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COVERING UNINSURED KIDS: MISSED OPPORTUNITIES FOR MOVING FORWARD

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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CONTENTS

	Page
Hon. Frank Pallone Jr., a Representative in Congress from the State of New Jersey, opening statement	1
Hon. Nathan Deal, a Representative in Congress from the State of Georgia, opening statement	3
Hon. Anna G. Eshoo, a Representative in Congress from the State of California, opening statement	4
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	5
Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement	5
Hon. Joe Barton, a Representative in Congress from the State of Texas, opening statement	6
Hon. Lois Capps, a Representative in Congress from the State of California, opening statement	8
Hon. Marsha Blackburn, a Representative in Congress from the State of Tennessee, opening statement	9
Hon. Diana DeGette, a Representative in Congress from the State of Colorado, opening statement	10
Hon. Tim Murphy, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	11
Hon. Darlene Hooley, a Representative in Congress from the State of Oregon, opening statement	12
Hon. John B. Shadegg, a Representative in Congress from the State of Arizona, opening statement	613
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	15
Hon. John D. Dingell, a Representative in Congress from the State of Michigan, prepared statement	16
Hon. Jan Schakowsky, a Representative in Congress from the State of Illinois, prepared statement	126
Hon. Edolphus Towns, a Representative in Congress from the State of New York, prepared statement	130

WITNESSES

Cynthia Mann, Research Professor and Executive Director, Center for Children and Families, Georgetown University Health Policy Institute	18
Prepared statement	20
Chris Peterson, Specialist in Health Care Financing, Domestic Social Policy Division, Congressional Research Service	40
Prepared statement	42
Carolyn Taylor Chester, Nursing Assistant, Service Employees International Union	62
Prepared statement	63
Louis F. Rossiter, Research Professor and Director, Schroeder Center for Health Care Policy, College of William and Mary	64
Prepared statement	65
Bruce Lesley, President, First Focus, Alexandria, VA	66
Prepared statement	69
Answers to submitted questions	
Ann C. Kohler, Deputy Commissioner, New Jersey Department of Human Services	98
Prepared statement	100
Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services	101

Page

Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services—Continued
Prepared statement 102
Tricia Brooks, President and CEO, New Hampshire Healthy Kids Corporation 106
Prepared statement 108

SUBMITTED MATERIAL

Chart, Monthly Costs of Living 128
Chart, "Coverage of Recent SCHIP Enrollees During the Six Months Before They Enrolled," submitted by Ms. DeGette 129

COVERING UNINSURED KIDS: MISSED OPPORTUNITIES FOR MOVING FORWARD

TUESDAY, JANUARY 29, 2008

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

The subcommittee met, pursuant to call, at 10:13 a.m., in room 2128, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Eshoo, Green, DeGette, Capps, Solis, Hooley, Deal, Cubin, Shadegg, Pitts, Murphy, Burgess, Blackburn, and Barton (Ex Officio).

Staff Present: Purvee Kempf, Bridgett Taylor, Robert Clark, Amy Hall, Yvette Fontenot, Hasan Sarsour, Brin Frazier, Lauren Bloomberg, Brandon Clark, and Chad Grant.

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

Mr. PALLONE. The hearing of the subcommittee is called to order. Today's hearing is entitled Covering Uninsured Kids, Missed Opportunities For Moving Forward. Last week the House tried for a second time to override the President's veto of bipartisan bicameral legislation that would have reauthorized the Children's Health Insurance Program and moved our Nation towards making sure no American child has to go without health insurance. To be honest, it is hard for me to understand the President's logic or the rationale of those within Congress who voted to uphold his veto. I think we all have forgotten or simply do not understand the challenges that American families face in securing affordable health coverage for their children.

Perhaps today's hearing will remind us about the day-to-day struggle millions of American families face in order to afford the costs of health insurance. As health care costs continue to rise, employer-sponsored insurance is eroding. Employers are shifting more cost to workers or they are dropping coverage all together. For those who don't have employer insurance purchasing insurance health insurance in the individual market is not really a viable option. The result has been a steady increase in the number of uninsured Americans since 2001, 9 million of which are children.

Now as the economy continues to slump, things are only going to get worse for these families that have no health insurance. Unemployment rates are increasing, which means more and more

Americans are going to lose the health coverage that was tied to their jobs, will have fewer dollars in their pocket to pay for private insurance.

Soon enough, many of these families are going to come to rely on CHIP or Medicaid for their children's health coverage, and I think it is questionable whether or not the States will have the ability to respond to this increasing level of need. As we learned from last year's debate, States are already having great difficulty in meeting the needs of those presently enrolled, not to mention the millions of kids who are currently eligible but unenrolled. Every year, the number of States that experience a shortfall increases. I distinctly remember members of the Georgia legislature descending upon Washington last year, pleading with congressional leaders to provide them with additional funds in order to prevent an enrollment freeze. We answered their call and filled in their shortfall so no child on the program had to lose their health care. But we didn't stop there. We worked in a bipartisan fashion with our colleagues in the Senate to craft a bill that would strengthen CHIP so that there wouldn't be any more shortfalls. Our bill would have provided $35 billion over 5 years to the States to maintain and expand coverage to 10 million children.

We provided the States with the tools and resources necessary to go out and sign up the lowest-income children first. We strengthened the benefits offered under CHIP including the mental and dental benefits. We took note of the administration's concerns and removed adults from the program faster than the President could by simply disapproving waiver renewals. And we also strengthened the program so only U.S. citizens could enroll in CHIP or Medicaid. But none of this seemed to satisfy the President. Instead of living up to the promise he made to enroll millions of poor children in CHIP during the 2004 presidential campaign, he issued veto after veto, and he didn't stop there.

It was simply not enough to deny the States the resources they need to insure the children of their State. The Bush administration has also tried to tie their hands with a torrent of erroneous policies on CHIP and Medicaid. Today, this administration has issued seven regulations that would collectively gut the Medicaid program and roll back coverage for millions of Americans. Some of the most egregious regulations are targeted towards health care services for low income and disabled children. In addition to the Medicaid regulations, the administration's misguided CHIP directive contained in the August 17 letter to State Medicaid directors is truly atrocious.

It would, amongst other things, force a child to go one full year without health insurance before they could enroll in CHIP. I guess a kid can just go to the emergency room for his or her health care like the President suggested. But I would like to see the President send one of his children to the emergency room instead of their family doctor. If it is good enough for hardworking families, it should certainly be good enough for his children as well.

The bottom line is that instead of working with us to move our Nation forward and provide health care to kids, the President has chosen to wage an all-out attack on our Nation's safety net system and those who rely upon it. I am glad we have someone here from the administration today, Mr. Smith, who can try to justify these

policies. But I also want to put Mr. Smith and the President on notice that I don't intend to sit idly by as more and more Americans lose their health coverage.

We are determined to work together to strengthen CHIP and Medicaid so every American child can access the care that they need to grow up healthy. And while the President may not be in the habit of living up to his promises when it comes to children's health care, that is a promise from me to you that anyone can take to the bank. I would obviously like if over the next year we can come up and negotiate an expansion of SCHIP that provides additional coverage for children on a bipartisan basis. Nothing ever happens around here unless it is done in a bipartisan basis. But I also think it is important and today's hearing is part of that process, it is important to show that we can't just sit by. That we are going to continue to have kids that are uninsured and the numbers are going to increase and something has to be done. And that is the purpose of this hearing, to find out what actually is going on out there. And with that, I would yield to the gentleman from Georgia, Mr. Deal.

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

Mr. DEAL. Thank you, Mr. Chairman. You and I get along very well on a personal basis. I find it regrettable that your opening statement is so partisan, a continued effort to beat up on our President. We ought to be concerned about what we either do or don't do right here on our own Health Subcommittee. We ought to ask ourselves the very hard question, why was it in both iterations of the SCHIP bill that came before the House to vote on we never had a legislative hearing on either of those versions?

This is what this committee is supposed to be about. We are supposed to have input. I heard your reference to you worked on a bipartisan basis with the Senate. Well, we are not the Senate. We are all elected to come here to this committee in this body and try to work together. And I pledge to you that we will do that if given the opportunity. But we agree on some things, we disagree on others. One of the things we agree on is that SCHIP ought to be reauthorized. It should have been reauthorized and we should have learned the lessons of the first 10 years of its existence.

No piece of legislation is perfect, and over 10 years of being in existence we should have learned where the mistakes and the errors were. One of those mistakes was it should have been a children's insurance plan and yet we find that in the versions that we were asked to vote on, we offer a bill or a version to get adults out of the children's health program and that was rejected.

Now GAO recently issued a report looking at those States that have covered adults in SCHIP and they conclude that overall adults account for 54 percent of the total SCHIP expenditures in those nine States. That is not a children's program. And it ought not to be working that way. The other thing we should have learned is, it was intended at the outset to focus on children that were above the Medicaid eligibility levels and at a 200 percent or below of the poverty levels.

And yet we have found States that—my State, as you alluded to, Georgia, we went to 235 percent. I think yours went to 350 percent. We had States that were using income disregards that could bring your earnings in a family of four far above the $42,400 for a family of four, which should have been the target area for those families and below. Now we offered a meaningful test that would have eliminated income disregards and that was rejected.

Now, where are we and what can we do? First of all, I think we ought to acknowledge that the program has value and merit, and it should be reauthorized. But it should not be used as a spring board for a larger plan of universal government-run health care for everybody. And if we want to keep it in a bipartisan fashion, then let's focus on the things that we agree on and those are many. And I would hope that in today's hearing as we listen to witnesses, we can focus on those things that we can agree on and make the program work as it was originally intended, to help poor children first.

And I personally think that any State that says that they are not willing to enroll 90 to 95 percent of their children that are poor children below 200 percent of poverty, but instead want to go up the economic scale to extend benefits to families with 70 and 80 and above earning income, I think that is wrong. It is a perversion of the intent of the program. And we ought to do something to stop it. I look forward—we have two good panels of witnesses and thank you for putting them here today. Thank you.

Mr. PALLONE. Thank you, Mr. Deal. The gentlewoman from California, Ms. Eshoo.

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

Ms. ESHOO. Mr. Chairman, thank you for holding this hearing. I can't help but think that this is really very sad that we are here to review the impacts of what is not being done. I get up every day and that is an act of optimism and I think the information that we will get will be important. I can't really figure out why those that are so into States rights, that when the States want to exercise something and come up with the dollars for it, that they be able to do so. I think my friends on the other side of the aisle are squarely against every American having health insurance. That is why this is so menacing to them. The best place we know to start is children. They are the cheapest to insure. We know how to do it. We have had success with the program. It is one of the best offerings that has been set up. And so today, we will learn more from the witnesses through their expertise about how this is going to affect children across the country. I think it is regrettable that we are where we are. But I look forward to a new day when not only when all children are insured but that their mothers and fathers, their families are as well. So thank you for having the hearing and I look forward to what the witness will instruct us.

Mr. PALLONE. Thank you. The gentleman from Pennsylvania, Mr. Pitts.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Well, Mr. Chairman, I wasn't going to say anything, but since the dialog is so good. In SCHIP, we were talking about poor children without insurance, children, not adults, poor children, not children of middle income families. Children without any insurance, not bringing people off the private insurance markets for government-run health care. You know, the purpose of government is not to provide all the needs of people. The purpose of government is to provide atmosphere in which people can meet their own needs. We are for every American having health insurance, just not government-owned health insurance. Government may be organized in insurance, private insurance but not one-size-fits-all. I find it sad that we are deteriorating into this partisanship so soon. I would hope that we could be a little bit more bipartisan in looking at some of the solutions and I look forward to hearing the witnesses. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. The gentleman from Texas, our Vice Chair, Mr. Green.

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

Mr. GREEN. Thank you, Mr. Chairman. And I have to respond to some of the opposition. And for someone that has dealt with insurance both as a State legislator and now in Congress, health plans—it is interesting, last night we had the State of the Union and the President decided one of his proposals was to remove employer-based insurance tax deductions. And yet in our country after World War II, the countries that were coming out of World War II were receiving national health care, Japan, western Europe, our country, because of World War II stuck with employer-based insurance. And by and large, it was very good up until we found out that employers often didn't cover their employees for retirement so Medicare was created and Medicaid in 1965. And in 1997, we found out that children oftentimes, even though the employer maybe provided coverage for that employee, low-wage workers, they couldn't afford the dependent care.

So the SCHIP program has created a partnership similar to Medicaid in many States to cover these low-income children. Those children may have access to employer-based insurance, but they can't afford it if you make $15 an hour and have two or three children.

So that is why it has to be created. The private insurance market will work as long as they can make money. 20, 25, 30 percent. But when the market doesn't work, we have to make sure we depopulate our emergency rooms in dealing with persons 65, with the poor and the elderly, and now, in 1997, the children. And so that is why I think it is interesting. I support the private insurance market, but there are a lot of areas that they don't want to cover folks and this is one of them. I think it is interesting, the CHIP program was created in 1997 for children. But because of various administrations, two administrations have given waivers to certain States to be able to cover adults.

In the bill that the President vetoed allowed those adults who were on there for 1 year so they can find another coverage if they can. But that wasn't a congressional decision. That was an administrative decision. And to call for the removing of adults, the easiest way they could have done it is never allow them to begin with. And it wasn't a congressional decision to do that. My frustration in the 10 years since Congress created the SCHIP program is that I come from a State like Texas where nationwide, we still have 9.4 million children are uninsured.

Unfortunately 100,000 of those children are in my home State of Texas. And I hope our witnesses today will help answer some of the questions. Our State, because of local controls, they erected significant barriers that make it difficult enrolling new children in SCHIP. And it will kick children off of CHIP in 2003, and it resulted in enrollment of about 500,000 children in Texas in 2003 going down to 200,000, 350,000 in 2007.

And while these numbers were dropping, we still have the growth in children who qualify. U.S. citizens data puts the number of uninsured Texas children below 200 percent of Federal poverty at 1.5 million. Of these 1.5 million children, almost 750,000 or 850,000 are eligible for Medicaid or SCHIP. Approximately 3/4 of those 750,000, 850,000, I am sure are eligible but not enrolled. The majority of these children would qualify for Medicaid and the remainder for SCHIP. Let me put it another way, Texas HHS estimates somewhere between 200,000, 300,000 children are eligible for SCHIP but simply not enrolled in my home State.

And Mr. Chairman, I know we have a limit on time and I have lots of information. But I think it is atrocious that the President vetoed the reauthorization of the SCHIP program. And I would hope that when we do reauthorize it, if not this year then next year, we will make sure that we make—that we cover as many children as possible and not allow States who pay less than in case of the third of the SCHIP to be able to send back money and have uninsured children in a State like I have in Texas. And I would like my home State to be placed into the record. And I yield back my time.

Mr. PALLONE. Thank you. The gentlewoman from—oh, Mr. Barton is here. I am sorry. Our ranking member of the full committee, Mr. Barton. I apologize that there is no time posted anywhere. I have a little clock on my left here. But there is nothing else for the rest of you to know what the time is unfortunately.

Mr. BARTON. That is what you get when you get outside our committee room, see.

Mr. GREEN. Mr. Chairman, not to interrupt, but they take our jurisdiction and they don't even give us a clock.

Mr. PALLONE. Or another way of saying it, they don't even give us the time of day.

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

Mr. BARTON. But the blue color is soothing though. It is good to be here, to see Mr. Leach and some of the other former chairmen of this committee. Mr. Gonzalez, a fine Texan. Mr. Oxley. It is good to be here. Well, thank you, Mr. Chairman, for this hearing. I can

go either way on that. I hope we are substantive today. It is obvious that there are lots of children in America that need help, their families need help to provide health insurance and health care for them. Their parents don't make the money or don't work in the situation where their companies provide health insurance. People on my side of the aisle have been asking for over a year to have a hearing that was focused just on SCHIP and just on the children. And today we have that opportunity. I hope it doesn't become political. But so far this year, or last year, almost everything that was involved with SCHIP was political, which is acceptable.

It is understandable in an atmosphere where people get elected by parties and sometimes we have partisanship. Having said that, I know that you and my friends on the Democratic side are totally supportive of the Children's Health Insurance Program. And I can assure you that myself and people on the Republican side of the aisle are just as supportive. Our differences of opinion, when we really get down to the policy, are about which children should be covered. Those of us on the Republican side believe that the program, as it was initiated 10 years ago or 11 years ago now, should be focused on the near low income, those children between 100 and 200 percent of parents whose parent or parent in some cases do not have health insurance in the workplace. There is still work to be done in that targeted area.

Now we know that there are many children below 100 percent of poverty in America. Those children are covered by a program called Medicaid. We also know that there are many children above 200 percent of poverty or 250 percent of poverty whose family may or may not have health insurance. And those children also are deserving of help. But study after study has shown that in the initial original target group of 100 to 200 percent of poverty, there is still many children that could be covered that are not covered.

And what we on the Republican side of the aisle, Mr. Chairman, are saying, let's do the very best job we can to cover those kids first. That is what the President was saying when he put out his proposal that we have to cover 95 percent of those children before you go above 200—I believe 250 percent of poverty. And that is what Mr. Deal and I were saying when we put out our proposal, that again, allowed to go above the 200 percent level which you got and I believe we said 90 percent.

So I hope at some point in the hearing, Mr. Chairman, we focus on that. I also hope that we focus on ways to do better outreach. Mr. Pallone and myself have had off-the-record informal discussions, but I think the Republicans would be very willing to look at ways to encourage States to go out and again find innovative ways to get children enrolled that could be enrolled if their parents just knew how to enroll in the program. I think we could also look at the enrollment period. I know in my State of Texas until recently you had to re-enroll every 6 months. Well, that is silly.

Surely there is a way to get a child enrolled and maintain that child's enrollment over a longer period of time than a 6-month period. So Mr. Chairman, we are very excited that we are finally having a hearing just on SCHIP. I hope that it leads to another hearing and a legislative markup in a bipartisan drafting exercise. It is not impossible even in this political environment to permanently

reauthorize or reauthorize for an extended period of time the SCHIP program. If it devolves into a partisan mud-slinging contest, obviously nothing is going to happen. But if we really work constructively together, I am very confident that this committee and the full committee could come up with a program that both sides of the aisle could support. With that, Mr. Chairman, I yield back.

Mr. PALLONE. Thank you. The gentlewoman from California, Mrs. Capps.

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

Mrs. CAPPS. Thank you, Chairman Pallone, for this hearing and the demonstration of your continued dedication to the hearing and health and well-being of children in this country. I might add yet another of several hearings on children's health and lack thereof. We have also, as I recall, had a very painful markup experience on the State Children's Health Insurance Program, which, of course, is administered through the various States through private vehicles.

I am proud to serve on this subcommittee and to be part of the ongoing effort to ensure access to health care for every child in this country. I always welcome the chance to talk about it and listen to the expert witnesses talk about the importance of providing quality health care to children and families. It is unfortunate, however, I believe that we need to hold a hearing to discuss missed opportunities. Last week we had another chance to provide health insurance coverage for the most vulnerable members of society through the Children's Health Insurance Program. And once again, this opportunity was denied by this President and his allies in Congress.

We worked long and hard to construct a package that would have protected not only 6.6 million children currently enrolled in SCHIP but 4 million additional children who are eligible, clearly eligible and have no access to care. I am extremely disappointed that the misguided opposition of the President and a few of our Republican colleagues derailed this important bipartisan effort despite the overwhelming support of the American people. As a result of this indefensible act of obstruction, millions of low-income children will continue to remain uninsured. You know, their lives don't stand still while we do this. And we can't afford to wait any longer.

In the face of an economic downturn that continues to threaten important American families, we have failed to offer the comfort of knowing that their children's care or health care will be covered. How many more mothers are going to be forced to make this impossible decision between putting food on the table or taking her child to the doctor and paying cash?

As a former school nurse, I have seen firsthand the consequences of that result from this kind of inaction, these kinds of painful choices. Millions of children are not receiving proper primary care or dental care, and they are suffering from preventable illnesses. They will be sent to school sick, interfering with their ability to learn. Our children count on us to protect them. They can't do it by themselves.

So it is our responsibility to give voice to their needs when they can't advocate. It is imperative that we work together to overcome the roadblocks posed by those who do not value the health and safety of our children above all else. So I thank you, and I know that we can do better for our children and I know we are going to learn a great deal from our witnesses. And I thank you all for coming. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from Tennessee, Mrs. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I thank you for the hearing. I want to welcome all of our witnesses. And I am one of those individuals that is a strong supporter of the SCHIP program as it was originally put in place. And we have heard about how successful this program is. That is because of the way that the structure was placed in order for it to be a block grant program, not an entitlement program. We have heard about the need for getting health care to poor children and yes indeed, the children of the working poor are to be the ones that realize the benefits of this program and previously they have.

Now, I do have concerns that we have had a litany of missed opportunities in this committee due to a lack of regular order, if you will. This is only the second hearing that we have done on SCHIP. We never had a hearing on the legislation when it came to committee for unfinished markup. So those are regrettable because we have seen SCHIP on the floor 13 different times, 13 different times on the floor of the House. So I find myself sitting here listening to the opening statements thinking, how many times is the House going to have to vote down the majority's attempts to socialize health care before they realize that working in a bipartisan manner with regular order is what is going to be necessary to produce better legislation that will deal with the original intent of SCHIP and will allow for its continued success? So I think that we have heard time and again, Mr. Chairman, people are not interested in seeing adults on SCHIP. They have concerns about that. There are concerns about loopholes that may have been in the legislation that was presented to us earlier this year that would allow illegal immigrants to access services. They are concerned about spending billions of dollars to substitute private health insurance coverage when, with a government-run health care coverage, they are concerned about focussing on enrolling higher-income kids instead of the low-income uninsured kids.

They are concerned about a flawed tobacco tax scheme to the tune of $70 billion. I am pleased with the efforts that we have had to reject some of this. I do look forward to working with the committee, and working to achieve consensus on SCHIP legislation that will focus on securing health care for the under served children and children of the working poor. And I yield back.

Mr. PALLONE. Thank you. Ms. DeGette.

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

Ms. DEGETTE. Thank you, Mr. Chairman. Well, listening to the comments of my colleague who spoke last, I guess we could both—all of us keep beating a dead horse for this term of Congress and yet we would still have 12 million kids in this country who don't have health insurance. I don't think that is good for those kids and I don't think that is good for our country and I don't think anybody would. The topic of this hearing is Covering Uninsured Kids, Missed Opportunities For Moving Forward.

I will talk about SCHIP in a minute more globally. But there is a couple of missed opportunities that no one has yet mentioned that I am looking forward to hearing our witnesses talk about. The first one is the CMS regulation recently promulgated that serves to limit States' flexibility and undermine our safety net. On August 17, CMS ordered a directive that hinders long-standing State flexibility surrounding SCHIP eligibility levels. Now, all of us agree SCHIP should be used for the children of the working poor, people whose parents can't afford health insurance. What this directive does, though, is it says that States cannot expand coverage levels above 250 percent of the Federal poverty level unless they meet a 90 percent participation rate for below 200 percent of the Federal poverty level. But CMS has not provided any guidance to the States as to how to meet those standards or even what data will be used to calculate a 95 percent compliance rate.

So how can States be expected to meet minimum standards when CMS won't even tell States how the standards are calculated? Now to all of us, we all say well, we want to cover children of the working poor. But in fact, the reason we gave States flexibility in this State Children's Health Insurance Program is because income levels and ability to buy insurance vary widely from State to State.

The most recent expansion of the number of uninsured children in this country is from families who make from 200 percent to 400 percent of poverty. And the reason is because two things have happened: Number one, insurance premiums have skyrocketed; and number two, employers have been covering less and less of those premiums. And so since 2000 the average cost for a family of four for insurance around the country is almost $12,000, and in some parts of the country, like New York and New Jersey, it can be $20,000.

So while it seems ridiculous to give SCHIP to a family making $53,000, if you have a family of four living in New York, making $53,000 and their insurance premium is $20,000, I am going to guarantee you, they are not going to insure their kids. And Mr. Chairman, members of this committee all have the Federal employees health insurance so we don't realize what a burden these bills are on American families.

One last issue. There is another CMS regulation that went into effect this year which limits reimbursement for school-based rehabilitation services and another one limits hospitals' ability to access the Medicaid dish funding by inappropriately changing the definition of public hospitals. In my State alone, Colorado, this is going to cost us $140 million. The impact of this would be devastating

both to individuals and safety net providers. The rule is slated to go into effect the end of May. But if we don't fix it much in advance, Mr. Chairman, what will happen is the hospitals are going to simply start cutting their budgets now. I hope we can do something about this and all of these other problems. And I look forward to the rest of the hearing today.

Mr. PALLONE. Thank you. The gentleman from Pennsylvania, Mr. Murphy.

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

Mr. MURPHY. Thank you, Mr. Chairman, and thank you for continuing to work on issues for our children. Many times the discussion that takes place on Capitol Hill when it comes to issues dealing with health care are really discussions about health insurance. And regardless of what side of the aisle one is on, the discussions are often the same. For example, we talk about health care as being expensive and so we say let's have the Federal Government pay for it. We talk about health care as being expensive, so we say let's have the Federal Government manage it through such things as tax breaks for people to purchase it. We expand Medicare and Medicaid and SCHIP and see those price goes up to the point that 45 percent of our Federal mandatory spending is health care. And yet the expanses continue to rise. Now we understand for families, they need health insurance coverage at one time or another. But we also have to do it as a Congress.

I still have hope that this session of Congress will do something about it, is deal with the spiraling cost of health care. Let me give you a couple of examples. When it comes to infection rates that are picked up at hospitals and clinics, the CDC tells us that there are about 2 million cases a year, 2 million cases that cost $50 billion and 90,000 lives a year. Illnesses people pick up in hospitals when someone doesn't wash their hands or use sterile equipment or use antibiotics before or after surgery. There are tens of billions a year wasted when people have a chronic illness that is difficult to manage. And so amidst the multiple doctors' appointments and medications and treatments and therapies, it is inevitable that patients will feel overwhelmed by that and oftentimes not follow through correctly.

Oddly enough, many times the Federal insurance programs that we have will not pay $5 for a nurse to call a patient and say what is your blood glucose level? Did you pick up your insulin? How is your diet? How is your weight? Won't pay $5 for a nurse to do that but will pay thousands of dollars to have a diabetic's foot amputated when they have complications. Something is wrong there. We also have a system where we realize that people who have chronic illness have a high incidence of depression, twice that of the general population, twice that. And yet if a person has untreated depression and chronic illness, their medical costs double while we struggle to getting a mental health parity bill done in this Congress.

We have electronic medical records issues that we have tried to move forward. The RAND Corporation estimates $162 billion a

year savings would come if we are able to get electronic medical records use nationally and then save employers an additional $150 billion a year in other lost wages and lost work time. I still hold out hope that perhaps in this SCHIP bill or some other vehicle this committee can move through that we have both the passion and compassion to work to save lives and save money. We should be working hard on these issues to make sure that we incorporate all these things, ways of paying for all of these health care reforms and not just insurance.

I am glad we are dealing with SCHIP. It is an important issue. But I still hope that this committee, this subcommittee will add to it or other bills issues that could really save money so we can expand health care to those who need it and not just continue to expand ways to pay for it. I yield back. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I recognize the gentlewoman from Oregon, Ms. Hooley.

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

Ms. HOOLEY. Thank you, Mr. Chair, for holding this hearing today on missed opportunities because of the President's veto of overwhelmingly bipartisan legislation to reauthorize the State Children's Health Insurance Program, SCHIP. It was over 11 years ago when I first came to Congress that I was working with a group of women to provide health insurance for children. A year ago, when I first became a member of this Subcommittee on Health, I had hoped that we would be holding hearings this year, discussing the early successes of a bipartisan SCHIP reauthorization. Although Congress extended SCHIP reauthorization through March 2009, I thank you, Mr. Chair, for continuing to push this important issue to the front of our agenda.

The debate about SCHIP has always been about priorities. I tell my constituents who implore me to continue fighting to expand children's health care that I will not stop working until we realize that goal. And every corner of my district, constituents tell me they do not understand why the President would oppose providing health care to more low-income children. More than 9 million American children, including nearly 116,000 children in Oregon, are currently uninsured. That is simply not acceptable.

Nearly 4 million more children, including over 36,000 Oregon children, would have received health insurance under TERPA. As the economy softens, more parents are likely to lose their jobs and thus, their health insurance. Employers may also drop their coverage for employees as premium costs rise and profits fall. Since 2000, health insurance premiums have skyrocketed by 87 percent and that growth trend seems likely to continue. Family incomes have simply not kept pace with health care inflation.

In these uncertain economic times, we must act for our children's sake now more than ever. Providing health insurance through SCHIP is the most cost effective way to provide health care to our Nation's children. We cannot afford not to act. The lack of access to adequate medical care creates a terrible burden for our children. Uninsurance leads to delayed diagnosis for treatable conditions that may become acute, chronic or life threatening.

As a former schoolteacher, I can also say from experience that poor health leads to poor performance in schools. No society can expect to achieve and maintain its prosperity while compromising on the well-being of their children. I would also like to briefly mention my concern with some of the regulatory action taken last year by the administration. For example, the Centers for Medicare & Medicaid Services, CMS, August 17 directive placing unreasonable restrictions on States in their efforts to expand coverage to more low-income children will likely force States to drop thousands of currently covered children. Regulations creating cost limits for public providers and reduction in payments for graduate medical education are two more of CMS regulations that will have a harmful effect on our children.

The latter two regulations are particularly important for Oregon's Health and Science University, the location for much of the best pediatric care in Oregon. Legislation and regulatory roadblocks set up by this administration last year will make it more difficult for children to receive health care. I hope we can begin to overcome those hurdles this year and reach sensible compromises that meets our children's health care needs. Again, thank you, Mr. Chairman for holding this hearing.

Mr. PALLONE. Thank you. I will recognize the gentleman from Arizona, Mr. Shadegg.

OPENING STATEMENT OF HON. JOHN B. SHADEGG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SHADEGG. Thank you, Mr. Chairman, and thank you for holding this hearing. I think this is a critically important issue and I am glad we are discussing it. I want to make something very clear, I have introduced a refundable tax credit to provide cash to every single child that would be eligible for SCHIP funding every year since I have been here in Congress. I believe that it is a shame that there are so many children in America without insurance and I believe that it is a shame that there are so many Americans without insurance and without health care coverage. What I think this debate needs to be about, however, is how we go about achieving the end.

I personally believe that America made the decision as a Nation a number of years ago that nobody should go without health care, not the least of us in our society should have to go without health care, and certainly our children shouldn't. But I think the fundamental question that we need to ask here is how do we go about improving health care? Let me ask you some questions. Are there problems with health care in America and with the access of children to health care in America because we as individuals have too much control over our health care and our health care decisions and who our doctor is? Or are there problems because we as individuals have too little control? Is it better off to have third parties, like our employers or our insurance company or the government making health care decisions for us? Or would we be better off if we made health care decisions? Let me ask kind of a fundamental question, would the cost of health care go down if we gave more control of health care and health care decisions to the government, to our employers, to our insurance companies? Or would the cost

of health care go down if we had, as individuals, more control over our health care?

Would, for example, the quality of health care in America go up if we gave more control to our employers or to our insurance companies or to the government? Or would, in fact, the quality of health care in America go up if we could hire and fire our insurance company, if we as individuals could hire and fire our health insurance plan, if we could hold our health insurance plan accountable by firing it when it did a lousy job rather than having to go and complain to our employer, I suggest we get both lower cost and higher quality. If in fact we could decide who we wanted to provide our insurance because the government helped us get money to go buy our own health plan and we can hold accountable, wouldn't that both drive down cost and up quality? And I would suggest it would.

And that is why I believe what we need to be doing in this country to insure the children of America is to provide a refundable tax credit to every single family in America. If you don't make enough money to pay income taxes, we will give you cash, provided you go out and buy yourself a health insurance plan. It is your health insurance plan. You can pick the plan that has the doctors you want. If you don't like the plan, you can fire the plan. It is not your employer's health insurance plan. It is not the government's plan. And the reason that I don't favor SCHIP is because I think giving those basic health care decisions, who my health insurer is, whether it is responsive to me or not, which doctors it hires, giving those decisions away to the government, as SCHIP does, simply divorces the consumer of the good from the provider of the good and when you divorce the consumer of the good health care from the provider of the good, you get no accountability.

So costs go up as they have in America when we have had more and more third-party pay, and quality goes down as we have had in America, as we have had more and more third-party control over our health decisions. So what is the answer? Why isn't the answer to say to every American, you get a tax credit. If you are too poor to pay income taxes, you get money from the government. If you are already paying income taxes, you reduce the amount you send to the government, and you go take that tax credit and you buy a health insurance plan. Whether you are poor or whether you are rich, it is your money. You get to hire the plan, not your employer. You get to fire the plan, not your employer. The government doesn't hire the plan. The government doesn't fire the plan. The government doesn't let the plan pick the doctors. You do. Wouldn't giving people control over their own health care improve quality and lower cost? And isn't that a much better system than expanding even further the third party control we already have in this country where we have divorced the consumer from the provider and therefore you can't fire your doctor, you can't fire your health care plan and you can't demand higher quality or lower cost? I thank the gentleman and yield back my time.

Mr. PALLONE. Thank you. The gentleman from Texas, Mr. Burgess.

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

Mr. BURGESS. Thank you, Mr. Chairman. I too am glad we are having this hearing today early in the year. Probably some of the most interesting time i have spent during my short tenure in congress was in the unintended SCHIP negotiations that worked their way through this Congress last fall and worked really on conference committee because we never appointed conferees from the House and the Senate. It was just people who showed up when we talked health care oftentimes well into the night. The consequence of that was the 18-month extension that we passed last December, and I am grateful that we were able to do that. No child in this country lost health insurance because Congress was not able to do its work in a timely fashion. Now we are tasked with getting this job done. We have given ourselves an extension. It is incumbent on us to utilize that time wisely. But a lot of the issues that have come up this morning, and we do need to talk about how we are going to maintain a network of providers, the workforce the doctors, the nurses, the nurse practitioners, the pediatric specialists to ensure that children who are covered whether it be by partial insurance or by SCHIP will have timely access to medical professionals.

How do we keep from removing children from private insurance when parents have the means to pay for their children's coverage? And is that even important? Well I think that it is. Doing an informal survey back home in my district from pediatricians and talking to them about—even as bad as our insurance companies are, we all know they are terrible. But the average of the four largest third party payers in my district in north Texas, CPT code 99213, office visit low level of complexity, the four largest insurers compensate at an average price of $71 for that visit of 99213. Under the State Children's Health Insurance Program, State of Texas 99213 reimburses at a rate of $37.64. So a little more than half of what the four largest insurers, as bad as they are, a little less than half of what the four largest insurers compensate. 99214, office visit established medium complex. The bad insurance companies, as bad as they are, reimbursed at a rate of $109. 99214, the State Children's Health Insurance Program, State of Texas Dallas/Fort Worth area $52.86.

Again, we are talking a little less than half. What is the effect of our pediatric workforce if we move children from commercial insurance, as bad as it is, and I am not going to argue that commercial insurance is good or companies behave properly. But as bad as it is, what is the effect if we remove children from commercial insurance? Now when we had multiple hearings during the negotiations, we had figures from the Congressional Budget Office, and the figure of 10 million children was always brought up. Well, 6 million children are already on SCHIP. There are 800,000 kids that could be on SCHIP today but they are hard to find. It is hard work. It is hard for the States to go find them.

And guess what, if the States do the work and go find them, they pick up 1,200 children who could be on Medicaid. So there are children that could be covered under today's rules under today's expansion without any expansion of the program. And in fact, according

to the CBO's own figures, to get that 10 million figure, 2 million children will have to be pulled off of private health insurance. Is that a problem?

Again, I submit the notations that I got from a survey of pediatricians back in my district back in north Texas. We are putting their reimbursement rates by about half by taking children from SCHIP, from commercial insurance and putting them on SCHIP. That may not be a problem if you are an academic pediatrician, it may not be a problem if you practice in a Federally qualified health center. But if you are out there in the neighborhood doing the work in my district, it will have an extremely deleterious effect on the pediatric workforce.

Mr. PALLONE. I would just want to notify the gentleman he is over a minute. If you could wrap it up.

Mr. BURGESS. Where is our clock, Mr. Chairman?

Mr. PALLONE. Unfortunately we don't have one and people have been going over.

Mr. BURGESS. Reserving the right to object, I think I have made my point. And I will yield back my time. But I thank you for holding the hearing. I think it is important and I look forward to the testimony of our witnesses. And I think it is incumbent on all of us to work hard. We have to put the partisanship aside and get the work done for the American people. And that is what I look forward to doing today. And I will yield back.

Mr. PALLONE. Thank you. I have one but no one else does. So we will try to bear with it.

Let me ask unanimous consent that a statement of our full committee Chairman, Mr. Dingell, be entered into the record. Without objection, so ordered.

[The prepared statement of Mr. Dingell follows:]

STATEMENT OF HON. JOHN D. DINGELL

Thank you for holding this hearing. I am pleased that there are two distinguished panels of witnesses before us today to discuss missed opportunities for providing health care to America's children. Certainly the most obvious ones are the Administration's two vetoes of our efforts to reauthorize and expand the Children's Health Insurance Program.

Not once, but twice this Administration rejected legislation that would reauthorize the Children's Health Insurance Program for the next five years and add sufficient funding to protect existing coverage and improve access for millions of additional low income children.

There are many States without enough money to cover their children under the existing program. The bills passed by Congress would have averted these likely funding' shortfalls, expected to affect some 42 States by 2012.

Last year's CHIP reauthorization also made great strides in the area of children's dental and mental health, as well as in quality measurement and improvement. With the President's veto we lost this as well.

Most importantly, the bill went right to the heart of finding and enrolling uninsured but eligible children through financial incentives for States and new tools, such as express lane eligibility, to streamline enrollment paperwork.

It is a sad legacy indeed that this Administration leaves behind on children's health.

If preventing health coverage for 10 million additional children isn't bad enough, the Administration has proposed to cut more than $12 billion from the Medicaid program over the next 5 years.

We can also thank the Bush Administration for the now-infamous "August 17 guidance," which is being used to derail State plans to cover uninsured children. With little regard for the well-being of poor children in America, the Administration

would prohibit a child's enrollment in CHIP for a full year after the date the child's parent loses employer-sponsored coverage.

That is a full year of immunizations, well-child visits, ear aches, strep throat, dental care, and other needs that will go untreated. This is simply bad and, frankly, mean-spirited public policy.

Our Nation has record numbers of Americans who are uninsured and, in addition, millions more who are under-insured. Nearly 1 in 4 families under the age of 65 will spend more than 10 percent of their pre-tax income on healthcare costs in 2008. With the pending recession, programs such as CHIP and Medicaid take on heightened importance. As we all know, health coverage is often an early casualty of a parent who is laid off, and children should not be the ones who suffer as a result.

States need the ability to keep these vital programs strong—especially in times of economic downturn—and we should be seeking ways in addition to CHIP that provide State assistance in the form of increased Federal funding of Medicaid. States also need the ability to ramp up these programs to help those working Americans whose incomes are not keeping pace with health costs. We should not have any more missed opportunities for this country or its children.

I thank today's witnesses for joining us, and in particular Ms. Taylor-Chester for sharing her very compelling story of her son's experience with CHIP.

Mr. PALLONE. And now that concludes our opening statements by the Members of Congress. I will now turn to our witnesses. If the members of the first panel could come up to the table there, I would appreciate it.

I understand there are other Members on both sides that would like to submit opening statements for the record. So without objection, I will ask unanimous consent that those all be entered into the record. And let the record be open for those opening statements. Without objection, so ordered.

First of all, welcome. Let me introduce the first panel and I will go from my left. We have Cynthia Mann, who is research professor and executive director at the Center For Children and Families at Georgetown University Health Policy Institute. And next to her is Mr. Chris Peterson who is a specialist in health care financing, domestic social policy division of the Congressional Research Service. And then next to him is Ms. Carolyn Chester who is a nursing assistant. And she is speaking on behalf of Service Employees International Union. And then we have Dr. Louis Rossiter who is a research professor and director of the Schroeder Center For Health Care Policy at the College of William and Mary. And then the last on my right is Mr. Bruce Lesley who is President of First Focus based here in Alexandria, Virginia.

Mr. PALLONE. We are going to have 5-minute opening statements from each of you. They will be made part of the record. And again, you don't have a clock. So I may just have to tell you when the 5 minutes are up. Each witness may, in the discretion of the committee, submit additional brief and pertinent statements for inclusion in the record. I am going to try to stick to the 5 minutes and give you some notice when the 5 minutes is over. We will start with Ms. Mann. I recognize her at this point. Thank you for being here.

STATEMENT OF CYNTHIA MANN, RESEARCH PROFESSOR AND EXECUTIVE DIRECTOR, CENTER FOR CHILDREN AND FAMILIES, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

Ms. MANN. Thank you. Good morning, Chairman Pallone, and Representatives Barton, Deal and other members of the subcommittee. I am Cindy Mann, research professor at Georgetown University and director of the Center For Children and Families. I am pleased to be with you today to talk about the topic of children's coverage and missed opportunities to move that coverage forward. During my remarks, I will refer to some of the figures that were included in my testimony beginning on page 16. When 2007 began, all signs were that CHIP reauthorization would go forward and that it would be accomplished in a manner that would actually legally strengthen children's coverage both in the CHIP program and in the Medicaid program. But instead, we had a year of missed opportunities in terms of children's coverage, and in fact, as a result of the directive issued by the Centers for Medicare & Medicaid service, the August 17 directive that some of you have referenced.

Federal policy governing children's coverage has actually moved backward over this past year. It is particularly troubling that this has happened because despite a decade of progress in terms of lowering the rate of uninsured children. We have begun to see that number rise in the last 2 years under census data. And it is growing again at a rate of about 2,000 children a day. The weakening economy will inevitably push these numbers upward unless further action is taken by Congress to put the Nation back on the right track.

There were many hopeful signs as we began the year 2007. The first we had a program with a 10-year track record. It was a much studied program. And we know from the studies from the State experiences that it worked. In fact, it exceeded expectations. It was regarded widely as resoundingly successful. 6.7 million children were enrolled in CHIP as we began the year. And millions more had been brought in the Medicaid program because of the focus on covering children had prompted States around the country to ease up their Medicaid enrollment processes and make it easier for families with eligible children to enroll their children into coverage. Not only were children gaining coverage, but the studies also showed that the children with coverage had greater access to care, access that was comparable to counterparts with private coverage.

As a result of CHIP and Medicaid over these last 10 years, the uninsured rate among low-income children, children below 200 percent of the poverty line dropped by a third. That is an astounding development, particularly when you think about that during this period of time we had rising health care costs, declining employer-based coverage for both children and adults, and the number of adults without insurance rising sharply.

So as the debate over CHIP began, we had a program with a proven track record and where the results had actually exceeded expectations. We also had very willing partners at the State level. You know, we will hear from two of them today, two CHIP directors. During the years 2006 and 2007, we began to see a resurgent, a new wave of activity going on around the country as States began

to reinvest their energies, reinvest their resources into coverage for children. So whatever changes Congress was about to make in 2007 through CHIP reauthorization, you had a ready and willing audience at the State level. States were eager to move coverage forward and you will see in my testimony the States that did so were quite diverse. They were Oklahoma they were Indiana they were Washington, Texas, Alaska, Pennsylvania, States in all regions of the country and with leadership on both sides of the political aisle, moved coverage forward.

In this environment, Congress also moved forward. You passed a very strong bill now known as CHIPRA, the Children's Health Insurance Program Reauthorization Act of 2007. It didn't have all of the provisions that was in the House reauthorization, the CHAMP bill that would have moved coverage forward for children. But it was a very strong bill. And according to the Congressional Budget Office, it would have brought coverage to an additional 4 million children who otherwise didn't have access to affordable health insurance coverage.

It is important when you think about the missed opportunities and where we are today to think about what CHIPRA would have done. It would have strengthened coverage in three ways. Put CHIP on secure financial footing over the next period of time, give States new resources, new tools, new options to make sure that the lowest-income children were covered, and it also would have strengthened the benefit package and adopt new quality initiatives for children. CHIP would gain the support of the large majorities of the members of Congress, but of course not enough to override the veto. And as a result, the opportunities presented by that legislation were lost.

Let me now focus on two of the consequences of those missed opportunities. One is the weakening economy. As I mentioned before, we began to see the uninsured rate among children pick up.

Mr. PALLONE. Ms. Mann, you are over 5 minutes. So if you could try to wrap it up. I apologize because I know there is no clock there.

Ms. MANN. That is fine. I will try to be very brief. The lack of CHIP moving forward is obviously more of a problem now because of the weakening economy where we will see more children be uninsured. Let me just finally touch on the August 17 directive which remains in place. I think there is a sense that by extending CHIP through the March 2009, you left the status quo in place, but in fact, we have a new policy that has actually thwarted States' efforts to move forward. We have already had six States affected. We will have 23 States affected by August 2008. They are stopped from making the decisions that they have decided were best for the children in their State which is to cover children with no affordable health care options. Thank you, Mr. Chairman.

[The prepared statement of Ms. Mann follows:]

"Covering Uninsured Kids: Missed Opportunities for Moving Forward"

Testimony Submitted to the

Subcommittee on Health

Committee on Energy and Commerce

By

Cindy Mann, JD

Research Professor and Executive Director

Center for Children and Families

Georgetown University Health Policy Institute

January 29, 2008

Good morning Chairmen Dingell and Pallone, Representatives Barton and Deal and Distinguished members of the Subcommittee. Thank you for the invitation to participate in this hearing on missed opportunities to provide children with health coverage. I am Cindy Mann, a Research Professor at Georgetown University and the Executive Director of the Center for Children and Families, a research and policy center at Georgetown University's Health Policy Institute. Soon after enactment of SCHIP in 1997, I served as the director of the group within the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) that oversaw the implementation of SCHIP at the federal level. Since then, first at the Kaiser Commission on Medicaid and the Uninsured and for the past five years at Georgetown University, I have worked with federal and state policymakers on SCHIP policy and implementation issues and have analyzed how federal and state policies and procedures have affected children's coverage. In my testimony I will review the policy and political environment as Congress began to consider SCHIP reauthorization, summarize the opportunities for coverage advancement that the SCHIP reauthorization legislation would have offered, and describe some of the ways that recent developments are affecting children's coverage.

2007 was to be the year of SCHIP reauthorization. When the year began, all indications were that reauthorization not only would be accomplished but would be done in a manner that would further strengthen the program and efforts to cover the nation's children. 2007, however, turned into a year of missed opportunities, in terms of moving forward on children's coverage. In fact, it was a year when federal policy and support for children's coverage actually moved backward due to unilateral and far-reaching changes in program

rules that have been imposed by the federal agency that administers SCHIP and Medicaid (the Centers for Medicare and Medicaid Services, CMS). With an estimated 2,000 additional children becoming uninsured in America each day and a weakening economy that is certain to push that number upward in the months ahead, the lost opportunities and the constraining new CMS policies will take a major toll on the health of our nation's children. Ironically, this backward movement comes at a time when support for children's coverage improvements is extraordinarily strong. Recent federal developments are markedly out of sync with the direction that the public, state policymakers, and the majority of the members of Congress believe the nation should be taking.

SCHIP's Track Record

As Congress began considering SCHIP reauthorization, SCHIP had been operating for ten years and was broadly viewed as a resounding success. Within one year of enactment, every state had adopted SCHIP and within a few years states were aggressively enrolling children, most of whom, according to the Congressionally mandated evaluation of SCHIP, would have been uninsured in the absence of SCHIP. By 2006, 6.7 million children were covered in SCHIP and millions more children had gained coverage through Medicaid. Indeed one of SCHIP's most significant achievements was that by focusing the nation's attention on children's coverage, SCHIP prompted states and localities to simplify application and renewal procedures in their Medicaid programs and conduct outreach for both programs. About half of the coverage gains for children

that were achieved since SCHIP was enacted were due to enrollment gains in Medicaid, allowing the lowest income children to obtain much-needed coverage.

As a result of SCHIP and Medicaid, the uninsured rate among children declined and more children had access to the health care they needed. Between 1996 and 2006, the uninsured rate among low-income children dropped by more than one-third (Figure 1). This is a stunning achievement especially when you consider that during this period health care costs rose steadily, rates of employer-based coverage declined for both children and adults, and the number of uninsured adults climbed sharply. State and national studies consistently showed that children with SCHIP or Medicaid coverage had access to care at levels similar to their privately insured counterparts and well above the levels for uninsured children.

It is rare that a program exceeds expectations, particularly in the context of health reform where progress often seems illusive. SCHIP's success indeed exceeded expectations. But the opportunity presented by SCHIP reauthorization was not merely to maintain this level of success. As Congress began its work on SCHIP reauthorization, more than nine million children still lacked health insurance and the number of children without insurance was growing for the first time in a decade.

States Moving Forward to Cover More Children

As 2007 began, many states were prepared to meet the challenge by moving forward to cover more children. In the year leading up to SCHIP reauthorization, a new wave of activity around children's coverage had begun to sweep the country to an extent not seen

since SCHIP was first enacted. Triggered by action taken in Illinois and Massachusetts, between January 2006 and mid-2007, more than half the states adopted legislation to improve children's coverage to a significant degree. More states followed this course over the year (Figure 2).

Most of these state measures included provisions that focused on increasing participation among children who were already eligible for SCHIP and Medicaid but uninsured. Many states also expanded the reach of their SCHIP programs by raising income eligibility levels. Just as notable as the number of states that were moving children's coverage forward is the diversity among these states. Children's coverage improvements were adopted in all regions of the country, in both urban and rural areas, and in states with leadership on both sides of the political aisle.

Adding to this backdrop as Congress embarked on SCHIP reauthorization was the strong public support for children's coverage and SCHIP. Polls conducted in late 2006 and throughout 2007 consistently showed that large majorities of voters supported renewing SCHIP and deepening the federal government's investment in children's coverage. Editorials throughout the nation echoed this support throughout the year; during 2007, over 400 editorials in papers across the nation called upon Congress to adopt a strong SCHIP reauthorization bill.

CHIPRA

Congress did just that in the Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA). While some important provisions that were originally in the House's SCHIP reauthorization bill (the Children's Health and Medicare Program Improvement Act or "CHAMP") were not included in CHIPRA, most notably the elimination of the bar on covering legal immigrant children and pregnant women in the country for less than five years, CHIPRA would have resulted in four million uninsured children gaining coverage. It would have strengthened children's coverage in three key ways.

First, CHIPRA would have put SCHIP on secure financial footing. SCHIP funding levels had been set in 1997 before anyone knew what the take up would be among states and families. The amount of funding available in 2007 was only modestly above the level allocated for in 1998 (with the infamous "SCHIP dip" in the intervening years) notwithstanding sharply rising health care costs. Adding to the problem was that the formula adopted in the original SCHIP law to distribute available funds among states had serious flaws. The mismatch between the funding states had available for coverage and their need for funding had been growing over the decade (Figure 3). States managed by relying on unspent funds from prior years (i.e., carryover and redistributed funds), but those funds were drying up. Last year, the Congressional Research Service projected that if 2007 funding levels were maintained in 2008, 19 states would have exhausted all of their available federal SCHIP funds in 2008.

CHIPRA addressed these funding issues by increasing the annual national allotments for SCHIP by $36.4 billion over the five-year reauthorization period. It also relied primarily on actual and projected state expenditures (subject to the overall national cap on funding) rather than a data-driven formula to distribute funds among the states. New mechanisms were designed to promote stability and avoid the need for Congress to adopt legislation to redistribute dollars and fill SCHIP funding shortfalls in the future.

The second major area of improvement in children's coverage in CHIPRA was to provide states with new funding and tools to more effectively reach and enroll the lowest income uninsured children – those who are already eligible for SCHIP or Medicaid but unenrolled. About seven out of every ten uninsured children are eligible for SCHIP or Medicaid but not enrolled (Figure 4). CHIPRA focused on these children in a number of ways, including creating new performance-based payments to help defray the cost of coverage for states that were successful in boosting enrollment among children eligible for Medicaid; offering states a new option for documenting citizenship to address the extensive loss of Medicaid coverage among citizen children that had occurred following the implementation of the Deficit Reduction Act of 2005; and providing states with new tools, such as "express lane," to reach eligible children.

As a result of these and related measures, 84 percent of the nearly four million uninsured children the Congressional Budget Office projected would gain coverage as a result of the first CHIPRA bill were children who were eligible for SCHIP or Medicaid under current program rules. Further changes that were adopted in the second version of

CHIPRA deepened the focus on the lowest income children. Nearly nine out of every ten uninsured children (87 percent) who would have gained coverage under the second CHIPRA bill would have been uninsured children already eligible for SCHIP or Medicaid (Figure 5). CHIPRA's focus on covering the lowest income children already eligible for SCHIP and Medicaid was a major reason why the legislation had relatively low crowd out rates – rates that CBO director Peter Orzag has described as about as efficient as possible for any health reform plan that achieves this extent of new coverage without new mandates.

The third broad area of improvement for children's coverage that would have been accomplished had CHIPRA been enacted into law relates to the scope of benefits and the quality of care that children would have received. CHIPRA included improvements in SCHIP benefits, such as dental care, clarifications of Medicaid EPSDT provisions, and a new quality care initiative for children covered through either public or private insurance.

Given these important areas of improvement, CHIPRA enjoyed strong bipartisan support in the House as well as in the Senate. Not quite enough, however, to override a Presidential veto.

Consequences for Children's Coverage

Where do the President's vetoes and the inability to override the vetoes leave the nation's efforts to cover children? Other witnesses testifying this morning will describe some of the consequences for states, programs and children. I will focus on two separate but

closely related consequences that in the absence of further Congressional action are certain to push the number of uninsured children upward to a significant degree.

CHIPRA would have helped states cover more children, efforts that are needed even more now given the worsening economy.

The most recent Census Bureau data released in August 2007 showed that the percent of children without health insurance climbed in 2006 following a smaller increase in 2005. The Center for Children and Families calculated that if children continued to lose coverage in 2007 at the same rate they lost coverage in 2006, 2,000 children a day would join the ranks of the uninsured. CHIPRA would have helped states not only stem the tide of the growing number of uninsured children but make significant additional progress narrowing the uninsurance gap among children.

Given the economic downturn, the number of uninsured children will likely grow at an even higher rate, and public programs will be under added pressure to offset private coverage declines. Recent research by the Joint Economic Committee confirms earlier studies that find that a weakened economy – with fewer parents employed in full-time full-year jobs, with employers and employees less able to absorb rising health care premium costs, with job market shifts that result in a larger share of workers in jobs that do not offer affordable coverage – results in private insurance coverage declines, greater pressure on publicly-funded public programs, and a rise in the number of uninsured. An

analysis released by the Kaiser Family Foundation in 2002, for example, found that for every 100 people losing their jobs, 85 become uninsured.

The stable and predictable levels of funding for SCHIP that would have been provided through CHIPRA, the new tools that CHIPRA offered states to help them enroll and retain eligible children, and the performance-based payments that would have helped states that cover more Medicaid-eligible children defray some of the cost that coverage (for which states receive a lower federal matching rate, relative to SCHIP) would have provided states with help addressing the rising number of uninsured children caused by the downturn. The lack of a strong reauthorization of SCHIP would have hurt efforts to lower the number of uninsured children in the best of times. In a downturn, the missed opportunity will be even more acute.

The August 17th directive remains in place, stopping states from covering uninsured children who lack other affordable options.

In December 2007, Congress adopted temporary funding for SCHIP through March 2009, perhaps assuming that at least the status quo would be maintained pending action on SCHIP reauthorization. Status quo, however, has not been achieved because of a major new policy unilaterally imposed on states by CMS.

On August 17, 2007, without any change in law, CMS issued a new directive that radically altered longstanding state flexibility to set SCHIP and Medicaid income

eligibility levels for children. The directive effectively imposes a gross income cap equal to 250 percent of the federal poverty level (FPL), the equivalent of $42,925 a year for a family of three. The cap applies to states that have long covered children in this income range as well as to states that had enacted laws to cover these children in the future.

In the short period since the CMS directive has been in effect, tens of thousands of uninsured children have already lost out on coverage that their state had determined they needed. Many more will lose coverage or the opportunity of coverage, as more states are required to comply with the directive. According to a recent report we prepared, to date, children's coverage has been stopped, restricted, or delayed as a result of the directive in Indiana, Louisiana, New York, Oklahoma, and Ohio. Two other states – Wisconsin and Illinois – are state-funding their expansions for the time being as a result of the change in federal policy. Nearly half of all states will be affected by August 2008 (Figure 6).

The CMS directive is inconsistent both with longstanding SCHIP policy and the new provisions that Congress was prepared to adopt as part of CHIPRA. Contrary to statements often made during the CHIPRA debate, SCHIP has always permitted states the discretion to set their income eligibility levels, subject to available state and federal funding. This flexibility has allowed states to address differences in costs of living, health care costs, and state income levels (Figure 7). CHIPRA did not expand eligibility under SCHIP; state flexibility to set eligibility levels has been part of the program since 1997. CHIPRA – particularly the second CHIPRA bill – would have constrained this longstanding flexibility, but in ways significantly different than the August 17th directive.

The second CHIPRA bill would have stopped states from using SCHIP funds to expand coverage to children with incomes above 300 percent of the FPL (allowing for some deductions, such as for child care expenses), and it would have replaced the directive with new studies and standards aimed at increasing coverage among the lowest income children.

States have been taking steps to increase their SCHIP eligibility levels because the cost of private health insurance has been growing. SCHIP was designed to cover children whose family incomes were above existing Medicaid eligibility levels but too low to afford private health insurance. According to the 2007 Kaiser Family Foundation/HRET Survey of Employer Health Benefits, the average employer-sponsored family plan costs $12,106 a year in premiums (not considering deductibles, co-payments, and uncovered medical care). The average employee share is $3,281, the equivalent of six percent of the annual income for a family with the median income and more than one month's income for a family at 250 percent of the FPL. For families without an employer contribution, premiums alone would consume fully one-fifth of income for families with median incomes or 28 percent of income for families at 250 percent of the FPL. (According to the Current Population Survey, in 2006 the median income for a family with children under 18 was $58,865; in 2007, 250 percent of the FPL was $42,925 for a family of three.)

Figure 8 illustrates the growing affordability gap. A SCHIP income eligibility level set at 200 percent of the FPL in 1997 grew in real dollar terms by 24 percent by 2005. (The

FPL is adjusted annually to account for overall increases in the cost of living.) Over that same period, private insurance premium costs for families grew by 102 percent. It is not surprising, therefore, that nearly half of the additional 710,000 children who became uninsured between 2005 and 2006 were in families with more moderate incomes. Many families in this income range have access to affordable coverage for their children through their jobs, but increasingly some do not.

Over the years, and particularly over the past two years, states have addressed this growing affordability gap by increasing their SCHIP eligibility levels. According to a survey by the Center on Budget and Policy Priorities in a report just released by the Kaiser Commission on Medicaid and the Uninsured, 26 states (including the District of Columbia) either now cover or have enacted legislation to cover children with incomes above 200 percent of the FPL (Figure 9). Twenty-three states cover or have enacted legislation to cover children with incomes above 250 percent of the FPL. As the new Kaiser Commission report notes, 2007 was a "pivotal year" in terms of eligibility increases for children, but the August 17, 2007 directive is impeding state efforts to cover the children made eligible through the newly authorized expansions. This new impediment to state coverage efforts on behalf of children has taken place without Congressional authorization.

Conclusion

By virtually every measure, SCHIP has been a remarkably successful program, partnering with Medicaid to cover children who otherwise would not have had insurance.

Over the years states have built on this success and most recently many are responding to the difficulties a growing number of families are experiencing trying to insure their children. The program, however, remains focused on lower income children. More than 90 percent of all children covered in SCHIP in 2006 had incomes below 200 percent of the FPL and 99.95 percent had incomes below 300 percent of the FPL (Figure 10).

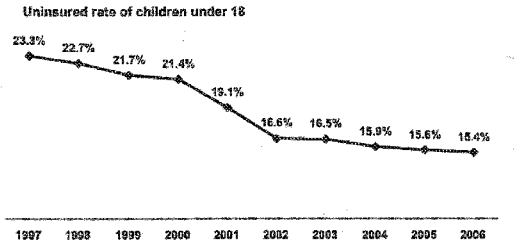
CHIPRA would have supported these efforts by further strengthening SCHIP and Medicaid, consistent with the public's desire that children have health insurance that provides access to the health care services they need. Over the year, as the SCHIP debate increasingly became a public debate, the strength of this public support became even more apparent. Congress approved CHIPRA with strong bipartisan majorities, although without sufficient support in the House of Representative to override the President's vetoes. As a result, the opportunity to put the program on secure financial footing, to cover an additional four million uninsured children – overwhelmingly the lowest income uninsured children who are already eligible for SCHIP and Medicaid – and to improve benefits and the quality of children's health care received were lost, at least for the time being. This is particularly troubling given the weakening economy and the pressures the economic downturn could place on coverage. Legislation adopted by Congress in December extends SCHIP funding through March 2009, but the CMS's August 17, 2007 directive remains in place and is already taking a considerable toll on state efforts to cover children.

Given continued strong support for SCHIP among the public and policymakers, the

question is not whether SCHIP will be reauthorized but when and by whom, and how many children will lose the opportunity for coverage before action is taken.

Figure 1

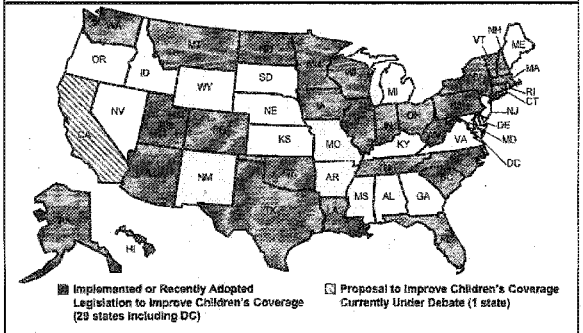
Trends in the Uninsured Rate of Low-Income Children, 1997 - 2006



Source: Analysis conducted for the Center for Children and Families by the Johns Hopkins University School of Public Health of the National Health Interview Survey.

Figure 2

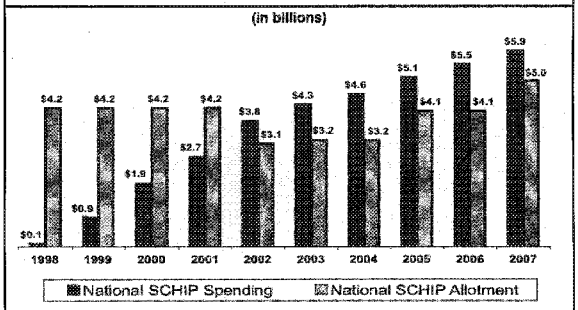
States That Have Taken Significant Action to Improve Children's Coverage (2006-2007)



Source: As of January 1, 2008 based on a review by the Center for Children and Families of state initiatives in 2006 and 2007.

Figure 3

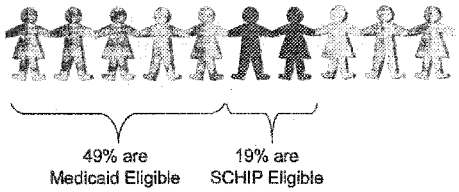
The Mismatch Between SCHIP Allotments and SCHIP Spending Has Grown Over Time



Source: K. Allen, "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization," Government Accountability Office (March 1, 2007); 2007 spending updated by the Center for Children and Families based on final 2007 spending data provided by the Centers for Medicare and Medicaid Services.

Figure 4

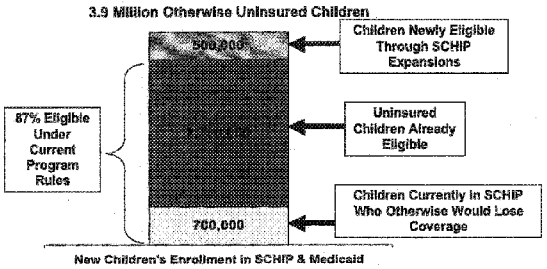
7 out of 10 Uninsured Children are Eligible But Unenrolled in Medicaid/SCHIP



Source: L.Dubay, J. Guyer, C. Mann & M. Odeh, "Medicaid At The Ten-Year Anniversary Of SCHIP: Looking Back And Moving Forward," *Health Affairs*, 26:370-381 (2007). Data are from 2005 Current Population Survey using July 2004 state eligibility rules.

Figure 5

CHIPRA 2 Was Projected to Cover Nearly 4 Million Otherwise Uninsured Children

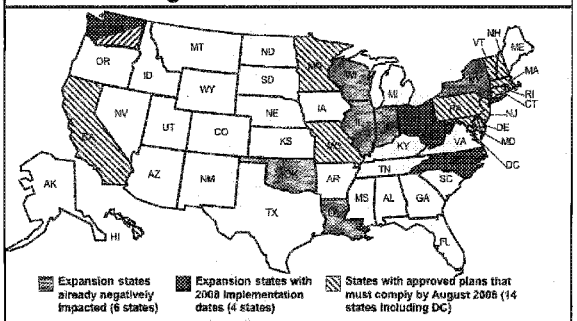


Note: Average monthly enrollment for fiscal year 2012; SCHIP & Medicaid would cover 5.8 million children when reductions in other coverage are included; numbers may not sum due to rounding.

Source: Congressional Budget Office estimate of changes in SCHIP and Medicaid enrollment of children under the Children's Health Insurance Program Reauthorization Act of 2007 (October 24, 2007).

Figure 6

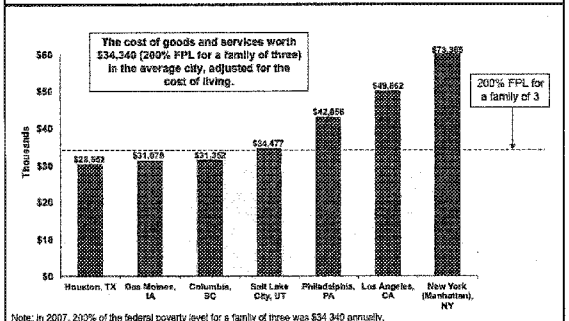
23 States Are Affected by the "August 17th" CMS Directive



Source: Center for Children and Families, "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children," (December 2007)

Figure 7

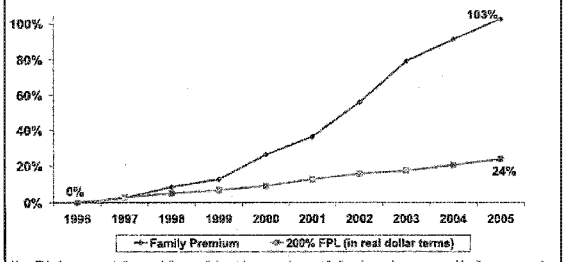
The Cost of Living Varies Widely Across the United States



Note: In 2007, 200% of the federal poverty level for a family of three was $34,340 annually.
Source: Center for Children and Families analysis of ACCRA cost of living index for the first quarter of 2007.

Figure 8

The Growing Affordability Gap Between 200% FPL and the Cost of Private Coverage

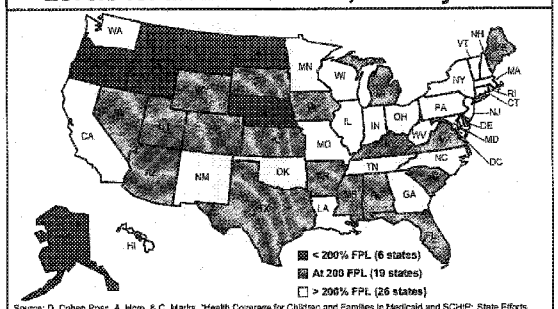


Note: This data represents the cumulative growth in employee premium contributions for employer-sponsored family coverage and the federal poverty level for a family of three, compared to the cumulative growth in the federal poverty level adjusted each year by the federal government.

Source: Agency for Healthcare Research and Quality estimates of 1996-2005 Medical Expenditure Panel Survey Insurance Component Tables, generated using MEPSnetIC (August 21, 2007); and CCF analysis of 1996-2005 Federal Poverty Guidelines.

Figure 9

State-authorized Children's Income Eligibility Levels for Medicaid/SCHIP, January 2008



Source: D. Cohen Ross, A. Horn, & C. Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Kaiser Commission on Medicaid and the Uninsured (January 2008).
Note: These levels include states that have enacted expansions but have not yet implemented them.

Figure 10

Nearly All Children Enrolled in SCHIP Have Family Incomes Below 300% FPL

Income Range	Percent of SCHIP Enrollees
Above 350% FPL	None
301-350% FPL	0.05%
201-300% FPL	8.65%
100-200% FPL	91.30%
Total SCHIP Children = 6.7 Million	

99.95% Below 300% FPL

Note: Medicaid, not SCHIP, covers children under 100% FPL.

Source: Center for Children and Families analysis based on FY06 SCHIP enrollment data from C. Peterson & E. Herz, "Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees," Congressional Research Service (March 13, 2007) and data provided by the New Jersey Department of Human Services on SCHIP enrollment as of August 2007.

Mr. PALLONE. Thank you. Mr. Peterson.

STATEMENT OF CHRIS PETERSON, SPECIALIST IN HEALTH CARE FINANCING, DOMESTIC SOCIAL POLICY DIVISION, CONGRESSIONAL RESEARCH SERVICE

Mr. PETERSON. Thank you, Chairman Pallone, Mr. Deal and members of the subcommittee. I am going to pose four questions to frame health insurance issues generally in SCHIP reauthorization specifically and then I will discuss how those questions were addressed in the three House passed reauthorization bills: CHAMP, which the Senate did not take up, and the two CHIPRA bills vetoed by the President. Obviously, my role is not to assess whether any particular approach was right, but rather to instill the complex issues into a framework of describing bills that I hope is useful. Much greater detail is in my written testimony. The first question is, if you build it, will they come? In 2006, 9 million children were uninsured, nearly two-thirds of them eligible for Medicaid or SCHIP. The Federal Government and States built it. But 6 million uninsured eligible kids haven't come.

To address this, the House-passed bills would have provided bonus payments to States that increased child enrollment by certain amounts and that outperform certain activities. CBO estimated CHAMP would increase Medicaid and CHIP enrollment by 2012 by 7.5 million. The two vetoed CHIPRA bills would have increased enrollment by 5.8 million. In all three the increase was mostly about current eligibility groups, which leads to the second question, if you build it, how many nontargeted individuals will come? And how many is acceptable? Note the question is not whether nontargeted individuals will come but how many. Children not targeted by SCHIP include those already enrolled in job-based coverage. According to CBO the House-passed reauthorization bills had crowd-out rates of a third. This means that for every three people enrolled in Medicaid or SCHIP because of the legislation, two would have been uninsured and one would have had other coverage in its absence.

However, CBO's director said quote, we don't see very many other policy options that would reduce the number of uninsured children by the same amount without creating more crowding. As one economist put it, it is like fishing for tuna, when you let down the tuna nets, you catch some dolphins too. Again, the policy question is, how much is acceptable? The third question is, if you build it, who should design it? And with how much flexibility? For example, the tension between State flexibility and federal specificity is illustrated by recent debates over how high up the income scale SCHIP eligibility should go and whether adults should be eligible.

This is also discussed in greater detail in my written statement. The fourth and final question is, if you build it, what should the structure be? Nearly 100 years ago Americans debated whether coverage proposals linked too heavily toward government involvement versus the free market concerns also raised regarding SCHIP. But discussions about what health insurance structure we should have are impeded by challenges to defining what structure we currently are. Private insurance is projected to generate public tax ex-

penditures of $130 billion this year. On the flip side, public insurance, like Medicaid and SCHIP, provides much of its coverage through private insurers. Thus, health policy options are rarely binary choices between something wholly private or public but tend to be gradations of one over the other in the hopes the trade-offs are beneficial.

If one's goal for SCHIP is to lean more toward private coverage, one option is premium assistance where SCHIP pays a portion of job-based premiums. Of course when considering a different structure like this, it raises the first three questions again. If you build it, will they come? How many nontargeted individuals will come? And who does the designing? With how much flexibility? Because current restrictions on SCHIP premiums make it so difficult, most States with these programs use waivers to give them more flexibility. CHAMP had no premium assistance provisions, but CHIPRA would have made SCHIP premium assistance easier to implement without waivers.

In conclusion, getting health insurance to children in any population is not rocket science. It is harder. In rocket science, you have constants. You know what speed is necessary to escape the earth's atmosphere and how often do you hear debates about the measure of gravity's pull or whether a certain orbit is too high or too low or what the best path is to get there? When it comes to health insurance, however, there are important fundamental questions about what the goals are and how best to accomplish them. I hope my testimony has helped frame these questions in a useful way. Thank you.

[The prepared statement of Mr. Peterson follows:]

Children's Health Insurance and the House-passed 2007 SCHIP Reauthorization Legislation

Testimony, House Energy & Commerce Health Subcommittee
January 29, 2008

Chris L. Peterson
Specialist in Health Care Financing
Domestic Social Policy Division

Summary of CRS Testimony

In 2006, the percentage of children in the United States without health insurance increased significantly for the first time in several years. In December 2007, the unemployment rate jumped to 5.0%, its highest level in two years. The January 2008 unemployment numbers are scheduled for release on Friday and may give insight to future health insurance trends, since research has shown that health insurance coverage closely follows employment.

The changing picture of children's health insurance coverage and the evolving nature of last year's SCHIP legislation has provoked some fundamental questions about health insurance proposals generally and SCHIP in particular, which I pose as follows:

1. If you build it, will they come?
2. If you build it, how many non-targeted individuals will come — and how many is acceptable?
3. If you build it, who should design the structure — and with how much flexibility?
4. If you build it, what should that structure be?

This testimony responds to each of these questions using the provisions in the three House-passed SCHIP reauthorization bills in 2007. The role of CRS is *not* to assess whether any particular approach or answer is the "right" one. Rather, it is to distill the complex issues that are inevitable with any health insurance proposal into a framework that may be helpful, and to use that framework to analyze the House-passed SCHIP reauthorization bills. Doing so thus provides a case study on how the questions above can be answered while describing how some specific, controversial aspects of SCHIP coverage were addressed in the legislation.

Chairman Pallone, Mr. Deal, and other members of the Subcommittee, my name is Chris Peterson, and I am a Specialist in Health Care Financing with the Congressional Research Service (CRS). Thank you for the opportunity to testify about the characteristics of uninsured children and of SCHIP reauthorization legislation passed in the House over the past year.

The three SCHIP reauthorization bills passed by the House in 2007 were:

- H.R. 3162 (Children's Health and Medicare Protection Act of 2007, or CHAMP);
- H.R. 976 (Children's Health Insurance Program Reauthorization Act of 2007, or CHIPRA); and
- H.R. 3963 (also known as CHIPRA).

Although CHAMP passed only the House, both CHIPRA bills (H.R. 976 and H.R. 3963) passed both chambers of Congress and were vetoed by the President in 2007.

Getting health insurance to children (or any population) is not rocket science — it's harder. In rocket science, you have constants. You know what speed is necessary to escape the Earth's atmosphere. You can calculate precisely how much fuel is needed. How often do you hear debates about the measure of gravity's pull, whether a certain orbit is too high or too low, or what the best path is to get there? But when it comes to health insurance, there are important, fundamental debates about what the goal is, what the best path is to that goal, who should pay for it, and how to reconcile the tensions between laudable but often contradictory aims.

In the movie "Field of Dreams," the main character cuts a baseball field out of his Iowa cornfield in response to a voice that whispered, "If you build it, he will come." To

help frame the complex issues regarding SCHIP reauthorization and uninsured children, both for looking back and moving forward, I'll ask four questions that are variants of that movie quote that I hope will be illuminating. The first is:

If you build it, will they come?

The question holds for virtually all efforts to expand health insurance through federal legislation, whether through public programs, tax initiatives, etc. With respect to children, on any given day in 2006, approximately nine million were without health insurance. Most of these children came from two-parent families (53%). Most had a parent who worked full time all year (63%).[1] And most were *eligible* for Medicaid or SCHIP (62%).[2] In other words, the Federal government and states built it, but 6 million eligible uninsured kids did not come. Among these eligible uninsured children, it is still the case that most were in two-parent families and in a family where a parent worked full time.[3]

So how to get them to come? All of the House-passed SCHIP reauthorization bills would have provided bonus payments to states that (1) increased child enrollment in Medicaid or SCHIP by certain amounts, and (2) performed a certain number of specified outreach or enrollment activities. This latter requirement ensured that enrollment growth alone — from a recession, for example — was not enough to prompt bonus payments to

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[1]CRS Report 97-975, *Health Insurance Coverage of Children, 2006*, by Chris L. Peterson and April Grady, September 12, 2007.

[2]Julie L. Hudson and Thomas M. Selden, "Children's Eligibility And Coverage: Recent Trends And A Look Ahead," *Health Affairs* Web exclusive, August 16, 2007, pp. w618-629.

[3]Op. cit., Exhibit 3, online data supplement.

states. According to the Congressional Budget Office (CBO), the first House-passed SCHIP reauthorization bill, CHAMP, would have increased Medicaid and SCHIP enrollment by 7.5 million in FY2012, for a total of 35.8 million enrollees. The two vetoed CHIPRA bills both would have increased FY2012 enrollment by 5.8 million, for a total of 34.1 million enrollees. In all three bills, the increased enrollment would have occurred largely among current eligibility groups, rather than new ones.[4]

This leads to the second question regarding health insurance proposals:

If you build it, how many *non-targeted* individuals will come — and how many is acceptable?

Crowd-out. The question is not *whether* non-targeted individuals will come, but how many. In terms of who is *not* targeted for SCHIP, the original SCHIP statute is clear that (1) children must be uninsured in order to be eligible for SCHIP,[5] and (2) states must have strategies to prevent the substitution of SCHIP coverage for private coverage,[6] commonly referred to as crowd-out.[7]

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[4]CBO cost estimates for H.R. 3162 (8/1/07), H.R. 976 (9/25/07), and H.R. 3963 (10/24/07), available at [www.cbo.gov]. In FY2012 specifically, Titles I and VIII of H.R. 3162 would have increased federal spending by $16.5 billion; H.R. 976 and H.R. 3963 would have increased federal spending by $10.6 billion and $10.8 billion, respectively. Cumulatively over FY2008 to FY2012, increased federal spending for Medicaid and SCHIP would have been $51.8 billion, $34.9 billion, and $35.4 billion, respectively.

[5]For example, see §2110(b)(1)(C) of the Social Security Act.

[6]For example, see §2102(b)(3)(C) of the Social Security Act.

[7]It is helpful to think about crowd-out not only in terms of individuals but also dollars. For example, if a proposal would provide additional funds for the purchase of health insurance to those who already have coverage, then public dollars are crowding out private dollars.

Crowd-out is problematic for those whose sole objective is to lower the number of uninsured children with a particular amount of funding.[8] If funds set aside for reducing the number of uninsured go entirely to those who are already insured, then the funds would be exhausted without affecting the number of uninsured. Thus, for those wishing to maximize the reduction in uninsured with a particular amount of funding, crowd-out should be minimized. In other words, if you build it, then build it so the fewest non-targeted individuals come.

According to CBO, all three House-passed SCHIP reauthorization bills had similar crowd-out rates, of about one-third. This means that for every three individuals enrolled in Medicaid or SCHIP in FY2012 because of the legislation, two would have been uninsured and one would have had other coverage in the absence of the legislation. While CHAMP and the first CHIPRA bill were being debated, the Director of CBO said the bills "are tilting the incentives towards lower income populations which are associated with lower crowd-out rates. ... (I)n our analysis, we don't see very many other policy options that would reduce the number of uninsured children by the same amount without creating more crowd-out than under the House and Senate proposals [H.R. 3162 and H.R. 976, respectively]. The policy question at hand is whether those types of reductions are worth the cost that is involved."[9] As health economist Jon Gruber (who

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[8]There may be other health policy goals, such as ensuring an adequate benefit package or obtaining increased enrollment in certain types of coverage, for which crowd-out might not be counterproductive.

[9]Peter Orszag, presentation at Alliance for Health Reform briefing "Who's Counting? What is Crowd-Out, How Big Is It and Does It Matter for SCHIP?" August 29, 2007, transcript pp. 17, 19, available at [http://www.allhealth.org/briefingmaterials/CrowdOutandSCHIP-879.pdf].

has corresponded with this Committee on crowd-out issues[10]) put it, "It's like fishing for tuna. When you let down the tuna nets, you catch some dolphin too."[11] For any number of tuna caught, how many dolphins are acceptable — if any? In other words, whether the crowd-out is "too much" compared to the reduction in uninsured is a more subjective question than a technical one.

Certain immigrants' ineligibility. Another group that SCHIP does not target for enrollment is legal immigrants who have been in the country for less than five years and unauthorized aliens (the latter group often referred to as "illegal immigrants").[12] If these individuals meet all eligibility criteria except immigration status, then health care providers who give emergency medical care to them may receive reimbursement from Medicaid. However, these noncitizens are not eligible to be "insured" with full coverage by Medicaid or SCHIP under current law. CHAMP would have given states the option to extend eligibility to legal immigrants who have not been in the U.S. for five years.[13] The CHIPRA legislation vetoed by the President did not include this provision. None of the three House-passed bills would have changed current law regarding illegal aliens'

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[10]Letter from Jonathan Gruber, professor of economics, Massachusetts Institute of Technology, to Representative John Dingell, Chairman, House Energy and Commerce Committee, February 28, 2007, available at [http://energycommerce.house.gov/Press_110/110-ltr.022807.Gruber_ltr_to_Dingell.pdf].

[11]Jane Bryant Quinn, "The Kids Aren't All Right," *Newsweek*, October 20, 2007, available at [www.newsweek.com/id/57366/output/print].

[12]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193).

[13]Sec. 132 of CHAMP.

eligibility for Medicaid or SCHIP; individuals who are not legal residents would still be ineligible for non-emergency coverage.[14]

Citizenship documentation. The Deficit Reduction Act of 2005 (DRA) requires citizens and nationals applying for Medicaid who claim to be citizens to provide both proof of citizenship and identity. Before DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence.[15]

CHAMP would have made the DRA Medicaid citizenship documentation requirements for children optional to states, among other changes.[16] Rather than make the documentation requirements entirely optional, the first CHIPRA bill provided a specific alternative, which would allow state to use the Social Security Number (SSN) provided by individuals and verified by the Social Security Administration (SSA). The bill also would have added a requirement for citizenship documentation in SCHIP.[17] The second CHIPRA bill had these provisions, but also would have provided $5 million for SSA and required SSA to determine whether an individual's name and SSN were consistent with its records.[18]

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[14]Sec. 135 of CHAMP and Sec. 605 of CHIPRA.

[15]For additional information, see CRS Report RS22629, *Medicaid Citizenship Documentation*, by April Grady.

[16]Sec. 143 of CHAMP.

[17]Sec. 211 of H.R. 976.

[18]Sec. 211 of H.R. 3963.

According to CBO, CHAMP's altering of citizenship documentation would increase federal spending in FY2008-2012 by approximately $800 million. Over that same period, federal spending under both CHIPRA bills would have increased because of the changes in citizenship documentation by $1.4 billion.[19] CBO suggests that this cost would result from increased enrollment among citizens, rather than unauthorized aliens or other ineligible noncitizens, since "(a)vailable evidence, based on state reports and other information provided by state officials, suggests that virtually all of those who have been unable to provide the required documentation are U.S. citizens."[20]

The third question is:

If you build it, who should design the structure — and with how much flexibility?

Children in higher-income families. For example, the statute clearly states that SCHIP eligibility is for "targeted low-income children" whose family income is below 200% of poverty[21] or, if higher, up to 50 percentage points above the state's pre-SCHIP Medicaid levels.[22] On the other hand, states have the flexibility to define how income is counted so that states could effectively expand eligibility of all children to

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[19]CBO cost estimates for H.R. 3162 (8/1/07), H.R. 976 (9/25/07), and H.R. 3963 (10/24/07), available at [www.cbo.gov].

[20]Letter from CBO Director Peter R. Orszag to Speaker Nancy Pelosi, October 25, 2007, available at [http://www.cbo.gov/ftpdoc.cfm?index=8742&type=1].

[21]For 2008, 200% of poverty for a family of three is approximately $35,000 a year in countable income.

[22]§2110(b) of the Social Security Act. Children are defined in SCHIP statute as under age 19. CHAMP would have given states the option to expand eligibility to those under age 21 (Sec. 131). This provision was not in the CHIPRA bills vetoed by the President.

whatever income level they choose.[23] This flexibility may now be limited somewhat, based on the criteria set forth in the August 17, 2007, letter from Dennis Smith to state health officials for states seeking to expand SCHIP eligibility to children with "effective" family income above 250% of poverty.[24] The letter illustrates the ongoing tension between state flexibility versus federal control and between the legislative branch and the executive branch: If you build it, who designs it — and with how much flexibility?

CHAMP, which was passed by the House prior to the issuance of the August 17 CMS letter, had no provisions altering states' flexibility in defining income or the federal matching rate for various SCHIP-enrolled individuals. (The federal government reimburses approximately 57% of states' Medicaid costs, based on a state-specific percentage called the Federal Medical Assistance Percentage, or FMAP. For SCHIP, there is an enhanced FMAP, or E-FMAP, which averages about 70% of states' costs.) The two CHIPRA bills that ultimately passed both chambers of Congress would have effectively nullified the August 17 letter.[25]

Unlike CHAMP, the CHIPRA bills would have reduced or eliminated federal SCHIP payments for certain higher-income SCHIP children. The first House-passed CHIPRA bill specified that the regular FMAP would be used for SCHIP enrollees whose effective family income would exceed 300% of poverty using the state's policy of

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[23]See 66 *Federal Register* 2320, January 11, 2001, and 42 CFR 457.10. For additional discussion, see April Grady, "Overview of Medicaid and Medicaid-Expansion SCHIP Eligibility for Children and Rules for Counting Income," CRS Congressional Distribution memorandum, November 29, 2007, available upon request.

[24]Letter from Dennis G. Smith, Director of the Center for Medicaid and State Operations of the Centers for Medicare and Medicaid Services (CMS), SHO #07-001, August 17, 2007, available at [http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf].

[25]Sec. 116(g) of CHIPRA.

excluding "a block of income that is not determined by type of expense or type of income," with an exception for states that already had a federally approved plan or that had enacted such state legislation.[26] The second version of CHIPRA would have prohibited *any* federal SCHIP payments for SCHIP enrollees whose effective family income would exceed 300% of poverty using the state's policy of excluding "a block of income that is not determined by type of expense or type of income," with an exception for states that already had a federally approved plan but *not* for states that had merely enacted such state legislation.[27] Those who want to eliminate any possibility of federal payments for children above 300% of poverty have correctly stated that the legislation could still permit payment for some children with gross income above that level. For example, SCHIP financing would be permitted and could occur if states disregarded income above 300% of poverty that is a particular type of income, such as wages, or by using Medicaid funding, for which states' flexibility to count income would not have been altered by the CHIPRA bills.[28]

SCHIP coverage of adults. Another issue that highlights the trade-offs with providing flexibility to states and the executive branch is the use of Section 1115 waivers, by which the Administration can waive certain strictures of statute. Certain states that have covered adults with SCHIP funds were permitted to do so almost entirely through the use of these waivers. These waivers, which initially are effective for five

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[26]Sec. 114 of H.R. 976.

[27]Sec. 114 of H.R. 3963.

[28]Sec. 115(a) of both CHIPRA bills, H.R. 976 and H.R. 3963.

years, must be approved by the Administration and then are subject to re-approval every three years.

Waivers permitting the coverage of parents with SCHIP funds were first approved under the Clinton Administration. However, Clinton Administration officials said that waivers to cover nonpregnant childless adults in SCHIP would not be approved.[29] SCHIP waivers covering nonpregnant childless adults were granted under the Administration of George W. Bush. These approvals occurred in response to a Bush initiative (Health Insurance Flexibility and Accountability (HIFA) demonstration initiative) to expand health insurance coverage to low-income individuals, and at a time when $2 billion to $3 billion in unspent SCHIP funds was available for redistribution among certain states.[30]

By FY2006, however, several states faced the prospect of being "shortfall states" — that is, states that exhausted all their available federal SCHIP funding. Although none of the potential shortfall states covered childless adults under SCHIP as an eligibility category, several covered parents. In addition to appropriating $283 million to eliminate projected FY2006 shortfalls, DRA also prohibited the Administration from approving any new waivers that permitted SCHIP funds to be used for nonpregnant childless

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[29]Health Care Financing Administration (HCFA), Letter to State Health Officials, July 31, 2000, available at [http://www.cms.hhs.gov/smdl/downloads/sho073100.pdf], p. 6: "We also will consider SCHIP demonstration requests to cover pregnant women with incomes above 185 percent of the Federal poverty level (for States that have already covered pregnant women up to 185 percent of the FPL through Medicaid at the regular matching rate), but we will not consider demonstration proposals to use SCHIP funds to cover other adults without children."

[30]Evelyne P. Baumrucker, "Chronological Analysis of Populations Added to the State Children's Health Insurance Program (SCHIP) through March 2007," draft Congressional Distribution memo.

adults.[31] States that already had approved waivers for coverage of nonpregnant childless adults could continue them.

Prior to 2007, waiver renewals for states covering parents were approved, even for those projected to face shortfalls for the foreseeable future (e.g., New Jersey, Rhode Island). Beginning in 2007, however, waiver renewals for states covering parents have *not* been approved (e.g., Illinois, Oregon) or have begun to transition parents out of SCHIP coverage (e.g., Wisconsin). Oregon also covered childless adults under its SCHIP waiver but has never been projected to be in shortfall; its SCHIP waiver expired October 31, 2007. Some of these adult groups are now eligible for Medicaid-financed coverage in the state.[32] The only SCHIP adult coverage waiver up for renewal in FY2008 is Rhode Island's, which is set to expire on July 31, 2008.

While these waiver negotiations were ongoing between certain states and the Administration in 2007, the SCHIP legislation also addressed the issue of adult SCHIP coverage. Under CHAMP, the Secretary of Health and Human Services (HHS) would be prohibited from paying SCHIP funds to a state for adult coverage — childless adults or parents — "unless the Secretary determines that no eligible targeted low-income child in the State would be denied coverage because of such eligibility. In making such determination, the Secretary must receive assurances that (1) there is no waiting list ... for targeted low-income children ... ; and (2) the State has in place an outreach program to reach all targeted low-income children in families with incomes less than 200 percent of

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[31] P.L. 109-171, Sec. 6102.

[32], p. 12.

the poverty line."[33] In a letter to state health officials on July 31, 2000, the Clinton Administration effectively established these criteria as a precondition for approving expansions to groups that are not "the core population of low-income children intended to be served by SCHIP."[34]

The first House-passed version of CHIPRA would have phased out SCHIP coverage of nonpregnant childless adults after two years. In FY2009, federal reimbursement for such coverage would be reduced to the Medicaid FMAP, and only for individuals who were actually enrolled in FY2008; new nonpregnant childless adults would not be eligible for federal SCHIP payments in FY2009. Under the second CHIPRA bill, SCHIP coverage of nonpregnant childless adults would have terminated on December 31, 2008. Under both bills, such states would be permitted to apply for Medicaid waivers to continue coverage for these populations, but subject to a specified budget-neutrality standard (tied to the state's 2008 spending on this population).[35]

The two versions of CHIPRA were identical with respect to the treatment of parents. Coverage of parents would still be allowed, but beginning in FY2010, allowable spending under the waivers would be subject to a set-aside amount from a separate allotment and would be matched at the state's regular Medicaid FMAP unless the state was able to prove it met certain coverage benchmarks (related to performance in providing coverage to children). In FY2011 and FY2012, even states meeting the

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[33]Sec. 134 of CHAMP.

[34]Health Care Financing Administration (HCFA), Letter to State Health Officials, July 31, 2000, available at [http://www.cms.hhs.gov/smdl/downloads/sho073100.pdf], p. 4.

[35]Sec. 112 of CHIPRA.

coverage benchmarks would not get the enhanced FMAP for parents but an amount between the regular and enhanced FMAPs.[36]

The fourth and final, and perhaps most fundamental, question posed here regarding health insurance proposals:

If you build it, what should that structure be?

Public vs. private. Nearly 100 years ago, Americans debated whether health insurance proposals leaned too heavily toward government regulation and mandates versus the free market and individual choice.[37] Similar concerns were raised regarding the SCHIP reauthorization legislation last year.[38] But discussions about what structure of health insurance the nation *should* have are impeded by the challenges to defining what structure the nation *currently* has. The current U.S. health insurance system is a hodgepodge of public and private influences. For example, "private insurance," including employer-sponsored coverage, is projected to generate tax expenditures of at least $130 billion this year.[39] In addition, public policy often requires private insurance to meet certain criteria, in terms of the benefits offered, the requirements necessary for

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[36]Ibid.

[37]Theodore Roosevelt, address before the convention of the National Progressive Party, Chicago, August 1912, available at [http://www.ssa.gov/history/trplatform.html]. "Health Insurance for New York's Workers," *New York Times*, January 30, 1916, p. SM8. "McSweeney Opposes Sickness Insurance," *Boston Daily Globe*, December 8, 1916, p. 12.

[38]See, for example, Michael F. Cannon, "Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs," *Cato Institute Briefing Papers*, No. 99, September 13, 2007, available at [http://www.cato.org/pubs/bp/bp99.pdf].

[39]U.S. Joint Committee on Taxation, "Estimates of Federal Tax Expenditures for Fiscal Years 2007-2011," September 24, 2007, p. 33, available at [http://www.house.gov/jct/s-3-07.pdf].

certain regulatory or tax advantages, etc. On the flip side, "public" insurance, like Medicaid and SCHIP, provides much of its coverage through private insurers.[40] Thus, health policy options are rarely binary choices between something wholly "private" or "public," but tend to be gradations of one over the other, in the hopes that the trade-offs are beneficial on net.

Premium assistance. One way in which SCHIP can lean more toward private coverage is to "encourage more states to adopt premium assistance,"[41] which is where SCHIP funds are used to pay a portion of the premium for employer-sponsored health insurance. When considering any variation in health insurance structure, such as premium assistance, the first three questions can be considered again: If you build it, will they come? How many non-targeted individuals will come — and how many is acceptable? Who will design the structure — and with how much flexibility?

In March 2007, CMS noted that a dozen states had implemented premium assistance programs with SCHIP funds.[42] One of the largest obstacles to states creating SCHIP premium assistance programs has been the strictures in the statute, hearkening back to the question of who should do the designing. Under current law, states may implement premium assistance programs in SCHIP if the employer plan (1) covers

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[40]"We find that, in 2005, approximately 70 percent of all children enrolled in SCHIP were in managed care plans and almost 90 percent of SCHIP programs using managed care contracted with one or more plans that primarily serve the commercial market" (John McInerney, "SCHIP Delivery Systems," National Academy for State Health Policy's *State Health Policy Monitor*, October 2007, p. 1, available at [www.nashp.org/files/shpmonitor_SCHIPdelivery.pdf]).

[41]Nina Owcharenko, "Reforming SCHIP: Using Premium Assistance to Expand Coverage," The Heritage Foundation's *WebMemo*, No. 1466, May 22, 2007, p. 1, available at [www.heritage.org/research/healthcare/wm1466.cfm].

[42]"The State Children's Health Insurance Program (SCHIP)," CMS PowerPoint presentation, March 22, 2007, p. 14.

SCHIP minimum benefits, (2) meets SCHIP cost-sharing ceilings (5% of family income), and (3) ensured enrollees have not had group coverage for a specified period of time (typically four to six months). However, it has proved prohibitive for many employer plans and states to meet all of these requirements. In addition, in the event the plan's benefit package or cost-sharing burdens do not abide by the SCHIP statute, federal law prohibits SCHIP from providing wrap-around coverage.[43] "Covering only children (as opposed to whole families) within a narrow band of eligibility appears to be a contributing factor to low enrollment."[44] To circumvent these restrictions, most states operating SCHIP premium assistance programs do so under waivers.[45]

One of the reasons the waiver authority for SCHIP premium assistance seemed advantageous was because states could provide coverage to members of the entire family under the group plan who might not otherwise be eligible for Medicaid or SCHIP (e.g., parents). Thus, policies seeking to limit the enrollment of certain non-targeted individuals might work against efforts to increase enrollment in a structure like premium assistance. Comparisons across states also found that enrollment in premium assistance programs was greatest when the state *required* SCHIP-eligible individuals to enroll in the

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[43]The Medicaid premium assistance program permits a wrap-around to ensure adequate coverage and appears to have substantially more enrollment.

[44]Cynthia Shirk and Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum's *Issue Brief*, No. 812, July 17, 2006, p. 8, available at [http://nhpf.ags.com/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf].

[45]The Bush Administration's HIFA initiative required states' waiver proposals to emphasize private health insurance coverage, with premium assistance noted for particular flexibility that would be granted to states in terms of benefits, cost-sharing and cost-effectiveness requirements. Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative," July 25, 2001, available at [http://www.nahu.org/legislative/uninsured/CMS_HIFAguide.doc].

job-based coverage they were offered as a precondition of SCHIP enrollment, which hearkens back to the trade-off between government mandates and individual choice.[46]

In the absence of a workable premium assistance program, if a child's coverage through SCHIP is much less expensive to the family relative to out-of-pocket premiums for job-based coverage, a parent might opt to have the child in SCHIP. Recent research from the Agency for Healthcare Research and Quality shows this might be the case. For example, in 1997, prior to the implementation of SCHIP, 5.1% of single parents had private coverage for themselves but public coverage for the kids; by 2005, that percentage rose significantly, to 15.5%.[47] One might argue that premium support should be crafted to prevent the further growth in this percentage, particularly if the increase observed among children between 1997 and 2005 was among those who would have had private coverage in the absence of public coverage. However, the research did not attempt to determine this (and such estimates are difficult and extremely sensitive to the technical assumptions made in the analysis). Considering that one out of six families in job-based coverage pay more than 10% of their take-home income in health insurance and health care, it is possible that enrolling the children in public coverage like SCHIP

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[46]Shirk and Ryan, p. 12.

[47]Among single parents who were *not* offered job-based coverage, the percentage with the entire family uninsured dropped, primarily because of a significant increase in the percentage of families where the adults were uninsured but the children had public coverage (20% in 1997 and 30% in 2005). Jessica P. Vistnes and Barbara S. Schone, "Pathways To Coverage: The Changing Roles Of Public And Private Sources," *Health Affairs*, January/February 2008, Exhibits 2 and 3.

may have prevented the entire family from becoming uninsured because of the cost of family coverage.[48]

The House-passed CHAMP bill had no premium assistance provisions. Title III of both House-passed CHIPRA bills was devoted to premium assistance. Under CHIPRA, states would have the option to offer premium assistance for children eligible for employer-based coverage, if the employer pays at least 40% of the total premium (and meets certain other requirements). Under CHIPRA, a state offering premium assistance could not require SCHIP-eligible individuals to enroll in an employer's plan; individuals eligible for SCHIP and for employment-based coverage could choose to enroll in regular SCHIP rather than the premium assistance program. The premium assistance subsidy would generally be the difference between the worker's out-of-pocket premium that included the child(ren) versus only covering the employee.[49]

Under CHIPRA, for employer plans that do not meet SCHIP benefit requirements, not only is a wrap-around permitted but would be required. For the child's coverage using premium assistance, no cost-effectiveness test would be required regarding the cost of the private coverage (plus any necessary wrap-around) relative to

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[48]Jessica S. Banthin et al., "Financial Burden of Health Care, 2001-2004," *Health Affairs*, January/February 2008, Exhibit 1. See also "Shared Testimony of Craig and Kim Lee Bedford," testimony before the Senate Finance Committee, February 1, 2007, available at [http://finance.senate.gov/hearings/testimony/2007test/020107kbtest.pdf]. Mr. Bedford said he was self-employed and purchased private coverage for himself and his wife, but the children were enrolled in SCHIP. Prior to enrolling the Bedford children in SCHIP, "(e)ven though the business was growing, our health insurance costs were still close to 25% of our gross income." After enrolling the children in SCHIP, the family was "able to cut our health spending by 60%. ... Unfortunately, the cost of our coverage has grown also. In 2006, health insurance premiums for my wife and me cost the same as the family plan we had in 2002, and still account for 13% of our gross income" (p. 5).

[49]Generally, the premium costs of parents would not have been covered. The exception would be where the parent is already eligible for SCHIP in the state using waiver authority, as previously discussed.

regular SCHIP coverage. However, if the SCHIP cost of covering the entire family in the employer-sponsored plan is less than regular SCHIP coverage for the eligible individual(s) alone, then the premium assistance subsidy could be used to pay the entire family's share of the premium. In states that offered premium assistance, CHIPRA would have required states and participating employers to do outreach.

I hope my comments have been helpful. Thank you.

Mr. PALLONE. Thank you. Ms. Chester.

STATEMENT OF CAROLYN TAYLOR CHESTER, NURSING ASSISTANT, SERVICE EMPLOYEES INTERNATIONAL UNION

Ms. CHESTER. Good morning, my name is Caroline Taylor Chester and I live in Baltimore with my husband Jerry and son, Keith. He is 11 years old. I work at Wesley Assisted Living in Baltimore, which just changed from a nursing home to assisted living. I have worked there for almost 8 years, and I do it because I like helping elderly and taking care of patients. The work is hard and it does not pay much, but I get to meet special people and their families. I like making their days a little better.

Last year my family earned about $20,000. Wesley offers health insurance, but it is very, very expensive to cover my family. There is no way in the world I would be able to afford it. It would cost over $298 per pay period for my check to cover my husband and Keith. That would eat up almost 30 percent of my family's income just for health insurance. On top of that, there are still deductible and a $30 co-pay for a primary care physician, $40 co-pay for visits to the specialist. This does not even cover dental insurance either, that is more.

Every year the cost of family coverage just keeps going up and up. God knows I appreciate SCHIP. We pray on my husband staying healthy without insurance, but at least our son is covered. Keith has been helped by the Maryland CHIP program all his life. With the Maryland CHIP program, Keith sees a pediatrician on a regular basis, gets tested early for allergies and asthma and sees an allergist when needed.

My son had a lot of ailments when he was younger. He has had asthma pretty bad. With MCHIP we are able to treat Keith's breathing problem early and we do not use the hospital emergency room, which is sometimes the only option for families like mine.

The relationship you have with your doctor is one that needs to be built on trust and understanding. Not only has Keith been able to see the same pediatrician his entire life, he is the same pediatrician I went to when I was a child. He denies it to the end, he says he was not the one, but he did treat me.

Keith also gets a regular dental checkup with the MCHIP program. Since we were first enrolled with CHIP in the program for about 12 years Maryland has made it easier for a family like ours to renew our coverage from the mail. We have moved a lot so we can live in better places. It is not easy for us to make sure that Keith stays insured under MCHIP.

I brought a picture of Keith with me today because I am very proud of him. He is a healthy, strong sixth grader who doesn't have to miss school all the time because he is sick. He can focus on his schoolwork and just being a kid. This is my family's story. I wanted you to hear because it is not just about Keith, it is about people like my coworker Antoinette whose daughter lost her health insurance when the SCHIP expansion funding was cut. There are millions of people like us whose families and health depend on the program.

I used to work on the health suite at Baltimore City Public Schools when I was employed by the schools and I knew the chal-

lenge of just finding parents just to remember to renew your insurance every year. It was hard and we had to look for parents. Teachers would send children to the health suite, they were sick, and it was like we do not have any insurance. Children are in need of insurance, families are in need of help because we cannot afford to have the health insurance that is needed for the parents that need to have health insurance. They quit their jobs or do whatever they need to do to be able to provide insurance for their children. It is not fair that I should choose whether to work or whether my child should have health insurance. We live in the richest country in the United States, and it is a shame for anyone to say we can't afford health insurance for each and everyone that lives in the United States.

Thank you for your time.

[The prepared statement of Ms. Chester follows:]

STATEMENT OF CAROLYN TAYLOR CHESTER

My name is Carolyn Taylor Chester and I live in Baltimore, MD, with my husband Jerry and son Keith. He is 11 years old.

I work at Wesley Assisted Living Center in Baltimore, which just changed from a nursing home to an assisted living center. I have worked there for almost 8 years, and I do it because I like helping the elderly and taking care of my patients. The work is hard, and it doesn't pay much, but I get to meet special people and their families and I like making their days a little bit better.

Last year my family earned about $20,000. Wesley offers health insurance, but it is very, very expensive to cover my family. There's no way in the world I'd be able to afford it. It would cost over $260 per pay period from my check to cover my husband and Keith. That would eat up about 30% of my family's income just for health care. On top of that, there are still deductibles and a $30 copay for each primary care visit—and $40 copays for each visit to a specialist. This does not even cover dental insurance either—that's more. Every year, the cost of family coverage just keeps going up and up.

God knows I appreciate SCHIP. We pray on my husband staying healthy without insurance but at least our son is covered. Keith has been helped by the Maryland CHIP program all his life. With the Maryland CHIP program, Keith sees a pediatrician on a regular basis, gets tested early for allergies and asthma, and sees an allergist when he needs to. My son had a lot of ailments and allergies when he was younger. He had asthma pretty bad. With MCHIP, we were able to treat Keith's breathing problems early, and we don't use the hospital emergency room—which is sometimes the only option for families like mine.

The relationship you have with your doctor is one that needs to be built on trust and understanding. Not only has Keith been able to see the same pediatrician his entire life, he's the same pediatrician I went to when I was a child! Keith also gets regular dental check-ups with the MCHIP program.

Since we first enrolled Keith in the CHIP program 12 years ago, Maryland has made it easier for families like ours to renew our coverage through the mail. We've moved a lot so we can live in better places. It's now easier for us to make sure that Keith stays insured under MCHIP.

I brought a picture of Keith with me today, because I am very proud of him. He is a healthy and strong 6th grader who doesn't have to miss school all the time because he's sick. He can focus on his schoolwork and just being a kid.

This is my family's story. I wanted you to hear it because it's not just about Keith. It's about people like my coworker Antoinette whose daughter lost her insurance when the SCHIP expansion funding was cut. There are millions more like us whose children's lives and health depend on this program.

Thank you for your time.

Mr. PALLONE. Thank you, Ms. Chester; appreciate it.

Dr. Rossiter.

STATEMENT OF LOUIS F. ROSSITER, RESEARCH PROFESSOR AND DIRECTOR, SCHROEDER CENTER FOR HEALTH CARE POLICY, COLLEGE OF WILLIAM AND MARY

Mr. ROSSITER. Good morning, Chairman Pallone, Ranking Member Deal and distinguished members of the committee and subcommittee. I am pleased to be here to discuss missed opportunities in covering uninsured families.

I think the number one missed opportunity, in my opinion, is not doing enough to incorporate the principles of welfare reform in SCHIP. President Clinton outlined these in 1995. He said, "Number 1, focus on work." Number 2, "Have real work requirements." He said with regard to—with welfare, with money now spent on welfare and food stamps to subsidize private sector jobs the SCHIP case would be to subsidize private sector jobs with health insurance. The number 3 quote he said, have real incentives to reward States who put people to work. I would add in our case here today to put people to work with jobs with health insurance.

Because we don't focus on work in the SCHIP program we are not maximizing group health coverage. Our experience with SCHIP fosters all or nothing welfare-like coverage and it encourages uninsurance because some children have their coverage switched and there are the required periods of no insurance. It also fragments coverage for families and it lures parents to drop their own group coverage. It also encourages small employers with low income workers to abandon coverage.

We know we are trading off 2 for 1. Adding 2 uninsured children to the SCHIP rolls means 1 child who loses existing coverage. The tradeoff rises to 1 to 1 at the higher income levels.

That brings me to the number 2 missed opportunity with this bill that we are talking about, which is understanding health insurance trends. Since enactment of SCHIP the rate of employer-sponsored insurance has declined and the uninsurance rate increased. No one really understands why. While we might say these trends would have been worse without SCHIP, with millions of children covered by SCHIP, neither can we rule out an SCHIP effect on all these families. SCHIP is obviously helping some children, but it could also be harming the U.S. economy and the health insurance system and their ability to cover even more children.

The number 3 missed opportunity is the opportunity to grow group health insurance for small firms with low wage workers.

I have three recommendations for your consideration as we look at this bill. Number 1, focus on work with health insurance. I would recommend gradually eliminating the Medicaid expansion option the States have under SCHIP. Medicaid expansion programs let the States really cop out of the hard work involved with organizing and subsidizing group health insurance. SCHIP should be separate from Medicaid, focused on helping parents at work by subsidizing private sector jobs with insurance.

The second recommendation is to have real work requirements on SCHIP participation and cover families, not just children. A welfare recipient must work for benefits, the parents of an SCHIP recipient do not. Whenever possible to strengthen the link to group coverage, the State should have sensible work requirement at jobs with insurance.

The third recommendation is to have real incentives for States who can place people into publicly organized and subsidized group insurance. Don't merely establish a task force for nationwide education outreach for small business. Low income parents should face stiff provisions to enroll their children and use the benefits appropriately.

The government requires all sorts of things for parents, including sending kids to school, immunizations, the paying of taxes and the provision of child support. The States should have similar provisions with regard to subsidized health insurance for them and their children.

Mr. Chairman, it is sad when a child goes on Medicaid. The goal should be reducing, not increasing the number of children on Medicaid. Bringing SCHIP into alignment with the original principles of welfare reform is an opportunity we do not want to miss, especially for the children.

Thank you.

[The prepared statement of Dr. Rossiter follows:]

TESTIMONY OF LOUIS F. ROSSITER, PH.D.

Good morning Chairman Pallone, Representative Barton, Representative Nathan, and distinguished members of the Subcommittee. I am pleased to be here today to discuss missed opportunities in covering uninsured families. I am a health economist with Medicaid experience at The Centers for Medicare & Medicaid Services (CMS) (1990–1992), and responsibility to the Governor of Virginia on the implementation and operation of our State Children's Health Insurance Program (SCHIP or FAMIS in Virginia) (2000–2002). More recently, I co-authored the Medicaid chapter in a recent Brookings Institution Press book (edited by Alice Rivlin of the Brookings Institution and Joe Antos of the American Enterprise Institute) entitled Restoring Fiscal Sanity 2007: The Health Care Spending Challenge. Based upon this and other research I want to share three missed opportunities represented by H.R. 3963 and why significant improvements can be made.

NUMBER ONE MISSED OPPORTUNITY: ALIGN SCHIP WITH WELFARE REFORM

No one wants uninsured children. Yet, SCHIP should not be renewed without alignment with Welfare Reform[1]: There are three principles that the current SCHIP violates:

1."focus on work"

2."have real work requirements" with "money now spent on welfare and food stamps [redirected] to subsidize private sector jobs"

3."have real incentives to reward states who put people to work".

The provisions of the SCHIP (1997) program are a step backward from the Welfare Reform (1996), passed just one year prior. The capped-grant feature of SCHIP is an improvement over the perverse incentives of Medicaid (Weil and Rossiter 2007). But rather than maximizing group health coverage, our experience with SCHIP fosters all-or-nothing welfare-like coverage and:

1.Encourages uninsurance due to switched coverage for children who may already have access to group coverage and a lag in the period of coverage

2.Fragments coverage for families and lures parents to drop their own group coverage

3. Encourages small employers with low-income workers to abandon coverage

We know we are trading off "two for one"—we buy two uninsured children SCHIP coverage at the cost of existing coverage for one child. The trade off rises to "one to one" at the higher income levels. One reason is that SCHIP does not focus on work.

NUMBER TWO MISSED OPPORTUNITY: UNDERSTANDING HEALTH INSURANCE TRENDS

What is wrong with having more children covered by P-SCHIP even though it means crowding out private coverage? Since enactment of SCHIP, the rate of employer-sponsored insurance has declined and the uninsurance rate increased. No one really understands why. While we might say these trends would have been worse

without SCHIP, with millions of children covered by SCHIP, neither can we rule out an SCHIP effect on all of these families. SCHIP is obviously helping some children but could be harming the U.S. health insurance system and our ability to cover even more children.

NUMBER THREE MISSED OPPORTUNITY: GROUP HEALTH INSURANCE FOR SMALL FIRMS WITH LOW-WAGE WORKERS

To bring SCHIP into alignment with Welfare Reform and ensure that the unintended consequences of SCHIP are minimized, the authorizing legislation needs to be rewritten this Spring to accomplish the following:

A."Focus on work" and gradually eliminate the Medicaid-expansion option the states have under SCHIP. Medicaid expansion programs let the states cop-out of the hard work involved with organizing and subsidizing group health insurance. SCHIP should be separate from Medicaid, focused on work for the parents and used to subsidize private-sector jobs.

B."Have real work requirements" on SCHIP participation and cover families, not just children. A welfare recipient must work for benefits. The parents of an SCHIP recipient do not. Whenever possible, to strengthen the link to group coverage, the states should have a sensible work requirement.

C."Have real incentives for states who can place people" into publicly organized and subsidized group health insurance . Do not merely establish a task force for nationwide education and outreach for small business (H.R. 3963). Revise all of the provisions in HR 3963 to demand that the states aggressively establish programs separately from Medicaid—as 18 states have done—and rapidly grow the separate programs we already have. Low income parents should face stiff provisions to enroll their children and use the benefits appropriately. Ten years of voluntary SCHIP outreach programs is not cost-effective use of public funds. Government requires all sorts of things from parents including immunizations, the paying of taxes and the provision of child support. We should have similar provisions for subsidized health insurance for them and their children.

It is sad when a child goes on Medicaid. We should set the goal of reducing, not increasing, the number of children on Medicaid. Bringing SCHIP into alignment with the original principles of Welfare Reform is an opportunity we do not want to miss.

[1] President Clinton on Welfare Reform, National Governors' Association Summit on Small Children, June 6, 1995. http://www.libertynet.org/edcivic/welfclin.html accessed January 26, 2008.

[2] Rosenbaum, Sara, Borzi, Phyllis C., Smith, Vernon. 2001: Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage through Public Programs. Inquiry: Vol. 38, No. 2, pp. 193-201.

Mr. PALLONE. Mr. Lesley.

STATEMENT OF BRUCE LESLEY, PRESIDENT, FIRST FOCUS, ALEXANDRIA, VA

Mr. LESLEY. Thank you, Mr. Chairman. My name is Bruce Lesley. I am the President of First Focus, a bipartisan children's advocacy organization dedicated to making children and families a priority in Federal policy and budget decisions.

I spent some time working on this committee for Congresswoman Diana DeGette and it was a wonderful experience, worked on many children's health issues as that is a priority of hers, worked on some SCHIP provisions related to covering pregnant women, presumptive eligibility, but also she championed a pediatric organ transplant bill that passed the House I think by 400-something to 3. So I have spent some time working on this committee working on children's health issues.

There is a perception in this town that children fare better than the reality when it comes to Federal legislation. It is epitomized by Dana Milbank's column in the Washington Post during the middle of the SCHIP debate, where he wrote, lawmakers on both sides of

the aisle know that a piece of legislation stands a much better chance of passage if it is about children. He went on to cite eight pieces of legislation as examples. However, he didn't take the next step which was then to look to see how they are faring, and none of them have passed the Congress. It is a disturbing trend that First Focus has increasingly found.

According to an Urban Institute report that First Focus commissioned this past year, entitled Kids Share 2007, the share of Federal domestic spending on children has actually declined by an astonishing 23 percent since 1960. And based on projections from the Congressional Budget Office, that downward trend will drop further over the next decade unless Congress takes specific actions to reverse that trend.

I say that because this I think epitomizes the SCHIP debate. Years ago I worked for Senator Jeff Bingaman on the Senate Finance Committee, and we were faced with the task of what are we going to do about Medicare prescription drug coverage for senior citizens. Congress passed a $400 billion bill very much supported by the President of the United States.

Last year when we were working on SCHIP we had a bill that would have provided $35 billion, far less than the $400 billion provided for senior citizens, and yet we couldn't get it through the administration, who vetoed it twice. I will note that what finally did pass was an $800 million extension. So if you compare 400 billion to 800 million, that is a 500:1 ratio when we dealt with how we dealt with senior citizens and how we dealt with children, but it is not because of the lack of broad public support from the public.

We commissioned a poll by Republican Frank Luntz that showed that 83 percent of Americans supported renewing SCHIP programing, including a 2:1 margin of support from Republican voters.

I think that some of the issues that people outlined today were good ones about how we should move forward. I think that we should all keep in mind is three goals. One is that there are 9 million children in this country who are uninsured and we should keep that as the first and foremost goal. We should also make, and I agree with some of the members who talked about this, the lowest income children the top priority. And last, failing meeting those goals, we should always make sure not to backtrack on coverage, we should definitely do no harm.

I used to play basketball in high school and we used to go out and do training with the track team, and I always was most amazed by the people who did the high hurdles because I tried and failed. But the analogy is that in Medicare we saw an end goal of we needed to provide prescription drug coverage to 43 million Americans, there were hurdles. One thing is that 71 percent of senior citizens had former drug coverage, prescription drug coverage already. What Congress didn't do is say, oh, we can't jump that hurdle, Congress figured out ways around that problem and in the end got to the goal of providing drug coverage for senior citizens.

What I see, I was reading the testimony from CMS, and what instead has happened with the administration this year was that first whole hurdle of cut, crowd-out, which was far lower for SCHIP if you think the crowd-out rate is 34 percent as opposed to 71 percent potentially for Medicare. What we did was stopped and started

looking at that, and that became the goal, and it is that issue rather than getting to the end game of getting low income children covered.

Also the problem is that wasn't the only issue we were hearing. We also heard it was kind of the moving goal. We also—when talking to the White House it was it is not that we have a problem with SCHIP, it is that we want to get our tax credits passed. In talking with OMB, it was an issue of well it is not that we have any problems with any of the legislation, it is the 35 billion is our problem. We put in our budget for 5 billion, which we all know would have actually meant a million children would have lost health insurance.

So what I appreciated Congressman Deal and Congressman Barton talking about is how can we move forward. And one of the ways I think the administration repeated this more than 50 times during the SCHIP debate, and it is let's look at the poorest kids first. I would note that as Cindy Mann testified, the CHIPRA bill, actually the newly covered children, the 3.9 million children who would have been covered, 87 percent of those kids would have been children below 200 percent of poverty. So it took very strong steps toward achieving that goal.

As we move forward though, what we could do is at least take those provisions from that legislation and start there. And some of the things that were in that legislation were the outreach enrollment provision, the express lane eligibility provisions. We have done a great deal in the Medicare side of using health information technology and those kinds of things, and we could do a better job on the SCHIP side on that as well. We could also move forward on quality provisions. We have passed numerous pieces of legislation and CMS has been moving forward on quality for senior citizens. We could do the same and take the provisions out of the CHIPRA bill on quality and move forward.

Just a few words about express lane enrollment. When a child is eligible for—I know I am running out of time, so I will hurry.

Mr. PALLONE. You are about a minute over.

Mr. LESLEY. Over, okay. I will just finish up then. On express lane enrollment, the issue is that if a child is enrolled in food stamps or school lunch or those other kind of programs, States have in their systems that data, the eligibility data, that shows that these kids are—you know for a fact are eligible for Medicaid or SCHIP. So one of the things that was really great about the CHIPRA bill is that it had language that allowed that data to be used for eligibility determination for the SCHIP and Medicaid programs. It is in that vein that I think we can move forward. That is something that I did not hear any opposition for, and I hope we will start from there and move forward.

Thank you very much.

[The prepared statement of Mr. Lesley follows:]

FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

TESTIMONY OF
BRUCE LESLEY, PRESIDENT, FIRST FOCUS

HOUSE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

"COVERING UNINSURED KIDS: MISSED OPPORTUNITIES FOR MOVING FORWARD"

JANUARY 29, 2008

Good morning Chairman Pallone, Ranking Member Deal, and all other members and staff of the Energy and Commerce Health Subcommittee. I am Bruce Lesley, President of First Focus, a bipartisan children's advocacy organization affiliated with the America's Promise Alliance dedicated to making children and families a priority in federal policy and budget decisions.

I have worked in federal, state, and local policymaking for 20 years. Most recently, I spent six years working for Senator Jeff Bingaman on the Senate Finance and Health, Education, Labor, and Pensions Committees, but I also worked for Senator John Breaux back in 1997 during enactment of the State Children's Health Insurance Program (SCHIP) and for the National Association of Children's Hospitals during the initial implementation of SCHIP. I also covered the issues under this committee's jurisdiction when I worked for Congresswoman Diana DeGette several years ago, and am honored to be sitting before you today.

I appreciate the opportunity to testify today about what we can do now to improve health coverage for the 9 million children in our nation who are currently uninsured. This is an American issue that affects not only our children but all of our futures. It is also a choice between investing now in improving the health and well-being of America's children or dealing with the effects of childhood obesity, growing levels of children diabetes, and the lack of preventable disease when today's young people become adults.

Federal Policy: The Perception and the Reality

There is a perception in this town that children likely fare far better than the reality when it comes to federal legislation. It is epitomized by Dana Milbank of the *Washington Post* when he wrote during the middle of the SCHIP debate last year, "[L]awmakers on both sides know that a piece of legislation stands a much better chance of passage if its about kids." He went on to cite eight pieces of legislation, including the "Kids Come First Act," the "Protect Our Children First Act," and the "Safe Babies Act," as examples. However, he should have taken the next step, which would be to look at their status in the legislative process. Not a single one had even passed a Congressional committee. This is a disturbing trend that First Focus has increasingly found.

According to an Urban Institute report that First Focus commissioned this past year entitled "Kids' Share 2007," the share of domestic spending on children has actually *declined* by an astounding 23

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percent since 1960 and, based on projections from the Congressional Budget Office, that downward trend will drop further over the next decade unless Congress takes specific actions to reverse the path.

Although the American public believes that the federal government likely spends about the same on senior citizens as children in terms of health care[1], the fact is that federal health care spending exceeds that for children by more than a 10-to-1 ratio. In 2003, the Congress passed a Medicare prescription drug benefit that was expected to cost $400 billion over five years and around a trillion dollars over 10 years. Four years later, as we are all painfully aware, Congress passed a $35 billion expansion for children's health, but it was vetoed on two occasions by President Bush. In response to the veto, Congress passed an extension bill at the end of last year that increased funding for children's health by a mere $800 million. In terms of funding, the numbers are pretty stark: CBO figures show that Congress passed an increase in Medicare for prescription drugs in the amount of $400 billion compared to $800 million for children. This is a 500-to-1 ratio.

However, the disparity is also apparent when it comes to investing in areas such as quality improvement and information technology in the Medicare program as compared to Medicaid and SCHIP, which are the health programs critical to children.

At various times, Congress has taken critically important steps in addressing problems facing children and the downward trend in investment in the next generation. In the 1990s for example, a Democratic Congress passed President George H,W, Bush's Healthy Start initiative to reduce infant mortality. In 1997, a Republican Congress and President Clinton confronted the crisis of 10 million uninsured children in this country by passing SCHIP. Healthy Start and SCHIP have been unqualified success stories, as Healthy Start helped reduce infant mortality rates in this nation and SCHIP contributed to reducing the number of uninsured children by one-third, reducing racial and ethnic health disparities, and improving access to care for children.[2]

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[1] Marc Berk, et al, "Americans' Views About the Adequacy of Health Care for Children and the Elderly," *Health Affairs*, September 14, 2004.

[2] Genevieve Kenney and Justin Yee, "SCHIP at a Crossroads: Experiences to Date and Challenges Ahead," *Health Affairs*, March/April 2007; and, Genevieve Kenney, "The Impacts of the State Children's Health Insurance Program on Children Who Enroll: Findings From Ten States," *Health Research and Education Trust*, August 2007.

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Unfortunately, Healthy Start funding has stagnated, the program has not been reauthorized, and infant mortality is on the up-tick. It should also be noted that other children's initiatives, such as the Children's Health Act, have either not been reauthorized or, like the Maternal Child Health Block Grant, have seen dramatic declines in funding in recent years.

Meanwhile, as we entered last year, funding for SCHIP faced a $15 billion shortfall over a five-year period, while the number of uninsured children had reversed course, increasing by one million during the past two years. While that trend is alarming, a state-by-state look at the insurance status of children reveals trends that are, perhaps, of even greater concern. In 39 states and the District of Columbia, the percentage of children without insurance was higher in 2006 than it was in 2004. In 29 states, the rate increased by a full percentage point or more. I have included an analysis of these trends as Appendix A.

It is this negative trend that we call upon Congress to reverse.

The Public is Calling for Immediate Action for Children

If we truly wish to ensure the next generation is healthier than this one, we cannot wait. It is an American issue that concerns us all. According to public opinion research conducted by Republican pollster Frank Luntz last year, a majority of the American public believe, for the first time, that the next generation will fare worse than the current generation. Moreover, over 70 percent of Americans believe that the state of children's health care in this nation is either a crisis or a major problem and 83 percent supported reauthorization of SCHIP last year.[3] Furthermore, in a poll of Republican voters only, Fabrizio, McLaughlin & Associates found that "by a 2 to 1 margin, a majority of Republicans favor renewing and providing additional resources for the State Children's Health Program."[4]

This is a timely issue not only because of our collective efforts last year on SCHIP reauthorization, but also in light of the recent wave of regulatory actions targeting children's health programs and the

[3] Luntz, Maslansky Strategic Research, "Making Children a Priority: Survey 2007," July 2007 (conducted for First Focus and can be viewed at http://www.firstfocus.net/pages/3206/).

[4] Fabrizio, McLaughlin & Associates, "National Survey of Republican Voters," September 21-23, 2007 (conducted for First Focus and can be viewed at http://www.firstfocus.net/pages/3206/).

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current economic forecast for our country, which will likely mean that many more low-income children will be added to the rolls of the uninsured in the coming months.

Although we were not able to reach a five-year deal on SCHIP last year, as we move forward I believe that it is important to recognize that in both the House and the Senate, broad bipartisan majorities supported reauthorization.

We also are grateful for the near unanimous support that the SCHIP extension won in both the House and the Senate at the end of last year, as the legislation passed the Senate by unanimous consent and in the House by a vote of 411-3. We would like to thank everybody on this Committee, particularly Chairman Dingell and Congressmen Barton, Pallone, and Deal for their leadership in working across the aisle to fully fund SCHIP and to ensure that state SCHIP programs were able to continue to operate. The final language reflected much of Congressman Barton's legislation and was no inconsequential task, as CBO had estimated that the pending funding shortfall threatened the health insurance coverage of 1.4 million children and pregnant women across the country.

Starting from Those Areas of Common-Ground

In the months ahead, it is important to note that the SCHIP negotiations produced broad areas of consensus between the House and Senate SCHIP bills. Rather than focusing on those areas that divide the two parties, we urge the Congress to begin renewed discussions around SCHIP from those areas of common-ground and broad consensus. Perhaps most notably, I think we all agree that the poorest children in our nation should be our foremost priority for coverage.

Proponents of the SCHIP reauthorization bills last year pointed to the CBO estimates that the vast majority of children covered under the legislation were children eligible for but unenrolled in either Medicaid or SCHIP. At the same time, many opponents of the Congressional SCHIP proposals repeatedly voiced their support for the principle that coverage should be provided for low-income children first. For example, throughout the fall debate, the Administration repeated more than 50 times its principle that SCHIP should indeed cover the "poorest children first." Although we often strongly disagreed with the positions that the Administration took on SCHIP last year, we certainly do support the idea that the focus should be on the 5-6 million children in this country that are eligible for but unenrolled in either Medicaid or SCHIP.

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Rather than waiting to 2009 to improve SCHIP, Congress could lay the groundwork for full reauthorization by enacting those items of common-ground and widespread agreement, including improving coverage for the very lowest income uninsured children in our nation. Although the task of targeting our nation's poorest kids is not an easy one, it is certainly achievable, as the vast majority of these children are already eligible for and participate in other federal benefits programs. According to data from the Agency for Health Care Research and Quality (AHRQ), 62 percent of all uninsured children are eligible but unenrolled in either Medicaid or SCHIP. AHRQ economists Julie Hudson and Tom Selden note, "Of these [children], 36.1 percent were in families with incomes below poverty, and another 41.1 percent were in families with incomes of 100-200 percent of poverty...Clearly, this group includes some of the most disadvantaged children in the United States."[5]

Therefore, I urge Congress to take up the President's goal and campaign promise[6] to reach more of the so-called "eligible but unenrolled" children by making more extensive use of the data collected by other needs-based public programs, to help identify and enroll children in Medicaid and SCHIP through what is referred to as "Express Lane Eligibility."

The essence of Express Lane Eligibility, legislation introduced by Senators Richard Lugar and Jeff Bingaman in the Senate and contained in the SCHIP reauthorization bill by Chairman Dingell, is that if a child is eligible for federal programs such as the school lunch program, the Food Stamp program, the Women, Infants, and Children, or WIC program, and others, then we have data on these children's income, their residence, their household size, etc. For the majority of the eligible but unenrolled children in this country, the federal government already has virtually all of the data it needs to determine whether the child is eligible for Medicaid or SCHIP – often in the exact same computer system that tracks Medicaid and SCHIP eligibility. In fact, the Urban Institute estimates that 70 percent of the children who are currently eligible but unenrolled in Medicaid or SCHIP would get coverage if Express Lane Eligibility was put into place.

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[5] Julie Hudson and Thomas Selden, "Children's Eligibility and Coverage: Recent Trends and a Look Ahead," *Health Affairs*, Web Exclusive, August 16, 2007.

[6] President Bush said in his speech at the Republican National Convention on September 2, 2004, while campaigning for reelection, "America's children must also have a healthy start in life. In a new term, we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for the government's health insurance programs. We will not allow a lack of attention, or information, to stand between these children and the health care they need."

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For example, if a child participates in the federal Head Start program or the federal Food Stamp program, the state has actual data in its computer systems about that child's family income level – often in the same computer system. Through this data, the states could easily determine whether these children also qualify for health coverage through Medicaid or SCHIP. Rather than requiring both the states and low-income families to once again have to provide duplicative documentation, including pay stubs, electric bills, etc., Congress could allow that data from other federally-financed programs to be used for eligibility determination.

The concept is actually a fairly simple one, as the Medicare drug program already uses eligibility determinations for senior citizens and the disabled in both Medicaid and SSI to ascertain auto-enrollment in the low-income subsidy. Once again, if eliminating unnecessary bureaucracy and red tape is good for senior citizens, why not children?

The bottom line is that if the federal government already knows a child's income, their residence, their citizenship, or whatever other data is needed to determine eligibility, Congress should allow the states to take whatever steps are necessary to allow the simple transfer of that data from one program to another to get that child the health care they need.

In addition, other consensus items could include language from the reauthorizations bills already passed by this Congress on three occasions:

- Express Lane Eligibility;
- Outreach and enrollment;
- Health quality improvement;
- Health information technology and model electronic records;
- Grants to reduce racial and ethnic disparities;
- Improved data collection;
- Coverage of dental care;
- Coverage of pregnant women;
- Demonstration projects on childhood obesity;
- Demonstration projects related to childhood diabetes prevention.

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We also urge Congress to push for studies to help reach a solution to those areas of disagreement this year, including:

- Substitution of SCHIP coverage for private coverage (including a look at how that is working in the Medicare prescription drug program and how Medicare and Medicaid use wrap-around coverage to reduce crowd-out);
- Access to care for primary and specialty care services;
- Problems related to citizenship and identity documentation, particularly as it relates to children;
- Update of the federal evaluation of SCHIP.

We should not lose sight for even a moment of what we are talking about here. Devonte Johnson, a young boy from Texas, lost his Medicaid coverage due to bureaucratic errors and he died from untreated kidney cancer. Deamonte Driver, a young boy from Maryland, lost his Medicaid coverage due to bureaucratic errors and died from an untreated dental infection.

Thus, children's health care coverage is about that ensuring children have access to affordable health care services they need. It is about ensuring that children with cancer get the chemotherapy treatment they need and that children with dental infections or cavities get the treatment they need. No child should die or suffer because of system failures and lack of health insurance coverage. And fundamentally, it is on this matter that we can agree and we urge action upon as soon as possible.

Before I close, I also wanted to thank Chairman Dingell and Chairman Pallone for their recent letter to Secretary Leavitt regarding the recent wave of regulations from the Centers for Medicare and Medicaid Services, to restrict states in their efforts to reduce their numbers of uninsured children. We are pleased that Congress included in the SCHIP extension bill a moratorium on implementation of a Medicaid regulation restricting payment for various school services, including outreach funding. This effort was intended by Congress to ensure that no child would lose health care coverage during the interim period before Congress sought to once again pass a reauthorization bill.

However, the Administration has decided the status quo is not the direction in which they wish to head, and instead have issued a number of other regulations and guidance changes that will both cut

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children off of coverage and severely limit services or the reimbursement of services for their care. According to an analysis of the various actions by the Centers for Medicare & Medicaid Services, if the various regulatory or guidance changes are implemented, over $12 billion in federal Medicaid spending will be cut over five years. The National Association of Children's Hospitals estimates that "over 54 percent of the federal savings is the result of changes that would seriously impact children with special health care needs."[7]

The goal should be to drive toward covering all children, and, as Congress intended, to at least do no harm in the interim. The goal, however, should not be to increase the number of uninsured children to 10 million or to further cut children off from much needed health care services.

To highlight one of those changes, we are particularly concerned about the Administration's August 17th directive to states that effectively cuts off coverage for children who are in families with incomes above 250 percent of the federal poverty level. This will have negative consequences on the health coverage of children in 23 states, including states such as New Jersey, Ohio, Indiana, North Carolina, Louisiana, and Oklahoma, and we respectfully urge Congress to take whatever action necessary to ensure that no child who is currently eligible for coverage loses health care as a result of this or any other directive. As a nation, we cannot allow vulnerable children to be denied much needed health coverage by administrative fiat and disregard for Congressional policy-making and intent. As such, we urge Congress to take whatever action is necessary, including legislative or appropriations vehicles or through use of the Congressional Review Act to block these harmful regulations to children.

And finally, First Focus urges the Energy and Commerce Committee to also enact the bipartisan Healthy Start reauthorization bill introduced by Representatives Towns and Upton to combat infant mortality, as well as the provisions within this Committee's jurisdiction related to the Indian Health Care Improvement Act and other measures that are important to Native American children, and to begin work in coordination with the Ways and Means Committee to take a focused look at the special health care needs of children in the foster care system.

Thank you again for the opportunity to testify. I will end where I began – while some of the aspects of last year's SCHIP debate may have been in dispute, there was, and continues to be, near universal

[7] National Association of Children's Hospitals, "Impact of Recent CMS Actions on Child Health Care and Children's Hospitals," December 21, 2007.

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support for providing SCHIP or Medicaid coverage for the nation's lowest-income uninsured children who already qualify for Medicaid or SCHIP.

Although children may represent just one-quarter of our nation's population, they represent all of our future. We must continue to build upon SCHIP's success in reducing the number of uninsured and not to head backward. The health and well-being of our nation's children cannot wait.

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APPENDIX A

FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

Kids without Coverage:

State by State Trends, 2004-2006

Summary

Each year the Census Bureau releases information regarding the health insurance status of Americans. This year, that data showed that 8.7 million children were without health coverage in 2006. This amounts to 11.7% of all children, and is a significant increase from 2005, when 10.9% of all children were uninsured. While the jump in the national rate is certainly alarming, a state by state look at the insurance status of children reveals trends that are, perhaps, of even greater concern. Most states across the country saw rises in the percentage of children without coverage from 2005 to 2006, and even more saw rises in this percentage over the two year period from 2004 to 2006. While there are some regional differences, the national trend of more and more children without insurance is happening on the local level as well.

"Highlights"

- In 39 states and the District of Columbia, the percentage of children without insurance was higher in 2006 than it was in 2004

- 15 states experienced climbs in their rate of uninsured children in both of the past two years. Only 9 states enjoyed two straight years of reducing the percentage of uninsured children.

- The biggest jump in uninsured children was in Louisiana, with its rate more than doubling since 2004 (from 7% to nearly 16%). The biggest drop was in Oklahoma, going from 16.2% in 2004 to 12.5% last year (nevertheless, Oklahoma's rate is still higher than the national rate).

- 6 states had rates of uninsured kids that jumped more than 4 percentage points since 2004, and no states dropped that much. The percentage of uninsured children grew by more than 1 full percentage point in 31 states over that time.

APPENDIX A

- In 2006, 17 states had higher rates of uninsured kids than the national rate, including some of the largest states like California, Texas, and Florida. This is up from only 11 states in 2003.[8]

Regional Differences

States in the Midwest and the Northeast tend to have lower rates of uninsured children than the rest of the country (west of the Mississippi and north of Virginia, only New Jersey and Delaware have more than 10% of their kids uninsured), while children in the South and the Southwest generally fare the worst (Texas tops the list with 21.12% of its children without coverage). While there are easily identifiable regional clusters when it comes to rates of coverage, these clusters disappear somewhat when looking at the year to year changes. States that saw increases in uninsured children two years in row can be found all over the map, from New York to Hawaii, from Idaho to Florida. However, more than half of the 11 states that have lowered their percentages of uninsured children since 2004 can be found in the mid-Atlantic and Midwest region.

While variations exist across states for numerous reasons, including economic conditions, eligibility rules for public coverage, and the level of resources dedicated to public health, there can be no doubt that the national trend of higher rates of uninsured children is reflected in and perhaps generated by the state trends.

Limitations of the Data

The numbers used in this report come from the US Census Bureau's Current Population Survey Social and Economic Supplement from 2004 to 2006. These numbers are generated from sampling, and as such, there is the potential for error. When using subsets of data (like children in specific states), the margin of error grows. Because of this unavoidable sampling error, for many of the differences between rates from one year to the next, we cannot say with a high degree of certainty, that the difference is "real." That is to say some of the differences are not statistically significant. Those that are statistically significant are marked that way in the table on the following page.

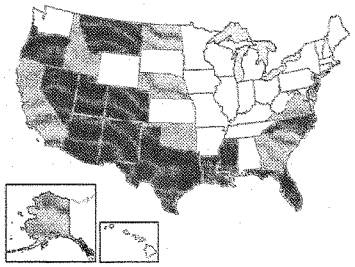
[8] Peterson, Chris L. Health Insurance: Uninsured Children by State, 2001-2003. Congressional Research Service. August 31, 2004.

APPENDIX A

	2004	2005	2006
United States	10.5%	10.9%	11.7%*
ALABAMA	6.3%	4.5%	7.4%*
ALASKA	9.7%	8.6%	10.5%
ARIZONA‡	13.8%	16.4%	17.0%
ARKANSAS§	6.2%	10.7%	9.3%
CALIFORNIA	11.8%	13.4%*	12.8%
COLORADO	14.5%	13.7%*	14.6%
CONNECTICUT	7.1%	7.7%	6.0%
DELAWARE	11.3%	11.7%	11.7%
DISTRICT OF COLUMBIA	7.1%	6.3%	8.7%
FLORIDA‡	14.4%	18.1%	18.9%
GEORGIA	11.4%	11.0%	12.8%
HAWAII§	3.8%	5.2%	6.4%
IDAHO‡	8.6%	11.4%	12.9%
ILLINOIS	10.5%	10.0%	9.5%
INDIANA	8.5%	9.8%	7.8%
IOWA	5.9%	5.0%	6.2%
KANSAS	6.4%	6.2%	7.3%
KENTUCKY	8.3%	6.8%	9.7%†
LOUISIANA‡	7.0%	8.4%	15.9%*
MAINE	4.5%	7.5%†	6.3%
MARYLAND	9.4%	8.3%	9.9%
MASSACHUSETTS	5.8%	4.2%	7.0%*
MICHIGAN	6.0%	5.0%	4.7%
MINNESOTA	6.2%	5.9%	8.3%
MISSISSIPPI‡	13.4%	11.3%	18.9%*
MISSOURI	7.3%	7.5%	9.1%
MONTANA	14.0%	14.0%	14.6%
NEBRASKA‡	5.9%	5.2%	10.1%*
NEVADA	16.0%	14.4%	18.8%†
NEW HAMPSHIRE	6.2%	5.4%	7.3%
NEW JERSEY‡	10.1%	10.5%	13.3%†
NEW MEXICO	14.5%	20.1%*	17.9%
NEW YORK‡	6.7%	7.7%	8.4%
NORTH CAROLINA‡	10.0%	11.7%	14.0%
NORTH DAKOTA‡	9.0%	9.2%	10.4%
OHIO‡	7.9%	7.6%	5.6%*
OKLAHOMA§	16.2%	11.0%*	12.5%
OREGON	10.5%	10.3%	13.1%
PENNSYLVANIA‡	9.5%	7.4%*	7.3%
RHODE ISLAND§	7.1%	7.6%	4.2%*
SOUTH CAROLINA§	7.8%	10.2%	10.7%
SOUTH DAKOTA	7.9%	8.0%	9.3%
TENNESSEE‡	9.4%	9.1%	6.4%†
TEXAS	20.7%	18.9%†	21.2%*
UTAH‡	10.2%	12.3%	15.0%
VERMONT‡	4.5%	5.3%	8.3%†
VIRGINIA‡	7.2%	8.5%	10.1%
WASHINGTON	6.6%	8.7%	6.9%
WEST VIRGINIA	8.8%	6.7%	8.6%
WISCONSIN	4.7%	6.9%†	4.9%
WYOMING	8.5%	11.0%	8.1%

* Statistically significant difference from previous year, $p < 5\%$
† Statistically significant difference from previous year, $p < 10\%$
‡ State's rate in 2006 is significantly different from 2004, $p < 5\%$
§ State's rate in 2006 is significantly different from 2004, $p < 10\%$

Rate of Health Insurance Coverage Among Children, 2006

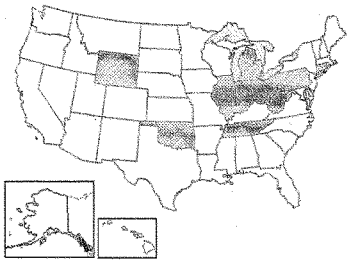


Percentage of children without health coverage is less than 10%

Percentage of children without health Coverage between 10 and 13%

Percentage of children without health coverage is greater than 13%

Change in the Rate of Health Insurance Coverage Among Children from 2004 to 2006



Percentage of children without health coverage has increased since 2004

Percentage of children without health coverage has decreased since 2004

Mr. PALLONE. Thank you, and I thank all of the panel for your opening statements. Now we will go to questions and I will recognize myself initially for 5 minutes. I wanted to start with Ms. Mann.

Just so you understand my perspective, I remember a year ago when the State delegations were coming here and saying, you know, we are running out of money, we are going to have to take kids off SCHIP. So we passed a temporary measure then. I think it was part of the supplemental to carry them. But the main goal was to have the much larger program to cover up to 10 million kids, which was the CHAMP bill, which unfortunately was vetoed twice by the President.

We then, as you know, passed as part of the omnibus, I guess, to continue SCHIP and theoretically at least hold harmless and make sure there was enough money for the next year. My concern obviously is that there won't be and with the economic slump we will start to see more and more people that need SCHIP as well as Medicaid. But even beyond that, the August 17th directive, instead of allowing us to expand the kids, puts such a crimp on it that States are going to now actually have to not be able to enroll kids who are currently enrolled. So my fear is that we just can't wait around here until 2009 or the next President or whatever, that we are going to face an increasing crisis.

So I wanted to ask you, Ms. Mann, you have spent a lot of time studying this August 17th directive, and CMS says it was a way to improve coverage for low income children. Do you believe that that will be the result or is this directive going to have the opposite impact? And if you don't agree with the administration that this is actually going to improve coverage, what do you think is going to happen? How will kids be affected? How many States, or kids are going to be negatively impacted? We're just trying to get a handle on it.

Ms. MANN. Well, thank you for the question, Chairman Pallone. There is not even a theoretical answer anymore, there is an actual answer. We have had activity taking place since the directive was issued between CMS and with States and no State has gotten an approval of their coverage plan to go forward to cover kids over 250 percent over the poverty line since the directive. We have had two States that have had denials and we have had other States that have cut back their planned expansions, expansions that their State legislatures had determined were needed in their States because of the directive. As a result, we have already seen just in the short time since the directive has been in place tens of thousands of children who otherwise would have had coverage not get the coverage that their State has already determined that they needed.

When we come around to August '08, even more States will be under the requirements of the directive that CMS gave the States that had already been covering children above 250 percent of poverty, States like your State of New Jersey, until August '08 to come into compliance. CMS has said that the children in those States who are already enrolled do not have to come off the program, but the State will not be able to enroll any new children, including the children who might have income fluctuating and go off and on again.

So it will have a decimating effect, and it is very important to think about it in light of the worsening, weakening economy.

We are going to be seeing more children become uninsured, children who are eligible for Medicaid, children eligible for CHIP and children in that in between area who simply don't have an opportunity to buy affordable health insurance coverage. That really was CHIP's original intent. There was a lot of discussion about did CHIP go beyond its original intent. Its intent was to bridge that affordability gap between Medicaid and private health insurance coverage. That gap has been growing, and we need to take into account that that gap has been growing.

Mr. PALLONE. So there is no doubt on your part that over the next year because of the economy, because of this directive, we are just going to have a lot more kids that are not going to be covered.

Ms. MANN. We will go backward over this year, absolutely. CHIPRA would have helped the States move forward by giving stable and predictable funding, by helping with the performance based payments for Medicaid as States enrolled children. The Medicaid eligible children have a lower Federal match rate so States, particularly when they are in a weakened economic circumstance, are reluctant to enroll those Medicaid eligible children, they bring less Federal dollars. CHIPRA would have addressed that. CHIPRA would have given States new tools like express lane to encourage the enrollment of eligible children, focusing the resources on the lowest income children. All of those opportunities are not now on the table as well as the August 17th directive that stops States in their tracks from moving forward for families who have a growing affordability problem purchasing health insurance.

Mr. PALLONE. Mr. Lesley, you wanted to talk about the missed opportunities in terms of outreach and all that. Just briefly because my time is pretty much over.

Mr. LESLEY. Sure. Just to build on that. As Ms. Mann pointed out and your question is that if the third principle of what Congress did last year in passing the extension was really affirming that no, that we should at least maintain the status quo and we should not go backtrack. The problem with the regulations is that that is exactly what we are doing, and we will see increased numbers of uninsured children.

On outreach and enrollment, I do believe that we do have an opportunity. The President when he was running for reelection stood on the platform at the Republican National Convention and declared he would do everything in his second term to address this issue of eligible but unenrolled children. He put in the budget a few years ago a billion dollars for outreach and enrollment. Somehow that has disappeared. And what we would like to do is to take up that promise, and I think that that is something we could do now and really take some of the aspects of CHIPRA, and they were not controversial, and move forward in terms of trying to get express lane enrollment and outreach enrollment. A part of that is dealing with the regulations because they do cause a backward momentum for kids.

Thank you.

Mr. Deal.

Mr. DEAL. I would observe at the beginning that my understanding is that CBO has said that there would be a 3.3 percent annual rate of growth in the SCHIP program under the extension that we have already passed, so I think that is a question of whether there is a regression or a continued state of growth.

Dr. Rossiter, you are an economist and many people here on the Hill as we talk about a stimulus package today in all of our States are concerned about the economy. Let me ask you a question as to whether you think the CHIPRA bill would have a positive or a negative effect on the American economy?

Mr. ROSSITER. I guess I have a different view than has been expressed regarding the impact of these expansions, because my concern is that we have not ruled out the possibility that SCHIP and especially in its form of Medicaid expansions is really doing more harm to our health insurance system and employers, especially to small employers than if the States worked really hard, as some States are doing. Some States have separate programs and seem very happy with them and are working real hard. And by the way, they happen to be States that are also working on general health insurance reform.

The missed opportunities that we have allowed SCHIP to morph into in many parts of a Medicaid only program and forgotten the welfare principals. And because of that it is having a negative impact on small employers who will probably be the first to be hard hit by a recession if that is what we are in.

Mr. DEAL. Would you expand upon the implications if a State were to eliminate the Medicaid expansion options to a State? What effect would that have for the SCHIP program?

Mr. ROSSITER. Well, there are only nine States that are Medicaid only, and then there is a mixture. There are other States like Virginia who are a mixture, so they could reduce their Medicaid only portion. But there are other States that are separate programs entirely, and those include Georgia, Pennsylvania, New York and Texas.

One thing I could see is that in a revised bill that you bring the match level in line for those who are in SCHIP who are Medicaid only, make it the same match rate as Medicaid. Why should the match rate be higher than for a higher income child and lower income? Why should there be no work requirements or any other requirements, including asset tests, and yet the Federal Government is paying a higher rate? It would save money and you would be able to expand and encourage States to put in place separate programs that would better blend and merge and support the private health insurance industry.

Mr. DEAL. Thank you.

Mr. Peterson, I have just a very brief question. Looking at the CBO scoring of the CHIPRA bill, it appears to me that they are projecting that only 800,000 individuals who are currently enrolled for SCHIP would be enrolled in the expansion; is that the way that you read that?

Mr. PETERSON. Say that again, please?

Mr. DEAL. That in terms of expanding coverage for currently eligible SCHIP children that there would only be 800,000 that would fit that category.

Mr. PETERSON. I would have to look up the CBO.

Mr. DEAL. Well, that would be those who are eligible, but unenrolled. I will share the chart with you.

Mr. PETERSON. Yeah. I will follow up with you.

Mr. DEAL. All right.

One of the things that I think concerns all of us is that we have different numbers that people are throwing around here. In looking at that CBO score it appears to me that if you look at the bottom line they say that under the bill that was proposed there would be 7.4 million enrollees in SCHIP and yet we hear the figure of 10 million children thrown around. And yet even in the 7.4 there is a significant crowd-out of children who currently have private insurance that would be included in that number.

Dr. Rossiter, can you give us some insight as to why the numbers don't seem to add up?

Mr. ROSSITER. The numbers don't add up probably because that crowd-out figure, it could be underestimated and I think also it tends to be a question of tactics rather than strategy that gets applied when we use these numbers. By that I mean we talk about the children. Of course no one wants uninsured children, but what kind of system are we building if we continue to use Federal funds to match the State funds that possibly could be harming private health insurance industry? And after all, where do we want it to go in the long run? So I think the figures are important, but they come into question because we haven't agreed upon what kind of health care system we would like for our children in the future.

Mr. DEAL. Thank you, Mr. Chair.

Mr. PALLONE. Thank you, Mr. Deal. The gentlewoman from California, Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman, and thank you to all of the witnesses. I think you did an excellent job. I just want to make a couple of comments about some of the things that were said and then quickly go to my questions.

Mr. Lesley, thank you for everything that you said and your good work, and I was very pleased that in your testimony that you mentioned the benefits of Health Information Technology, HIT. It is an area that the Congress I believe needs to address. I think it is a nonpartisan issue. I think that billions of dollars potentially could be saved. We put into place an effective system and I am proud to have introduced bipartisan legislation on it and look forward to the committee taking that up.

To Dr. Rossiter, I am a bit puzzled about some of your testimony. The whole issue of tying children's health insurance to people that work. I don't think that is the basis by which we solely establish health care coverage for children. Children don't work and their parents, many parents, have a huge problem getting coverage. And so the incentive was to offer this so the children are insured. So I am kind of puzzled by that nexus that you established in your testimony.

But let me get to my questions. To Ms. Mann, thank you for the work that you do at the Center for Children and Families at Georgetown. Much has been made about the phenomenon called crowd-out. You know what crowd-out is, we know what it is. For the record, they are workers who may be able to get private insur-

ance for their families at work and they instead opt out for coverage under SCHIP.

To what degree does crowd-out exist? Can you give us some information about that and what factors lead to it? If you can set that down for the record, I think it would be helpful to us.

Again, if you could briefly restate for us, you began to touch on this, but your time ran out in your testimony about States that wanted to expand their health insurance for children and the directive that has come from the Federal Government which I think myself is absolutely punitive. I mean it is like we are going to show you you are not going to be able to do this.

So if you could address those two things. Again, Mr. Chairman, thank you for having the hearing.

Ms. MANN. Thank you. First, let me address crowd-out. It is unfortunately not as simple a topic on—different measures of crowd-out look at different things. The CBO analysis is a very broad conception looking more at the population as a whole, looking at the economy. What might have happened in terms of public or private coverage or uninsured rates had CHIP not been in place or had the Congress not passed the CHIPRA law.

States often look at the issue of crowd-out to examine what coverage did families have before they went into CHIP, and did they drop private coverage, and if they dropped private coverage for what reasons. When States have examined that question, and the congressionally mandated evaluation of CHIP also looked at that question, they have found a very small portion of crowd-out, very small, around 7 percent of families that had private coverage drop them. A lot of families that might have had private coverage in the income range of the CHIP program had it at a very high cost. They were paying very high premiums. The average family premium last year, according to the Kaiser study, is about $12,000 per year without an employer contribution. So if your employer doesn't contribute towards family coverage, it is very difficult to afford.

Ms. ESHOO. If I might jump in, that is an extraordinary number, and it goes to the heart of this debate about both the directive and how it presses down, depresses the whole situation, but the huge criticism that my colleagues on the other side of the aisle have leveled about the costs and what families would be eligible for this. I mean, one child, $12,000 a year?

Ms. MANN. For family coverage.

Ms. ESHOO. You know, we make some $160,000 a year. What about each one of us, with the number of children that we have, paying $12,000 a year for a policy?

Ms. DEGETTE. And will the gentlelady yield? In some States, like New York and New Jersey, for a family of four that is an average, $12,000 is an average in some of those States, like Mr. Pallone's State insurance premiums for that same family can be $20,000.

Ms. ESHOO. Thank you.

Ms. MANN. And I think that is Ms. Chester's point as well, is that she had an offer of health insurance from her job but it was simply unaffordable, and that is increasingly the case.

The other point to remember, as CHIP States go up the income ladder a bit and address the affordability problem, they are not providing free coverage for families. Families pay premiums in the

CHIP program, so CHIP does not give out free coverage. It provides affordable coverage, which is of course exactly the goal.

Ms. ESHOO. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Ranking Member, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman, and I thank the witnesses. I want to talk a little bit about adults in SCHIP. I know the focus is children in SCHIP, as it should be. I am told that if we didn't cover adults we would have a lot more money for children, which we all support. So I want to ask Mr. Peterson, do you have any information about what it costs to cover an adult under SCHIP and how much money would be freed up if we didn't cover adults under SCHIP?

Mr. PETERSON. Well, we had done an analysis that adults' cost on average doubles what children cost. Adult coverage, however, when it was first offered through waivers, it was specified under the Clinton administration that if the administration was going to approve that, that the State would have to ensure that they were doing a good job of covering those targeted low income children. But on the per capita cost in particular, yes, it is true that adults are approximately double.

Mr. BARTON. Okay. Dr. Mann, do you up support phasing adults out of SCHIP so we have more money for children?

Ms. MANN. The action taken by the Congress in CHIPRA shows that there is support for coverage generally and that the tradeoff is between a child at $42,000 versus a child at $18,000.

Mr. BARTON. I am asking do you support adults being covered under SCHIP?

Ms. MANN. I support the opportunity for States to cover adults when they are also able to cover children.

Mr. BARTON. So you think it is okay for us all to be under SCHIP?

Ms. MANN. The earlier waivers that Mr. Peterson talked about, I was actually at the Health Care Financing Administration when those were issued. We issued that policy and it said explicitly to States that were looking to cover adults, to cover parents. We didn't allow States to cover childless adults through that waiver policy, that you had to be doing a good job covering children.

States have found when they covered their parents they have increased enrollment of children. I think our experiences in New Jersey that will testify in the next panel substantiates that. It has not been a trade off in terms of covering parents versus children.

Mr. BARTON. So you dispute what Mr. Peterson says, that it will cost twice as much to cover an adult?

Ms. MANN. My understanding is that it is about 1.6 difference.

Mr. PETERSON. Yeah, that was our original analysis. There has been new data.

Ms. MANN. And there are also adults that are covered in CHIP that are pregnant women, and they are far more expensive than the parents who are covered. So it varies.

If I might point out, one of the reasons why a few States, and there is really only at this point 11 States with parent waivers, 10 States that are operating them still, some of the reasons why States used waivers is that they were not able to use their CHIP

dollars to cover children. They had already expanded coverage for children——

Mr. BARTON. They had 100 percent coverage in the eligible population. That is not true.

Ms. MANN. No, what I am saying is they weren't allowed by the provisions of CHIP law to use any of their CHIP dollars to cover children. They didn't have 100 percent participation rate, but they were blocked from using CHIP dollars because the State that had already expanded Medicaid before CHIP was enacted were foreclosed from using CHIP dollars for children. And so some of those States were then given the opportunity to use some of their CHIP dollars.

Mr. BARTON. Dr. Rossiter, what is your position on adults in SCHIP?

Mr. ROSSITER. I think the childless adults don't make sense to me in SCHIP, but——

Mr. PALLONE. I don't think his mike is on.

Mr. ROSSITER. Childless adults should not be covered under SCHIP. They do cost more, we can cover more children, but family coverage does make some sense to me, especially when you have a separate program that is not Medicaid and you can use those funds to subsidize private based insurance. Just as an example, Maryland is a Medicaid only State, and she commented that her husband is without insurance. If Maryland had set up a separate program and used the funds, perhaps they could have bought coverage for the entire family.

Mr. BARTON. Mr. Lesley?

Mr. LESLEY. On this issue I agree with Mr. Rossiter, in that when this issue came before Congress we did a study and asked Sarah Rosenbaum of George Washington University to look at this issue. So we agree that childless adults make no sense in the SCHIP program, but do see some value in instances of having family coverage. For example, in the premium support provisions that people support you are basically doing premium support for family coverage. So there are instances where it does make sense for us to allow, but childless adults we agree should not be covered by SCHIP.

Mr. BARTON. Mrs. Chester, do you have a position?

Ms. CHESTER. My position is that each family is different.

Mr. PALLONE. Is your mike on?

Ms. CHESTER. I pushed it.

Mr. BARTON. She is just very polite, Mr. Chairman.

Ms. CHESTER. Thank you. My position is that each family is different and they need to investigate instead of cutting and taking. You need to check and see what is going on. Things change and different things happen. So that is why people don't have insurance.

Mr. BARTON. Thank you. Final question——

Mr. PALLONE. You are——

Mr. BARTON. Am I out of time?

Mr. PALLONE. Yes, you are a minute over.

Mr. BARTON. I am sorry.

Mr. PALLONE. That is all right.

Ms. DEGETTE. Just to follow up on Mr. Barton's question, putting the childless adults aside, which I think a lot of us agreed, if you could rewrite SCHIP the right way then States would be able to use their funds to really target the children and they wouldn't have extra money so that they would be covering extra people like childless adults. But one of the rationales that some States had in covering parents, covering adults with children in outreach and enrollment, it helped get the kids in when they could put the whole family in; is that correct?

Ms. MANN. That is correct. And if I can just review a bit. The legislation does not allow States to cover parents with—the 1997 legislation does not allow States to cover any adults with CHIP dollars except in a very narrow instance of premium——

Ms. DEGETTE. But what I am saying is there is some public policy reason to allows States the option when they have met other requirements to do outreach to parents who don't have health insurance who meet the income eligibility requirements in order to get the kids in, right?

Ms. MANN. Absolutely, and there has been solid experience that that has worked in many States.

Ms. DEGETTE. And so that helps get more kids enrolled?

Ms. MANN. That is correct.

Ms. DEGETTE. I want to follow up on the questions Ms. Eshoo was asking about crowd-out. I think there is a miscommunication or misunderstanding about crowd-out. Some people say we shouldn't invest in Medicaid and SCHIP because of crowd-out, because families will drop their employer coverage in order to cover children under SCHIP. How much evidence is there that this is really a problem?

Ms. MANN. There is very little evidence that we have had families actually dropping coverage. And to the extent that families have dropped coverage, the coverage that they had often had been unaffordable. They have been—it is sustaining it because they have had no other way to do it.

Ms. DEGETTE. I have a chart and I have staff making copies of this chart. It was a congressionally mandated evaluation of SCHIP that showed that coverage of recent SCHIP enrollees during the 6 months before they enrolled, and it shows that there was in fact 28 percent of those people—43 percent were uninsured, 29 percent had been on Medicaid. So I guess they got a job and that bumped them up to SCHIP, but then 28 percent had been in private insurance, which might seem like a big number, except for when you look at that 28 percent, a lot of those people didn't just move over from private insurance. It is as you are saying, they had private insurance but they lost their job or their family structure changed, someone was divorced or whatever. They couldn't afford their premiums. Only 2 percent shifted because they preferred SCHIP to their insurance.

So really it really seems to me if you get below the surface of the 28 percent it is actually not a huge number that are leaving private insurance for the SCHIP program; would that be correct?

Ms. MANN. That's right. Small numbers have private insurance and most of those families lost their private insurance because of a job change, or because the parent died, or because the employer

himself or herself dropped insurance and the insurance was no longer available. So that you have really about 7 percent who have dropped coverage for other, what are considered to be more voluntary reasons. And some of those voluntary reasons also relate to the issues of affordability.

If we can go back to the August 17th directive, we talked about it would require participation rates. It would require if a State met those participation rates, every child they covered would have to have a 12-month waiting period regardless of any of these factors, including if the employer had dropped the coverage, including if the parents had gotten divorced, and so it would force uninsurance on children regardless of the reasons for why they no longer have private health insurance.

Ms. DEGETTE. Ms. Chester, when I heard you talk about your son, I am just so grateful he's been able to have that insurance. Can you imagine if somebody said to you, you know, your status has changed so your son can't now have insurance for 12 months until we are sure he is eligible. I don't think that would be a very satisfactory result for kids, do you?

Ms. CHESTER. I do not think that would be a very good result because then we would have to use the emergency room. I cannot treat my child and say you are sick and it is okay. It is not right.

Ms. DEGETTE. Right, I agree. Thank you very much. I yield back.

Mr. PALLONE. The gentleman from Pennsylvania, Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman. Mr. Peterson, just one clarification on what Mr. Deal had asked about on the CBO score on H.R. 3963. I understand that CBO projects that only 800,000 currently SCHIP eligible but unenrolled people would be added to SCHIP by fiscal year 2012, is that true?

Mr. PETERSON. Yes, that is true. I was able to turn to the chart, and that is indeed what it says.

Mr. PITTS. In talking about the cost of covering an adult, I think you said it would be about twice as much as it costs to cover a child on SCHIP. Assuming this is true and a State has 100,000 adults in their SCHIP program, is it accurate to say that it is possible for that State to enroll over 200,000 additional kids in their SCHIP program without increasing their SCHIP spending if they would simply transition their adults out of their SCHIP program?

Mr. PETERSON. I suppose on average that is the case, but it is still true that there is remarkable variance across States in terms of what adults cost, because some States only cover pregnant women. So you can imagine that their costs are even higher on a per capita basis. So there are tradeoffs in terms of again who these non-targeted people are. If they are pregnant women, maybe the calculation is a little different.

And then to an earlier point as well, the structure matters. So if one wants premium assistance, then the best way to do that, one might argue, is to try to get the whole family enrolled. So in that case you do get parents enrolled and it may not be as expensive. So there are those tradeoffs.

Mr. PITTS. Dr. Rossiter, if you think adults should not be covered in SCHIP, what would be a reasonable transition period to take the adults off of SCHIP?

Mr. ROSSITER. I think about 2 years would be a reasonable transition time. Also, it seems to me it is a reasonable compromise to cover families—families are important, families are important to providing health care. Probably most of us in this room with private insurance have family coverage. It is a staple of health insurance, and so a good compromise would be to cover those parents of SCHIP eligible children and gradually reduce the childless adults on the SCHIP program.

Mr. PITTS. Now is it true that H.R. 3963 will increase taxes on smokers by over $71 billion over the next 10 years in order to pay for only 5 years of SCHIP? Can you explain why that is fiscally responsible?

Mr. ROSSITER. Well, it probably isn't fiscally responsible, but we are in Washington and it is a way to get us going in the first 5 years, but it leaves a big cliff at the end. By the way, that will hit at about the same time the boomers are hitting the Medicaid program. It is a problem that is discussed in a new book that I hope everyone will get, Restoring Fiscal Sanity: The 2007 Health Care Spending Challenge, and I and Alan Weil wrote the Medicaid chapter in that book from Brookings Institution, and it covers it clearly and shows that this kind of financing, it doesn't make a whole lot of sense given what we are facing in the future in health care spending.

Mr. PITTS. And what you are referring to as the cliff, fiscal year 2013 to -17, no funding for SCHIP but the increased tax on smokers would be kept in place?

Mr. ROSSITER. And it would probably have to increase further to keep pace with rising SCHIP costs. And also for the record, taxes on tobacco are very regressive and hit the lowest income people the most.

Mr. PITTS. Mr. Peterson, could you explain how income disregards work; for instance, how the State of New Jersey is able to cover populations at greater incomes, far greater than what appears to be the statutory limit?

Mr. PETERSON. Well, this gets back to the point I had made earlier in terms of the tension between State flexibility and Federal control. The SCHIP statute states very clearly that eligibility is for children up to 200 percent of poverty, plus 50 percentage points above those pre-CHIP Medicaid levels.

On the other hand, the statute says that income is defined by the State and the same is true for Medicaid as well. So in New Jersey what they did is they disregarded all income between 200 percent of poverty and 350 percent of poverty and they used that flexibility. So really what we are talking about is that tension between the State flexibility versus the Federal control and then who those nontargeted individuals are.

Mr. PITTS. Finally, Dr. Rossiter, we were talking about crowding out. What impact would crowding out over 2 million people from their private health insurance coverage and placing them in a government run, taxpayer financed program have on our economy?

Mr. ROSSITER. As I said, it hits the small businesses the most. And as I said in my testimony, it just gives me great concern that in the 10 years of SCHIP that it doesn't make sense to me that we are covering more children and some more adults and yet we still

see the uninsurance rates go up and we still see the most troubling figure is the percent covered by employment-based health insurance. And I just ask the question is SCHIP contributing to this, does it have anything to do with it or nothing at all? We want children covered, but are we having ill effects and unintended effects on our private health insurance market. It seems like it should be fairly easy in this bill, it is a missed opportunity that we haven't done it yet, to do some things that will help support private health insurance, not harm it.

Mr. PITTS. I yield back.

Mr. PALLONE. Thank you. Ms. Solis.

Ms. SOLIS. Thank you, Mr. Chairman. I apologize for coming in late. I was at another event talking about expanding services to HIV/AIDS population in low income communities, but this is a very important issue and I want to thank the chairman for having a very good panel and the discussion that is taking place.

I have a lot of concerns and questions. Obviously I represent a very large State, and a disproportionate number of low income and minorities are affected by the lack of health care insurance. And we know in California that there is a large number of continued uninsured Latino families and African American families.

I just want to know from Ms. Mann and also from Mr. Lesley, why is it important that we continue to look at trying to expand access and different outreach efforts, and what kinds of—maybe you can give me an idea which programs did work or do work. We know now we are coming back and we are regressing, we are actually going in the opposite direction, and our population continues to grow. We continue to see the recession really having a devastating effect in cities that I represent where unemployment is over 7 percent and no one really talks about what is going to happen to these families. They are working families, but they are working poor. So if you could shed a light on that, and I would start with you, Ms. Mann.

Ms. MANN. Thank you. Well, a large problem in terms of the uninsured rate among children, which has been actually dropping significantly over the last decade, is with respect, however, to the remaining children who are uninsured, and many of them are uninsured for reasons of language access. Many of them are uninsured because their parents may be working two or three jobs. It is difficult to learn about the programs, it is difficult to get to apply for the programs. States have made progress over the last 10 years, some more than others, in terms of easing their application system. California started with a 28-page application, you had to have an in-person interview at the county welfare offices to get children health care coverage in California. That is no longer the case.

So there are important steps going forward. However, we had a change also in the Deficit Reduction Act of 2005 which required States to ask for more paperwork on citizen children, and that has led to an extensive backward movement, a loss of coverage for children, the poorest children who are in the Medicaid program.

Ms. SOLIS. Would you on that point—I often look at reports that state that in fact because of the Deficit Reduction Act and the fact that you have to provide more documentation that we are actually hurting more citizen children. Can you elaborate on that?

Ms. MANN. It is a provision that explicitly goes to the citizen children. The Deficit Reduction Act did not change the rules for documenting for eligibility for immigrant kids. They had to provide documentation of immigration status. It changed the rules for citizen children and required a lot more paperwork both for citizenship and the issue of identity. And there are documents that I would have trouble finding for my children and that in fact many families have had trouble finding.

Ms. SOLIS. Give me an example of what that means though just quickly.

Ms. MANN. It means you have to provide an original birth certificate, for example.

Ms. SOLIS. If you were born in your home you might not have that birth certificate. If you were born in Louisiana and Hurricane Katrina wiped away your documents, if you were born in Nebraska but now you are applying in California and don't have your original birth certificate, it would at least take time and money to be able to get that original birth certificate. You also need different identity documents in order to now show citizen children—show that they are eligible.

Ms. SOLIS. Has there been any evidence to show that more actual citizen children have been excluded because of this maybe? Mr. Lesley, you are nodding your head there.

Mr. LESLEY. Yes, absolutely, there has been several studies that show that hundreds of thousands of kids have been—in various States have lost coverage due to these barriers and very little evidence that it has actually excluded immigrant children. And so citizenship documentation is one problem, and back to your original question, if you look at the eligible but unenrolled children, I grew up in El Paso, Texas and worked at the public hospital there, and we would go around on the pediatric ward, and you could see all the kids because they were uninsured, there are preventable diseases that were lost opportunities for these kids, that if they had had insurance—and if you look at the eligible but unenrolled they are disproportionately Hispanic. And so providing health insurance to those children you reduce health disparities, and so getting kids enrolled in things that work are one of your bills, the Community Health Workers bill.

Ms. SOLIS. Can you talk about that?

Mr. LESLEY. Yeah, absolutely. The Community Health Workers bill that you have introduced, one of the things we did was one of those dreaded earmarks, but there was an earmark that Senator Bingaman put in a few years ago to test this program and to see. And we provided an earmark of funding for community health workers in some community health centers in New Mexico. For example, the earmark that went for Dona Ana County, which is in Los Cruces, New Mexico, right on the border, it was so effective, it was so effective that they actually enrolled more children than they thought were eligible because the two women who got the grant would go around, they were like block mothers and they would go to the fair and they would go to the schools and they would enroll these children, and it was wildly successful.

And also the other thing about getting coverage is it does reduce health disparities, and an express lane would also—which was in

the CHIPRA bill, would also be very beneficial to the Hispanic community.

Mr. PALLONE. We are a minute over.

Ms. SOLIS. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from Wyoming.

Mrs. CUBIN. Thank you, Mr. Chairman. This is better anyway because I am sitting up higher, I feel like I can see all of you. I usually carry a box with me I am so short.

I just have a couple questions, and I would like to start with Mr. Peterson. Can you confirm that H.R. 3963, the second CHIPRA which was vetoed by President Bush, scheduled a precipitous drop in funding in the fifth year of the program? In fact, it is so precipitous that the funding went to zero in 2013?

Mr. PETERSON. Well, the bill was meant to provide SCHIP funding through 2012.

So just as the original CHIP bill provided funding for 2007, necessitating taking action. CHIPRA was structured the same similarly, except it was a 4- or 5-year period. But CBO, however, is required to—notwithstanding the fact it was on a 5-year bill essentially to do 10-year cost estimates. So that is why you see that.

Mrs. CUBIN. And that is because that is the only way—for 5 years is the only way that it would meet the PAYGO rules, isn't that right?

Mr. PETERSON. Well, they structured the bill to meet the PAYGO rules using what spending and the Federal revenue offsets that were raised. So yes.

Mrs. CUBIN. Okay. Well, is the tobacco tax that is being used to pay for the program counted—taken up 10 years of the tobacco tax?

Mr. PETERSON. Yes.

Mrs. CUBIN. And paying for only 5 years of the program; is that correct?

Mr. PETERSON. In terms of what the program was intended to provide in this bill, yes.

Mrs. CUBIN. And Dr. Rossiter, I understand that you are a father. And I was just curious, would you rather have your children on State Medicare or would you rather have them on a quality private policy like Blue Cross/Blue Shield offers for example?

Mr. ROSSITER. Well, yes. I would prefer a private policy. I didn't know we could bring pictures of children today. I would have liked to bring my daughter's picture, although Ms. Chester's son looks like a wonderful young man.

Mrs. CUBIN. We can always bring pictures of babies.

Mr. ROSSITER. The big concern for me is, we recently did a study at the Center For Health Care Policy, and we were trying to figure out access to physician care. And guess what, it was very interesting because the fee-for-service Medicaid recipients who were in the survey had very similar access to care as those uninsured. Part of the reason is that not that many doctors accept Medicaid. We are pretty well off in Virginia. But there are some States, I understand, like Michigan who are having terrible problems with physician participation in Medicaid and partly—and because of the fees, but also because we heard billing problems.

So access to care was actually not unlike being uninsured. I think that is because some of the uninsured are wealthy enough to pay the doctor bills when they come in the door and the doctors know that and they accept that. So you know it is a problem. And I often—I used to be responsible for the Medicaid program in Virginia when I was Secretary of Health and Human Resources and often thought in the spirit of Virginia that those who run Medicaid programs and those who are responsible for them should also have the option to enroll in the Medicaid program just to keep—to keep—to help them understand what kind of program they are running, and to take ownership of that program and that notion would extend to the Congress as well.

Mrs. CUBIN. Not a bad idea. I think I didn't make my point very well about the funding for the program. I do understand your point, Mr. Peterson, that you know most of the things that we fund are for a certain period and then you know it drops off. But actually, I think it is just more slight of hand to pass an expensive program that we can't afford because we are just pushing that responsibility off for 5 years to the people that are going to be here in 5 years.

And they are either going to have to raise taxes or cut drastically someplace else to make up for that money that isn't coming in for the program. Could you respond to that?

Mr. PETERSON. Probably that the argument could have been the same 10 years ago, that if this is not done beyond 10 years in the money provided up front, then that is pushing it off on a future Congress. And to some extent there is truth to that. So once the program's funding is over with and the new Congress has to revisit that, and that is put into effect, both in 1997 and CHIP reauthorization, then that is a concern one could raise.

Mrs. CUBIN. But my point is that the bill actually does break the PAYGO rules because it goes, you know, 10 years forward on the tobacco tax and only 5 years forward on the program. Is my time up?

Mr. PALLONE. Yeah. You are over a minute.

Mrs. CUBIN. Sorry.

Mr. PALLONE. That is all right.

Mrs. CUBIN. Thank you, Mr. Chairman.

Mr. PALLONE. It is almost 2:00 so I have to move on. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. I apologize I had to leave, but I am glad to be back. Ms. Mann, I would like to ask you this question now, and I would like to ask a couple other witnesses the same question. Do you think that a tax policy that says, employers get a deduction for providing health care to employees and the value of that health care is not income to an employee, but which tax policy goes on and says that if you don't get health insurance from your employer, you have to buy it with after-tax dollars, meaning it costs 25 to 30 to 33 percent or more for the individual that does not get it from their employer, do you think that tax policy is rational or fair or defensible?

Ms. MANN. I am sorry. Is that question directed to me?

Mr. SHADEGG. Yeah. Basically should we say, should we be saying to everyone in America, it doesn't matter if you get your health

insurance from your employer or you go out and get it yourself, the Tax Code will treat you the same and it is not going to punish people who have to go out and buy it on their own?

Ms. MANN. I suppose I would maybe be the last person, but I will be the first person to say that I think there is nothing personally rational about our entire health care system and how we finance it, and that would include our tax code.

Mr. SHADEGG. So I will take that as a yes on that point?

Ms. MANN. I will take it as a yes on that but I think there are debates about what the right solution is.

Mr. SHADEGG. Fair enough. I just wanted to get to whether or not this policy is rational. Mr. Rossiter, do you think that a policy that says if you get your health insurance from your employer, it is tax free but if you buy it on your own, you have to pay for it after tax dollars, do you think that is rational or fair?

Mr. ROSSITER. No, I don't, and I think it is actually one of the biggest things that we could change in the health care system to make it more rational and to provide the right incentives to encourage private insurance with employers. And, for example, I grew up in a restaurant family. The waitresses in that restaurant, they had to pay, of course, their wage taxes, they had to pay their income taxes, but they didn't have health insurance. So it doesn't make sense for them to have to subsidize coverage for everyone else. And then seeing that those funds go, actually as in the case of SCHIP is what I have been talking about, having them go toward subsidizing coverage for someone else's children.

Mr. SHADEGG. Mr. Lesley, I see you raising your hand. Do you think that is rational or fair?

Mr. LESLEY. I worked for Senator Bingaman and we worked on legislation to do exactly what you are talking about, which is to address that unfairness. And one of the things that as a children's organization that we are concerned about too in the Tax Code is that when, for example, in some of the proposals that people had for tax credits, you have got to make sure that you address the fact that family policies cost almost three times that of an individual.

And some of the tax proposals put forth, for example, the administration's proposal is a 2-to-1 ratio. The effect of that you are adding the spouse but you are leaving the kids completely out. So one of the things we are really encouraging people who are looking at the Tax Code is to really address the fact that family policies cost almost three times that of an individual.

Mr. SHADEGG. I ask the question because it drives me insane that by and large, people who don't get their health insurance from their employer are the least among us, at least there are some people who are self-employed and do well and don't get health insurance from their employer. But there are many people who don't get health insurance from their employer who are on the bottom rung of our society. We say to them that it is responsible and it is an appropriate thing for you to go out and get health insurance. But then we give them the back of our hand and say, oh, by the way if you do, you have to do it with after tax dollars, which I just think is unfair, outrageous and indiscriminatory.

Mr. ROSSITER. It is a missed opportunity that this bill doesn't address that.

Mr. SHADEGG. I agree with you completely.

Ms. MANN. It is also a question of what is the most efficient way to provide that health insurance coverage.

Mr. SHADEGG. I completely agree. I think the efficient way to provide it and the way that I believe will both bring down cost and increase quality is to put more people in charge. But the debate goes beyond our discussion today.

Mr. Peterson, you talked about crowd-out. And you analyzed crowd-out. Crowd-out—maybe you can briefly explain the effect of crowd-out by when we expand SCHIP, what does crowd-out do?

Mr. PETERSON. Well, you know there are many choices in terms of what is the impact of people going to private coverage? And you know people often raise the issues of, well, does CHIP cost more or less than private coverage?

Mr. SHADEGG. Was it true that under this bill at certain levels, the crowd-out effect would have been up to 50 percent? Isn't that what——

Mr. PETERSON. CBO found that at the higher income levels that was true.

Mr. SHADEGG. If alternatively—because I am running out of time—we said, look you have a choice, you can stay on the SCHIP program or we will give you cash, a premium support to stay in your employer's plan, assuming you are already in your employer's plan or to stay in a plan you purchased yourself, then the issue of crowd-out would go away, wouldn't it?

Mr. PALLONE. This has got to be the last question because it is a minute over again.

Mr. PETERSON. That depends on how it is structured again because you can think of individuals who are currently in employer-sponsored coverage who are paying out of pocket for the entire thing. And then suddenly this—you can provide public dollars. So in that sense, there may be crowd-out in the sense of what was formerly being paid by individuals entirely for the coverage, now the public sector is kicking in for that.

Mr. SHADEGG. The crowd-out, if you give them cash to buy that same insurance whether it is a part of the premium or all of the premium, that enables them to choose to either stay in that private insurance or go into SCHIP, right?

Mr. PALLONE. We have to move on, yes.

Mr. PETERSON. Depending on the structure.

Mr. SHADEGG. Thank you.

Mr. PALLONE. I want to thank this panel. Thank you very much. This has been very helpful. And as I expressed before, the concern is what is going to happen over the next year? So you are certainly helping us in that regard as we move forward on trying to deal with SCHIP and look at an expansion. So thank you again. You wanted to——

Mr. LESLEY. Yeah, Mr. Chairman. Can I provide——

Mr. PALLONE. Very briefly please.

Mr. LESLEY. I will say one thing for the record. We did an analysis of at 250 percent of poverty for each of the congressional districts representing. For example, your congressional district, if you look at what that income level provides you, and you deduct housing costs, food costs, child care costs, transportation, taxes and then

add private health insurance, it leaves a family in New Jersey with negative $1,723 a month. So that is one of the issues that there is a disparity in terms of what 50 percent of poverty means in New Jersey as opposed to in Tulsa, Oklahoma. And I would like to provide this to you.

Mr. PALLONE. You make a very good point. And if you would like to submit that for the record, I would ask unanimous consent that you submit that and get back to us.

Mr. LESLEY. Thank you.

Mr. PALLONE. So ordered. Thank you again. I am just moving on because we have another panel. But I appreciate everything that you said to us this morning. Thank you. And I will ask the second panel to come forward please.

Okay. Thank you. Welcome again. Let me introduce each of the members of the second panel. They are representing different states. First, from my home State of New Jersey, Ms. Ann Kohler, who is deputy commissioner of the New Jersey Department of Human Services. Welcome; Mr. Dennis Smith, who is director of the Center for Medicaid and State Operations at the Centers for Medicare & Medicaid Services here in D.C. obviously. And last is Tricia Brooks, who is President and CEO of the New Hampshire Healthy Kids Corporation from Concord.

Mr. PALLONE. I had the opportunity to spend a little time in Concord during the primary. We get to go to New Hampshire every 4 years. Okay. I will say you know 5-minute opening statements again. They will be part of the record. We may submit additional questions to you later that you would respond to. But let's start today with Ms. Kohler. Thank you for being here. You see how New Jersey is often the focus of attention when we come to SCHIP.

STATEMENT OF ANN C. KOHLER, DEPUTY COMMISSIONER, NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Ms. KOHLER. Well, good morning, Mr. Chair. And thank you very much for having me here. My name is Ann Kohler, as you know, and I am over both the Medicaid and the SCHIP committee programs in New Jersey. I very much appreciate the opportunity to be here today to talk to you about the importance of both Medicaid and SCHIP across the Nation, and especially in New Jersey. Providing affordable health care coverage has become increasingly important given the state of our current economy and the difficulties faced by many of our vulnerable citizens. Medicaid and SCHIP has significantly reduced the number of uninsured children in New Jersey. We currently provide health care coverage to over 1 million individuals, that is one out of every eight people in the State are covered. We cover 430,000 adults and 570,000 children between Medicaid and SCHIP. Since Governor Corzine has taken office, we have had enrolled over 180,000 new children into our programs. As you know, New Jersey has made a very strong commitment to both Medicaid and SCHIP and any proposals to limit our ability to cover these children are a serious concern to us. While New Jersey uses a higher percentage of the Federal poverty level for eligibility for SCHIP, we also have one of the highest median family incomes in the Nation.

The median family income for a family of four in New Jersey is $90,261. However, in our 10 largest cities, the median income is only $30,000, slightly over $30,000. And over 30 percent of that income goes to cover the families' housing cost. Over 34 percent of all the children in our major cities live in poverty. And in Camden, our poorest city over 58 percent of the children live in poverty. Currently over 80 percent of the children we have in our Medicaid—in our SCHIP program have families below 133 percent of the Federal poverty level, which is just over $27,000 for a family of four. And the very small number of children, 1.7 percent of our population, with incomes above 250 percent of the Federal poverty level, pay $125 each month for their coverage under SCHIP. We are concerned that recent Federal proposals to change SCHIP may prevent our ability to continue to provide this critical health care coverage to the working poor.

As the economy worsens, these families must rely on the safety net provided by Medicaid and SCHIP to provide health insurance for their children. The proposed regulation regarding crowd-out in SCHIP would require children to remain uninsured for a full year before they can become eligible. This cannot happen. New Jersey's own experience with the crowd-out provisions has shown that reducing—that increasing coverage and reducing the period that the child remains uninsured has not significantly resulted in an increase in people dropping their private insurance. We believe that the CMS requirement that children remain uninsured for a year would cause havoc with our program and jeopardize coverage of needy children. I know there has been a great deal of discussion over what is being called the private insurance decline. The August 2007 CMS letter prohibits States from covering children above 250 percent of the Federal poverty level if employer based coverage of children among the targeted population has declined in their State by more than a certain percentage.

In New Jersey, we do require that our families enroll in private insurance if it is offered through their employers. However, fewer employer plans provide fewer benefits and include high copays and deductibles, and therefore, become unaffordable to the families. In addition, many of the part-time employees are not covered by their employer plans and often work rules are designed to make sure they never obtain coverage.

As our country enters a recession, cutting health benefits flies in the face of many efforts needed to stimulate our economy and provide the needed services to our working poor. Providing health care benefits improves health outcomes in school attendance for our children, reducing caretaker absenteeism from work, keeping people at work and earning a paycheck. It also creates job opportunities for allied health care professionals in the health care arena. There is a multitude of reasons to expand our coverage of children, not decrease it. I believe that we all agree that providing health care insurance for our children is vital to the Nation.

Healthier children create healthier families. And I believe it is in our collective best interest to urge the administration to take a more reasoned approach towards our Nation's children, one of our most important national assets. Thank you again for the oppor-

tunity to be here and speak to you this morning. And I am happy to answer any questions that you may have.

Mr. PALLONE. Thank you very much.

[The prepared statement of Ms. Kohler follows:]

STATEMENT OF ANN CLEMENCY KOHLER

•Good morning, I am Ann Clemency Kohler, Deputy Commissioner with the New Jersey Department of Human Services. As Deputy Commissioner, I oversee both the SCHIP and Medicaid programs in New Jersey.

•I very much appreciate the opportunity to be here today to talk to you about the importance of the Medicaid and SCHIP programs across the nation and in New Jersey. Providing affordable health care coverage has become increasingly important given the state of our current economy and the difficulties faced by many of the most vulnerable in our society.

•Medicaid and SCHIP have significantly reduced the number of children without access to quality medical care.

•In New Jersey, we provide health care coverage to well over one million individuals. We cover over 430,000 adults and 570,000 children through our SCHIP program and Medicaid programs.

•Since Governor Corzine took office, New Jersey has enrolled just under 180,000 new children.

•New Jersey has made a strong commitment to the Medicaid and SCHIP programs.

•Any proposals to limiting our Medicaid and SCHIP programs are of serious concern to us.

•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 median family income levels in the nation.

•The median family income for a family of four in New Jersey is $90,261. However, in our 10 largest cities, the median income is only $30,110 and over 30% of that income goes to cover the families housing costs. Over 34% of all children living in these cities live in poverty. In Camden, our poorest city, over 58% of all children live in poverty.

•Currently, almost 80% of the children covered under Medicaid and SCHIP live in families with incomes below 133% of the federal poverty level—which is just over $27,000 for a family of four.

•Both Medicaid and SCHIP are essential programs to these families. By keeping the children healthy they allow the parents to go to work.

•However, recent federal proposals to change SCHIP may prevent our ability to continue to provide this critical health care coverage to the working poor.

• As the economy worsens, these families must rely on the safety net provided by Medicaid and SCHIP to provide health insurance for their children.

•The proposed regulation regarding crowd out in SCHIP would require children to remain uninsured for a full year before they can receive SCHIP coverage. This cannot happen.

•New Jersey's own experience with the crowd out provision has shown that reducing crowd out does not have a significant impact on enrollment.

•We believe that the CMS requirement of one year will cause havoc with our program and could jeopardize coverage for thousands of children.

•I know there has also been much discussion over what is being called "the private insurance decline standard." The August 2007 CMS directive prohibits states from covering children above 250 percent of the FPL through SCHIP if employer based coverage of children among the target population has declined in their state by more than a certain percentage.

•In New Jersey, we do require that clients enroll into private insurance plans through our premium support program. However, because private employer plans provide fewer benefits and include copay and deductibles, these plans fail to meet the "cost effectiveness" test to qualify for premium support.

•In addition, part time employees are not covered by employer plans and often work rules are designed so that a large percentage of employees are part time.

•As our country enters a recession, cutting health benefits flies in the face of any efforts to stimulate the economy and provide much needed services to the poor.

•Providing health care benefits improves health outcomes and school attendance thus reducing caretaker absenteeism from work, keeping people at work and earning a paycheck. It also creates job opportunities for health care and allied profes-

sional workers in the health care arena. There are a multitude of reasons to expand our efforts to provide health care to our children.

•I believe that we can all agree that providing health insurance for children is vital to the health of this nation. Healthier children create healthier families

•And so I believe it is in our collective best interest to urge the administration to take a more reasoned approach towards our nation's children and one of our most important national assets—their health.

•Thank you again for the opportunity to speak here this morning and I would be happy to answer any questions you may have.

Mr. PALLONE. Mr. Smith.

STATEMENT OF DENNIS G. SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. SMITH. Thank you, Mr. Chairman. It is a pleasure to be with you. I have a statement for the record. And I think, given the time, perhaps it would be most helpful to the subcommittee if I sort of address some of the things that came up in the previous panel that would be helpful as we do look forward to the full reauthorization of SCHIP. I first want to hasten to emphatically say, the administration strongly supports the SCHIP program and its reauthorization. The funding has been provided for the program to assure stability through March 2009. I think—as we take this time to work with all Members during this period to achieve the goal of reauthorization through 2013.

Last night, the President said in his State of the Union remarks, we share a common goal, making health care more affordable and accessible for all Americans. So we do believe that there is a vision to look at the entire system and how we provide health insurance coverage and access to affordable health insurance coverage. A couple of things—and obviously the August 17 guidelines have been the topic of some discussion and questions. And I would say we have three lawsuits that we are looking at from various States and beneficiary groups regarding the S&D letter.

So it has gained a great deal of attention. But I want to emphasize the purpose of the S&D letter. A to say, find your poorer children first. They must come first. I think that in that respect, we have been far more successful. States have been far more successful in achieving that 95 percent goal than many people here in Washington have given them credit for.

So we do believe the number of States will be able to achieve the 95 percent threshold and we move on from there. In our discussions with States, we have reached out to the States affected by the policy to engage them in a discussion and go through data and their policies over the next few weeks to work on implementing the August 17 goals. We are also saying that it should be—States do have an obligation under the SCHIP statute. We have talked a lot about crowd-out. There is different ways to measure it. There is different ways to view it. But I think the SCHIP original statute is clear.

States do have an obligation to try to prevent it. And when we have seen States that come in with very high income levels with no cost sharing or very little cost sharing, no waiting period or very little waiting period, then we do question whether or not that they

are meeting their obligation to prevent the substitution of private insurance for the public. Substituting insurance does not insure more kids. It is only shifting the cost. A couple of things in the previous panel, I think, that are helpful to talk about. The income disregards—and again I think there is a lot of misinformation and a lot of misunderstanding in the previous SCHIP.

What was the Secretary's authority? There are supporters of the SCHIP—supporters of the legislation that said the Secretary had full authority to deny State planning amendments that went to higher income levels. Income disregards. Is there a really a cap on income or not? And we have talked about the State flexibility to define what income is. And yet that flexibility was given in context of capped allotments. So there was—obviously 10 years ago there was an understanding that there would be competing pressures and competing interest and States would work accordingly. But now it is virtually, fund any decisions that the States make at any income level and regardless of what their strategies to prevent crowd-out is. Then we are simply paying the States to make any decision. That is not the way the original statute worked.

On employer-sponsored health insurance, I think it is important—Ms. Mann from the previous panel. We are talking about in different States the cost of health insurance. Employer-sponsored health insurance U.S. total in 2005, the coverage was $728. Roughly a third of that the employee is paying directly. So yes, that insurance has increased over time. But the vast majority of cases, the employer is also contributing and contributing at least much of the cost. So I don't want Members to think $12,000 is the rule and families are paying the full freight. But I think it is also important to then———

Mr. PALLONE. You are almost at a minute. So if you could wrap it up.

Mr. SMITH. Yes, sir. And also in the context of the cost of that. When we look at, for example, comparing the cost to the SCHIP of what family coverage would cost in New York, there is an example using 2005, the employee contribution for the family premium was $217 on average. The PMPM that New York Medicaid—New York SCHIP pays is $154 PMPM. So if you have two children in New York, you have—for the price of what you pay for those two children——

Mr. PALLONE. I am sorry, Mr. Smith. It is like a minute and a half over.

Mr. SMITH. Thank you, Mr. Chairman. I look forward to your questions.

Mr. PALLONE. Sure.

[The prepared statement of Mr. Smith follows:]

STATEMENT OF DENNIS G. SMITH

Chairman Pallone, Congressman Deal, thank you for inviting me to testify on today's topic as you renew the important work of reauthorizing the State Children's Health Insurance Program (SCHIP). The Administration strongly supports this important program and its full reauthorization. Last year, additional funding for the program was provided to ensure stability in the program through March 2009. We look forward to working with all members during this time to achieve the goal of reauthorization through 2013.

The full picture of our commitment to insuring low-income children includes Medicaid as well as SCHIP. Medicaid is approximately four times larger than SCHIP in terms of enrollment of children and just over six times larger in terms of expenditures for children. Total Federal and State Medicaid spending on children will exceed $400 billion over the next five years and $1 trillion over the next ten years. There are important budgetary and programmatic interactions between SCHIP and Medicaid that are appropriate to consider in the context of reauthorization.

BACKGROUND

When Congress was considering the legislation that became Title XXI more than ten years ago, there was a widely held view that 10 million children in the United States lacked health insurance. It was recognized that many of these children were already eligible for Medicaid but were not enrolled, and that many of these children were uninsured but lived in families with sufficient income to be able to afford coverage. Congress ultimately adopted an approach that was targeted to children with family incomes above existing Medicaid levels who lived in families for which the cost of insurance was beyond their reach. It set a general upper limit of income eligibility at the higher of 200 percent of the federal poverty level (FPL) or 50 percentage points above a state's Medicaid level. Under the FPL guidelines released last week for 2008, 200 percent of FPL is $42,400 for a family of four and 250 percent of FPL is $53,000 for a family of four. Just by way of comparison: the median income in the United States for a family of four is approximately $59,000.

SCHIP is a unique compound of incentives and checks and balances. Congress rejected the idea of simply re-creating Medicaid and its complexities. States with an approved SCHIP plan are eligible for Federal matching payments drawn from a state-specific capped allotment. While the program provides states with a great deal of program flexibility, including using Medicaid as their vehicle for administering Title XXI, it also creates the expectation that states will adopt policies to stay within their capped allotments. Capped appropriations and capped allotments were critical features of that bipartisan compromise. The legislation appropriated $40 billion over ten years, an amount that would support the number of children thought to be in the target population group. That level of funding clearly was not designed or intended to serve children at all income levels, nor was it intended to create a new entitlement for coverage.

Congress also realized that millions of children were eligible for Medicaid but were not enrolled. To ensure the success of SCHIP and avoid the possibility of creating a new program that would not be taken up by the states, the idea of an enhanced match rate was ultimately adopted as the means of providing states with sufficient incentive to aggressively find and enroll uninsured low-income children. Thus, SCHIP provides a 70 percent federal match rate on an average national basis compared to the 57 percent average match rate for Medicaid. But central to the bipartisan discussion at that time was the question, "for whom is the enhanced match intended?" That question remains central to reauthorization today.

ENROLLMENT EXCEEDS EXPECTATIONS

If the goal ten years ago was to enroll 10 million children, then expectations have been exceeded. In 1998, the number of children "ever-enrolled" in Medicaid (enrolled at least for some period of time) was 19.6 million. States enrolled approximately 670,000 children in SCHIP in that first year for a combined total of more than 20 million children. Since then, combined Medicaid and SCHIP enrollment has increased every year. In FY 2006, more than 36 million children were enrolled (at least for some period of time) in Medicaid and SCHIP combined, an increase of 16 million children above the 1998 Medicaid level.

Since 1998, enrollment of children in SCHIP and Medicaid has increased nearly 80 percent, while growth in the total number of children in the U.S. population as well as the number of children in families below 200 percent FPL over the same period has been nominal. Enrollment in Medicaid and SCHIP now exceeds the number of children below 200 percent FPL. Therefore, it is clear that Medicaid and SCHIP are covering children in higher-income families.

"95 PERCENT ENROLLMENT GOAL"

It is because of this tremendous growth in Medicaid and SCHIP enrollment relative to the overall population and to the low-income population specifically that we believe our adopted goal of 95 percent enrollment of low-income children before expanding eligibility to higher income populations is both reasonable, in light of the statutory purpose of SCHIP to serve low-income children, and is achievable.

We anticipate working with states to determine their specific rates of coverage. It is unfortunate that some groups have prejudged compliance as they have relied on flawed national data to make comparisons regarding state performance. For example, it is widely recognized that the Current Population Survey (CPS) undercounts Medicaid participation. In the most recent CPS data released last year, the Census Bureau reported 20.7 million children ever enrolled in FY 2006, when enrollment reported by states for Medicaid and SCHIP combined in that same period was over 36 million.

We believe the 95 percent goal is further supported by last year's work conducted by the Urban Institute which shows much lower uninsurance rates among Medicaid and SCHIP eligible children than expected.[1] This study was not unanimously received as good news at the time, but we believe it demonstrates that states are far more successful than given credit. Therefore the 95 percent goal is not only achievable, but should be expected and demanded. Indeed, our view is that a number of states are already meeting the 95 percent goal.

We strongly believe, as the future of SCHIP as a program is considered, that states be required to put poor children first before they expand to higher income levels. The federal government has tied financial incentives to performance standards in other public benefits programs with good results.

I want to reaffirm our previously stated position that children currently enrolled in SCHIP should not be affected as we work with states to implement the August 17, 2007 State Health Official (SHO) letter. The guidance sets out procedures and assurances that should be in place when states enroll new applicants with family incomes in excess of 250 percent of the federal poverty level (FPL)—that is, in excess of the median family income in the United States. But the guidance is not intended to affect enrollment, procedures, or other terms for such individuals currently enrolled in State programs.

"CROWD-OUT"

The goal of SCHIP is to increase the rate of insurance among our nation's children in low-income families. "Crowd-out" or the substitution of existing coverage does not increase insurance rates, it merely shifts the source of funding. It is a public policy concern because it increases public expenditures without necessarily improving access to care or health status. It is also a concern because, as healthy lives are shifted out of the private sector insurance pools, there is a detrimental impact on those who remain. Insurance fundamentally means the sharing of risk. When the private pool of healthy insured lives shrinks and the risk cannot be spread as widely as before, the cost will rise for those who remain, triggering another cost increase which is likely to displace yet another group of people, whether employers or employees or both.

Crowd-out is not a new topic. There were numerous papers written on Medicaid and crowd-out prior to the enactment of SCHIP and it remains a popular subject today. The pre-SCHIP papers on crowd-out dealt primarily with populations below 200 percent of FPL, many of whom were assumed to not have access to employer-sponsored health insurance or the means to contribute the employee share of costs. There are a variety of opinions on how to define crowd-out, how to measure it, and how to prevent it. In its paper on SCHIP last May, the Congressional Budget Office (CBO) neatly summarized the research on this topic and concluded that, ". in general, expanding the program to children in higher-income families is likely to generate more of an offsetting reduction in private coverage (and therefore less of a net reduction in uninsurance) than expanding the program to more children in low-income families." The CBO estimates on the SCHIP legislation that the President vetoed reinforce the findings of its May study.

As early as February 1998, the federal government released instructions to the states on how it would review strategies to protect against substitution of private coverage. In a February 13, 1998 State Health Official letter, co-signed by the Director of the Center for Medicaid and State Operations at the Health Care Financing Administration and the Acting Administrator of the Health Resources and Services Administration, the federal government provided that, "States that provide insurance coverage through a children's only and/or a State plan (as opposed to subsidizing employer-sponsored coverage) or expand through Medicaid will be required to describe procedures in their State CHIP plans that reduce the potential for substitution. . After a reasonable period of time, the Department will review States' procedures to limit substitution. If this review shows they have not adequately addressed substitution, the Department may require States to alter their plans."

Another federal agency within the Department of Health and Human Services, the Agency for Healthcare Research and Quality, listed several strategies to prevent crowd-out at that time which included:[2]

•Institute waiting periods (3, 6, or 12 months)

•Limit eligibility to uninsured or under-insured

•Subsidize employer-based coverage

•Impose premium contributions for families above 150 percent of the Federal poverty level

•Set premiums and coverage and levels comparable to employer-sponsored coverage

•Monitor crowd-out and implement prevention strategies if crowd-out becomes a problem

States faced competing pressures as they designed their SCHIP programs. Effective crowd-out strategies were measured against pressures to quickly build enrollment. Decision makers at the state level faced strong public criticism for "turning back" federal funds that would go to other states or be returned to the Federal Treasury.

As the 16 million children were being added to Medicaid and SCHIP, the percent of children between 100 and 200 percent of poverty with private insurance declined. In 1997 according to data from the 2006 National Health Interview Survey, 55 percent of children in families with income at this level had private insurance. But by 2006, the percentage had declined to 36 percent.[3]

ELIGIBILITY EXPANSIONS

Currently there are 20 jurisdictions (19 states and the District of Columbia) that cover children in families with income greater than 200 percent of FPL, of which 17 jurisdictions cover children in families with income equal to or greater than 250 percent FPL. In addition, there are three states that cover children in families with income thresholds above 200 percent of FPL that apply income disregards in an amount we believe is likely to exceed the 250 percent FPL threshold. Expansions of SCHIP to higher income levels occurred early in the program or just in the past two years. Of the 19 states and the District of Columbia that provide coverage above 200 percent of the poverty level, 13 of them received approval to cover those higher incomes by July 2001 or earlier. Of those 13 states, eight were "qualifying states," that had increased Medicaid eligibility prior to the creation of SCHIP.

The other seven states that have expanded eligibility above 200 percent FPL occurred in January 2006 or later. With the exception of Hawaii, the eligibility limits were approved as state plan amendments, not as waivers as has been widely reported. After a five-year period in which no state raised their eligibility level, there clearly are growing interests or pressures among additional states to expand eligibility beyond the statutory definition. It is important to understand those interests or pressures in order to design an appropriate response.

Federal responses may be different than the choices made ten years ago and should include approaches outside of SCHIP as well as within the program. One area that seems particularly ripe for a new approach within SCHIP is premium assistance. Perhaps some of the crowd-out effect could have been prevented if SCHIP were used to a greater extent to support private coverage rather than replace it.

CONCLUSION

SCHIP has been highly successful in the mission it was given to increase coverage among uninsured low-income children. But that success does not mean SCHIP can or will be as successful when populations at higher incomes are involved.

We hope that the lessons of the past will guide how we use the fresh opportunity before us and the Administration looks forward to working with all members to forge reauthorization in the same bipartisan spirit in which SCHIP was created.

[1] "Eligible But Not Enrolled: How SCHIP Reauthorization Can Help," September 24, 2007 [available at http://www.urban.org/publications/411549.html].

[2] See http://www.ahrq.gov/chip/Content/crowd—out/crowd—out—topics.htm.

[3] See http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200712.pdf. The data are derived from the Family Core component of the 1997-2007 NHIS, which collects information on all family members in each household. Data analyses for the January–June 2007 NHIS were based on 41,823 persons in the Family Core.

Mr. PALLONE. Ms. Brooks.

STATEMENT OF TRICIA BROOKS, PRESIDENT AND CEO, NEW HAMPSHIRE HEALTHY KIDS CORPORATION

Ms. BROOKS. Thank you, Mr. Chairman. Thank you for your patience, and I welcome the opportunity to share New Hampshire's story with you. For the record, my name is Tricia Brooks. I run a legislatively-created nonprofit by statute administers our SCHIP program. We also take the lead in coordinating outreach application assistance for both Medicaid and SCHIP. New Hampshire is fiscally conservative State, but we have made children's health insurance coverage our top priority. Our SCHIP program was specifically designed to be responsive to the needs of working families and self-employed who want to insure their children but cannot afford to do so in the private market.

We also recognize the need to provide transitional coverage to families who encounter disruptions in employment and income. To do so, it was imperative in New Hampshire that we address the high cost of living and high cost of insurance by setting eligibility at three times the poverty level. This level was approved by CMS in our very original plan and it has been in place for the past decade.

Much of the debate around SCHIP has been around whether the lowest income children are getting served first. In New Hampshire, the numbers speak for themselves. For every one child that is enrolled in SCHIP by our mail-in unit, six children and one pregnant woman is enrolled in Medicaid. Of the 71,000 children covered by Medicaid and SCHIP, 91 percent have incomes below two times the poverty level. After celebrating Congress's success in passing the bipartisan CHIPRA bill last year, I am really discouraged that progress has been thwarted by the subsequent presidential vetoes.

States need the predictability of the SCHIP reauthorization and the many positive provisions of CHIPRA to move forward in covering kids. I am not going to go into some of those positive items. They have been covered by other speakers. But on another front, I do want to talk about the fact that the CHIPRA bill would have eased the administrative barriers and unintended consequences of new requirements for verifying citizenship and identity. When the so-called CIT-DOC rules went into effect, New Hampshire already had in place a system for verifying citizenship of our applicants. This system has been disrupted by additional unnecessary requirements that have left eligible children uninsured.

Although Congress extended the current SCHIP program with sufficient funding to offset expected shortfalls in States, States are still being stopped from taking full advantage of the flexibility allowed under current SCHIP rules by the so-called CMS 8/17 directive. Furthermore, a number of States, including New Hampshire, face the untenable task of cutting back their programs unless Congress intervenes. This directive is the single biggest threat to the gains we have made in covering kids in New Hampshire over the past decade. This directive was issued arbitrarily without any public notice or any public process or advanced notice. It establishes preconditions to cover kids above 250 percent based on unreasonable and unattainable benchmarks for which no reliable data sources exists. It imposes new eligibility criteria.

For example, a waiting period of a year does not allow a child access if their parent has lost a job or worse, if the child has lost a parent. Cost sharing comparable to the private market means eligible children and their families will not be able to afford to participate. This directive is even broader because it eliminates the use of deductions from income such as child care expenses that have long been a standard in Medicaid. In New Hampshire, we understand the importance of ensuring public coverage does not substitute for private coverages.

Our outreach efforts and eligibility requirements strictly target uninsured children, but we also recognize that certain circumstances are beyond the control of families and warrant exceptions. Our policies have been effective in that employer-sponsored insurance of children has remained steady while enrollment in Medicaid and SCHIP have grown. Assertions that currently enrolled children are not affected by this directive puts forth false expectations about its true impact. SCHIP provides transitional coverage.

In New Hampshire, 75 percent of children enrolled above 2-1/2 times the poverty level were on the program for 12 months or less. While currently enrolled children will stay on, the children who lose coverage will not be able to come in and fill their places. And they will be uninsured and they will not have continuity of care. Like many States, New Hampshire's State budget is in trouble. I know $50 million sounds like a rounding era down here. But it is a lot of money in our State budget and there are no surplus State funds that can be used as a stop gap to fill the void if this directive is allowed to stand. So in closing, let me reiterate.

The predictability of a full SCHIP reauthorization is essential to States to move forward in covering kids. But more urgently, time is running out for States that must come into compliance with the 8/17 directive. Unless Congress places a moratorium on the directive, New Hampshire and other States will be force to the move backward, not forward in covering kids. Thank you.

[The prepared statement of Tricia Brooks appears at the conclusion of the hearing:]

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TESTIMONY SUBMITTED TO
THE HOUSE ENEGERY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
January 29, 2008
By: Tricia Brooks
President & CEO
NH Healthy Kids Corporation
Concord, New Hampshire

"UNINSURED CHILDREN:
MISSED OPPORTUNITIES FOR MOVING FORWARD"

Good morning, Mr. Chairman, and members of the Subcommittee on Health. I am honored to have the opportunity to share my experience and passion for covering kids. For the record, my name is Tricia Brooks. It has been my privilege to serve as the President and Chief Executive Officer of New Hampshire Healthy Kids Corporation (NHHK) since its inception in 1994.

NHHK is a legislatively-created nonprofit dedicated to providing uninsured children with access to affordable, quality health coverage. Although our legal status is a private, not-for-profit organization, NHHK is considered a state instrumentality performing important functions of state government. As stipulated in New Hampshire statute, NHHK serves as the SCHIP administrator. Our volunteer Board of Directors includes six representatives of state government including appointments by the Governor, Speaker of the House, Senate President and Commissioners of Insurance, Education and Health & Human Services.

Under a cooperative, contractual partnership with the New Hampshire Department of Health & Human Services, NHHK leads the effort to educate the public about children's health coverage options and to assist families in applying for coverage. NHHK directly administers the

premium-based SCHIP/Title XXI program through insurance subcontracts. Our headquarters in the state capital serves as the mail-in application and enrollment center for both Medicaid and SCHIP which are known as Healthy Kids. I am not an official state representative but having administered the SCHIP program for the past decade, I am knowledgeable about all programmatic aspects and the impact of federal policy on our program.

NHHK began covering kids four years prior to SCHIP so I know first-hand what the federal partnership has meant to our state. My organization's success in its early years was inhibited by one constraint – a lack of funding. We made great strides in increasing awareness of the importance of medical insurance to children's health and performance in school. We created a terrific health plan that focused on the preventive and primary care that kids need most. We fostered essential partnerships with hospitals and healthcare providers to keep the cost of services low. We engaged schools and social service agencies to help us identify and enroll children. But without funding to subsidize premiums, participation remained out of the financial reach of many families. This all changed when Congress established SCHIP.

It was unequivocally the influx of federal dollars that spurred New Hampshire's progress in covering kids – progress that reduced the percentage of uninsured children in New Hampshire by half from 10.8% in 1993 to as low as 5.2% in 2003. Like many states, our uninsured rate has increased in recent years to about 6.3% based on the latest data.

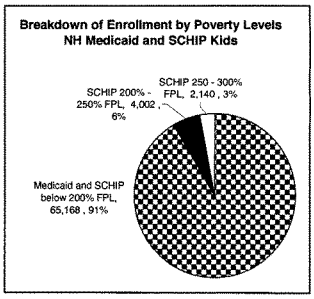
Although a fiscally conservative state, New Hampshire has made children's health coverage one of its top public policy priorities. From establishing a non-profit dedicated to the mission of advancing children's coverage to the design of our SCHIP program, our state has taken practical, cost-effective steps to expand children's access to insurance. We were purposeful in creating our SCHIP program to be responsive to the needs of workers and self-employed families who

want to insure their children but cannot afford coverage in the private market and to families who encounter disruptions in employment and income. In doing so, it was imperative that we address the high cost of living and high cost of insurance in our state by covering kids up to 300% of the federal poverty level (FPL). This eligibility level was approved by the Centers for Medicaid and Medicare (CMS) in our original SCHIP plan and has enhanced our efforts to enroll low income children in Medicaid. Today our programs are as follows:

- Medicaid is a state-run fee-for-service program that covers pregnant women and children under the age of 19 in families with income up to 185% FPL.
- Infants under the age of 1 with family income up to 300% FPL are covered as a Medicaid expansion group using SCHIP funding.
- SCHIP provides a private, managed care health plan to uninsured children with premiums based on a sliding income scale:
  - 185% and 250% FPL – $25 per child per month ($100 family maximum)
  - 250% and 300% FPL – $45 per child per month ($135 family maximum)
- Families with income between 300% and 400% FPL and others who do not qualify for Medicaid or SCHIP can buy into the SCHIP group benefit plan for an unsubsidized cost of $165 per child per month.

Currently over 71,000 children are covered by Medicaid and SCHIP. This chart clearly shows that our low income children are well served:

- 91% of enrolled children have income below 200% FPL
- 6% are between 200 and 250% FPL
- 3% are between 250% and 300% FPL



Since much of the debate around SCHIP reauthorization has focused on whether the lowest income children are covered first, it is appropriate to point out that our outreach and application assistance efforts enroll pregnant women and children in Medicaid at much higher rates than SCHIP. Of every eight new applicants enrolled by our mail-in application center, six children and one pregnant woman are eligible for Medicaid and one child is enrolled in SCHIP. These results clearly indicate that despite high eligibility levels and separate Medicaid /SCHIP programs, a seamless and coordinated approach to outreach and application assistance is clearly effective in serving the lowest income children first.

With that background let me turn to the issues at hand. After celebrating Congress's success in passing the bipartisan CHIPRA bill last year, I am discouraged that progress has been thwarted by the President's subsequent vetoes. While there are certainly missed opportunities for continuing to move forward in covering kids, I am equally – if not more – concerned about losing ground if Congress does not intervene.

Although Congress extended the current SCHIP program with sufficient funding to offset expected state shortfalls, states are being stopped from taking full advantage of flexibility allowed under the current SCHIP rules by CMS. Furthermore, a number of states face the untenable task of cutting back their programs as a direct result of the so-called "August 17 CMS Directive." This directive which was issued arbitrarily without any public process came out of the blue. It was a shock to our state given that it overturned the long-standing rules under which New Hampshire has operated its program since 1998.

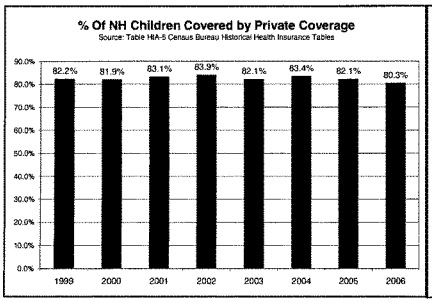
The directive establishes preconditions that fundamentally make it impossible for states to continue to cover children in families with income above 250% FPL:

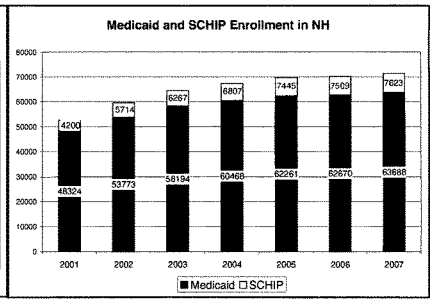
- First, each state must prove that it has enrolled at least 95% of children in the state below 200% FPL who are eligible for Medicaid or SCHIP. This is an unrealistic standard for a means-tested program where people have to apply and be reviewed at least annually for eligibility. Even Medicare which automatically enrolls people without any means-testing has a participation rate of only 95%.
- Second, each state must ensure that employer-sponsored coverage of children has not declined by more than two percentage points over the past five years. This precondition disregards the fact that states have little control over trends in employer based coverage which have resulted in sharp declines in coverage for workers and their dependents.

Had CMS sought input from program administrators or policy experts, they would have quickly learned that setting unreasonable benchmarks for which no reliable data exist makes preconditions for covering kids above 250% FPL unattainable. Beyond meeting the preconditions, rigid eligibility criteria presents additional barriers for families. A one-year waiting period with no exceptions denies access to a child whose parent has died or lost a job. Imposing cost-sharing comparable to the private market means eligible families cannot afford to participate.

In the Northeast and on the West Coast, in large metropolitan areas and elsewhere, the ability to cover kids in families with income greater than 250% FPL is necessary to equalize regional differences in the cost of living. 250% of poverty is $42,948 for a family of three. Based on the available data, the cost of living in New Hampshire is between 15% and 39% higher than the national average. By ignoring this fact and not giving administrators the flexibility to design programs to meet the individual needs of their states, CMS is in effect discriminating against working families in high cost of living areas.

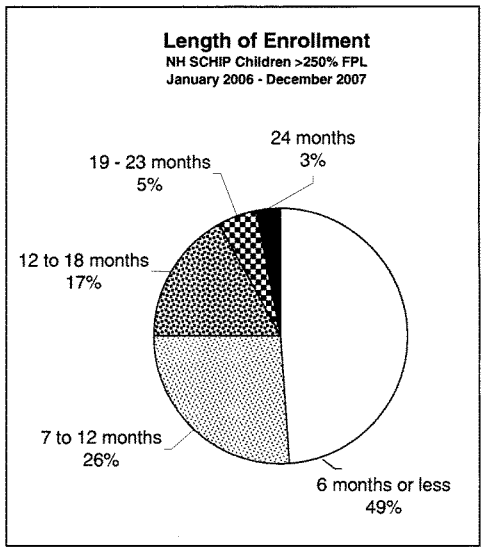
New Hampshire understands the importance of ensuring that public coverage is not substituted for private coverage. Eligibility criterion disallows the substitution of public coverage for private coverage by targeting uninsured children. However, we recognize that certain circumstances are beyond the control of families and warrant exceptions. It is not right to deny healthcare to a child if their parent loses a job involuntary or worse if a child loses a parent. Our policies have been effective. This is substantiated by the fact that employer-based coverage of kids remains high while enrollment in Medicaid and SCHIP has increased over time as shown in these graphs. This experience clearly illustrates that SCHIP in New Hampshire has not resulted in an erosion of private coverage that the directive claims it must remedy.





The directive will have even greater implications because it eliminates the use of deductions from income such as childcare expenses which have long been standards in Medicaid. Having consistent deductions for Medicaid and SCHIP streamlines the eligibility process and lessens complexity in the design of eligibility systems. So while twenty-eight percent (28% or 2,200) of New Hampshire children enrolled in SCHIP have income above 250% FPL, an estimated seventeen percent (17% or 1,300) of enrollees with adjusted family income below 250% FPL would also be affected because these deductions are no longer allowed. Altogether, the directive impacts almost half of New Hampshire SCHIP kids.

Assertions that currently enrolled kids are not affected by the directive put forth false expectations about its true impact. This directive will rapidly decimate the top premium tier of New Hampshire's SCHIP program and result in an increase in the number of uninsured children. This is inevitable because at higher eligibility levels SCHIP provides transitional coverage for families who experience a disruption in employment and income. As such, it provides vital continuity of care for children who would otherwise be uninsured and offers financial relief and security to their families at a time they need it most. This chart shows that in 2006 and 2007, seventy-five percent (75%) of families with income above 250% FPL were enrolled for twelve months or less. Only three percent (3%) of children were enrolled for the full twenty-four months. New Hampshire's SCHIP program serves these working families by effectively creating a bridge between the public and private markets.



Despite the short duration of enrollment, overall enrollment in this group has remained consistent over the past few years, meaning that as children transition off, new children enroll to take their place. Immediately upon compliance with the CMS directive, this option will no longer be available to new families who need the program. In two years, we would anticipate that only a handful of children would remain enrolled at this level. The lack of SCHIP coverage for

families who find themselves displaced in the private market will directly result in an increase in the number of uninsured children in New Hampshire by at least 18%. The full impact is not known as there is insufficient data to estimate how many more children would be denied access because they have not been uninsured for a full year or because their families cannot afford cost-sharing comparable to the private market.

Like many states, New Hampshire's state budget is in trouble. The Governor anticipates a $50 million deficit and the Commissioner of Health & Human Services is meeting with key stakeholders this afternoon to begin the process of determining how his department's forty three percent (43%) share of that deficit can be addressed. ***There are no surplus state dollars that can be used as a stop gap to replace federal funds if this directive is allowed to stand.***

Faced with the diminishing prospects of a timely SCHIP reauthorization that would address the directive, New Hampshire has begun planning the complex tasks associated with complying with the directive. ***Compliance will be extremely costly and administratively burdensome for states.*** Making extensive eligibility system changes, retraining eligibility and outreach workers, reprinting public education materials, re-tooling websites, conducting outreach to community partners, and communicating with families will be confusing, expensive and time-consuming.

While some hold hope that at worst the directive will be temporary, there is simply no logic or value in the wasted effort, cost and disruption to families that would occur in the interim. Despite claims to the contrary, the directive will impact kids. It has already done so in states that filed plan amendments that have been subsequently denied by CMS based on the directive. And it will affect children who lose private coverage through no fault of their own and are unable to access the program because of the forced changes in eligibility. The result will be an increase in

the number of uninsured children and thus an increase in the number of children who go without needed healthcare services.

States need the predictability of a full SCHIP reauthorization to move forward in covering kids. ***In the meantime, Congress must take action – to assure that New Hampshire and other states can continue to operate their highly successful programs under rules put into place a decade ago – by placing a moratorium on the directive.***

On another front, the CHIPRA bill would also have eased the administrative barriers and unintended consequences of the new requirements for verifying citizenship and identify imposed by the Deficit Reduction Act (DRA) of 2005. When the so-called "CIT-DOC" rules went into effect, New Hampshire had in place a functioning system for verifying citizenship of applicants. This system has been disrupted by additional, unnecessary federal requirements which have essentially stalled our momentum in covering kids.

It is important to point out that the "CIT-DOC" requirement did not change the way that immigrant children prove eligibility. The brunt of the impact is being felt by citizen children. Under the new CMS rules, a U.S. birth certificate is not sufficient to prove citizenship and identity. Children who don't have passports must provide separate documents to prove identity. School or medical records are the only options for proving the identity of children under the age of 16. Thus, the administrative burden is spread to schools and healthcare providers and delays in obtaining documents often mean that families can't meet processing deadlines. The impact of the CIT-DOC requirement on New Hampshire has been substantial even though our state was one of a few that continued to require citizenship verification when the new rules went into effective.

The addition of identity verification has negatively impacted New Hampshire's application process and stalled enrollment growth. Before the CIT-DOC requirement, about one-third of

applications were received with all documents needed to verify eligibility. Immediately after the new requirement was put into place, the completion rate dropped, by half, to about 16%. This means more follow-up by staff, longer delays in the eligibility process and ultimately an increase in applications that cannot be processed. The percentage of applications closed for missing verifications jumped from about 10% to 16% of applications. The end result is that fewer eligible children are getting through the process, the administrative burden is higher, the backlog in processing applications is larger and eligible children are going without needed healthcare services. In the year the following the implementation of the new requirement, our Medicaid program of some 63,000 kids grew by only 519 children or less than 1%, compared to 4% and 8% in the previous two years, respectively. CHIPRA would have given states new options to verify citizenship and identity that hopefully would have ameliorated this problem.

Before I close, it is worth highlighting several positive components of the CHIPRA bill that would have expanded children's health coverage and advanced quality of care and cost-effectiveness.

The CHIPRA bill was very thoughtful in giving states not only new tools and resources to be more effective in reaching out to uninsured children but also incentives to encourage the implementation of best practices in outreach and application assistance. Additionally, the bill looked beyond providing an insurance card to assuring that kids receive appropriate, cost-effective services to stay healthy. The development of consistent measures that would help identify opportunities for improvement, coupled with incentives for carrying out those improvements, were essential components of the bill.

But rather than move forward, states have been put on the defensive by CMS. Actions by the administration will force states to cut back their programs and add more complexity to pro-

gram administration. Such rules make it harder for families to enroll and retain their coverage. These actions are completely out of the step with the sentiment of the American people. Overwhelming majorities of voters and residents across American and in New Hampshire resoundingly believe that as a nation and as states we must do more, not less, to provide health coverage to our children. In the world's wealthiest nation, how can we justify that nine million American children do not have access to the healthcare they need to grow and learn and become productive citizens tomorrow?

In closing, let me reiterate that states need the predictability of SCHIP reauthorization and the many positive provisions of CHIPRA to move forward in covering children. Without a successful reauthorization however a number of states are faced with sliding backwards unless Congress takes swift and decisive action by placing a moratorium on the CMS August 17 directive.

Thank you.

Mr. PALLONE. Thank you. And I thank all of the panel. Let's go now to questions. And I will recognize myself for 5 minutes.

I guess I am going to ask of this of Ms. Kohler because I think that Ms. Brooks sort of answered it for New Hampshire, although I may get back to you. Again, going back to my opening statement, I was very happy at the beginning of 2007 because obviously in New Jersey, as you said, the Governor was going out of his way to try to enroll new kids. You mentioned 180,000 new kids were enrolled. And part of what we were trying to do with the CHAMP bill was to essentially put the vices in place so you could capture more kids and go out and do outreach and all that.

So I kind of wanted to ask, you know, what you did to get to that 180,000 new kids, you know, what the CHAMP bill allows you to do even better you know in terms of some of the initiatives that were in there? But at the same time going back to this directive, what is going to be the practical effect of that? You know, what is that going to mean if you are not successful in barring the August 17 directive from taking place, what kind of changes would you have to make to the CHIP programs in terms of eligibility and all that? So I will ask you first, and then if Ms. Brooks has anything to add.

Ms. KOHLER. Okay. We have implemented a number of things in New Jersey to help us identify enrolled children. We have an entire cabinet to help us in this effort. So, for example, the Department of Education when they collect information on No Child Left Behind, they put in their database whether the child has insurance and sends out outreach material. Similarly, our division of taxation, if it appears the child may be eligible, the family may be eligible for our program, they will also mail them information to help enroll them. We have liked a lot of provisions in the express lane enrollment that were in the bill, in the champs bill that would allow us to just use other Federal programs, such as food stamps to automatically enroll people into our SCHIP and our Medicaid program. We think all of those things are very helpful and they have helped us enroll so many new children. Unfortunately on the downside, some of the new provisions coming out—for example, the citizenship provision——

Mr. PALLONE. You are talking about the August 17 directive?

Ms. KOHLER. I am sorry. The August 17 directive will slow down our ability because it will require children to remain uninsured for up to a year before we can enroll them. The other provision that I think was mentioned in the last panel is the new requirement on citizenship verification that was part of the Deficit Reduction Act. At any one time, we have over 7,000 children in the process of us trying to verify their citizenship because we had to take down our existing program. And we do try and do as much electronically as we can. We match all of our statistic records in-house. But we still have a large number of children whose enrollment is delayed.

Mr. PALLONE. What is going to be the practical effect of this August 17 directive if you are not able to, you know, to bar it from taking effect?

Ms. KOHLER. Well, we are concerned that children will lose eligibility. Some of our children do go on and off as their family income changes. And of course, if they lose eligibility—well, CMS has indi-

cated possibly the current enrollment, enrolled children can remain. And a new child could not come on. Similarly, we enroll children if they lose their employer-sponsored insurance through no fault of their own. If their parent dies, we allow them to enroll in our program. Under the August 17 program, they would have to stay uninsured for a full year before we could enroll them, and we do not think that is fair to children.

Mr. PALLONE. Did you want to add anything in this regard, Ms. Brooks, in terms of your State?

Ms. BROOKS. Yes. We believe ultimately half of our SCHIP children will be affected between either their more rigid eligibility, the loss of deductions as well as just the straight income tiers. And we know that this group has been a steady group of about 3,500 kids. The numbers are small. But if they are not allowed an option to come onto SCHIP as a transition between bridging between their public program or their private program coverage periods, then it will increase the number of uninsured children by as much as 20 percent within 2 years in our State.

Mr. PALLONE. And Ms. Kohler, earlier Dr. Rossiter spoke about eliminating the Medicaid option for States to operate their CHIP program and reducing the CHIP match to the level of the Medicaid match. What would the impact of that be on New Jersey?

Ms. KOHLER. What that would do is reduce the amount of Federal funding that we have say over 15 percent. That would be a significant loss of Federal funding in New Jersey. We also are facing a significant budget deficit. Ours is $2.5 billion. And there is no way the State could make up those additional Federal dollars. New Jersey has a mixed program. A portion of our program is a Medicaid localized to the lowest-income children. And the bulk of our program is free standing. So any loss in Federal funding would be disastrous for us.

Mr. PALLONE. I just wanted to mention, Mr. Smith—and I am just going to end with this. For the record, you mention on page 2 of your written testimony, you state that the median income for a family of four in the U.S. is approximately $59,000. But actually, the median income is $73,415. The median income for all families in the U.S. is the $58,407 figure. And then on page 3, you state enrollment in Medicaid and SCHIP exceeds the number of children below 200 percent of the Federal poverty level. But according to the current population survey, there are 30.2 million children in families with incomes below 200 percent of the Federal poverty level. And there are 20.75 million children in families at or below that income level enrolled in Medicaid and SCHIP. Mr. Deal?

Mr. SMITH. Did you want me to respond?

Mr. PALLONE. I am just saying the facts of what I have.

Mr. DEAL. You know, one of the things that I have been concerned about in the reauthorization of SCHIP is the creation of great inequities between rich States and poor States. Richer States, which I presume from standards of my State of Georgia, New Jersey and New Hampshire qualify as those richer States, although when I hear you talking about budget deficits there, and my State doesn't have a deficit, and my State is being able to cover children, for example, it makes me wonder.

Ms. Kohler, the last time we had a hearing, which was roughly a year ago on this issue, we had a panel of people from all over the spectrum. And one of the questions that I asked was whether or not—what percentage should we insist on of covering children that are eligible for Medicare and Medicaid? What is an achievable percentage? And as I recall, the panel unanimously all agreed 90 percent was a realistic and achievable goal.

Now, that same hearing or one shortly thereafter, the statistic was presented that New Jersey at that time had some 23 percent of its eligible children, that is those who are eligible for SCHIP and Medicaid and/or Medicaid, that were still enrolled in neither. Now I have been told that now the Census Bureau says that you dropped to 22 percent of those eligible children that are still unenrolled. It would seem to me that if there was any one thing we all ought to agree on, and that is that the program was designed to fill the gap for the near poor and that they ought to have a priority, and yet we continue to hear witnesses railing against the letter, the August letter that had some of those criteria in it. Now I am short on time, so I will try to move as quickly as possible.

One thing I would like to ask Mr. Smith is this, a recent GAO report that I alluded to earlier said that in the nine States that had high percentages of adults enrolled in their program that they cost about 54 percent of the total of the SCHIP programs in those States. I would like to know, when a State is spending over 50 percent of its funding on adults, I think it clearly is not having the goal of SCHIP in mind.

Could you please tell us what the administration is doing to help ensure that needy children who are the top priority for this SCHIP program are actually going to be reached and covered? That is a broad question, but it needs an answer.

Mr. SMITH. Thank you, Mr. Deal. And obviously our coverage of adults has been controversial in SCHIP. And to sort of help put things into perspective, in those original waivers in which States agreed to terms and conditions under that waiver, there were specific provisions on what the State would do if, in fact, they ran out of their allotment. So the States from the very beginning agreed that they were running out of their allotment. To some States, most States were then to go to transition those adults into Medicaid, come back with a Medicaid waiver. And I believe one respect, the State agreed to fund those adults with State-only money entirely.

So from the very beginning we always had an agreement with States, what would happen if they exceeded their allotments. So we believed we were always preserving SCHIP for children to assure that no children would be denied coverage in those States by virtue of covering adults. To sort of bring you up to date in the adult coverage, last year in 2007, three States that had had waivers to cover adults, Illinois, Oregon and Wisconsin, those States have agreed to move those adults out of SCHIP into Medicaid. And again, we aren't talking about them losing coverage. What we are talking about is the difference between Medicaid match and SCHIP match. In 2008, Rhode Island will also be in that category, they come up for renewal, and as we have previously said we would not be re-

newing. In 2009, then five States, including New Jersey and Michigan, come up for renewal in January of 2009.

All these—Nevada we have already entered into discussions. They are out to 2011. But they have had so few uptake on the administrative side, they are already saying we are going to end this now. So we think it is appropriate just to—again, transition all of the adults to Medicaid. In many respects, take the argument off the table now by getting all of those adults into Medicaid by the end of this year.

Mr. DEAL. Thank you. My time is up. I appreciate the answers. Thank you, Mr. Chairman.

Mr. PALLONE. Dr. Burgess.

Mr. BURGESS. Again there is no clock. So watch me like a hawk. Mr. Smith, you started to talk about the per member, per month allocation when you were finishing your testimony and you ran out of time. Would you mind just finishing your thought for us?

Mr. SMITH. Yes, Dr. Burgess. And again, what I was trying to convey is in the respect of States going up to higher income levels, what families are paying for their share of family coverage, to insure the entire family, usually which means the addition of a spouse and however many children are in the family——

Mr. BURGESS. Those figures were not exclusively for adding a child to the coverage.

Mr. SMITH. That is correct. But I could break down what the employee's shares and the rest of the family coverage. But what we were trying to convey is, when you get—for family coverage, then you are covering all of the family, whether it is one child or two children or three children. In the case of myself, four children. It is all the same price because you have purchased that. In Medicaid and SCHIP, if they are in a managed care plan, what you are typically doing is paying a per member, per month amount. So what I was trying to relate was, for the price of two children that we are paying now a managed care plan, for that same price you can cover the entire family was the point that I was trying to make.

Mr. BURGESS. Now, would the administration be okay—because presumably a spouse could be covered under that, that is an adult that could be covered under SCHIP, would that be okay?

Mr. SMITH. Well, again, in family coverage and employer sponsored, I think we have set that premium assistance, the way to build on that, again, then you are not replacing private coverage. You are building on that private coverage for less cost than what you are paying now if you are paying for at least two children.

Mr. BURGESS. Now in the bill that was up when we were reauthorizing the SCHIP, the bill that came up in September and October, I think on the second generation of that, I spoke on—or engaged with our Chairman of the full committee, Chairman Dingell, in colloquy on the House floor, trying to ascertain what the upper limit of income was that would be eligible for coverage under SCHIP.

The stated amount on the bill or the amount that was referred to in the debates that morning was a figure somewhat over $60,000 a year that was in the bill. But there was also a possibility for income set-asides. And I think we have heard one of them alluded to this morning because of the child care exclusion, and the Chair-

man agreed with the fact that a $500 a year for a family's income could be excluded for child care expense. Do you agree with the Chairman? It was probably not an unreasonable position. But was the Chairman accurate on that?

Mr. SMITH. I think that it was accurate. And I listened to the debate and I read the statements afterwards. And again, I think it goes back to the question, for whom is the enhanced match really intended to be? And to some extent, is there really an upper limit to get around those rules?

Mr. BURGESS. And that was the furtherance of that colloquy. Because then we talked about a $20,000 exclusion for living expenses, $10,000 for transportation expenditures, and $10,000 for clothing allowance. And it seemed to me just doing simple math that I am capable of doing that we were already somewhat north of $100,000 for a family of four. Was that accurate that what the Chairman related?

Mr. SMITH. I think the Chairman did speak accurately. Part of this is all a bit ironic. In terms of the very history and the purpose of what income disregards in public benefit programs were for in the first place, which was to help families who were on welfare. That is where they were starting. They were on welfare. And it was meant as a work incentive to help those families return to work so they weren't penalized by losing their health insurance.

So income disregards were where you are starting at a higher income level but subtracting earned income, for example, the old $90 in the old AFDC rules, or a 30-1/3 or work-related expenses such as child care. Those were all intended for people leaving welfare.

Now we have sort of turned it upside down and said, now we are going to use income disregards to people who are well above poverty levels, or even near poverty levels in order to start subtracting out their income in order to qualify them for these programs. It is almost the absolute reverse of what income disregards were historically used for.

Mr. BURGESS. Okay. I appreciate the clarification. Ms. Kohler, in the little bit of time I have left, if we could get some clarification on the citizenship verification issue that you alluded to.

Under the existing law that expired September 30, what were the citizenship verification requirements under the existing law?

Mr. PALLONE. This is going to be the last one because he is over his time limit.

Ms. KOHLER. Okay.

Mr. BURGESS. See, I don't know that. So it is okay. I can't possibly——

Mr. PALLONE. You have to take my word for it.

Ms. KOHLER. Under the existing law, you have to prove both your citizenship plus your identification. So I think, as Cindy Mann explained, you need to come in with an original birth certificate.

Mr. BURGESS. And briefly under the new bill, the CHIPRA bill that was vetoed and sustained, what was the citizenship verification under that law?

Ms. KOHLER. There could be some attestations available to the families. But you didn't have to come in with your original document.

Mr. BURGESS. Attestation meaning you say that this is, in fact, correct. But was there at any point of documentation requirement or was it just simply the attestation?

Mr. PALLONE. Okay. That is the last one.

Ms. KOHLER. Okay. It was a combination. We had attestations plus we did require some verification.

Mr. BURGESS. Well, Mr. Chairman, this is an important point because we heard over and over again from your side when the second bill came up that there would be no relaxation of the citizenship verification. My side, in fact, was criticized when we brought up the fact that there might be a relaxation for citizenship verification. And while it may not be an issue in New Jersey or New Hampshire, I promise you, in the State of Texas, we have a lot of people in our State without the benefit of an accurate Social Security number. And not casting any other aspersions on why they don't have a Social Security number, it is a huge problem. And if we provide that type of relaxation of the citizenship requirement we are going to suddenly shift the burden significantly to border States like Texas. And I just think it is an important——

Mr. PALLONE. I understand your concern.

Ms. KOHLER. If I could just say, we actually did a study prior to the new requirements, and we found that we did not have any significant number of people on the program who were not citizens.

Mr. BURGESS. And I don't doubt that in New Jersey. I suspect in Texas it is different.

Mr. PALLONE. Let's move on. Mr. Green.

Mr. GREEN. Mr. Chairman, I have some other questions. I want to follow up with my colleague from Texas, because I think obviously we have some difference of opinion on it. The citizenship requirements may have been relaxed, but I can tell you there are examples in Texas, particularly south Texas or even in an urban area like I have, that it is much more difficult to get that certified copy of a birth certificate, particularly when we have children born at home, even in urban areas with midwives.

And again there is a cultural issue here. But wasn't the bill—and CMS can join in on this. I think the bill that we passed, that was vetoed, if someone who is not a citizen—and CMS did an audit, the State paid for that child because it was the State's decision, State-run program with Federal money. But wasn't that correct that if there was an audit by CMS, whether it be Medicaid or the CHIP program, that if you found out someone didn't have proper documentation, it was the State sticking it, not the Federal taxpayer?

Mr. SMITH. Actually, Mr. Green the penalty would have been only for the individual and could not be extrapolated to the rest of the population. So literally the——

Mr. GREEN. Oh, I know it would be the individual. But if you did an audit of the State of Texas and found you know, we have 10,000 of these children—you didn't have the verification, you think questionable, the State taxpayer picked that up, that individual that they found.

Mr. SMITH. Actually, Mr. Green, no. Because you would have done it on a sample and you would have found 20. Usually in audits, you extrapolate to the rest of the population. But the way it was drafted, it literally was only the 20.

Mr. GREEN. But if you showed 20, then depending on what your universe would be, 20 out of, you know, 10,000 may be much smaller. But it would show you evidence that maybe you need to——

Didn't CMS have the ability to require the State to also do other verifications other than maybe weighing too much on attestations, and if you found a high significance of children who were undocumented on there?

Mr. SMITH. Well, again, what the bill provided for itself, a State might be very well willing to take the risk because the penalty was so small. There are other provisions in the bill on the express lane, for example, that we believed were loopholes in the eligibility. For example, at the school, you might not be asking about the insurance status. So where in SCHIP specifically you have to be uninsured, but if you weren't asking all the right questions, then the potential was you would be letting people who were not eligible for the program.

Mr. GREEN. It sounds like CMS, if we want to run a Federal program we can. And frankly, I consider the percentages—for example, State of Texas receives from SCHIP is higher than the percentages we receive for Medicaid. You know, if we want to do that, then why would we want to trust the States to do it? Maybe it goes to the original concept of the SCHIP. I don't mind putting whatever requirements. But sometimes I see—particularly this CMS with the new regulations—and I have a question on that.

Mr. Chairman, I know I am running out of time. But you know, if you want to put all these barriers in place, then the program will not get to those folks, and particularly in a poorer population. My children, I have no trouble with getting them their certified copies of their birth certificates, or even our grandchildren. But if my children were born with a midwife in south Texas, then it is much more difficult. So that is why I think States who know that history and who use it for other verification, we use it for other verification, for example, in Harris County, our main issue in Harris County is that you need to first be a resident of the county because our public health system serves the Harris County residents.

I guess that is the frustration that we had the differences in the CHIP bill. And of course, I come from a different part of the State than my colleague, in a different district. I also know that if I am going to err, I would rather err on the side of getting that child health care. And that is what I think ought to be the concern of the Federal Government. And hopefully some day, even State government.

Let me get back to my questions, Mr. Chairman. This is a question for both Ms. Brooks and Ms. Kohler. With the recession we are talking about, and we are getting ready to vote on the stimulus that puts money back into the economy. In previous times with economic stimulus, the last time Congress passed a stimulus bill, it included $20 billion, for example, for State fiscal relief, $10 billion increased medicaid funding and $10 billion for State grants.

My concern is that, what we are doing today may be hardly even putting on our finger in the dike in what we are doing. And considering recent Congress commission on Medicaid and uninsured report that States Medicaid directors note that many States are now facing economic situations. It will either level off in the last of 2007

due to troubles in the housing market, targeted across-the-board Medicaid cuts before the end of the calendar year 2008, the coming possibility. Would you agree that the assessment with the economic downturn affects the state's ability to fund Medicaid and CHIP, Ms. Kohler?

Ms. KOHLER. Yes. It is a significant issue. As I said, in New Jersey we are basically in $2.5 billion deficit that we are trying to find ways to reduce our spending to live within our means. If I could say the last time Congress passed an economic stimulus package, it did include money for both Medicaid as well as block grants to the States. And that was a very, very effective way of getting the money very quickly out there in the economy. And it really did help prevent the recession.

Mr. PALLONE. I am going to let whoever wants to answer this and that is—because his time is over too. Go ahead.

Ms. BROOK. Just very briefly. 43 percent of the deficit in New Hampshire is going to have to be made up by the Department of Health and Human Services. Certainly an enhanced F map in New Hampshire would help us go a long way to help us bridge that. But also we know there is going to be increased demand if there continues to be an downturn in the economy, people are going to lose jobs and they are going to need health coverage.

Mr. GREEN. Mr. Chairman, my concern about it, if we don't assist the States and if you are in some States, the States will have trouble coming up with the money, we will just see our uninsured population go up even more, particularly with the Medicaid population. So thank you, Mr. Chairman, for your patience.

Mr. PALLONE. Thank you. And thank you to all of you. I will end with this and say that you know we are going to have more discussion of this. We have Mr. Leavitt coming in to talk, I guess, during the budget review. In February, we are going to have another panel like this. There is the concern that as we move on, as the economic slump becomes worse, you know, what the impact is going to be. So this is a very important part of what we are looking at as a subcommittee in terms of where we go with not only SCHIP, but Medicaid and the need, as you said, to do something in terms of the match. So I appreciate it.

I know we are ending on this note. But I think it is sort of a beginning of what we will have to look at in the subcommittee over the next few months.

Thank you all very much. Let me mention that Members may submit additional questions for the record to be answered by you. They should be submitted to the committee clerk within the next 10 days, and then you would be notified. So we may get some additional questions in writing for you to answer. But thank you again. And without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 1:19 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF HON. JAN SCHAKOWSKY

Thank you, Mr. Chairman. You have been a real leader on the issue of covering more children, and I know this Committee appreciates your leadership and persistence.

Over the next 2 years, 27 million American children will be uninsured for some period of time. They will go without preventive care. They won't be able to see a doctor or a dentist, and some will grow up with life-long health care problems that could have been prevented with early care.

When a bill to cover 10 million children—which is supported by the House and the Senate, Governors in both parties, consumers, people of faith, medical associations, hospitals, pharmacies and insurers—is held back by the very few—truly this was a missed opportunity.

The House SCHIP reauthorization legislation would have brought health coverage to approximately ten million children in need—preserving coverage for all 6.6 million children currently covered by SCHIP, and extending coverage to 3.8 million children who are currently uninsured. In my home state of Illinois, this would have meant covering a total of 300,000 Illinois children—constituting an expansion to over 150,000 eligible, but not yet enrolled Illinois children.

How can anyone justify leaving millions of our own children so vulnerable? It is a black mark on our country. It is a moral issue as well as a health issue. People in every other industrialized nation must shake their head in disbelief. We are a powerful and wealthy nation—the wealthiest in fact—and we know that we can do better. I am grateful to be having this hearing today because, though we extended SCHIP through to March 2009, and will continue to work at expanding and improving children's health insurance in the meantime, the Administration seems set on a course to fight us every step of the way.

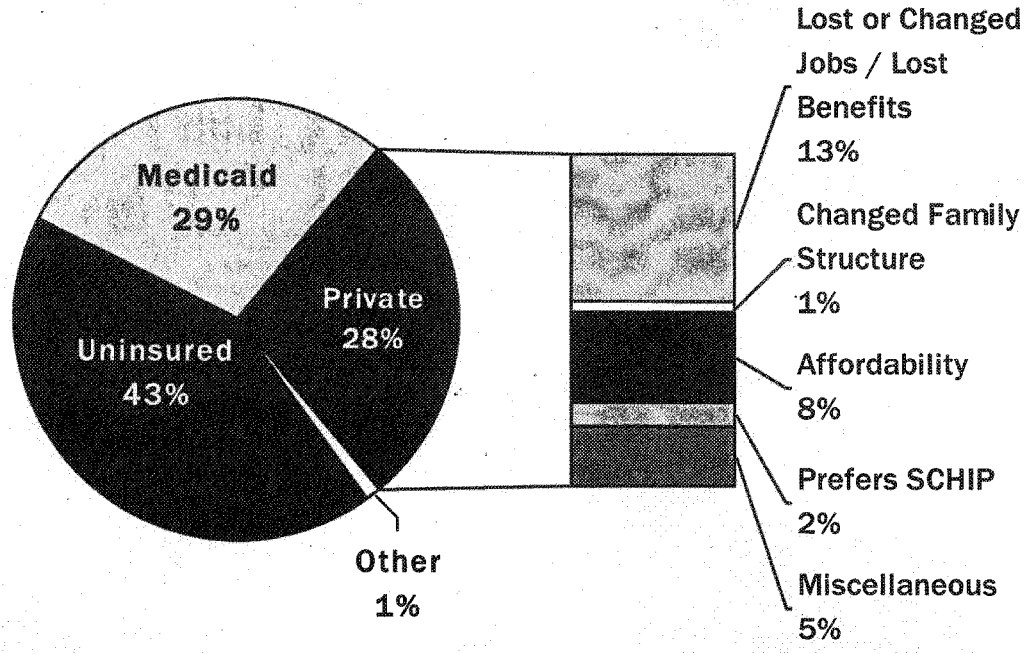
By issuing regulations that chip away at critical services, CMS is acting in direct opposition to numerous states—including my own—that are working hard to expand on the coverage they currently provide through SCHIP, Medicaid, or a combination of both. By tying the hands of states who want to help children get access to essential services through its draconian regulations, the Bush Administration is preventing assistance from reaching families who are truly hurting.

Given the worsening economic conditions and slow job growth, states that are already cash-strapped will soon face between 700,000 and 1.1 million additional applicants for their SCHIP and or Medicaid programs. This is no time to cut back on working families.

I am glad to be starting the year off with such an important and timely hearing. I'd like to thank our witnesses for being here and with that, I yield back. Thank you, Mr. Chairman.

Community		Monthly Costs of Living						Monthly Total	Private Health Insurance	Money Remaining		
Town	State	Housing	Food	Childcare	Transp.	Other	Taxes		Monthly Premium	Families at 200% FPL	Families at 225% FPL	Families at 250% FPL
Albuquerque	NM	$768.90	$645.70	$955.90	$425.70	$381.70	$209.00	$3,723.90	$337.00	-$281.90	$148.10	$578.10
Charlotte	NC	$790.90	$645.70	$952.60	$393.80	$388.30	$310.00	$3,921.93	$440.63	-$479.93	-$49.93	$380.07
Chattanooga (Ga. portion)	GA	$625.90	$645.70	$968.00	$356.40	$343.20	$243.00	$3,729.44	$547.24	-$287.44	$142.56	$572.56
Cheyenne	WY	$651.20	$645.70	$654.50	$412.50	$349.80	$22.00	$3,216.90	$481.20	$225.10	$655.10	$1,085.10
Chicago	IL	$996.60	$645.70	$839.30	$353.10	$443.30	$312.00	$4,002.98	$412.98	-$560.98	-$130.98	$299.02
Dallas	TX	$954.80	$645.70	$792.00	$353.10	$432.30	$185.00	$3,962.90	$600.00	-$520.90	-$90.90	$339.10
Denver	CO	$976.80	$645.70	$1,101.10	$393.80	$437.80	$394.00	$4,348.30	$399.10	-$906.30	-$476.30	-$46.30
Houston	TX	$806.30	$645.70	$792.00	$353.10	$391.60	$128.00	$3,743.21	$626.51	-$501.21	$128.79	$558.79
Lafayette	IN	$727.10	$645.70	$931.70	$412.50	$370.70	$306.00	$3,873.70	$480.00	-$431.70	-$1.70	$428.30
Lancaster	PA	$707.30	$645.70	$1,049.40	$356.40	$365.20	$332.00	$3,886.00	$430.00	-$444.00	-$14.00	$416.00
Lansing	MI	$709.50	$645.70	$771.10	$356.40	$366.30	$174.00	$3,358.00	$335.00	$84.00	$514.00	$944.00
Los Angeles	CA	$1,236.40	$645.70	$981.20	$353.10	$508.20	$290.00	$5,069.93	$1,055.33	-$1,627.93	-$1,197.93	-$767.93
Madison	WI	$820.60	$645.70	$841.50	$356.40	$396.00	$245.00	$3,673.58	$368.38	-$231.58	$198.42	$628.42
Middlesex	NJ	$1,331.00	$645.70	$844.80	$393.80	$533.50	$479.00	$6,025.64	$1,797.84	-$2,583.64	-$2,153.64	-$1,723.64
Nashville	TN	$719.40	$645.70	$860.20	$393.80	$368.50	$89.00	$3,547.69	$471.09	-$105.69	$324.31	$754.31
New York	NY	$1,182.50	$645.70	$1,314.50	$353.10	$493.90	$747.00	$5,916.42	$1,179.72	-$2,474.42	-$2,044.42	-$1,614.42
Pheonix	AZ	$898.70	$645.70	$662.20	$393.80	$416.90	$174.00	$3,663.30	$472.00	-$221.30	$208.70	$638.70
Pine Bluff	AR	$574.20	$645.70	$745.80	$412.50	$328.90	$105.00	$3,143.82	$331.72	$298.18	$728.18	$1,158.18
Pittsburgh	PA	$702.90	$645.70	$1,049.40	$393.80	$364.10	$422.00	$3,974.96	$397.06	-$532.96	-$102.96	$327.04
Portland	ME	$984.50	$645.70	$983.40	$412.50	$440.00	$397.00	$5,863.10	No Info	$421.10	$8.90	$438.90
Salem	OR	$677.60	$645.70	$940.50	$356.40	$357.50	$316.00	$3,775.70	$482.00	-$333.70	$96.30	$526.30
Salt Lake City	UT	$750.20	$645.70	$762.30	$393.80	$377.30	$173.00	$3,502.01	$399.71	-$60.01	$369.99	$799.99
San Jose	CA	$1,444.30	$645.70	$981.20	$393.80	$564.30	$392.00	$5,230.33	$809.03	-$1,788.33	-$1,358.33	-$928.33
Santa Barbara	CA	$1,104.40	$645.70	$981.20	$356.40	$473.00	$235.00	$4,616.13	$820.43	-$1,174.13	-$744.13	-$314.13
Texarkana	TX	$561.00	$645.70	$792.00	$412.50	$325.60	$61.00	$3,381.24	$583.44	$60.76	$490.76	$920.76
Tulsa	OK	$704.00	$645.70	$814.00	$425.70	$364.10	$305.00	$3,669.50	$411.00	-$227.50	$202.50	$632.50

Coverage of Recent SCHIP Enrollees During the Six Months Before They Enrolled



Source: Wooldridge et al., 2005. Congressionally-mandated evaluation of SCHIP. The categories do not necessarily sum to 100% due to rounding.

Congressman Edolphus Towns (D-NY) Statement for the Record: "Covering Uninsured Kids: Missed Opportunities for Moving Forward"

House Energy and Commerce Subcommittee on Health Hearing of Tuesday, Jan. 29th at 10:00 a.m., in room 2128 Rayburn House Office Building.

Thank you Mr. Chairman and Ranking Member for holding this most important hearing: *"Covering Uninsured Kids: Missed Opportunities for Moving Forward".* I welcome today's witnesses. As an ardent fighter for uninsured children, I am pleased we are exploring, today, how recent government actions have affected uninsured children. New York Governor Spitzer found that 400,000 New York children are uninsured. Regretfully, this Administration that preaches compassion vetoed SCHIP legislation twice, then temporarily extended SCHIP at current funding levels, despite the weakened economy and the increase in the numbers of uninsured children. Last August, CMS issued a directive that imposes an income eligibility cap in the State Children's Health Insurance Program and Medicaid. This action robbed New York of the flexibility it has used since 1977, to establish income eligibility based on state specific factors, such as cost of living, healthcare costs and state income levels. New York is one of six "expansion" states that's said to have been negatively impacted by the CMS directive. I believe today's testimony will highlight the problems surrounding the directive and give congress needed perspective to address full reauthorization moving forward, so that uninsured children can receive much needed coverage. Thank you Mr. Chairman.

FIRST FOCUS
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March 26, 2008

The Honorable John Dingell
Chairman
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Chairman, Health Subcommittee
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Joe Barton
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Nathan Deal
Ranking Member, Health Subcommittee
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Lois Capps
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Dingell, Chairman Pallone and Representatives Barton, Deal and Capps:

I am writing in response to your request for additional information related to the testimony I provided before the House Energy and Commerce Committee Health Subcommittee on January 29th during the hearing, "Covering Uninsured Kids: Missed Opportunities for Moving Forward." I was pleased to have the opportunity to provide the Committee with information and recommendations regarding legislative efforts to reduce the numbers of uninsured children in the U.S.

As President of First Focus, a bipartisan advocacy organization committed to making children and their families a priority in federal policy and budget decisions, I am heartened by your leadership on children's issues, and would like to thank you and members of the Subcommittee for bringing the important voice of children to this discussion.

Along with your questions, I am providing below the additional information you requested in your letter of March 12th.

1. *One of the impediments to passing legislation that provides health coverage to more eligible children is that they have a fiscal impact. I am interested in transforming how we evaluate legislation so that CBO's score of prevention programs takes into account well-documented savings to government programs that accrue from programmatic outcomes. One example is evidence-based nurse home visitation programs, such as Nurse-Family Partnership, which promote early access to prenatal care, parenting skills and child health services. I have some material on scoring H.R. 3024 (which would provide states with an option to include program like NFP in Medicaid) from Brookings, which is preliminary but which I would like included in the Hearing Record. The Brookings analysis demonstrates significant saving to the Medicaid program (22% offset to*

Medicaid costs over 5 years and 43% over 10 years) from H.R. 3024 that are related to NFP's proven record in reducing pre-term births, emergency room use, and subsequent births. Do you think these savings should be taken into account in scoring H.R. 3024?

First Focus wholeheartedly agrees that the current scoring system employed by the Congressional Budget Office (CBO) should take into account expected savings when it is developing the overall cost or so-called "score" for legislative proposals. The current system, which fails to recognize the potential savings that would likely result from investments in our nation's health care system, is both out-dated and short-sighted. A more dynamic scoring system is especially important for health-related legislation because while these proposals often require an upfront investment, in the long run, the evidence shows significant cost savings and improved health outcomes. As Americans call on Congress to take action on key issues including legislation to improve health coverage for uninsured children and broader health system reforms, the CBO scoring issue is a critical one and we are grateful for your interest.

Under the current scoring system, CBO relies, for the most part, on long-used models to analyze the costs of proposed legislation. Unfortunately, these models ignore the economic growth, efficiencies, and cost savings that result from implementing innovative and transformational policies. Notwithstanding the overwhelming evidence that investments in health-related prevention programs and health information technology systems dramatically improve health care quality, improve patient outcomes, and reduce fraud, CBO's current scoring methods do not employ macroeconomic analyses that would take into consideration the latest research and information. In turn, Congress is missing important information when making decisions on legislation that has the potential to reap dramatic savings or public health improvements. Ultimately, the impact of CBO's static scoring method is that legislative proposals which receive a high CBO score often do not receive serious consideration on Capitol Hill due the costs associated with their implementation.

On the healthcare front, the greatest examples of the shortcomings of CBO's current system can be found in legislative proposals that seek to invest in health promotion and disease prevention programs. It is well-documented that preventive health programs often result in savings that far exceed their costs. Nevertheless, CBO does not consider the long term cost benefits associated with such investments. Your legislation, the Healthy Children and Families Act (H.R. 3024), is an excellent example of a program that would not only improve access to cost-effective primary and preventive health services for low-income mothers and babies, it would also save taxpayer dollars. A recent research study by First Focus fellow Julia Isaacs of the Brookings Institution, "Cost Effective Investments in Children," affirms these findings. Sadly, despite the strong evidence that programs like nurse home visitation save money, this important legislation has not been advanced on Capitol Hill due in no small part to CBO's cost estimate. This is just one among many examples of legislation that may not receive due consideration by Congress because there is a long list of priorities competing for federal resources and it scores too high on a CBO spreadsheet. H.R. 3024 is an apt example of a proposal for which CBO should take into account the overall cost savings that would result from its implementation.

Ignoring the savings and improved health outcomes that result from investments in preventive health is bad public policy. The current CBO approach poses a significant barrier to passing legislation that has the potential to both substantially improve health care and reduce health care costs. Ensuring

more accurate CBO scoring could lead to a dramatic improvement in the health of our citizens and in our health care system as a whole, helping save lives and tax dollars.

2. *Other examples are programs that reduce premature births and diabetes and a host of health problems that arise from the lack of adequate health care. Do you believe that these prevention programs save government resources? Should those savings be reflected when these programs are scored?*

The evidence is clear that investments in preventive health, especially health care for children, are among the most cost effective investments we can make as a nation. It is well-documented that preventive health programs often result in savings that far exceed their costs. In addition to your legislation, H.R. 3024, there are scores of programs that demonstrate this point including: health coverage programs like Medicaid and SCHIP, which allow children to get the routine care they need to keep them healthy and out of the high-cost emergency room setting; Healthy Start, which supports prenatal and early infant care; and immunization programs like the Vaccines for Children program, which prevent costly illness and help children stay healthy. First Focus supports all of these federal programs, which, with modest federal investments, improve children's health and save lives.

The inadequacies of the current scoring system are not only apparent when it comes to scoring prevention programs, they are also apparent when it comes to legislative efforts to improve the use of health information technology (HIT) systems. Because CBO does not score the savings related to HIT improvements, Congress is impeded from making wise investments in HIT innovations despite the fact that the evidence shows that such investments would save federal dollars and improve health care delivery in the future. When it comes to children's health, this is especially true for efforts to develop data systems that would improve income eligibility processes and the enrollment of children into public health coverage programs.

As I noted in my testimony, a large portion of our nation's uninsured children are eligible for Medicaid or SCHIP but currently uninsured. Both of the Children's Health Insurance Program Reauthorization Acts (CHIPRA I and CHIPRA II) (H.R. 976, H.R. 3963) passed by Congress last fall included so-called Express Lane Eligibility provisions that would allow states to develop HIT systems to facilitate the enrollment of eligible children into Medicaid or SCHIP. Under Express Lane Eligibility, states would be able to expedite the enrollment of currently eligible but unenrolled children by targeting outreach to those children who are already participating in needs-based programs. It is estimated that more than 70 percent of low-income, uninsured children are in families that are already enrolled in the Food Stamp program, the Women with Infants and Children (WIC) program, or the National School Lunch Program (NSLP). We know by definition that children enrolled in these other federally means-tested programs are also income eligible for Medicaid or SCHIP. By investing a few dollars in eligibility system upgrades for states, we could eliminate a great deal of unnecessary red tape and bureaucratic costs both for the states and for low-income families. Unfortunately, this commonsense application of HIT is difficult to enact because there is an initial upfront investment of federal resources and because the significant cost savings that ultimately would be achieved are not recognized by CBO.

On a related point, I wanted to address another CBO scoring issue that is currently before the Congress. Specifically, Congress is currently considering legislation that would halt the Executive Branch's efforts to secure policy changes to the Medicaid program through regulatory actions. In

essence, Congress seeks to maintain the current law. However, under the current CBO scoring methodology, congressional proposals to maintain the status quo are scored as a cost to the federal government. Congress should retain its authority to protect the integrity of the laws it passes from what it may deem as Executive Branch overreach and failure to recognize congressional intent. Therefore, it seems reasonable that Congress should require CBO to score the blocking of regulatory actions by the Executive Branch as budget neutral. Because CBO currently scores the savings associated with efforts to block regulatory actions, Congress is facing serious constraints even though it seeks only to safeguard congressional intent, to curtail Executive Brach overreach, and desires only to maintain current law.

For example, even if Congress deems the recent wave of administrative rules by CMS to contravene statutory language, CBO is able to score these regulatory changes as saving approximately $15-50 billion. As a result, under current PAYGO rules, in order to halt these proposed regulatory changes, Congress is required to identify a similar level of offsets just to maintain "current law." This is a surprising acquiescence of congressional authority given that Congress itself sets its own scoring procedures.

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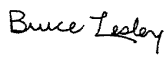
I hope this information is helpful. We are grateful for your leadership and indeed all of your efforts on behalf of children and other vulnerable populations. We welcome the opportunity to work with you in the future on legislation to address the health care needs of our nation's most precious resource, our children.

Sincerely,



Bruce Lesley
President

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