Georgetown University Health Policy Institute
Center for Children and Families

"Covering Uninsured Kids: Missed Opportunities for Moving Forward"

Testimony Submitted to the

Subcommittee on Health

Committee on Energy and Commerce

By

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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).

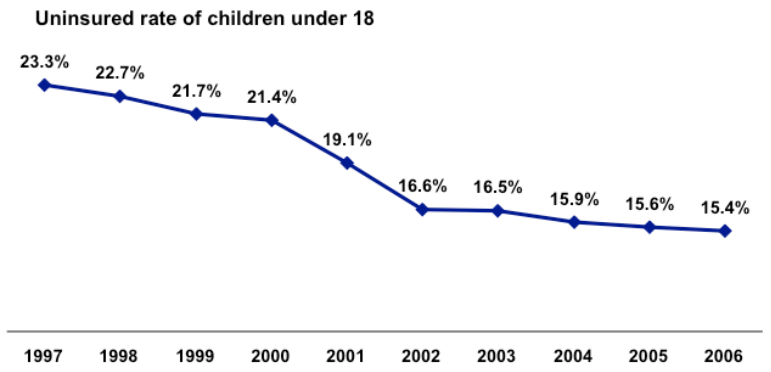
CHIPRA would have supported these efforts by further strengthening SCHIP and Medicaid, consistent with the public's desire that children have health insurance that provides access to the health care services they need. Over the year, as the SCHIP debate increasingly became a public debate, the strength 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

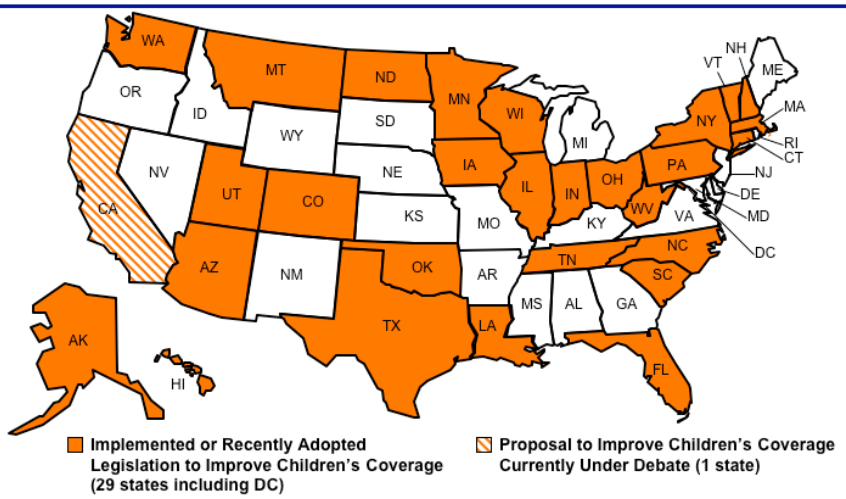
Trends in the Uninsured Rate of Low-Income Children, 1997 - 2006



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

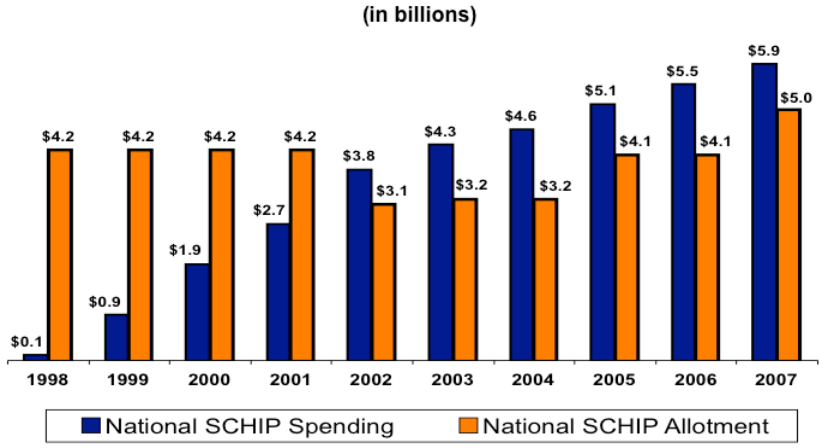
States That Have Taken Significant Action to Improve Children's Coverage (2006-2007)



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

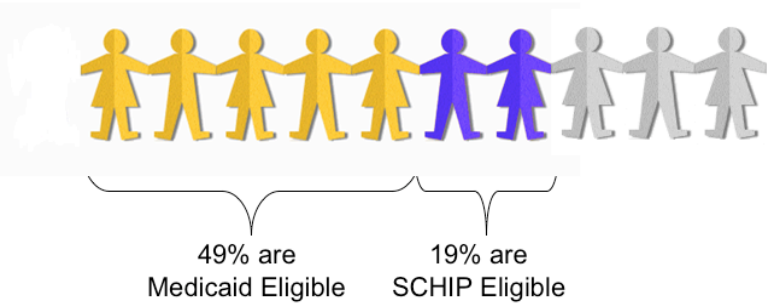
The Mismatch Between SCHIP Allotments and SCHIP Spending Has Grown Over Time



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

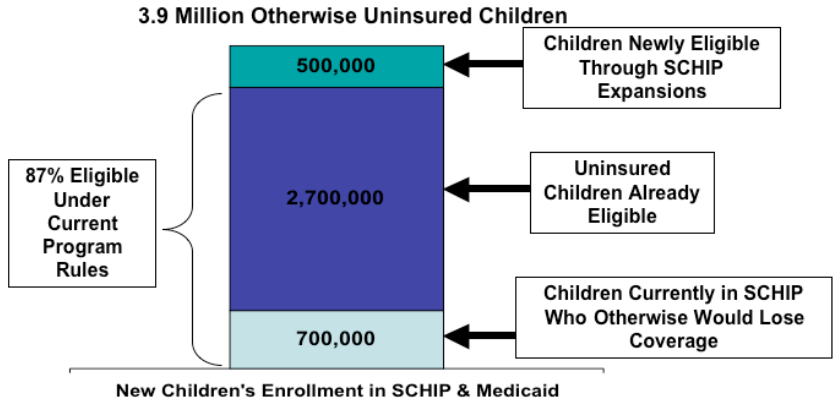
7 out of 10 Uninsured Children are Eligible But Unenrolled in Medicaid/SCHIP



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

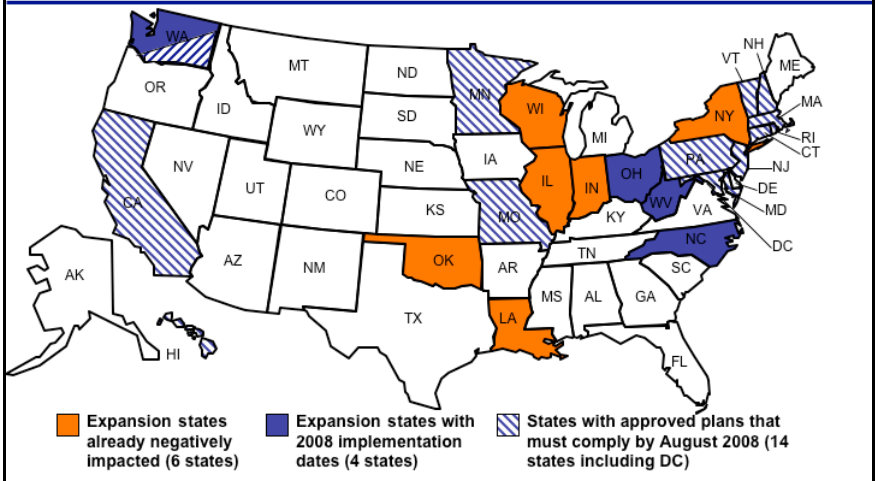


Note: Average monthly enrollment for fiscal year 2012; SCHIP & Medicaid would cover 5.8 million children when reductions in other coverage are included; numbers may not sum due to rounding.

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)

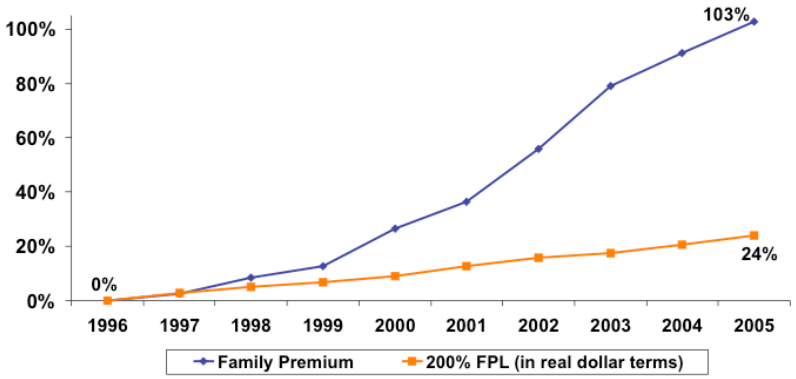
Figure 7

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

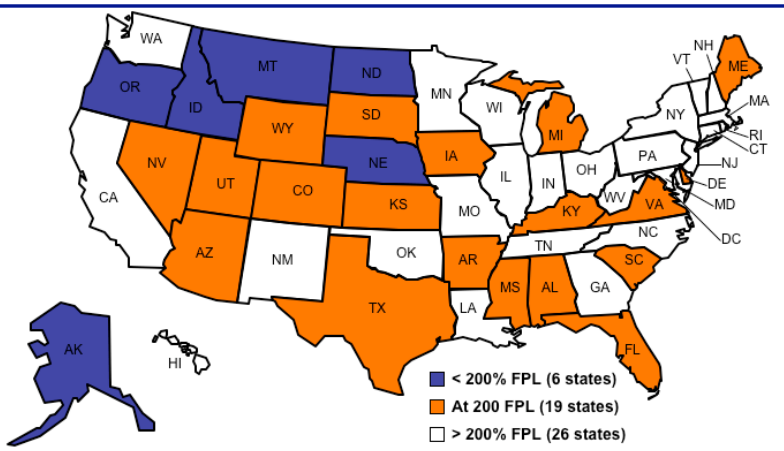


Note: This data represents the cumulative growth in employee premium contributions for employer-sponsored family coverage and the federal poverty level for a family of three, compared to the cumulative growth in the federal poverty level adjusted each year by the federal government.

Source: Agency for Healthcare Research and Quality estimates of 1996-2005 Medical Expenditure Panel Survey Insurance Component Tables, generated using MEPSnet/IC (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.