

Testimony of Jeanne M. Lambrew, PhD
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Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

February 14, 2007

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

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

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

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

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

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

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

Access to Care

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

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

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

Impact on Health and Quality of Life

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

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

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

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

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

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

The Value of the Investment in Coverage for Children

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

NOTES

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

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