Testimony of

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The CHIP Program: From the States' Perspective

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Senator Hatch, Senator Rockefeller, and distinguished members of the Senate Finance Committee, Sub-Committee on Health, I am pleased to have the opportunity to speak with you today about the State Children's Health Insurance Program. My name is Lisa Dubay and I am a Research Scientist at the Johns Hopkins Bloomberg School of Public Health, as well as the Research and Policy Advisor at Georgetown University's Center for Children and Families. Prior to joining the public health school at Hopkins, I was a Principal Research Associate at the Urban Institute where I participated in the Congressionally mandated evaluation of SCHIP. Over the course of 19 years at the Urban Institute, I led other evaluations of the SCHIP program and evaluations of the Medicaid expansions for children and pregnant women. Importantly, the views that I will express today are my own.

My testimony will focus on two issues: what have been the major accomplishments of the SCHIP program; and what are the opportunities to use SCHIP reauthorization to move towards the goal of assuring that all children have health insurance coverage that provides access to high quality health care. Our children are our future and their health is critical to the nation as a whole.

Background on SCHIP

As you all know, the SCHIP program triggered a major expansion in eligibility for public health insurance coverage for children, following the important groundwork laid a decade earlier when Congress delinked Medicaid eligibility from welfare eligibility for children and set a national floor for children's eligibility for coverage under the Medicaid program. Designed to sit on the shoulders of Medicaid, SCHIP provides states with resources and incentives to cover uninsured children whose family incomes are too

high to qualify for Medicaid but too low to afford private insurance. Crafters of the SCHIP legislation, including members of this Committee, offered states the choice to use their SCHIP funds either to expand Medicaid or cover children through a separate child health program and granted states considerable flexibility to set the eligibility rules for their SCHIP programs.

Currently 18 states use their SCHIP funds to cover children in a separate program only; 11 states and the District of Columbia use their SCHIP funds only to expand Medicaid; and 22 states employ a combination approach.[1] As of July 2006, 26 states cover children up to 200 percent of the federal poverty line ($33,200 in annual earnings for a family of three), while 15 states have adopted income eligibility limits above that level and 10 have income eligibility thresholds below that level.[2] Consistent with the choices accorded states in the SCHIP law, some states apply these eligibility limits to gross income while others consider work-related expenses that reduce families' ability to afford coverage, such as taxes and child care costs. The various choices states have made reflect differences in state preferences and political inclinations, as well as differences in fiscal capacity, local economies, and family incomes. Perhaps most important to families, this flexibility allows states to account for the geographic variation in the cost of living. For example, it allows states to recognize that a family living in San Diego at 250 percent of the federal poverty line has same buying power as a family living in Houston at 154 percent of the federal poverty line.[3]

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[1] FY 2005 Annual SCHIP Enrollment Report, CMS (http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1184785).

[2] Ibid.

[3] Author's calculation based on 2006 cost of living data from ACCRA – the Council for Community and Economic Research.

SCHIP has also had an important impact on Medicaid. Mindful of Medicaid's role in covering children, Congress included key provisions in the law to assure that states with separate programs coordinated their new programs with Medicaid so no children fell through the cracks. The Congress also adopted new Medicaid options in other parts of the Balanced Budget Act of 1997 to allow states to implement continuous and presumptive eligibility for children eligible for Medicaid. These changes, along with the outreach and simplification efforts that states adopted and that carried over to Medicaid as well as SCHIP, have proved to be key components of the SCHIP success story.

The enactment of SCHIP was followed by unprecedented levels of activity aimed at reducing the rate of uninsurance among children. By 1999, every state had enacted SCHIP in one form or another, and states, as well as community organizations, schools, national foundations, and others concerned about children's health undertook efforts to inform families about the availability of coverage. The level of outreach was unprecedented, but the change in the paradigm went well beyond outreach. The focus on covering children prompted a close examination of the systems for enrolling children into public coverage programs. The new SCHIP programs were designed in ways that would promote participation, and, just as significantly in terms of the number of children affected, is that SCHIP triggered a re-examination of state Medicaid application and renewal procedures. Complex forms and unnecessary and burdensome procedures for enrolling and renewing coverage for children in Medicaid were replaced in most states by simplified and more family-friendly systems.

In many respects, SCHIP has been a model program, garnering widespread, bi-partisan support from state and federal officials, as well as the families it serves. The most consistent set of concerns affecting the program relate to its financing. In the early years of SCHIP, as states were getting their child coverage initiatives underway, significant numbers of states were unable to use the SCHIP funds made available to them under the timeframe outlined in the original SCHIP statute. Congress repeatedly had to take action to extend the life of SCHIP funds to ensure that the resources would be available in future years for states when they were needed.

More recently, however, the picture has shifted dramatically. In fiscal year 2006, nearly all states – 38 out of 50 – used more federal SCHIP matching funds than they received in their annual allotments. In total, states spent some $6.3 billion in federal matching funds in 2006 compared to the $5 billion they received in their SCHIP allotments. States addressed much of this mismatch by drawing on unspent funds from earlier years and resources reallocated from other states. But, these options are rapidly disappearing as the size of the fundamental mismatch between the need for federal funds and the amount being made newly available continues to grow rapidly.

What Have We Achieved?

According to the Center for Medicaid and Medicare, there were 6.1 million children ever enrolled in the SCHIP program in FY 2005, 4.3 million ever enrolled in the last quarter of FY 2005, and 3.9 million enrolled on the last day of FY 2005.[4,5] In addition to increases in coverage under the SCHIP program, coverage under the Medicaid

[4] Ibid.
[5] FY 2005 4th Quarter Enrollment Report (CMS)
http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS056615

program has also increased since SCHIP implementation. As can bee seen in Table 1, Medicaid participation rates increased from 74 percent in 1997 to 82 percent in 2002 for children. And participation in SCHIP increased from 48 percent to 68 percent between 1999 and 2002.

Since SCHIP was implemented, the number of children 18 years old and younger uninsured at a point in time has fallen from 10.0 in 1997 to 7.5 million in 2005 according to the National Health Insurance Survey and the percentage of all children uninsured has fallen from 13.5 percent to 9.7 percent (See Table 2 and Table 3). When you consider only children in families with incomes below 200 percent of the federal poverty level, you see large and significant reductions in both the number and the rate of uninsurance. Among low-income children the uninsurance rate declined from 22.3 percent in 1997 to 14.9 percent in 2005.

In many respects, these declines in the uninsurance rate understate the impact of the SCHIP program on public coverage as secular declines in employer-sponsored coverage due to both economic and inflationary forces would have resulted in higher rates of uninsurance were it not for the safety net of Medicaid and SCHIP for children. Because of these two programs, low-income children were protected from increases in the rate of uninsurance experienced by low-income adults between 1997 and 2005 and actually experienced reductions in uninsurance.

Who are the Uninsured Children?

Uninsured children are of all ages and races and live in all regions of the country. According to the March 2005 Current Population Survey, 68 percent of uninsured children live in families with one or more full time workers and another 9 percent live in

families with part-time workers. Moreover, their parents work in firms of all sizes. It is well known that the vast majority of uninsured children are eligible for Medicaid or SCHIP. Table 4 shows data from the National Survey of America's Families in 2002 for all uninsured children and for low-income children. Forty-nine percent of all uninsured children are eligible for Medicaid and 23 percent are eligible for SCHIP. When we focus on low-income uninsured children, you can see that 58 percent are eligible for Medicaid and 22 percent are eligible for SCHIP. Importantly, most low-income uninsured children who are not eligible for Medicaid or SCHIP are not eligible due primarily to their immigration status. Only 5 percent of low-income uninsured children are not eligible because the state they live in does not cover children with family incomes up to 200 percent of the federal poverty line.[6] Consequently, solving the problem of uninsured children is in large part an issue of increasing and maintaining rates of enrollment and retention in the Medicaid and SCHIP programs.

Why Are So Many Children Eligible but Not Enrolled?

This problem is particularly puzzling given that states have been quite successful over the past decade in increasing the rate at which eligible children participate in public programs. First, much of the explanation lies in a "good news" story. Since 1997, states have expanded eligibility for coverage, greatly increasing the size of the eligible but not enrolled population. As a result, despite the fact that states are far more successful than they used to be in enrolling eligible children, they still have significant numbers of uninsured children who are eligible for coverage. In effect, they have made their own jobs far more challenging by extending eligibility for coverage to millions more of

[6] More current data using the Current Population Survey, but not yet releasable, indicates that while the number of uninsured children has changed, the vast majority of uninsured children remain are eligible for Medicaid or SCHIP

America's uninsured children. In addition, when the economy turned down, families lost economic ground and more became eligible for public coverage.

Second, although the state response to SCHIP has been impressive and Governors from both sides of the aisle have shown a strong commitment to covering children, budgetary constraints keep some states from fully embracing or maintaining *all* of the strategies that are known to be effective in increasing children's participation. The reality is that when states enroll more eligible children, they face higher coverage costs, which may be difficult for them to afford. Particularly if they are facing economic difficulties or fierce competition for state resources, they may be reluctant to aggressively pursue the enrollment of eligible uninsured children. Indeed, in the aftermath of the last economic downturn, when faced with slow or negative revenue growth and growing numbers of families in need of coverage for their children, nearly half of all states (23 states) reinstated or adopted new procedural barriers to enrollment and retention of coverage, making it harder for eligible uninsured children to secure the coverage that they need.[7] Even when not faced with downturns, some states may be hard-pressed to absorb the coverage costs generated by successful enrollment initiatives. The issue is particularly acute with regard to Medicaid-eligible children because the federal government covers a smaller share of coverage costs for children covered by Medicaid than for children covered by SCHIP.

Third, some families continue to be unaware that they could secure coverage for their uninsured children through Medicaid or SCHIP. In many cases, these families are under the erroneous impression that you must be on welfare in order to secure health care

[7] Donna Cohen Ross et al, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2004.

coverage for your children. For example, data from the 2002 round of the National Survey of American Families indicates that for uninsured children whose parents had heard of Medicaid or SCHIP, only 56.7 percent understood that welfare receipt is not a prerequisite for enrollment in health coverage.[8] With the further passage of years since these data were collected, that percentage may well be much lower today. However, it is important to note that, when informed that they can enroll their children in Medicaid or SCHIP, the vast majority of families are eager to do so. In the NSAF, we asked low-income parents of uninsured children who had heard of the Medicaid or SCHIP programs whether they would enroll their child in these programs if told that the child was eligible. Eighty-seven percent of children had a parent who responded that that, yes, they would enroll their child if they knew they were eligible, 12.6 percent had parents who said no, and 5.7 percent had parents who were undecided. [9]

Finally, a new, but growing issue is the federal mandate included in the Deficit Reduction Act of 2005 requiring states to secure documentation of the citizenship status of citizens seeking Medicaid coverage. States are given little discretion in how they implement the requirement and some are reporting that it creates unnecessary barriers to eligible children enrolling in coverage. For example, states must require families to provide hard copies of their children's birth certificates and proof of their identities even in circumstances when the state paid the hospital bill for the birth of the child and, thus, there is no dispute that the child is a citizen.

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[8] Kenney G, J Haley, A Tebay. "Familiarity with Medicaid and SCHIP Programs grows and Interest in Enrolling Children is High." *Assessing the New Federalism, Snapshots III.* Washington, DC: The Urban Institute, July 2003.
[9] Ibid.

How Can We Get to the Finish Line?

In light of the success of SCHIP and Medicaid in covering children, as well as the shape of the remaining population of uninsured children, Congress has at its disposal several tools for moving forward.

First, a threshold issue is whether the SCHIP program will be fully funded in 2007 and beyond, allowing states to sustain and build on their successful implementation of SCHIP. The vast majority of states now find themselves facing the prospect of running out of federal SCHIP funding in the years ahead, with some 17 states slated to run short of funds as early as this year (fiscal year 2007).[10] Administration estimates suggest that these budget challenges, if left unaddressed, will translate into some 1.9 million children losing SCHIP coverage by 2016. To address this issue, federal matching funds in excess of the amount set aside for SCHIP under congressional budget rules -- $5 billion a year – will be needed. This amount falls short of what states currently spend using the dwindling supply of unspent funds from earlier years and is not slated to be indexed for health care inflation or expected growth in the number of eligible uninsured children. It also provides no room for states to experiment with further expansions of coverage or initiatives to reach eligible, uninsured children. The state and federal financial partnership behind SCHIP has been a critical component of its success and there is little doubt that children will lose coverage and the country will be unable to make further progress unless the federal government provides the funds necessary to continue playing a full role in this partnership.

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[10] Broaddus M, E Park "Freezing SCHIP Funding in SCHIP Reauthorization Would Threaten Recent Gains in Health Coverage." Washington DC: Center on Budget and Policy Priorities, July 2006.

Second, it will be vital to identify strategies for reaching the more than two-thirds of uninsured children who already are eligible for Medicaid or SCHIP. To this end, it will be important to 1) support and strengthen state interest in reaching eligible uninsured children, such as by offering performance-based assistance with coverage costs to states that successful cover more uninsured children; 2) provide families with information about their children's eligibility for coverage and assistance in applying for and retaining coverage, such as through community-based outreach efforts; 3) give states the flexibility and tools needed to reduce the paperwork burden associated with enrolling and keeping children in coverage, including, to decide the best way to ascertain a child's citizenship status.

Third, we know that one of the most effective methods for increasing participation of eligible but uninsured children is to cover their parents. As we move forward with SCHIP reauthorization it is critical to do the most that we can to ensure full participation of all eligible children. While family based coverage has coverage costs that accompany it, it is also associated a 14 percentage point increase in participation of children in health insurance programs and with greater use of preventive care visits among children. [11,12]

Fourth, states will need new tools for reaching uninsured children who are ineligible for publicly-financed coverage, including some legal immigrant children and

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[11] Dubay, Lisa and Genevieve Kenney. "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid." Health Services Research, 38 (5): Oct 2003.

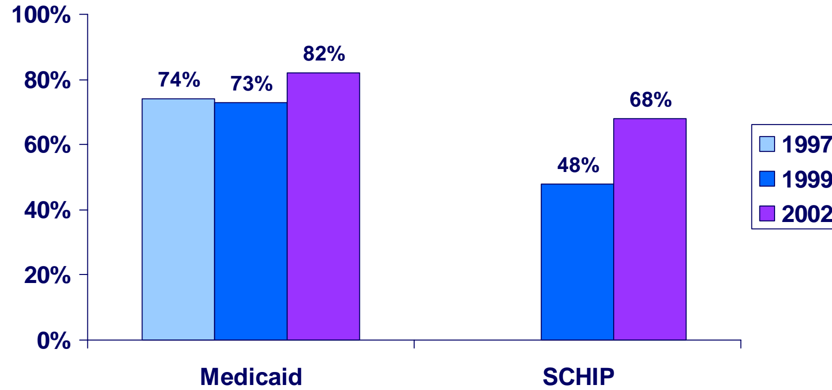
[12] Davidoff, Amy, Lisa Dubay, Genevieve Kenney, Alshedye Yemane. "The Effect of Parent's Insurance Coverage on Access to Care for Low Income Children." Inquiry, 40(3): Fall 2003.

children in somewhat more moderate-income families who nevertheless are unable to afford coverage.

Conclusion

With the 10-year anniversary of SCHIP creation rapidly approaching, we are at a crossroads in children's coverage and the evidence is clear: This program and its partner, Medicaid, have together worked to significantly lower the number and percent of uninsured children. We should fully fund the SCHIP program to continue this progress and move forward in finding ways to ensure that all uninsured children secure coverage that assures high quality access to care.

Table 1
Medicaid and SCHIP Participation 1997, 1999, 2002



Source: 1997,1999,2002 National Survey of America's Families

Note: Excludes children with private coverage and defined for citizen children ages 0 to 17.

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Table 2
Uninsured Children in 1997 and 2005

	1997	2005
Number of Uninsured Children	10.0 million	7.5 million
Percentage of All Children Uninsured	13.5%	9.7%
Percentage of Low Income Uninsured	22.3%	14.9%

Source: Authors tabulations of 1997 and 2005 National Health Interview Survey

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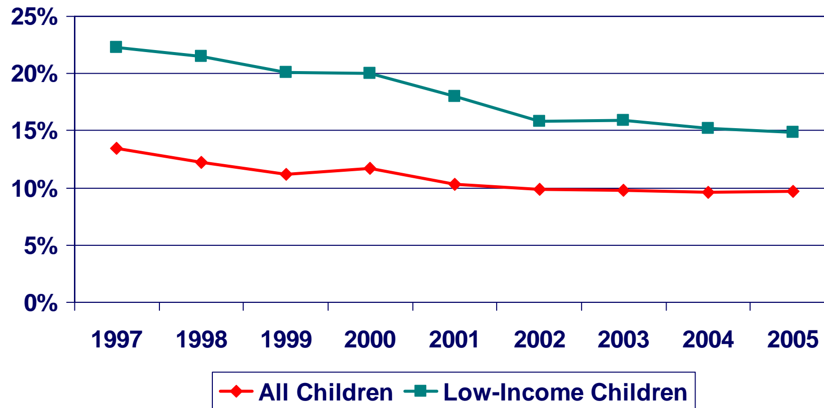
Table 3
Trends in the Percentage of Uninsured Children 1997 – 2005, All Children and Low-Income Children



Source: Authors tabulations of 1997-2005 National Health Interview Survey.

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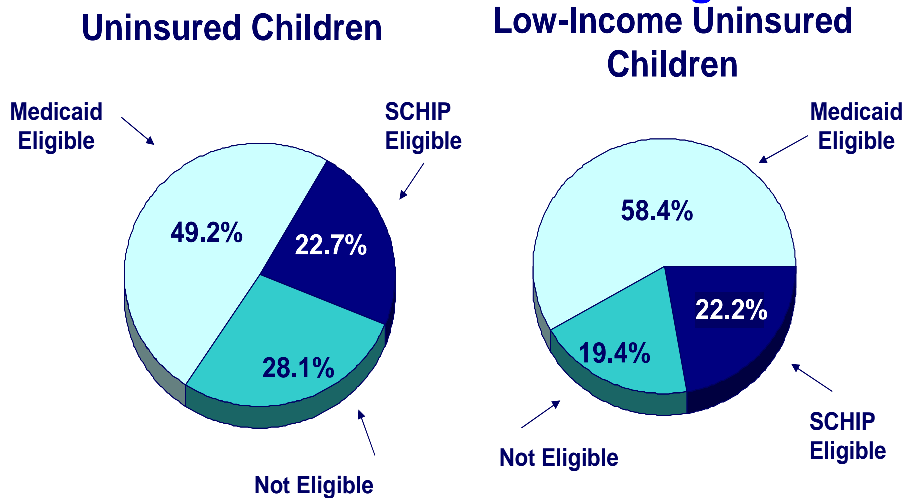
Table 4
Most Uninsured Children are Eligible for Public Insurance Coverage



Source: 2002 National Survey of America's Families using July 2002 eligibility rules.

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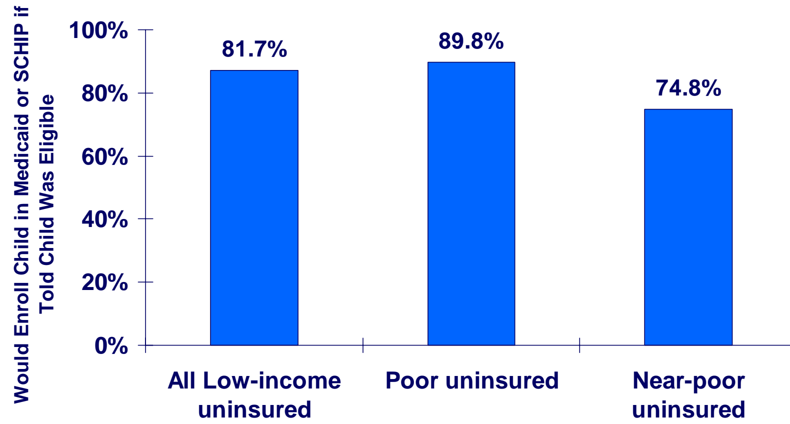
Table 5
Interest in Enrolling in Medicaid and SCHIP is High, 2002



Source: Kenney, Haley and Tebay (2003)

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