeted nearly \$900 million to reimburse hospitals for percentage of the costs they absorb for treating the uninsured. In total, our State's hospitals provide nearly \$2 billion of uncompensated care, a financial strain that has put many of our hospitals at risk.

New Jersey greatly appreciates the opportunities that the SCHIP program provides States. Through our SCHIP program, we have been able to provide health insurance and needed health care to the most vulnerable population among us, and that is 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 process for application and the intense outreach efforts we have undertaken. The prospect of limiting or, at worse, eliminating our SCHIP program to lower income level families would be devastating to our State's budget and to the families of our State.

New Jersey has historically spent its entire annual Federal SCHIP allotment, and although we have been eligible for SCHIP funds not used by other States, these reallocated resources have been diminishing over the years. There is an urgent need for Congress to increase annual allocations to States to meet the ever-growing need for health care insurance for our children.

I will conclude my remarks by asking the members of this very important committee to prevent shortfalls in funding for the

SCHIP program and to advocate for increased support. Both Medicaid and SCHIP have been successful and efficient in expanding coverage to children. By promoting the continued success of these programs, we can ensure that children and their families get the health care that they need. This collaboration between the Federal Government and the States, and with premium sharing by consumers where it is possible, allows the kind of partnership in health care that is a model for success. Without this continuing alliance, millions of children and their families will simply be unable to access the kind of care that the rest of us have and some take for granted.

Thank you for this opportunity.

[The prepared statement of Mr. Vitale appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Senator. I appreciate your being here.

Our next witness is Alan Weil, who is executive director of the National Academy for State Health Policy. Thank you.

**STATEMENT OF ALAN WEIL, EXECUTIVE DIRECTOR OF THE
NATIONAL ACADEMY FOR STATE HEALTH POLICY**

Mr. WEIL. Mr. Chairman, members of the subcommittee, thank you for the opportunity to appear here today. My name is Alan Weil and I am the executive director of the National Academy for State Health Policy, a nonprofit, nonpartisan organization dedicated to improving State health policy and practice. My organization has worked closely with the Nation's SCHIP directors and monitored and reported on the shape of the program since its inception. While we serve as the informal home of the SCHIP directors, I do not purport to speak for them.

The SCHIP has accomplished a great deal covering children, providing them with access to services and reducing unmet health care needs. Your decisions in reauthorization will determine whether we continue this impressive track record. The primary goal of my testimony is to provide a context to the reauthorization debate that is sometimes missing.

States embraced the SCHIP program quickly yet as was expected, it took time for eligible families to learn of the program, come to trust it and ultimately enroll. In the early years of the program, States were subject to substantial criticism for underspending. In response, States and the Federal Government took four steps. First, States substantially increased their efforts to reach out and find the eligible children within their States and keep them on the program once they were made eligible. Second, States increased their eligibility standards. Between 1998 and 2005, the number of States with income limits for SCHIP below 200 percent of poverty went from 22 down to just eight. Third, some States that already had expansive coverage for children when SCHIP was enacted sought Federal permission to use their SCHIP funds to cover families or other adults, and finally the Bush administration announced its HIFA waiver initiative which explicitly encouraged States to apply unspent SCHIP funds to the needs of low-income adults. Now some are criticizing States that are experiencing shortfalls but the complex SCHIP funding mechanism makes planning almost impos-

sible. Shortfalls and underspending are inevitable and do not reflect a lack of fiscal discipline on the part of States.

The SCHIP program is good example of cooperative federalism. Working from a shared goal, the Federal Government developed a framework and provided substantial resources while States contributed their own resources and tailored the program to their own circumstances. State choices vary along many dimensions, not just on the eligibility levels and categories that have received so much attention but also on the benefit package, the delivery system, provider payment levels, health plan accountability mechanisms, family premiums and co-payments and integration with employer-sponsored insurance and Medicaid. States' varied choices reflect the economy, health care systems, values, politics and fiscal capacity that each State has.

Federalism is not orderly but the tremendous success and bipartisan popularity of this program is directly tied to the flexible structure. By delegating key decisions to the States, the Federal Government has obtained a level of political, financial and administrative support at the State level that is unusual in the realm of social programs. Efforts to remake this program with a different vision run the risk of undermining the Federal-State partnership that has enabled it to thrive.

Now, underlying the debate over the appropriate level of funding and reauthorization is the question of whether or not the target population for the program should be modified. Each of the six million Americans reached by this program last year needs health insurance. Program modifications that prohibit covering anyone currently on the program will add another person to the growing ranks of the uninsured. Funding levels inadequate to sustain coverage for those currently on the program or that fail to account for the costs of reaching those who are eligible but not yet enrolled will have the same negative effect.

At a time when the number of uninsured Americans continues to rise, an ideological division impedes broader health reform efforts. SCHIP has been a tremendous achievement. States need prompt reauthorization so they can plan for the future. The expiration of the current authorization is only 7 months away, and States need an expanded Federal financial commitment of resources so they can continue making progress meeting the needs of their citizens who would otherwise go without health insurance. An effective Federal-State partnership brought us to this point. A continued partnership is the best framework for meeting the tremendous remaining needs of children and families.

I appreciate the opportunity to offer this testimony.

[The prepared statement of Mr. Weil appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Mr. Weil.

Dr. Sloyer.

STATEMENT OF PHYLLIS SLOYER, R.N., PH.D.

Ms. SLOYER. Thank you, Chairman Pallone, Ranking Member Deal, members of the health subcommittee. On behalf of Governor Charlie Crist and the State of Florida, thank you for the opportunity to appear before you today to address reauthorization of a

very important program, the State Children's Health Insurance Program, better known as SCHIP.

I am here today representing the Florida SCHIP program known as the Florida KidCare. We provide services to over 1.4 million low-income children through four components: the Florida Medicaid program for children, the Healthy Kids Corporation, the MediKids program and the Children's Medical Services Network.

At the State level, this month and in the upcoming months, Governor Crist and our legislature are looking at ways to simplify our program and ensure seamless coverage and we believe that there are several steps that we can take to improve efficiencies of our program and we are looking to make those changes. Today, however, I would like to outline several Federal challenges that will help us if they can be overcome in making our program even more efficient.

Some of these challenges were highlighted in our 2007 Florida KidCare Coordinating Council Annual Report, which was recently submitted to our Florida State leadership. This council was developed in State law in 1998 to deliberate and make recommendations to the Governor and legislature about the ways that we can improve our SCHIP program. It represents a diverse group of individuals including advocates, agencies and health care providers, and I ask that that report along with this testimony be submitted for the record this afternoon.

We know in Florida that we currently have a discrepancy in our eligible versus enrolled ratio under our KidCare program. This discrepancy is a result in part of Federal statutory barriers and I would like to describe several of them.

First, outreach efforts are extremely critical to reaching diverse populations of children and retaining them. Florida is unique. It is a microcosm of population trends happening nationwide and we have communities who face many cultural, social and language barriers. However, outreach currently is funding through the 10 percent administrative expenditure cap in the program and frankly, in order for us to cover administrative processing, premium processing, application processing, call center functions, there simply is not enough money left in that cap to support targeted and critical outreach functions for families. We ask that you consider funding outreach outside of that 10 percent cap.

In addition, one of the hallmarks of our SCHIP program is the ability to simplify procedures so that eligible children can obtain health insurance without unnecessary roadblocks. The documentation requirements imposed on the Medicaid program under the Deficit Reduction Act of 2005, which require a State to prove a beneficiary is a United States citizen, impedes families from obtaining Medicaid coverage. However, it also has a spillover effect on the SCHIP program since families have to be screened and apply for Medicaid before they can go through the SCHIP application process. I am not here today to discuss the overall purpose or merit of the Deficit Reduction Act but rather to shed some light on some of those unintended consequences. We ask that Congress and the Federal Government consider changes to some of the procedural requirements so that we can promote uniformity and increase the

number of eligible children enrolled in our SCHIP program and assist us in offering a more seamless benefit.

Continuous coverage is also important to maintaining our children's health. In those States without expansion programs, and Florida is one of those, this coverage can be interrupted due to different cost requirements between the SCHIP program and Medicaid program. When a child transitions from having no premium under Medicaid to a premium-based SCHIP benefit, there can be a temporary gap in health care coverage and actually a temporary gap in continuity of care and in active treatment until that premium is paid. As a result, children temporarily lose coverage and may not re-enroll in SCHIP. We encourage Congress to provide direction to States without expansion waivers and with separate SCHIP benefits to implement policies that ensure children who lose Medicaid coverage are able to move to our SCHIP program without breaks in coverage.

In addition, today Florida public employees' dependents can qualify for Medicaid benefits if they are deemed eligible. However, under current Federal statute, those same families' dependents cannot qualify for SCHIP if their income level meets the SCHIP threshold. These families, as an example who earn 200 percent of the Federal Poverty Level, make about \$40,000 a year for a family of four. They have to pay at least 6 percent of their income in monthly health care premiums which actually becomes quite prohibitive for them. We are asking you to consider removing that prohibition for dependents of public employees who may qualify for SCHIP benefits.

Finally, we urge you to align coverage for pregnant women to ensure it is consistent with the coverage of infants provided under the SCHIP program. For example, if an infant is eligible at 200 percent of the Federal Poverty Level, the pregnant woman should be eligible at that same income level so that we can ensure adequate prenatal care and better birth outcomes.

Mr. PALLONE. Doctor, I am just going to ask you to summarize if you will.

Ms. SLOYER. OK. We realize that States have expanded their SCHIP programs outside of the original intent of the legislation. As a result, we understand that several States are concerned about forecast deficits. While we recognize that expansions were done with the support of the Federal Government, we are concerned that a State like Florida who has remained true to the intent of the program will be penalized in reauthorization. While we may have some allocations sitting on the table, we are working to reach those children that remain uninsured and are committing to using our funding.

While these recommendations come from our experiences, we believe that many States would agree increased flexibility is critical, these changes will help create a more fiscally responsible SCHIP program and help cover more children. Thank you.

[The prepared statement of Ms. Sloyer appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you.

Ms. Allen.

STATEMENT OF KATHRYN G. ALLEN, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. ALLEN. Mr. Chairman, Mr. Deal and members of the subcommittee, I am pleased to be here today as you address these very important issues about the State Children's Health Insurance Program and how it has helped to meet the needs of uninsured children since the program's inception 10 years ago and issues concerning the program's reauthorization. SCHIP indeed offers States considerable flexibility in how they provide health insurance coverage to children and families whose incomes exceed eligibility requirements for Medicaid.

States have three options in designing their programs. They may offer a Medicaid expansion, which offers the same benefits and services that their State Medicaid program provides. They may offer a separate child health program which is distinct from Medicaid that uses specified public or private health insurance plans or they may offer a combination program which incorporates features of both. At the time of enactment, Congress appropriated a fixed amount of funds, about \$40 billion over 10 years, to be distributed amongst States with approved SCHIP plans. Unlike Medicaid, however, SCHIP is not an open-ended entitlement to services for beneficiaries but it is a capped grant—or allotment—to States. Each State's annual allotment is available as a Federal match based on State expenditures and is available for three year after which time any unspent funds may be redistributed to States that have already spent their allotments for that year.

Now, my remarks today will focus primarily on two issues that will describe the experience across all States. What I will do is provide some numbers that describe the experience of all States, provides a little more detail beyond the context that has already been provided. I will describe some recent trends in SCHIP enrollment and the current design of all States' SCHIP programs, State spending experiences under SCHIP and then I will comment briefly on some issues for consideration under reauthorization.

First, SCHIP enrollment increased rapidly during the program's early years but it has stabilized in recent years. Total annual enrollment has leveled off at about 6 million individuals including just over 600,000 adults with about 4 million individuals enrolled at any point in time. Many States adopted innovative outreach strategies and simplified and streamlined their enrollment process in order to reach as many eligible children as possible. Nevertheless, 11.7 percent of children nationwide, about 9 million children, remain uninsured, many of whom are eligible for SCHIP. States' SCHIP programs reflect the flexibility for them in their overall program design. Currently, 18 States operate a separate child health program, 11 use a Medicaid expansion program and 21 use a combination of the two. As of fiscal year 2005, about 27 States had opted to cover children and families with incomes up to 200 percent of the Federal Poverty level. Another 14 States had opted to exceed that threshold with seven States covering children and families up to 300 percent of poverty or higher. Thirty-nine States require families to contribute to the cost of their families' care through some form of cost-sharing such as premiums or co-payments. Few States, however, only nine, operate premium assistance programs using

SCHIP funds to help pay premiums for available employer-sponsored coverage, in part because States find these programs difficult to administer. As of last month, February, we identified 14 States that have approved waivers to cover one or more of three categories of adults in the programs: parents of eligible Medicaid or SCHIP children, pregnant women or childless adults.

Second, SCHIP spending was low initially but now threatens to exceed available funding. Some States have consistently spent more than their allotments while other consistently less. In the first years of the program, States that overspent their annual allotments over the 3-year period of availability could rely on other States' unspent funds which were redistributed to cover excess expenditures. Over time, however, spending has grown and the pool of funds available for redistribution has shrunk. As a result, 18 States were projected to have funding shortfalls in at least one of the final 3 years of the program, that is, they were expected to exhaust available funds including current and prior year allotments. To respond to these projected shortfalls, Congress has appropriated an additional \$283 million for fiscal year 2006 and recently redistributed certain unspent allotments from fiscal years 2004 and 2005. Even so, as has already been mentioned, 14 States are projected to exhaust their allotments in fiscal year 2007.

Finally, Mr. Chairman, as Congress addresses SCHIP reauthorization, the single issue at the forefront may very well center on the financing of the program yet this decision involves many moving and interdependent parts. They include how to maintain States' flexibility within the program without compromising the overarching goal of covering uninsured children, how to help ensure stable yet fiscally sustainable public commitments at both the State and Federal levels, and finally, how to assess issues associated with equity including better targeting of SCHIP funds to achieve certain public policy goals more consistently nationwide.

Mr. Chairman, this concludes my remarks.

[The prepared statement of Ms. Allen appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Ms. Allen. Let me just tell everybody, we have 12 minutes remaining for the first vote. There are five votes. These are the last votes for the day and there is also the debate for 10 minutes on a motion to recommit so we will be a while. I was just figuring since there is 12 minutes, I will yield myself five and then we will break, so if anybody wants to go, they can leave now and then we will have the rest of the questions after.

Mr. HALL. Mr. Chairman, will you yield?

Mr. PALLONE. Yes.

Mr. HALL. Will you make available to us to submit questions and ask them to respond in a reasonable time.

Mr. PALLONE. Absolutely. So ordered.

Mr. HALL. Thank you, sir.

Mr. PALLONE. But I will start and yield myself 5 minutes so we can at least get that 5 minutes in.

I wanted to ask Mr. Weil, some groups who are opposed to shoring up the SCHIP program argue that when there is public coverage available, families will drop their employer coverage in order to get it or employers will stop offering coverage, and I have heard

opponents of SCHIP argue that because we have seen a decline in employer-sponsored coverage over the last 10 years and at the same we have seen an increase in SCHIP coverage, that SCHIP has in some way caused the drop in employer-sponsored coverage. This is the crowd-out issue, if you will. On the first day of the hearing, the last hearing that we had, Ms. Owcharenko cited a paper by Jonathan Gruver and Kazala Simon that supported this assertion. However, Jonathan Gruver has sent a letter to Chairman Dingell clarifying the information in his study and I would like to introduce those, both Mr. Dingell's letter and the response into the record, and he says in his response, "In our most general specification, we find no evidence of crowd-out associated with SCHIP per se." In addition, he states that public expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage. So I would like you to talk about this crowd-out issue, whether in your opinion SCHIP is causing crowd-out or the decline in employer-sponsored health insurance coverage and can you give us your thoughts on Dr. Gruver and Simon's report and letter which I assume that you have seen.

Mr. BARTON. Mr. Chairman, before he answers, can the minority have copies of these letters, please?

Mr. PALLONE. Yes, certainly. We will circulate them as I speak hopefully.

Mr. BARTON. Thank you.

Mr. PALLONE. Mr. Weil?

Mr. WEIL. Mr. Chairman, the issue of crowd-out is very complex. The methods that economists use to try to pull it apart are not quite to the task and so if you look at a variety of estimates that very smart people have made, you will see a range. This new study adds yet another data point but does not really change the overall conclusion, which is that there is not a lot but there is some. There is no way the Government can invest in an area where some people are spending their own money without a certain response but the estimates in the paper are consistent actually with the ones that have been given before, a quarter or so, and I think your prior witness's characterization of the conclusion of the paper is not really quite right. The paper does not reach the conclusion that there is a 60 percent crowd-out rate, and it tries to look at families in a way that, without getting bogged down in the methodological issues, I think is stretching and not quite looking at the question right, and I have spoken to some colleagues about that.

A fair reading of the Gruver-Simon paper is another piece of evidence that there is a small amount but this is not a new bombshell telling you to stop running this program because you are wasting your money. I would just say though that any area, whether it is education, public safety, anywhere that the Government makes an appropriation and expenditure, there is some chance there will be some private citizens who reduce theirs. The issue is really the policy response to crowd-out, not whether or not it exists, and I think there is really no reason to think given the size of the estimates that the right policy response is either to reduce eligibility or to increase the hurdles to getting into the program. In fact, in this Gruver-Simon paper, he estimates that the provisions that States made to try to prevent people from dropping private coverage and

moving into SCHIP actually caused more crowd-out than they prevented. So I just think we have to accept that if we are going to help people without health insurance, that that is the priority and that that the reason employers are dropping coverage has primarily to do with growing costs that are affecting everyone. You have an obligation to meet the needs of your citizens and I think it is fair to say that the SCHIP program based on the overall review of the evidence is a very effective investment in addressing that problem.

Mr. PALLONE. Thank you, and I am going to quickly get to Senator Vitale with only a few minutes left.

Could you discuss, Senator, how the cap on Federal funding on SCHIP has affected New Jersey, and more specifically, since Federal SCHIP spending is capped at \$5.4 billion a year into the future, what will this mean for New Jersey's ability to continue those they are already covering as well as any new children in the future?

Mr. VITALE. We are currently experiencing a \$195 million shortfall from SCHIP so that is that the State treasury is making up the difference for that shortfall. We are covering more children in New Jersey than most of the States by way of Federal poverty but it is that New Jersey has an ever-growing divide between the haves and have-nots, and the reallocation or the diminishing reallocation of funds on an annualized basis has a significant effect in terms of the way it is New Jersey can afford to underwrite the costs of what is left. We have 64,000 children in New Jersey who are still eligible for SCHIP or Medicaid but not yet enrolled and we are aggressively pursuing them through a number of means but the failure to re-allocate—and I would advocate that we increase funding for SCHIP because it has been so successful as a method to reach the rest of those children, particularly in States that have not expanded to the levels that New Jersey has.

Mr. PALLONE. Thank you. We are out of time and we are going to have to break now, and I estimate probably about 45 minutes or so before we come back, so thank you.

[Recess.]

Mr. PALLONE. I would ask our panelists to come back up and we will begin and I yield to our ranking member, Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman, and thanks to the panel for being here. As we consider the issue of reauthorization of SCHIP, obviously there are many points of view and this panel has expressed some of them here today.

Let me start, Dr. Sloyer, with the State of Florida since you have been one of the more responsible States in terms of living within your means and the allocations of the program. Does Florida have plans to spend all of its 2007 allocation prior to its expiration in 2009?

Ms. SLOYER. We most certainly do. We in our last revenue estimating conference anticipate that we will spend every dime by the end of our roll forward period in 2009.

Mr. DEAL. So I assume that you would be a little reluctant for any proposal for either the shortfall or otherwise that would take away that money to help States who have not lived within their means?

Ms. SLOYER. I would say a little reluctant is an understatement.

Mr. DEAL. One of the problems that we have in looking at reauthorization as I view it is the great discrepancy and variance among the States. Now, I know Mr. Weil says that that is federalism and it is, but there generally have to be general parameters, and Senator Vitale, we don't mean to pick on you but Frank invited you so you have become the poster child for maybe some of us viewing what is wrong, even though my State is in a shortfall and we didn't exceed it by insuring adults or singles or parents or anybody else. If we are criticized for anything, I guess it is we are 235 percent of poverty rather than 200 percent, which seems to be the standard. But as I understand it, in the State of New Jersey, with some of the provisions that allow you to have income disregards, that a family of four in New Jersey can have an income of maybe in excess of \$72,000. Does that sound about right to you?

Mr. VITALE. Yes, close enough.

Mr. DEAL. For a program that by the legislative authorization was designed to deal with children who are at a "near poverty level", that becomes very difficult for some of us to understand how it fits into the mix, and I know you will understand that that is one of the criticisms that we all have to take into account.

With regard to where do we go from here, I think one of the questions is, should we get to a more uniform-type standard as the basis for it, and one of the great criticisms of some States and yet the advocacy for it on the others who have advocated it is that parents should be included in the mix of children who are eligible. Senator Vitale, have you all look at the possibility of including the parents with the Medicaid FMAP as opposed to the SCHIP FMAP, and would you be as interested in doing it that way with the lower FMAP matching for those people?

Mr. VITALE. We currently cover parents, only parents of children, not the childless adults but parents, up to only 115 percent of poverty. There are parents in Medicaid of course who would otherwise not be eligible for FamilyCare or SCHIP but I think it is appropriate that we cover—100 percent of the poverty level, even 200 percent of poverty in New Jersey is an extremely low amount of annual income for a family and since we don't cover childless adults, only parents of children who are in the program but not all children, and since we go to 350 percent for our kids and for a time we were at 200 percent for parents, it was really a match-up for parents and kids and now we of course have abandoned 200 percent and we are back down to 115. It seems appropriate. These are individuals who will never, ever in their wildest dreams have access to health insurance. Their primary care physician is the emergency room doctor or nurse.

Mr. DEAL. When a State like yours and others—I think when you put Illinois along with you, those two States alone have consumed all of the unused funds from all of the other States combined over the last 2-year period. I believe you all have consistently been at like 270 percent of your allocations. Now, my State, as I say is not blameless because we haven't kept and lived within our means either. The problem I think we have with it is that hopefully we will keep this as a block grant program. It gets to look more and more like an entitlement when we consistently overspend at the State

level and then expect the Federal Government to make up the shortfall. It begins to make it look like an entitlement program but only an entitlement program for those States who have overspent and that creates the inequity I think we have to deal with and obviously is going to be one of those situations that we all have to be concerned with in reauthorization.

I overstayed my time, I guess. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Deal.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

I guess coming from Texas I philosophically agree with my colleague from Georgia although in Texas we haven't overspent our allocation. In fact, we haven't spent what I wanted them to on their allocation, but that is an issue hopefully we will deal with. My State of Texas provides 6 months for SCHIP coverage before kids have to re-enroll in the program. The States that operate the separate SCHIP, only Texas and Oregon cover children for the 6 months at a time, and since Texas implemented the policy in 2003, we lost approximately 180,000 children from SCHIP rolls and 50 percent of those children remain uninsured. It seems pretty simple that 12 months of uninterrupted coverage will help keep kids on the rolls and result in better health care outcomes for children. However, according to the Texas Children's Hospital, one of the HMOs insuring Texas children under SCHIP in Houston, a 12-month coverage policy has added benefit, actually saving the States money. In fact, Texas Children's Health Plan data shows that 12-month coverage results in a 25 percent reduction in claims cost per child, and can the witnesses speak to that issue and the cost savings that States accrue by covering children for 12 months as opposed to the 6 months? Because it is clear that at least in Texas the 6 months coverage was enacted to suppress the enrollment and keep State costs down.

Mr. VITALE. If I could, I think there are certainly a number of issues. One, of course, is the issue of the continuum of care and that children have access and they may not access their insurance or access a provider within the first 6 months of their enrollment, and if they have to re-enroll every time and if that re-enrollment process is a little difficult where there are barriers to re-enrollment in terms of when they have to begin to reapply, if there are mistakes in their application, that holds up their re-enrollment. So I think for any numbers of reasons it makes sense that we do in New Jersey, we have annual enrollment. We have one card that we give to the parent for the child for their coverage. That saved the State millions of dollars. We were giving out one card per month for membership. But enrolling them for the entirety of the year gives them the continuum of care for that 12-month period and in New Jersey what we have provided is for an aggressive re-enrollment process to make sure that they are, No. 1 eligible to re-enroll, and we do that not only through the application process but through Wage and Hour and Treasury. We have backtracked electronically what the income is for the family to make sure that it is valid. For any number of reasons an annual enrollment or an annual eligibility is the best way to go for two different reasons.

Mr. GREEN. When you say you backtracked it, that is through your State treasury?

Mr. VITALE. Yes, through Wage and Hour through the treasury.

Mr. GREEN. Is that information available to some States—we don't have an income tax, for example. Is that available from the Federal side?

Mr. VITALE. Gee, I don't know. It is from our Wage and Hour locally so when companies submit their data monthly, we were able to capture that information.

Mr. GREEN. Any other response to that question?

A follow-up question is, can you speak to the effect of the 6- versus 12-month coverage for the State Medicaid cost? For example, 2004 data from our Texas Health and Human Services Commission indicates that the number of children moving from SCHIP to Medicaid is far higher than the number of children moving from Medicaid to SCHIP, so we are having children going from SCHIP to Medicaid and less than from Medicaid to SCHIP. While the 6-month coverage period may keep enrollment down, and ironically also contributes to a net loss of State dollars, since the State receives a better match for children under SCHIP than they do under Medicaid, can you comment on the effect of keeping children in SCHIP longer would have on the State Medicaid budgets? Is there an effort to keep children on SCHIP as compared to Medicaid because of the additional cost to the State?

Mr. WEIL. I think it is very difficult to generalize about the budget effects across different States in these policies. I do think the States have learned a lot in these 10 years and one of the things they have learned is that 12-month continuous enrollment helps achieve the objective of the program, which is to assure that children have health insurance. But you do have in the structure of this program, States have the choice to decide a lot of things, and for budgetary reasons, for their own decisions about the kind of program they want to run, they don't have to do that. There is a combination of a financial component to the decisions States make but there is also a choice about how they want to run the program and I think those States that are most interested in achieving enrollment and retaining enrollment have gone the route of longer periods of eligibility. Clearly there is a cost to Medicaid to programs that do not take full advantage of SCHIP so just because a State saves money on one side does not mean they will save it on the other side, and similarly, there is a cost to the Federal Government if States are not fully—although they get a higher match in SCHIP, if they are taking actions that yield more folks over on the Medicaid side, then the cost may show up over there.

Mr. GREEN. Mr. Chairman, I know my time has run out, and I have two other questions that I would like to submit to the panel later if that is OK.

Mr. PALLONE. You can, but we also will have a second round, so it is up to you.

Mr. GREEN. I will probably submit them.

Mr. PALLONE. I will leave it up to you. So moved. That is fine.

Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman.

Dr. McDavid, I want to thank you for being here on behalf of the National Association of Children's Hospitals. I have great admiration for the service that Children's Hospital in my area such as Montefiore Children's Hospital in my district in Bronx, New York, and Blythedale at the New York Presbyterian in Manhattan provide to my constituents, and I am thrilled to welcome you to our committee.

Sixty-one national advocacy groups devoted to improving children's health requested \$60 billion in additional monies to reauthorize SCHIP this year. The President countered with \$4.8 billion. Clearly there is a disconnect and we know based on the administration's own estimates, only funding the program at \$4.8 billion could cause up to 400,000 children to lose SCHIP coverage. Can you please tell me where does the National Association of Children's Hospitals stand on the issues of SCHIP funding? I think I know but I want you to say it. And do you believe that it would be acceptable for Congress to allow so many children to lose their SCHIP coverage over the next 5 years? Obviously I am outraged over it and I think it is morally imperative and fiscally responsible to devote more resources to providing and even improving and extending children's coverage. So I hope you agree with this statement and I would like to hear your views on it.

Dr. McDAVID. Well, the National Association of Children's Hospitals would like to have all children covered, that funding for SCHIP and Medicaid be sufficient not only to cover the children who are now enrolled but to enroll the children who are eligible but are not enrolled, Mr. Engel. The exact number, I would respond that NACH can help with that but that will be a CBO designation. That number will evolve as we know what the requirements are going to be. The position of NACH is that all children be covered, that Medicaid and SCHIP be appropriately funded, and eligible and unenrolled children be enrolled.

Mr. ENGEL. Thank you. I want to ask you about asthma because my area of the world in the Bronx, we have the largest, I think, percentage of asthmatic children of virtually anywhere in the country. Two of my own children have asthma, my wife has asthma, and a study several years ago noted that children living in New York City primarily in the Bronx were almost twice as likely to be hospitalized for asthma compared to the nationwide average. Obviously it contributes to school absenteeism for children and it is very, very difficult and I want to tell you that I was pleased that in your testimony you focused on the importance of comprehensive care for children with chronic illnesses so I would like if you could please comment on how chronic care management by programs like SCHIP and Medicaid can reduce overall costs to families and safety net providers.

Dr. McDAVID. Well, medicine has evolved. We have learned more in the last 100 years that we knew in the previous 1,000 years, and the illnesses that children used to die from they no longer die from. Immunizations have made an incredible inroad into child health. With the introduction of the H. influenza B vaccine, we basically eradicated the No. 1 cause of bacterial meningitis in children under 6 within 8 years of the introduction of that vaccine. My residents don't know what measles looks like. They don't know what chicken

pox looks like. Those are the diseases that used to make children sick and also families would have to lose time at work.

Mr. ENGEL. I had them both.

Dr. MCDAVID. Well, they wouldn't know what it looks like now. When I was training, which wasn't that long ago, but it was some time ago, 80 percent of all children who were diagnosed with leukemia would die and now 80 percent of children who are diagnosed with leukemia live. That is a chronic illness. Asthma is a chronic illness. Diabetes is a chronic illness in children and we are seeing type 2 diabetes in children. So a lot of diseases that children didn't live long enough to have or didn't live long with, they are now living. We are doing better. So we have to provide that kind of care. My concern is that children go to school and families are allowed to work and that is what good care on a routine basis does for families.

Mr. ENGEL. Thank you.

Thank you very much, Mr. Chairman. I see my time is just about up. So thank you.

Mr. PALLONE. Thank you.

We are going to go into a second round, so I guess I am next. I will just yield myself 5 minutes.

I wanted to follow up on this idea of, I call it flexibility. That when the SCHIP program was founded and I think everybody who is up here now was here at the time, it was not an entitlement the way, Mr. Deal mentioned. It wasn't intended to be. And the idea was flexibility, that each State basically would be able to try to tailor the program to its own needs and so now we do have the proposal by the President to cut back the 200 percent and not include for children and not include the adults other than those I guess that have already been covered and so I just wanted to hear from some of you about why you think some States have gone beyond the guidelines now that the President is proposing and what it would mean if we cut back, and I guess I will ask Senator Vitale, I will ask Dr. Sloyer, anybody else who wants to get into it, but just explain to us why this was done. One of the statements that was made by the Governor of Tennessee at the National Governors Association—I was there on Monday—was that we submitted these proposals to go beyond the 200 percent or to include adults and they are approved. They have been approved all along so why all of a sudden are we being told to cut back. And if you just would comment on it?

Mr. VITALE. Sure.

Mr. PALLONE. I will start with you.

Mr. VITALE. Thank you, Congressman. You are right that when we were first at 200 percent of poverty in the beginning of KidCare in 1998, it was widely publicized and accepted that it was a great thing for kids. But we also recognize that New Jersey's cost of living was much higher than most States, its median income, per capita income was much higher and the cost of living—to rent a one-bedroom apartment in the average community is nearly \$1,300 a month, and those are issues that I can't solve but what I can try to solve is the health care issues for children. We did apply and it was Governor Whitman at the time, a Republican Governor, who applied for expansion to 350 percent. It was approved by CMS and

so essentially we believed that we a deal. We had an agreement and this is going to be a partnership that would be ongoing. We didn't decide to go to 350 percent because we wanted to relieve someone else the responsibility and obligation to provide the health care. It wasn't affordable for those individuals. It should also be noted that at 350 percent or even at 300 percent and even below that, there is a premium contribution by the parent so it is not a freebie. There is, for lack of a better term, skin in the game for those who are above 200 percent and get closer to 350 percent and it is significant in terms of being responsible and we found also that those parents how are covered closer to 350 percent want to be able to contribute some dollars toward that. Some of them that we have interviewed and we have talked to have said that they don't—maybe it is a personal thing but they don't feel as though—it is an entitlement that they don't think that they want to be associated with. They don't mind spending a few dollars to provide their premium coverage.

But the comments that other States have lived within their means, I don't understand that. I think I understand the perspective that at one time the Federal Government gave us the opportunity to go to 200 percent, this was the limit, but when you say you can go to 350 percent and we will match it at 65 percent, then it is that we took advantage of that for the sole purpose of providing health insurance for children who would never, ever have that opportunity for that kind of care.

Mr. PALLONE. Well, let me just ask Mr. Weil, over the past few weeks we have heard a number of people suggest that SCHIP has gone well beyond its intended reach. Do you think the program really has run amok with all these waivers that were permitted under the law? Are there beneficial aspects to the fact that we are going above the 200 percent for kids and allowing adults, parents, or do you think we have gone amok?

Mr. WEIL. We certainly haven't gone amok, and the statute in its own language says that HHS will reallocate unspent dollars to those States that need them and therefore seeing other States not using the funds did exactly what the statute anticipated. Why did States go further? Some were already covering at higher levels and the statute took that into consideration. Some found that the data on which their allocations were based didn't match the reality as they went out to find families. Some used the funds as part of an overall strategy to try to reach more uninsured people in their States whether children or families and in some instances, but not many, childless adults and of course Congress has already taken that option away, and States are charging cost-sharing to families. I would just note the real bottom-line answer to your question is, States took advantage of this program because the Federal Government was taking no action on a problem that States saw as central, which is the growing number of uninsured and the growing cost problem that small businesses and families were facing, and this was the only opportunity for States to interact with the Federal Government and Federal programs to address that problem. If there had been other avenues open, I am sure States would have considered them as alternatives. There were no alternatives.

Mr. PALLONE. Thank you.

Mr. Deal?

Mr. DEAL. Thank you.

I want to get back to considerations for reauthorization and I think the first place we ought to start is to remember that the C in SCHIP is children, and they ought to be the primary focus. Now, some people are saying we ought to have 100 percent of all children who are 200 percent of poverty or below enrolled in SCHIP. I personally don't think you will ever get 100 percent of any particular category enrolled. What is an agreeable percent of 200 percent of poverty of children that should be sort of a baseline, if you will? Should it be 90 percent? Anybody think it ought to be lower than 90 percent of below 200 percent of poverty children in the SCHIP program as a priority? Anybody think it ought to be less than 90 percent? Is 90 percent achievable? I think we have had States that demonstrated that it is achievable. Does anybody disagree with that? Does it get problematic when you fix that baseline above 90 percent? Does it become very difficult to achieve? I think I see most people agreeing that it probably does. OK. So if we are looking at where we should spend our money, is there anybody that disagrees with the fact that we ought to set a baseline of, say, 90 percent of children at 200 percent of poverty or below as a prerequisite for spending SCHIP money on other categories such as adults or pregnant women or whoever? Does anybody disagree with that proposition?

Mr. VITALE. I do, Congressman.

Mr. DEAL. Why?

Mr. VITALE. Because it is that there are children who live at 210 percent of poverty or 250 percent of poverty and that is—

Mr. DEAL. They are not as bad off as the ones below 200 percent though.

Mr. VITALE. Well, you are right, but it is also marginal, so let me give you an example of a family of two in New Jersey at 200 percent of poverty is \$27,000 a year. That is one parent and one kid.

Mr. DEAL. Well, let me stop you though. If we agree 90 percent of those below 200 percent of poverty ought to be the sort of thing everybody ought to be able to achieve, I am not saying you can't spend it on those above it. I am just saying that as a prerequisite to that, you ought to achieve a certain penetration level of those lower income children. OK. That is the point I was making.

Let me go quickly to another part, and Ms. Allen, I was looking in the recommendations section because one of the things that my State says is a problem is the formula. You allude to it, and as I understand the formula, 50 percent of the formula is based on the Medicaid formula of per capita income. Is that correct? Same as you use in the Medicaid program?

Ms. ALLEN. That is correct.

Mr. DEAL. The other 50 percent is based on the uninsured children and those in the poverty level and the complaint my State makes is that once they have been successful in enrolling the children in an SCHIP program, they don't get to count those children for future allocations of money. Does that make any sense to anybody?

Ms. ALLEN. Yes, sir. There are concerns about the formula does disadvantage those States that are achieving a high rate of insur-

ing children and that is one of the recommendations that some are making to relook at that formula.

Mr. DEAL. So theoretically, if you have 100 percent of your eligible poverty children, you would lose 50 percent or more of your funding for the next allocation period. I think that is a huge problem and that does penalize the good actors in the process. Would anybody agree we ought not to look at trying to fix that? Anybody disagree with trying to fix that? OK. I think I got your approval on that one.

One of the things that I think we also have to look at as we approach this is that we shouldn't lose sight of the fact that it is a block grant program and trying to keep it in that category I think is very important. We earlier in the day talked about the possibility that this might foreclose private insurance in the marketplace for employer-based insurance that might be available to families who might say well, I can get under the SCHIP program and therefore, I don't elect the employer-based. One of the suggestions—and some States I think are already doing it. I know there is some in Medicaid—of using SCHIP money to assist families in that situation to buy in to the private plans that are available through that employer-based system. It certainly saves a State money, I think, to do that. Have you all done, Senator?

Mr. VITALE. Yes, sir, we have. In New Jersey we have the premium assistance program for parents whose children are already covered in dependent coverage at work, so in a small group market if your child is covered, the State if they would be—if they are FamilyCare eligible but enrolled in their parent's employer's plan, then two things can happen. One is that they would have to go bare for 3 months before they would be eligible for our SCHIP program, which prevents the crowd-out piece. But we do though say that since you are doing the right thing, you are insuring your kid at work and you are paying the premium but you are FamilyCare eligible, we will pay a piece of your premium to help you support that premium because we know that you are eligible so let us do the right thing; you have done the right thing, we will help you out a little bit as well through premium support. And then our next sort of iteration of that is to make a determination upon enrollment going forward this legislation we are considering that would first ask parents if they have health insurance opportunities at work, and if they do and they are FamilyCare eligible and if the premium is equal to or greater than, then we would help them with that as well to sort of try to keep them in employer-based coverage and support that system as well.

Mr. DEAL. Thank you very much.

Thank you, Mr. Chairman.

Mr. PALLONE. Mr. Burgess, questions?

Mr. BURGESS. Thank you, Mr. Chairman. If you don't mind, I actually do have a couple of questions that have come up and I apologize about our voting schedule. At least we got to hear from all of you before we had to leave.

I apologize because I wasn't here for the early questions. If I am re-asking something that has already been covered to just be patient with me, it won't hurt for this committee to hear it more than once anyway.

Ms. Allen, let me ask you about the eligibility for SCHIP in New Jersey for those whose net income is 200 percent of the Federal poverty level or below. That is by definition the definition of eligibility. Is that correct?

Ms. ALLEN. In New Jersey it is 350 percent percent of poverty.

Mr. BURGESS. Well, is that technically in compliance with the requirement that the program cover a population of 200 percent of poverty and below as was intended when Congress passed SCHIP? Anyone can answer.

Mr. VITALE. I can answer that. We first began in 1998 with SCHIP when it first rolled out and we went to 200 percent of poverty for kids but we received a waiver from CMS to go to 350 percent the following year to enroll more children. So our waiver was granted by the Federal Government and maintaining that 65 percent/35 percent Federal match.

Mr. BURGESS. So you covered all the kids in New Jersey if they were 200 percent of poverty and below by that time?

Mr. VITALE. Most of the children in New Jersey are covered below 200 percent, either FamilyCare or Medicaid, and we have more children enrolled above 200 percent to 350 percent. The numbers get a little less as you go closer to 350 percent because those are kids whose parents come in and out of insurance. They lose their job, they lose their insurance and get back into it. So we have a much higher enrollment at 250 or at 200 percent below and above that.

Mr. BURGESS. So now we go up to 350 percent percent of poverty basically. Now, let me just be sure that I am correct on my understanding of this. This is not the State of New Jersey spending New Jersey money for everything above 200 percent percent of poverty to 350 percent? It is the Federal money that you are drawing down from the SCHIP program?

Mr. VITALE. That is correct. The Federal Government is paying 65 percent. We are paying 35 percent out of our State treasury.

Mr. BURGESS. So in a sense, you are then disregarding the income for those between 200 percent of poverty and 350 percent of poverty?

Mr. VITALE. Well, sir, we are not disregarding anything. We are not disregarding a Federal rule because we were given a waiver by CMS to allow us to cover kids above 200 percent to 350 percent so we are in compliance with the waiver.

Mr. BURGESS. Then we would be in agreement that the waiver is the problem? OK.

Mr. VITALE. No, we would not.

Mr. BURGESS. Well, Senator, let me just stay with you for a minute. It is my understanding that legislation has been introduced in Congress that would take 2005 allotments and 2006 allotments from States that have not yet expended these allotments before the 3-year time period that they had to expend the funds and take those monies and redistribute to States who will spend their entire 2007 allotment before the end of the fiscal year. Am I correct about that?

Mr. VITALE. Yes.

Mr. BURGESS. I think I am one of those States that would lose money in a deal like that, but you are supportive of that concept?

Mr. VITALE. Well, sir, I am not supportive of any State losing their allocation but I do believe that all States that enter into this partnership with the Federal Government have an obligation to do all that they can to enroll all the children above—or not above but to their limit.

Mr. BURGESS. No argument.

Mr. VITALE. There are States that have done a less than adequate job in enrolling those children so since there was a finite pot of money, we want to be able to redistribute it to those States who actually use it.

Mr. BURGESS. But we heard from other witnesses earlier in their testimony that one of the problems is that we are inconsistent and it would seem to me to be the height of inconsistency if we say Texas, you have got 3 years to spend these funds but oh, by the way, now we are doing a quicker look-back for you and we are going to take those funds that should be yours until 2008, 2005 funds that should be yours until 2008 but we are going to zip those off to someone else to cover their population. In Texas, we are not as generous as you are in New Jersey. We don't go up as high as 350 percent of poverty. Well, it is just a question of fundamental fairness. Your position is that since the Federal Government allows that to happen and you have the waiver that that is OK? We are looking at reauthorizing this bill and we want to do it as best as we can. We want to be fair to all the States and we hope the States will play by the rules but then we should play by those rules that we set out, I think. I had a discussion with Albert Hawkins, our State HHS director, last week when I was home, and I said Albert, is 3 years not enough time for you to allocate that money? Texas of course has a legislature that meets every 2 years. Some people say that is too often. But because of that, that was the reason we were behind on spending our money going back to 1998. We didn't meet in 1998. We met in 1999 and began our expenditures of the SCHIP program. But we have adjusted to that and now we are on that steady state of a 3-year timeline and Mr. Hawkins said as long as we stay on the 3-year timeline, we are fine. Because I asked him, I said do you need more time to spend the money; maybe you ought to spend more on doctors because they could get paid more. And he said no, what we are doing is good but we just need the stability of having that 3-year timeline not be interrupted for us to be able to make our plans back in the State with the partnership that Texas entered into with the Federal Government.

I see my time has expired, Mr. Chairman. You have been very indulgent. Thank you.

Mr. PALLONE. OK, sure. We are just going to go one more round here and then we will close because I don't want to keep all of you.

I just wanted to ask about more outreach because we know for example in New Jersey, and I know it is true in other States, that even now there are more kids eligible for the SCHIP program that are not enrolled than are actually enrolled, at least in my State, and I know that is true in many other States. I would ask Dr. McDavid and then again Senator Vitale if he likes, there are currently 9 million uninsured children in the country. Of those, two-third currently qualify for public programs such as SCHIP and Medicaid but are not enrolled. Some States have more barriers to

enrollment than others, but just talk to us about what things States have done that have improved enrollment, what kind of barriers have been put up and certainly part of this may be—because I know that Senator Vitale has told me in the past that enrolling the adults is one way of enrolling the kids. What would you recommend to get more kids enrolled? What kind of outreach, what kind of changes to the program as we go through the reauthorization?

Dr. MCDAVID. I can tell you what we have done in Ohio, and Ohio has actually put everyone into Medicaid. We don't have a separate SCHIP program. Twelve months continuous eligibility is very helpful. I think that if any of us in this room had to pick our insurance every 6 months and gather up a bunch of materials and take it down to the center, we probably wouldn't get it done. So we have to think about the barriers that low-income working families have to face to get re-enrolled. So 12 months continuous eligibility, presumptive eligibility. If your income is low enough for you to meet certain other programs in your State, then families need to know about for us Medicaid and make sure that we get their kids enrolled. At my hospital, we have a person that we hire that we pay for who literally helps families get the documentation together so that they have the receipts and they help them get the birth certificates and the things that they need, because for many families it is a very difficult thing to do. If you are born at our hospital, then we know that you have got a birth certificate somewhere—not our hospital, we have a women's hospital with us.

The other thing we did in Cayuga County, which is the county that I am from, we did a 2-year pilot with self-declared income. People could say what their income was, and when we did it we found that there was very little fraud, that people do honestly self-report their income. So there are things that you can do to decrease the barriers. Personally, I find that we ask people who have less resources and skills than we do to do things that we probably wouldn't do, and I think we have to think about how the people who stock the shelves at—can I say it—Wal-Mart and change your oil at the lube stop and pass you your burger at the Burger King, the kinds of things that you and I may not think of as barriers are huge barriers to them.

Mr. PALLONE. Talk to me or tell us, Senator, about how, enrolling the adults is a factor in enrolling the children or any other outreach that New Jersey has done to try to get more kids enrolled.

Mr. VITALE. We have seen that. We don't know what the reasons are. We kind of guess why that is. We know that when families participate as a family, that there is higher enrollment for kids. I don't know why that is. You would think that even if a parent weren't eligible that they would get their kids in anyway. So I kind of scratched my head on that notion. But 2 years ago when we reformed FamilyCare and we did FamilyCare II, our original application was 14 pages long, two sides. I used to joke that it looked like an application for tuition assistance to Annapolis and it was that difficult to fill out, and it was a challenge for me and for my staff to fill it out without making a mistake, and if you mail it in and you had a mistake, then it wasn't processed, it sat in a pile for 6 months until they figured out where it came from. So we went

down to a 1-page form and asked for income. We went from three pay stubs to one pay stub. We enroll online now. We have reached out to hospitals to get them to participate in enrollment. We weren't asking for a Medicaid waiver so that we can have a certified individual in the hospital actually certify the application as opposed to having that application filled out by a hospital employee, then have to go to the country to be certified and find its way through the process and finally make it down to Trenton to be finalized. We have also done a lot of average with FQHCs with schools, with clinics. We have set up enrollment sites at legislative offices inclusive of mine, then in reach within the departments, the Department of Health and Senior Services. We have women's, infants' and children's program and through the FQHC process where we begin to now enroll. Each department head meets—every time there is a staff meeting in Trenton, every department head, every commissioner has to report to the Governor and to the commissioner of human services what they have done to help provide outreach and awareness through their department, whether is the Department of Education, Department of Health.

And last, in the Department of Education, we have identified through a pilot program that will expand next year, we have been outreaching to all children who are eligible for free and reduced school lunch. So everyone who is eligible is certainly eligible for SCHIP. But in New Jersey, since we have a higher eligibility, we are looking for all children so now we are educating school districts, school nurses and others so that they can participate in the enrollment process as well.

Mr. PALLONE. OK. Thanks a lot.

Mr. Deal.

Mr. DEAL. One of the things that I encounter when I talk with my State legislature and Governor with regard to their shortfall was that the Georgia statute that put in place our Peach Care program prohibits our State from adding State dollars when the Federal match runs out. Do you have a similar prohibition under New Jersey law, Senator, that you are aware of?

Mr. VITALE. No, Congressman, we do not.

Mr. DEAL. And as I understand it, there is no prohibition in the Federal statute that would prohibit a State when they are approaching a shortfall from self-funding whatever the shortfall might be. Am I correct on that? There is no Federal prohibition against it?

Ms. ALLEN. I am not aware of any, no.

Mr. DEAL. Obviously one of the reasons that SCHIP is so popular is that the FMAP differential is much more favorable to a State than is the Medicaid FMAP. In my State, it is little slightly less than a 16½ percent differential and I know that must vary from State to State. Ms. Allen, did you all look at that issue of the differential between the Medicaid and the SCHIP differential on the FMAP, and how big of variance do we see in States. Mr. Weil, you may know.

Mr. WEIL. The formula is in statute and it is a little complicated. The State has to put in 30 percent less than it would for the Medicaid program. So for the States at the 50 end of the range, it is 50/

65 so it is a 15-point gap as you move up into matches that move slightly but it is a pretty good rule of thumb.

Mr. DEAL. So it sort of starts at 15 percent? Is that what I understand you to say?

Mr. WEIL. Yes.

Mr. DEAL. So there is great incentive to maximize the use of your SCHIP if at all possible.

Ms. ALLEN. Yes.

Mr. DEAL. Well, we have a task of reauthorization and trying to deal with some of these issues that we are confronted with. I have come to the conclusion though that there are some things that are immutable. One is, if it is a choice of me paying for something or somebody else, namely the taxpayer paying for it, I am going to choose the taxpayer every time. If it is a choice of the State paying for it or the Federal Government paying for it, the State is going to always choose the Federal Government to pay for it. Those are the laws of human nature and we are not going to pass anything up here that is going to repeal the laws of human nature, and I think what we have to do is work within those to try to make a program as far as possible. Because quite frankly, people from States like Texas, as Dr. Burgess has indicated, they have a right to be indignant when they were given their allowance by Uncle Sam just like my State was given its allowance by Uncle Sam and we have overspent ours and we come running back and saying well, take part of his or give me some more to make up the difference. Those inequities are going to haunt us until we try to get a handle on them to address them as appropriately as possible, and it is going to take good faith and it is going to take a willingness to try to deal with the tough issues because otherwise politics will take over and human nature is going to take over and sometimes it does not draft the best kind of legislation for the long term.

So Mr. Chairman, I appreciate the time and I especially appreciate these witnesses being here today, and we probably are going to have questions that some of our members who are not here are going to submit to you and hopefully you will be able to respond to those, and any suggestions—I would simply say that any suggestions that you have about things we haven't even talked about or haven't even thought about perhaps, and I would and I am sure the chairman would too, we would welcome your input on all those. Thank you.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Let me just echo what Ranking Member Deal just outlined because I think that is extremely important. Maybe since I am so new to this process and I really don't understand all the time what something like a waiver might be or might look like, perhaps we can ask CMS for some examples of waivers, perhaps the waiver that is provided to your State, Mr. Chairman, and waivers that have been provided to some of the other States as well just so we have an opportunity to look at—I am always concerned about Medicaid as a Federal program because it requires 2,800 waivers to work well. Maybe we ought to try to get it right the first time and not require the CMS to come back and give us waivers to make it

work when it is not working well for the people it is intended to serve, and it is a good goal to serve children, provide children with coverage. It is after all preventive medicine at its best. I think we heard from our previous panel when we had our first hearing that for every dollar that it costs to cover an adult, you can get comparable coverage for a child for about 60 cents because we are obviously treating disease much, much earlier in someone's life span and so we can expect our therapeutic outcomes to be enhanced, which leads me to the question of—well, let me back up for a minute and ask Ms. McDavid, I think I heard you say during your opening statement that you are looking at possibly providing financial incentives for people to enroll in SCHIP. Is that correct?

Dr. McDAVID. That wasn't me.

Mr. BURGESS. Maybe I misheard that. Well, the whole concept of covering adults on a children's health insurance statute is one that I just intellectually have some trouble with. If we are going to be covering adults, we should cover adults. If we are going to be covering children, let us cover children. Let us decide what we are going to do and do it well and do it better than anyone else. Does anyone have any thoughts on the concept of expanding the populations to include adults? In the interest of full disclosure, I was an OB/GYN doctor in my former life so I do think we ought to cover pregnant adults because that really is preventive medicine at its very best because we are going to prevent problems before birth. But aside from the individual who is pregnant, non-pregnant adults and childless adults, does anyone have any thoughts about it? Are these populations we should be seeking to cover with the SCHIP program?

Dr. McDAVID. I would like to state on behalf of the National Association of Children's Hospitals that our fundamental focus should be making sure that children are insured, that there is an adequate amount of money to cover the children who are already enrolled and that we do outreach and enroll those children that are not enrolled. I agree with you, in Ohio we cover pregnant women to 150 percent of poverty and, as you know, it is very effective. You come in, you give your urine, you get measured, you get your blood pressure taken, you have ruled out gestational diabetes, intra-uterine growth retardation, preeclampsia. We understand that, but for children, our emphasis is that children should be adequately covered and after that has been taken care of, then we can look at other populations.

Mr. BURGESS. So we would be in agreement that the children should be the primary focus of this as we reauthorize this legislation?

Dr. McDAVID. Yes.

Mr. BURGESS. And, Mr. Chairman, I may be wrong on this but I think when we do our supplemental appropriation request from the administration in a couple of weeks, we are going to be asked to add funding to SCHIP for the shortfalls that are occurring throughout the country and all well and good if we are not paying our bills, by all means, let us step up and do that, but if we are incurring those bills because of not using the program for the original intention, the original purpose for which it was intended, then I think we have to look at how we have structured it, and again,

it just leads me back to the coverage of adults. So if anyone else has any thoughts on that, I will be happy to hear them in the 54 seconds I have left.

Mr. VITALE. If I could be so bold, Doctor—

Mr. BURGESS. Actually, if you are talking, I will bet the chairman will give you as much time as you may consume.

Mr. VITALE. Congressman, thank you. I think fundamentally that there is—let me back up. I believe that we can cover all the children in our States. In New Jersey we have done a great job. We only have 64,000 kids left who are not covered at our poverty level of 350 percent. The States who are at 200 percent or 250 percent or 225 percent, I believe that with the right kind of effort they can get to their goal of almost 100 percent coverage if they really try because generally they don't mandate coverage but through the appropriate kind of average we can get really close to insuring most of those kids. But it is fundamentally important as a matter of not just fairness and equity. As a physician, you understand that. Anyone who goes uncovered for so long, the health consequences are enormous and it is also health consequences that provides for an enormous amount of strain and burden on State and Federal budgets.

Mr. BURGESS. I am not going to argue about that but let me just—

Mr. VITALE. We can change the name, change SCHIP to something else.

Mr. BURGESS. And if that is something that this Congress needs to take up, then perhaps we should do that. But there are four States that I am aware of where there are more adults covered than children. Clearly the intent of the program is not being followed if you have four States where you might have double the number of adults that you have children covered. I would suspect that just looking at the numbers that I was given the other day, that in those States there are probably children under 200 percent of poverty who are not being covered in those States, and for that reason we are not doing the job that—and I see we but I wasn't here in 1997 but that the Congress intended when this legislation was passed 10 years ago.

Mr. VITALE. I think you are right. I think it is a shame that there are more parents than children covered in those four States but I would just caution all of us not to throw the baby out with the bath water because there are 46 other States doing the right thing.

Mr. BURGESS. Well, yes, but we do need to be good stewards of the taxpayer money at the Federal level. We are not always seen in that role but it is important that we keep that role in mind.

Thank you, Mr. Chairman. You have been very indulgent. I will yield back.

Mr. PALLONE. Thank you, and I want to thank all of our witnesses for being here today. I thought this was very thought-provoking and helpful for us as we move to reauthorization of SCHIP. I just wanted to mention—well, first of all I will enter into the record a letter that went from the National Governors Association. This is from Governor Corzine, Governor Douglas on a bipartisan basis to the House leadership about the SCHIP program, and I also

wanted to remind the members that you may submit additional questions for the record to be answered by the relevant witnesses. The questions should be submitted to the committee clerk within the next 10 days and the clerk of course will notify your offices of the procedures.

Thank you all again. This was very helpful. And without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 4:58 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

March 1, 2007

CHILDREN'S HEALTH INSURANCE

States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization



Highlights of GAO-07-558T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

In August 1997, Congress created the State Children's Health Insurance Program (SCHIP) with the goal of significantly reducing the number of low-income uninsured children, especially those who lived in families with incomes exceeding Medicaid eligibility requirements. Unlike Medicaid, SCHIP is not an entitlement to services for beneficiaries but a capped allotment to states. Congress provided a fixed amount—approximately \$40 billion from fiscal years 1998 through 2007—to states with approved SCHIP plans. Funds are allocated to states annually. Subject to certain exceptions, states have 3 years to use each year's allocation, after which unspent funds may be redistributed to states that have already spent all of that year's allocation.

GAO's testimony addresses trends in SCHIP enrollment and the current composition of SCHIP programs across the states, states' spending experiences under SCHIP, and considerations GAO has identified for SCHIP reauthorization.

GAO's testimony is based on its prior work, particularly testimony before the Senate Finance Committee on February 1, 2007 (see GAO-07-447T). GAO updated this work with the Centers for Medicare & Medicaid Services' (CMS) January 2007 approval of Tennessee's SCHIP program.

www.gao.gov/cgi-bin/getrpt?GAO-07-558T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

SCHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. As of fiscal year 2005, the latest year for which data are available, SCHIP covered approximately 6 million enrollees, including about 639,000 adults, with about 4 million enrollees in June of that year. Many states adopted innovative outreach strategies and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible. States' SCHIP programs reflect the flexibility federal law allows in structuring approaches to providing health care coverage. As of July 2006, states had opted for the following from among their choices of program structures allowed: a separate child health program (18 states), an expansion of a state's Medicaid program (11), or a combination of the two (21). In addition, 41 states opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher, with 7 of these states covering children in families with incomes at 300 percent of FPL or higher. Thirty-nine states required families to contribute to the cost of their children's care in SCHIP programs through a cost-sharing requirement, such as a premium or copayment; 11 states charged no cost-sharing. As of February 2007, GAO identified 14 states that had waivers in place to cover adults in their programs; these included parents and caretaker relatives of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

SCHIP spending was initially low, but now threatens to exceed available funding. Since 1998, some states have consistently spent more than their allotments, while others spent consistently less. States that earlier overspent their annual allotments over the 3-year period of availability could rely on other states' unspent SCHIP funds, a portion of which were redistributed to cover other states' excess expenditures. By fiscal year 2002, however, states' aggregate annual spending began to exceed annual allotments. As spending has grown, the pool of funds available for redistribution has shrunk. As a result, 18 states were projected to have "shortfalls" of SCHIP funds—meaning they had exhausted all available funds—in at least one of the final 3 years of the program. To cover projected shortfalls faced by several states, Congress appropriated an additional \$283 million for fiscal year 2006.

SCHIP reauthorization occurs in the context of debate on broader national health care reform and competing budgetary priorities, highlighting the tension between the desire to provide affordable health insurance coverage to uninsured individuals, including low-income children, and the recognition of the growing strain of health care coverage on federal and state budgets. As Congress addresses reauthorization, issues to consider include (1) maintaining flexibility within the program without compromising the primary goal to cover children, (2) considering the program's financing strategy, including the financial sustainability of public commitments, and (3) assessing issues associated with equity, including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you address the reauthorization of the State Children's Health Insurance Program (SCHIP). In August 1997, Congress created SCHIP with the goal of significantly reducing the number of low-income uninsured children.¹ Prior to SCHIP, approximately 19 million Medicaid beneficiaries were children, and combined federal and state expenditures on their behalf totaled \$32 billion. However, there remained an estimated 9 million to 11.6 million children who were uninsured at some time during 1997. SCHIP was established to provide health coverage to uninsured children in families whose incomes exceeded the eligibility requirements for Medicaid. Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses.

SCHIP offers states flexibility in how they provide health insurance coverage to children. States implementing SCHIP have three choices in designing their programs: (1) a Medicaid expansion, which affords SCHIP-eligible children the same benefits and services that a state's Medicaid program provides; (2) a separate child health program distinct from Medicaid that uses, for example, specified public or private insurance plans; or (3) a combination program, which has a Medicaid expansion and a separate child health program. At the time of enactment, Congress appropriated a fixed amount of funds—approximately \$40 billion from fiscal years 1998 through 2007—to be distributed among states with approved SCHIP plans. Unlike Medicaid, SCHIP is not an entitlement to services for beneficiaries, but a capped grant—or allotment—to states. SCHIP funds are allocated annually to the 50 states, the District of Columbia, and the U.S. commonwealths and territories.² Each state's annual SCHIP allotment is available as a federal match based on state expenditures and is available for 3 years, after which time any unspent

¹Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552-570 (Aug. 5, 1997) (adding Title XXI and new sections 2101-2110 to the Social Security Act, codified, as amended, at 42 U.S.C. §§ 1397aa-1397jj). For the remainder of this testimony, we will only refer to provisions of the U.S. Code when referencing SCHIP requirements.

²This testimony focuses on SCHIP programs in the 50 states and the District of Columbia. While Tennessee has not had a SCHIP program since October 2002, in January 2007, the Centers for Medicare & Medicaid Services (CMS) approved the state's plan for a separate child health program under SCHIP. According to state information, the program will be implemented in early 2007.

funds may be redistributed to states that have already spent their allotments.³

As Congress considers reauthorization of the SCHIP program, my remarks will address (1) recent data regarding trends in SCHIP enrollment and the estimated number of children who remain uninsured, (2) the current composition of SCHIP programs—including their overall design—across the states, (3) states' spending experiences under SCHIP, and (4) issues we have identified for consideration during SCHIP reauthorization. My testimony is based on prior GAO work, particularly testimony before the Senate Finance Committee on February 1, 2007.⁴ We updated this work based on the Centers for Medicare & Medicaid Services' (CMS) January 2007 approval of Tennessee's new SCHIP program. We conducted our work in February 2007 in accordance with generally accepted government auditing standards.

In summary, SCHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. SCHIP programs reported total enrollment of approximately 6 million individuals—including about 639,000 adults—as of fiscal year 2005, the latest year for which data were available, with about 4 million individuals enrolled in June of that year. Many states adopted innovative outreach strategies, and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible. Nevertheless, about 11.7 percent of children nationwide remain uninsured, many of whom are eligible for SCHIP or Medicaid. The rate of uninsured children varies widely across states, ranging from a low of 5.6 percent to a high of 20.4 percent.

States' SCHIP programs reflect the flexibility allowed in structuring approaches to providing health care coverage through a Medicaid expansion or a separate child health program. In fiscal year 2005, 41 states had opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher, including 7 states that covered children in families with incomes at 300 percent of FPL or higher. In addition, 39 states required families to contribute to the cost of their children's care in SCHIP programs through some type of cost-sharing

³In some cases, states have been allowed to retain a portion of unspent allotments.

⁴See GAO, *Children's Health Insurance: State Experiences in Implementing SCHIP and Considerations for Reauthorization*, GAO-07-447T (Washington, D.C.: February 1, 2007). Related GAO Products are included at the end of this statement.

requirement, such as premiums or copayments; 11 states charged no cost-sharing. Few states (9) reported operating premium assistance programs, which allow states to use SCHIP funds to help pay premiums for available employer-based health plan coverage, in part because states often find these programs are difficult to administer. As of February 2007, we identified 14 states that had approved waivers to cover one or more of three categories of adults: parents and caretaker relatives of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

SCHIP program spending was low initially but now threatens to exceed available funding. Since 1998, some states have consistently spent more than their allotments, while others have consistently spent less. In the first years of the program, states that overspent their annual allotments over the 3-year period of availability could rely on other states' unspent SCHIP funds, which were redistributed to cover excess expenditures. Over time, however, spending has grown, and the pool of funds available for redistribution has shrunk. As a result, in at least one of the final 3 years of the program, 18 states were projected to have "shortfalls" of SCHIP funding—that is, they were expected to exhaust available funds, including current and prior-year allotments. To cover projected shortfalls faced by states, Congress appropriated an additional \$283 million for fiscal year 2006. As of January 2007, 14 states were projected to exhaust their allotments in fiscal year 2007.

SCHIP reauthorization is occurring within the context of consideration of broader national health care reform and competing budgetary priorities. There is an obvious tension between the desire to provide affordable health insurance coverage for uninsured individuals, including low-income children, and the recognition of the high cost that health care coverage exerts as a growing share of federal and state budgets. As Congress addresses SCHIP reauthorization, issues that may be considered include (1) maintaining flexibility within the program without compromising the primary goal to cover children, (2) considering the program's financing strategy, including the financial sustainability of public commitments, and (3) assessing issues including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

Background

In general, SCHIP funds are targeted to uninsured children in families whose incomes are too high to qualify for Medicaid but are at or below 200 percent of FPL.⁵ Recognizing the variability in state Medicaid programs, federal SCHIP law allows a state to cover children in families with incomes up to 200 percent of FPL or 50 percentage points above its existing Medicaid eligibility standard as of March 31, 1997.⁶ Additional flexibility regarding eligibility levels is available, however, as Medicaid and SCHIP provide some flexibility in how a state defines income for purposes of eligibility determinations.⁷ Congress appropriated approximately \$40 billion over 10 years (from fiscal years 1998 through 2007) for distribution among states with approved SCHIP plans. Allocations to states are based on a formula that takes into account the number of low-income children in a state. In general, states that choose to expand Medicaid to enroll eligible children under SCHIP must follow Medicaid rules, while separate child health programs have additional flexibilities in benefits, cost-sharing, and other program elements. Under certain circumstances, states may also cover adults under SCHIP.

SCHIP Allotments to States

SCHIP allotments to states are based on an allocation formula that uses (1) the number of children, which is expressed as a combination of two estimates—the number of low-income children without health insurance and the number of all low-income children, and (2) a factor representing state variation in health care costs. Under federal SCHIP law and subject to certain exceptions, states have 3 years to use each fiscal year's allocation, after which any remaining funds are redistributed among the states that had used all of that fiscal year's allocation.⁸ Federal law does

⁵FPL refers to the federal poverty guidelines, which are used to establish eligibility for certain federal assistance programs. The guidelines are updated annually to reflect changes in the cost of living and vary according to family size. For example, in 1998, 200 percent of FPL for a family of four was \$32,900, compared with \$41,300 in 2007.

⁶42 U.S.C. § 1397j(b). For example, Alabama covered children aged 15 to 18 up to 15 percent of FPL, while Washington covered this same group up to 200 percent of FPL. Therefore, Alabama would be allowed to establish SCHIP eligibility for children in families with incomes up to 200 percent of FPL, while Washington would be allowed to go as high as 250 percent of FPL.

⁷Some states have expanded income eligibility levels for families through "income disregards," which ignore certain types of family income for purposes of determining eligibility. Such disregards have been imposed as high as 100 percent of FPL, which means that a family with an income equal to 300 percent of FPL is treated as if its income were 200 percent of FPL.

⁸42 U.S.C. § 1397dd(e),(f).

not specify a redistribution formula but leaves it to the Secretary of Health and Human Services (HHS) to determine an appropriate procedure for redistribution of unused allocations.⁹ Absent congressional action, states are generally provided 1 year to spend any redistributed funds, after which time funds may revert to the U.S. Treasury. Each state's SCHIP allotment is available as a federal match based on state expenditures. SCHIP offers a strong incentive for states to participate by providing an enhanced federal matching rate that is based on the federal matching rate for a state's Medicaid program—for example, the federal government will reimburse at a 65 percent match under SCHIP for a state receiving a 50 percent match under Medicaid.

There are different formulas for allocating funds to states, depending on the fiscal year. For fiscal years 1998 and 1999, the formula used estimates of the number of low-income uninsured children to allocate funds to states. For fiscal year 2000, the formula changed to include estimates of the total number of low-income children as well.¹⁰

SCHIP Design Choices

SCHIP gives the states the choice of three design approaches: (1) a Medicaid expansion program, (2) a separate child health program with more flexible rules and increased financial control over expenditures, or (3) a combination program, which has both a Medicaid expansion program and a separate child health program. Initially, states had until September 30, 1998, to select a design approach, submit their SCHIP plans, and obtain HHS approval in order to qualify for their fiscal year 1998 allotment.¹¹ With an approved state child health plan, a state could begin to enroll children and draw down its SCHIP funds.

⁹42 U.S.C. § 1397dd(f).

¹⁰For fiscal year 2000, the allocation formula used 75 percent of the number of uninsured low-income children plus 25 percent of the number of all low-income children. For fiscal year 2001 and subsequent fiscal years, the allocation formula evenly weighted the number of uninsured low-income children (50 percent) and the total number of low-income children (50 percent). 42 U.S.C. § 1397dd(b). See also Congressional Research Service (CRS), *SCHIP Original Allotments: Funding Formula Issues and Options* (Washington, D.C.: Apr. 18, 2006).

¹¹In May 1998, Congress extended this deadline, allowing states to receive fiscal year 1998 funding if they had submitted and received approval of a state child health plan by September 30, 1998. 1998 Supplemental Appropriations and Rescissions Act, Pub. L. No. 105-174, § 4001, 112 Stat. 1500 (May 1, 1998).

The design approach a state chooses has important financial and programmatic consequences, as shown below.

- **Expenditures.** In separate child health programs, federal matching funds cease after a state expends its allotment, and non-benefit-related expenses (for administration, direct services, and outreach) are limited to 10 percent of claims for services delivered to beneficiaries. In contrast, Medicaid expansion programs may continue to receive federal funds for benefits and for non-benefit-related expenses at the Medicaid matching rate after states exhaust their SCHIP allotments.
- **Enrollment.** Separate child health programs may establish separate eligibility rules and establish enrollment caps. In addition, a separate child health program may limit its own annual contribution, create waiting lists, or stop enrollment once the funds it budgeted for SCHIP are exhausted. A Medicaid expansion must follow Medicaid eligibility rules regarding income, residency, and disability status, and thus generally cannot limit enrollment.
- **Benefits.** Separate child health programs must use, for example, benchmark benefit standards that use specified private or public insurance plans as the basis for coverage. However, Medicaid—and therefore a Medicaid expansion—must provide coverage of all benefits available to the Medicaid population, including certain services for children. In particular, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requires states to cover treatments or stabilize conditions diagnosed during routine screenings—regardless of whether the benefit would otherwise be covered under the state’s Medicaid program.¹² A separate child health program does not require EPSDT coverage.
- **Beneficiary cost-sharing.** Separate child health programs may impose limited cost-sharing—through premiums, copayments, or enrollment fees—for children in families with incomes above 150 percent of FPL up to 5 percent of family income annually. Since the Medicaid program did not

¹²While coverage of EPSDT is difficult to measure, federal studies have generally found state efforts to be inadequate. See GAO, *Medicaid: Stronger Efforts Needed to Ensure Children’s Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001).

previously allow cost-sharing for children, a Medicaid expansion program under SCHIP would have followed this rule.¹³

SCHIP Coverage of Adults

In general, states may cover adults under the SCHIP program under two key approaches.

- First, federal SCHIP law allows the purchase of coverage for adults in families with children eligible for SCHIP under a waiver if a state can show that it is cost-effective to do so and demonstrates that such coverage does not result in “crowd-out”—a phenomenon in which new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.¹⁴ The cost-effectiveness test requires the states to demonstrate that covering both adults and children in a family under SCHIP is no more expensive than covering only the children. The states may also elect to cover children whose parents have access to employer-based or private health insurance coverage by using SCHIP funding to subsidize the cost.
- Second, under section 1115 of the Social Security Act, states may receive approval to waive certain Medicaid or SCHIP requirements or authorize Medicaid or SCHIP expenditures. The Secretary of Health and Human Services may approve waivers of statutory requirements or authorize expenditures in the case of experimental, pilot, or demonstration projects that are likely to promote program objectives.¹⁵ In August 2001, HHS indicated that it would allow states greater latitude in using section 1115 demonstration projects (or waivers) to modify their Medicaid and SCHIP programs and that it would expedite consideration of state proposals. One initiative, the Health Insurance Flexibility and Accountability Initiative (HIFA), focuses on proposals for covering more uninsured people while at the same time not raising program costs. States have received approval of

¹³As of March 31, 2006, states may impose cost-sharing for children whom the state has chosen to cover under Medicaid. 42 U.S.C. § 1396o-1. If a state imposes cost-sharing for Medicaid, a Medicaid expansion program for SCHIP-eligible children would follow this rule.

¹⁴See 42 U.S.C. § 1397ee(c)(3).

¹⁵42 U.S.C. § 1315.

section 1115 waivers that provide coverage of adults using SCHIP funding.¹⁶

SCHIP Enrollment Has Grown Rapidly; States' Rates of Uninsured Children Vary Significantly

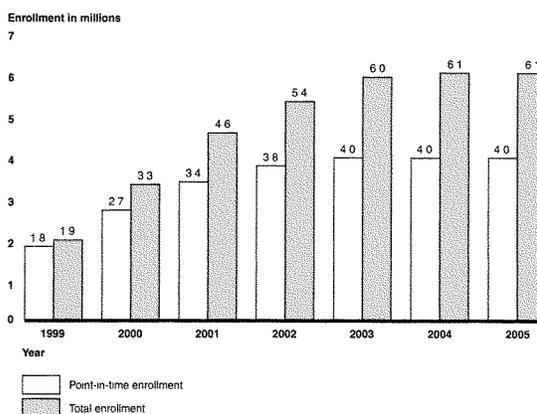
SCHIP enrollment increased rapidly over the first years of the program, and has stabilized for the past several years. In 2005, the most recent year for which data are available, 4.0 million individuals were enrolled during the month of June, while the total enrollment count—which represents a cumulative count of individuals enrolled at any time during fiscal year 2005—was 6.1 million. Of these 6.1 million enrollees, 639,000 were adults. Because SCHIP requires that applicants are first screened for Medicaid eligibility, some states have experienced increases in their Medicaid programs as well, further contributing to public health insurance coverage of low-income children during this same period. Based on a 3-year average of 2003 through 2005 Current Population Survey (CPS) data, the percentage of uninsured children varied considerably by state, with a national average of 11.7 percent.

SCHIP annual enrollment grew quickly from program inception through 2002 and then stabilized at about 4 million from 2003 through 2005, on the basis of a point-in-time enrollment count. Total enrollment, which counts individuals enrolled at any time during a particular fiscal year, showed a similar pattern of growth and was over 6 million as of June 2005 (see fig. 1).¹⁷ Generally, point-in-time enrollment is a subset of total enrollment, as it represents the number of individuals enrolled during a particular month. In contrast, total enrollment includes an unduplicated count of any individual enrolled at any time during the fiscal year; thus the data are cumulative, with new enrollments occurring monthly.

¹⁶As of October 1, 2005, the Secretary of Health and Human Services was prohibited from approving new section 1115 waivers that use SCHIP funds to provide coverage of nonpregnant childless adults. See Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397gg).

¹⁷The 4 million enrollment count is based on "point-in-time enrollment," representing the number of enrollees in states' SCHIP programs for the month of December for 1999 through 2004; for 2005, data for the month of June were used. See Vernon K. Smith, David Rousseau, and Caryn Marks, *SCHIP Program Enrollment: June 2005 Update* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, December 2006). The total enrollment count reflects all enrollees in the SCHIP program for a fiscal year from 1999 through 2005. See, for example, the 2005 annual enrollment report, at http://www.cms.hhs.gov/NationalSCHIPPolicy/06_SCHIPAnnualReports.asp (downloaded Jan. 28, 2007).

Figure 1: SCHIP Enrollment, 1999-2005



Source: CMS and state enrollment data.

Note: Point-in-time enrollment represents the number of enrollees in states' SCHIP programs for the month of December for 1999 through 2004; for 2005, data for the month of June were used. Total enrollment represents the cumulative number of individuals who enrolled in the program at any time during the fiscal year. We obtained enrollment data from Vernon K. Smith, David Rousseau, and Caryn Marks, *SCHIP Program Enrollment: June 2005 Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, December 2006); Vernon K. Smith and David M. Rousseau, *SCHIP Enrollment in 50 States: December 2004 Data Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, September 2005); and Vernon K. Smith, David M. Rousseau, and Molly O'Malley, *SCHIP Program Enrollment: December 2003 Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2004).

Our prior work has shown that certain obstacles can prevent low-income families from enrolling their children into public programs such as Medicaid or SCHIP.¹⁸ Primary obstacles included families' lack of knowledge about program availability and that, even when children were

¹⁸GAO-03-191; GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-00-65 (Washington, D.C.: May 14, 1999); and GAO, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*, GAO/HEHS-98-93 (Washington, D.C.: Mar. 20, 1998).

eligible to participate, complex eligibility rules and documentation requirements complicated the application process.

During the early years of SCHIP program operation, we found that many states developed and deployed outreach strategies in an effort to overcome these enrollment barriers. Many states adopted innovative outreach strategies and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible.¹⁹ Examples follow.

- States launched ambitious public education campaigns that included multimedia campaigns, direct mailings, and the widespread distribution of applications.
- To overcome the barrier of a long, complicated SCHIP eligibility determination process, states reduced verification and documentation requirements that exceeded federal requirements, shortened the length of applications, and used joint SCHIP-Medicaid applications.
- States also located eligibility workers in places other than welfare offices—schools, child care centers, churches, local tribal organizations, and Social Security offices—to help families with the initial processing of applications.
- States eased the process by which applicants reapplied for SCHIP at the end of their coverage period. For example, one state mailed families a summary of the information on their last application, and asked families to update any changes to the information.

Because states must also screen for Medicaid eligibility before enrolling children into SCHIP, some states have noted increased enrollment in Medicaid as a result of SCHIP. For example, Alabama reported a net increase of approximately 121,000 children in Medicaid since its SCHIP program began in 1998. New York reported that, for fiscal year 2005, approximately 204,000 children were enrolled in Medicaid as a result of outreach activities, compared with 618,973 children enrolled in SCHIP. In contrast, not all states found that their Medicaid enrollment was

¹⁹See GAO, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, GAO-01-883 (Washington, D.C.: Sept. 10, 2001); *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, GAO/HEHS-00-86 (Washington, D.C.: Apr. 14, 2000); and GAO/HEHS-99-65.

significantly affected by SCHIP. For example, Idaho reported that a negligible number of children were found eligible for Medicaid as a result of outreach related to its SCHIP program. Maryland identified an increase of 0.2 percent between June 2004 and June 2005.

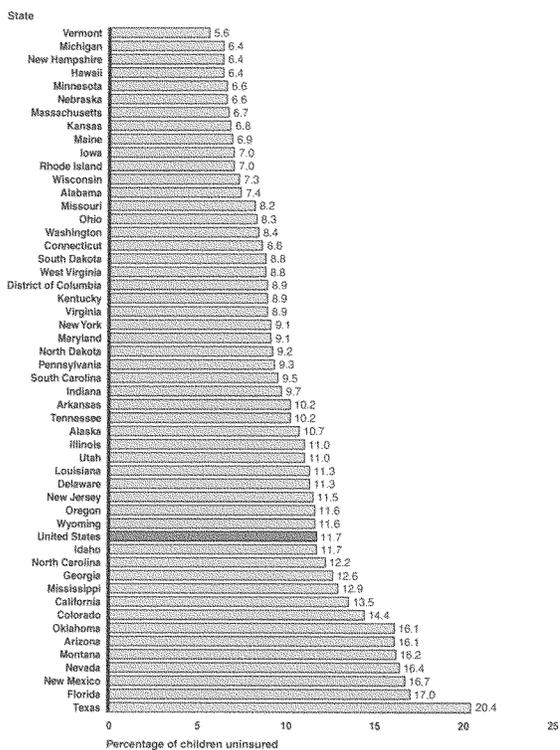
Based on a 3-year average of 2003 through 2005 CPS data, the percentage of uninsured children varied considerably by state and had a national average of 11.7 percent.²⁰ The percentage of uninsured children ranged from 5.6 percent in Vermont to 20.4 percent in Texas (see fig. 2).²¹ According to the Congressional Research Service (CRS) analysis of 2005 CPS data, the percentage of uninsured children was higher in the southern (13.7 percent) and western (13.8 percent) regions of the United States compared with children living in northeastern (8.5 percent) and midwestern (8.2 percent) regions.²² Nearly 40 percent of the nation's uninsured children lived in three of the most populous states—California, Florida, and Texas—each of which had percentages of uninsured children above the national average.

²⁰Estimates of the number of uninsured children are derived from the annual health insurance supplement to the CPS. Health insurance information is collected through the Annual Social and Economic Supplement, formerly termed the March supplement.

²¹Because sample sizes can be relatively small in less populous states, state estimates are developed using a 3-year average, which is the same method used in the formula to allocate funds to states for SCHIP. Since the authorization of SCHIP in 1997, there have been changes to the CPS. In March 2001, the CPS sample was expanded, which was expected to result in more precise state estimates of individuals' health insurance status for all states.

²²CRS, *Health Insurance Coverage of Children, 2005* (Washington, D.C.: Sept. 6, 2006).

Figure 2: Percentage of Uninsured Children, by State, 2003-2005



Source: GAO analysis of CPS data, 3-year average (2003 through 2005).

Variations across states in rates of uninsured children may be linked to a number of factors, including the availability of employer-sponsored coverage.²³ We have previously reported that certain types of workers were less likely to have had access to employer-sponsored insurance and thus were more likely to be uninsured.²⁴ In particular, those working part-time, for small firms, or in certain industries such as agriculture or construction, were among the most likely to be uninsured. Additionally, states with high uninsured rates and those with low rates often were distinct with regard to several characteristics. For example, states with higher than average uninsured rates tended to have higher unemployment and proportionally fewer employers offering coverage to their workers. Small employers—those with less than 10 employees—were much less likely to offer health insurance to their employees than larger employers.

States' SCHIP Programs Reflect a Variety of Approaches to Providing Health Care Coverage

States' SCHIP programs reflect the flexibility allowed in structuring approaches to providing health care coverage, including their choice among three program designs—Medicaid expansions, separate child health programs, and combination programs, which have both a Medicaid expansion and a separate child health program component. As of fiscal year 2005, 41 state SCHIP programs covered children in families whose incomes are up to 200 percent of FPL or higher, with 7 of the 41 states covering children in families whose incomes are at 300 percent of FPL or higher. States generally imposed some type of cost-sharing in their programs, with 39 states charging some combination of premiums, copayments, or enrollment fees, compared with 11 states that did not charge cost-sharing. Nine states reported operating premium assistance programs that use SCHIP funding to subsidize the cost of premiums for private health insurance coverage. As of February 2007, we identified 14 states with approved section 1115 waivers to cover adults, including parents and caretaker relatives, pregnant women, and, in some cases, childless adults.

²³Genevieve Kenney and Allison Cook, "Coverage Patterns among SCHIP-Eligible Children and Their Parents," *Health Policy Online*, no. 15 (February 2007), downloaded on 2/12/2007 from <http://www.urban.org/url.cfm?ID=311420>; and Linda J. Blumberg, Amy J. Davidoff, *Exploring State Variation in Uninsurance Rates among Low-Income Workers* (Washington, D.C.: Urban Institute, Oct. 8, 2003).

²⁴See GAO, *Health Insurance: States' Protections and Programs Benefit Some Unemployed Individuals*, GAO-03-191 (Washington, D.C.: Oct. 25, 2002).

States Employ All Three Design Approaches, with Coverage Generally Extending to 200 Percent of FPL

As of July 2006, of the 50 states currently operating SCHIP programs, 11 states had Medicaid expansion programs, 18 states had separate child health programs, and 21 states had a combination of both approaches (see fig. 3).²⁵ When the states initially designed their SCHIP programs, 27 states opted for expansions to their Medicaid programs.²⁶ Many of these initial Medicaid expansion programs served as “placeholders” for the state—that is, minimal expansions in Medicaid eligibility were used to guarantee the 1998 fiscal year SCHIP allocation while allowing time for the state to plan a separate child health program. Other initial Medicaid expansions—whether placeholders or part of a combination program—also accelerated the expansion of coverage for children aged 14 to 18 up to 100 percent of FPL, which states are already required to cover under federal Medicaid law.²⁷

²⁵The 50 states include the District of Columbia. In January 2007, CMS approved Tennessee’s plan for a separate child health program under SCHIP. According to state information, the program will be implemented in early 2007.

²⁶GAO/HEHS-99-65.

²⁷42 U.S.C. § 1396a(a)(10)(A)(i)(vii) requires states to provide Medicaid coverage to children born after September 30, 1983, aged 6 to 18.

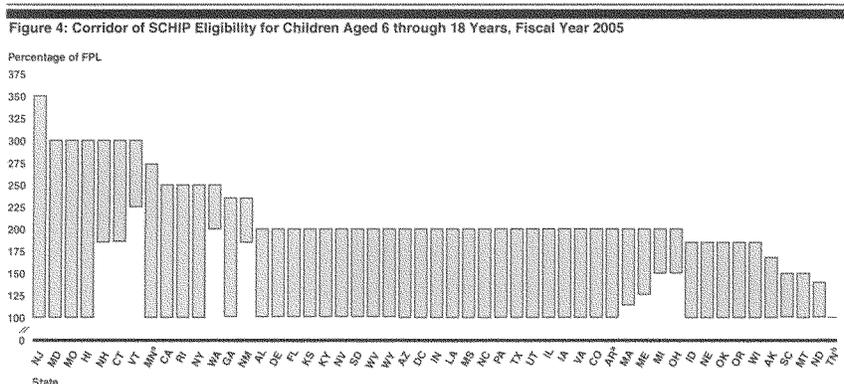
with higher income levels in their Medicaid programs.²⁹ Each state's starting point essentially creates a "corridor"—generally, SCHIP coverage begins where Medicaid ends and then continues upward, depending on each state's eligibility policy.³⁰

In fiscal year 2005, 41 states used SCHIP funding to cover children in families with incomes up to 200 percent of FPL or higher, including 7 states that covered children in families with incomes up to 300 percent of FPL or higher.³¹ In total, 27 states provided SCHIP coverage for children in families with incomes up to 200 percent of FPL, which was \$38,700 for a family of four in 2005. Another 14 states covered children in families with incomes above 200 percent of FPL, with New Jersey reaching as high as 350 percent of FPL in its separate child health program. Finally, 9 states set SCHIP eligibility levels for children in families with incomes below 200 percent of FPL. For example, North Dakota covered children in its separate child health program up to 140 percent of FPL. (See fig. 4.) (See app. I for the SCHIP upper income eligibility levels by state, as a percentage of FPL.)

²⁹States also have the option under federal Medicaid law to extend coverage of children in families with incomes at or below 185 percent of FPL, or even at higher income levels under a section 1115 waiver. 42 U.S.C. §§ 1315, 1396a(a)(10)(A)(i)(ix).

³⁰The corridor represents the FPL levels in states' SCHIP programs above the levels offered by their Medicaid programs. A state's starting point for SCHIP eligibility is dependent on the eligibility levels previously established in its Medicaid program. However, states' SCHIP programs may provide coverage to individuals who have incomes at the Medicaid level if they cannot qualify for Medicaid. For example, states may offer SCHIP coverage to individuals whose incomes are at the Medicaid level, but who cannot qualify for Medicaid because they cannot meet documentation or other Medicaid eligibility requirements.

³¹In January 2007, CMS approved Tennessee's SCHIP plan, which covers pregnant women and children in families with incomes up to 250 percent of FPL. According to state information, the program will be implemented in early 2007.



Source: GAO analysis of states' annual SCHIP reports for 2005 and the National Academy for State Health Policy. Note: In some cases, we obtained data from Neva Kaye, Cynthia Pemice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

The corridor represents the FPL levels in states' SCHIP programs above the levels offered by their Medicaid programs. A state's starting point for SCHIP eligibility is dependent on the eligibility levels previously established in its Medicaid programs. However, states' SCHIP programs may provide coverage to individuals who have incomes at the Medicaid level if they cannot qualify for Medicaid. For example, states may offer SCHIP coverage to individuals whose incomes are at the Medicaid level, but who cannot qualify for Medicaid because they cannot meet documentation or other Medicaid eligibility requirements.

*State did not have an FPL eligibility level for SCHIP that was above its Medicaid eligibility level for this age group because its Medicaid program also covered children up to this FPL level. The state provided SCHIP coverage to individuals whose incomes are at the Medicaid level but who cannot qualify for Medicaid because of documentation or other requirements.

*In January 2007, CMS approved Tennessee's SCHIP plan, which covers pregnant women and children in families with incomes up to 250 percent of FPL. According to state information, the program will be implemented in early 2007.

Separate Child Health Program Benefit Packages Reflect the Full Range of SCHIP Options

Under federal SCHIP law, states with separate child health programs have the option of using different bases for establishing their benefit packages. Separate child health programs can choose to base their benefit packages on (1) one of several benchmarks specified in federal SCHIP law, such as the Federal Employees Health Benefits Program (FEHBP) or state employee coverage; (2) a benchmark-equivalent set of services, as defined under federal law; (3) coverage equivalent to state-funded child health

programs in Florida, New York, or Pennsylvania; or (4) a benefit package approved by the Secretary of Health and Human Services (see table 1).

Table 1: Basis for Required Scope of Health Insurance Coverage for States with Separate Child Health Programs

Basis of coverage	Description	State
Benchmark (14 states)	Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield standard option, or coverage generally available to state employees, or coverage under the states' health maintenance organization with the largest insured commercial non-Medicaid enrollment.	Alabama, California, Connecticut, Delaware, Iowa, ¹ Kansas, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, North Carolina, Texas
Benchmark-equivalent (12 states)	Basic coverage for inpatient and outpatient hospital, physicians' surgical and medical, laboratory and x-ray, and well-baby and well-child care, including age-appropriate immunizations. Coverage must be equal to the value of benchmark coverage.	Colorado, Georgia, Illinois, Indiana, Iowa, ² Kentucky, Montana, North Dakota, Rhode Island, Utah, Virginia, West Virginia
Existing comprehensive state coverage (3 states)	Coverage equivalent to state-funded child health programs in Florida, New York, or Pennsylvania.	Florida, New York, Pennsylvania
Secretary-approved (8 states) ³	Coverage determined appropriate for targeted low-income children.	Arizona, Arkansas, Idaho, Maine, Nevada, Oregon, Vermont, Wyoming

Source: Assistant Secretary for Planning and Evaluation SCHIP Database, 2001, states' annual SCHIP reports for 2002 through 2005, and GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-06-05 (Washington, D.C. May 14, 1999).

¹State's SCHIP program reports using two bases of coverage—benchmark and benchmark-equivalent.

²In January 2007, CMS approved Tennessee's SCHIP plan, which has a Secretary-approved benefits package. According to state information, the program will be implemented in early 2007.

In some cases, separate child health programs have changed their benefit packages, adding and removing benefits over time, as follows.

- In 2003, Texas discontinued dental services, hospice services, skilled nursing facilities coverage, tobacco cessation programs, vision services, and chiropractic services. In 2005, the state added many of these services (chiropractic services, hospice services, skilled nursing facilities, tobacco cessation services, and vision care) back into the SCHIP benefit package and increased coverage of mental health and substance abuse services.

- In January 2002, Utah changed its benefit structure for dental services, reducing coverage for preventive (cleanings, examinations, and x-rays) and emergency dental services in order to cover as many children as possible with limited funding. In September 2002, the dental benefit package was further restructured to include dental coverage for accidents, as well as fluoride treatments and sealants.

**Most SCHIP Programs
Require Cost-Sharing, but
Amounts Charged Vary
Considerably**

In 2005, most states' SCHIP programs required families to contribute to the cost of care with some kind of cost-sharing requirement. The two major types of cost-sharing—premiums and copayments—can have different behavioral effects on an individual's participation in a health plan.³² Generally, premiums are seen as restricting entry into a program, whereas copayments affect the use of services within the program. There is research indicating that if cost-sharing is too high, or imposed on families whose income is too low, it can impede access to care and create financial burdens for families.³³

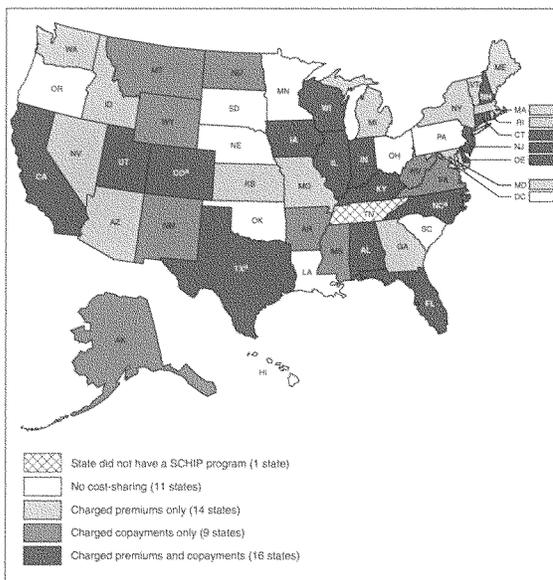
In 2005, states' annual SCHIP reports showed that 39 states had some type of cost-sharing—premiums, copayments, or enrollment fees—while 11 states reported no cost-sharing in their SCHIP programs.³⁴ Overall, 16 states charged premiums and copayments, 14 states charged premiums only, and 9 states charged copayments only (see fig. 5).

³²Opinions differ over the extent to which different types of cost-sharing are appropriate and useful tools for managing health care utilization among low-income populations. Premiums are sometimes viewed as promoting personal responsibility by having the beneficiary participate in the cost of coverage. Proponents of cost-sharing believe that copayments can make individuals more price-conscious consumers of health care services, which may reduce the use of unnecessary services. Others believe that cost-sharing requirements may limit service use, such as physician visits, causing individuals to defer necessary treatment, resulting in more severe conditions and potentially higher expenses. See GAO, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries*, GAO-04-491 (Washington, D.C.: Mar. 31, 2004).

³³See Tricia Johnson, Mary Rimsza, and William G. Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health* (April 2006); Leighton Ku and Teresa A. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington, D.C.: The Urban Institute, Mar. 1, 1997); and Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, May 2005).

³⁴In January 2007, CMS approved Tennessee's SCHIP plan, which allows the state to impose copayments on services. According to state information, the program will be implemented in early 2007.

Figure 5: Types of Cost-Sharing under SCHIP, Fiscal Year 2005



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of states' annual SCHIP reports.

Note: In January 2007, CMS approved Tennessee's SCHIP plan, which allows the state to impose copayments on services. According to state information, the program will be implemented in early 2007.

*State charged an enrollment fee.

Cost-sharing occurred more frequently in the separate child health programs than in Medicaid expansion programs. For example, 8 states with Medicaid expansion programs had cost-sharing requirements, compared with 34 states operating separate child health program

components.³⁶ The amount of premiums charged varied considerably among the states that charged cost-sharing. For example, premiums ranged from \$5.00 per family per month for children in families with incomes from 150 to 200 percent of FPL in Michigan to \$117 per family per month for children in families with incomes from 300 to 350 percent of FPL in New Jersey. Federal SCHIP law prohibits states from imposing cost-sharing on SCHIP-eligible children that totals more than 5 percent of family income annually.³⁶ In addition, cost-sharing for children may be imposed on the basis of family income. For example, we earlier reported that in 2003, Virginia SCHIP copayments for children in families with incomes from 133 percent to below 150 percent of FPL were \$2 per physician visit or per prescription and \$5 for services for children in families with higher incomes.³⁷

Few States Offer Premium Assistance Programs

In fiscal year 2005, nine states reported operating premium assistance programs (see table 2), but implementation remains a challenge. Enrollment in these programs varied across the states. For example, Louisiana reported having under 200 enrollees and Oregon reported having nearly 6,000 enrollees.³⁸ To be eligible for SCHIP, a child must not be covered under any other health coverage program or have private health insurance. However, some uninsured children may live in families with access to employer-sponsored health insurance coverage. Therefore, states may choose to establish premium assistance programs, where the state uses SCHIP funds to contribute to health insurance premium

³⁶States that opt for Medicaid expansions must follow Medicaid rules—and cost-sharing for children is generally not allowed.

³⁶42 U.S.C. § 1397cc(e). Federal SCHIP regulations include other limits on cost-sharing. For example, states with separate child health programs are not permitted to impose any cost-sharing on covered well-baby and well-child care services. Additionally, states may require cost-sharing for children in families with incomes at or below 150 percent of FPL, but premium amounts cannot exceed the maximum charges that are permitted under Medicaid. States are also prohibited from charging cost-sharing to American Indians or Alaska Natives. 42 C.F.R. §§ 457.520, et. seq.

³⁷GAO-04-491.

³⁸Data for premium assistance program enrollment for Louisiana were obtained from CMS's 2005 annual SCHIP report and for Oregon from Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

payments.³⁹ To the extent that such coverage is not equivalent to the states' Medicaid or SCHIP level of benefits, including limited cost-sharing, states are required to pay for supplemental benefits and cost-sharing to make up this difference. Under certain section 1115 waivers, however, states have not been required to provide this supplemental coverage to participants.

Table 2: Premium Assistance Programs in Nine States, Fiscal Year 2005

State	Design of SCHIP program	Authority for premium assistance program	Population covered under authority		Supplemental coverage for benefits or cost-sharing
			Children	Adults	
Idaho	Combination	Section 1906	✓		No
		Section 1115 HIFA	✓	✓	
Illinois	Combination	Section 1115 HIFA	✓	*	No
Louisiana	Medicaid expansion	Section 1906	✓	✓	Yes, for benefits and cost-sharing
Massachusetts	Combination	Premium assistance under SCHIP plan	✓		No
		Section 1115 non-HIFA	✓		
New Jersey	Combination	Section 1115 non-HIFA	✓	✓	Yes, for benefits and cost-sharing
Oregon	Separate program	Section 1115 HIFA	✓	✓	No
Rhode Island	Combination	Premium assistance under SCHIP plan	✓		Yes, for benefits and cost-sharing
		Family coverage under SCHIP plan	✓	✓	
		Section 1115 non-HIFA	✓	✓	
		Section 1906	✓	✓	
Virginia ^a	Combination	Premium assistance under SCHIP plan	✓		Yes, for benefits ^a
		Section 1115 HIFA	✓		
		Section 1906	✓	✓	
Wisconsin	Medicaid expansion	Section 1115 non-HIFA	✓	✓	Yes, for benefits and cost-sharing

Source: CMS, states' Annual SCHIP Reports for 2005, and Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me: National Academy for State Health Policy, September 2006).

*Coverage of adults under Illinois' program became effective January 1, 2006.

³⁹States may establish premium assistance programs under separate child health programs or under Medicaid programs, including as part of a section 1115 waiver. See 42 U.S.C. §§ 1315, 1396c; 42 C.F.R. § 457.810.

⁹Virginia offered a SCHIP premium assistance program from October 2001 until July 31, 2005, entitled the Employer Sponsored Health Insurance (ESHI) program. On August 1, 2005, the ESHI program was replaced by a new SCHIP premium assistance program entitled Family Access to Medical Insurance Security (FAMIS) Select. CMS approved this program on July 1, 2005, as part of a section 1115 waiver.

¹⁰Virginia's supplemental payments were limited to immunizations not covered by the employer/private health plan.

Several states reported facing challenges implementing their premium assistance programs. Louisiana, Massachusetts, New Jersey, and Virginia cited administration of the program as labor intensive. For example, Massachusetts noted that it is a challenge to maintain current information on program participants' employment status, choice of health plan, and employer contributions, but such information is needed to ensure accurate premium payments. Two states—Rhode Island and Wisconsin—noted the challenges of operating premium assistance programs, given changes in employer-sponsored health plans and accompanying costs. For example, Rhode Island indicated that increases in premiums are being passed to employees, which makes it more difficult to meet cost-effectiveness tests applicable to the purchase of family coverage.⁴⁰

Adult Coverage in SCHIP Is Primarily Accomplished through Waivers

States opting to cover adult populations using SCHIP funding may do so under an approved section 1115 waiver. As of February 2007, we identified 14 states with approved waivers to cover at least one of three categories of adults: parents of eligible Medicaid and SCHIP children, pregnant women, and childless adults. (See table 3.) The Deficit Reduction Act of 2005 (DRA), however, has prohibited the use of SCHIP funds to cover nonpregnant childless adults.⁴¹ Effective October 1, 2005, the Secretary of Health and Human Services may not approve new section 1115 waivers that use SCHIP funds for covering nonpregnant childless adults. However, waivers for covering these adults that were approved prior to this date are allowed to continue until the end of the waiver. Additionally, the Secretary may continue to approve section 1115 waivers that extend SCHIP coverage to pregnant adults, as well as parents and other caretaker relatives of children eligible for Medicaid or SCHIP.

⁴⁰The cost-effectiveness test requires the states to demonstrate that covering both adults and children in a family under SCHIP is not more expensive than covering only the children. 42 U.S.C. §1397ee(c).

⁴¹DRA, Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified as amended at 42 U.S.C. § 1397gg).

Table 3: States with the Authority to Cover Adults in SCHIP under Section 1115 Waivers, Categories of Covered Adults, and Upper Income Eligibility Thresholds as a Percentage of FPL

State	Covered adults			Percentage of FPL
	Parents	Pregnant women	Childless adults ^a	
Arizona	✓		✓	200 (parents); 100 (childless adults)
Arkansas	✓			200
Colorado		✓		200
Idaho	✓	✓	✓	185 ^b
Illinois	✓		✓	185
Michigan			✓	35
Minnesota	✓			200
Nevada	✓	✓		200 (parents); 185 (pregnant women)
New Jersey	✓	✓		200
New Mexico	✓		✓	200
Oregon	✓		✓	185
Rhode Island	✓	✓		185 (parents); 250 (pregnant women)
Virginia		✓		166
Wisconsin	✓			200

Source: CMS, as of February 2007.

^aThe DRA prohibited the use of SCHIP funds to cover nonpregnant childless adults. Effective October 1, 2005, the Secretary of Health and Human Services may not approve new section 1115 waivers that use SCHIP funds for covering nonpregnant childless adults. However, waivers approved prior to that date are allowed to continue until the end of the waiver.

^bIncome eligibility for parents and childless adults is set at less than 185 percent of FPL; for pregnant women, income eligibility includes 185 percent of FPL.

States' SCHIP Spending Was Initially Low but Now Threatens to Exceed Available Funding

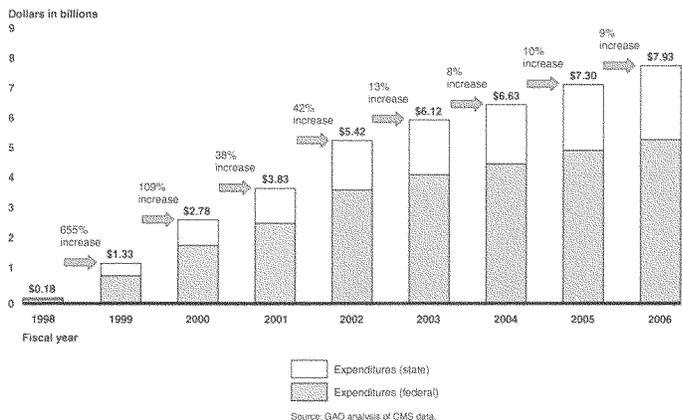
SCHIP program spending was low initially, as many states did not implement their programs or report expenditures until 1999 or later, but spending was much higher in the program's later years and now threatens to exceed available funding. Beginning in fiscal year 2002, states together spent more federal dollars than they were allotted for the year and thus relied on the 3-year availability of SCHIP allotments or on redistributed SCHIP funds to cover additional expenditures. But as spending has grown, the pool of funds available for redistribution has shrunk. Some states consistently spent more than their allotted funds, while other states

consistently spent less. Overall, 18 states were projected to have shortfalls—that is, they were expected to exhaust available funds, including current and prior-year allotments—in at least 1 year from 2005 through 2007. To cover projected shortfalls that several states faced, Congress appropriated an additional \$283 million for fiscal year 2006. As of January 2007, 14 states are projected to exhaust their allotments in fiscal year 2007.

Program Spending, Low in SCHIP's Early Years, Exceeded Allotments by 2002

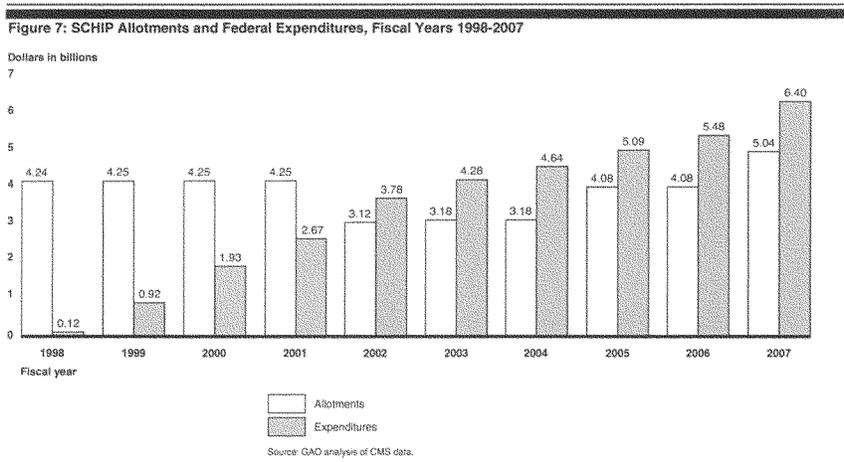
SCHIP program spending began low, but by fiscal year 2002, states' aggregate annual spending from their federal allotments exceeded their annual allotments. Spending was low in the program's first 2 years because many states did not implement their programs or report expenditures until fiscal year 1999 or later. Combined federal and state spending was \$180 million in 1998 and \$1.3 billion in 1999. However, by the end of the program's third fiscal year (2000), all 50 states and the District of Columbia had implemented their programs and were drawing down their federal allotments. Since fiscal year 2002, SCHIP spending has grown by an average of about 10 percent per year. (See fig. 6.)

Figure 6: Combined State and Federal SCHIP Expenditures, Fiscal Years 1998-2006



From fiscal year 1998 through 2001, annual federal SCHIP expenditures were well below annual allotments, ranging from 3 percent of allotments in fiscal year 1998 to 63 percent in fiscal year 2001. In fiscal year 2002, the states together spent more federal dollars than they were allotted for the year, in part because total allotments dropped from \$4.25 billion in fiscal year 2001 to \$3.12 billion in fiscal year 2002, marking the beginning of the so-called "SCHIP dip."¹⁴ However, even after annual SCHIP appropriations increased in fiscal year 2005, expenditures continued to exceed allotments (see fig. 7). Generally, states were able to draw on unused funds from prior years' allotments to cover expenditures incurred in a given year that were in excess of their allotment for that year, because, as discussed earlier, the federal SCHIP law gave states 3 years to spend each annual allotment. In certain circumstances, states also retained a portion of unused allotments.

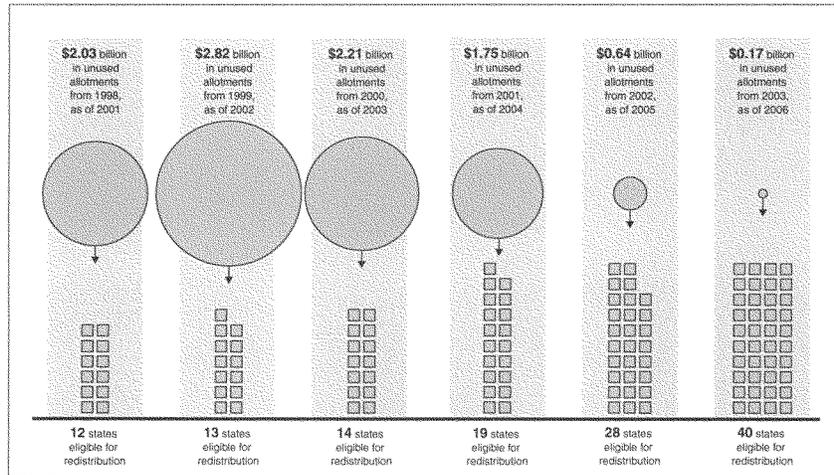
¹⁴The SCHIP dip refers to the decrease in SCHIP appropriations for fiscal years 2002 through 2004, which was necessary to address budgetary constraints applicable at the time the BBA was enacted.



Notes: Fiscal year 2007 expenditures are estimates based on budgets submitted by the states to CMS in November 2006. Expenditures may exceed allotments in any single year because allotments are available for 3 years and may be expended in years later than allotted.

States that have outspent their annual allotments over the 3-year period of availability have also relied on redistributed SCHIP funds to cover excess expenditures. But as overall spending has grown, the pool of funds available for redistribution has shrunk from a high of \$2.82 billion in unused funds from fiscal year 1999 to \$0.17 billion in unused funds from fiscal year 2003. Meanwhile, the number of states eligible for redistributions has grown from 12 states in fiscal year 2001 to 40 states in fiscal year 2006. (See fig. 8.)

Figure 8: Unused SCHIP Allotments from Fiscal Year 1998 through 2003 and Number of States Eligible for Redistribution, Fiscal Years 2001-2006



Source: GAO analysis of CMS data.

Note: States are eligible to receive redistribution in a particular fiscal year if they have expended all of their allotment for that year.

Congress has acted on several occasions to change the way SCHIP funds are redistributed. In fiscal years 2000 and 2003, Congress amended statutory provisions for the redistribution and availability of unused SCHIP allotments from fiscal years 1998 through 2001,⁴³ reducing the amounts available for redistribution and allowing states that had not exhausted their allotments by the end of the 3-year period of availability to retain some of these funds for additional years. Despite these steps, \$1.4 billion in unused SCHIP funds reverted to the U.S. Treasury by the end of fiscal year 2005.

Congress has also appropriated additional funds to cover states' projected SCHIP program shortfalls. The DRA included a \$283 million appropriation to cover projected shortfalls for fiscal year 2006.⁴⁴ CMS divided these funds among 12 states as well as the territories.

In the beginning of fiscal year 2007, Congress acted to redistribute unused SCHIP allotments from fiscal year 2004 to states projected to face shortfalls in fiscal year 2007.⁴⁵ The National Institutes of Health Reform Act of 2006 makes these funds available to states in the order in which they experience shortfalls. In January 2007, CRS projected that although 14 states will face shortfalls, the \$147 million in unused fiscal year 2004 allotments will be redistributed to the five states that are expected to

⁴³The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) allowed states that used their fiscal year 1998 and 1999 allotments to receive redistributed funds and allowed states that had not used these allotments to retain a portion of remaining funds. BIPA also extended the availability of all redistributed and retained funds through the end of fiscal year 2002. BIPA, Pub. L. No. 106-554, § 1(a)(6), 114 Stat. 2763, 2763A-578-580 (Dec. 21, 2000) (codified, as amended, at 42 U.S.C. § 1397dd(g)). The State Children's Health Insurance Program Allotments Extension Act (SCHIP Extension Act) further extended the availability of redistributed and retained allotments from fiscal years 1998 and 1999 another 2 years, to the end of fiscal year 2004. The law also established a new method for reallocating unspent allotments from fiscal years 2000 and 2001, allowing states that did not expend these funds to retain 50 percent of the funds and redistributing the remaining 50 percent to states that had spent their allotments. In addition, the law established authority for certain states—generally, states that covered at least one category of children other than infants in families with incomes up to at least 185 percent of FPL—to use up to 20 percent of original fiscal year allotments for 1995 through 2001 for Medicaid eligible children with family income over 150 percent of FPL. SCHIP Extensions Act, Pub. L. No. 108-74, §§ 1(a)(4), 1(b), 117 Stat. 895-896 (Aug. 15, 2003) (codified, as amended, at 42 U.S.C. § 1397dd(g), 1397ee(g)).

⁴⁴DRA, Pub. L. No. 109-171, § 6101(a), 120 Stat. 130 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397dd(d)).

⁴⁵National Institutes of Health Reform Act of 2006 (NIH Reform Act), Pub. L. No. 109-482, § 201, 120 Stat. 3675 (Jan. 15, 2007) (to be codified at 42 U.S.C. § 1397dd(h)).

experience shortfalls first. The NIH Reform Act also created a redistribution pool of funds by redirecting fiscal year 2005 allotments from states that at midyear (March 31, 2007) have more than twice the SCHIP funds they are projected to need for the year.⁴⁶

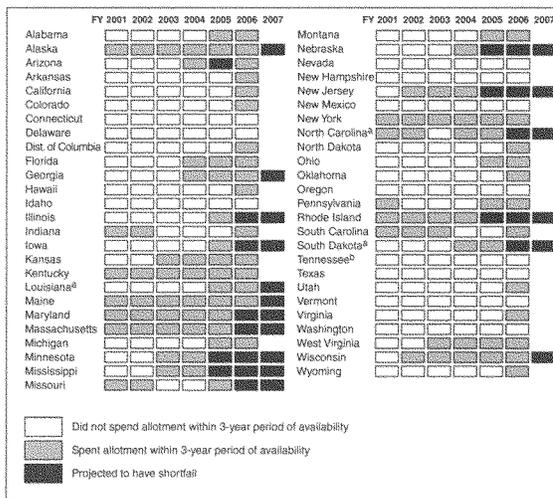
Some States Consistently Spent More than Their Allotted Funds

Some states consistently spent more than their allotted funds, while other states consistently spent less. From fiscal years 2001 through 2006, 40 states spent their entire allotments at least once, thereby qualifying for redistributions of other states' unused allotments; 11 states spent their entire allotments in at least 5 of the 6 years that funds were redistributed. Moreover, 18 states were projected to face shortfalls—that is, they were expected to exhaust available funds, including current and prior-year allotments—in at least 1 of the final 3 years of the program.⁴⁷ (See fig. 9.) As of January 2007, 14 states were projected to exhaust their allotments in fiscal year 2007.

⁴⁶These states are required to contribute half of their remaining 2005 allotments, up to a maximum of \$20 million, to the redistribution pool. NIH Reform Act, Pub. L. No. 109-482, § 201, 120 Stat. 3675 (Jan. 15, 2007) (to be codified at 42 U.S.C. § 1397dd(h)). CRS estimates the redistribution pool to have \$125 million available. According to CMS projections, as of January 2007, these funds will be distributed to seven states, including the five projected to receive redistributed 2004 allotments.

⁴⁷In fiscal years 2005 and 2006, CMS projected that 13 states would face shortfalls of SCHIP funds in one or both of those years, and in October 2006, CRS projected that 17 states would face shortfalls in fiscal year 2007. The 17 states CRS identified include 12 of the 13 states CMS identified, for a total of 18 states identified as facing shortfalls in fiscal years 2005, 2006, and/or 2007.

Figure 9: States that Did or Did Not Spend Allotments and/or Were Projected to Have Shortfalls



Source: GAO analysis of data obtained from CMS and Congressional Research Service (CRS).

Note: The years refer to the fiscal years in which unspent allotments from 3 years prior became available for redistribution. Under federal SCHIP law, subject to certain exceptions, states were given 3 years to spend each allotment, after which any unspent funds were to be redistributed among states that had spent their entire allotments. States projected to have shortfalls were projected to exhaust available funds, including current and prior-year allotments. Shortfalls for 2005 and 2006 were projected by CMS in those years. Shortfalls for 2007 were projected by CRS in October 2006 on the basis of states' budget data from August 2006. States that had spent their entire 2004 allotments had not been announced by the Secretary of Health and Human Services as of January 25, 2007.

¹As of January 2007, CRS was no longer projecting a shortfall for this state for fiscal year 2007.

²Although Tennessee did not have a SCHIP program as of October 2002, it continued to be allotted SCHIP funds. On September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL. CMS approved this plan in January 2007; according to state information, the program will be implemented in early 2007.

When we compared the 18 states that were projected to have shortfalls with the 32 states that were not, we found that the shortfall states were more likely to have a Medicaid component to their SCHIP program, to have a SCHIP eligibility corridor broader than the median,⁴⁹ and to cover adults in SCHIP under section 1115 waivers (see table 4). It is unclear, however, to what extent these characteristics contributed to states' overall spending experiences with the program, as many other factors have also affected states' program balances, including prior coverage of children under Medicaid, and SCHIP eligibility criteria, benefit packages, enrollment policies, outreach efforts, and payment rates to providers. In addition, we and others have noted that the formula for allocating funds to states has flaws that led to underestimates of the number of eligible children in some states and thus underfunding.⁴⁰ Fifteen of the 18 shortfall states (83 percent) had Medicaid expansion programs or combination programs that included Medicaid expansions, which generally follow Medicaid rules, such as providing the full Medicaid benefit package and continuing to provide coverage to all eligible individuals even after the states' SCHIP allotments are exhausted. The shortfall states tended to have a broader eligibility corridor in their SCHIP programs, indicating that, on average, the shortfall states covered children in SCHIP from lower income levels, from higher income levels, or both. For example, 33 percent of the shortfall states covered children in their SCHIP programs above 200 percent of FPL, compared with 25 percent of the nonshortfall states. Finally, 6 of the 18 shortfall states (33 percent) were covering adults in SCHIP under section 1115 waivers by the end of fiscal year 2006, compared with 6 of the 32 nonshortfall states (19 percent).

⁴⁹The SCHIP eligibility corridor is defined as the difference between the highest and lowest income levels (expressed as a percentage of FPL) eligible for SCHIP within a specified age group. For example, if a state covers children aged 6 and older with family incomes from 100 percent to 200 percent of FPL, the eligibility corridor for this age group is 100 percentage points (200 minus 100). In 2006, the median SCHIP eligibility corridor for children aged 6 and older was 100 percentage points.

⁴⁰See CRS, *SCHIP Original Allotments: Funding Formula Issues and Options*; GAO, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97 (Washington, D.C.: October 18, 2006); Genevieve Kenney and Debbie I. Chang, "The State Children's Health Insurance Program: Successes, Shortcomings, And Challenges," *Health Affairs*, vol 23, no. 5 (2004): 51-62.; and GAO/HEHS-99-65.

Table 4: Selected SCHIP Program Characteristics of Shortfall and Nonshortfall States

SCHIP program characteristic	Percentage of states	
	Shortfall states (n=18)	Nonshortfall states (n=32)
Medicaid expansion or combination programs	83	53
Eligibility corridor for children aged 6 and older that is broader than the median ^a	28	16
Adult coverage in SCHIP under section 1115 waivers before FY 2007 ^b	33	19

Source: GAO analysis, as of January 29, 2007, of data obtained from CMS, CRS, and NASHIP.

Note: Shortfall states are states that were identified by CMS or CRS as being unable to cover their projected SCHIP expenditures with available funds in fiscal years 2005, 2006, and/or 2007 in the absence of redistributions or additional appropriations. Nonshortfall states are states that were not projected to experience such shortfalls in any of the 3 years. Tennessee did not have a SCHIP program as of October 2002. However, on September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL. CMS approved this plan in January 2007; according to state information, the program will be implemented in early 2007.

^aThe SCHIP eligibility corridor is defined as the difference between the highest and lowest income levels (expressed as a percentage of FPL) eligible for SCHIP within a specified age group. For example, if a state covers children aged 6 and older with family incomes from 100 percent to 200 percent of FPL, the eligibility corridor for this age group is 100 percentage points (200 minus 100). In 2006, the median SCHIP eligibility corridor for children aged 6 and older was 100 percentage points.

^bIn fiscal year 2007, two nonshortfall states implemented SCHIP-funded coverage for adults—Arkansas on October 1, 2006, and Nevada on December 1, 2006.

On average, the shortfall states that covered adults began covering them earlier than nonshortfall states and enrolled a higher proportion of adults. At the end of fiscal year 2006, 12 states covered adults under section 1115 waivers using SCHIP funds.³⁰ Five of these 12 states began covering adults before fiscal year 2003, and all 5 states faced shortfalls in at least 1 of the final 3 years of the program. In contrast, none of the 4 states that began covering adults with SCHIP funds in the period from fiscal year 2004

³⁰As of February 2007, we had identified 14 states with approved section 1115 waivers to cover adults with their SCHIP allotments (see table 3). In fiscal year 2007, two of these 14 states began covering adults under SCHIP—Arkansas on October 1, 2006, and Nevada on December 1, 2006.

through 2006 faced shortfalls.⁶¹ On average, the shortfall states covered adults more than twice as long as nonshortfall states (5.1 years compared with 2.3 years by the end of fiscal year 2006).

Shortfall states also enrolled a higher proportion of adults. Nine states, including six shortfall states, covered adults using SCHIP funds throughout fiscal year 2005.⁶² In these nine states, adults accounted for an average of 45 percent of total enrollment. However, in the shortfall states, the average proportion was more than twice as high as in nonshortfall states. Adults accounted for an average of 55 percent of enrollees in the shortfall states, compared with 24 percent in the nonshortfall states. (See table 5.)

⁶¹Three states began covering adults under section 1115 waivers in fiscal year 2003; one faced shortfalls and two did not.

⁶²On July 1, 2005, three additional states began using SCHIP funds to cover adults under section 1115 waivers.

Table 5: SCHIP Total Enrollment in States Using SCHIP Funds to Cover Adults under Section 1115 Waivers throughout Fiscal Year 2005

State ^e	Total enrollment			Adults as a percentage of total ^b
	Total	Children	Adults	
Shortfall states^c				
Arizona	201,626	88,005	113,621	56
Illinois	457,426	281,432	175,994	38
Minnesota	40,087	5,076	35,011	87
New Jersey	196,418	129,591	66,827	34
Rhode Island	51,313	27,144	24,169	47
Wisconsin	165,973	57,165	108,808	66
Nonshortfall states^d				
Colorado	61,105	59,530	1,575	3
Michigan	190,540	89,257	101,283	53
Oregon	64,088	52,722	11,366	18
Summary				
Shortfall states (6)	1,112,843	588,413	524,430	55
Nonshortfall states (3)	315,733	201,509	114,224	24
All states (9)	1,428,576	789,922	638,654	45

Source: GAO analysis of CMS data.

^aAs of February 2007, we had identified 14 states with approved section 1115 waivers to cover adults with their SCHIP allotments. Five of these 14 states were omitted from the table: Idaho, New Mexico, and Virginia implemented section 1115 waivers for adults on July 1, 2005, and are omitted from the table because only partial-year data are available for them for fiscal year 2005. The remaining two states had not implemented their waivers as of 2005: Arkansas and Nevada implemented section 1115 coverage for adults in fiscal year 2007.

^bSummary data shown in this column are averages of the state percentages.

^cShortfall states are states that were identified by CMS or the Congressional Research Service (CRS) as being unable to cover their projected SCHIP expenditures with available funds in fiscal years 2005, 2006, and/or 2007.

^dNonshortfall states are states that were not projected to experience such shortfalls in any of the 3 years.

While analyses of states as a group reveal some broad characteristics of states' programs, examining the experiences of individual states offers insights into other factors that have influenced states' program balances. States themselves have offered a variety of reasons for shortfalls and surpluses. These examples, while not exhaustive, highlight additional factors that have shaped states' financial circumstances under SCHIP.

- **Inaccuracies in the CPS-based estimates on which states' allotments were based.** North Carolina, a shortfall state, offers a case in point. In 2004, the state had more low-income children enrolled in the program than CPS estimates indicated were eligible. To curb spending, North Carolina shifted children through age 5 from the state's separate child health program to a Medicaid expansion, reduced provider payments, and limited enrollment growth.
- **Annual funding levels that did not reflect enrollment growth.** Iowa, another shortfall state, noted that annual allocations provided too many funds in the early years of the program and too few in the later years. Iowa did not use all its allocations in the first 4 years and thus the state's funds were redistributed to other states. Subsequently, however, the state has faced shortfalls as its program matured.
- **Impact of policies designed to curb or expand program growth.** Some states have attempted to manage program growth through ongoing adjustments to program parameters and outreach efforts. For example, when Florida's enrollment exceeded a predetermined target in 2003, the state implemented a waiting list and eliminated outreach funding. When enrollment began to decline, the state reinstated open enrollment and outreach. Similarly, Texas—commensurate with its budget constraints and projected surpluses—has tightened and loosened eligibility requirements and limited and expanded benefits over time in order to manage enrollment and spending.

Considerations for SCHIP Reauthorization

Children without health insurance are at increased risk of foregoing routine medical and dental care, immunizations, treatment for injuries, and treatment for chronic illnesses. Yet, the states and the federal government face challenges in their efforts to continue to finance health care coverage for children. As health care consumes a growing share of state general fund or operating budgets, slowdowns in economic growth can affect states' abilities—and efforts—to address the demand for public financing of health services. Moreover, without substantive programmatic or revenue changes, the federal government faces near- and long-term

fiscal challenges as the U.S. population ages because spending for retirement and health care programs will grow dramatically.⁵³ Given these circumstances, we would like to suggest several issues for consideration as Congress addresses the reauthorization of SCHIP. These include the following:

- **Maintaining flexibility without compromising the goals of SCHIP.** The federal-state SCHIP partnership has provided an important opportunity for innovation on the part of states for the overall benefit of children's health. Providing three design choices for states—Medicaid expansions, separate child health programs, or a combination of both approaches—affords them the opportunity to focus on their own unique and specific priorities. For example, expansions of Medicaid offer Medicaid's comprehensive benefits and administrative structures and ensure children's coverage if states exhaust their SCHIP allotments. However, this entitlement status also increases financial risk to states. In contrast, SCHIP separate child health programs offer a "block grant" approach to covering children. As long as the states meet statutory requirements, they have the flexibility to structure coverage on an employer-based health plan model and can better control program spending than they can with a Medicaid expansion.

However, flexibility within the SCHIP program, such as that available through section 1115 waivers, may also result in consequences that can run counter to SCHIP's goal—covering children. For example, we identified 15 states that have authority to cover adults with their federal SCHIP funds, with several states covering more adults than children. States' rationale is that covering low-income parents in public programs such as SCHIP and Medicaid increases the enrollment of eligible children as well, with the result that fewer children go uninsured.⁵⁴ Federal SCHIP law provides that families may be covered only if such coverage is cost-effective; that is, covering families costs no more than covering the SCHIP-eligible children. We earlier reported that HHS had approved state proposals for section 1115 waivers to use SCHIP funds to cover parents of SCHIP- and Medicaid-eligible children without regard to cost-

⁵³GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, GAO-05-325SP (Washington, D.C.: February 2005); and GAO, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, GAO-02-544T (Washington, D.C.: Mar. 21, 2002).

⁵⁴See Leighton Ku and Matthew Broaddus, *Coverage of Parents Helps Children, Too* (Washington, D.C.: Center on Budget and Policy Priorities, Oct. 20, 2006).

effectiveness.⁵⁶ We also reported that HHS approved state proposals for section 1115 waivers to use SCHIP funds to cover childless adults, which in our view was inconsistent with federal SCHIP law and allowed SCHIP funds to be diverted from the needs of low-income children.⁵⁶ We suggested that Congress consider amending the SCHIP statute to specify that SCHIP funds were not available to provide health insurance coverage for childless adults. Under the DRA, Congress prohibited the Secretary of Health and Human Services from approving any new section 1115 waivers to cover nonpregnant childless adults after October 1, 2005, but allowed waivers approved prior to that date to continue.⁵⁷

It is important to consider the implications of states' use of allowable flexibility for other aspects of their programs. For example, what assurances exist that SCHIP funds are being spent in the most cost-effective manner, as required under federal law? In view of current federal fiscal constraints, to what extent should SCHIP funds be available for adult coverage? How has states' use of available flexibility to establish expanded financial eligibility categories and covered populations affected their ability to operate their SCHIP programs within the original allotments provided to them?

- **Considering the federal financing strategy, including the financial sustainability of public commitments.** As SCHIP programs have matured, states' spending experience can help inform future federal financing decisions. CRS testified in July 2006 that 40 states were now spending more annually than they received in their annual original SCHIP allotments.⁵⁸ While many of them did not face shortfalls in 2006 because of available prior-year balances, redistributed funds, and the supplemental DRA appropriation, 14 states are currently projected to face shortfalls in 2007. With the pool of funds available for redistribution virtually exhausted, the continued potential for funding shortfalls for many states

⁵⁶GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

⁵⁶See GAO-02-817 and GAO, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals*, GAO-04-166R (Washington, D.C.: Jan. 5, 2004).

⁵⁷DRA, Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397gg).

⁵⁸*Federal SCHIP Financing*, Hearing Before the Subcomm. on Health Care of the Senate Finance Comm., 109th Cong., 2nd Sess. (Jul. 25, 2006) (statement of the Congressional Research Service).

raises some fundamental questions about SCHIP financing. If SCHIP is indeed a capped grant program, to what extent does the federal government have a responsibility to address shortfalls in individual states, especially those that have chosen to expand their programs beyond certain parameters? In contrast, if the policy goal is to ensure that states do not exhaust their federal SCHIP allotments, by providing for the continuing redistribution of funds or additional federal appropriations, does the program begin to take on the characteristics of an entitlement similar to Medicaid? What overall implications does this have for the federal budget?

- **Assessing issues associated with equity.** The 10 years of SCHIP experience that states now have could help inform any policy decisions with respect to equity as part of the SCHIP reauthorization process. Although SCHIP generally targets children in families with incomes at or below 200 percent of FPL, 9 states are relatively more restrictive with their eligibility levels, while 14 states are more expansive, ranging as high as 350 percent of FPL. Given the policy goal of reducing the rate of uninsured among the nation's children, to what extent should SCHIP funds be targeted to those states that have not yet achieved certain minimum coverage levels? Given current and future federal fiscal constraints, to what extent should the federal government provide federal financial participation above certain thresholds? What broader implications might this have for flexibility, choice, and equity across state programs?

Another consideration is whether the formulas used in SCHIP—both the formula to determine the federal matching rate and the formula to allocate funds to states—could be refined to better target funding to certain states for the benefit of covering uninsured children. Because the SCHIP formula is based on the Medicaid formula for federal matching funds, it has some inherent shortcomings that are likely beyond the scope of consideration for SCHIP reauthorization.⁵⁹

⁵⁹The Medicaid formula uses a state's per capita income (PCI) in relation to national PCI to determine the federal share of matching funds for a state's allowable Medicaid spending. We earlier reported, however, that the use of PCI as a measure of states' funding ability is problematic because it does not accurately represent states' funding ability or account for the size and cost of serving states' poverty populations. See GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620 (Washington, D.C.: July 10, 2003). We also recently reported on potential strategies to help make the Medicaid formula more responsive to economic downturns, which could have implications for the SCHIP formula. See GAO-07-37.

For the allocation formula that determines the amount of funds a state will receive each year, several analysts, including CRS, have noted alternatives that could be considered. These include altering the methods for estimating the number of children at the state level, adjusting the extent to which the SCHIP formula for allocating funds to states includes the number of uninsured versus low-income children, and incorporating states' actual spending experiences to date into the formula. Considering the effects of any one or combination of these—or other—policy options would likely entail iterative analysis and thoughtful consideration of relevant trade-offs.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other members of the Subcommittee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please contact Kathryn G. Allen at (202) 512-7118 or at allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Carolyn L. Yocom, Assistant Director; Nancy Fasciano; Kaycee M. Glavich; Paul B. Gold; JoAnn Martinez-Shriver; and Elizabeth T. Morrison made key contributions to this statement.

Appendix I: SCHIP Upper Income Eligibility by State, Fiscal Year 2005

State	Upper income eligibility, expressed as a percentage of FPL
Alabama	200
Alaska	168
Arizona	200
Arkansas	200
California	250
Colorado	200
Connecticut	300
Delaware	200
District of Columbia	200
Florida	200
Georgia	235
Hawaii	300
Idaho	185
Illinois	200
Indiana	200
Iowa	200
Kansas	200
Kentucky	200
Louisiana	200
Maine	200
Maryland	300
Massachusetts	200
Michigan	200
Minnesota	280
Mississippi	200
Missouri	300
Montana	150
Nebraska	185
Nevada	200
New Hampshire	300
New Jersey	350
New Mexico	235
New York	250
North Carolina	200

Appendix I: SCHIP Upper Income Eligibility
by State, Fiscal Year 2005

State	Upper income eligibility, expressed as a percentage of FPL
North Dakota	140
Ohio	200
Oklahoma	185
Oregon	185
Pennsylvania	200
Rhode Island	250
South Carolina	150
South Dakota	200
Tennessee	*
Texas	200
Utah	200
Vermont	300
Virginia	200
Washington	250
West Virginia	200
Wisconsin	185
Wyoming	200

Source: GAO analysis of states' annual SCHIP reports for 2005 and the National Academy for State Health Policy.

Note: In some cases, we obtained data from Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

*While Tennessee has not had a SCHIP program since October 2002, in January 2007, CMS approved Tennessee's SCHIP plan, which covers pregnant women and children in families with incomes up to 250 percent of FPL. According to state information, the program will be implemented in early 2007.

**Statement of Phyllis Sloyer, RN, PhD, FAAP, Division Director of Children's Medical
Services in the Florida Department of Health**

**Testimony before the Subcommittee on Health
of the House Committee on Energy & Commerce**

March 1, 2007

Chairman Pallone, Ranking Member Deal, members of the Health subcommittee: on behalf of Governor Charlie Crist and the State of Florida, thank you for the opportunity to appear before you today to address reauthorization of the State Children's Health Insurance Program (SCHIP).

I represent the Florida SCHIP program, known as Florida KidCare. Florida KidCare provides health care services to uninsured children under age 19 in our state who otherwise might not have access to medical care. Florida Kid Care incorporates services from Medicaid for children, Florida Healthy Kids, MediKids, and the Children's Medical Services Network in order to provide quality comprehensive medical services to more than 1.4 million Florida children.

At the state level, Governor Crist and the Florida Legislature are looking at ways to simplify the Florida KidCare program and ensure seamless coverage. We believe there are several steps that we can take to improve the efficiency of our program and we are looking to make those changes. We are willing to do our part at the state level and are hopeful that we will have the necessary assistance at the federal level to ensure that we are able to both improve and sustain our KidCare program. Today, I would like to outline the federal challenges to the SCHIP program and hopefully, discuss ways that we can work together.

Some of these challenges were highlighted in the 2007 Florida KidCare Coordinating Council Annual Report, which was submitted last month to our Florida State leadership. The

KidCare Coordinating Council was developed by the State Legislature in 1998 to deliberate and make recommendations to the Governor and Legislature about ways to improve the KidCare program. The Council represents a diverse group of child advocates, health care providers, local government representatives and state agencies. I humbly ask that the annual report, along with this testimony, be submitted for the Congressional record this morning.

As I mentioned, the State of Florida has more than 1.4 million children enrolled in KidCare. However, current estimations show that Florida still has 220,000 uninsured children who may qualify for SCHIP but are not currently enrolled in the program for a variety of reasons. We must get these eligible children enrolled in KidCare in order for Florida to meet our program goal.

As Congress begins the reauthorization process of SCHIP, I would like to present to the Committee today what the State of Florida has done to focus this program on the most vulnerable in our communities. We also urge that any program changes continue to allow us to reach the over 220,000 eligible children that are still uninsured—a number that we recognize is growing everyday in our state.

Florida currently has a discrepancy in its eligible versus enrolled ratio under the KidCare program. This discrepancy is a result of several federal statutory barriers. First, outreach efforts are absolutely critical to reaching diverse populations of children. Florida is unique because it is a microcosm of population trends happening nationwide. We have many communities who may face cultural, social and language barriers who we cannot reach through traditional outreach efforts. Because of that, we know it is not enough to market our programs through television and radio advertising. Targeting these families and children requires the application of research-based public health strategies that have been well-proven over time. For example, we target physician offices and community health centers throughout the State of Florida and offer "tool kits" to help families apply for coverage. We have developed strong partnerships with community leaders to help us reach underserved children and to use peer

trainers and resource grandparents to reach the families and children. However, the resources available for critical outreach efforts are often times limited by federal caps on administrative expenditures. For example, the state must cover certain administrative costs related to application and premium processing as well as our contracting and call center functions. These important components are a significant portion of the ten percent cap, which significantly limits resources available for critical outreach. As a result of federal limitations, we have had to support outreach through limited state-only funds. Congress should allocate outreach funds outside of the imposed ten percent administrative expenditure cap. We believe that moving the outreach dollars outside of the administrative cap would give us the flexibility we need to use our resources to reach and enroll eligible children.

In addition, one of the hallmarks of the SCHIP program is the ability to simplify procedures so that eligible children can obtain health insurance without unnecessary roadblocks. The documentation requirements imposed on the Medicaid program under the Deficit Reduction Act of 2005, which require a State to prove a beneficiary is a United States citizen, impedes many families from obtaining Medicaid coverage. Since a family must apply for Medicaid first, these requirements have had spillover effects on the SCHIP Program in Florida. I am not here today to discuss the overall purpose or merit of the Deficit Reduction Act, but rather to shed light on some of the unintended consequences that have created additional challenges for states like Florida to deliver health care services. We ask that Congress and the Federal Government consider changes to procedural requirements and promote uniformity, which would increase the number of eligible children enrolled in the SCHIP program and assist state program officers in implementing a more seamless benefit.

Continuous coverage is also important in order to maintain our children's health. For states without expansion programs, this coverage can be interrupted due to different cost requirements between the separate SCHIP and Medicaid programs. When a child transitions from having no premium under Medicaid to a premium-based SCHIP benefit, there is a

temporary gap in healthcare coverage until that premium is paid by the client. As a result, the children that temporarily lose coverage often do not reenroll in SCHIP. Our experience in Florida is that only about 50 percent of children come back into the program. We encourage Congress to provide direction to states without expansion waivers and with separate SCHIP benefits to implement policies that ensure children who lose Medicaid coverage are able to move without breaks in coverage to the Title XXI-funded program.

In addition, today, Florida public employees can qualify for Medicaid benefits if deemed eligible by the Department of Children and Families (DCF). However, under current federal statute, those same families could not qualify for SCHIP if their income level was above the Medicaid eligibility level, but fell under the 200 percent federal poverty level. Many of these families cannot afford the coverage through their employer, as the average premium costs far exceed five percent of their annual incomes. For example, a state employee with three dependents at 200 percent federal poverty level (approximately \$40,000 annual salary) would have to pay at least six percent of their salary, or approximately \$2,350 per year, to purchase health insurance, and that does not include the co-pays or deductibles required under most policies. In an effort to remove this barrier for many eligible American families, we ask that you consider removing the prohibition for public employees.

Finally, we urge you to align coverage for pregnant women to ensure it is consistent with the coverage of infants provided under the SCHIP program. For example, if an infant is eligible for SCHIP at 200 percent of the federal poverty level, the pregnant woman should be eligible at the same income level to ensure quality prenatal care and better birth outcomes. Again, this change in federal statute would align with the principles of the original law, which called for a commitment to preventive health care and improved quality standards.

We realize that many states have expanded their SCHIP programs outside of the original intent of the 1997 legislation to include adult populations. As a result, we understand that several states are concerned about forecast deficits for their programs in the near future.

While we recognize that expansions were done with the support of the Federal government, we are concerned that a state like Florida who has remained true to the intent of the program will be penalized in reauthorization. While Florida today may have an unused allocation of SCHIP funding, we are working to reach a continually growing number of eligible children in our state and are committed to using our funding in the allowed time period. The redistribution of SCHIP dollars without careful consideration of the original purpose of the SCHIP legislation will simply shift funding challenges from one state to another.

While these recommendations stem from experiences in Florida, we believe many states would agree that increased flexibility is critical to SCHIP reauthorization. We encourage Congress to focus their efforts on reducing the number of uninsured children by looking at the original intent of the program and offering ways to simplify program administration, remove documentation barriers, and provide states more flexibility for outreach efforts. These changes will help create more fiscally-responsible SCHIP programs that offer the neediest children quality health care, which in turn, will reduce some of the overall financial burdens placed on our healthcare system.

STATEMENT OF LOLITA M. MCDAVID

Mr. Chairman and members of the committee, thank you for the opportunity to testify on behalf of the National Association of Children's Hospitals (N.A.C.H.) in support of Federal efforts to ensure all children have health coverage, beginning with reauthorizing and strengthening the State Children's Health Insurance Program (SCHIP).

I am Lolita M. McDavid, M.D., M.P.H. As a pediatrician, I have devoted my medical career to children. Currently, I serve as medical director of child advocacy and protection for Rainbow Babies and Children's Hospital, the pediatric hospital of University Hospitals of Case Western Reserve University School of Medicine in

Cleveland. Earlier in my career, I was head of general pediatrics at MetroHealth Medical Center in Cleveland, the largest public hospital in Ohio. I am also an associate professor of pediatrics at Case Western Reserve University.

N.A.C.H. is the only national, not-for-profit trade association of children's hospitals, including more than 135 independent acute care and specialty children's hospitals and children's hospitals that operate within larger hospitals or health systems. A longstanding member of N.A.C.H., Rainbow Babies and Children's Hospital was founded in 1886. It is a 244-bed pediatric academic medical center that serves children from every county in Ohio, as well as children from many other states throughout the country. We devote more than 52 percent of our patient care to children assisted by Medicaid or the Ohio version of the State Children's Health Insurance Program.

Children's hospitals are the backbone of health care for children in America. Less than five percent of all hospitals in the nation, children's hospitals deliver more than 40 percent of all hospital care for children as well as the large majority of hospital care for children with complex and serious medical conditions such as cancer or heart defects.

In addition, children's hospitals are the health care safety net for their communities, devoting, on average, more than 50 percent of their patient care to uninsured children or children covered by public programs, despite the fact that public programs often pay well below the cost of care. Finally, children's hospitals train most of the Nation's pediatric workforce and house the nation's premier pediatric research centers. Directly or indirectly, through clinical care, training and research, children's hospitals touch the lives of every child in this country.

Children's Stories I have been asked to draw from my professional experience to describe the importance of health coverage for children. I have two stories.

The first is a story about the powerful difference that health coverage can make in the life of a child and the child's family. Eugene and Rhonesha are a brother and sister who are both patients in my practice. They live with their mom and dad, and their family income qualifies them for SCHIP.

Gene is 10 years old—the same age as SCHIP. He is a great student and a great kid. And with the exception of needing glasses, he has had only routine health care needs. But Rhonesha, who is 6 years old, has a diagnosis commonly seen in our patient population—asthma.

I became Rhonesha's doctor when she was 2 months old. She had required well child care visits like all children but by the time she was 17 months of age, she was showing signs of reactive airway disease, often a precursor of asthma. We supplied her with an aerosol machine and instructed her mother in how to use it. By the time Rhonesha was 22 months of age, it was clear that she was asthmatic. She is categorized as having mild persistent asthma.

In many cases like this, I could tell you about emergency room visits, hospitalizations and missed days of work, but that has not happened with Rhonesha. Her asthma has been controlled by medications. When she has an occasional flare-up, because she has a cold or there is a climate change, her mother manages her illness. Dr. John Carl, a pediatric pulmonologist at Rainbow Babies and Children's Hospital, sees her every six months for evaluation and any needed medication adjustments.

We are now at the point that I only see Rhonesha for her annual routine visits. When I last saw her, she was as healthy as her brother Gene. She is an outstanding first grade student whose favorite subject is math. And, like Gene, she was wearing glasses. Because Gene and Rhonesha have coverage through SCHIP, her mother has a relationship with Dr. Carl and me. Rhonesha can access regular care and not use costly emergency care services. And because she has the medications she needs, her asthma is controlled and she doesn't need to be hospitalized. She doesn't miss school and her mother doesn't miss work. That's the wonderful promise of health coverage—it not only directly promotes health, it also indirectly promotes learning and employment.

My second story is about a child who was eligible for public health coverage but who was not enrolled until after he was admitted to our hospital. Baby Nick (name changed) was brought to our emergency department by his parents on New Year's Day. He was 5 weeks old with respiratory symptoms, vomiting and diarrhea.

Although Nick's mother had insurance coverage for herself from her employment at a supply company, Nick was uninsured. He was admitted to Rainbow Babies and Children's Hospital with a diagnosis of respiratory syncytial virus (RSV) pneumonia. While hospitalized, it was determined that his family income qualified him to be enrolled in SCHIP. Happily, Nick went home after three days. He was well and now had health insurance through SCHIP that will cover his immunizations and doctor's visits, which hopefully will keep him out of the emergency room.

Ohio's Story In the last decade, expanded public coverage has made a world of difference not only to individual children such as Rhonesha, Gene, and Nick but also to children across the country, including in my home state of Ohio.

According to Georgetown University's Center for Children and Families, over the last decade, the number of uninsured Americans has steadily risen, now totaling more than 46 million. At the same time, however, the number of uninsured children declined by about one-third, even as private and employer-based coverage for children continued to erode.

Together, Medicaid and SCHIP cover more than one-third of all children in the country, and they have made the difference, according to U.S. Census Bureau analysis. In fact, the number of uninsured children began to increase in 2005 but only after states, faced with record breaking deficits, were forced to curtail Medicaid or SCHIP or both. Today, 69 percent of all uninsured children nationwide are eligible but not enrolled in Medicaid or SCHIP, according to the American Academy of Pediatrics.

These programs have been especially important to industrial states such as Ohio, which have been losing not only employer-based insurance but also industrial jobs that in the past provided insurance for the families of those who fill them. The Brookings Institution reports that the between 1995 and 2005, Ohio lost more than 52,000 manufacturing jobs—a decline of more than 26 percent of such jobs. The loss of those jobs brought with it the loss of health coverage for thousands of families.

Ohio is one of 33 states that have opted to administer SCHIP either through its Medicaid program or through the combination of its SCHIP and Medicaid programs. Together, Medicaid and SCHIP cover about one-third of all Ohio children, according to the Ohio Bureau of Budget Management and Analysis in 2006. Between 1998 and 2004, the percentage of uninsured children declined from 9.8 percent to 5.4 percent, based on data from the Ohio Family Health Survey. In state fiscal year 2007, Ohio's SCHIP program will cover an estimated 145,000 children, at a cost of about \$290 million.

The proportion of Ohio children who remain uninsured could be reduced substantially simply by fulfilling the promise of existing Federal and state law, since 68 percent of all uninsured children in Ohio are eligible for, but not enrolled in, Medicaid or SCHIP, according to the Health Policy Institute of Ohio.

Recommendations As the stories of Rhonesha, Gene and Nick demonstrate, having health coverage makes a real difference—not only in a child's health but also in the cost of the child's health care and in his or her ability to be ready to learn and grow up to be healthy and productive.

Building on the foundation of Medicaid's coverage of 28 million children—who are among the nation's poorest and sickest children—SCHIP has made it possible for states to cover an additional 6 million children of families whose incomes exceed Medicaid eligibility criteria but who cannot afford or are unable to obtain private coverage for their children. At a time when the rising number of uninsured Americans is testimony to the limitations of our system of health coverage, the last decade of declining numbers of uninsured children is a measure of the combined success of SCHIP and Medicaid.

The program's success can be seen in the broad spectrum of support that exists for the reauthorization of SCHIP. No matter where you turn, national organizations of business groups, insurers, providers and consumers are saying the best way to turn

around the loss of health coverage for Americans is to start by building on a solid foundation of Medicaid and to expand SCHIP to cover more children.

The same breadth of support can be seen across Congress and state capitals, where there is strong support among members of both parties for reauthorizing SCHIP and expanding children's coverage. Many governors have made expanded coverage for children one of their priorities. Many more, including Ohio's new governor, a former member of your committee, are exploring how expanding children's health coverage might be possible.

Because of this success, N.A.C.H. recommends that Congress commit to achieving the goal of health coverage for all children. The first step should be to build on the foundation of Medicaid and SCHIP. In particular, N.A.C.H. offers four recommendations:

- **Reauthorize and Fully Fund SCHIP:** Congress should reauthorize and fully fund SCHIP—at least to fill in all projected state shortfalls and to enable states to cover all eligible but unenrolled children.

- **Improve Outreach and Enrollment:** Reauthorization of SCHIP should include specific measures that help states to improve outreach and enrollment of children who are eligible for Medicaid or SCHIP. Measures might include financial incentives, simplified and unified application forms, extended continuous eligibility, and others.

For example, a few years ago, Cuyahoga County in Ohio undertook a 12-month demonstration of self-declaration of income by low-income families applying for Medicaid and SCHIP, as part of a larger strategy of improving enrollment of eligible children. A study found that self-declaration of income by parents resulted in at least 24,000 eligible children being enrolled, with a 98 percent accuracy rate. Approval rates of applications reached 85 percent, up from 65 percent prior to self-declaration, and the time taken to process applications was reduced from between 30 and 60 days to between 14 and 30 days.

In Ohio, we are recommending to our governor new public investment in outreach, enrollment and retention, which were successful before the state cut back its funding. We also are recommending a change in the frequency of re-determination of eligibility so that it is the same for children and adults, as well as establishment of presumptive eligibility for children, among other initiatives.

- **Protect Medicaid's Safety Net for Children:** As I have said, the success of SCHIP stands on the shoulders of Medicaid. Our ability to sustain this success, as the Nation reaches out to cover all children, depends on both programs having the funds to meet their goals.

To be sure, neither Medicaid nor SCHIP is perfect. SCHIP is capped; when funds run short, as 14 states are projected to experience this year, children are left waiting in line for coverage. Medicaid's historically low reimbursement rates—particularly for physicians—too often leave children without a community physician or medical home. Nonetheless, together SCHIP and Medicaid have created an essential safety net of coverage for low-income children and children with disabilities or other special needs.

Children's health care, especially for children with serious illnesses or chronic conditions, is much more concentrated and regionalized than comparable care for adults. Health coverage for all children, including all of the patients of children's hospitals, relies heavily on the strength of our public insurance programs for children of low-income families.

- **Invest in the Development of Quality and Performance Measures for Children:** Finally, more and more payers are asking for quality and performance measures for health care providers. Providers like Rainbow Babies and Children's Hospital are pursuing quality and performance measurement as well. We are responding not simply to payers but also to the need for ever better, safer care for our patients.

The American Academy of Pediatrics, American Board of Pediatrics, Child Health Corporation of America and N.A.C.H. are working together to identify measures for hospital and physician care for children and for ways to validate those measures. But we cannot do this alone. Achieving quality and performance measures for children needs Federal leadership.

Measures need to be tested, and they need to gain consensus support and wide-acceptance. Private and public investment has made this progress possible for measures for adult health care. The Federal Government's leading role in public investment has focused largely on adult measures and Medicare. A commensurate investment for children's measures has not been made, even though public coverage through Medicaid and SCHIP is the nation's single largest payer of children's health care.

It's time to make the same investment in quality and performance measures for children's health care that has been made for adults. We ask that you provide the Federal Government, through the Centers for Medicare and Medicaid Services, with the authority and resources needed to support the development and advancement of pediatric quality and performance measures. This will greatly enhance our ability for states, providers and consumers to have a portfolio of measures they can use for children.

Ten years ago, Congress faced and met an unprecedented bipartisan challenge—how to put the Federal Government on a solid path toward elimination of the Federal deficit. That successful effort culminated in the “Balanced Budget Act of 1997”

(BBA). And, precisely because it was setting priorities vital to the future of our nation, Congress created SCHIP as part of the BBA to expand health coverage for children. In effect, Congress made children's coverage a priority within a balanced budget.

Ten years later, Congress faces the same challenge—to achieve fiscal control while at the same time taking the next step to cover all children. It should reauthorize and expand SCHIP, while keeping Medicaid coverage for children strong. Ten years of success, broad support throughout the private sector, and bipartisan support in Congress and state capitals all argue for taking that next step.

As a spokesperson for children's hospitals, I can tell you that Medicaid and SCHIP are fundamental to the financial infrastructure of health care for all children, through the work of children's hospitals. The decisions Congress makes on SCHIP and Medicaid will affect the health care of every child in this country.

STATEMENT OF SENATOR JOSEPH VITALE

Good morning. It is a welcome opportunity to be here to discuss the importance of the SCHIP program across the Nation and in particular to the many children and parents of New Jersey.

New Jersey implemented the SCHIP program in March 1998 by covering children of families with annual income up to 200 percent of the Federal Poverty Level (FPL) and called it NJ KidCare. An example of 200 percent FPL is a family of three whose annual income does not exceed \$33,200. The program was met with great anticipation and excitement over the prospect of providing health insurance to thousands of uninsured children.

As enrollment slowly grew, we recognized how many more children needed health care coverage and in July 1999 expanded eligibility to children with family income up to 350 percent FPL (ex. family of 3 with income not exceeding \$58,100).

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 also know that providing health care coverage to pregnant women leads to healthier babies and moms.

And so in September 2000, New Jersey made a decision to cover parents up to 200 percent FPL and the program was re-named NJ FamilyCare.

Unfortunately, due to consecutive budget crises, New Jersey had to close the program to parents in June 2002, leaving only those already enrolled to continue participating.

In September 2005, I sponsored legislation that in addition to streamlining the application process, again made FamilyCare available to low-income parents and guardians up to 115 percent FPL (\$19,090 family of 3) in 2006 and up to 133 percent FPL (\$22,078 family of 3) beginning September 2007.

We now provide health insurance coverage to over 125,000 New Jersey children and over 79,000 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, in partnership with the Federal Government, New Jersey provides health insurance coverage to over one million parents 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 more generous eligibility income level in order to reach those truly needy children and families with low income levels.

Through SCHIP and Medicaid, it is also a much more economically responsible way to provide health care. In New Jersey, where we have 1.4 million uninsured, access to all levels of care for that population is typically provided by our State's hospitals. In fiscal year 2007, the State has budgeted nearly 900 million dollars to reimburse hospitals for a percentage of the costs they absorb treating the uninsured. In total, our State's hospitals provide nearly 2 billion dollars of uncompensated care; a financial strain that has put many hospitals at risk.

New Jersey greatly appreciates the opportunities that the SCHIP program provides states. Through our SCHIP program, we have been able to provide health insurance and needed health care to the most vulnerable population: 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 under-

taken. The prospect of limiting or, at worse, eliminating our SCHIP program to lower income level families would be devastating to our State's budget and to the families of our State.

New Jersey has historically spent its entire annual Federal SCHIP allotment. And though we have been eligible for SCHIP funds not used by other states, these reallocated resources have been diminishing over the years. There is an urgent need for Congress to increase annual allocations to states to meet the ever-growing national need for health care insurance.

I will conclude my remarks by asking the members of this important committee to prevent shortfalls in funding for the SCHIP program and to advocate for increased support. Both Medicaid and SCHIP have been successful and efficient in expanding coverage to children. By promoting the continued success of these programs, we can ensure that children and families get the health care that they need.

This collaboration between the Federal Government and the states, and with premium sharing by consumers where it is possible, allows the kind of partnership in health care that is a model for success. Without this continuing alliance, millions of children and families will simply be unable to access the kind of care that the rest of us have and some take for granted.

Thank you, again, for your interest in this urgent issue. I hope that my remarks will help to support the need for leadership and long-term solutions to this ever-increasing need.

TESTIMONY OF ALAN R. WEIL

Chairman Pallone, Ranking Member Deal, and members of the committee, my name is Alan Weil and I am the Executive Director of the National Academy for State Health Policy (NASHP), a non-profit, non-partisan organization with offices in Washington, DC, and Portland, Maine. Thank you for the opportunity to appear before you today to discuss health insurance for children and the reauthorization of the State Children's Health Insurance Program (SCHIP).

This hearing comes at a very important time for the SCHIP program and for children's health insurance. There is much to celebrate. The Centers for Medicare and Medicaid Services (CMS) reports that approximately 6.1 million children were enrolled in the SCHIP program during the past fiscal year. Millions more children have obtained Medicaid coverage due to the outreach and enrollment efforts associated with SCHIP. A solid base of evidence now exists linking the SCHIP program to improved access to health care services for children. The nation observed declines in the percentage of uninsured children for six consecutive years, coinciding with the development and maturation of the SCHIP program. But now, as the SCHIP program is up for reauthorization, these gains have come to a halt. Your decisions with respect to the program will determine whether we continue to make progress on children's coverage or we return to the gloomy days when we took as a given that the number of uninsured children would grow inexorably year after year.

NASHP AND SCHIP

My organization is dedicated to promoting excellence in state health policy and practice. We have provided technical assistance to state SCHIP programs and worked in partnership with the Federal Government since the program was created. We serve as the informal "home" of the SCHIP directors' convening them each year to discuss their progress and concerns implementing the program, and maintaining inter-state communication throughout the year. We track state choices in the SCHIP program and have published three surveys of state SCHIP programs, entitled "Charting SCHIP: An Analysis of the Comprehensive Survey of State Children's Health Insurance Programs." The "Charting SCHIP" series, published in 1998, 2001, and 2006, has documented the progress states have made building their SCHIP programs and described the various choices made, including program design, populations covered, and benefit offerings.

While my organization works closely with the nation's SCHIP directors, I do not purport to speak for them. My testimony is solely on behalf of my organization, but its content is shaped by the lessons I have learned from the SCHIP directors and my great respect for their commitment and dedication to the people of their states as they have developed and refined this important program.

The primary goal of my testimony is to provide context to the SCHIP reauthorization debate—context that sometimes seems absent as I listen to characterizations of the program's design and evolution. My testimony will focus on why the program looks the way it does today and what is at stake in your deliberations.

“COOPERATIVE” FEDERALISM

The SCHIP program is a good example of “cooperative federalism.” The states and the Federal Government shared a goal. The Federal Government developed a framework for addressing that goal and provided substantial resources to the states. The states, in turn, contributed their own resources and tailored the program to their own circumstances. In an unusual step, many of the major features of the program, including the key regulations and reporting requirements, were developed through negotiations directly with the states rather than through edicts handed down from Washington.

Within the constraints of the Federal statute and regulations, states took the program in different directions. Recently, there has been a great deal of attention paid to how state choices vary on the income guidelines for eligibility and on the choice to cover some parents and other adults. But state choices vary on a tremendous range of dimensions such as the benefit package, the delivery system, provider payment levels, health plan accountability mechanisms, family premiums and copayments, and integration with employer-sponsored insurance and Medicaid. And, of course, states have made varying decisions on what was a key compromise in the original statute—whether to operate SCHIP as a Medicaid expansion, as a separate program, or a combination of the two.

federalism is frustrating—it allows for, indeed it celebrates, the diversity of our nation—and it is not orderly. Each of you may have a preferred vision for the program with respect to these many parameters. Your preferences may be aligned with the choices made in your own state, or you may look around the country and see other states operating programs more in line with your own views.

My overarching message to you is that the tremendous success and bipartisan popularity of this program is directly tied to its flexible, Federal structure. Efforts to remake the program with a different vision run the risk of undermining the Federal-state partnership that has allowed it to thrive. This is not to say that the program cannot or should not be modified. It is to say that the balance that SCHIP represents was carefully crafted to meet objectives that spanned the political spectrum and met the needs of the Federal Government and states. Altering that balance risks undermining the roots of the program’s success.

As someone who has been studying the SCHIP program since its inception, I find the current focus on the dozen states that cover families, the half-dozen states that cover childless adults, and the eight states that extend SCHIP coverage above 250 percent of the Federal poverty level to be strangely removed from context.

Washington Called—and States Answered

States embraced the SCHIP program far more quickly than they did the Medicaid program when the latter was enacted four decades ago. Forty-five states and the District of Columbia created programs within one year of SCHIP enactment and all but one jurisdiction had a program in place by 2000. Yet, as was expected, it took time for eligible families to learn of the program, come to trust it, and ultimately enroll. And there was great uncertainty at the time of enactment regarding the precise number of eligible children in each state so states tended to be conservative in their estimates, not wanting to overspend the available resources.

In the early years of the program, states were subject to substantial criticism for underspending. As the unspent balance amassed, Congress seriously considered reducing the size of the SCHIP appropriation. Ultimately, political pressure within states combined with urgings from the Federal Government led to four responses.

First, states substantially increased their efforts to reach out and find the eligible children within their states. The working families that are served by SCHIP are not the traditional Medicaid or welfare population. No one had much experience marketing a program to this population. States took a variety of approaches and learned from each other as they developed outreach plans. Such state-to-state learning has continued as states have sought to retain children on the program rather than have them cycle on and off.

Second, states increased their eligibility standards. The trend line is clear. In 1998, twenty-two states had income limits for SCHIP below 200 percent of the poverty level. By 2005, only eight states had income limits that low. In 2005, twenty-nine states were at twice the poverty level, and 13 states were above that level.

Third, every state had an SCHIP allocation—even those like Minnesota that already covered children up to 275 percent of the Federal poverty level at the time the program was enacted. Facing the same pressures to spend their allocation that every other state faced, these leadership states had the choice of going even farther up the income scale or seeking permission to use their SCHIP funds to cover families or other adults. States that chose to cover parents and families did so on the basis of a diagnosis of unmet need, an understanding that families are the typical

unit for health insurance coverage, and evidence showing that family coverage improves program enrollment and increases the odds of appropriate utilization by the children.

Fourth, the Bush Administration's announced in 2001 its Health Insurance Flexibility and Accountability (HIFA) waiver initiative which explicitly encouraged states to apply for waivers to expand coverage to low income populations. Since the overwhelming majority of low-income children were already eligible for existing programs, the target population for HIFA was adults. CMS also explicitly identified SCHIP funds as a desired source of funding for these waiver programs. In the absence of any other major Federal initiative, this waiver process, which included no new resources, represented and continues to represent the primary vehicle available to states that wanted to provide health insurance to childless adults.

These four steps took place at a time when the available resources to any given state seemed limitless. With states given three years to spend each year's allotment, as the program's fourth year approached it was clear that there would be substantial funds available for at least a few years for all states that exceeded their allotments. The combination of large unspent balances, pressure to draw down all available funds, and the incentive of an enhanced matching rate, made it possible for all but the largest states to expand their programs as far as they wanted to, confident that reallocated funds would be available to pay for the Federal share. And it is worth noting that the larger states are underrepresented in lists of states that have gone beyond the original core parameters of the SCHIP program. Larger states could not be confident that reallocated resources would be sufficient to meet their greater needs.

The purpose of telling this story is to explain that, as the program was maturing, ample Federal resources were available. States were under great pressure to spend those resources, and the Federal Government was actively encouraging states to draw down SCHIP dollars to meet the needs of children in families with income above twice the poverty level as well as low-income adults. Washington called, and states answered the call.

THE SCHIP STRUCTURE MAKES PLANNING DIFFICULT

Today the picture looks quite different. We speak of shortfalls and states are criticized for the choices they were encouraged to make just a few years ago.

Rather than point fingers we should acknowledge that the structure of the SCHIP program makes planning difficult, and at times impossible. The actual resources available to a state in a given year cannot be known until shortly before the year begins, at which point it becomes possible to estimate how many funds are available for reallocation and how many other states are eligible to receive reallocated funds. The reallocation formula and timelines have been modified over the years—generally with the positive intention of preserving resources for children's coverage—but the knowledge that the formula can change at any time makes planning quite difficult. And, of course, with any health insurance program, the needs of the population are constantly changing.

Why is there a hint of approbation directed at those states that have shortfalls, when there is mostly silence regarding those states that have not spent their full allotment? The fact is that the allocation formula and process all but guarantee that there will be overspending and underspending. The law creates an impossible task for states: project your spending perfectly using imperfect information. The states should not be scapegoats for problems inherent in the program's design.

LEARNING FROM THE SCHIP EXPERIENCE

The SCHIP program has been a successful Federal-state partnership. By delegating key decisions to the states, the Federal Government has obtained a level of political, financial, and administrative support at the state level that is unusual in the realm of social programs. States' choices reflect the economy, health care systems, values, politics, and fiscal capacity that each state has. What happens if Congress substitutes its judgment for those of the states? Of course that is your prerogative, but with that authority comes the responsibility to recognize the likely consequences. Taking a program that states consider a success and a reflection of their values and priorities and forcing them to modify that program in a manner that may diverge from those priorities risks losing the investment and support that states currently have. Changes at the margin likely have limited risks, but major changes carry substantial risks.

In addition, please keep in mind that the states have their own list of concerns regarding the program. In particular, SCHIP directors have told us of their frustration at their inability to provide supplemental benefits in key areas such as dental

care for children whose private insurance does not include this benefit. The prohibition on covering children of state employees not only is inequitable but it poses administrative barriers to enrolling all children since it lengthens the application process. Rules regarding premium assistance programs are cumbersome. My point in listing these items is to remind you that the program is not perfect in anyone's eyes. Compromise is a central feature of SCHIP.

But the most important lesson from SCHIP is that it is possible to develop a successful program that overcomes the ideological chasm that has generally prevented progress toward addressing the needs of the 47 million Americans without health insurance. Congress could not resolve the key ideological choice when SCHIP was enacted: Should it be a Medicaid expansion or should it be a separate program patterned on commercial health insurance? Congress passed that decision to the states. These were hard-fought battles in some states, but every state rose to the occasion, made choices, and moved forward with implementation.

In an era in which people question whether or not government can do anything right, here is a program that has accomplished exactly what it set out to accomplish. It has not done it perfectly, and it has not done it consistent with any one person's unified vision for how a program ought to look, but it has done it in a truly American way reflecting our nation's diversity and diverse values.

WHAT IS AT STAKE IN REAUTHORIZATION?

It might be tempting to go back and use the same playbook in reauthorizing SCHIP that was used ten years ago. Yet, that would overlook a whole wealth of information, gained through experience, states have provided policymakers. States know first-hand what has worked and what has failed in their state. In many cases states have redesigned their programs over time to achieve better results. States have taken seriously the flexibility and responsibility granted in the original statute.

Much of the reauthorization debate focuses on the level of funding. This is a critical issue, but it is a debate to which I have little to add. Other aspects of the debate have turned to whether or not the target population for the program should be redefined. On that issue I simply note that each of the 6 million Americans reached by this program last year came to his respective state because he needed help meeting a basic need—the need for health insurance. Any modifications that prohibit covering anyone currently on the program will add another person to the growing ranks of the uninsured. Any calculation of future levels of funding that fails to account for the resources needed to retain coverage for those currently on the program will have the same negative effect. Funding allocations that fail to consider the eroding effects of health care inflation and premium increases will result in fewer people covered each year. And any funding level that fails to account for the costs of reaching those who are eligible for this program but not enrolled will serve as a barrier to finishing the job that SCHIP so successfully began.

While the Deficit Reduction Act prohibited CMS from approving additional waivers that enable states to use SCHIP funds to cover childless adults, one comment on this topic is warranted. Nearly one out of three 19 to 24 year olds in this country is uninsured—a rate far higher than for children. Targeting limited resources to children is an appropriate value judgment, but we should not ignore the fact that as children become young adults (and enter their child-bearing years) our existing public programs and private insurance policies shove them off a cliff of eligibility. The importance of health insurance for a 20 year old is no less than for a 17 year old, but our nation's commitment to meeting the health needs of 20 year olds is far more limited than it is to people just a few years younger.

At a time when the number of uninsured Americans continues to rise and ideological division often impedes broader health reform efforts, SCHIP has been a tremendous achievement. States rose to the occasion, showing an ability to break through the ideological divide and implement a successful health program. States expanded coverage and helped cut the ranks of the uninsured. States need prompt reauthorization so they can plan for the future—the expiration of the current authorization is only seven months away and states are already well into the process of setting their budgets for next year. And, ultimately, states need an expanded Federal financial commitment of resources so they can continue making progress meeting the needs of their citizens who would otherwise go without health insurance.

An effective Federal/state partnership brought us to this point. A continued partnership is the best framework for meeting the tremendous remaining needs of children and families.

STATEMENT OF JANET STOKES TRAUTWEIN

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage.

In the course of conducting their business, NAHU members regularly encounter parents of SCHIP-eligible children that have access to employer-sponsored health insurance coverage but cannot afford their portion of the dependent premiums. Some of these parents enroll their children in SCHIP, but many children remain uninsured. NAHU would like to see the process for states to voluntarily use SCHIP dollars to subsidize such employer-sponsored coverage made much simpler so that more families can be covered together under the same private-market plans.

With the upcoming reauthorization of SCHIP, NAHU feels that there is a great opportunity at hand to improve SCHIP's existing public/private partnership structure and more cost-effectively cover more low-income uninsured children by removing some current restrictions that have hindered premium-subsidy efforts of private-market employer-sponsored coverage. Doing so would have the following benefits:

- More families would accept employer-sponsored coverage for their children, lowering the number of uninsured children.
- The administrative burden on low-income families would be lessened, as families could be covered together on the same health insurance plan.
- It would reduce the "crowd-out" of the private market that occurs when parents decline employer-sponsored coverage in favor of SCHIP coverage for their dependents.
- It would lower costs by taking advantage of any premium dollars employers are willing to contribute toward their eligible employee dependent premiums—money that is now often "left on the table."
- It would also reduce SCHIP costs because the risk associated with covering the children with employer-sponsored coverage would be borne by the private market plan rather than the public program.
- Licensed health insurance producers, who are already helping millions of business owners purchase health insurance coverage for their employees nationally, could provide outreach and enrollment assistance at virtually no cost to the SCHIP program.

The original SCHIP legislation included an option for states to subsidize employer-based family coverage for eligible children if the coverage met certain requirements. But these rules are considered onerous by states; consequently, only nine have attempted to implement premium-assistance programs. In order to receive federal approval to operate an employer-buy-in program under SCHIP, states must demonstrate that the premium assistance will be directed to employer plans that meet SCHIP requirements, including benefit standards, enrollee cost-sharing limits, and minimum employer premium contribution levels. In addition, states must show that buying the private insurance plan is cost-effective in comparison to the cost of covering the enrollee directly through the state SCHIP program.

NAHU feels that it is crucial for Congress to make the SCHIP premium subsidy process as simple as possible for both states and employers during the upcoming program reauthorization process. While subsidization of employer-sponsored health insurance certainly won't be the solution for all SCHIP-eligible children, it would be an attractive option for many working families, and NAHU members work every day with employers that would love to be able to offer this type of subsidized coverage to their eligible employees as a benefit. However, for this option to work, it needs to be easy for states to implement and administer, and more importantly, the regulations governing this option need to be flexible enough to apply to all different types of employers and their varying benefit plan options. Congress could improve the ability of states and employers to offer and qualify for premium subsidies by making the following changes to SCHIP:

Restructure the Cost-Sharing Requirements. The current SCHIP legislation virtually prohibits cost-sharing for children in families under 150 percent of the poverty level, and it is limited to five percent of family income for families with incomes that exceed 150 percent. Unfortunately, cost sharing is defined to not only include premiums, but also co-payments, deductibles and co-insurance. As such, most "average" private plans would exceed the five-percent maximum for many eligible participants, and the rule hinders qualifying employers from making changes to plan designs. If the cost-sharing language was amended to only cover health plan premiums, this problem would be alleviated.

Make Changes to the “Crowd-Out” Requirements. A further challenge is that SCHIP regulations specify that children have to be without employer-sponsored coverage for at least six months to be eligible. This provision was originally put in place to prevent the crowd-out, but it actually has had the reverse effect. It hinders employer subsidization efforts as it penalizes those employers that have already been subsidizing the coverage of SCHIP-eligible dependents. The SCHIP crowd-out requirements are also inconsistent with Medicaid rules, which allow for children to receive subsidized coverage if they have employer-sponsored coverage. Since the majority of states combine their SCHIP programs with Medicaid in whole or in part, the inconsistency serves as a further obstacle to premium assistance. To fix this problem we would like to see the reauthorization legislation specify that income-eligible children who already have access to employer-sponsored coverage be immediately eligible for SCHIP premium assistance.

Make it simpler for employer-sponsored health benefit plans to qualify. Current SCHIP rules require that states set minimum employer contribution amounts or percentages for employers to qualify for premium subsidy programs. Employers structure employee cost-sharing requirements differently based on a variety of factors, and don't always use percentages or flat-dollar amounts to determine their contribution. Also, overly specific requirements can be difficult for states to administer, as it necessitates that they review every potential participating employer's benefit plan structure every year. This regulation was put into place to make sure that participating employers contribute to premiums, but it is really not necessary to ensure employer participation. The cost-effectiveness test, if properly applied, will be enough to determine adequate employer contributions. As such, NAHU recommends that the reauthorization legislation specify that premium contributions are required for an employer plan to qualify for participation in any SCHIP premium-subsidy program, but it should also specify that the means of contribution must be left up to the individual employer's discretion.

Improve the design for the cost-effectiveness test. Like with Medicaid, any SCHIP premium subsidy must be cost-effective for the state. However, unlike with Medicaid premium subsidy programs, states with SCHIP programs that are separate from their Medicaid programs must apply for a special waiver when non-eligible family members are included in the employer-premium that is being subsidized. Under this “family waiver” scenario, the cost of insuring the entire family privately must be less than the cost of insuring just the SCHIP-eligible child in the public program. Since almost all employer health insurance policies for dependents are based on a family rate and/or a rate for a parent plus his/her dependent children rather than a separate rate for just the children, the vast majority of private plans fall into this family waiver category, making this test formula virtually impossible for most employer plans to meet. NAHU recommends that the SCHIP reauthorization legislation eliminate the family waiver requirement and instead apply the Medicaid cost-effectiveness standard, which merely compares the cost of covering the eligible individual(s) privately versus publicly.

Make Medicaid and SCHIP rules consistent. In addition to the cost-effectiveness test requirements, many SCHIP premium-subsidy regulations are inconsistent with Medicaid rules on the same topics. This poses a significant administrative challenge to states, because in the majority of states these programs are at least partially combined. The reauthorization legislation should specify that all of these regulations be reviewed and the inconsistencies resolved, with the goal of simplifying the employer plan integration process for both Federal programs.

Make premium subsidy programs easier to administer. One of the biggest obstacles to successful premium subsidy programs, from both the employer and administrative perspective are the plan benchmark standards. Since these requirements must be implemented on a case-by-case basis, with an annual review of every employer-sponsored health benefit plan that wishes to participate, they are very hard for states to administer. Also, since SCHIP benchmarks do not conform to most private-market employer-sponsored plan designs (in some states, there aren't even fully insured products available for private employers to buy that would meet these standards), the benchmarks have really hindered program enrollment in the states that have attempted premium subsidies.

Clearly, the reasons plan benchmarks were included in the original SCHIP legislation was to ensure that program beneficiaries were receiving adequate coverage. However, NAHU feels that this goal can be achieved in a way that would be simpler for the states to administer and allow many more employer plans to qualify. We recommend that instead of including benchmarks for employer-sponsored plans, the reauthorization legislation should specify that eligible children who participate in an employer-subsidy program also be eligible for SCHIP wrap-around coverage for services not covered by their employer-sponsored plan. SCHIP coverage would be used

by eligible children merely to fill in any gaps in coverage, a method that has been used successfully and cost-effectively in the Medicaid programs in many states.

Make sure that employees know about the programs. In order for employer premium-subsidy programs to work, employees have to know about them. However, ERISA prevents states from requiring employers to notify their employees about the existence of such programs. As such, NAHU recommends that Congress amend ERISA as part of the reauthorization legislation to require employer notification about Medicaid and SCHIP premium subsidy programs, similar to way that employers are required to notify eligible employees about Medicare Part D benefits.

Make it easier for states to get information about employer sponsored plans. A final challenge to SCHIP subsidization of employer coverage is state-level reporting requirements. To calculate the cost-effectiveness test needed for employer premium subsidy programs, states need to obtain information about employer-sponsored plan designs. Due to ERISA obstacles, there is no way of imposing reporting requirements on private employer-sponsored plans. This barrier has hindered many states from taking up the idea of premium subsidies. Under current law, states can either ask employers to provide this information voluntarily (which many do, but not all) or ask the parents of SCHIP beneficiaries to obtain/provide it (which is both inefficient and also overly burdensome for parents). Congress could make this process much more efficient for states and also easy for employers by amending ERISA to require employers participating in an SCHIP premium subsidy program to directly provide their summary plan descriptions to the state upon request. Right now ERISA plans are already required to provide employees, upon their request, with summary plan descriptions. The information contained in these summaries would be sufficient for the states to determine the cost-effectiveness of an employer plan.

Thank you for this opportunity to provide information about how SCHIP could be modified to cover more uninsured children through the employer-based health insurance delivery system. NAHU feels that SCHIP effectiveness could increase dramatically by eliminating legislative and regulatory barriers that have made it difficult for states to develop private-market based plans. We look forward to working with Congress and the Energy and Commerce Committee during the upcoming reauthorization process to address this issue. If you have any questions, or if NAHU could be of further assistance, please do not hesitate to either contact me directly at either (703) 276-3806 or jtrautwein@nahu.org, or speak with our Vice President of Congressional Affairs, John Greene, at (703) 276-3807 or jgreene@nahu.org.

