

**SCHIP and BEYOND: Improving Health Care
Coverage and Quality for Children
Commonwealth Fund and Alliance for Health Reform
March 12, 2007**

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ED HOWARD: Good afternoon. I'm Ed Howard with the Alliance for Health Reform, if I can say it, excuse me. And on behalf of the Alliance; our chairman, Jay Rockefeller; our co-chair, Susan Collins; and the other members of our board want to welcome you to a briefing on the health policy topic that gets more attention than any other this spring, I guess, and that is getting affordable, high-quality health insurance to low-income children. Now, our partner today in this briefing is the Commonwealth Fund, which has a longstanding interest in this subject. You'll hear from Ann Gothier from the fund in just a moment.

Today we're going to look at both whether young Americans have health coverage and also what kind of health care that that coverage gets them. And I suppose that subsidiary topic would be how their actual health is affected, which of course is the ultimate goal. Not only do we have an outstanding panel of speakers to help us examine the topic, we have the assistance of the March/April issue of *Health Affairs* which, if you have not picked up a copy, you ought to. It focuses specifically on children's health and its many aspects and we want to thank *Health Affairs* and John Iglehart [misspelled?] and his staff and the folks who

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supported that issue for making copies of this issue available to everyone here today.

I mentioned that the Commonwealth Fund is co-sponsoring this event and representing the Fund today and sharing moderator duties is the senior policy director of the Funds Commission on High Performance Health System, Ann Gothier. Ann.

ANN GOTHIER: Thanks, Ed. Welcome, everyone. We are delighted to co-sponsor this briefing today and I'm personally to co-moderate with the master. But I've been given the job of quickly setting the stage for those of you who may not yet be as familiar with this program and if you aren't yet you certainly will because this is what you'll be dealing with quite a bit this year.

The SCHIP program was born 10 years ago. Hence, it's time for renewal this year. It was adopted as part of the Balance Budget Act of 1997 to provide health insurance coverage to low income children up to age nineteen under 200-percent of the federal poverty level. But for states that had already been covering kids up to that age group, up to that poverty level, they were allowed to expand up to 50 percentage points higher than their Medicaid eligibility. States may develop their SCHIP programs in three basic ways. They could develop back then, they could make choices. In a

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moment, I'll show you a picture of how that happened, but they could either expand their Medicaid program or they could develop alternative standalone programs, or they could create a program that was a combination of both Medicaid and SCHIP.

SCHIP is financed by both the federal and state governments. Currently, about 70-percent of the dollars come from the federal government and 30-percent from the states and it's administered by the states. Within federal guidelines, states have a great deal of flexibility. They can determine specific program design, eligibility categories, benefits, provider payments and a variety of operating and administrative procedures. There was a strong incentive for states to take up the federal government on this opportunity. States receive an enhanced federal matching rate that exceeds their Medicaid match by about 30-percent, with the federal share capped at 85-percent.

Just two quick pictures. You see that states did take a variety of approaches. Remember that the three options they had was really a compromise between those who wanted this program to be an entitlement and those who wanted it to be a block grant with a cap. So in 2006, we have 11 states in the District of Columbia that have Medicaid-based SCHIP programs. We have 18 that have separate programs and 21 states have a combination of the two to form what my

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friend Alan Wiles [misspelled?] said recently, "Quite the patchwork quilt."

There's just as much variation, but perhaps a little bit less in terms of the income eligibility levels for the children's separate programs and you seen in 2006 we had 28 states that were at 200-percent of the federal poverty level, we have eight that where the eligibility is lower and we have 15 where the eligibility is higher. We're going to cover a variety of the critical issues today that you'll be facing in terms of the reauthorization and we'll start first with the financing of the SCHIP program by turning to Jeannene. Should I kick it back to you, Ed, first? Or should we go on? Are we ready?

ED HOWARD: I think our panel is distinguished enough that we ought to say a couple of words about the panel. Obviously, we're not going to do them justice. We refer you to the material, the biographical material, in the kits for further information. But Jeannene Lambrew is indeed our first speaker. She's an associate professor at George Washington and a senior fellow at the Center for American Progress and has held senior positions at OMB and the White House. She's also the author of the *Excellent Issue Brief* about SCHIP in your packets that was prepared for January's

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retreat for members of Congress that was sponsored by the Alliance and Commonwealth.

Then we're going to hear from Nina Owcharenko, who's a senior health care policy analyst for the Heritage Foundation. There are two of her monographs about today's topic in your materials. Nina served on Hillstaffs for three different members of Congress over the course of a decade.

Sara Rosenbaum will follow Nina. She's chair of George Washington's Department of Health Policy and a Hirsh professor. She's an attorney by training, author of more articles and studies on health law and policy than most of us have ever read. And Debbie Chang will [inaudible 6:56] clean up. She's senior vice president and executive director of Nemours Health and Prevention Services in Delaware. She actually ran the Medicaid and SCHIP programs in Maryland for a while. She led the initial implementation of SCHIP nationally and spent a number of years right here in the Senate as a senior legislative staffer. So we're very pleased to have a distinguished group to help us through this broad list of issues. And as Ann said, we're going to start with Jeannene Lambrew. Jeannene.

JEANNE LAMBREW, Ph.D.: Thank you, Ed. And thank you all for coming. We're actually going to try to in this panel really dig deep into several of the major issues that are

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likely to be confronted this year in Congress. And probably, the most immediate issue and potentially the one that we'll be dealing with in the most difficult ways is financing. What I'm going to try to do in 10 minutes is really cover three big areas of financing for the State Children's Health Insurance Program.

The state allocation, meaning how much each state gets from a fixed amount that's in legislation. Second is talk about that actual amount that will be contemplated to put into legislation because that federal amount per cap matters. And they're at the state share of SCHIP funding because how much states have to pay determines how much they're willing to expand coverage.

But to start with, basically the way that SCHIP works today is that there's a number in law and that number for this year is \$5 billion dollars and it gets divided up across all states and the territories. The current formula divides up that money in an initial allocation based on two different factors. One is called the "State Cost Factor," the other is called "The Number of Children." The State Cost Factor is nothing much more than a wage index to account for geographic differences and prices, whereas The Number of Children is composed of both the number of low income, uninsured children in a state, as well as the overall number of low income

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children in a state. So the money is allocated across states using these very simple factors.

A state has actually three years to use that allocation and if it doesn't use that funding, it reverts to be reallocated to states that need it. So they keep that money for three years and then as we distribute it what are called "shortfall states," states that don't have enough money to cover their current needs. Pretty simple, straightforward approach to how we allocate this money.

What the problems have been in this past 10-year period, first of all some conceptual problems. What we've see in some states that have been very successful expanding coverage is that they've actually reduced the proportion of low-income, uninsured kids. So the more you expand, the less need you have for the less money you get, so greater problems you have. So there's some conceptual flaws in the program, as well as this issue of taking away money to states you give it to. So say that we give the funding to a state, it spends a year or two trying to spend it, it doesn't spend it. Is that money that state's money or should it be reallocated to other states for low-income children who need it? These are conceptual issues that have come in the past 10 years.

We've also some measurement issues. I won't get into this in detail now, but the data source has some issues with

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it. The current population survey doesn't have a lot of sample in certain states. There are time lags with the data and there are also kind of questions of what is a shortfall state. These are all kind of formula allocation issues that we've experienced in the past 10 years. How do we know we've experienced them? Well, if you look at this chart, what it's showing you in the green bars is states actual spend - excuse me, the percent of the state's spending as their allotment. So a state that got exactly enough money will get 100-percent and we only see that about nine states had, within plus or minus 10-percent, enough money in its allotment for its needs.

Basically, you had either too much allotment or too little and we see that we've not done a good job of spreading that money across the states. So in the next couple months, we're going to see a lot of options for new ways of allocating this money. Some would focus on this initial allocation. Maybe we actually blend in actual enrollment experience in these states into how much the money the state gets. We could base some of that funding on historical spending. Why not for a state that's been successful give them some sort of percent allocation that's based on their success. Or maybe we should be looking at new data sources,

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either state-based data sources or improving our federal data sources so we can do a better job at targeting that money.

Another set of ideas we say, "Okay, well, maybe we can't necessarily get it right the first time, let's work on that redistribution. Let's shorten the amount of time that a state can spend this money going from maybe three years to one year as the administration would recommend. Some people are considering two years in legislation. Maybe we do rules and who gets that money when it gets redistributed." I really can't say that word and I apologize for that. Redistributed? I'm not sure how to say that. But anyway, there might be rules about you get that money to states to really try to say, "How do you make a more perfect block grant?" which is what these types of ideas do.

But obviously, allocation issues matter to the extent that there's enough money in the system. This chart is talking about the federal money, because SCHIP is a cap program. There's a number written into law, this is how much we're going to spend. And what that red line on this chart is showing you how much was written into law. It was about \$4.2 billion dollars for the first two years of the program. It went down due to budget constraints and in two thousand seven it's about \$5 billion dollars. But with no changes this year, the Congressional Budget Office assumes it will

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continue at that dotted line of about \$5 billion dollars a year.

The problem is that program costs are growing, both the number of children eligible for the program, enrolled in the program. Health care costs growth, medical intensity. All these things continue to march up over time. So what you seen in that orangish part is what is the amount of federal funding that would be needed to maintain the current programs that we have today. And if you add that all up, it's about \$13.4 billion dollars over the next five years, not counting two important things. 2007, where we have some shortfalls. We're about short \$700 million dollars, according to CVO, in 2007. And there's also kind of some Medicaid interactions that are not counted in this chart.

So we basically have a problem in terms of our federal funding cap. Even if though we were able to get that kind of wish that I just showed you in that chart. There this other kind of issue out there which is there's a lot of children who are eligible but not enrolled in the programs. We know that SCHIP covers about four million kids at a point in time anywhere from six to seven million at any point during the year.

A significant percentage and number of children are eligible, but unenrolled. And that ranges from about two to

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three million for SCHIP to three to four million for Medicaid. And if we were to try to, on top of that wage I just showed you, cover some of those eligible but uninsured kids, some rules of thumb are it could cost about \$8 billion dollars over five years to cover a couple of million kids in SCHIP, another \$12 billion dollars to cover a couple million kids in Medicaid. So we really do have, on top of numbers I just showed you, this other issue, which is how do we get funding for those kids who are not covered today?

What this chart shows is taking kind of that base line of about \$8 billion dollars to cover two million SCHIP in overlays to say if there were no federal funding limit in SCHIP today, roughly this is what the program would cost from a federal perspective, about \$50 billion dollars over five years, not counting Medicaid. It's important to recognize that any time we do outreach, we get children in Medicaid and this chart doesn't show this. So if we had no cap this is what the program would look like.

So now we have to figure out what is the cap we put into law. There are three basic options for what we could do. One is we put a high cap in. We put a number in here and where you can see in this red bar is a pretty high bar beginning at about \$10 billion dollars and going up to about \$14 billion dollars a year. Why put in a high bar? Well,

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remember that reallocation and allocation formula issue I was talking about earlier? If we're not good at getting money from the federal government to the right states, we have to build in a cushion, otherwise states are not going to have enough money to get all these eligible, unenrolled kids, as well as the kids in the base line.

This does put less pressure on your allocation formula, but it does have the political downside of a pretty high bar right there. Option two is that you basically try to put the dollars that are in legislation as close to what you think you need as possible. That kind of is good fiscal policy because you're trying to put in only the allocation here begins at about \$8 billion and goes to about \$12 billion dollars on that red line. The challenge is you have to do a very good job of getting that federal amount to the states that need it. This is no easy task. If you looked at that earlier chart where we show where state spending is, it really does vary. It's not going to be easy to define a formula that would get there. We need lots of allocation rules associated with it, but it has a top line this close to what we need.

And the last thing that Congress could do is kind of set a low bar, set a low cap. In this case, that red line, which is the federal allotment, begins at about \$7 and a half

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billion and goes up to about \$10 billion dollars. And again, its call the "low bar," but that's in 2012, twice the level we have today. The challenge is we're either leaving children who are eligible unenrolled out of the system because there's not enough money to get all those children. Or you could do proposals like we saw in the bipartisan Healthy Kids Acts, that tries to get at enrollment adjustment. So we come in after the fact to try to compensate states. Your performance bonuses are other means to kind of fill in that gap. We can talk about this a little bit more in the details. But it is going to be a challenge to figure out how we allocate – or figure out what federal dollars to put into law.

Now there's a third financing issue that we have to face because let's say we figured out how to allocate the money and figured out what to put in federal law. We also encourage states to spend money, because if we got a high federal allotment, some states would not or could not spend that money. So there are some options that Congress could consider. It could increase the federal share of spending if states do certain things like continuous eligibility or meet performance targets. It could blend the Medicaid SCHIP matching rate so over time, they're the same. So there's also different options that could be considered to encourage states to spend irrespective of the federal dollars.

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But I want to close by saying that I've been talking a lot about numbers and a lot about federal costs, I do think we should remember that when we're looking at all these numbers we are just looking at one fraction of the costs that are out there. Whenever we increase federal costs we're decreasing family costs in the form of reducing waiting lists that have proven to be problems for families. We're helping businesses because sick children typically grow into be sicker or poorer workers as adults. And lastly, we have a societal cost because we know that children who are uninsured don't use the right and appropriate care the potential they're not learning to their potential and we know that it hurts their child development, as we'll hear from our other speakers later. Thank you very much.

ED HOWARD: Nina.

NINA OWCHARENKO: Thank you for having me. I'm going to kind of take a broader vision of Children's Health Insurance beyond SCHIP itself and talk about health care coverage for children overall. First of all, I certainly agree that uninsured children versus children with coverage there's a big distinction and while uninsured children are still the smallest portion of the uninsured, except for those 65 and older - they're the smallest portion of the uninsured, it's still a very important issue for Congress to address and for policymakers to look at because the implication, as Jeanne already pointed out, are drastic.

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The uninsured children in particular tend to get care at a very inefficient and costly manner, and I think that's important for all policymakers to remember that this is not something that we should be encouraging that children don't have health care coverage as they're in society. And as was pointed out also, we see some access issues that reflect this. We know already that 25-percent of children have no usual place of care compared to children with coverage, that's public or private coverage. And I think that's very important to stress that these are children that really don't have a medical home or a place to go when they get sick, that's why we see an increasing number of uninsured in the emergency rooms, overcrowding and crowding out services that really need to be taking place in the emergency rooms.

The second is actually something from a conservative perspective that I like to stress which is there is a cost to taxpayers. Sometimes people say, "Well, we really shouldn't worry about the uninsured. They're getting care. It's not the greatest but there aren't people dying in the streets of America and they're getting care in some form or fashion." But I would say it's a very important issue because the cost to providing that care in an inefficient system is costing taxpayers at the end of the day and as taxpayers we certainly should be concerned about people that don't have health care coverage. And there are some estimates back in two thousand and four that had about \$34 billion dollars in federal,

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state and local funding that was spent on uncompensated care for the uninsured as a whole. I think that's important to stress and a reason why policymakers should come together at looking at options for providing coverage to children.

I now want to talk a little bit about, what's the interaction between public coverage and private coverage for children? I think this is an important place in particular in discussing SCHIP, which tends to focus on working low-income families. So these are not the poorest of the poor. These aren't children below 100-percent of poverty who have no other options. These are children in families who usually have a working parent or predominantly have a working parent involved, et cetera. So what is this interaction of public coverage and private coverage? We hear a lot about children being eligible for public coverage but not enrolled. But the flip side of that is also, well, why are they not enrolled? What are the other options out there? What are the effects of it continuing to expand and enroll children in the public programs? What's that impact on private market itself?

And we know that there was a recent re-analysis that was done on the crowd-out phenomenon where, what is the crowd-out effect of expanding public programs in the private market and in dealing with the uninsured? And they did recognize, Jonathan Gruper and his colleague did state that there was a tremendous crowd-out effect, somewhere around 60-percent crowd-out effect of public program

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expansions since SCHIP. And I think that's important to note as well as that the implications are stronger when you look at the entire family and that's what really we're talking about as well. It's not kids as individuals, but we want to look at the interaction of public coverage for the child and the interaction of that with private coverage for the family.

So in saying that, I want to talk a little bit about private sector and kind of quality of care that children can get in the private sector. There's a lot talk about, "Well, SCHIP, if it's for children, that must be the only vehicle there is for children to get health insurance." And I would argue that there is a private market that is working that children can participate in and probably could get coverage in as well if we look to broader than just looking at building on SCHIP in its current form. The private sector still does today provide better access to care than it does for those in public coverage and certainly better than those that are uninsured, I think that's important to note. And it's also important to note that public programs tend to sometimes promise more than they can deliver. We do know that now today doctors are seeing fewer – pediatric doctors and Medicaid are seeing fewer Medicaid patients than they did in previous years. That should be an issue of concern for children. How do you get access? You qualify for coverage, it says you have coverage, but who's going to see you? Who's actually going to

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provide that coverage to you? I think that's an important issue to think about.

There are quality initiatives. Some of the discussion we're talking today is about quality of care and what kind of quality initiatives are out there. I want to touch on a couple in the private sector, actually, that are going on that are existing today because the private sector itself through markets and through consumer demand can actually improve access and quality as well to children. Employer-based coverage is probably the number one area that people think about the most when they think about private health insurance and how do we get health care coverage. Still, the majority of Americans, well over 60-percent, get their health insurance through the place of work. So it's interesting to take a look and see what's going in the employer-based market that's focused on improving quality for care for children as well as their families, and I'm going to touch on a couple.

First of all, the Leap Frog initiative is something that's been under way for a long time. It's purchasers for health insurance kind of joining together and starting to create, encourage and reward providers for increasing quality. They have a big hospital rating system that they do. This is valuable information and actually people who are purchasing the products in the private market joining together and trying to say, "How can we make health care better

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quality and better for the consumers and better for the people we're purchasing the coverage for?" So I think that's an important piece.

Bridges to Excellence is another type of quality initiative that was underway. It's a coalition of purchasers as well as physicians. Other folks in the health care industry and the health care sectors teaming together to say, "How do we move forward on improving quality of care that's involved in the health care system?" And finally, what we have seen most recently is the administration's initiative at HHS called "Values Driven Health Care Initiatives." It's based in the four cornerstones of policy issues for the private sector. It's not a mandate. It's simply how do we look and encourage the private markets and encourage the private sector to help with improving the quality of care that is delivered in our system? It talks about establishing health records, medical health records. Something that would be very important for children, especially if they're in and out of health care systems.

It gives them one place to have their information held over their lifetime, which, I think there is great value in that. Measuring, publishing actually quality data. That's a very interesting piece and a very important piece, especially when you team it up with the third piece, which talks about reporting quality and price and on pricing information. Teaming quality and price is probably the most dramatic tool that consumers have, parents will have for their children, in deciding how best to get care and

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services. It's not just who's the lowest price, "Let's see how low we can make a physician take a payment." But the idea is, how do we increase the quality too? We see this in the other area of the market where when you have competition you have increased consumer demand for better quality and those are the things we should want to demand out of the health care system.

And then the final thing that within the values-driven health care is creating positive incentives for the consumers themselves, rewarding good behavior. If you take your child to get their immunization shots, what can the private sector do and what are private models we can look at to reward that type of behavior?

Those are some of these four cornerstones, I believe, are things that can also help within the public program. So they're not exclusive to the private sector, but there's a great deal of information and a great deal of momentum in the private sector that can be reviewed and used in the public programs as well. So it's not exclusive, so there are a lot of good lessons in there.

Non-employer-based coverage. There is still a small portion, there is still a very small amount of people and families buying coverage on their own, meaning outside the place of work but buying private health insurance. But there has been some analysis done on, "Well, what are they buying? Is it really health care coverage?" We hear a lot about, "Well, gosh, they're a high deductible plans. You don't have access to anything who's actually going to use them."

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Actually, you find that it's a broad cross section of people. They have PPOs, people are purchasing HMOs. There are a variety of choices that are out there and consumers themselves look at the idea of what's price and the quality that's going to be provided that help them decide what to choose.

I point out that some of the survey by America's Health Insurance Plan found that actually of the HMOs that people purchased, 100-percent of them covered well baby care. That's important information to know, I think. When you think about what are people buying, they're not buying the complete stripped package of nothing there, no coverage at all. These are policies that include preventative medicine as well, and I think that's important to stress.

So where does this put us in the whole debate on SCHIP coverage and what to do next? My stress is that there's a way maybe to find ways of coordinating public and private coverage together to make it more useful for the consumers themselves, more useful for children. How do we look at expanding options for these families? So it's not, "Either you put your child in SCHIP and I remain uninsured or I'll join an employer-based policy, but leave my kid in SCIP." How do you integrate these two models to make it work more seamlessly?

And I think ideas such as expanding on the premium assistance models that some of the states have use in SCHIP. Expanding it,

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which allows the families to take a subsidy from SCHIP and help pay for the private coverage that they purchase. Currently, it's really defying just as the premium. I would go further and say that those funds should be able to be set aside for the child to be used for not only the premiums, but any cost share requirements. So, let's say you do have an employer-based policy, what's the problem? Well, maybe the cost sharing is too much, maybe the deductible is too much. If you take the subsidy from the SCHIP program that may help alleviate some of those holes that may exist in the current system. So I think that there's a lot of opportunity to expand the relationship between the existing SCHIP program as well as the private coverage options that some families may prefer to use.

ED HOWARD: Thank you, Nina. Sara, I would like to hear your views on this.

SARA ROSENBAUM, J.D.: Thank you. My task on this panel is actually to talk to you a little bit about the issue that lies just below the surface of what Jeanne covered and, to some degree, what Nina covered, which is the design of the program itself. What kinds of benefits, what kinds of services do children receive under SCHIP and how the SCHIP benefit design relates to the Medicaid benefit design, which is essentially encapsulated in a benefit known as Early Imperiodic Screening Diagnostic AND Treatment Services, EPSDT.

I've started with the floor, Medicaid. If you think about the relationship between Medicaid and SCHIP, Medicaid is the floor. It

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covers this, of course, slide being shown you. The great majority of low-income children who get direct government public finance through federal programs. EPSDT is a mandatory benefit. It's required for all categorically needy children, for medically needy children. EPSDT is actually an option dating back to the early 1980s. This requirement of getting the full EPSDT benefit to children, actually all individuals if they're covered up to the age of 21 in states, does not change as a result of the Deficit Reduction Act, but I'm going to come back to that. If you look at the cost of the EPSDT benefit itself, it is actually a rather limited cost, which is very important when we get to the next slide on the difference between Medicaid benefit design and SCHIP benefit design.

EPSDT benefits are actually Medicaid benefits for children, this is from some work that Ann and I did for the Commonwealth Fund a couple of years ago, comes in at about \$1,300 dollars compared to – you can see, of course, the costs are understandably much higher for people who have serious disabilities or who are frail and elderly. Children make up a minority of the high-cost users on Medicaid services. This I believe is actually from some work that Jeanne did earlier. But they are a significant proportion. There are a significant number of children who depend on public finance, who have very advanced health care needs and they make up about one in five of all children who are considered high cost to state Medicaid programs.

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Some interesting work coming out of a series of studies of children who get Medicaid and children who get their subsidies through SCHIP programs, whether they're administered as Medicaid expansions or as separate programs, suggested there really is no difference in terms of the health status of children who are financed through SCHIP as opposed to children who are financed through Medicaid. They are all predominantly children who are low income. Low-income children, of course, are more likely to have serious and significant health problems. This is our attempt to get onto one slide something that actually typically involves much more writing, which is a sense of the differences and similarities between and SCHIP.

The assumption on the SCHIP column is that we're talking about states that are administering their benefits as a separate program. If a states uses its SCHIP funds to expand Medicaid, which many states do in whole or in part, they are essentially providing what is known as EPSDT of their children. If they choose, in whole or in part, to set up a separate program, they are providing a SCHIP benefit. The SCHIP in a separately administered state looks much more like what Nina was describing. That is, it's premium support into a private plan. States that are running separate SCHIP programs run their programs almost entirely by purchasing coverage. They purchase coverage in the equivalent in an individual market for children it doesn't necessarily get regulated as an individual

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insurance market, but they're buying private enrollment by and large into pediatric benefit plans.

And SCHIP is designed, when separately administered, to allow states to buy the equivalent of what would be a standard commercial product offering. That is the meaning of the benchmark. And so instead of EPSDT's emphasis on developmental early intervention for children who have risks for long-term health and developmental delays, what you see is a standard well child benefit: vision, dental and hearing care are optional the way they are in the commercial market. The benefit design is tied to actuarial estimates with very, very limited requirements. Really, none of the defined benefit requirements one finds in Medicaid. Insurers are free to design a medical necessity standard and can, in fact, be more limiting than the kind of medical necessity standard used in Medicaid, which is an early ameliorative standard meant to ameliorate the affects of developmental conditions.

Cost sharing in the old days of Medicaid was prohibited entirely. Now it's allowed to some degree. It, of course, in SCHIP, when separately administered, it's permitted to some degree. The important shift in policy which I want to draw your attention to is the DRA. The DRA essentially creates a third way and the effect of this third way is really only beginning to be understood in states, because states are only beginning to think about using DRA flexibility. What DRA essentially did was to import the benchmark

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language from SCHIP into Medicaid for low-income children. However, the DRA also specifies that all EPSDT benefits remain a required feature of the program. Of course, the DRA also brought in states options around cost sharing.

So in an article I actually did with Paul Wise for this issue of *Health Affairs*, what we have started to think about is the interactive effect of the DRA, EPSDT and the SCHIP benchmark. Essentially, where the DRA begins to move us is toward something that might be thought of as a tiered benefit for children. That is a standard commercial offering supplemented by the kinds of expanded services and benefits that one typically would get through EPSDT. Most of the children who need all of the EPSDT interventions are children with significant mental and developmental and physical health problems. Exactly the children, actually, from Senator Grassley helped with his expanded eligibility rule for children with private insurance but who have serious disabilities. That was also part of the DRA.

We actually have identified several issues that we think are the big issues in this SCHIP Medicaid action in the coming years which will see states maybe rethinking how they align their child health financing to both emphasize where they want to market intervention, which actually just builds on what states in managed care already under Medicaid, supplemented by a tiered benefit for children with serious health conditions. That would mean reframing the benefit as

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a benchmark plus a supplement, thinking hard about the role of the developmental assessment, which is absolutely crucial to EPSDT and would be part of a standard benefit plan for a child potentially, even in the commercial market.

How to integrate the EPSDT medical necessity standard into commercial offerings, once part of the benchmark, what's extra. And finally creating what we call a developmental utilization management technique as well as quality performance measures to make sure that benefit design, however it's structured, is adequate for both healthy children and those with special needs.

ED HOWARD: Thanks, Sara. We'll get you a pointer, Debbie, and then we'll be off to the races.

DEBBIE CHANG, M.P.H.: What I'm going to do is really cover two areas. The first is that I'm going to talk about the fact that we need a system to really measure the quality of care. By that, I really mean the performance of our child health system and its impact on children. It really should answer the question, "Are children getting what they need in terms of their overall health and development so they can reach optimal health and development."

The second thing I want to talk about is the type of child health system they need, because our kids need more than just an insurance card, more than just coverage. They really need a system that responds to their needs. So I'm really going to talk about the need for prevention oriented child health system. So I'm first going

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to talk about quality and data under SCHIP and I want to make the point here that what I'm saying applies to our whole system, it's not just public coverage or private coverage for children. It really applies to our whole system. We don't have a system for really measuring the performance of our health care system. So SCHIP in this sense is really an example of the successes and challenges. In terms of successes, if you look at general satisfaction on the left-hand side, surveys show that parents are generally satisfied with SCHIP and also we know that attention has been focused on monitoring and tracking enrollment data.

In addition, there's a voluntary system that CMS has that requests states to report on four performance measures. Two are related as you see on the chart to well child visit, the third is the use of appropriate asthma medication and the last is access to primary care practitioners. And again, this a voluntary system on four measures. There's also data, and it's in your packet that shows that it's a survey done by Vern Smith, that shows that the vast majority of states are engaged in some type of performance measurement, because just as the federal government cares about accountability, states care about accountability as well.

Now some of the challenges are with this voluntary system, most state report at least on one child measure, but no single measure was reported by all states and there was a wide variation reporting methodology. In addition, if you really want to look at the

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performance of the system, you need to have individual level enrollment data and claims data and that will help in overall monitoring of the system. In addition, if you look at SCHIP, there's data that shows enrollees access to primary care is very good. Enrollees receive more preventive services, they had fewer unmet needs, actually parents had greater peace of mind. Enrollees reported better access to and communication with providers. And one evaluation even found that enrollees had fewer asthma attacks after enrollment.

But the challenges are that the children didn't receive the full range of preventive visits and as with all public and private plans responding to emerging threats like child obesity is a challenge. The other thing was because of the lack of data, there is a real in that we need additional data to look at the implication of program design, features like benefit package and cost sharing on access to care.

So let me then get to the second point I wanted to make, which is - and I'll come back to this issue of quality. The second point I wanted to make that we need to think more broadly about our child health system and really being able to address the needs of children and only then can we have a high impact on the quality of their care and insurance coverage is just one step. If you look at those three steps: access to primary care, specialty care, that's the medical care that children get, but they also need prevention. And in

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addition, they need prevention and medical care integrated at the individual level but they also need it integrated at the community level because a child lives in a community.

So that's the thing I'm going to focus on is that prevention and medical care need to be integrated at the individual level and the community level and that applies to where children live, learn and play: at child care centers, primary care centers, schools and the community. So what we really need is a system that provides child health and well being and development. And children are not just little people. They have unique needs and they have health needs that span a lifetime. If you look at this chart here, if you look at the child health development over time you see that there's a dark blue line there and that dark blue line is the average trajectory of health care for children over time. Ultimately I'm on slide seven, I'm skipping. I'm not going through all the slides.

Ultimately, we want a system that encourages optimum health and development. What we mean here is that we are encouraging the protective factors and reducing the risk factors. And if we can have a system that really encourages the productive factors we can really deal with the optimal health and development for children. And so what this chart also shows is that over a period of time, there's a greater impact on children's health. It happens at the earlier age as you can see, there's a steeper slope in terms of development and health. And when I talk about the child, I really mean the whole

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child because health care's just one piece of a child's development and when I talk about health child, I mean the balance of physical, emotional, cognitive and social well being. And you can see these different petals, they represent the different determinates of health and health care's obviously a key determinate, but there's the community, the school.

So it's the child's interaction with this environment, with his or her environment, over time that determines the child full development. So this really builds the case for prevention and prevention can really improve child health in the short term as well as provide benefits into adulthood. And more and more, our children are facing preventable chronic diseases that have their precursors in childhood. A perfect example of that is child obesity, where the prevalence of child obesity has really been growing and this applies to injuries and asthma, other preventable conditions. So if we can get at these chronic diseases or preventable conditions, we can really have an impact not only on a child's health, but also expenditures because the 30-percent of chronic diseases that are prevalent in children are between 70- to 90-percent of health care costs.

So this is why prevention is such a critical part of our health system and as this chart shows by Charlie Bruner, prevention is really linked to the overall healthy development of children. So if we really wanted to look a prevention-oriented system we would

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integrate both prevention and medical care together and also couple that with a community-based intervention and that's what we've done at Nemours. We are a operating foundation which had primarily focused on clinical care, but now we're focusing on integrating prevention with medical care to get maximum impact for children. So ultimately we want a prevention-oriented system that provides, on the left-hand side, the community support – I'm on slide 15 – community services, prevention, specialty care and, ultimately, treatment. But all these services are provided in a full continuum for children. So we're looking at a system that goes beyond the biomedical view of health to a more multifaceted view of health that goes from just acute episodic illness to focusing on chronic disease prevention and management, to go beyond just focusing on individuals themselves, to focusing on the community, to focus not only on the cure but on prevention and then to focus on overall health and not just disease.

So with that, I'm going to end with my two slides to bring it back to the system we need. We really need – whatever our system is in terms of health services we need to evaluate the system and it's impact on children. And what that means is we need a core set of indicators that should apply to all programs, not just to children's programs, but to all programs. And we don't have current benchmarks available, but we do need to develop those.

Now the IUM recommends a tracking system that looks at effectiveness, efficiency, accessibility, appropriateness,

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capability, safety, continuity, acceptability and equity. And then the Commonwealth also has done some work and what you need for a high-performance system and that looks at four general areas or four point framework; high quality care, which includes prevention, acts as an equity for all; efficient care, in terms of how it's delivered, and system and work force innovation and improvement.

Now let me just close by saying in terms of the system we need for child health and one of the things I wanted to point out in this session was I think we need four things. The first thing, I think, is an obvious statement and perhaps it goes without saying, but one thing we need leadership. We need leadership at the federal level and at the state level to make measurement and quality a high priority because it's a federal/state program. So it's not just the feds, it's not just the states. And there's so many different things going on at the state level that it needs to be a priority.

As I said earlier, we need a core set of measures and by that, I really mean core, I don't mean 50 measures. We have to figure out what are the most important measures to really measure the overall system and its impact on children and those measures need to be done in collaboration, the feds with the states. States have a ton of experience in this area and you can look at the documents in your packet and there's a lot of examples of what states are doing. They have a lot of practical experience in terms of what is doable in this area of measurement and that leads me to the third point which is

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that states can't do it alone. There needs to be technical systems and supports or states to foster innovation, to identify best practices, to put in place the mechanisms that are needed and for that, they need funding to do that. Again, because it has to be made a priority.

And the last thing and perhaps the most important is that if we're going to collect this data, we need to use it. We need to use the data for performance measurement. The worst thing that could happen is to have a set of measures, collect the data and it sits over at the federal government and nobody looks at it. So that gets back to the point I made about really working with the states in developing these measures, because what you want to do is build on the data systems that states have already. Build on what they're doing, incorporate that into the overall core set of measures and develop something that states can really use to measure the performance in their system. In fact, I also wanted to if I could - Nemours was one of the three sponsors of the *Health Affairs* issue and I just - we did this with the California Endowment and the Packard Foundation and there's a lot of great articles in this. There's a one-page summary that each of you have that is just hot off the press that we did to summarize the collection of articles, but I really recommend that you look at that *Health Affairs* journal. Thank you.

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ED HOWARD: You have your choice of the one-page summary, well, actually two-page summary, or the 609 pages of the journal itself. It's a good place to start. Thank you, Debbie.

I neglected to do the logistical housekeeping chores that I usually do up front because we wanted to get to the presentations. Let me just remind you that speakers who had slides have those slides in your packets available for you. They'll also be on our Web site, allhealth.org, if they're not already, they will be soon. You'll be able to watch a webcast of this briefing on kaisernetwork.org and see the materials on there electronically. You can even download a podcast, for those of you who have nothing better to do on your metro ride in. Let me also just make a -

ANN GOTHIER: If I could jump in, Ed.

ED HOWARD: Go ahead.

ANN GOTHIER: There's just - while he's gone through that, there will be one more mechanism. We'll be making this into a Commonwealth e-forum, which if you prefer not to watch us live, you can actually click through and you'll hear the speakers' voices but you can actually advance to the slides of the presentation you want and that will be ready in a couple of weeks.

ED HOWARD: And it's fairly very easy to follow. It's a good way to do it. Thank you, Ann. And more immediately, if you would pull out those blue evaluation forms and prepare to fill them out as we go along we'll try to make improvements to these programs as we go

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along. You'll also find the green question cards. I know that will shock those of you who've been here before. You can fill a question – you can write a question down, hold it up and someone will bring it forward. There are also some microphones you can use to ask a question in person and I happened to have an advance submitted question to get us started if I can. And it actually relates to some of the things that Sara said and indirectly to what Nina was saying as well.

The question is, "How does benefit adequacy square with the idea of making it easier to subsidize kids on parents' employer coverage using SCHIP dollars?" And I guess I would add to that, "How do you address the complaints that we've heard in other forums from people dealing with this at the state level that trying to do that, to integrate the two coverages, is incredibly difficult and burdensome?"

JEANNE LAMBREW, Ph.D.: Why don't I start and turn it over to Nina? The issue of essentially coordination of benefits is extremely difficult. Medicaid actually makes life a little bit easier for people because you can have dual coverage. You can have an employer plan, which you are bought into, and then you can supplement it and of course that is what Senator Grassley has now codified as formal policy, it works a little bit different from the old coordination of benefits provision, but its his bill that set this as formal policy for moderate income underinsured children with disabilities.

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SCHIP is very, very difficult because, at least in my view from looking at this from an operational point of view, when you run it as a separate program because of course for the reasons that Nina alluded to, SCHIP has anticranta [misspelled?] provisions built in. So you essentially can go one route or the other route, but you cannot buy a child a group benefit plan and then, for example, provide a dental benefit or vision care benefits, things that might not be in the group plan but that a low income family would need primary financing assistance to get. Or for example, a child, like the Senator Grassley child, with some employer coverage and then supplementation.

So SCHIP really, when separately administered, is set up to run as a means of getting a child into the market with the market strengths and limitations. Medicaid is actually more flexible in that you can use it to get a child into the market, but you can also supplement.

NINA OWCHARENKO: I would just add that the idea behind the whole concept of, or what I talk a lot about, trying to push ideas like premium assistance and other models, is that it gives parents choices. Today, it seems like our entire health care system is based on "Are you eligible for this program? You get put in this bucket. If you're eligible for this, you're put in that bucket." There's no integration between the various approaches to providing health care coverage and by using a premium assistance model you really can

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empower parents to decide, "Would I rather have my child with me on my employer policy? Would I rather buy a policy on my own in the market itself?" It's not like it's prohibited for people to buying in the market itself. Or would you rather keep your child in SCHIP, which is more of a government controlled marketplace?

And so I think that's probably the most important feature, is how do you give parents and empower parents to make these choices instead of having these administrative hurdles that make the decisions for the parents?

ED HOWARD: Somebody have the microphone back there? Or just someone reticent to come forward? Ann, you want to read a question from a card?

ANN GOTHIER: We've gotten the questions. CDC recently released new prevalence rates on autism, noting that one in 150 have autism and the questions are, does SCHIP provide access to treatments for these kids or is it some type of EPSDT supplement needed? And also, any estimates of the percentage of kids in SCHIP who may have significant needs that might need an EPSDT supplement? Sara, do you want to start?

SARA ROSENBAUM, J.D.: Sure. This is a variation on the question before, but this time focused on specifically the diagnosis of autism. If a child – if a state uses its SCHIP funds to expand the Medicaid program, the EPSDT benefit is broad enough and flexible enough so that within allowable limits imposed by the federal

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government, a state can do a great deal to fashion the kinds of long term care interventions that are needed by children with autism. For example, something at the level of a day clinic where a young child might go, if you walk in the door it feels more like a nursery school but it's actually a day clinical treatment program. Very prevention-oriented, but aimed at a child who needs that special therapeutic intervention to attain functioning. That's the whole point of EPSDT. It's a detainment program for children who may have developed mental risks or actual diagnosed conditions that impair development.

In the case of a separately administered SCHIP program, there is absolutely no reason why a state cannot do the same thing with its allotment. The definition of child health assistance is actually as broad in SCHIP as it is in Medicaid. It's just that the custom in SCHIP is to use the benefit the way Nina described, as premium support. So that the emphasis over the years has been on buying what is much more traditional commercial insurance like benefit or helping a family acquire what might be available through the employer and not using it for children with significant long-term and chronic conditions.

The reason I identified the DRA shift is because an important consideration for states, I think, in administering SCHIP, is whether in fact they want to use the new flexibility they're given to do more supplementation of a standard benchmark plan.

ED HOWARD: Debbie?

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DEBBIE CHANG, M.P.H.: Yeah, I was just – let me just add to what Sara was saying that certainly there's flexibility in either an SCHIP or Medicaid, certainly the private sector too, in terms of developing a package that we really meet the child's needs. But a key issue is having that screening, that screening tool and that screening and development tool so you can identify early autism. And that's part of what I was talking about earlier in terms of needing a comprehensive prevention oriented set of benefits. I guess the third thing I was going to say to answer the question more literally, it really depends on what state you're in how your services will be addressed, that's part of our federal/state system right now for children's health, it's going to vary by state.

But I guess the key is that the state does have the flexibility under SCHIP and under Medicaid to address these needs.

ANN GOTHIER: Turning to perhaps some of the issues that – Debbie, that you raised, that you ended with. A question here asks "Where will the funds come from for the individual level data systems..." and Jeanne, you may want to chime in as well. The question or comments that states can't even report immunization rates broken out for SCHIP children how can we go beyond the four existing performance measures to examine the content and the quality of care in SCHIP. And maybe, Debbie, you want to start with the kinds of measures and Jeanne, you might want to comment a bit on the financing, and others as they like.

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DEBBIE CHANG, M.P.H.: Well, just a general comment. Actually, in terms of immunization, states have very good population base data that look at immunization rates and while it may be more difficult to track it by program type at least when you look at the overall population you get a good view of rates of immunizations by states.

I think that certainly what I was talking about was the need for more investment by the federal government in terms of administrative costs to really build that infrastructure that's needed for data systems and that's going to vary by the state and what's going in a state, but there are several different needs. There's the need for IT. There's the need for funds for demonstration programs. So there's a variety of needs that would be critical in the development of this overall system. But some of it is, as I said earlier, leadership. It's making it a priority. Getting the feds and key states together to develop a core set of measures, that could be done without a lot of funding as long as there's the will to do it.

So there's some parts of what I said that I think involve funding and some parts that involve us making it a priority to have a high performance system. And I really want to commend the Commonwealth for their work and really bringing attention to this, because some of it is funding and some of it is just making it a priority.

JEANNE LAMBREW, Ph.D.: And I will say that we do have two options that we've used in the past to do this. One is

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states have up to 10-percent of their allotment that they could use on direct services, administrative costs and other sorts of collections and some states have used these funds for that. But we also in the past have used our matching rate for administrative costs to encourage investments in certain data areas. So we historically use a 90-percent federal rate to develop data systems for Medicaid and I've done that for outreach in past periods. Right now, frankly, there's been a administration proposal to cut back on that for many of the administrative services that are out there that hopefully Congress won't consider because the truth of the matter is it's harder for states if Congress is cutting back or the administration's cutting back on administrative matching rates. But there are certainly options for doing so under the systems.

ANN GOTHIER: And an additional option is perhaps in some of the Medicaid transformation grants. A number of the proposals are specific to some of the data systems. Again, I think that underscores Debbie's point and I certainly agree with it, which is we have to have the will to want to make a high-performance system and some of it isn't just funding, it's just priorities.

MALE SPEAKER: A couple things. On the House side, let's see, we've had two hearings, at least four briefings on SCHIP and it is – the Energy and Commerce Subcommittee on health's first priority,

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however, as you probably are all aware we'll probably do something at the margins and that's probably going to be what we do. But I'm hearing that there's a lot of will on this panel at least to do something more. So I guess my question is in combining both the private sector and the public sector, really, that's an enormous undertaking that's going to go well beyond the reauthorization limits for this year.

One is, what do you suggest we do in reality? And then two, I guess on the data collection side – I just came back from the HIMMS Conference and there is a lot of will on the data collection side and hopefully we'll incorporate that within the bills at least on the House side that we're going to get out this year.

JEANNE LAMBREW, Ph.D.: I'll partly answer that excellent question by starting to say that I think there's challenge that you all face which is we're going in the wrong direction, right. Currently we have a declining number of uninsured and a declining base line for children's health. So if you look at what the Congressional Budget Office released recently, they were showing that today we're covering about, throughout the year, about seven and a half million people in SCHIOP. But that's going to drop down to about three and half by the year 2012, excuse me, 2017, without any changes.

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So I think the priority must be to at least maintain our existing programs and then go after this population that's eligible but unenrolled. Meaning, when we started this program a decade ago the goal was to significantly reduce the proportionate number of uninsured children who are low income and certainly the program has done well at that, but has not finished the job. So in addition to maintaining our current services and getting out our target population, there has been this question about what about the remaining children who are not eligible for the program today.

I think we have proposals out there we'll be hearing more about. I think that we've heard that Senator Clinton and John Dingler are thinking about some sort of covering all kids proposal. The Children's Defense Fund has been out there saying this is the year we should consider this. I do think we'll be seeing more activity and action around this issue, but I can only imagine that SCHIP has the first turn, which is finding the funding to maintain the existing program, then kind of target the children who are eligible and enroll.

And then hopefully, if there is the will and the way, meaning the budget funding allocated towards this we might see that remaining increment on the public policy.

ED HOWARD: Yeah, Sara, go ahead.

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SARA ROSENBAUM, J.D.: Just echoing what Jeanne has said. I think the number one issue this year is the financing question. If you look at SCHIP and it's interaction with Medicaid, the options on the table once states have sufficient mail to run with are not bad and we could always do things to improve the functioning of any program, SCHIP or Medicaid. But the real crunch here is simply keeping a flow of funds going to states so that using their additional funding either separately or in combination with Medicaid depending on the circumstances of the state and the issues it chooses to target.

If it wants to beef up primary prevention, it may dictate one kind of design approach. If a high priority is upgrading chronic illness and disability services there may be another design approach. As Jeanne mentioned, you can do investments and infrastructure and quality reporting, even under current law. I think the big issue was the money.

ED HOWARD: Could I just follow up with a question on another card that raises sort of the next step and whether you ought to take it? How have SCHIP expansion programs to cover parents or other populations function? And what are the primary obstacles they face to effectively covering SCHIP families? How far do you want to go? Anybody?

NINA OWCHARENKO: I'll be happy. I think it gets back to what was discussed. It's all on financing and what is the scope of the

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proposal. The discussion today, the vehicle is SCHIP. But I think it's also important – I was going to answer after you finished the first question – to not to forget that there are other populations that are still uninsured and while a child's coverage and children's health insurance is important, it needs to be discussed and what we're doing in the broader context of overall health care reform. And I think that sometimes get lost in the discussions of, "Well, we'll take care of this population and we'll figure out another solution."

But these solutions still, I think one of the problems we have is that they're very disjointed and we need to find ways to fix the system as a whole so it's not dependent on just one program and say, "Here's SCHIP. Here's a vehicle. We'll put everyone on this program." But really looking at what's wrong with the current system. Why are these children uninsured and what can we do to help encourage greater continuity in coverage for the long term?

JEANNE LAMBREW, Ph.D.: And I would just add the fact that one of the things that we discovered in looking at children's health through the past 10 years is that when you cover parents, you're more likely to get the children enrolled, which makes a lot of sense in terms of common sense, but the researcher has been backing this up. So we do know that participation rates are higher when parents are also eligible. Some states have done this, some states

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haven't. But we can't forget that the median income eligibility level for a parent is well below the poverty threshold. Whereas we have most states, not all states, at 200-percent of poverty for children.

So we have to remember we have this big disconnect between children and parents today. But I will note that this is going to be an issue this year because people are concerned about the so-called crowd-out effect, which is if you extend access to parents, will you be crowding out private insurance? And I do think it's important to sort of view what we know about that topic.

The federal evaluation that Congress sponsored on the State Children's Health Insurance Program said, "The program did not lead to widespread substitution of SCHIP for employer coverage even though almost all families enrolling their children had at least one working parent." We also know from some studies that the Urban Institute did that only about a third of kids who are in SCHIP have a parent who has employer based coverage. Only 10-percent of children in Medicaid have a parent who has employer-based coverage. So we do see these disconnects.

I think the last important thing to remember is that when we actually look at children enrolled in the program we know that most of them are coming from being uninsured, about 43-

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percent according to the federal evaluation; 29-percent are coming from Medicaid. So their parents earn more income which, in previous history, would have meant that they were ineligible for program participation, but 29-percent of kids are moving from Medicaid into SCHIP as their parents are earning more money. And only about 28-percent of children enrolling in SCHIP had previously had private insurance, with about half of them having lost coverage through their employer system before they got into the programs.

So I do think that we have to keep an eye on this crowd issue because you're going to be hearing a lot about this year. I think that most of our evidence shows that there's not a major problem in SCHIP.

ED HOWARD: Got a question that's initially directed anyway to Nina with respect to premium subsidies. Do you have a position on how best to administer such a program? It's kind of an echo of what we were talking about before, that is, through state social service agencies or through tax credits or some other means.

NINA OWCHARENKO: Well, I think there are a variety of ways of administering one. I think that's probably the second-tier issue. I think if you look at just children that already is a combined federal, this is just one example, combined federal/state programs. So you have federal dollars involved, you have state dollars

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involved. But ideas of fixing tax credits, utilizing tax credits possibly for the parents, could be an option of looking at how do we encourage the parents to obtain private coverage in the private market, especially if they're uninsured and their children are uninsured. How do we move away from simply enrolling them all into SCHIP?

We hear a lot about, "We should just enroll the eligible, but enroll them into the program." But I think the alternative is what are the other options and I think tax policies such as tax credits or refundable, advanceable, assignable tax credits. So that means even the lower income people get the full credit. It's simply a system of delivering the subsidy. It could be a good starting point, especially when we're looking at these populations we have to remember that there's a distinction. We can't just bulge everyone into one group and saying children or low-income children.

A lot of these states are already at 300-percent of poverty, those are \$60,000 dollars or more family's household. And so what do we do in the policy-wise of designing subsidies that may more effectively address the needs of that population? For example, allowing them to use funding through subsidies through SCHIP or a tax proposal in order to provide private health insurance.

ED HOWARD: Debbie?

DEBBIE CHANG, M.P.H.: In Maryland, we had implemented a premium assistance program and as been mentioned by many of the panelists, it

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really involves a coordination of benefits. So to implement this, you need to take into account that there needs to be a coordinating entity that coordinates the benefits because it's very complicated. So I think more if you had it with tax credits you would still have to have some type of entity that's actually coordinating the benefits because you're coordinating your federal, your state and then your private benefits. So whatever you do in this area in terms of implementing it, you do have to get to that second tier that focuses on how you actually can most effectively coordinate the benefits.

ANN GOTHIER: To add onto that and then jump into another question. Most states have found it very difficult to do administratively for the number of children that they insure, which is why they haven't gone that route but there may be some obstacles in the way it's designed and changes in those would make it easier.

But let me also jump in a question that's related to what we were talking about is that talking about options for low income, working families aren't their lower offer rates for many of the low income workers. And a second question is that we've talked about access to comprehensive benefits being necessary for kids, but many of the private benefits – or the question was asked, "How do these benefits compare to medically necessary care that get provided under the EPSTD benefit?" In other words, that is a richer benefit than is found in most employer coverage, especially that for low-income workers. So the person, I guess, asked, how do these two compare?

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ED HOWARD: Let Jeanne start with the offer.

JEANNE LAMBREW, Ph.D.: We'll divide up the answer.

Which is on the employer issue, without a doubt, low-income people have less access to employer-based insurance. And I think it's important to put this in the bigger context. We have seen a significant erosion in the percentage of employers offering coverage and the percentage of workers getting coverage through their workplace. But it's also important to recognize that even among lower income workers, those who have access to it tend to participate. It really is – not that there are a bunch of people out there who have access to it who are not necessarily paying it, the vast majority of people who have access to employer-based coverage across the income spectrum participate when given that access.

We're generally talking about people who don't really have the option. So it does become like a needle in the haystack trying to figure out who are those families who have that access but can't afford it and how do we help them. I would note that there are two different models out there for how you could help these types of people in that content nexus.

One is like what the state of Maine did, which is trying to create a purchasing pool where Medicaid and SCHIP are

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buying people into this purchasing pool for small businesses and small businesses are independently buying into it and when you merge the money that way it alleviates this coordination of benefits issue. And some states have proposed to allow employers, as well as families, to buy into SCHIP because, as I mentioned earlier, these are basic private insurance plans offering benefits that are typically private insurance benefits with a state subsidy. So it's not like it's emimicable [misspelled?] to kind of a private sector model.

So we have three models. One is classic premium support to try to keep the kid in the employer-based coverage plan. Two is like Maine, where you try to create a purchasing pool and subsidize that. And third is just simply allowing the employers to buy into a state-based SCHIP plan and these are all ways you could all simplify and coordinate this coverage.

DEBBIE CHANG, M.P.H.: With respect to the benefits, I think here's the easiest way to think about. When you buy a private plan, whether you're buying it through the employer-sponsored group market or the individual market, or a third way, a group market that is created, but that is to function as a group insurance market. You're buying insurance, so you're buying what insurance is and insurance is a risk contract. And so the structure of a risk contract looks

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nothing like the structure of Medicaid, particularly for children. It's a much narrower set of benefit classes.

A lot of benefit classes that you would find in Medicaid don't exist in a risk contract world. There are a lot more exclusions, either by the diagnosis or by some other attribute of the person holding the policy or the setting of care. For example, no care in the home, no care in a school setting. There's a lot more cost sharing obviously. Even when it's controlled it's going to be more than one would typically find in Medicaid, at least traditionally and there is a much narrower definition of medical necessity.

So when you're insuring a child or covering a child through Medicaid, even if you take a portion of that financing and go out, as most states do now, and buy an insurance-like product, they buy a managed care enrollment. Here in D.C. we have 100,000 children enrolled with a commercially designed managed care plan. But what state Medicaid programs do is essentially supplement that enrollment, number one, with the low prevalence high cost services. And number two, the enrollment agreements actually have modifications in them that have them depart from standard commercial. So for example, here in D.C. the contract has a full developmental assessment. Provides a lot of the services that are associated with EPSDT and says to the marketer, "When you sell this product, we want you to add some services in that you don't normally sell to an employer group." So that's sort of the compromise.

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ED HOWARD: Well, there's a question in this one. A person makes the observation that the IOM insurance reports point to the stability of coverage as extremely important for children and families. There are now counter cyclical provisions being considered as part of the SCHIP reauthorization that will encourage states to maintain SCHIP coverage during a recession. I guess that's a question. I know the answer to that question is yes, but the exact nature of them, what they are, what they should be, whether it's a good or a bad idea, I'd very much like to hear from the panel.

JEANNE LAMBREW, Ph.D.: I'll take a quick shot at this and then I think Debbie might have some more to add. Which is, if we try to figure out about how do we actually ensure that we get those eligible unenrolled kids and then how do we keep those children. There is lots of good research that shows that a few things do work. Number one is trying to have longer periods of eligibility. We don't see that much income instability in this population, so giving continuous eligibility for a year works according to most of our studies. We also know that making the eligibility process on the way in, as well as redetermination, is an important phenomenon because if we look at we call "disenrollment surveys," what happens after children leave.

The federal evaluation found that only 14-percent gained private coverage. About 34-percent lose income and go back

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to Medicaid eligibility and 48-percent of children leaving SCHIP become uninsured, which is very distressing. So we know that continuous eligibility, simple eligibility and redetermination matter. But also importantly, some of the rules that Congress has imposed are a problem. We saw in *The New York Times* today an article about citizenship documentation in which states are being required to use certain types of forms. Like actual birth certificates with raised seals, to have families prove that their child or their individuals are citizens.

And these eligibility rules are having major dampening affects on out reach enrollment efforts for legal immigrants, undocumented children, as well as citizens of the U.S. And these are the sorts of barriers that if we're really serious about trying to get continuous eligibility in a program, keeping those children eligible. We have to readdress.

DEBBIE CHANG, M.P.H.: I would only just add one other one. I do want to underscore that making the redetermination process is as simple as possible and presuming somebody is eligible rather than not eligible. But the other one is self declaration of income. Those kinds of things states have also been doing. One of the great things about SCHIP was that over the last 10 years there's been a lot of innovation from the states in terms of what works in terms of

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continuous eligibility and redetermination and the eligibility process.

So there's a lot of best practices and Jeanne identified some of them. I've identified some of them that really help to ensure that the child is enrolled for longer periods of time, which will then help during the counter cyclical periods.

ED HOWARD: Nina.

NINA OWCHARENKO: I just want to add a little bit to that as well. Having eligibility enrollment for a program is fine, but at some point you're still going to have the effect of going into private coverage and then yet again you're losing the continuity of coverage. Now, some can argue that we need to have a single payer, government run healthcare system. But I think that also is an argument about saying what about empowering people to hold and maintain private coverage on their lifetime so you're not worried about whether the employer is offering the right kind of coverage or whether the market is actually agreeing with me.

I think a lot of the problems we see in the individual market, in particular in what policies are being offered although they are comprehensive. I think it's important to note that it's because these people are in the market temporarily. There are very few people who buy insurance policies for health care as they do with other types of

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policy, like life insurance where it's a whole life; you buy something you're going to stay with that plan.

Or even in the car insurance market, which is different but the same mentality that you're saying I'm going to stay with this insurance company. Now they have an investment in me. It's not the investment in the government, it's not an investment in the employer themselves, but it's an investment in me to say if I have a child who's five and who has a developmental disability, that insurance plan, if I have a contract with them, has incentive to screen and get that care done early instead of waiting until things are way out of control.

The same thing can be done on diseases, and obesity in particular. Having children and saying if you're a diabetic, if you know that diabetes is going to hit this child soon because of obesity and other issues, then it creates a different dynamic which we're not seeing today. But I think in the future we can look at it little bit differently instead of saying how do we get more people in one program as children and what do we do when that child's family earns another 10-percent more in income? And I think we need to look at broader health care reform and how do we give individuals greater control over their health insurance instead of just waiting to see what bucket they'll fall into.

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ED HOWARD: I have, I guess it's a comment on a card. It's listed on a question card, but if I summarize correctly, I think I can do this without having to ask a question. The person in response to Nina's citing of Jonathan Gruber's study about crowd out notes that the Energy and Commerce Subcommittee on health is communication from John Gruber pointing out that the estimates of crowd-out for families under 200-percent of the poverty line are lower and I can't tell from the way this is worded what the citation for that lower rate is, but I commend to you both his original testimony and his study and the letter dated apparently March 1 to make sure that we're citing that figure in the correct way.

So there is that. Ann, you want to get going here?

ANN GOTHIER: We also did get some questions about how we can improve dental care for low-income kids and I'm sure that that's a big problem. I'm not sure that that's the expertise of our panel.

DEBBIE CHANG, M.P.H.: Well, some of it's coverage.

ANN GOTHIER: In terms of getting even the providers coming in.

SARA ROSENBAUM, J.D.: Well, yes. I'm sure there's nobody in this area who missed the terrible story from a couple of weeks ago now about the child who died in suburban Washington because Medicaid

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had lapsed, lost the coverage, was homeless and could not find a dentist in any event to deal with the child's teeth. Clearly, a starting point is the coverage. Most states, even in a separately administered SCHIP situation, are providing at least some dental coverage. Medicaid, of course, mandates dental coverage, very broad dental coverage for children. But the huge issue in dental care for children is not just the financing, it's the access to care.

There have been a lot of efforts over the years to try and deal with this. Some of the most effective, quite frankly, are less those that rely on synthesization of the private market and much more deliberate interventions where, for example, a community health center will partner with a teaching program. Columbia Dental Program has a wonderful partnership with the city's community health centers in New York and have gotten dental care out into many neighborhoods.

There is a large dental program in Colorado that serves thousands of people. There is a program in northern Wisconsin that is bringing people from Milwaukee, three-hour bus trips paid for by the Medicaid program to get publicly operated dental services. One of the, I think, most important things that will happen around dentistry is the reauthorization of the National Health Service Corps and community health centers. That's really, aside from just the expansion of the financing, where Congress as a policy matter can make a huge difference. That and teaching. Not getting rid of the

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teaching component in Medicaid payments for hospitals where actually a lot of dental residents are trained as well.

ANN GOTHIER: I was just going to make a point about the work force issues. As Sara ended with, it's also a huge work force issue when trying to get people trained who will go into areas where vulnerable children are to serve them. That's a huge issue as well.

ED HOWARD: We're just about out of time. And I'm going to ask our panelists to offer a final comment if they would like and as I give them a chance to adjust to that unforeseen request, let me take that time to ask you to make a few final remarks as well on the blue evaluation form as we come to the close of the program here. Why don't we start with Sara?

SARA ROSENBAUM, J.D.: I think I've made all the remarks I need to make. I would just note that the issue of what we pay for children is as important as do we cover them at all. If we are not mindful of the kinds of issues that Debbie raised, the kinds of issues that we deal in benefit design we can end up with a situation in which [inaudible]. But that the coverage is really not aligned with what we know about children's growth and development and their health care needs going from preventive to all the way to long term.

JEANNE LAMBREW, Ph.D.: And because I was speaking of financing, I'll just say that financing matters. If we think about what have complained about with SCHIP and states? What

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has Congress changed? And there's only one thing and that is the financing formula isn't how we pay for this program. We need to obviously fix that, but I think we also have to recognize that if we keep the current structure we may be seeing these same types of challenges over the next decade, especially if we're saying to states find and enroll those eligible uninsured kids. I hope that this Congress considers new ideas for how we can actually share financial responsibility level with states that do successful outreach be it through some sort of enrollment adjustment as has been proposed by some people; hold harmless' so that the state is not held liable for any costs that are above the allotment due to outreach.

Other types of mechanisms I hope will be considered in this Congress so we don't spend our next 10 years doing what we've done in the past 10 years. And I will say lastly, I know that it sounds like it's all new spending, but it's not like there aren't necessarily ways to pay for this. Senator Smith has talked about a tobacco tax as one source of financing.

The Congressional Budget Office has done its deficit reduction book which has a myriad of health savings, including potential Medicare HMO over payments, which I think have been spent 10 times over and will be difficult to get

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anyway. But there are options out there and I do hope that this Congress really does look harder at that because money does matter.

NINA OWCHARENKO: I just want to stress the part on the title of the program The Beyond SCHIP because I think there are more options for thinking about how to cover children beyond the context of the box of SCHIP that we have today. And that policymakers should really explore those types of alternatives that really promote continuity and care for the lifetime of a child, not simply just looking at how to get them into a program itself and simply checking a box and saying, "Yes. This child is now enrolled in a program."

And I would also like to stress that the private sector does offer alternative and it is a good place to look to see what can we do to actually improve quality and care that is being delivered in the private market itself instead of simply just saying, "Well, we'll just focus on SCHIP itself." There's a lot of lessons in the private market that can also be integrated not only into SCHIP, but as a stepping stone to private coverage for all children.

DEBBIE CHANG, M.P.H.: My final comments are that SCHIP and coverage is a critical step, it's critical first step and that we really need to think beyond that and think about our child health system in developing a system that really addresses the needs of

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children over time. And also on the issue of performance measurement and quality that there really be a joint effort between the states and the federal government in terms developing that system.

States have a lot of experience in this area. And as we know from Medicaid and from SCHIP, there's been a lot of innovation and there's a lot happening at the state level and the area of qualify. And that we really need to build off what's already happening when we think about this system.

ED HOWARD: Ann?

ANN GOTHIER: I guess I would just like to emphasize that although there has been some disagreement about what directions we might go there's a great deal of agreement across this panel here that it is critical that we cover children and we cover them early and we get them the services that they need. The comments about broader reform I'd also like to underscore, which is not only do we need to provide quality coverage but we do need to look at improving the quality of care and the efficiency and delivery. There is money in the system, we need more of it, but there is money in the system if we would improve those aspects. Which is why you saw that chart that Debbie used that our Commission is looking simultaneously at coverage efficiency and quality and part of the key is there.

And my very final thing is, as Jeanne put it, financing matters.

But when you think about the costs of covering kids they are really low in comparison to so many other things we are spending.

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Even a \$50 billion dollar shortfall is a very small amount of money compared with other priorities, and we need to think about them in that context. So we're pleased to have made those points.

ED HOWARD: Very good. Thank you, Ann. Let me just also add in thinking about broader contexts for these reforms that you all should be putting on your calendar the program scheduled for next Monday. In partnership with the Commonwealth Fund, the Alliance will be holding a briefing looking at broader ways to broaden coverage. Everything from the president's proposals to promote coverage more in the individual market to Medicare for all and lots of stuff in between. So mark your calendars. Respond to the e-mail when you get back. Let me just also say to reiterate, thanks to Jon Ingelhard and Project Hope and the folks at *Health Affairs* for making sure that we have the text for this discussion and for your study over the next couple of weeks. Thanks again to the Commonwealth Fund for the active participation of Ann and her staff at the Fund and for their support and co-sponsorship of the event. And ask you to join me in thanking the panel for an excellent exposition of some very difficult issues.

[END RECORDING]

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