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IMPLEMENTATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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IMPLEMENTATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

THURSDAY, APRIL 29, 1999

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr., (chairman of the committee) presiding.

Also present: Senators Chafee, Hatch, Rockefeller, Conrad, and Robb.

The CHAIRMAN. The committee will please be in order.

Senator Hatch has to chair another hearing, so I, with the indulgence of the other members, am going to call upon him.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you very much, Mr. Chairman. I am very appreciative of it, because I have a mark-up in Judiciary that started 5 minutes ago, and I would like to be able to get over there. But this is very important to me.

Two years ago, when Senator Chafee, Senator Rockefeller, Senator Jeffords, Senator Kennedy, and I started a major push to devote additional efforts toward child health insurance coverage, many thought we were on a fool's errand. Expand Federal spending on top of balancing the budget? Create a new program? A lot of people doubted it could be done.

The good news is, we stuck to our principles. We fought for the 10 million kids who lacked adequate medical insurance. We fought to create a responsible program, a program that recognized our budgetary realities, that recognized that a solid Federal/State partnership had to be the basis for our efforts. Every member of this committee knows how hard it was to put this program together.

It was hard to break through the rhetoric and craft and approach that paid proper respect to the foundations of Medicaid, yet which allowed the States the flexibility to write their own responsible programs.

It was hard to fight the tobacco companies and find the funding. It was hard to bridge the partisan gaps. But we did it. And we did it in the good old Finance Committee tradition, that bipartisan spirit which has led this committee to find solutions time and time again to thorny public policy problems.

Are there problems with this fledgling program? Of course there are. This is true with any new program. But working with the administration and the Governors, I am sure we will find a way to resolve those problems.

In fact, Governor Pataki told me that this was the best program that he has seen that takes into consideration the needs of the States and gives the flexibility to be able to do what has to be done.

I am proud that, because of our bill, because of the work of this committee, of all of us on this committee, enrollment in Utah's CHIP program is more than 8,000 children today, and of course that is growing. Could we enroll more? Of course, and we will.

But the numbers alone do not tell the story. Take, for example, Susan Basong of Alpine, Utah. She wrote to the State, "Whoever is instrumental in getting this CHIP program together for us single moms, I want to give you and them a big bear hug. I'm going to school to upgrade my education, and if it wasn't for this program, my kids would be in big trouble.

Unfortunately, it's the kids that suffer when there is any financial crunch in a family. I'm so very, very grateful to you and all of those who work for this program to come to fruition. I love you all, and God bless you."

Now, that is what this work is all about, and that is what it should continue to be about. I want to thank my Chairman for the help that he gave. I want to thank him for giving me this privilege of making these few remarks.

And my colleagues on the other side, for allowing me to go forward. I know this is unusual on the Finance Committee, and I apologize for having to do that, but I think my Chairman does understand my difficulties on the Judiciary Committee.

But I am grateful for this program. I am grateful for all of those who voted for it on this committee and helped push it through the Senate and through the House. I just believe it is one of the better programs that will really help people and families who deserve the help in ways that will really resolve problems for a long time to come.

Thank you, Mr. Chairman. I really appreciate your showing me this courtesy.

The CHAIRMAN. Thank you, Senator Hatch.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Well, we are here today, not to discuss problems or the need for reform. Instead, I think we are going to focus on a success story, the implementation of a State Children's Health Insurance Program, better known as CHIP.

During the debate over the Balanced Budget Act of 1997, the Finance Committee was instrumental in the creation of a new program to provide health insurance to low-income, uninsured children. Through our efforts, States can create new insurance programs for kids, expand Medicaid, or combine both approaches.

In the 18 months since CHIP funds became available, nearly 1 million children have enrolled in the new program. These children now have a doctor to visit when they develop ear infections, or they

have access to the regular check-ups that will help them grow and thrive.

When serious problems arise, nearly 1 million previously uninsured children can now go to the hospital without exposing their families to financial hardship. By any measure, this constitutes success.

No new program can operate at full capacity immediately, but CHIP has exceeded expectations. The Congressional Budget Office assumed that 800,000 children would be covered by CHIP in the first year. States have exceeded that projection by 20 percent.

Without question, CHIP had a strong first year. But the program still has a long way to go to meet the goals we had in creating the program and in setting aside $24 billion for children's health. Congress made the program a real priority and we expect to see real results.

Ideally, there would be no problem with health insurance access, but since that is not the case, I would like to see as many as 5 million uninsured children covered as a result of CHIP or the Medicaid outreach efforts that accompany the new program. As I say, after 1 year we are off to a good start, for which I congratulate both the States and HCFA. Now it is my pleasure to turn to Senator Conrad.

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Thank you very much, Mr. Chairman. Thank you for holding this hearing. I believe this program presents a real opportunity to States, more importantly to children. Children are the least expensive group to cover in this country, yet it is the best investment because a healthy child provides a basis for a lifetime.

I am very encouraged by what I see happening. It looks like we are on track to go to 2.5 million over this initial phase of the program. What a difference that makes, to have a family, when they face a medical emergency, know that they can go to a doctor and they do not have to worry.

My State is in a virtual agriculture depression, Mr. Chairman. You know that, because you are originally from a neighboring State and still come to our part of the country on occasion. You know what is happening out there.

Very often, parents are being forced to choose between food, shelter, and health care for their children. This program makes a profound difference. Our State has just met in legislative assembly. We only meet every 2 years. They have decided to cover children and families with incomes up to 140 percent of poverty.

They could have gone higher; I wish they had. But it is a beginning, and I think we see that across the country and it is making a difference in the lives of lots of kids. They are going to have a chance to have a healthy beginning because they have access to the finest health care system in the world.

But we can do better and we can do more, and we should. So I am glad we are putting the focus on it in this hearing today, and I again want to thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Conrad.

Next, we have Senator Robb.

OPENING STATEMENT OF HON. CHARLES S. ROBB, A U.S. SENATOR FROM VIRGINIA

Senator ROBB. Thank you, Mr. Chairman. I join our colleagues in thanking you for holding this hearing. Certainly, it does focus on an area where we have seen some very good early signs. We still have 11 million children, I believe is the total, that are not covered by health insurance.

I must confess that my own State has not been as quick off the mark as others have, and has not gotten as fast a start on implementation. So I am particularly looking forward not only to hearing from the HCFA administrator, but from the experiences of both Ohio and New York, as to how other States might benefit from their experience. But this is extraordinarily important, and I thank you for holding the hearing.

I will not be able to remain for all of the testimony because I have another hearing at which I have to make a presentation myself, but I will look forward to reviewing the record. Again, I thank you, Mr. Chairman, for holding the hearing.

The CHAIRMAN. Thank you, Senator Robb.

Senator Chafee?

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you very much, Mr. Chairman. I would just like to reiterate what Senator Robb said about the more than 10 million children in this country who do not have health insurance.

One of the interesting things, is that there are over 4.5 million children who are eligible for Medicaid, but are not enrolled. Maybe that fact has been stated here. But the purpose of this program is to pick up uninsured children.

I am deeply interested in this whole procedure and commend you, Mr. Chairman, for holding this hearing. In our State, they have done a good job, but I am confident they would be the first to say they can do an even better job. So, I am just very happy you are doing what you are doing, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Chafee.

Now it is a pleasure to turn to our witnesses, beginning with Hon. Nancy-Ann Min DeParle, who is Administrator of the Health Care Financing Administration.

Ms. DeParle, it is a pleasure, as always, to have you. Please proceed with your comments.

STATEMENT OF HON. NANCY-ANN MIN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Ms. DEPARLE. Thank you, Mr. Chairman and distinguished committee members. Thank you for inviting me here to discuss our progress in implementing the Children's Health Insurance Program, or CHIP.

CHIP is a tremendous achievement of the bipartisan Balanced Budget Act, Mr. Chairman. It addresses the fact that one in seven American children are uninsured. It addresses the problems of working families in this country who earn too little to afford pri-

vate insurance for their children on their own, but too much to be eligible for Medicaid.

I am happy to report to the committee that the CHIP program is strong and growing, and, Mr. Chairman, I believe that it will achieve the vision that the Congress set forth.

We estimate right now that there are about 1 million children enrolled in the program after only a year. To date, we have approved 52 plans that States and territories expect to cover up to 2.5 million children by the end of the year 2000. We also have already approved 15 amendments that expand or make other program changes to States' initial CHIP plans.

Our primary challenge now is to increase and improve outreach and get more eligible children enrolled in both CHIP and in Medicaid. It is important to stress that the BBA also gave States important new options for increasing enrollment of the more than 4 million uninsured children who are eligible for Medicaid.

To meet the outreach challenge, the President has launched a broad and innovative outreach campaign in February that we are calling Insure Kids Now. It uses public/private partnerships, like some that the States have employed themselves, to identify and enroll eligible children in Medicaid and CHIP.

The campaign includes a toll-free hotline, 1-877-KIDSNOW, that connects callers anywhere in the country directly to specific information about the CHIP plan in their State.

The number is being promoted through public service ads and it is being printed on commonly used products that families would see, like diaper boxes, grocery bags, child safety seats, and school buses.

It is already getting results. Some 41,000 people were connected to their State's CHIP and Medicaid programs through this toll-free line in just its first seven weeks of operation.

Many States are also using innovative outreach approaches and having good success, and the committee is going to be hearing from some of them this morning. But States have told us that outreach has been hampered by limited funding.

The statute lets States use only 10 percent of their CHIP expenditures on administrative expenses, including outreach. Actual spending, of course, has been low, as these programs are just getting up and running.

The President has offered some proposals to the committee to deal with this problem in the fiscal year 2000 budget. One of them would let States spend another 3 percent of program expenditures on outreach.

They also would let States conduct wider outreach with a special $500 million fund that is now aimed at outreach to children losing welfare benefits, and we look forward to working with the committee on these proposals.

Mr. Chairman, we think it is very important that we keep our commitment to give the States all the CHIP funding that they have been promised. I think, when this committee began to work on that bill, it understood that it takes time for States to implement new programs, and that is what we are seeing.

You gave States 3 years to spend their allotments. We fully expect, and our actuaries expect, States to spend all of the CHIP funds within the time that you have allotted.

We look forward to continuing to work with the committee and with the States to ensure the success of this historic program. I know that the Congress will be proud of its investment that you have made in these children, and I am happy to answer your questions.

[The prepared statement of Ms. DeParle appears in the appendix.]

The CHAIRMAN. Thank you. Let me start out by saying that critics have argued that CHIP has gotten off to a slow, disappointing start. Do you agree?

Ms. DEPARLE. No, sir, I do not. For example, when you look at the numbers of how many children have been enrolled so far, and you realize that the first CHIP plan was approved just a year ago, really, there were only 17 States that were fully up and running for the last year. Even with that, we have over-achieved what the States expected.

Now, as you pointed out in your statement, some have gotten a faster start than others, particularly when you realize that the way this was set up, it was to allow States a lot of flexibility.

So some States had a State-wide committee that worked to set up their program and to decide how they wanted to implement it in their State. It takes some time after that to get the infrastructure up and running.

So, given all of that, I think, in fact, really, it is an amazing achievement to have gotten this going so quickly. If you had told me a year ago that we would have this many plans in place and States moving forward as fast as they are, I would have been very happy.

The CHAIRMAN. Well, as I said earlier, I am very pleased that we have 1 million now enrolled.

I am concerned about the waiver authority. When we created the new program, Congress specifically applied 1115 waiver authority to CHIP. Yet, no waiver request has been granted, or even entertained, by HCFA thus far. As you know, some States, like Tennessee, have expressed interest in pursuing the waiver option.

When, specifically, will HCFA begin to consider these waiver requests?

Ms. DEPARLE. Well, Mr. Chairman, our view of the waiver situation is that, with the Medicaid program, the so-called 1115 waiver authority has been used extensively by this administration, as you know, to grant a number of waivers to States.

With CHIP, though, after looking at it carefully, we felt that, given the hard work that this committee and the Congress put into designing the program and the delicate balance that you struck between State flexibility on the one hand and making sure that there was a guaranteed set of benefits on the other, that it made sense for States to have at least a year of experience in operating a program under those rules before they came to us saying they wanted a waiver.

Now, if the State had chosen to implement CHIP through the Medicaid program, which was one of the options, we are entertain-

ing 1115 waivers for that. There have been three States where we have granted those waivers. Missouri was one, and I believe Wisconsin was another. I cannot remember the third.

But with the CHIP program, we said we expected them to have at least a year of implementing what the Congress designed, and then an evaluation of that.

The CHAIRMAN. Let me point out, that was not written into the law.

Ms. DEPARLE. No, it was not.

The CHAIRMAN. It seems to me that this is a HCFA initiative. We want some flexibility in the program. So, I go back to my question: when are you going to begin using the waiver authority?

Ms. DEPARLE. Well, there are a number of States who have now been in operation for about a year. If those States come to us and ask for a waiver, we will be in a position to begin entertaining them. We have asked them to be implemented for a year and to provide us with an evaluation of their program. So I would say sometime this year we would be in a position, if a State wants a waiver, to consider it.

The CHAIRMAN. Well, just let me say, that is not what we wrote into the law. I just think that there should be more flexibility shown by your organization, and I would ask you to keep me advised as to what progress is made.

Ms. DEPARLE. I will.

The CHAIRMAN. A number of States have indicated an interested in pursuing expansions that involve subsidization of employer-based coverage, but have encountered difficulties with securing approval of their plans. Would you comment on HCFA views on employer subsidies?

Ms. DEPARLE. Yes, sir. That was an option, of course, that the Congress included, so that a State could choose to expand children's health insurance through a program that involved employer-sponsored insurance.

The problem is, as the statute is worded, it imposes some conditions, including that the employer-sponsored insurance, for a family, has to be less expensive, or no more expensive, than it would have been just to ensure the children.

That has proven to be a very difficult thing to find, an employer-sponsored insurance that would be no more expensive than covering the entire family. We have gone forward with one State that has done that, the State of Massachusetts, and we are working with several other States that want to do that. But it has proven to be difficult to do.

There is also a concern, and this does go back to the statute as well, in addition to the pricing of such insurance policies, about what we call "crowd out." You may remember, Mr. Chairman, there was a big debate in the Congress when the Children's Health Insurance Program was enacted about, I think, no one wanted this program to crowd out private insurance. We did not want private employers to say, oh, great, the government is going to do this so I do not have to do it any more.

So we have also said that States, if they want to go this route, should make sure that the children did not have insurance for 6 months before that. That was just a condition that we put in to try

to make sure that we would not have a situation where private employers were dropping their coverage of children and dependents in order to get the government to cover it. This is a very difficult area, and we would be happy to work with you on it.

The CHAIRMAN. Well, I think it is a very important area and we would like to work with you.

Along the same lines, what would States have to do to be able to demonstrate to HCFA's satisfaction that family coverage can be cost effective under CHIP?

Ms. DEPARLE. Well, the cost effectiveness test that we have used, and we believe this is what the Congress intended—as I said, I do not have the exact statutory language in front of me, but it said something to the effect of, as I said, no less expensive than providing just a children-only policy. The situation I am aware of where that test has been met is in Massachusetts, where the employers were also subsidizing the policy somewhat.

So, for the State's contribution, the State could actually make its contribution and purchase coverage for the entire family and it would still be the same price, or less, than if they had bought it for just the children. So, in that case, it was able to work because the employers were making a contribution.

The CHAIRMAN. Are there any other States involved?

Ms. DEPARLE. I know at least one other State has tried to do this, Wisconsin, and they were not able to meet the actuarial test of showing that it was no less expensive. As I said, I believe there may be some other States who are exploring this right now, and I would be happy to supply that to you for the record.

The CHAIRMAN. Well, we would appreciate that. As I said, we would like to work with you because we want to see as much flexibility as possible within the program.

[The following information referred to above was subsequently received for the record:]

[Submitted by Ms. DeParle.] "The States that have indicated an interest in subsidizing coverage under employer-sponsored group health plans include: California, Colorado, Iowa, Kentucky, Maryland, Michigan, Minnesota, New Jersey, New York, Oregon, Rhode Island, and Virginia. Some of these States may decide to take advantage of employer subsidies to meet the cost-effectiveness test for family coverage."

The CHAIRMAN. Now, I would call on Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. Thank you for being here, Nancy-Ann. I appreciate, very much, your participation.

In my State, the argument was made that we should not cover children in families who are above the average income. In other words, my State income, average income, in 1997, was $22,000. We could have gone up to $36,000 under the 200 percent of poverty test in terms of coverage of children. The legislature chose to go to 140 percent, which is roughly $24,000 a year of income.

What would be your response to those who say we should not go beyond the average income of people in the State in terms of paying for health insurance for the children of those families?

Ms. DEPARLE. Well, I do not want to offend anyone in your State, but I think if we have the opportunity to cover the children—so long as we are not encouraging private employers not to offer insurance because that is the basis of our insurance system in the

country right now; we would not want to encourage that—I think it would be good to take advantage of that opportunity.

It sounds like your State has made a first step, and that is what we are seeing across the country. Some States are making a first step, and then coming back and looking at it again. So, perhaps, when they see how successful this can be and how much a difference it can make in those children's and families' lives, then maybe they will come back and look at it again.

Senator CONRAD. We have about 14,000 children in my State that do not have health insurance coverage. Under the CHIP program, we could have covered 4,500 of them. The State legislature has chosen to cover about 1,800. So, there are 2,700 children we could have covered that we are not covering.

I personally see it as a missed opportunity. To me, it is the most cost-effective thing you can do, providing health care coverage to children. Number one, it is inexpensive. Number two, it pays a lifetime of dividends. Because if you give a child a healthy start, that carries through their entire life.

So I do think it is very important that we go with an aggressive outreach effort, because we are missing an opportunity here beyond the question of what States do, to the question of those who are eligible not getting the coverage.

What do you believe are the key elements of an effective outreach program?

Ms. DEPARLE. Well, from what I have seen, one of the key elements is going where the children really are and going where these families are. The most innovative programs I have seen are ones where States have gone to the schools, to the day care centers, in some cases door to door. Chicago is going into the schools.

You are going to hear from New York and Ohio about some of the innovative things they have done. So that is one of the things. You cannot just sit back in the State welfare offices, or wherever we used to all operate out of, and expect them to come to you. You have to go out and find them.

One of the most exciting things to me about this, is that we are learning from States anecdotally that, when they go out and do their outreach for this new Children's Health Insurance Program, they are finding a lot of the children that Senator Chafee was talking about. They are finding children who are eligible for Medicaid, but who have not enrolled. I think that is very exciting, and I believe that is a huge amount of progress as well.

The other thing I would point to, Senator, is simplifying the processes for enrolling children and these families. Five, 6 years ago, most States were using application forms that were 20, 30 pages long. And I am not criticizing them, because I was in one of those States and we did that. I do not know what we were thinking, frankly.

Now, looking at it, there are application forms out there, the State of Michigan has one that is two pages. Those kinds of things are really helping to get these working families enrolled in the program.

So, that is another thing that the States have done that I think is really a tremendous help in enrolling eligible children.

Senator CONRAD. Well, I thank you for that. I heard you say that you think all the money will be used.

Ms. DEPARLE. That is right, I do. I am basing that on what our actuaries tell me about the rate of spending. They only have information—I guess the first bills did not start getting paid until last July or August, because it takes a while, even if you did a Medicaid expansion, to get this set up. But, based on the quarterly expenditure information they have and their projections, they believe that the States will end up spending all of the money.

Senator CONRAD. And could you just tell us briefly—this is my last question, Mr. Chairman—what we are seeing in terms of State adoption of programs? What are they doing, are they going the Medicaid expansion route, are they setting up new programs, are they doing a combination? What are we seeing most frequently?

Ms. DEPARLE. It is all over the board. In the beginning, especially at the beginning of last year, at that time the law was such that States had to lock in their allotment before September of last year. So, many of them came in initially with a Medicaid expansion just so they could lock in their allotment.

Then the Congress changed the law to allow them more time to lock in their allotments. Many of them have since come back with amendments to have a separate Children's Health Insurance Program in their State that is not necessarily a Medicaid expansion. So, it is about half and half right now. I would say the amendments that we are entertaining now are more likely to be a separate child health insurance program.

For example, in the State of Texas, they did an initial plan to us. They have not actually got it up and running yet, but they did a plan that is a Medicaid expansion, because that was easy to agree to.

Then they have a State commission that has been spending the last year working on how they really want to tailor this to the State of Texas. So, it is really, really quite a varied bag about what they have done.

Senator CONRAD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Conrad.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. I am disturbed over an article I read in the New York Times of April 12 about Robert Peare, "Poor Workers Lose Medicaid Coverage Despite Eligibility." This follows on with your discussion with Senator Conrad.

But, as you know, when we did this CHIP program we put in an amendment that provided that a person who is now on the TANF program that was eligible under the prior cash assistance program for Medicaid, would receive Medicaid. Right?

Ms. DEPARLE. Yes, sir.

Senator CHAFEE. But apparently the States are saying, we are coming up with these new criteria under the TANF program. The cut-off is lower than it was under the cash assistance program.

So, these people who are getting the TANF will not be eligible for Medicaid. Apparently that is happening. That is the only thing I can found out to account for this change in eligibility. Am I on the right track or not?

Ms. DEPARLE. Well, yes, sir. There are a couple of things happening, though, from what we can tell. There are some States that have been using their authority under TANF to divert new applicants for TANF, for cash assistance, to Job Search, which is one of the things they are allowed to do.

They have not been, at the same time—when the person comes to the welfare office to ask for cash assistance and they say, well, now you need to go look for a job—they have not been telling them, but you may be eligible for Medicaid and your children may be eligible, so let us talk about that.

So I believe the article that you are referring to talks about two situations that I am aware of here on the east coast, which is New York and Pennsylvania. There are also a few situations that we found in other States and we are working on that, working with those States, because I believe you are correct, sir, that that is not what Congress intended.

Senator CHAFEE. Well, I know, because I happened to write the amendment.

Ms. DEPARLE. I know you did.

Senator CHAFEE. But it was very clear. There was no doubt about it. They were not to lose their eligibility for Medicaid because the cash assistance or the TANF was different than it had been in the prior welfare program.

You come up in our conversations a lot. You are a very important person.

Ms. DEPARLE. I hope you do not mean me, personally.

Senator CHAFEE. Not you, personally, but your department. I feel as though I know you well.

Ms. DEPARLE. Well, I have been to Rhode Island a couple of times, as you know, and I imagine I do come up quite a lot.

Senator CHAFEE. But, more importantly, you figure in Medicare and in all of our programs. Yesterday we had testimony that it is a great triumph, perhaps, in Medicare that there is only 2 percent used for overhead costs. But I am not so sure that is such a triumph. It may well be that you are to have more money. Do you think you should have more money?

Ms. DEPARLE. Well, yes, sir, I do. In fact, the way I describe that when I am talking to folks about the Medicare program, is I say that it is both a strength and a weakness. Yes, I think the taxpayers have an efficient program. You are right. I think it is even less than 2 percent now of our costs of running the Medicare program is spent on administering it.

I believe it is also a weakness. I believe that we are stewards of this program. We have a lot of responsibilities. This committee has been very clear with me about what you expect in terms of program integrity and other things, and it is very difficult to do those things with the level of spending that we have had.

Yes, I certainly do support a strengthened budget. I want to thank the committee and the Congress. Last year, you did give us an increase—I think the largest one that we have received in years—to try to help us meet some of these responsibilities. You, I hope, will see fit to do something like that again this year.

In this program we are talking about today, Senator, there are only about 100 people working on the CHIP program. That may

work for approving the State plans, but when it gets to really working with the States intensively on outreach and those sorts of things, we are limited in what we can do.

Senator CHAFEE. Well, also, I know I am diverting a little bit, Mr. Chairman, from the rationale for this hearing today, but yesterday when we had that testimony it seemed to me there was a great gap in outcomes research.

There was discussion about great variances between certain procedures in different hospitals. One hospital would have X percentage of these procedures, another hospital would have half X of these procedures. Yet, Medicare blithely pays both groups without question under the fee-for-service program.

I just came away from that hearing yesterday thinking that your organization can use some strengthening. You cannot do it on 2 percent, when the insurance companies are way higher than that. Maybe you are much more efficient than they are, but there is a limit to efficiency.

So, I am giving you a chance to say, give us more money. [Laughter.]

Ms. DEPARLE. Well, I hope that is what I said earlier. I appreciate your acknowledgement of the enormous responsibilities that we have. And Dr. Wennberg's study, which I have also seen—I believe he is the one you are referring to who testified.

Senator CHAFEE. That is right.

Ms. DEPARLE. One interesting thing about that, though, is some of that goes back 35 years ago, basically, to the beginning of Medicare and the way the program was set up to not only allow for, but perhaps even to promote, local variation. Thirty years later, maybe it is time to look at some of that. I think that was what Dr. Wennberg was suggesting.

Senator CHAFEE. But we prefer to have it come from you. Dr. Wennberg is fine, but it seems to me you are the person on the firing line there. If you have got problems, I, for one—I do not know about the Chairman; he can speak for himself—am anxious to hear what you need, because there are problems with this program. When I say this program, I am talking about the Medicare program. I do not have to tell you about the financing problems we have got.

Well, thank you very much, Mr. Chairman.

Ms. DEPARLE. Well, both you and the Chairman have been supportive, and I appreciate that.

Senator CHAFEE. Thank you.

The CHAIRMAN. Well, thank you for being here today, Nancy. I have to say, I am not surprised that you said you could use more money. I would have been shocked if you had said otherwise.

We have a vote, so I think that ends our questioning of you. We appreciate your being here. Going back to the CHIP program, we are glad that it is off to a good start. It has a long ways to go. I think it pays big, big dividends, as Senator Conrad pointed out, for a lifetime for these young people.

So, thank you very much for being here today.

Ms. DEPARLE. Thank you.

The CHAIRMAN. We will temporarily be in recess.

[Whereupon, at 10:43 a.m., the hearing was recessed to reconvene at 10:57 a.m.]

The CHAIRMAN. The committee will please be in order. We are now very honored to welcome the panel. I would ask Cindy Mann, who is a Senior Fellow at the Center for Budget and Policy Priorities to come forward; Janet Corrigan, director of the Health Care Services Division of the National Academy of Science, Institute of Medicine; Ms. Barbara Edwards, Medicaid director for the State of Ohio; and Judith Arnold, the deputy commissioner of the New York State Department of Health. It is a pleasure to welcome all four of you.

Ms. Arnold, we will start with your testimony. All of your full statements will be included as if read.

Ms. Arnold?

STATEMENT OF JUDITH ARNOLD, DEPUTY COMMISSIONER, DIVISION OF PLANNING, POLICY AND RESOURCE DEVELOPMENT, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, NY

Ms. ARNOLD. Thank you, and good morning. I am Judith Arnold, deputy commissioner for Planning and Policy for the New York State Department of Health. Thank you, Chairman Roth and members of the committee, for inviting me to speak with you today.

My responsibilities in the Health Department include the development and implementation of New York State's expanded Child Health Insurance Initiative. During my testimony to you today, I wish to emphasize three key messages.

The first, is that we are very grateful for the Federal funding that New York has received through Title XXI. It has allowed us to insure thousands more children and substantially expand the health care services these children receive.

The second key message, is that the reason we are now so successful is that we began slowly, took time to grow, and received the flexibility to tailor the program to fit our State-specific needs.

Because New York had a preexisting program, we were ready to take full advantage of Title XXI. Based on our experience, the Federal Government should expect some delays with other States who are just starting Title XXI programs, and who may be taking longer than expected to enroll significant numbers of children.

The third key message is that, while New York is currently operating the most ambitious program in the Nation, in terms of the number of children enrolled, we will soon need additional funding in order to maintain our program and meet the increasing demand.

Now I would like to give you a little background on New York's program and a progress report on where we are today. In August 1997, when Title XXI was signed into law, New York already had the largest State-subsidized health insurance program in the Nation. The name of our program is Child Health Plus, and at that time there were 124,000 children already enrolled in the program.

Child Health Plus was originally created in New York in 1990, with strong bipartisan support. But it was in 1995, when Governor George Pataki took office, that the program really took off.

In fact, prior to the enactment of Title XXI, Governor Pataki tripled State funding for Child Health Plus, and he expanded the age eligibility and covered services under the program.

With the enactment of Title XXI, we submitted our State plan on November 3, and 5 months later on April 1 we received Federal approval and began drawing down Federal resources.

In June, the New York State legislature approved another bill introduced by Governor Pataki that further expanded covered services for the Child Health Plus program.

In addition, eligibility for both Medicaid and Child Health Plus was expanded so that families with incomes up to 250 percent of the Federal poverty level are eligible for subsidized insurance. That is about 45,000 for a family of four.

Premium contributions were reduced or eliminated for children in lower income families, and co-payments were eliminated for all services.

With the support of the Federal Government, we have been able to greatly expand both the benefits and number of children enrolled in this program. I am extremely proud to report that, today, enrollment in New York's Child Health Plus program has reached 300,000 children. Since New York was able to begin drawing on the Federal funds 12 months ago, enrollment has increased by 124,000, an average of 10,000 children a month.

I want to make one comment about the spending down of Title XXI dollars in this program because I am aware that some in the Federal Government feel that States are spending this funding too slowly. Our experience indicates otherwise. In fact, New York will completely exhaust its first-year Title XXI allotment by July of this year.

Our projections indicate that, at the rate we are enrolling children, we will exhaust Federal dollars at a faster rate each year. For example, while it will take 15 months to spend the first year's allotment, it will take 9 months to spend the third year's allotment, and only 4 months to spend the fifth year's allotment.

In early 2001, we will need additional Federal dollars in order to maintain our current program and meet the increasing enrollment demands. A major problem that States are facing is that, just as we get our programs fully operational, the total Federal allotment is scheduled to decrease by 25 percent. So we are enrolling children quickly, and we are spending the money even more quickly to support a growing program.

I mentioned in my introduction that Congress should be patient with States that are starting children's health insurance programs. These are States that, due to the time required to set up the initial program, get the necessary State and Federal approvals, and become operational, have not been able to spend their Federal allotments as quickly as New York has.

When Congress adopted Title XXI, New York had a distinct advantage over other States because we already had a successful program in place. But getting New York's original program started in 1990 took time, and our program, like those in other States, needed time to develop.

It is because of that experience that I urge you to be patient with States that are still trying to put their programs in place.

I want to take a moment now to describe some of our marketing outreach and enrollment activities. New York is currently spending $3.5 million on multi-media advertising to make families aware of Child Health Plus.

This effort includes ads on TV, radio, and billboards, a blimp that travels to county fairs, as well as the distribution of brochures and other handouts to community organizations across the State.

In New York City, we are also working with the Children's Defense Fund and Statewide Youth Advocacy to provide enrollment assistance for Medicaid and Child Health Plus. One project is focusing on providing application assistance to parents at 500 day care centers in New York City to identify and enroll children. Another project is providing application assistance to families in the Washington Heights area of New York.

We also have a major initiative under way to provide a seamless system between our Medicaid and Child Health Plus programs. For example, it is our goal that the same health plans participate in both Medicaid and Child Health Plus so that children may move easily from one program to the other as their eligibility changes.

We have also developed a simplified joint application in which families are simultaneously screened for eligibility in Child Health Plus, Medicaid, and WIC. We are currently pilot-testing this application in the two projects I noted earlier, and will be using it Statewide in the fall.

I am also pleased to say that we will begin an enrollment process for Medicaid and Child Health Plus that is referred to as facilitated enrollment. Facilitated enrollment entails providing application assistance in convenient, community-based locations such as schools, community centers, and clinics, with evening and weekend hours.

We recently issued a request for proposals for $10 million for this program, with responses due in May. Facilitated enrollers will use the new simplified joint application to assist families in determining eligibility and complete the application process for Medicaid, Child Health Plus, and WIC.

This assistance will include screening the family for the appropriate program, completing the application, collecting the required documentation, and forwarding the completed application to the appropriate program.

Applicants will be able to complete the face-to-face interviews required for Medicaid enrollment without going to the office of the local social services agency, and they will be able to do this at times convenient to their work schedule, such as evenings and weekends.

We are initiating this new program because we believe that eliminating a visit to a government agency, providing assistance in obtaining documents, and the availability of evening and weekend hours will reduce barriers to enrollment.

To conclude my testimony to you today, Title XXI provides an historic opportunity to significantly improve the health status of our Nation's children. Today in New York, thousands more children are receiving the health care they need to grow up healthy, to learn in school, and to lead productive lives.

On behalf of these children and on behalf of Governor Pataki and New York State, I want to thank you for your efforts to expand

health insurance to uninsured children, and I urge your continued support for this program. Thank you.

[The prepared statement of Ms. Arnold appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Arnold.

Now, Ms. Edwards, I believe you are the Medicaid director for the State of Ohio, so we will come back to you, Ms. Corrigan. But I would be interested in hearing from you now.

STATEMENT OF BARBARA C. EDWARDS, DEPUTY DIRECTOR FOR THE OFFICE OF MEDICAID, OHIO DEPARTMENT OF HUMAN SERVICES, COLUMBUS, OH

Ms. EDWARDS. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to testify this morning before the Committee on Finance to share Ohio's Title XXI Children's Health Plan experience.

I am Barbara Edwards. I oversee the Office of Medicaid within the Ohio Department of Human Services. Medicaid in Ohio is a $6.5 billion a year health care plan that serves over 1.4 million Ohioans, including more than 600,000 children. I also direct Ohio's Title XXI Children's Health Insurance Plan.

The State of Ohio implemented its Title XXI plan on January 1, 1998. We offer comprehensive health coverage to all children ages zero through 18 living in families with countable income at or below 150 percent of the Federal poverty level.

Ohio's Governor, Bob Taft, has proposed expanding the Title XXI plan to include all children in families up to 200 percent of the Federal poverty level beginning in January 2000.

A fully implemented Children's Health Plan under Title XXI is seen as a strong support for families seeking to establish and maintain self-sufficiency in the work force.

Through March, over 104,000 children have enrolled in our Title XXI Children's Health Plan. We estimate that this includes 55 percent of the State's uninsured children in the targeted expansion group.

Ohio expects to have reached up to 125,000 children by the end of June. With the planned expansion to 100 percent of poverty, an additional 27,000 children could be enrolled by the end of the next biennium.

Ohio was the fourth State in the Nation to receive approval for its CHIP plan. Under the leadership of former Governor and now U.S. Senator George Voynavich, Ohio's 1998–1999 biennial budget included an expansion of Ohio's Medicaid program for children even before the enactment of Title XXI.

Like New York, this then put Ohio in the enviable position of having both the authority and the funding to take early advantage of the opportunity offered in the Balanced Budget Act.

Using both the Title XIX and a Title XXI State plan filing, Ohio expanded income eligibility up to 150 percent of poverty for Healthy Start, our Medicaid plan for children.

Ohioans supported offering the full Healthy Start EPSDT benefit package to low-income children. In addition, since Ohio Medicaid already contracts with licensed private sector managed care plans in all the major urban areas of the State, most children enrolled

under Healthy Start expansion received their benefits through a private health insurance plan.

The most compelling reason Ohio selected the Medicaid option was the ability to offer wrap-around insurance to under-insured children under Title XIX in addition to offering covering to uninsured children under Title XXI.

To encourage enrollment in the Children's Health Plan, Ohio uses a simplified, three-page Healthy Start application that can be mailed in. Parents do not have to visit any government office in order to apply.

Ohio also offers a very popular toll-free consumer hotline with evening and weekend hours to make it easy for families to get information about the Children's Plan and to apply by phone.

Finally, Ohio has engaged local communities in developing and implementing outreach efforts to low-income working families. Ohio has allocated to its counties almost all of the $16.1 million in enhanced Federal matching funds available to the State under the Federal Personal Responsibility and Work Opportunity Reconciliation Act to conduct Medicaid outreach to families who leave cash assistance programs. Ohio strongly supports the continued availability of the PRWORA funds to support outreach efforts into the future.

I have attached to my testimony a description of the CHIP outreach initiatives undertaken by the State in addition to those initiated at the local level. Some of the most successful have included direct mail campaigns to women who are in the WIC nutritional program, working with Head Start centers, with day care centers, school nurses, and we are even considering bringing up a program that would offer a payment to private insurance brokers who assist families in applying for the Children's Health Insurance Plan for their children.

As a result of State and local efforts, Ohio has experienced a recent net increase in covered children across all Title XIX and Title XXI programs, even while cash assistance case loads continue to decline in the State. This includes a 23-percent increase in the percentage of new enrollees in non-CHIP Healthy Start.

Even so, we are not fully satisfied with our expansion efforts. Our enrollment information shows that we are still mostly reaching children and families who already have some connection to the Medicaid health plan. The majority of new enrollees are children who either were previously covered by non-CHIP Healthy Start themselves or who have younger siblings covered by non-CHIP Healthy Start.

This suggests that there may be significant numbers of children whose families still do not know that coverage is available or who, for some reason, are reluctant to enroll their children in a public health plan.

We also are concerned that we lose a significant number of children from the program at eligibility redetermination. While over 104,000 children have been enrolled to date, 54,000 children were covered in the expansion group in March.

We add about 8,000 children each month, and we lose 7,000. Now, half of the children who leave the expansion program at the

required six-month redetermination move to non-CHIP Healthy Start, and so still have full health coverage.

From the families' perspective, that coverage is continuous and seamless. So that is the good news. Most of these kids are still insured. But we do not know what is happening to the rest of the children who lose coverage each month, and we are concerned that they may become uninsured.

As we look to the future, Ohio is committed to further simplifying the application and eligibility processes for both Title XIX and Title XXI health plans. We will pay particular attention to reapplication requirements to minimize the number of children who lose coverage because of time lines and paperwork. We are committed to working with local communities to clarify the message that health care is not welfare.

Access to quality health care is critical to healthy development in early childhood, to having children start school ready to learn, and to supporting children as they grow to be productive adults.

My sincere thanks to you, Mr. Chairman, and to the members of your committee, for your interest in States' efforts to implement Title XXI. Each State faces a unique set of challenges and opportunities as we seek to provide health care services to our children.

I encourage the committee to continue to seek ways that the States can work in partnership with the Federal Government, and I encourage you especially to continue to increase flexibility for States administering both Title XIX and Title XXI health plans so that, together, we may achieve our mutual goal of good health for all of our children. Thank you.

[The prepared statement of Ms. Edwards appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Edwards.

I will now call on Cindy Mann, who is a senior fellow at the Center for Budget and Policy Priorities, who has, I guess, spent much of the last year studying the implementation of the CHIP program.

It is a pleasure to have you, Ms. Mann.

STATEMENT OF CINDY MANN, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES, WASHINGTON, DC

Ms. MANN. Thank you, Mr. Chairman. It is a pleasure to be here. Thank you for the opportunity to testify. I am at the Center on Budget and, over the last year and a half, almost 2 years, now, we have been working closely in many States, providing technical assistance on policy issues to State administrators, to State policy makers, and to local groups working with children on CHIP implementation and related Medicaid enrollment efforts. In addition, our office has operated a child health outreach campaign called Start Healthy, Stay Healthy since 1994.

Our experience over the last 18 to 20 months tells us very much that CHIP implementation is on track. I would like to make five points, five reasons why we are very encouraged by what we see in States and in local communities.

First of all, as Ms. DeParle noted, there has been an enthusiastic response to the CHIP initiative by States. States have developed plans, submitted plans. But I would like to emphasize that, in addition to having a large number of States that actually have sub-

mitted plans, we have now 25 States and 2 territories that have actually expanded coverage up to 200 percent of poverty for children, or beyond. So not only do we have plans, but we have some broad-based expansions that I think carry out the intentions of Congress.

In addition, we continue to see new States joining the crowd. As indicated before, Texas, for example, is, as we speak, I think, today poised to take a vote on its expansion and is looking to cover children again up to 200 percent of poverty, either some or all of their children, depending upon the age.

This represents a remarkable step forward in a relatively short period of time. We regularly survey States and keep track of where States' eligibility levels are at any given time.

In our survey in August of 1997, right at the point that the CHIP law was enacted, only seven States in this country provided coverage under Medicaid to children up to 200 percent of poverty or beyond, and four additional States had some State-funded coverage that provided that extent of coverage to some, but not necessarily all, of the children in their State. So, we have made remarkable progress, and continue to make progress in terms of actual expansion programs.

The second point, is that because of all the activity in the State, the good news is that I think the data that is presented by HHS about enrollment to date is out of date. There is so much activity going on every day that the numbers keep jumping, and jumping in the right direction.

For example, the HHS data submitted to the committee show that, as of the end of 1998, South Carolina had covered 44,000 children in its CHIP-funded Medicaid expansion, but administrators tell us that, as of mid-April, that number had almost doubled, had jumped to 86,000 children. In addition, there are several States that have begun implementation just after the close of the data period represented by the HCFA numbers.

Iowa and Kansas just began enrollment on January 1, West Virginia started phase two of its expansion on April 1, Alaska and New Mexico just started implementing this spring, and Kentucky is ready to begin implementing in early June, just to name a few States that are ready to move ahead or just recently moved ahead.

A third, and very important, factor that gives us reason to think that participation will actually be robust in the programs that States are creating is that States really are taking the time to do it right. I would really emphasize that point that has been made by other panelists this morning.

Studies have shown that application barriers will lead to low participation rates, that simplified applications, streamlined paperwork requirements for families and for agencies will make all the difference in the world.

In fact, a recent article from NGA quoting the South Carolina administrator attributed a simplified application procedure as being the major factor for their success in terms of participation.

States, by and large, are doing the right thing with respect to simplification. Most States have adopted short-form applications. And I would emphasize that they have done this not just in their

new separate State programs, but also when they have done Medicaid expansions.

Our survey of States showed, again, in August 1997 that slightly less than half the States had Medicaid mail-in procedures for children at the time CHIP was passed. As of November 1999, 11 more States adopted that, and several more States have adopted mail-in procedures where you do not have to go to the welfare office or the Medicaid office to apply in order to get your child coverage. Those are obviously very important advancements for children in low-income working families.

I would also emphasize, going back to Senator Chafee's point, that States have simplified these procedures not just in CHIP, but in the Medicaid program. It is critically important that, if we are looking at the overall goal of lowering the number of uninsured children, that we pay close attention to the 4.7 million children estimated to be eligible for Medicaid, but not enrolled.

Simplified application procedures, procedures that create coordinated systems with the new CHIP programs and existing Medicaid programs are critical if we are to reach those children and reach, overall, our goals of insuring low-income children.

The fourth factor I would note as giving us a great sense of encouragement about where CHIP is going is that communities are enormously energized. There really is a shared mission on the part of States, localities, community organizations, schools, Head Start centers, child care centers, with the common goal of enrolling children and making sure that no child in the State lacks health insurance due to income.

We see very creative efforts being unleashed and cooperation that I think has not been witnessed for a long time amongst many diverse players.

Finally, I think it is important to note that I think that HHS has been very helpful in the process as well. They have emphasized to States the flexibility allowed to them, both under CHIP and also the Medicaid law, to simplify their applications. They have put out a model joint application which was two pages in length. They have also strongly encouraged coordination between the two programs, again, to create a seamless system.

While we think that the CHIP developments are very positive, I think it is important also to add a note of caution and concern. There is reason to worry that, notwithstanding very robust CHIP implementation, that the number of uninsured children may not be declining.

Ultimately, of course, the success of CHIP is not measured just by the number of CHIP children enrolled, but the number of uninsured children that continue to live in this country. While recent current data on uninsured children and on Medicaid enrollment is not available, there is a strong indication that Medicaid rolls are dropping in States.

This is due to a number of reasons, but one being the one that Senator Chafee raised, which is losing children as they move in and out of the TANF system, which was certainly not intended by the 1996 law, quite the contrary. HHS has issued new guidance just about one month ago on this issue.

States are paying increasing attention to it. It obviously does not move the cause further along if we are enrolling CHIP-eligible kids on one side while we are losing a tremendous number of children on the Medicaid side on the other hand. So it is an area that needs to have continued attention at all levels.

Let me just, finally, turn to four things that I think would be very important for Congress to do to take coverage expansions and higher participation rates a step further.

First and foremost, is showing your continued bipartisan support for CHIP and related coverage initiatives. The support shown by Congress has been critical to assure States that the funding will be there, that they can enroll children, that they can engage in aggressive outreach campaigns and will not see their money disappear. In fact, as New York indicated, they are hopeful of getting additional funds, if they should need it, for enrollment.

The second point, I would say, is that continued oversight is very important. These are preliminary data that we have. Certainly a sense of accountability, a sense of oversight by Congress is part of what is propelling States and the administration to do the best job that they can. Everybody at all levels, I think, needs to be held accountable so that children, in fact, get their insurance.

We are hoping also that Congress will take action to broaden State options for covering children, and particularly there is a group of legal immigrant children who have been left out of coverage. Their leaving them out is inconsistent, really, with the goals of CHIP, as well as with the flexibility allowed States to determine their eligibility rules in the CHIP program.

Finally, I would like to mention a point raised by Nancy-Ann Min DeParle, as well as by the testimony in Ohio, is that there are outreach funds that some States, including Ohio, have taken advantage of, a $500 million fund created by the welfare law that will sunset, that will expire.

There are many States that have not yet begun to take advantage of it. But, as Ohio's experience shows, there are some States that can use those funds, really, to increase enrollment and make a big difference.

So we are very hopeful that the sunset can be lifted and those funds continue to be available to States, and urge you to take that kind of action rather than increasing the cap in the CHIP program, which would take money away from coverage. The $500 million expansion would not do that.

Let me conclude by saying that CHIP coverage expansions have been very positive, perhaps exceeding expectations. Enrollment is lagging in some States and bounding forward in others, but all signs suggest that we can expect robust enrollment and high participation rates in most States.

Thank you very much for the opportunity.

[The prepared statement of Ms. Mann appears in the appendix.]

The CHAIRMAN. Just let me say how important I think oversight hearings are and the reason for the hearings today is to impress the executive branch and States of the importance we attach to this program. We appreciate your being here.

Now it is my pleasure to call on Ms. Corrigan, who is director of the Health Care Services Division of the National Academy of

Sciences, Institute of Medicine. She will help us think about the data needs associated with this program.

It is a pleasure to have you here, Ms. Corrigan.

STATEMENT OF JANET CORRIGAN, DIRECTOR, HEALTH CARE SERVICES DIVISION, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, WASHINGTON, DC

Ms. CORRIGAN. Thank you. Good morning, Mr. Chairman and members of the committee. It really is a pleasure to be here today and have the opportunity to share with you some of the findings of a very important Institute of Medicine study that is relevant to the State Children's Health Insurance Program.

In March of 1997, the IOM established the Committee on Children, Health Insurance, and Access to Care. The initial charge to this committee was really quite broad and included addressing a whole series of questions about health insurance and children's access to care.

However, in August of 1997 when Congress enacted the Balanced Budget Act and put CHIP in plan, the committee immediately realized, and I might add was delighted, that some of its work had been preempted. We could not be more pleased and supportive of such an important program that hopefully, and already is, beginning to assure access to many children who previously did not have it.

The committee decided that this program, although very welcome, did raise some new questions, though, and challenges. It decided to turn its attention to taking a close look at the whole issue of accountability and evaluation, how to assure that the program's expenditures would yield the greatest benefits and gains.

A little less than a year ago, two reports were released. One of them is "America's Children: Health Insurance and Access to Care," which is a comprehensive volume that really lays out a good deal of the evidence about the importance of health insurance to assuring access and better outcomes in improved health status.

The second report is a smaller volume called "Systems of Accountability." That is what I am going to spend most of my time talking about in the next few minutes. I do want to spend a little bit of time though initially just reviewing the committee's conclusions about the importance of insurance coverage.

Our committee found that insurance coverage is the major determinant of whether children had access to health care. It is not the only determinant, but it clearly is the major determinant.

Children who lack insurance coverage have many unmet health care needs. They are more likely to be sick as newborns, less likely to be immunized as preschoolers, less likely to receive medical treatment when they are injured, and less likely to receive treatment for illnesses such as acute or recurrent ear infections, asthma, and tooth decay. We have ample evidence to reach this conclusion.

We know that about 70 percent of children are really very healthy. They, too, have needs, though, for immunizations and other acute services from time to time. We also know that about 20 percent of children have mild chronic conditions such as asthma or recurrent ear infections. They need a good deal of access to the

health care system. If they do not get it, we see the effects in terms of poor performance at school, as well as work loss for many parents.

The last 10 percent of children generally have chronic impairments that really are very serious: juvenile diabetes, sickle cell, HIV, congenital heart defects, and things of the like.

For those children, insurance is absolutely imperative, as it is for the others, but they experience other barriers to access that need to be dealt with. They are children who really need comprehensive health and social services that are well-coordinated.

Because children's access to care is so directly correlated with insurance coverage, that is why we believe that CHIP is so critical. But our committee also believes that, for CHIP to realize its potential, it is absolutely critical to turn our attention at this time to gathering the necessary data to be able to manage this program and know whether we are making progress towards our goals.

So now let me talk about the committee's conclusions with regard to accountability and evaluation of the CHIP program. The committee based its recommendations on several principles.

First and foremost, about $24 billion in Federal funds have been allocated for CHIP and Medicaid improvements. That represents a significant national commitment to insurance expansion for children. This commitment should be monitored to ensure that the legislation's goals are fulfilled.

Second, though, and I think often overlooked, we have an unprecedented opportunity to learn how best to structure health insurance and delivery programs for low-income children.

You have heard today about the kind of variability that there is across States, whether it is variability in eligibility, variability in the benefits that are provided, a lot of variability in the kind of outreach and enrollment programs that had been put in place. There is a great deal that we can learn by studying these various programs. We have never had this opportunity before, I think, to really learn this much.

We also know that there is tremendous variability in the quality of care, not only within programs related to CHIP or Medicaid, but across the entire health care system. We want to understand that a lot better.

Third, I think it is important to note that, although CHIP will help to reduce the number of uninsured children, there will still be millions of children who remain who are uninsured or underinsured. To guide future insurance expansions, careful evaluation of a multitude of State approaches under CHIP is essential.

Our committee felt that there were really four important components of an accountability program for CHIP. The first recommendation, is that Congress should take immediate action to ensure that the funding is adequate to evaluate CHIP's impact. No distinct funding for data collection or evaluation was included in the original legislation, and we need to act now on this.

Second, the Department of Health and Human Services must establish a performance monitoring system for CHIP in collaboration with agencies from other levels of government, and also in collaboration with private sector organizations who are involved in quality oversight and monitoring activities.

As a part of that system, it is critical that we have a core set of performance measures so that we can have comparable information across all of the CHIP programs. By core performance measures, we mean measures of the technical quality of care as well as the outcomes in health status that are achieved by the children in these programs.

Another critical component of an accountability system is that the Department of Health and Human Services develop better systems to improve the availability of national- and State-level information on children's health insurance coverage, access, utilization, satisfaction, health status, and outcomes, particularly for children with special health care needs, that 10 percent of the clientele that are being served.

What we are thinking of here really are more population- or aggregate-level indicators. One way to go about doing this, is to make some changes in some of the existing national surveys that are already being conducted.

We currently have a National Health Interview Survey, a Current Population Survey, a Medical Expenditure Panel Survey, and all of these provide national and regional data on insurance coverage, on utilization, and health status. But these surveys do not provide State-level data for most States, and the data that they do provide is not always current.

Consideration should be given to increasing the sample sizes of these surveys to permit State-level estimates and evaluation. It would be one way to begin to track what is going on in these programs and whether we are making progress.

Another possibility is to do something that was done back in 1988, when the national health interview survey included a child health supplement. Were we to add such a supplement to the national health interview survey again, and to then do that periodically every few years, we would have more detailed information on what is happening to children in each of the States.

Fourth, and finally, we believe that States should immediately implement systems to produce meaningful information on CHIP's effects, and that such information should be made available to the public.

Comparative quality data should be made available to the public, as well as to those who are conducting the evaluations of the programs.

As much as possible, States should delegate the collection and synthesis of CHIP information to contracted health plans or providers, with requirements for independent auditing of these data.

Much of the data that we need for evaluation purposes is precisely the information that providers and health plans need for quality improvement internally. We want to encourage them to collect these data and use it as an ongoing part of their quality improvement activities.

States should also set conditions of participation in CHIP. They should experiment with a variety of incentives, financial and otherwise, to reward health plans for their performance, and develop the technical and analytic capacity to evaluate the impact of these incentives on health plan performance.

Mr. Chairman, time is of the essence. CHIP is historic, it is innovative, and it is rapidly evolving. We need baseline data if we are going to be able to evaluate this program in any comprehensive way.

Once again, it offers an unprecedented opportunity to move from traditional monitoring and compliance models of health care that focus on financial performance to a quality improvement program that fulfills the intent of the CHIP legislation.

Thank you for this opportunity to testify, and I would be happy to answer any questions.

[The prepared statement of Ms. Corrigan appears in the appendix.]

The CHAIRMAN. Well, thank you, Ms. Corrigan.

Let me direct a question to Ms. Arnold and Ms. Edwards. Both of your States, New York and Ohio, have made significant progress and impressive results in implementing CHIP. I think your States are really further along in the implementation than most other States.

My question is, what can other States learn from your experience? Ms. Arnold?

Ms. ARNOLD. I think in New York's example, since we had been running our own Child Health Plus program since 1990, we probably had a similar experience to other States just starting now.

I mean, States that did not have a program needed to secure the State match, they needed to develop a program to determine what they were going to do, and then develop the infrastructure in their agencies to run the program. We had that same experience. We started small, with a $20 million program, and grew it to a $207 million State program prior to Title XXI.

So I think that States are on the right track. It is natural to start slowly and to accelerate, and really getting the word out. I mean, we now have a brand name in New York State on Child Health Plus, and that takes some time to evolve as well.

The CHAIRMAN. Ms. Edwards?

Ms. EDWARDS. I would second what Judy is saying about States. There is sort of a natural process that you have to go through to get a new program up and running at the State level.

My best piece of advice to folks, from our experience, would be to pay attention early to what really happens at the point of the eligibility application being submitted.

We understand what our policies are, we understand what we are attempting to do in terms of simplification, but the process of really changing decades, in some cases, of practice at the local level, the interaction between the consumer and the public worker, takes a lot of attention and probably needs more attention sooner than we certainly thought to give it. I would certainly encourage people to pay attention early to the real process of application for consumers.

The CHAIRMAN. Ms. Mann, can you give us a sense of the role of the advocacy community in promoting eligibility outreach for this new program?

Ms. MANN. I think, Mr. Chairman, that the community, by and large, including child health advocates, providers of services like child care services, schools, have been very engaged in the outreach

process, as well as in the design of the program in many communities. That has been a very positive thing.

On one hand, States, I think, have really opened up their process. They are interested in enrollment and they have been opening up their process and listening to community-based organizations tell them, what are the problems, what are the barriers, how can we simplify the system and make sure we have higher levels of participation. So they have been, in many States, really, at the table in some of the design issues, as well as bringing attention to States of problems after implementation.

One of the things that I think has really been to many States' credit, is they have not implemented a program and then said, that is done, I am finished. They really continue to reexamine their process. The advocacy community and the local community, generally, has been very critical in bringing those issues to the attention of States and localities.

On outreach, I think some of the most successful models are when monies have been flowing from the State or from the country to very local community organizations. They are the groups that know the families, that are in daily contact with the families.

If you think about child care providers, they are already working with exactly the families we are trying to reach in terms of these outreach and enrollment campaigns. Many States, and some for years, actually—Louisiana, Ohio, Massachusetts, Oklahoma—have been using community-based organizations as their partners in outreach. I think that continues to be one of the major areas where people are seeing outreach activities make a real difference.

The CHAIRMAN. Thank you, Ms. Mann.

Ms. Corrigan, in your testimony you, of course, stressed the need for State-specific data to evaluate program performance. As you well know, States are having difficulty meeting current data requirements. Do you have any advice on how to balance data needs with an understanding of the computer system challenges States are facing as they prepare for the year 2000?

Ms. CORRIGAN. I think that the challenge that the States are confronting in terms of information technology are enormous. They are not alone, however. We see that all across the health care industry right now.

I think, in a nutshell, we have built systems for some degree of financial accountability, but we have not built systems for quality accountability. We have got to rethink the types of data that we are collecting and why we are collecting it, and whether it is really very useful.

That is a difficult undertaking. But one of the ways to begin to take a few small steps in that direction, and we are actually seeing a good deal of progress in this area, I think, at a national level, is to reach agreement on a core set of performance measures. It does not have to be a large set. You can start out with 5, maybe 10, and stop at that point and add others on as you move forward.

But on the quality side, there are some basic measures that you would always want to collect. Clearly, you want things like childhood immunization. If asthma is one of the most common conditions, as it is in children, you probably certainly want to be able to take a look at the proportion of children with asthma who had

unnecessary hospitalization that could have been avoided had they received earlier primary care or out-of-hospital care.

It is possible to devise 5, 10, or 12 measures, some of which may come from administrative data, some of which may require special data collection tools. And some of these are measures that States already use. One of the difficulties we have, though, is that everybody calculates things a little bit differently.

It is amazing how you can take a simple measure like immunization and set four or five different groups off, and they all come back with a slightly different numerator and denominator, and you cannot make any comparisons across the various programs.

Part of what we need here, really, is collaboration so that we can reach agreement on those measures. This goes even beyond CHIP and Medicaid. We are looking for collaboration across all insurers.

The CHAIRMAN. Thank you.

Senator Chafee?

Senator CHAFEE. Thank you very much. I would like to thank you for bringing to our attention that those children who are not covered are probably, potentially, the most sick ones and the ones who need it the most.

I suppose the smaller the group gets that is not covered, the potentially sicker and sicker that group is. I think that Senator Conrad touched on the benefits of the Medicaid program and in reaching out and taking care of these children at a young age so they get the immunizations you have been referring to.

Ms. Corrigan, I was looking at your third point, namely, "The Department of HHS must develop systems that improve the availability of national- and State-level information on children's insurance coverage, access, utilization, satisfaction, health status, and outcomes." But I do not understand why nobody is particularly interested in doing this. It seems to me people would be interested in what the results are.

Is it that that is something that always gets cut, since it is not a delivery of a service, it is really a study? Have you got any reasons?

Ms. CORRIGAN. There is an issue here of cost. When you attempt to expand the sample sizes of these various surveys to be adequate so that you can get a State-level estimate, you have expanded it by quite a bit, and it is expensive to conduct these surveys.

However, I would add that that kind of expansion would be a very modest expenditure and, I think, a reasonable way to begin to get both some baseline data and ongoing data on the effects of these programs.

So part of it, I think, is just recognizing the value of those additional data that allow the State-level estimates and how it can be used in evaluating a program of this nature.

Senator CHAFEE. What do you say to that, Ms. Arnold? Could you use it, these better studies, or do you figure you know what you are doing pretty well?

Ms. ARNOLD. We could use better data. That is a constant. The current population survey is a pretty limited tool for giving us information on the uninsured children at the State level, and even more importantly, below the State level.

Our legislation in our State included funding for a survey in our State so we could get below State-level estimates. But that, again, raises the issue that Janet raised about the comparability. So we may be able to get county-level estimates, but comparing that to other States becomes difficult.

Senator CHAFEE. Well, I thought that was the key point that Ms. Corrigan made, that you are not comparing apples to apples, that you are not working with the same material in trying to develop your baselines. That is just too bad. I do not know what to say.

It is hard for us, so maybe HHS should set forth the common denominator so that you could make some comparisons. I do not know how the different States can tell how they are doing if you are not comparing yourself on the same basis with other States.

You may think you are doing great on outreach, for example, or immunization, but if the true facts were known, you might not be. I think there is great value to competition to knowing how you compare with your fellow States.

Well, good luck in what you are doing. I know that Senator Moynihan is sorry he cannot be here today. By the way, will Ohio and New York spend all of your CHIP grant funds?

Ms. ARNOLD. Yes.

Ms. EDWARDS. We anticipate that we will when the program is mature.

Senator CHAFEE. Yes. There is a lag period there. Yes. All right. Fine.

Well, thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Chafee.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I have a couple of questions to ask. Before I do that, I need to make an apology to our Chairman which has absolutely nothing to do with this gathering today.

Yesterday we were discussing Medicare, which is sort of the opposite end of what we are talking about today.I made a comment yesterday about something that the Chairman said.

As I was thinking about it last night, what he said, he said jokingly, if the Chairman will remember. This had to do with the Medicare Commission. I was not much of a fan of what they produced in the way of result. Then I indicated that the Chairman had said, well, we hope we will win Jay over to our side.

But it occurred to me last night that, when he said that, he was joking. I mean, he had a smile on his face. Therefore, I misinterpreted what he said and gave a false impression of what he said, which is neither the way to treat a colleague, nor particularly one's Chairman. So, I apologize to the Chairman for that.

The CHAIRMAN. I will try to keep my humor down. [Laughter.]

Senator ROCKEFELLER. Good.

A couple of thoughts I had. Number one, it is interesting. I mean, I look at West Virginia. Senator Chafee and I had a lot to do with putting this together, and it was fragile.

I mean, it did not really come together, in fact, until we kicked everybody out of the room and had only 20 members of the Finance Committee sitting around the table, and then all of a sudden it kind of came together. It was a rather remarkable moment in the

Finance Committee's history, but it was also a fragile moment. I mean, it might not have worked. It did.

And this is just to put people on notice, but the Appropriations Committee is looking at this approximately $4.3 billion as a potential source of unused money, that unused portion of it, as a potential source of rescission money to spend on other projects.

So, we need to put people on notice about that, that CHIPS, although beginning, is still fragile and people need to be aware of that and, therefore, fight for it.

Second, I need to sort of comment that it is ironic to me, as I see 50 States struggling, some rather well, in the case of my own State, rather not so well, to try and work this program. That is sort of classic. I was always for doing it in the Medicaid approach and doing it uniformly throughout.

I think it would have been easier, I think it would have been better. But that is not what the Governors wanted and it ended up not being what the Senate and the Congress wanted. So, we did not do that.

So we have a lot of rather uneven results, and in my mind I keep thinking, if we just had something called universal coverage, we would not have to be talking about or worrying about any of this at all. I mean, it would just all be happening in a very natural way. But we do not have that, so we work within the world within which we live.

I also want to just ask, Ms. Mann, if you do not mind, it is my understanding that, in the case, for example, of West Virginia, which did not do full funding and has not sort of gotten up a full program for 1998, that they cannot necessarily expect to get money in 1999. In other words, if you do not fulfill your obligations, it does not mean that the money is there forever. Am I correct?

Ms. MANN. No. If you have a plan in operation, if you have an approved plan, you can continue to claim your dollars. You have to have expenditures. The dollars do not belong to any State unless, in fact, they have expenditures that draw down those dollars. But if they have a plan in operation, they can draw down those dollars and have 3 years in which to spend it.

So, at some point, that allotment does not stay with the State if they, in fact, do not have expenditures meeting the level of allotment. Then the law provides that it gets reallocated to other States.

Senator ROCKEFELLER. And that is the point that I want to make. If you do not draw down, because you do not spend, yourself, as a State, and yes, you have three years, but if you do not draw down your own money, you are not going to be getting, in the subsequent year, full Federal money. That will, therefore, be going to other places. So that West Virginia, by not enacting all that it could——

Ms. MANN. Is handing over its dollars to New York.

Senator ROCKEFELLER. Is handing money to other wonderful States. [Laughter.] But that is not really what I want to see in West Virginia, so I thought I would just drop that in there.

Another thing which is curious to met. West Virginia—and I will not get into the details of this—set up a program wherein they selected a board, and it was a board which did not know an enormous

amount about health care, so there was a long period of kind of getting the board whipped into shape. Then the board put an administrative cap on those who are handling this program.

The administrative cap, the effect of which—and it is so interesting how you can be talking about $48 billion over 10 years, and then you have the administrative cap—is there are actually only three or four people in the West Virginia State government who are authorized to go out and make this plan work in all respects. Now, they do get some help because some Medicaid folks helped them. I am not sure whether they want that known or not, on the QT.

But is that true in any other State, that you have administrative caps which, in fact, reduce to virtually an impossibility the possibility of making the program work because there are not enough people to do it?

Ms. EDWARDS. Senator Rockefeller, I think that the fact is, Title XXI itself contains some caps in terms of the amount of dollars that can be spent against the expenditures you actually spend toward administration.

I think States, particularly States that develop non-Medicaid expansion options, have found that particularly difficult in being able to bring up new programs, given the fact the early years of your program will have relatively smaller expenditures and, therefore, the cap is relatively small.

In Ohio, one of our focuses has been being as administratively efficient as we can. We chose a Medicaid expansion, in part, because it meant we did not have to create a new infrastructure. We received no additional staff, no additional resources to bring this program up within the Medicaid program.

Senator ROCKEFELLER. But you did it the right way.

Ms. EDWARDS. Well, we were able to take advantage of the staff that we had.

Senator ROCKEFELLER. Yes.

Ms. EDWARDS. I think it worked for Ohio. For another State, a different approached worked better. I think that there is no substitute for buy-in from the local communities and from the States if these programs are going to work.

I think that is where, while for Ohio a Medicaid expansion, we believe, was the best solution, what you really need is local commitment to these programs, and States value the flexibility that Title XXI offered us.

Senator ROCKEFELLER. Mr. Chairman, just allow me one more, very quickly.

I was very interested, Ms. Edwards, when you talked about 8,000 covered, 7,000, in the meantime, not covered, half of those covered by what you call Healthy Start.

Ms. EDWARDS. Yes.

Senator ROCKEFELLER. Therein lies an enormous problem, of course. It does not even talk about those that we do not reach at all, but the ones who are losing coverage, even as we are putting more on.

I am just wondering if you know that the half of the 7,000 that you manage to cover is something which is duplicated in relatively the majority of other States, or if it is relatively unique.

Ms. EDWARDS. Senator Rockefeller, I do not think that we know for sure how other States are experiencing this. To some extent, it is a systemic issue. Ever year, Medicaid coverage increases in Ohio to another age cohort, as we are adding the teenagers up to age 18.

So some of that is sort of systemic, and other States would also be experiencing those folks who technically move from a Title XXI category to a Title XIX category because the Medicaid program is changing under an older Federal law. So, some of this is a system impact that would be shared across States.

I think that what your question points out, is that we do have a fairly complex series of programs, plural, for providing health coverage to children. They are all very critical.

One of the challenges we have is how to make all of them work together well enough that, for families, coverage is seamless, and reliable, and predictable for them. I think that probably all States are struggling with the best ways to be, from the families' perspective, a health plan for children rather than this program A, program B, program C. And New York obviously has a different approach.

Ms. ARNOLD. What I would add to that, is we are enrolling a net increase of 10,000 children a month, on average, in our program. But we are also losing children, through children who either do not sign up again for Medicaid.

We have issues where they lose cash, they keep Medicaid, but then, when Medicaid is up for renewal, they do not come and renew Medicaid because what brought them into the office was the cash.

So, it is a recertification issue; similarly, with Child Health Plus. So, while we are doing everything to get them enrolled, we are now looking at, how do we simplify recertification so that we do not have a revolving door, we lose them, we find them again?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Thank you.

The CHAIRMAN. I want to thank all four of you for your very excellent testimonies. It is extraordinarily helpful. Please give us the advantage of your advice as experience moves on.

Senator CHAFEE. Mr. Chairman, could I just say one word?

The CHAIRMAN. Yes.

Senator CHAFEE. On the first day of the legislative session, Senator Moynihan and I did introduce legislation called the CHIP Data Improvement Act of 1999. That provides for the States to do an evaluation and a Federal evaluation, a total of $10 million in each of those. So maybe help is on its way, Ms. Corrigan.

Ms. CORRIGAN. I am glad to hear it. That is wonderful.

The CHAIRMAN. Thank you very much. The committee is in recess.

[Whereupon, at 11:58 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF JUDITH A. ARNOLD

INTRODUCTION

Good Morning. I am Judith Arnold, Deputy Commissioner of Planning and Policy for the New York State Department of Health. Thank you Chairman Roth, Senator Moynihan and Committee Members for inviting me to speak with you today.

My responsibilities in the Health Department include the development and implementation of New York State's expanded child health insurance initiative. During my testimony to you today, there are three key messages that I wish to emphasize. The first is that we are very grateful for the federal funding that New York has received through Title XXI because it has allowed us to enroll thousands more children into the state's program as well as substantially expand the health care services that these children can receive. The second key message is that the reason we are now so successful is that we began slowly, took time to grow, received the flexibility necessary to tailor the program to fit our state's specific needs, and were ready to take full advantage of Title XXI. Based on our experience in New York, the federal government should expect some delays with other states who are just starting Title XXI programs, and may be taking longer than expected to enroll significant numbers of children. The third key message is that, while New York currently is operating the most ambitious program in the nation in terms of children enrolled, we will need additional funding in the not too distant future in order to maintain the program and enroll new children.

Now I'd like to give you a little background on New York's program. And then I'll give you a progress report on where we are today.

BACKGROUND

In August 1997, when Title XXI was signed into law, New York already had the largest state-subsidized children's health insurance program in the nation. The name of our program is Child Health Plus, and, at that time in 1997, there were 124,000 children already enrolled in the program.

Child Health Plus was originally created in New York in 1990 with strong bipartisan support. But it was in 1995, when Governor George Pataki took office, that the program really took off. In fact, prior to the enactment of Title XXI, Governor Pataki increased state funding for Child Health Plus by 300 percent over a 3-year period. In addition, he expanded the age eligibility and covered services under the program.

In its infancy in 1990, New York's program provided only primary and preventive health care services for children through age 12. Low-income families—those with incomes below 222 percent of federal poverty level—received state subsidies. Higher-income families were also eligible to obtain the insurance for their uninsured children by paying full premium, which was considerably lower than other commercial insurance. Later, in 1994, eligibility was extended to children through age 15.

Then, as part of Governor Pataki's 1996 bill known as the Health Care Reform Act, a major expansion of the program was undertaken. His legislation expanded age eligibility through age 18; added inpatient hospital coverage to the benefit package; and increased state funding so that enrollment could be expanded from 100,000 children in 1996 to 250,000 in 1999. The Governor's legislation more than tripled state funding for the program to $207 million.

Once Title XXI was signed into law in August 1997, New York, like other states, scrambled to prepare a plan for using the funding. We submitted our state plan on November 3rd, and five months later, on April 1st, 1998, the federal government

approved New York's plan. On April 15th, 1998, we were allowed to begin drawing on the state's initial grant of $257 million.

About the same time, the New York State Legislature approved another bill introduced by Governor Pataki that further expanded covered services and benefits for the Child Health Plus program. That program expansion, which was a direct result of the new federal funding, provided New York with the support to make its Child Health Plus program more consistent with the benefit package provided under the Medicaid program.

The bill added to the covered services inpatient mental health, alcohol, and substance abuse services, as well as vision, dental and hearing services, to name a few. In addition, eligibility for subsidized insurance was expanded to families with incomes up to 250 percent of the federal poverty level. Premium contributions were reduced or eliminated for children in lower income families, and co-payments were eliminated for all services.

For example, under New York's program, a family of four with a yearly income of $26,654 or less would pay no monthly premium. A family of four with a yearly income between $26,654 and $37,074 would pay $9 per month per child, not to exceed $27 per month per family. A family of four with a yearly income between $37,074 and $38,477 would pay $15 per month per child, not to exceed $45 per month per family. A family of four with an income higher than $38,477 can still participate in Child Health Plus by paying the full premium, which varies depending on the insurer selected. However, the full premium is probably much less than a family would pay for other private insurance.

PROGRESS REPORT

With the support of the federal government, we have been able to greatly expand both the benefits and number of enrolled children in this program. I am extremely proud to report that today enrollment in New York's Child Health Plus program has reached 300,000 children.

Since New York was able to begin drawing on the federal funds 12 months ago, enrollment in the program has increased by 124,000 children. During that 12-month period, New York has enrolled on average over 10,000 new children into the program per month. So, enrollment in the program is growing rapidly.

I want to make one comment about the spending down of Title XXI dollars in this program, because I am aware that some in the federal government feel the states are spending this funding too slowly. Our experience indicates otherwise. In fact, New York will completely exhaust its first year Title XXI allotment by July of this year. Our projections indicate that, at the rate we are enrolling children, we will exhaust Federal dollars at a faster rate each year.

In early 2001, we will need additional Federal dollars in order to maintain our current program and meet the increasing enrollment demand. So, we are enrolling children quickly, and we are spending the money even more quickly to support the growing program.

I mentioned in my introduction that Congress should be patient with states that seem to be moving slowly to implement their children's health insurance programs. These are states that, due to the time required to set up the initial program, get the necessary state and federal approvals, and become operational, have not been able to spend their federal grants as quickly as New York has.

When Congress adopted Title XXI, New York had a distinct advantage over other states because we already had a successful program in place. Unlike many other states, we did not have to plan and design a program from scratch. We already had a good design, and research results from an independent evaluator had demonstrated that the program was achieving its goals.

But getting New York's original program started in 1990 took time, and our program, like those in other states today, started out slowly. There were many complex and difficult tasks involved in creating and starting up New York's program. It is because of that experience that I urge you to be patient with states that are still trying to get their programs going. It is a massive undertaking that requires a great deal of time to complete. A major problem that states face is that, just as we become fully operational, the total Federal allotment is scheduled to decrease by 25 percent.

MARKETING, OUTREACH AND ENROLLMENT

I want to take a moment now to describe some of the unique aspects of New York's program that relate to marketing, outreach and enrollment. New York is currently spending $3.5 million on multi-media advertising to make families aware of the Child Health Plus program. This effort includes ads on TV, radio and billboards,

a blimp that traveled to county fairs, as well as the distribution of brochures and other handouts to community organizations across the state.

An outreach contractor is performing marketing and outreach activities in schools and other community settings. We are also working with regional maternal-infant services networks across the state to make pregnant women aware of the program. In New York City, we are working with the Childrens Defense Fund and the Statewide Youth Advocacy organization to provide enrollment assistance. One project is focusing on providing application assistance to parents at 500 day care centers in New York City to identify uninsured children. The other project is providing application assistance to families in the Washington Heights area of New York.

We also have a major initiative underway to provide a seamless system between our Medicaid and Child Health Plus programs, and to increase the ease with which families can enroll in these two programs. For example, it is our goal that the same health plans participate in both Medicaid and Child Health Plus, so that children may move easily from one program to the other as their eligibility changes, with no disruption in care.

We have also developed a simplified joint application in which families are simultaneously screened for eligibility in Child Health Plus, Medicaid, and the WIC programs.

We are currently pilot testing this application in New York City in the two projects I noted earlier, and will soon begin testing it in upstate counties.

Shortly, I am pleased to say, we will begin an enrollment process for Medicaid and Child Health Plus that is referred to as facilitated enrollment. Facilitators will be located in convenient community-based locations with evening and weekend hours so that applicants will not be required to visit a social services agency or other government office. We recently issued a Request for Proposals for $10 million for this program, with responses due in May. We are hoping to contract with a number of lead organizations that will have contracts with extensive community-based organizations across their regions.

Facilitated enrollers will use the new, simplified joint application to assist families in determining eligibility and complete the application process for Medicaid or Child Health Plus and WIC. This assistance will include screening the family for the appropriate program, completing the application, collecting the required documentation, and forwarding the completed application to the appropriate program. Contractors will be required to place facilitators in convenient places in the community that people frequent, including clinics, schools, day care centers, libraries, community centers, and other locations.

We are initiating this new program because we believe that eliminating a visit to a government agency and providing assistance in obtaining documents will reduce barriers to enrollment. Applicants will be able to complete the face-to-face interviews required for Medicaid enrollment without going to the office of the local social services agency, and they will be able to do this at times convenient to their work schedule, such as evenings and weekends.

CONCLUSION

To conclude my testimony to you today, Title XXI provides an historic opportunity to significantly improve the health status of our nation's children. Today in New York, thousands more children are receiving the health care they need to grow up healthy, to learn in school, and to lead productive lives. On behalf of these children, and on behalf of Governor Pataki and New York State, I want to thank you for your efforts to expand health insurance to uninsured children, and I urge your continued support for this program. Thank you.

PREPARED STATEMENT OF HON. RICHARD H. BRYAN

Mr. Chairman: The enactment of the 1997 Balanced Budget Act's state children's health insurance program was a seminal event in addressing the problem of uninsured children in this nation. The $24 billion funding reflected the seriousness of the national commitment to ensuring children will have access to health care services. I commend the Chairman for holding this oversight hearing to ensure this important initiative, although early in its implementation, is meeting the goals this Committee set, and spending this massive funding commitment as intended.

Nevada unfortunately is one of the top ten states with the highest proportion of uninsured children. In the fall of 1997, I meet with the Nevada State Legislative Health Care Committee to implore the state decision makers to set the standard in Nevada for meeting the challenge to provide uninsured children with reliable health care insurance coverage.

Nevada's CHIP program—"Nevada CheckUp"—was approved by HCFA in August 1998 and began operating in October 1998. The program is separate from the Medicaid program; but the two are coordinated in the application process to ensure those children eligible for Medicaid are enrolled in that program. Nevada CheckUp CHIP program covers applicants up to 200% of the federal poverty level, and children up to age 18 years.

Since its October 1998 beginning, Nevada CheckUp has enrolled over 5,300 children. Average enrollment is 500 children per month, and currently there are 12,000 applications pending. Nevada CheckUp projects having 10,000 uninsured children in the program by the end of the year 2000. This is a good start. But there are estimates of thousands of children who are uninsured, who need health care coverage, and who must be found and covered.

Nevada CheckUp recently had a joint on-site review by HCFA and the Health Resources and Services Administration to review the program. Nevada's marketing and outreach efforts which are exceeding enrollment in neighboring states by 5% to 6% were particularly commended. Nevada's experience will be shared with other states to help increase outreach throughout the nation.

The CHIP program is in its infancy, and yet much has been accomplished toward reaching its goals. Some problems have arisen in finding the children eligible for the program, and in ensuring TANF program children who are Medicaid eligible continue that eligibility when their families no longer receive cash assistance, and these need to be addressed. I am hopeful as this program matures, the next Committee oversight hearing will show a most successful effort to cover our nation's children, and ensure their health care needs are met into the next century.

PREPARED STATEMENT OF JANET M. CORRIGAN, PH.D.

Good morning, Mr. Chairman and Senator Moynihan, and members of the Committee. My name is Janet Corrigan and I am the Director of the Division of Health Care Services at the Institute of Medicine. I very much appreciate the opportunity to present to you our findings on two studies which are relevant to the State Children's Health Insurance program. CHIP is an historic and innovative program. However, we believe there are a number of steps the Congress and the Department of Health and Human Services need to take to ensure that the program is properly monitored and managed, which my testimony will outline for you.

In March 1997, the Institute of Medicine and the National Research Council of the National Academies established the Committee on Children, Health Insurance, and Access to Care. The initial charge to this committee, which included an interdisciplinary group of clinicians, researchers, policy analysts, and administrators, was to address a series of questions about health insurance and children's access to care. However, in August 1997, before the Committee had completed its work, Congress passed the Balanced Budget Act of 1997, which enacted CHIP as Title XXI of the Social Security Act. The Committee was delighted to have some of its work preempted, but also recognized that assuring the success of this new program would require that careful attention be paid to 1) outreach and enrollment, and 2) accountability and evaluation. There were numerous efforts getting underway at the state and federal levels to establish effective outreach and enrollment processes, so the Committee decided to focus its efforts on accountability and evaluation.

Two reports were developed by this Committee—America's Children: Health Insurance and Access to Care which presents the committee's review of evidence and draws conclusions about the relationship of children's health insurance and access to care, and Systems of Accountability: Implementing Children's Health Insurance Programs which addresses practical concerns about the implementation and evaluation of CHIP. Both of these reports were published this past fall.

While time does not permit a lengthy discussion about all of the conclusions and recommendations reached by this IOM Committee, I would like to highlight key recommendations from America's Children regarding the value of health insurance programs for children, and then discuss the recommendations in Systems of Accountability about the need to develop policies and procedures for evaluating CHIP. Our committee believes that this program has great potential to expand access to care, but to reap these benefits, it is imperative that we engage in an ongoing learning process about the design and operation of the program. There is an enormous amount that we can learn if Congress, the Department of Health and Human Services and the states take proactive steps to gather the necessary data to monitor and oversee CHIP.

CHILDREN'S ACCESS TO CARE

First, let me address our findings from America's Children regarding children's access to care.

Our Committee found that insurance coverage is the major determinant of whether children have access to health care. A growing number of studies now demonstrate that access to health care can influence children's physical and emotional growth, development, and overall health and well being. Moreover, children who have insurance coverage, as compared to those who do not, have many unmet health care needs. They are more likely to be sick as newborns, less likely to be immunized as preschoolers, less likely to receive medical treatment when they are injured, and less likely to receive treatment for illnesses such as acute or recurrent ear infections, asthma, and tooth decay. Uninsured children are the least likely members of society to have routine access to a physician. Without a regular source of care, low-income children are more likely to use publicly funded clinics for standard preventive services such as immunizations and are more likely to use emergency rooms for care for acute illnesses. Some aspects of the health care system also can create barriers to access, particularly the shortages of providers to serve low-income groups, lack of cultural sensitivity, and inconvenient scheduling.

The IOM Committee came up with a number of recommendations to address the lack of access:

- All children should have health insurance;
- Non-financial barriers to care should be reduced through the provision of assistance with child care and transportation, through the provision of culturally appropriate services, and through the use of information technology;
- Outreach and enrollment procedures and coordination efforts should be designed so that all programs achieve the highest enrollment possible, particularly when states offer multiple programs with different eligibility requirements; and
- Information generated from children's health care and insurance programs should be designed to be useful in evaluating short-term trends and making program adjustments, and should be made widely available.

Children's access to care is correlated with insurance coverage, which is why we believe CHIP is so critical. However, our Committee also believes that CHIP will achieve its full potential only if systems are in place to give us the data necessary to manage the program.

EVALUATION OF CHIP

As part of our assessment of Title XXI, the Committee came to a number of conclusions and recommendations regarding the roles of Congress, the U.S. Department of Health and Human Services, and the states in assuring accountability for the new program. These recommendations were developed after conducting an extensive review of evidence on the relationship between insurance coverage and access to care. The Committee based these recommendations on the following two principles:

- The $24 billion in federal funds allocated for CHIP and Medicaid improvements represents a significant national commitment to insurance expansion for children, and this commitment should be monitored to ensure that the legislation's goals are fulfilled.
- Although CHIP will help to reduce the number of uninsured children, millions of children will remain uninsured or underinsured even assuming its full implementation. To guide future insurance expansions, careful evaluation of the multitude of state approaches used under CHIP will be essential.

Our first recommendation is that the Congress should take immediate action to ensure that funding is adequate to evaluate CHIP's impact. No distinct funding for data collection or evaluation was included in the original legislation creating CHIP.

Second, the Department of Health and Human Services must establish a performance monitoring system for CHIP in collaboration with agencies from other levels of government and with private organizations. This effort should be well coordinated with other ongoing performance monitoring activities, such as those concerned with public health, mental health, substance abuse, and education.

A well-chosen set of basic performance measures is needed to provide comparable information for all CHIP programs. Currently, states vary widely in their use of information systems, analytical and technical capacities, and measurement approaches. Without a minimum set of comparable data, it will be difficult to establish baseline information and to track changes in the number of uninsured children; to evaluate disparities in health status; to compare the scope of services in different programs, as well as utilization data for different groups, and the quality of care in different health plans; and to collect other information essential for evaluating the success of CHIP across states.

Another important component of this performance measurement system should be a rapid turnaround survey to track key indicators of CHIP performance at the state level. This survey should be repeated on an ongoing basis to monitor changes in children's health and well being after states have fully implemented their CHIP programs.

Third, the Department of Health and Human Services must develop systems that improve the availability of national and state-level information on children's insurance coverage, access, utilization, satisfaction, health status, and outcomes, particularly for children with special health care needs. While existing national health surveys, such as the National Health Interview Survey, the Current Population Survey, and the Medical Expenditure Panel Survey, can provide national and regional data on insurance coverage, utilization, and health status, these surveys do not provide state-level data for most states, and the data they do provide is not always current. Consideration should be given to increasing the sample size of these surveys to permit state-level estimates and evaluations.

Finally, we believe states should immediately implement systems to produce meaningful information on CHIP's effects, and such information should be made available to the public. As much as possible, states should delegate the collection and synthesis of CHIP information to contracted health plans or provider groups, with requirements for independent auditing of these data. States also should set conditions of participation in CHIP, experiment with a variety of incentives to reward health plans for their performance, and develop the technical and analytic capacity to evaluate the impact of incentives on health plan performance.

To the maximum extent possible, information systems designed to track CHIP should have been developed at the time the programs were being designed. As states are rapidly implementing their programs, time is of the essence. Without coordinated guidance and planning for state-level accountability systems, opportunities will be lost.

Mr. Chairman, CHIP is historic, innovative, and rapidly evolving. It offers an unprecedented opportunity to move from the traditional monitoring and compliance models of health care, which focus on financial performance, to a quality-improvement model that fulfills the intent of the CHIP legislation.

Over the next several years, it will be important to measure the extent to which the new state programs alleviate the pressure on other sources of funding for uncompensated care. Unless better data systems are developed, those outcomes will be extremely difficult to measure. In summary, the enactment of Title XXI offers a unique opportunity to track and measure changes in the number of uninsured children and to assess CHIP's effectiveness in improving access and children's health outcomes. Lessons learned through evaluating and monitoring the program will have important implications for fine tuning and strengthening CHIP.

Thank you for this opportunity to testify. I would be happy to answer any questions the Committee may have.

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PREPARED STATEMENT OF BARBARA COULTER EDWARDS

Mr. Chairman, members of the committee, I appreciate the opportunity to testify this morning before the Committee on Finance to share Ohio's Title XXI children's health plan experience.

I am Barbara Edwards. I oversee the Office of Medicaid within the Ohio Department of Human Services. Medicaid in Ohio is a $6.5 billion a year health care plan that serves over 1.4 million Ohioans, including more than 600,000 children. I also direct Ohio's Title XXI children's health insurance plan (CHIP).

The State of Ohio implemented its Title XXI plan on January 1, 1998. We offer comprehensive health coverage to all children ages 0 through 18 living in families with countable incomes at or below 150 percent of the federal poverty level. Ohio's Governor, Bob Taft, has proposed expanding the title XXI plan to include all children in families up to 200% of the federal poverty level beginning January 2000. A fully implemented children's health plan under Title XXI is seen as a strong support for families seeking to establish and maintain self-sufficiency in the work force.

Through March, over 104,000 children have enrolled in our Title XXI children's health plan. We estimate that this includes 55% of the state's uninsured children in the targeted expansion group. Ohio expects to have reached up to 125,000 children by the end of June. With the planned expansion to 200% of poverty, an additional 27,000 children could be enrolled by the end of the next biennium.

Ohio was the fourth state in the nation to receive approval for its CHIP plan. Under the leadership of former Governor, and now U.S. Senator, George V. Voinovich, Ohio's 1998–99 biennial budget included an expansion of Ohio's Medicaid program for children, even before enactment of title XXI. This put Ohio in the enviable position of having both the authority and the funding to take early advantage of the opportunity offered in the federal Balanced Budget Act.

Using both a Title XIX and a Title XXI state plan filing, Ohio expanded income eligibility up to 150% of poverty for HealthyStart, our Medicaid plan for children. Ohioans supported offering the full HealthyStart EPSDT benefit package to low-income children. In addition, since Ohio Medicaid already contracts with licensed private sector managed care plans in all the major urban areas of the state, most children enrolled under a HealthyStart expansion receive their benefits through a private health insurance plan.

The most compelling reason Ohio selected the Medicaid option was the ability to offer wrap-around insurance to under-insured children under title XIX, in addition to offering coverage to uninsured children under Title XXI.

To encourage enrollment in the children's health plan, Ohio uses a simplified three page HealthyStart application that can be mailed in; parents do not have to visit any government office in order to apply. Ohio also offers a very popular toll-free consumer hotline with evening and weekend hours to make it easy for families to get information about the children's health plan and to apply by phone.

Finally, Ohio has engaged local communities in developing and implementing outreach efforts to low-income working families. Ohio has allocated to its counties almost all of the $16.1 million in enhanced federal matching funds available to the state under the federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) to conduct Medicaid outreach to families who leave cash assistance programs. I have attached to my testimony a description of the CHIP outreach initiatives undertaken by the state, in addition to those initiated at the local level.

As a result of state and local efforts, Ohio has experienced a recent net increase in covered children across all Title XIX and Title XXI programs, even while cash

assistance caseloads continue to decline. This includes a 23% increase in the percentage of new enrollees in non-CHIP HealthyStart.

Even so, we are not fully satisfied with our expansion efforts. Our enrollment information shows that we are still mostly reaching children in families who already have some connection to the Medicaid health plan. The majority of new enrollees are children who either were previously covered by non-CHIP HealthyStart themselves or who have younger siblings covered by non-CHIP HealthyStart. This suggests there may be significant numbers of children whose families still do not know that coverage is available or who for some reason are reluctant to enroll their children in a public health plan.

We also are concerned that we "lose" a significant number of children from the program at eligibility redetermination. While over 104,000 children have been enrolled to date, only 54,000 children were covered in the expansion group in March. We add about 8000 children each month and lose 7000. Half of the children who leave the expansion program at the required six-month redetermination move to non-CHIP HealthyStart and so still have full health coverage. We do not know what is happening to the rest of the children who lose coverage each month; we are concerned that these children may be uninsured.

As we look to the future, Ohio is committed to further simplifying the application and eligibility processes for both Title XIX and Title XXI health plans. We will pay particular attention to reapplication requirements to minimize the number of children who lose coverage because of time lines and paperwork. And we are committed to working with local communities to clarify the message that health care is not welfare. Access to quality health care is critical to healthy development in early childhood, to having children start school ready to learn, and to supporting children as they grow to be productive adults.

My sincere thanks to you, Mr. Chairman, and to the members of your committee, for your interest in states' efforts to implement Title XXI. Each state faces a unique set of challenges and opportunities as we seek to provide health care services to children. I encourage the Committee to continue to seek ways that the states can work in partnership with the federal government. I encourage you, especially, to continue to increase flexibility for states administering both Title XIX and Title XXI health plans, so that together we may achieve our mutual goal of good health for all our children. Thank you.

Attachment I

TESTIMONY BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT, BARBARA COULTER EDWARDS, MEDICAID DIRECTOR, OHIO DEPARTMENT OF HUMAN SERVICES

SEPTEMBER 18, 1998

THE OHIO DEPARTMENT OF HUMAN SERVICES
CHILDREN'S HEALTH INSURANCE PROGRAM
OUTREACH ACTIVITIES THROUGH AUGUST 1998

ODHS OUTREACH ACTIVITIES THROUGH AUGUST 1998

ODHS is partnering with a variety of statewide and local agencies in order to best inform families about the availability of health coverage for children. What follows is a list of partners and a brief description of the partnership. This is not an exhaustive list but provides highlights of ODHS's outreach efforts and an idea of the strategy being used.

Ohio Family & Children First

ODHS has partnered with OFCF to take advantage of a similar audience and goal. OFCF's goal is to ensure that all children will enter school ready to learn. Provision of comprehensive and appropriate health care to children is essential to reaching that goal. ODHS has shared information and materials with: Family and Children First Cabinet

- Inter-Systems Coordinators
- Family Stability Project Coordinators
- Local FCF Councils
- Advertisement in the 1998 Help Me Grow Wellness Guide
- Help Me Grow Hotline

The department will make materials available at the upcoming Family & Children's First conference scheduled to take place in mid-October.

PRWORA Enhanced Outreach Dollars

The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 provides enhanced federal matching funds for targeted expenditures related to Medicaid eligibility outreach. While this eligibility outreach is not targeted specifically for children, a great deal of effort is being focused on children by a majority of counties. Ohio has allocated a majority of its federal allocation to counties. Counties must submit a consolidated county plan for approval by ODHS. For SFY '98, 61 county plans were submitted to ODHS, of which 61 were approved. ODHS expects these county plans and outreach activities to generate a great deal of enrollment. Combined federal and local funding of approximately $20 million was available for SFY 98 activities. A comparable funding level is available to support SFY 99 activities. Continuation plans for SFY 99 have been received by 50 counties and 11 counties who did not participate in SFY 98 have submitted plans for SFY 99 activities.

Head Start

ODHS has been working in conjunction with the Head Start program over the last year with a goal of increasing Medicaid penetration for the Head Start population. At a state level, ODHS has worked with the Ohio Head Start Association, Inc. to examine best practices for outreach to children and families through Head Start. Additionally, ODHS had provided informational materials and assistance to Head Start about the Healthy Start eligibility expansion through participation at the annual Head Start conference and through presentations to local Head Start agencies. The department is on the agenda to participate at the conference scheduled to take place in October.

Commission on Minority Health

During the month of April, ODHS participated in eight (8) Minority Health Month Events stationed throughout Ohio. Written materials that were requested through the consumer hotline were also provided to numerous organizations in recognition of Minority Health Month. ODHS has also supported the Commission in its submission of a grant proposal to Robert Wood Johnson to do outreach for children's health insurance. In addition, ODHS has submitted an article for the Commission's newsletter that reaches approximately 6,000 Ohio citizens.

Joint Advisory Councils (JACs)

JACs are a forum for local and community leaders, providers, advocates and consumers to focus on local needs related to Medicaid managed care. JACs are required in all mandatory managed care counties. Currently, JACs are established in Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Summit and Trumbull counties. These councils meet on regular basis, either monthly, bi-monthly, or quarterly. ODHS participates to provide information about the Medicaid program, and to get feedback from communities. JACS have provided an excellent forum through which to share information about the Healthy Start eligibility expansion for children.

Planned Parenthood & Family Planning Agencies

ODHS staff has met with the Ohio Planned Parenthood Association to discuss the health insurance expansion and provide materials. Additionally, ODHS has made presentations and provided informational materials to local planned parenthood offices and other family planning agencies.

Ohio Caring Program for Children

The Ohio Caring Program for Children has chosen to phase out its program. ODHS and the Caring Program are working cooperatively to transfer Caring Program children, and those on their waiting list, into Healthy Start. The two agencies jointly developed a notification letter that is being sent to Caring Program families that encourages families to apply for Healthy Start before their benefits through the Caring Program expire.

Ohio Department of Health

ODHS has continually partnered with ODH to coordinate outreach efforts and take advantage of existing communication channel with certain programs and local networks.

Women, Infants & Children (WIC)—ODHS has provided information to WIC to distribute to clinics so that local WIC staff are aware of increase availability of health insurance for children. Additionally, WIC identified 80,000 households currently involved in the WIC program that appeared to be without health insurance. ODHS sent a notice to these 80,000 households inviting families to call

the hotline to get information and/or apply for Healthy Start. ODHS received a tremendous response from WIC recipients through the Consumer Hotline. ODHS has also provided materials and presentations to local WIC sites.

- Bureau for Children with Medical Handicaps (BCMH)—BCMH is requiring its participants who are at or below 185 percent of the federal poverty level to apply for Healthy Start. These participants are directed to call the consumer hotline. A one-time mailing has been sent to approximately 5,000 current BCMH families with information about Healthy Start. On a monthly basis, BCMH will mail information about BCMH and Healthy Start to approximately 2,000 families who are either applying for BCMH or are being recertified for BCMH enrollment.
- County & City Health Departments—ODHS has worked with the ODH to provide educational materials to local health departments. ODHS has also made presentations and sent information directly to local sites.
- Child and Family Health Service Clinics (CFHS)—ODHS is working with ODH to provide these clinics with information. ODH invited ODHS to present information at regional CFHS project manager meetings in late 1997.

Ohio Department of Mental Health

ODHS is working with ODMH to provide information to mental health boards and providers about the Healthy Start expansion. ODHS has also provided materials and presentations to local boards.

Ohio Legislators

ODHS sent a packet to Ohio Legislators in January informing them of Ohio's health insurance expansion for children. A second informational packet was sent in May to provide an update on the health insurance expansion, and also to request assistance providing information to constituents about the expansion.

Ohio Department of Education

ODHS has been in contact with ODE to coordinate outreach efforts with Ohio schools. To date, the department has submitted materials to ODE that were included in the distribution of bi-monthly newsletters that were sent to Ohio's Superintendents. The purpose of this participation is to encourage superintendents to spread the word about this opportunity to their respective school districts. ODHS has also received word that Healthy Start materials have been distributed directly to all enrolled students in Hilliard, Ohio and to 1,100 sixth grade students in Pickaway County. Local county departments of human services are also coordinating efforts with local school districts to reach children potentially eligible for Healthy Start.

Ohio Bureau of Employment Services (OBES)

ODHS met with statewide coordinators of OBES's One-Stop-Shops to discuss the advantages of sharing information about the children's health insurance expansion at One-Stop locations. Following this meeting, ODHS provided One-Stop contacts with written materials to share with clients about Healthy Start. Additionally, information about Healthy Start has been added to One-Stop electronic service directories in several areas.

North American Indian Cultural Centers

ODHS provided the North American Indian Cultural Center in Summit County with information about the expanded availability of health insurance for children through Healthy Start. Through this initial contact, ODHS has mailed Healthy Start information to an additional seven Indian Cultural Centers throughout Ohio.

Ohio Department of Alcohol & Drug Addiction Services (ODADAS)

ODHS shared information with ODADAS and ODADAS participates in ODHS's outreach coordination workgroup. ODHS and ODADAS are working together to share information with local boards and providers.

Ohio School Nurse Association

ODHS was invited by the School Nurse Association to participate in four regional school nurse conferences. These conferences have provided an excellent opportunity to share information and materials that get into schools. Following these presentations, the hotline has received many requests for written materials to be used in schools.

Child Care Centers (both home & center based)

ODHS sent information about Healthy Start insurance for children to many child care centers resulting from requests over the hotline. In mid-June, a mailing was

distributed to 10,000 home and center based child care centers licensed by ODHS to ensure that all child care providers have information to share with families about Healthy Start.

County Departments of Human Services (CHDS)

Each CDHS is responsible for processing all applications and determining eligibility. Presentations have been given to ensure that CDHS staff are knowledgeable about the new expansion and have also been provided with informational materials for reference. Federal PRWORA outreach dollars have been made available to the counties through the county commissioners.

Information & Referral Lines

ODHS works with a variety of information and referral lines throughout Ohio to share information about Healthy Start directly and through their newsletter. ODHS also provided information packets in August about the expansion and the opportunity it presents for children.

Provider Associations

ODHS continually works through provider associations to reach respective members with new information because they are a key resource in educating and communicating with current and potential Medicaid consumers. ODHS believes that provider relationships create an essential referral flow and are extremely valuable to our outreach program. To date, ODHS staff have attended 20 medical association meetings this summer to provide an update on the Healthy Start expansion. A variety of providers have or are publishing articles regarding the Healthy Start expansion in association newsletters. These providers include the Ohio State Medical Association, Ohio Hospital Association, Ohio Dental Association, Ohio Ambulance Association and the Ohio Association of Medical Equipment Suppliers. Although ODHS has developed relationships with many providers, it remains a priority of ODHS to identify additional provider associations in the near future.

Ohio Churches

ODHS has partnered with the Commission on Minority to Health to initiate the process of notifying Ohio churches of the Healthy Start expansion. To date, the first of many informational mailings has been targeted to minority churches in the Cleveland area. A large mailing will take place during September in cooperation with the Ohio Council of Churches that will reach approximately 13,000 individuals associated with the council's goals.

State Fair

State agencies distributed a variety of child health promotional material at the 1998 Ohio State Fair.

In addition to working with the above groups, ODHS has provided written materials about the Healthy Start expansion, requested through the hotline, to the following groups:

Children's Hospitals & Hospitals throughout Ohio
College and Universities
Community Action Agencies
Local Courts
Salvation Army
Independent Living Centers
Developmental Centers
Urban Appalachian Council
Family Services & Advocacy Agencies
Schools (GRADS program)
Providers, Clinics & Medical Centers
Action for Children
Legal Services
Early Intervention Education Service Centers
Child Support Enforcement Agencies

PREPARED STATEMENT OF HON. BOB GRAHAM

Mr. Chairman, I would like to take this opportunity to thank the distinguished Chairman of the Finance Committee for holding this important hearing today on the implementation of the State Children's Health Insurance Program (SCHIP). The passage of this program as part of the Balanced Budget Act of 1997 represented the

second largest federal effort to provide health insurance coverage to uninsured, low income children since the enactment of Medicaid in 1965.

SCRIP targets uninsured children who live in families with incomes below 200% of the federal poverty level (FPL). There are about 5 million children in the nation within that category and last week First Lady Hillary Rodham Clinton announced that almost 1 million children had enrolled in SCRIP in 43 states. The Department of Health and Human Services estimates that states are well on their way to enrolling their target of 2.5 million children by the year 2000. Florida expects to enroll over 87,000 children in SCRIP, in over 40 counties statewide, by the beginning of May.

Florida's children's health insurance plan is a combination of Medicaid expansion and a separate state plan. SCRIP funding allows Florida to expand Medicaid coverage for children between 15 and 19 years of age with family incomes up to 100% of the FPL. In addition, the state uses SCHIP funds to provide subsidized premiums for children in families at or below 185% of poverty.

Since the passage of welfare reform in 1996, legal immigrant children who entered the country after August 22, 1996 have been banned from receiving federal means-tested public benefits for their first five years in the country. Because, SCHIP funds meet this criteria health insurance coverage cannot be made available to these immigrant children. Children without health insurance do not get important care for preventable diseases. Without adequate health care, common illnesses can turn into life-long crippling diseases, whereas appropriate treatment and care can help children with diseases like diabetes live relatively normal lives. A lack of adequate medical care will also hinder the social and educational development of children, as children who are sick and left untreated are less ready to learn.

All children share the same basic needs and that is why the Florida legislature has granted its children's health care program the authority to cover legal immigrant children. The state should be commended for its commitment to maintaining continuity of coverage to these populations at their own expense. Currently the state spends over $5 million covering almost 7,000 kids. The federal government should stand up, pay its share, and take responsibility to its commitment to legal immigrants, especially children, and grant states the option to cover these individuals with SCHIP funds. I am currently working with several of my colleagues to diminish the arbitrary cutoff date used in the 1996 welfare law to determine the eligibility of legal immigrants to benefits they desperately need, especially children.

Mr. Chairman, I would like to thank you again for having this hearing. It allows Members of the Committee to become familiar with some of the problems and triumphs states are facing while implementing the program. Covering legal immigrant children is just one of the many challenges states have faced during implementation and I am hopeful that we will be able to correct this, and other concerns during the 106th Congress.

PREPARED STATEMENT OF NANCY-ANN DEPARLE

Chairman Roth, Senator Moynihan, distinguished committee members, thank you for inviting me to discuss our progress with the Children's Health Insurance Program or "CHIP." This program is providing us with a landmark opportunity to improve children's health and help working families who do not earn enough to afford coverage for their children. This historic, bipartisan achievement is an excellent example of how Congress, the Administration, and States can work together constructively to genuinely improve the lives and health of American children.

I am happy to report that the CHIP program is strong and growing, with 52 plans now approved that States and territories expect to cover up to 2.5 million children by September 2000. We have also already approved 15 amendments that expand States' initial programs. And we estimate that there are now about 1 million children enrolled in the 43 States with programs operating during 1998, a year when many States were just beginning to enroll children. Only seven programs were enrolling children throughout the entire year and 10 of the 43 programs did not start enrollment until after October 1. These statistics indicate that States met their enrollment estimates for 1998 and are well on their way to enrolling their target of 2.5 million children by 2000.

Our primary challenge now is to increase and improve outreach efforts and get more eligible children enrolled in both CHIP and Medicaid. We must also work to ensure that we have consistent, reliable, and timely data on the effectiveness of each CHIP plan. The President launched a broad and innovative national outreach campaign in February, and his fiscal year 2000 budget proposal includes increased flexibility so States can use more of funding available to them for outreach. It would

increase access to CHIP funds for outreach, and expand the use of a special $500 million Medicaid fund now aimed at outreach to children losing welfare benefits, to fund outreach to all eligible children. We look forward to working with you to improve outreach efforts to make sure the CHIP program's promise of better health through affordable coverage becomes a reality for as many eligible children as possible.

BACKGROUND

The CHIP program was created through the bipartisan Balanced Budget Act of 1997 to address the fact that nearly 11 million American children—one in seven—are uninsured and therefore at significantly increased risk for preventable health problems. Many of these children are in working families that earn too little to afford private insurance on their own but too much to be eligible for Medicaid. Unfortunately, the number of uninsured children has been rising. The number of uninsured children rose from 8.2 million in 1987 to 10.6 million in 1996—from 13 percent to 16 percent of all children. The number of children covered through their parent's employer-based plans is also down, from 67 percent In 1987 to 59 percent in 1995.

Congress and the Administration wisely agreed to set aside $24 billion over five years, beginning in fiscal 1998, to create CHIP—the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage for children who already have coverage. Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets the broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, or a combination of these approaches. Of the 982,000 children enrolled at the end of 1998, about 540,000 were in separate State programs and about 442,000 were in Medicaid expansions.

States also have the opportunity to set eligibility criteria regarding age, income, resources, and residency within broad Federal guidelines. The Federal role is to ensure that State programs meet statutory requirements that are designed to ensure meaningful coverage under the program.

Making CHIP a success is one of this Administration's highest priorities. We have worked closely with States, Congress, the Health Resources and Services Administration and other Federal agencies to meet the challenge of implementing this program and defining its parameters, while at the same time, approving State plans as quickly as possible. We have provided extensive guidance and interim instructions so States can develop their plans and start using Federal funds to begin insuring children at the earliest possible date.

We began by providing States with a draft template, or standard application format, to help them provide information that is required by the statute. We have sent twenty letters to State health officials regarding specific policy issues, including outreach, financial issues, and cost sharing. We also have released more than 100 detailed answers to important policy questions. All these documents are available on the Internet at www.hcfa.gov, providing easy access and quick reference for all interested parties.

We are developing a regulation that will codify this extensive guidance that we have already issued on eligibility, benefits, beneficiary financial responsibilities, strategic planning, program integrity and beneficiary protections, reporting and evaluation, and Medicaid coordination. We anticipate that the regulation will be published in the Federal Register later this year. On March 4, 1999, we published in the Federal Register a regulation setting forth the methodologies and procedures to determine and disburse the allotments of Federal funds to States and the Territories.

PLAN APPROVALS

In the 21 months since legislation creating the program was enacted, we have approved 52 CHIP plans. We approved the first State plan, for Alabama, last January—just five months after the legislation was signed. States and territories esti-

mate that these programs have the potential to cover up to 2.5 million children by the year 2000.

Of the 52 CHIP approvals, 14 create or expand a separate State CHIP program, 26 expand existing Medicaid programs, and 12 use a combination of these two approaches. As predicted, States are moving quickly to expand their initial programs. We have already approved 15 amendments for eligibility expansions or program changes. Another 13 such amendments are under review, and another ten States have indicated that they plan to submit such amendments. We believe most States will eventually expand eligibility for children up to 200 percent of the Federal Poverty Level. About half of the approved CHIP plans are already at or above 200 percent of the Federal Poverty Level.

THE OUTREACH CHALLENGE

As mentioned above, our priority now is to find and enroll as many eligible children as possible. Successful outreach efforts will identify children who are eligible for both CHIP and Medicaid, and should increase total coverage rates well above what CHIP plans alone can provide. However, States have indicated that their outreach efforts have been hampered by limited funding. This is in large part because the Federal statute limits State spending for outreach and all other administrative expenses to 10 percent of program expenditures, which at first are naturally low.

In February, the President announced a broad and innovative national campaign called "Insure Kids Now" to increase enrollment in CHIP and Medicaid. It includes:

- a toll-free 877-KIDS-NOW hotline, developed with the National Governors Association and Bell Atlantic, that will connect callers anywhere in the country directly to specific information about the CHIP plan in their State;
- a national ad campaign to promote the toll-free number on network television, radio, and in newspapers;
- printing the toll-free number on commonly used products such as diaper boxes, grocery bags, toothbrushes, child safety seats, and school buses; and
- a special website with general CHIP information and links to State-specific web pages.

The President's fiscal year 2000 budget includes proposals to increase outreach funding for States. It would allow States to spend 3 percent of program expenditures on outreach in addition to the 10 percent cap on overall outreach and administrative spending. It also would permit States to expand use of a special $500 million Medicaid fund now aimed at outreach for children losing welfare benefits, to include outreach to all eligible uninsured children. We look forward to working with this Committee to enact these provisions and ensure that States are able to enroll as many eligible children as possible.

The President's budget also increases CHIP funding for Territories by a total of $144 million over 5 years to fulfill his pledge to work with Congress to provide more equitable funding for children's health care in the insular areas. The Balanced Budget Act set aside only 0.25 percent of total CHIP funds for the Territories, and last year's Omnibus Consolidated and Emergency Supplemental Appropriations Act allocated an additional $32 million to the Territories only for fiscal 1999.

Outreach Successes

Meanwhile many States are taking innovative approaches and making excellent outreach and enrollment progress.

South Carolina is among States that stand out. The State simplified its enrollment process and widely distributes applications in places like pharmacies and day care centers. Most applications are picked up in schools, where they are handed out by nurses, guidance counselors, and athletic directors. Churches have also been active partners in distributing applications and inviting speakers to talk to congregations about CHIP. The State worked with the Catawba Indian reservations to enroll Native Americans, with the March of Dimes to target Hispanics and migrant workers, and with the sorority Alpha Kappa Alpha to reach African-Americans. All this has paid off. The State enrolled 44,500 children in CHIP in just five months and, at the same time, increased Medicaid enrollment by 29,600.

Missouri has also had great success with a more tried-and-true grass roots approach. The State has gone door-to-door in low-income neighborhoods to help parents of potential enrollees fill out application forms. In just four months it enrolled more than 20,000 children.

We are taking lessons from these and other early successes and sharing them widely.

- We have issued two letters to States providing guidance on how to simplify and streamline the eligibility process, as that appears to be a key step to promoting

enrollment. This guidance included a simplified model application form that can be used as a joint CHIP and Medicaid application.
- We are expanding our HCFA website to facilitate faster sharing of outreach innovations.
- We continue to meet with States to gather and share outreach success stories, and to help States help each other address enrollment issues.
- We have held several outreach conferences around the country to identify more innovative and successful strategies used by State and local communities.
- And we are sponsoring, with the Health Resources and Services Administration, a series of focus groups and technical advisory panels to share successful outreach innovations.

While these early successes are encouraging, outreach results from States across the country are mixed. There is a great deal that remains to be done to ensure that eligible children are enrolled. One key element is ensuring that we have consistent, reliable, and timely data from States to evaluate their programs.

DATA COLLECTION AND EVALUATION

Monitoring CHIP plans and collecting meaningful data is another challenge we must meet to make the program a success. Data collection is necessary to meet the requirements of the statute, ensure Federal funds are being spent appropriately, track States' progress in meeting their enrollment goals, and help us identify problems that we should work with States to address.

As with outreach and enrollment, this is a challenge that is not yet met. Some States are still working to get programs off the ground. Some States have had data collection efforts hampered by efforts to make all computer systems Year 2000 compliant. And, as with funding for outreach and enrollment, States have indicated that funding for data collection is also limited under the provision in the statute limiting funding for all administrative expenses to 10 percent of program expenditures.

We are working with States to ensure that they meet the statutory requirements to collect and report financial and enrollment data. We are actively providing technical assistance to States to analyze data, to evaluate the effectiveness of their programs, and to establish a workable system to monitor and assure quality in CHIP programs. States are required to submit quarterly and annual reports to us, and to file their own evaluations of their programs in the year 2000. And the Health and Human Services Secretary is required to submit a report to Congress on CHIP in December of 2001.

We share Congress' strong interest in this information, and we are aggressively working with States to ensure that they can provide all the necessary data. In a December 6, 1997 letter to States, we outlined our requirements for the submission of financial data. In early 1998, we began consulting with States on the enrollment data. And in a December 4, 1998 letter to States, we provided further detail on requirements for submission of quarterly expenditure and enrollment data, the development of a baseline number of low-income, uninsured children who are potentially eligible under the Federal statute, and the fiscal year 1998 CHIP annual reports. We have tried to make all these different data requests consistent in order to streamline the reporting process.

Last month, in another letter to State health officials, we again stressed the importance of data collection and our eagerness to work with States to ensure that they can meet our data requirements. We want to help assess their ability to meet our deadlines, determine if they need some additional time and identify any needs for technical assistance. We urged States having data collection problems to at least provide aggregate enrollment data now, and to furnish other required enrollment data stratified by age and income at a later date.

An independent State workgroup is working to develop a model protocol for State CHIP annual reports and evaluations, which should help establish consistency in CHIP data from the States. We hope this voluntary effort is successful, because we need consistent, comparable data across States in order to evaluate the effectiveness of State programs.

CONCLUSION

We have had solid success in approving and implementing State CHIP plans. The fact that almost all States have approved plans upon which they can build is a substantial achievement. Each CHIP plan is different, and the States have designed programs to meet their individual needs.

Our primary challenge now is to increase and improve outreach efforts and get children enrolled. We must also work to ensure that we have consistent, reliable, and timely data on the effectiveness of each CHIP plan. We look forward to continu-

ing to work with States and this Committee on implementation of this historic program, especially outreach and data collection. I thank you for holding this hearing. And I am happy to answer your questions.

RESPONSES TO QUESTIONS FROM SENATOR GRAHAM

Question 1: Substitution of Coverage: There was a great deal of concern about substitution of coverage or "crowd-out" during the development of the child health insurance program legislation. I know HCFA has issued guidance to the States that include methods to minimize crowd-out, especially for employer-sponsored health insurance options.

In a February 13, 1998, letter to State Health Officials, Sally Richardson and Dr. Claude Earl Fox wrote:

> "To discourage employers from lowering their existing contributions for dependent coverage, States only will be permitted to make subsidies available for the purchase of dependent coverage through employer-sponsored group health plans in cases where the employer contributes at least 60 percent of the cost of family coverage, which is the median employer contribution nationwide. We can consider a somewhat lower level if States have additional provisions to limit employers ability to lower contribution levels. For ease of administration, the State may establish a minimum dollar employer contribution or some other method that is equivalent to the 60 percent requirement to assure that employers continue to pay a meaningful share of the costs in these programs."

Florida recently submitted an amendment to HCFA to add employer-sponsored dependent coverage to the State's Title XXI program. State officials inform me that they have encountered some difficulty with this amendment, primarily due to the 60 percent employer contribution issue. As the HCFA letter noted, the 60 percent figure is the "median employer contribution nationwide." Florida officials tell me that this amount is much too high for my State.

Florida is a state of small businesses, large numbers of which cannot afford to offer health benefits to employees, much less their dependents. In fact, a recent study by the Employee Benefit Research Institute found that in both Miami and Tampa the uninsured rate was higher than the national average and the population had a lower rate of private health insurance coverage.

Please explain to me what steps HCFA will take to balance concerns about substitution of coverage, while minimizing barriers for States that want to expand health care coverage to uninsured children as much as possible. Also, if HCFA is going to require extensive documentation of lower rates of employer contributions as a prerequisite for authorizing SCHIP funds for employer-sponsored coverage, will this delay health care coverage for otherwise eligible children and reduce a State's ability to access its Federal allotment in a timely manner?

Answer. Our policies for balancing these concerns are outlined in a February 13, 1998 letter to State Health Officials. It defined steps States must take to prevent CHIP coverage from substituting for, or "crowding out" existing private insurance coverage. States that provide insurance coverage directly must describe how they will reduce the potential for crowd out. Since crowd out concerns increase at higher income levels, we will apply greater scrutiny to States with higher income eligibility levels. Crowd out is of most concern when States subsidize employer-sponsored insurance. Therefore, in States providing CHIP coverage through employer-sponsored plans:

- a child must not have had employer-sponsored group health coverage within the previous six months;
- a State's payment for the child enrolled in a employer-sponsored group health plan can be no greater that the payment offered by the State if the child were enrolled in a separate State program (or Medicaid, if appropriate);
- the employer must contribute at least 60 percent of the cost of family coverage;
- the family must apply for the full premium contribution offered by the employer; and
- the State will conduct an evaluation that examines the amount (if any) of substitution that has occurred under the program.

We do not believe this requirement will cause unnecessary delays in a State's ability to extend health care coverage to eligible children. The 60 percent threshold for employer contributions is based on national data on median contributions now made by employers, and is designed to prevent employers from reducing their level of contribution for dependent coverage to take advantage of CHIP subsidies. However, we will allow State flexibility in implementing this requirement in certain cases.

For example, we have provided flexibility in Mississippi where, based on data showing that employer contributions for dependent coverage tend to be lower in that part of the country, we allowed the State to use an employer contribution threshold of at least 50 percent.

We are committed to providing flexibility to States while balancing the need to ensure Federal funds are not substituting for private funds. In February 1999, we co-sponsored a meeting with the Institute for Health Policy Solutions to gather 20 States interested in incorporating employer-sponsored coverage into their CHIP programs to brainstorm and share effective practices now being implemented in Massachusetts, Wisconsin and Mississippi. In reviewing other State proposals, such as Florida's amendment, we will consider State-specific or regional data that has a bearing on the policy parameters we have set forth.

Question 2: Continuous Eligibility for Medicaid: Congress authorized continuous eligibility for Medicaid children under age 19 as part of the Balanced Budget Act of 1997. Section 1902(e) (42 U.S.C. 1396a(e)) was amended to state:

> "(12) At the option of the State, the plan may provide than an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—
>
> (A) the end of a period (not to exceed 12 months) following the determination; or
>
> (B) the time that the individual exceeds that age."

Florida Medicaid staff inform me that Florida amended its Medicaid state plan to initiate six months of continuous eligibility for children under age 19, effective July 1, 1998. HCFA approved this state plan amendment. In December 1998, Florida submitted a Medicaid state plan amendment to extend an additional six months of Medicaid coverage (for a total of 12 months) to children under age five. On March 12, 1999, HCFA's regional office in Atlanta responded to Florida's state plan amendment by stating:

> "The State cannot elect multiple 'continuous eligibility periods.' Section 1902(e) authorizes an exception to comparability, but not multiple exceptions. It specifies an upper age limit (not a lower age limit) and a continuous eligibility period of time. Once the State has elected the upper age limit, everyone must be treated comparably if under that age limit, and given the same continuous eligibility."

As you know, there is already a precedent in Medicaid law to allow States to treat Medicaid beneficiaries differently based on certain factors. For example, a State may have higher Medicaid income eligibility levels for certain beneficiaries than for others. Florida Medicaid covers pregnant women and infants under age one with family incomes up to 185 percent of the poverty level, while the income eligibility levels for older children and other adults are lower.

Please state HCFA's justification for refusing to allow a state to create differing periods of continuous eligibility for Medicaid based on a child's age. Is the Administration willing to revise its interpretation of this provision?

Answer. We recognize the important advantages of providing a period of continuous eligibility to children and want to encourage States to adopt this option. We think Florida makes a valid point, and we are seriously considering changing our policy. We appreciate your bringing this up, and we look forward to working on this proposal with you.

Question 3: Vaccines for Children: On May 11, 1998, HCFA issued policy guidance to State Health Officials concerning the Vaccines for Children (VFC) program. The letter states in part:

> "Children who are newly eligible for Medicaid under Title XXI are Federally vaccine eligible, as are all other children eligible for Medicaid. However, because of Title XIX restrictions on eligibility for VFC, States that have designed a separate State health insurance program under CHIP (S-CHIP) may not treat children enrolled in such a program as Federally vaccine eligible."

The letter gives States two options for funding immunizations, which are required under the SCHIP law. States may define the children as "state vaccine eligible" and purchase vaccine at the Federal contract price without these expenditures being subject to the 10% cap on expenditures under SCHIP, or the State may choose to contract with insurers for the provision of vaccine at private sector market prices.

HCFA's interpretation, which prevents States that have chosen a non-Medicaid approach to their SCHIP programs from accessing the VFC program, while allowing its use for Medicaid expansion states, is unfair. States have established viable, efficient processes for distributing vaccines to providers through the VFC program. HCFA's interpretation places additional administrative and financial burdens on

non-Medicaid expansion States because they are precluded from using the VFC distribution system.

Please address whether the Administration is considering a revision of HCFA's current policy interpretation, or if you believe legislative guidance is required to change this policy.

Answer. The Vaccines for Children law (Section 1928(b)(2) of the SSA) limits use of its funding to children who are uninsured or covered under Medicaid. A child enrolled in an separate State CHIP program is neither uninsured nor covered under Medicaid, and therefore does not meet requirements for coverage under the Vaccines for Children law. We believe an amendment to the statute would be necessary to make children in separate State CHIP programs eligible for vaccines under the Vaccines for Children program.

States who have separate State CHIP programs may choose to purchase vaccine under the Federal contracts and may still use the Vaccines for Children provider distribution mechanism. Oregon, Georgia, and Delaware are providing vaccine to children in separate State CHIP programs in this manner.

RESPONSES TO QUESTIONS FROM SENATOR THOMPSON

Question 1: Waiver Authority: The Balanced Budget Act of 1997 allows States desiring to participate in the S-CHIP program the option to provide health coverage for uninsured children with family incomes below 200 percent of poverty through their Medicaid programs. When the Balanced Budget Act was passed, the State of Tennessee was already out in front of other States in providing health care coverage to uninsured children through the TennCare program. In April 1997, the TennCare program was expanded to provide access to health coverage to all uninsured children who lack access to private health insurance. In January 1998, the TennCare program was expanded further to provide access to health care to any Tennessee child with a family income below 200 percent of the poverty level, and the $250 deductible was eliminated for all children below 200 percent of the poverty level.

The State of Tennessee was granted a Section 1115 waiver of Medicaid requirements for its TennCare health program. The Health Care Financing Administration (HCFA) granted that waiver (and recently renewed the waiver) after thoroughly examining the details of the TennCare program, including the cost sharing requirements for Medicaid beneficiaries, and determining that the program would deliver comprehensive health care to Tennessee's Medicaid, high risk, and uninsured populations.

Although the Balanced Budget Act of 1997 specifies that State Children's Health Insurance Programs (S-CHIP) must meet Medicaid requirements, Congress also provided HCFA with 1115 waiver authority to deal with States like Tennessee that have been granted a Section 1115 waiver for their Medicaid programs. HCFA has thus far refused to exercise that authority. Therefore, Tennessee has been unable to gain approval and funding for its TennCare expansions that are meting the goal of the S-CHIP program—providing health coverage to 50,000 low-income children.

Why is the Health Care Financing Administration (HCFA) ignoring the will of Congress by failing to exercise the waiver authority it was granted under the S-CHIP program to deal with Section 1115 waiver States such as Tennessee?

Answer. This Administration has always promoted the innovative research and demonstration programs implemented under Section 1115 of the Social Security Act. Since 1993, it approved 17 of the 19 statewide health reform demonstration waivers proposed by States. We intend to promote similar demonstrations in CHIP, but States need experience in operating these programs before submitting demonstration proposals. Thus, we have a policy that requires States to have at least one year of experience, plus an evaluation of their CHIP program, prior to our consideration of a waiver proposal.

Question 2: TennCare Program: If HCFA has determined that the TennCare program is providing adequate health care coverage for children below 100 percent of poverty by granting and renewing its Section 1115 waiver, why is the exact same coverage not adequate for children between 100 percent of poverty and 200 percent of poverty?

Answer. States that use Medicaid 1115 waivers to include "optional targeted low-income children" in a Medicaid CHIP expansion must conform to the standards set out in CHIP law for non-Medicaid expansions. The CHIP statute has specific requirements related to cost-sharing and preventing the crowding out of private coverage. These CHIP requirements are different from Medicaid statutory requirements and may well be more rigorous than under previous Medicaid waiver policy. Congress intentionally included these new standards in the statute and we believe it is not appropriate to waive them. We have approved four Section 1115 Medicaid

waivers for the CHIP program—Missouri, New Mexico, Rhode Island and Wisconsin—all of which have met all Title XXI standards.

Question 3: Two-tiered health care system: Is HCFA supporting a two-tiered health care system depending upon a child's family income level?

Answer. No. The CHIP statute specifically says States may vary cost-sharing based on family income only in a manner that does not favor children from families with higher income over children from families with lower income. HCFA is enforcing the rules of the respective CHIP and Medicaid statutes.

Question 4: Expansion of TennCare: Isn't an expansion of the TennCare program a more efficient way to provide a seamless transition for children who graduate from Medicaid eligibility to CHIP eligibility than if Tennessee had established a separate CHIP program?

Answer. Many States have chosen to expand their existing Medicaid programs, citing this expansion as the most efficient way to implement the CHIP program. States choosing a CHIP Medicaid expansion already have a benefit package in place and a delivery system that is operating. Separate State programs often require development of new infrastrucutres, systems and additional staff that require training. The CHIP statute provides States with a significant amount of latitude to design their own programs. States have a choice to create or expand a separate State program, expand Medicaid or do a combination of both. The Federal government is not recommending one approach over another. We believe that States will make choices about program design issues that best serve the needs of their unique populations.

RESPONSES TO QUESTIONS FROM SENATOR MURKOWSKI

Question 1: Co-Payments and/or a Premium: Earlier this year, Alaska implemented Denali KidCare, it's Children's Health Insurance Program, to provide health care coverage to previously uninsured children under Title XXI. Denali KidCare extends Medicaid coverage to children and pregnant women who are in families earning as much as 200 percent of the federal poverty level—about $41,000 a year for a family of four. This program will extend Medicaid coverage to 11,600 more children and 800 more pregnant women.

For most enrollees, Denali KidCare pays the total cost of covered health care services. Only enrollees who are 18 years of age and not pregnant may be asked to pay a small amount of the cost of services, or a copayment.

Children who are already covered under a health insurance plan are still eligible for Denali KidCare as long as their family income is not greater than 150 percent of the federal poverty level. There is a 12 month waiting period for children whose family income is over the 150 percent income category if the family voluntarily becomes uninsured without good cause.

It seems to me that making copayments and/or premiums a part of CHIP merits consideration. First, if you pay for something, you tend to value it more. Second, this would seem to create a disincentive for families with health insurance who plan to drop their plan so that their children will be eligible under Denali KidCare. Does HCFA feel that copayments and/or premiums, not only in Alaska, but nationwide, are warranted?

It is important to note, however, that if the statutes were changed to allow for the collection of premiums under CHIP, Alaska Native children would have to be exempted because of their Indian Health Services (IHS) beneficiary status.

Answer. States can impose cost sharing when it operates its CHIP program under a separate child health program under the statute.

As you know, the State of Alaska currently operates its CHIP program under an expansion of its current Medicaid program. The Medicaid statute, however, does not allow cost sharing for children including those children enrolled in the Medicaid program under a Title XXI expansion.

We agree with your observation that beneficiaries who pay cost sharing may value their insurance more. Cost sharing also may serve as a disincentive for families to drop their private insurance coverage because cost sharing under CHIP may be similar to their own insurance. Cost sharing may, however, serve as a barrier to a child's enrollment in CHIP or decrease a child's utilization of CHIP services. HCFA plans to work with States to track the effects of cost sharing on service utilization and beneficiary enrollment.

We are also concerned that beneficiaries who experience temporary financial hardship may risk losing insurance coverage during that time due to cost sharing requirements. Therefore, we are encouraging those States that impose cost sharing to implement disenrollment protections for beneficiaries who may be experiencing financial hardship.

Question 2: CHIP Reporting Requirements: I would appreciate being advised by you as to CHIP reporting requirements. From what you have seen, does it appear that these requirements are too burdensome on States?

Answer. CHIP data from States is essential for us to ensure that Federal funds are being spent in a manner consistent with the CHIP statute and to track increases in enrollment due to the new program. We understand that the CHIP reporting requirements are being implemented at the same time States are aggressively moving to address their Year 2000 (Y2K) systems renovation efforts. We are committed to working with States to assure that they are able to provide timely and accurate reporting of critical CHIP information.

PREPARED STATEMENT OF CINDY MANN

I appreciate the opportunity to testify before you today on the implementation of the State Children's Health Insurance Program. My name is Cindy Mann and I am a Senior Fellow at the Center on Budget and Policy Priorities. The Center is a nonpartisan, nonprofit policy organization that conducts research and analysis on a wide range of issues affecting low- and moderate-income families. We are primarily funded by foundations and receive no federal funding. My work at the Center is focused on health policy issues at both the state and the federal levels. In addition, the Center on Budget has conducted a child health coverage outreach campaign, called Start Healthy Stay Healthy, since 1994.

The following points summarize my testimony before the Committee.

CHIP IMPLEMENTATION IS VERY MUCH ON TRACK

Almost all states have responded enthusiastically to the CHIP initiative

As of December, 1998, according to data released by the Department of Health and Human Services, 43 CHIP plans were in operation. The data show, moreover, that many states have implemented or are about to implement broad-based expansions in coverage. Some 25 states plus two territories have made coverage available to children with incomes at or above 200 percent of the federal poverty level.

Additional states are moving forward with expansion plans. For example, Texas, the state with the second largest share of the nation's uninsured children, is expected to adopt legislation that would expand coverage in that state significantly, most likely up to 200 percent of the federal poverty level.

These expansions in coverage represent a remarkable step forward in terms of children's coverage. An August 1997 survey of states by the Center on Budget and Policy Priorities shows that at the time CHIP was enacted into law only seven states were providing Medicaid coverage to children up to 200 percent of the federal poverty level. An additional four states had state-funded programs that covered many, but not necessarily all, of the children up to that income level.

The preliminary data released by HHS show that CHIP is covering hundreds of thousands of children

While all of us would like to see full participation of all eligible children under the programs financed with CHIP funds, the preliminary enrollment numbers released by HHS show that the new initiative has already provided coverage to almost a million children.

Moreover, while state-by-state monthly enrollment data are not generally available, enrollment in CHIP-funded expansions appears to be growing in many states. For example, South Carolina seems to be having great success increasing its enrollment numbers. The HHS data show that as of the end of 1998, South Carolina had covered 44,000 children in its CHIP-funded Medicaid expansion; according to state administrators, as of mid-April, 1999, cumulative enrollment had jumped to 86,000.

In addition, several states began to enroll children after the close of the period covered by the data released by HHS. For example, Kansas initiated enrollment in its new program on January 1, 1999; Alaska and New Mexico began enrolling children in their CHIP-funded Medicaid expansions on March 1, 1999 and April 1, 1999, respectively; and Kentucky expects to begin enrolling children under the second phase of its CHIP expansion in early June.

The numbers reported by HHS do not include the uninsured children who were eligible for Medicaid prior to CHIP and who enroll in Medicaid as a result of efforts to promote coverage prompted by the CHIP initiative. At the time CHIP was adopted, CBO projected that close to one-half million children (460,000) who had previously been eligible for Medicaid would be identified and enrolled as a result of CHIP coverage expansions and outreach efforts.

New application systems will promote enrollment.

Participation will be enhanced to the extent that the systems used to enroll children are easy for families to manage. Studies have shown that complex applications and burdensome and unnecessary application requirements have made it difficult in the past for families to enroll their children in health coverage programs. Recent state initiatives in this area have been encouraging.

The vast majority of states have developed simple applications and streamlined application procedures that allow families to enroll their children through a mail-in process. This is particularly important if states are to reach children whose parents cannot take time off from work to enroll their child. Under old Medicaid enrollment systems, it often took several visits to the welfare office to complete the application process.

By and large, states have adopted streamlined application procedures in their Medicaid programs as well as in their separate CHIP-funded child health programs. Most states that have used their CHIP funds to expand coverage exclusively through Medicaid have developed short applications and implemented simpler application procedures. In August, 1997 the Center on Budget and Policy Priorities identified 24 states that allowed families to mail in Medicaid applications for children; as of November, 1999, eleven more states used a mail-in enrollment system and several additional states plan to adopt mail-in procedures

In addition, most but not all states that have expanded coverage wholly or in part through a separate child health program have, at the same time, improved their Medicaid enrollment procedures. In our recent survey of state practices, among those states that have separate CHIP-funded child health programs, all but two states either use a joint application for their separate child health program and for Medicaid or have plans to implement a joint application in the near future. In New York, the joint application is currently being piloted, and in Pennsylvania, the joint application design work is nearly complete.

Simplified Medicaid enrollment procedures will help states cover newly eligible children and, just as important, they will help states make progress identifying and enrolling the estimated 4.7 million children who were eligible for Medicaid prior to CHIP but who were not enrolled in the program. According to 1996 data analyzed by the Agency for Health Care Policy Research, these children accounted for more than 40 percent of all uninsured children.

Another indication that enrollment numbers are likely to climb is that states seem to be regularly reexamining their policies and procedures and making changes that will promote enrollment. For example, after a few months of experience with its first joint program application, California responded to widespread complaints that the application process was difficult for families to manage, even with assistance. A new form and revamped application procedures went into effect this month. California's enrollment has been lagging, but there is reason to believe that the new procedures will help move enrollment forward.

Communities are energized

CHIP has mobilized community-based organizations, health care providers, child care centers, schools, and many other individuals and agencies that come in regular contact with low-income children. In many states, there is a shared sense of mission that is unleashing creative, on-the-ground efforts to identify and enroll eligible children. For some particularly hard-to-reach families, the support and engagement of local coalitions and grass roots organizations is critical.

HHS guidance is helping to promote enrollment

It is rare to see states and advocates agree on how HHS has managed its role, but there seems to be general agreement that the agency has served the interests of low-income uninsured children well since implementation began. Of critical importance has been HHS's guidance advising states of their options under federal CHIP and Medicaid laws to develop simplified enrollment systems and the agency's efforts to assure that states coordinate their Medicaid and separate state program enrollment procedures.

THERE IS SOME REASON TO BE CONCERNED THAT NOTWITHSTANDING CHIP IMPLEMENTATION THE NUMBER OF UNINSURED CHILDREN MAY NOT BE DECLINING

While HHS reports that the CHIP funds covered nearly one million children over the course of the past 14 months, it is not clear that we are making headway in terms of the broader goal of lowering the number of uninsured children. Ultimately, the success of CHIP will be measured not by the number of children enrolled in CHIP-funded expansions but by whether all of the initiatives undertaken at the fed-

eral and state levels result in more children with health insurance coverage. While current national data are not available, it appears that at the same time that more children are being covered through CHIP expansions, in many states, enrollment in "regular" Medicaid is dropping. There is a strong sense among some state administrators and local groups that work with families, supported by data available in some states, that the drop in enrollment is due at least in part to welfare and Medicaid agencies not properly determining Medicaid eligibility of families that are moving in and out of the TANF system, including families that become ineligible for welfare due to the parent's employment. The TANF/Medicaid interaction problems can be solved. In March, 1999, HHS issued detailed guidance on this issue, and it does appears that more states are addressing the problem. However, continued attention to this issue at all levels will be needed if child coverage goals are to be met.

CONGRESS CAN CONTINUE TO PROMOTE CHIP COVERAGE EXPANSIONS AND ENCOURAGE HIGHER LEVELS OF PARTICIPATION AMONG ELIGIBLE CHILDREN

Congress already has demonstrated strong bipartisan support for the CHIP initiative and more broadly for the goal of lowering substantially the number of uninsured children. What else could be done to promote coverage among low-income children?

Continued bipartisan support for CHIP and related coverage initiatives sends important signals to states that are thinking about expanding coverage and conducting aggressive outreach campaigns. State legislators and administrators are particularly sensitive to any sign that the federal CHIP funds might be in jeopardy.

Continued oversight is helpful, along with the kind of attention to enrollment that is demonstrated by this hearing. States, localities, and HHS should be held accountable to show that CHIP is living up to its full potential.

State options for covering children should be broadened so that all uninsured legal immigrant children can be covered, at state option, in CHIP and in Medicaid regardless of when they arrive in the United States. These children were left out of the child health initiatives adopted as part of the Balanced Budget Act of 1997. The exclusion of coverage is inconsistent with the flexibility generally accorded states under CHIP and with the goal of assuring that all low-income children have access to health insurance.

Outreach funds should be made available to states. The provision in the 1996 welfare law that delinked Medicaid eligibility from eligibility for cash assistance also established a $500 million fund to help states cover the cost of outreach and system changes that might be needed as a result of delinking. States have been slow to draw down these funds, however, and the opportunity to do so will soon expire unless Congress takes action. At the same time, the allowable uses for these funds should be broadened so that the funds can be spent to conduct outreach for all children, not just those affected by the delinking provision. In contrast to proposals to lift the current CHIP cap on noncoverage spending, action taken to extend the life of the $500 million fund and to make it a more flexible source of funding for states would not have the effect of reducing the dollars otherwise available to states for provide coverage to uninsured low-income children.

Thank you for the opportunity to present this testimony and for your continuing support of this very important initiative.

PREPARED STATEMENT OF HON. CHARLES H. ROBB

Mr. Chairman, thank you for calling this hearing to review the implementation of the Children's Health Insurance Program. I am very concerned, along with my colleagues, about the increasing number of Americans without health insurance, and in particular, almost eleven million children without insurance.

Ensuring the health of our children must be an imperative for America. Our investment in health care for this vulnerable group not only benefits each child, but also guarantees the long-term well-being of our nation. Ultimately, the health of our children represents the strength and health of our society.

I was pleased to be part of the bipartisan efforts in the 1997 Balanced Budget Act that led to the creation of the CHIP program. I look forward to hearing reports from our New York and Ohio witnesses on their work, planning and implementing their programs. Additionally, I am interested in the initial assessments of the program from the panel and guidance that our experience to date provides for the future.

I hope that this hearing is a first step in securing health coverage for uninsured children. This committee should continue to assess the effectiveness of the CHIP program and to assure that we move expeditiously to provide this critical benefit to children.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics is pleased to submit the following statement on the implementation of the State Children's Health Insurance Program on behalf of its 55,000 members. The American Academy of Pediatrics is committed to the attainment of optimal physical, mental, and social health for all infants, children, adolescents, and young adults. Accordingly, the successful implementation of the SCHIP program is one of the Academy's highest priorities.

The State Children's Health Insurance Program is an important step forward in the financing of health care for children. Not since the enactment of Medicaid has there been a greater investment in children's health care.

The Academy's goal is to maximize the use of SCHIP funds in each state to assure that the largest possible number of uninsured children receive comprehensive quality health care. Pediatricians have worked with policy makers in every state to this end.

The Academy has been encouraged by how qUickly many states have moved to implement the programs under Title = and the fact that almost every state has now implemented a program. Furthermore, many states are now submitting modifications to their programs to cover even more uninsured children.

We are also pleased that so many states have used this opportunity to expand coverage significantly. Currently, more than half of the states provide coverage, through Medicaid or a separate state program, for children over age 1 to 200% FPL or higher. Another eight (8) states have expanded this coverage to 185% FPL. We encourage states to continue these expansions.

The SCHIP program has also led many states to place greater emphasis on outreach and enrollment. Many, but not enough, have significantly simplified the application process, developed new strategies to enroll children, and in a number of cases, adopted continuous and presumptive eligibility. The fact that almost 1 million children have been enrolled to date speaks to these efforts. Additionally, these new outreach efforts are also helping to identify uninsured children who are eligible for other publicly financed health insurance programs such as the 4.8 million uninsured children who are eligible for the Medicaid program but not enrolled. Through coordinated and sustained outreach efforts, states are beginning to reach the more than seven million children who are eligible for one of these programs.

The work, however, is by no means complete. Half of states have not acted to cover as many children as the law allows under Title =. Most states have not adopted presumptive eligibility or continuous eligibility for their Medicaid programs. Every state can continue to expand their outreach efforts and simplify enrollment processes.

The Academy has also placed a high priority on evaluation of this program. In order to measure the success of the states' implementation of CHIP programs and enrollment of eligible children, we must have complete and comparable data. This will ensure that the best practices for finding and enrolling uninsured children can be identified and then shared with all states—making every dollar count. To this end, the Academy has endorsed the "CHIP Data and Evaluation Improvement Act of 1999" (S. 206), introduced by Senators Chafee and Moynihan. We believe that this legislation is a critical step in the future of the SCHIP program and encourage the Committee to take action on this measure as soon as possible. The Academy has also developed the SCHIP Evaluation Tool, which can be used to assist states in evaluating their programs.

Ensuring that there are adequate numbers of physicians and other providers to provide care to children, is also a critical component to the success of the program. Academy chapters across the country are working with state agencies to encourage pediatrician participation in the program. However, reimbursement for pediatric

services is often lower than pediatricians' practice costs, limiting the ability of many clinicians to participate in the program. The work of ensuring that coverage translates into access must be ongoing.

Finally, it is important to remember that although Title XXI is a significant step toward the goal of ensuring that all children in the United States have health insurance, because it is incremental it does not provide universal coverage. Even if every state maximized Title XXI funding, there will still be 3.2 million uninsured children who are not eligible for Medicaid or Title XXI. As the most prosperous nation in the history of the world, we cannot rest until the most vulnerable among us, all children, have health insurance coverage and access to ongoing, quality medical care. Thank you of you for your efforts to date, and we look forward to working with you in the future to insure all of America's children.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

[SUBMITTED BY RANDOLPH D. SMOAK, JR., MD, CHAIR, AMA BOARD OF TRUSTEES]

The American Medical Association strongly supports the State Children's Health Insurance Program (SCHIP). It is urgently needed to help provide health care coverage for the nation's 11 million uninsured children.

The need for SCHIP cannot be overstated. Without it, literally millions of children would not get the minimum health care they require. The failure to prevent, diagnose and treat illnesses and conditions early in life can have devastating consequences.

The AMA is committed to working with the National Governors Association, America's Promise, Congress and the Administration to inform physicians and parents about the new state programs. One example of the many innovative outreach strategies being developed under SCHIP is a nationwide toll-free number, 877-Kids-Now (877-543-7669). This toll-free number allows parents of uninsured children anywhere the country to be connected to an Insure Kids Now Hotline in their own state.

It is unconscionable that any child in America lack coverage for basic health care. SCHIP is a giant step in the right direction.

STATEMENT OF THE COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS (CWISH)

[SUBMITTED BY JANIS DUBOW]

INTRODUCTION

The Council of Women's and Infants' Specialty Hospitals (CWISH) is a group of eight of the largest subspecialty perinatal hospitals dedicated to the delivery of high risk obstetrical and neonatal care to mothers and their infants.[1] CWISH is pleased to present its views with regard to the status of the State Children's Health Insurance Program (CHIP).

CWISH APPLAUDS ENACTMENT OF CHIP

CWISH commends this Committee and the entire Congress for its work to enact CHIP. Indeed, CWISH was actively involved in the creation of CHIP during the debate on the Balanced Budget Act of 1997 and CWISH members are dedicated to participating in the CHIP implementation process in their states.

CWISH URGES TARGETED MODIFICATIONS TO CHIP, WHICH WILL FURTHER BUTTRESS THIS IMPORTANT PROGRAM

CHIP is an important step toward the goal of meaningful health insurance for all pregnant women and infants. CWISH believes, however, that the health of the nation's children could be further improved if three targeted modifications were enacted by Congress:

- CWISH urges Congress to provide additional flexibility within the CHIP program so that states have the option of covering all income-eligible pregnant women regardless of age. CHIP now provides health insurance coverage for income-eligible pregnant teens eighteen years of age and younger.
- CWISH urges Congress to provide for automatic enrollment in CHIP of infants born to CHIP-eligible mothers. This will ensure that there are no unnecessary gaps in health insurance coverage for newborns.

- CWISH urges Congress to extend the availability and expand the range of outreach activities allowable under the $500 million in funds authorized in the 1996 Work Opportunity and Personal Responsibility Act (the welfare reform bill) such that this money could support additional outreach activities designed to enroll eligible individuals, including pregnant women, in CHIP and Medicaid. This will increase the number of pregnant women who receive prenatal care which will result in healthier babies.

CWISH URGES ADDITIONAL STATE FLEXIBILITY IN ORDER TO FURTHER PROMOTE CHILDREN'S HEALTH

CWISH is extremely pleased that Representatives Henry Hyde and Nita Lowey introduced the Safe and Healthy Motherhood Act (H.R. 3837) in the 105th Congress. This bill would allow States the flexibility to use funds under the CHIP program for coverage of uninsured low-income pregnant women over eighteen years of age who are not eligible for Medicaid. Attached is a joint letter from ten health care organizations, including the American Academy of Pediatrics, CWISH, the March of Dimes, and the National Association of Children's Hospitals, which strongly support extending states this additional flexibility.

This legislative proposal would give states flexibility—it would not impose any new mandates nor would it increase federal CHIP spending. Instead States would be provided more flexibility in creating, administering, and amending their CHIP plans. This additional flexibility would allow States to broaden their coverage to include services which are vitally important to the health of infants and children.

It is expected that Representatives Hyde and Lowey will shortly reintroduce a modified version of last year's proposal. Already, omnibus children's health bills introduced this year in both the House and the Senate include proposals to allow states the flexibility to use their CHIP dollars to cover low-income pregnant women regardless of age. In the Senate, Senator Christopher "Kit" Bond introduced S.592, "The Healthy Kids 2000 Act" on March 11. Representative JoAnn Emerson introduced a companion measure, H.R. 1085, in the House. Also in the House, Representative Diana DeGette introduced H.R. 827, "The Improved Maternal and Children's Health Coverage Act of 1999" on February 25. Among other provisions, these bills would allow states the flexibility to cover all income-eligible pregnant women under the CHIP program.

In addition, both the Healthy Kids 2000 Act and the Improved Maternal and Children's Health Coverage Act provide for automatic enrollment in the CHIP program of infants born to CHIP-eligible mothers. CWISH strongly supports this automatic enrollment provision because it would ensure that there is no unnecessary gap in health insurance coverage of these infants.

RISK-APPROPRIATE PRENATAL CARE RESULTS IN HEALTHIER INFANTS

Because access to risk-appropriate prenatal care is known to improve the outcome of pregnancy, health insurance coverage for pregnant women through CHIP will contribute to the goal of improved health for the nation's children. Access to high risk obstetrical and neonatal services is critical because studies show that premature and low-birthweight infants born in large Level III subspecialty hospitals—such as CWISH hospitals—fare better than high risk deliveries in other settings without increased cost.[2] Moreover, a healthy pregnancy and delivery bolsters the chances for a healthy childhood and can avert expensive acute and/or long-term care.

According to the March of Dimes, prenatal care—especially among poor, minority and other high-risk women—reduces the risk of low-birthweight threefold and results in lower infant mortality rates and healthier infants. The American Hospital Association reports that leading the list of barriers to this important care is inadequate or total lack of health insurance.

AMENDING THE CHIP PROGRAM TO GIVE STATES THE FLEXIBILITY TO COVER PREGNANT WOMEN WILL ALSO REMOVE THE ELIGIBILITY DISTINCTION IN THE CHIP PROGRAM UNDER WHICH THE PROGRAM MAY PROVIDE CARE TO A CHILD ONCE BORN, BUT NOT PROVIDE CARE TO THE PREGNANT MOTHER PRIOR TO BIRTH

Not only will this added CHIP flexibility improve the health of infants and children, but it is consistent with other significant federal and state health insurance initiatives. To our knowledge, CHIP is presently the only large scale federal or state health insurance program to sever the link between pregnant women and their infants in providing access to health care.

In crafting other major health insurance programs, Congress has expressly recognized the importance of health insurance coverage for pregnant women and its im-

pact upon the health of their babies. Medicaid provides perhaps the best example, because it contains several eligibility provisions designed to maintain coverage for pregnant women who would otherwise lose their eligibility. For example, if a pregnant woman would lose eligibility because of an increase in family income during pregnancy or during postpartum coverage, she does not lose her eligibility until the end of the month in which a 60-day period, beginning on the last day of pregnancy, ends. (Social Security Act Section 1902(e)(6))

The Maternal and Child Health Services block grant offers another example of Congress protecting the health of infants and children by providing, through block grants to states, preventive and primary health care services for pregnant women and infants. (42 U.S.C. §705(a))

Similarly, FEHBP (the Federal Employee Health Benefits Program, covering federal employees and their dependents), CHAMPUS (the Civilian Health and Medical Program of the Uniformed Services, which covers certain members of the uniformed services and their dependents), and the Indian Health Service (which covers members of federally recognized Indian tribes and their dependents) do not create eligibility distinctions that provide care to a child once born, but do provide care to the pregnant mother prior to birth. Indeed, coverage will also be provided to a non-Indian woman pregnant with an eligible Indian's child during the period of her pregnancy through post-partum. (42 C.F.R. §36.12(b)(2))

These programs rightly recognize the vital link between health insurance coverage for pregnant women and the health of their infants and children.

VIRTUALLY UNIVERSAL HEALTH INSURANCE COVERAGE OF PREGNANT WOMEN IS ACHIEVABLE

According to a study released May 6, 1999 by the March of Dimes, health insurance coverage could be provided to more than 95% of uninsured pregnant women if existing policies are more intensely pursued and if CHIP is amended to allow states the flexibility to cover all income-eligible uninsured pregnant women regardless of age. What an exciting possibility!

The study, entitled "The Distribution of Health Insurance Coverage Among Pregnant Women, 1990-1997," reveals that despite the booming economy and recent Medicaid expansions, the number of uninsured pregnant women has increased from 11% in 1990 to nearly 14% in 1997. Through a combination of two legislative initiatives and full-scale implementation of the current CHIP program, nearly all of the approximately 465,000 uninsured pregnant women in this country could potentially receive health insurance coverage.

The largest subset of uninsured pregnant women, which represents approximately 77%, or 358,000, of the nation's uninsured pregnant women, were eligible for Medicaid in 1997, but did not report it as a source of health insurance. More aggressive Medicaid (and CHIP) outreach through expanding the allowable uses of the $500 million in funds provided in the 1996 welfare reform bill could potentially locate and enroll these women.

Approximately 40,000 of the uninsured pregnancies in this country occur in low-income uninsured teens age 18 and younger. These pregnancies could be covered by health insurance if states choose to fully implement the CHIP program. CHIP today has the potential of reaching this group, which represents approximately 9% of the uninsured pregnant women in this country. States should continue to be encouraged to fully implement their CHIP programs.

With respect to the final 45,000 uninsured pregnant women, representing approximately 10% of the nation's uninsured pregnant women, these women could potentially receive health insurance coverage if states were allowed to enroll all income-eligible pregnant women—regardless of age—in CHIP.

CWISH SUPPORTS PROPOSALS TO EXTEND ELIGIBILITY FOR MEDICAID AND CHIP TO CERTAIN LAWFULLY PRESENT IMMIGRANT PREGNANT WOMEN

As a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, legal immigrants entering the United States after August 22, 1996 must wait five years before becoming eligible for Medicaid or CHIP. CWISH urges Congress to adopt the proposal in the President's fiscal year 2000 budget which would provide states the option to extend Medicaid and CHIP coverage to lawfully residing pregnant immigrants who entered the country after August 22, 1996. As the President's budget maintains, this coverage would help reduce the number of high-risk pregnancies and would ensure healthier children. An estimated 23,000 legal immigrant pregnant women would be insured under this proposal by fiscal year 2004 at a cost to the federal government of $105 million.

Senator Daniel Patrick Moynihan and Congressman Sander Levin have introduced legislation which includes this proposal. Their bill, "The Fairness for Legal Immigrants Act of 1999," is currently pending before this Committee. CWISH urges adoption of this legislation so that states could be provided the option to extend health insurance coverage to lawfully present immigrant pregnant women under Medicaid and CHIP.

CONCLUSION

CWISH applauds the enactment of CHIP and its implementation around the country for the benefit of the nation's 11 million uninsured children. We respectfully urge that Congress take action this year to:

- allow states additional flexibility to cover all income-eligible pregnant women, regardless of age;
- provide for automatic enrollment in CHIP for one year of newborns born to CHIP-eligible mothers, and
- expand the uses to which the welfare reform outreach funds can be used.

This will improve the health and welfare of children.

CWISH appreciates this opportunity to submit its views. For further information, please contact our Washington Counsel Karen S. Sealander or Maggie A. Mitchell of McDermott, Will & Emery (202-756-8024).

ENDNOTES

[1] Perinatal services include maternal and infant care beginning before conception and continuing through the first year of an infant's life.

[2] The Effects of Patient Volume and Level of Care at the Hospital of Birth on Neonatal Mortality, Journal of the American Medical Association, Volume 276, No. 13, October 2, 1996, p. 1054.

STATEMENT OF THE MARCH OF DIMES BIRTH DEFECTS FOUNDATION

[SUBMITTED BY DR. MARINA L. WEISS, SENIOR VICE PRESIDENT FOR PUBLIC POLICY AND GOVERNMENT AFFAIRS]

The March of Dimes Birth Defects Foundation is pleased to submit the following statement on the implementation of the State Children's Health Insurance Program (SCHIP). The March of Dimes is a national voluntary health agency founded in 1938 by President Franklin Delano Roosevelt to address public health issues. The March of Dimes has more than 3 million volunteers and 1,600 staff members with 92 chapters located in every state, the District of Columbia and Puerto Rico. A unique partnership of scientists, clinicians, parents, business leaders and other volunteers, the Foundation works to improve the health of babies by preventing birth defects and infant mortality. In order to accomplish this mission, the March of Dimes conducts and funds programs of research, community services, education and advocacy.

In keeping with the March of Dimes' mission to improve the health of America's children, we have been especially concerned about the approximately 11 million children without health insurance. Therefore, the Foundation has been deeply involved in efforts to secure health insurance for mothers, infants and children, most recently the creation of SCHIP. In 1997, the Foundation worked closely with the Administration, Members of Congress, and other national organizations to enact SCHIP. The Foundation was especially engaged in the policy and legislative deliberations relating to maternal and infant care, in particular the development of the provisions relating to coverage of preventive services (e.g. immunization, well-baby and well-child care) and access to specialty services for medically compromised children.

Since the enactment of the federal legislation authorizing SCHIP, the March of Dimes has worked with health officials and legislators in two thirds of the states on the design and implementation of individual state programs. In December 1997, the Foundation issued a report written and produced jointly with the Healthcare Leadership Council entitled *Insuring America's Children: New Opportunities for States*. The report is a snapshot of the status of state efforts to insure children at the time the program was enacted and includes information about coverage for mothers and children in each state. The report was written to assist state policymakers in developing their SCHIP programs. Today, the Foundation is conducting SCHIP outreach in all 50 states and has partnered with Kmart to promote the Insure Kids Now campaign and national toll-free hotline.

The March of Dimes is pleased with the steps states are taking to implement and expand their programs and is gratified by many of the early successes of SCHIP;

but the Foundation is concerned about the lower than anticipated enrollment in the start up years of the program. Specifically, the Foundation believes that there are areas where the program could be strengthened to open the door to better health coverage for even more infants and children, and these are outlined below.

(1) More outreach activities are needed to improve enrollment in SCHIP. Experience with the Medicaid program has shown that aggressive outreach is critical to ensure that children who are eligible receive necessary services. SCHIP outreach may be even more challenging because the targeted populations are typically higher-income citizens who have little, if any, experience participating in publicly funded programs. As you know, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 provides states $500 million through fiscal year 2000 to support state Medicaid outreach activities. The March of Dimes supports the provision in the Administration's FY 2000 budget that would allow states to use these funds for SCHIP as well as Medicaid outreach and the proposal to extend the timeframe during which states can access these funds.

(2) The March of Dimes recommends that the Committee consider modifying the eligibility requirements of SCHIP to allow states to expand maternity coverage to pregnant women over the age of 18. Lack of health insurance can be a significant barrier to prenatal care, and women who receive no prenatal care are far more likely to have low birth weight babies and babies with other costly medical complications. While most pregnant women have health insurance, gaps in coverage remain. An estimated 13.7 percent of women who gave birth in 1997 (or 465,000 women) were uninsured.[1]

Effective Medicaid outreach would improve these figures (an estimated 77 percent of uninsured pregnant women in 1997 met Medicaid income eligibility requirements), but SCHIP could also play an important role in securing vital prenatal care. Under current law, 40,000 uninsured pregnant teens could be covered if states take maximum advantage of SCHIP by making the program available to all income-eligible adolescents. In addition, 45,000 uninsured pregnant women age 19 and older could be covered if states were allowed to extend eligibility for SCHIP to pregnant women who otherwise meet the income eligibility requirements. A recently released study done by Kenneth Thorpe, Ph.D. for the Foundation found that, in conjunction, these efforts would bring the rate of insured pregnancies in the country to approximately 95 percent.[2] Therefore, the March of Dimes strongly supports allowing states to enroll all income-eligible pregnant women in SCHIP.

(3) The March of Dimes believes that consistent and comparable data is the only objective means of evaluating the effectiveness of SCHIP. Mindful of the fact that the program has been authorized for a ten year period, the March of Dimes is working in every state to encourage policymakers include meaningful evaluation provisions in state plans. More work is needed, however, to ensure that SCHIP can be properly evaluated. Examples of the types of initiatives needed include an improved national survey for health information, standardized reporting requirements for annual reports, and federal evaluation of a targeted number of SCHIP programs. To this end, the March of Dimes strongly supports the "CHIP Data and Evaluation Improvement Act of 1999" (S. 206) introduced by Senators Moynihan and Chafee, and we look forward to working with the committee to enact this legislation.

(4) The March of Dimes has a long history of supporting efforts to ensure that all pregnant women and children in the United States, including immigrants, have access to medical care. Therefore, the Foundation supports provisions in the Fairness for Legal Immigrants Act of 1999 (S. 792) introduced by Senator Moynihan, and the provisions in the Administration's FY 2000 budget that extend SCHIP and Medicaid coverage to legal immigrants who lost coverage as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

The March of Dimes would like to thank the Committee for the opportunity to submit this statement and for the support members have given the SCHIP program. As a result of the efforts of Chairman Roth, Senator Moynihan, and other members of the Finance Committee, hundreds of thousands of children are receiving the health coverage they need. We look forward to working with the Committee to further improve the program through targeted modifications.

ENDNOTES

[1] Thorpe, Kenneth. "The Distribution of Health Insurance coverage Among Pregnant Women 1990-1997," March 1999. Paper prepared for the March of Dimes.

[2] Thorpe, Kenneth. "The Distribution of Health Insurance coverage Among Pregnant Women 1990-1997," March 1999. Paper prepared for the March of Dimes.

STATEMENT OF THE NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

My name is Janet Stokes Trautwein. I am the Director of Federal Policy Analysis and State Government Affairs for the National Association of Health Underwriters. NAHU's over 15,000 members are health insurance professionals involved in the sale and service of health insurance and related products. Many of NAHU's members have served on state task forces and committees in their individual states tasked with finding the best way to implement the Children's Health Insurance Program. They have consistently reported several shortcomings of the federal CHIP legislation, which have impeded the ability of their states to fully reach the largest number of uninsured children.

Under the Balanced Budget Act, states have a number of options for implementing plans most appropriate to the needs of their uninsured children. One of those options is to expand Medicaid. The other available options are centered in the private sector. One of the reasons many of the people who are already eligible for Medicaid today do not enroll is that they do not want the negative stigma associated with public assistance. Private sector programs can represent a transition from this stigma by allowing and encouraging people to embrace the concept of "self help" as opposed to the expectation of government entitlement. As you know, this is a concept that has ramifications that extend far beyond the health insurance benefits provided by the plan. Congress wisely considered these private sector advantages and not only authorized states to develop private sector CHIP programs, but also allowed for children to be enrolled in the employer-based plans of their parents.

Unfortunately, due to some of the inflexible provisions that were also contained in the bill, many states have been unable to adequately implement the full range of options allowed by the legislation. Even though it appears that states have a range of plan benefit options, that reality is virtually eliminated by the cost-sharing limitations contained in the legislation. Cost Sharing is virtually prohibited for children in families under 150% of the poverty level, and is limited to 5% of family income above that level. Unfortunately, cost sharing is defined to extend beyond premium to include co-payments and co-insurance. A quick calculation of the maximum potential co-insurance liability of an "average" plan such as might be offered to state employees, for example, would make that plan unacceptable, because coinsurance alone would exceed the 5% maximum for many eligible participants. This requirement, along with certain mandated benefit requirements which were also included in the legislation, virtually forces states to use a benchmark plan based on Medicaid level benefits, which, we would point out, are far in excess of what the average insured child enjoys today. This means that those parents who have already made the sacrifices necessary to see that their children are insured, many of whom are at an income level which would allow CHIP participation, are not only ineligible for CHIP funding because they are "already insured," but are in essence that the plans under which their children are insured aren't good enough for the children who aren't already insured.

The other problem associated with the cost sharing requirements is that even if a state implements a plan which allows CHIP funds to be used in employer-sponsored plans, because each employer plan is different, and the family income of each eligible child is different, a separate mathematical calculation is required for EACH participant, to be sure the 5% cost-sharing limitation is met for that particular plan and participant. Even though, this may be the easiest and most cost-effective option available for children and their families and will allow families the opportunity to all be enrolled on the same employer-sponsored plan, the separate calculation requirement makes plan administration unwieldy and expensive, and for this reason it is unlikely that opportunities for participation in employer-sponsored plans, which will be aggressively pursued. This frustrating provision of the legislation is only worsened by a ruling by HCFA that employer plans where employers are paying less than 60% of the family premium are not eligible for participation in the CHIP program. Not only does this ruling by HCFA have no legislative basis, but surveys show that other than on the East Coast, very few employers pay any part of the dependent premium, much less 60%. A recent NAHU survey indicated that on average large employers pay 85.51% of the employee premium and 17.62 % of the dependent premium, and that small employers contribute 78.06% of the employee premium and 5.14% of the dependent premium, a far cry from the arbitrary 60% requirement HCFA has imposed.

This is the reason many states have chosen at least initially to expand Medicaid programs, since benefits under Medicaid are covered at virtually 100% and there is no need to consider the 5% requirement. In fact, some are charging little or no premium to participants in order to simplify administration, even though there is considerable evidence to indicate that people are much more likely to place value on

items where they have some personal stake and in which they feel pride of ownership. Many of these same states have experienced the same problems they previously encountered with Medicaid eligibles, and have not been any more successful enrolling CHIP eligibles than they were enrolling Medicaid eligibles prior to CHIP. Other states that decided to move ahead with a private sector program were still unable to truly take advantage of the flexibility which seems to have been the legislative intent, again, because of the cost-sharing restrictions, and have been forced to implement private sector plans with Medicaid like benefits.

Regarding outreach, we have watched with interest the progress of different states in reaching their uninsured children and would only add that if the experience of Washington State's Basic Health Plan and the California Health Insurance Purchasing Cooperative are any indication, many more people will be reached if licensed professional insurance agents and brokers are used to enroll children. Insurance agents and brokers meet with uninsured adults every day, and the employers of many of the parents of uninsured children. They have a perfect opportunity to reach those that need the coverage the most, and since private health insurance plans already include a marketing component in their administrative cost, this can be done with no extra cost to the program.

In summary, the effectiveness of the Children's Health Insurance Program could be increased dramatically by:

- Eliminating the cost sharing provision and allowing states to establish their own guidelines for reasonable cost-sharing;
- Advising HCFA to withdraw their letter requiring a 60% employer contribution for CHIP participation in employer plans;
- Using insurance agents and brokers to increase the effectiveness of outreach efforts.

We appreciate this opportunity to comment on the CHIP program. Should you have any questions, please feel free to call me at (703) 276-3806.

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