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SCHIP: Let the Discussions Begin
Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured
February 9, 2007

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SEN. JAY ROCKEFELLER: My name is Jay Rockefeller and Susan Collins, who is co-chair will come along presently. we're glad that you're here and this is a briefing on what is sort of the biggest health care issue of the year which is the SCHIP program. We're looking at that in finance now. The Alliance which Susan and I co-chair is sponsoring this program and we have support and co-sponsorship from a place where we've been getting co-sponsorship from for as long as I can remember, which is called Diane Rowland, which is otherwise known as the Kaiser Commission on Medicaid and the Uninsured.

I think it's appropriate that we take such a — this is early in the year for us to be doing this but we're going to have a series of hearings on the SCHIP program because there isn't really anything that is more important in terms of health care — it's the only probable major adjustment that can be made during the course of this year. We no longer think universally; we think incrementally which is sad but we are where we are so we do what we can do. So SCHIP will march forward.

The President's budget — as our efforts — it's a challenge for us. SCHIP has been enormously successful across the country — insurance for more than six million of

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our nation's children. I remember ten years ago when we were passing this, it was a very dire situation; people all pitched in and everybody helped. Actually, President Clinton was for the wrong bill, wasn't he? So I'll just say that in the interest of bipartisanship. [Laughter] He was for the wrong bill, but we took care of him. We took care of him. Although he did send us a letter on the day that we passed the program which endorsed it, which didn't do much good but it was a nice thing to do.

I think there are several principles that should guide the SCHIP authorization debate. First, we have to maintain coverage for 6.1 children who are currently enrolled in the program. The Congressional research service, which never makes a mistake, and independent experts have estimated that we're going to need $15 billion over the next five years and the President has proposed one-third of that amount; $5 billion. That is equal to, obviously, a cut of $10 million and will kick tens and tens of thousands of children off of the SCHIP program. So that can't be allowed to stand. That comes at a very difficult time because we don't have any money. The Federal Government doesn't have any money. That's not credible usually, but it sure is credible now and the Democrats tend to want to be fiscally responsible this year, so we're doing pay-as-you-go. That's fine by me, but

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it's going to make it really hard by SCHIP and other initiatives we've got to get done. So it's going to be a very, very tough year and it's going to be very tough to get this done.

We have to reach the six million uninsured children who are eligible for SCHIP and who are not on SCHIP — good morning. Susan Collins has entered but she's gracefully said that we do not have to all rise. And we're partners on this stuff; we do a lot of legislation together. So we've got the six million that we can't reach. We have to get to them. We've got states like my own in West Virginia which is expanding SCHIP; trying to be aggressive, trying to take it up to 300-percent of poverty. Then that becomes very difficult. I don't think anybody in America, any children or parents or pregnant women, much less childless adults should lose health insurance as a result of SCHIP authorization. That's a complicated little formula matter. With over 46 million people uninsured in this country, Congress should focus on expanding, not reducing health insurance coverage. If you assume, as I do, and I hope I'm wrong, that this will be the only real move in health care, if the result is to reduce coverage that would not be good. That would not be good at all.

Governors have gotten really good at this. They are

getting much more aggressive. They weren't at the beginning when John Chafee and I and a number of others helped pass this bill ten years ago. We argued for not allowing the governors to get their hands on it because we were afraid that some would be very aggressive and some would be very passive which is the way it worked out. We wanted the whole thing run through Medicaid which everybody understood and people said, well, that's a welfare program, but it's a lot more than that. So we didn't prevail; we lost on that one and so the governors did get it and some were very aggressive and in West Virginia, we were quite un-aggressive and it took us three or four years to really get going because of a lethargic approach. And that differed, obviously, from state to state.

Anyway, today we're going to look at the fundamentals. Is that okay? This is the first time Susan and I have done this together. We've done good things for Medicaid, haven't we? Anyway, so we're going to do the fundamentals today and I'm going to introduce our speakers but only after I introduced Susan Collins from Maine. You know this place is made to be rant with political dissent, enmity, barbs and all the rest of that – well, you can just forget all about that, okay. Susan Collins and I are a great team. Aren't we, Susan?

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SEN. SUSAN COLLINS: We are. Absolutely.

SEN. JAY ROCKEFELLER: There you go.

SEN. SUSAN COLLINS: Thank you. First let me say how delighted I am to join my friend and colleague, Senator Rockefeller as the new co-chair. I'm really the vice-chair —

SEN. JAY ROCKEFELLER: Co-chair.

SEN. SUSAN COLLINS: — but he's kind enough to call me co-chair of the Alliance for Health Reform. And I'm very pleased to be here to start off this morning's briefings, the first of three on the State Children's Health Insurance Program. The Alliance is sponsoring these briefings jointly with the Kaiser Commission on Medicaid and the Uninsured. I will say that when Senator Rockefeller asked me last year if I'd be interested in succeeding Senator Frist as his co-chair, I jumped at the chance. We have worked together on a lot of issues and he is an eloquent and compassion advocate for better health care. We worked together on state fiscal relief, on end-of-life care and I have been a longtime fan of his and of the Alliance. The Alliance is a great resource for lawmakers and their staffs about the issues facing our U.S. health care system.

I'm particularly pleased that this first briefing is focused on the SCHIP program. When I first came to the Senate, this was one of the first pieces of legislation that

I co-sponsored ten years ago. And it's been a real success. It's contributed to a one-third decline in the uninsured rate of low income children. Today over six million children, including 14,500 children in Maine receive health care coverage through this remarkably effective health care program. But there is obviously more that we can do. Maine is one of 14 states that will face shortfalls in SCHIP funding this year and I'm pleased to be an original co-sponsor of legislation introduced by my colleague to eliminate these shortfalls to ensure that children that are currently enrolled in the program do not lose their coverage. Moreover, while Maine happens to rank among the top four states in reducing the number of uninsured children in taking advantage of this program, even in Maine there are still 20,000 children who do not have coverage. And nationally, about nine million children remain uninsured.

The SCHIP program is up for reauthorization this year. This presents us with the opportunity to renew our commitment to meeting the health care needs of our low-income children and their families. Before important decisions can be made about the program's future however, we need to have a thorough understanding of how the program has worked, and this briefing will provide the opportunity to gain just such an understanding and I look forward to the discussion. Thank

you.

SEN. JAY ROCKEFELLER: Thank you, Senator Collins. And Ed, why don't you run through a couple of the details. See, Senator Collins and I are up here, but we're expediters, moderators; so what we do is we tend to get lots of questions from you and then we farm them out to the most likely person to answer. And if we don't think anybody can answer, we just bury the question like it never existed. But we've never run into that in 13 years. How long, Ed? Fifteen years of the Alliance for Health Reform. It's amazing, isn't it?

SEN. SUSAN COLLINS: It is.

SEN. JAY ROCKEFELLER: It started out with Jack Danforth and then Nancy Casabahn [misspelled?], and then Bill Frist and Susan Collins.

SEN. SUSAN COLLINS: But always Jay Rockefeller.

SEN. JAY ROCKEFELLER: Yes, I was thinking how to phrase that. [Laughter] Anyway, the point of all of this is that, for example, were a Senator or a Congressman to enter the room, they would be immediately shot on the spot. No, don't — I didn't mean that. The point is this is all for staff. Staff — a theory of all of this from the very beginning is that Congressmen and Senators are supposed to sometimes pick up on very complex issues and this is one which never goes away and is always complex so that the whole

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concept is that if the staff really understands it, the legislative people understand it in each of the offices, then they go and they tell their Congressman or their Senator to get with it, pay more attention, go to hearings and behave. That really is the theory of it, so we don't have any Congressmen or Senators. We have you and that's our total privilege.

Do they have the green cards, Ed?

ED HOWARD: They do, sir.

SEN. JAY ROCKEFELLER: Are they still green?

ED HOWARD: They are indeed.

SEN. JAY ROCKEFELLER: Okay. Do you have any other announcements you want to make before I introduce?

ED HOWARD: I think we're fine, Senator. You've done a wonderful job (interposing).

SEN. JAY ROCKEFELLER: Are our collectors available? I see one collector – two collectors. Okay, three, four collectors. We're in great shape.

All right, first we're going to hear from Diane Rowland. Diane is part of our fabric and our history. She's Executive Director of the Kaiser Commission on Medicaid and the Uninsured and she's a professor in the Department of Health Policy and Management at some place called Johns Hopkins University. She's nationally known as an authority

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on Medicare, Medicaid, SCHIP and anything else to do with health care. She's an expert on low income, disabled, elderly Americans; she does it all. Her commission, as Susan pointed out, is a partner and has been for years and years in spreading knowledge. We do that through — we put out press books every year for the press to get them to understand what is going on. We work at it hard and I hope effectively. So Diane, you're our first.

DIANE ROWLAND, SC.D.: Thank you, Senator. And thank you, Senator Collins as well for joining us today to talk about health care coverage of children. I think there is no other issue that this year is as important in terms of a health reform debate as assuring that we continue to make progress in covering the children of America.

One of the things that, of course, brings us all here today is that we still leave many children uninsured in America. Today 12-percent of our nation's children are uninsured despite the advances we've made with coverage under Medicaid and the SCHIP program. As this graphic demonstrates, the uninsured rate varies tremendously across the country and is actually highest in the Southwest, which gives us pause when we think about the challenge that different states have in terms of being able to address their uninsured population.

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One of the pieces that we have to look at as we look at coverage of children is the fact that today one in four America children depend on Medicaid and SCHIP for their health insurance coverage. These programs are the mainstay of children's coverage today, with Medicaid covering some 28 million children and SCHIP another 6.1 million who have incomes somewhat above the Medicaid eligibility levels. The two programs have a lot of similarities in terms of their attempt to reach children, but some real differences in terms of both the targeted populations for the programs, the availability of financing — the SCHIP program has a somewhat higher matching rate then the Medicaid program, yet the Medicaid program is an open-ended program that allows states to continue to draw down funds, requiring no enrollment caps or other freezes when children are reaching the head of a budget. Whereas in the SCHIP program, we're dealing with a capped program for which funding is targeted to states but there is an allocation that, as Senator Collins mentioned, some states now are hitting the top of their allocation, which means they may have to cut back on services.

Yet over time these programs have really made a substantial contribution to reducing the un-insurance rate among low income children. However, one should note that despite this progress, it has been an uphill battle. What we

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see in the employer-based system day after day is fewer firms offering coverage and fewer workers being able to obtain that coverage for their families. Those hardest hit by the declines in employer-based coverage are low wage working families, the very families for whom SCHIP and Medicaid provide health and coverage, at least for their children and in some states for some of those adults. So we really see that the progress we're making here is against a backdrop of erosion of the employer-based system putting more and more pressure on the public programs for coverage.

What I think is important to note is just really the progress in terms of coverage of children, and it relates to the way in which state financing has also worked. As you see when the program began there were less than a million children on the SCHIP program. Today it's grown to six million, but at the same time we've seen a substantial increase in the number of children eligible and enrolled in the Medicaid program. That's because the philosophy about health coverage changed with the enactment of SCHIP from one of a welfare program where children only should get on if they meet certain means testing, if they go through a very complicated enrollment process. With the enactment of SCHIP, the nation made a commitment to trying to cover low income children and that coverage in getting children enrolled was a

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priority. It led to a number of simplifications in the SCHIP program that translated over into the Medicaid program: mail-in applications, elimination of face to face interviews, so that the progress that we've seen SCHIP promote has also benefited the lowest income children in the Medicaid program.

Notably, what we saw during this time was we went from coverage only at the poverty level, or below in some states, for children to today, almost all states providing coverage at at least 200-percent of poverty. Ten states are slightly below that, but not very much below for children and some 17 states that have increased their coverage levels to above 200-percent of poverty, something that may become an increasing debate as we look at the numbers in the President's budget against the priorities that the Congress may have for maintaining coverage.

But finally we know that many of the children who are still uninsured could benefit from these programs but are not enrolled. Today we can look at, just on an income eligibility basis, about 74—percent of America's eight million uninsured children are likely to qualify for either the Medicaid or the SCHIP program. Now we know that some of these children may not be eligible even though their income puts them in the category because they're undocumented. We think that may drop, by some estimates, the number who are

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uninsured and eligible for coverage to about two-thirds of the population. But still we're talking about a substantial number of children out there who could benefit from these programs if we can find them, do better outreach to them, simplify the process and get them enrolled. But we know that today, citizen documentation requirements and other kinds of eligibility restrictions are perhaps making this program less family-friendly than the authors intended when they enacted the program in 1997. Especially we need to work to help the states with their efforts to make kids' coverage more family-friendly. We've tracked over time the numbers of states that have changed the way in which they do eligibility and enrollment to try to promote better coverage and better enrollment practices. When the program was enacted, there were only six states that had their eligibility levels at or above 200-percent of poverty for children. Today there are 41. There were states that imposed asset tests on children. Most states have now eliminated that. There is no interview at enrollment. There is increased continuous eligibility so that the re-enrollment period, when children tend to fall off the rolls, is limited in 16 states. So we're really seeing that we've learned from this program about how to enroll children, how to reach them. We need to do a stepped up effort to get more children in, yet we know what matters in

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terms of helping families to get access to this coverage, and that has been, I think, one of the major contributors over the last decade in the SCHIP program’s implementation; learning how to make public programs work for the population that's being served.

We also know that the kind of coverage that was provided makes a real difference in terms of children's health, their access, their ability to go to school, their ability to contribute to the society as adults because they've had a healthy start and their well-being has been protected. Here we see that Medicaid and private coverage together have similar outcomes in terms of providing a usual source of care for those; not letting children delay care due to cost; not having unmet medical needs go on; continuing to seek physician visits; helping to meet dental needs; helping to provide dental visits. And compare that to the high rates you see of poor outcomes for children who are uninsured. Clearly bring children into the health insurance net is an important aspect of Medicaid and SCHIP, and the scope of benefits provided is critical to making sure that items like dental care and vision care are not eliminated from the children's health care coverage because they can't afford them on the family budget and they're not covered in the health plan.

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Yet we also know that they key to every health program is its financing and how do we provide adequate financial assistance to help the states to meet the targeted goals of enrolling and covering all children. In the early years as the program ramped up, in some states slower than others, the allocations for SCHIP exceeded the spending by states, allowing that money to be rolled over. But as you see now, since 2002, we've begun to see that the actual spending on SCHIP is exceeding the federal allotment, and so we're living on borrowed time and on borrowed funds from earlier days which leads to the real issue in the reauthorization of at what level will we continue to support, on a federal basis, the efforts of the states level to both maintain coverage for the children that have already been enrolled and to be able to extend coverage beyond that to pick up many of our remaining eight million uninsured children. And as Senator Collins noted, many states are already facing the prospect of exceeding their federal allotments in fiscal year 2007; 37 states expecting to see a shortfall in that period.

So the key questions as we go forward is, will we be able to maintain progress in covering our uninsured children as we move forward with SCHIP legislation? Will we be able to reach more of the eligible but not enrolled children,

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since finding them and enrolling them incurs cost for the medical care that they utilize? And will we be able to broaden coverage to more children and families without access to insurance on the job or the ability to afford the ever more expensive health insurance coverage? At what level will the federal and state dollars be available to support that coverage? What will we do over the next year to assure that our nation's children, especially our lowest income children, have access to care and a healthy start in life? This is the issue we're here today to talk about. Thank you.

SEN. JAY ROCKEFELLER: Thank you, Diane Rowland. Our second panelist will be Genny Kenny. She is a Principal Research Associate at the Urban Institute. She's a health economist, has done extensive evaluation of the SCHIP program since it began, has examined the program’s benefits and financing, also what efforts have states made towards enrollment, etcetera. She's also studied the impact of the program on children's access to health care, whether it has resulted, for example, in private sector crowd-out, which is an issue, and how it has affected insurance coverage more broadly. So that's a big plate. Genny, we welcome you.

GENEVIEVE KENNY: Thank you. What I'd like to do is build on Diane's presentation. To start by drawing out more of the experiences to date under SCHIP, the first decade;

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then I'd like to focus on a group of issues that have coalesced as key, I think, at this point, in the re-authorization debate. And then lay out what seems to be a spectrum of competing visions for SCHIP in the future.

As Diane indicated, SCHIP programs are quite diverse across the country and as SCHIP is being debated in the coming months, this particular feature of the program is going to be more and more prominent. The diversity extends not just to who is covered, what income levels are covered for children, but how income is defined, whether parents, childless adults, pregnant women are included, whether there is cost sharing, whether there are benefits. Really a hallmark of this program has been the flexibility that was embedded in the original statute and then was embellished upon through the waiver process over this past decade. But as a consequence, the SCHIP programs across this country are quite different and that's an essential element of the program that's going to be reckoned with and discussed as we go forward.

As Diane indicated and showed, we've seen progress in covering kids in the last decade. That progress happened against a context of an erosion of insurance coverage for adults. It was concentrated among low income children, both poor and near poor children, and it was powered by enrollment

increases that Diane showed you in Medicaid and in SCHIP. The issue that Senator Rockefeller alluded to of crowd-out is one that I would say hasn't been resolved. In a definitive way, we have all kinds of studies that have been done and they point to highly inconclusive evidence on crowd-out, but what we do know, and there's a paper that we're just putting out today that shows that most of the kids who are enrolled in SCHIP do not have access to employer coverage. So if you take a snapshot of the kids who are covered today, most of them don't live in families that have employer coverage.

The research evidence is also quite definitive in addition to showing insurance gains and documenting real improvements in access to care. When children enroll in SCHIP, they're much more likely to get a preventive care visit from a doctor. They are more likely to get preventive dental visits. They are more likely to get all kinds of other primary care services. They are less likely to have unmet health needs. Their parents are less likely to have anxiety and worry about meeting their children's health care needs. And the thing that I want to emphasize about this research is that these gains have been documented for all the different types of programs that we have. They're found for Medicaid expansions. They're found for separate programs. They're found for combination approaches. They're found for

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many different types of subgroups of children defined by their parent's educational attainment, by their race and ethnicity, for children with special health care needs, for adolescents, for younger children. So I think the evidence is quite clear that the benefits of the program are widespread and shared broadly across the country and across different groups of children. We also see that the program and the Medicaid coverage gains have resulted in a narrowing in race and ethnic gaps in coverage and access. So there are very real tangible benefits that this program has provided. The research that's been done has been through congressionally-mandated studies, foundation-supported efforts. There is a whole body of research that backs this up.

But notwithstanding this progress, there are some areas that have been identified where the program could be further improved. As Diane indicated, we still have millions of children who are uninsured despite being eligible for public coverage. Work that we're releasing today indicates that about two million children appear to be eligible for SCHIP but not enrolled. That suggests that there is more work to be done. The job isn't finished.

Second, to date there have been only limited ongoing efforts to monitor quality and access in a uniform,

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comprehensive way across all SCHIP programs. So I think that's an area where there is room for improvement. Third as Diane described, there have been perennial issues with the federal funding level and its structure, and these have grown more pressing over time as state programs have grown. I'll just allude to a couple of the issues. The federal funding formula depends on estimates on the number of low income uninsured children in every state. There are issues with measurement of that and whether that's a relevant indicator of need for coverage in the state, especially as programs grow; presumably the uninsured rates go down. In addition, states in the original statutes were given three years to use a given allotment, and that may have made sense at the time the program was ramping up, but as a consequence we have large balances of unspent funds in some states, where we have deficits in other states and that imbalance has grown over time.

In fact, at this point in time we're actually on the verge of what some people would characterize as a funding crisis. There was a partial fix to the federal funding shortages in late 2007, but by May 2007 anywhere from 14 to 17 states are projected to predict shortfalls. You may have seen news reports this week indicating that Georgia, which is the state that's really on the bubble here, has indicated

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that it will no longer be taking any new enrollees, and that even more drastic measures may need to be taken next month or the following month if more federal resources aren't forthcoming for that program. As I said, at the same time that states are facing shortfalls, there are $4 billion of unspent funds that have accumulated from past years. As it turns out about a quarter of those are in Texas, but there is no mechanism for getting them to the states that need them without really encountering some really hefty political battles.

So I think if I'm framing the key issues that seem to be coming to the surface of reauthorization, the first one has to do with the flexibility. How much to maintain and where to maintain it over a whole range of program choices that states have had over time. Second, how much federal funding to provide, how to allocate it across states, how to redistribute and whether to redistribute. Third, how and whether to tackle the uninsured kids who are eligible for these Medicaid and SCHIP programs but not participating, and there some of the policy issues that will be discussed involve policy changes, perhaps around revisiting documentation requirements that were implemented as part of the Deficit Reduction Act that a report that's in your packets suggests have had adverse impacts on Medicaid

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enrollment on children and spill-over effects on SCHIP enrollment as well. There are policy, federal policy issues around states being able to implement automatic or express lane eligibility programs and policies that can bring children more easily into public programs. It's a question of whether states have adequate financing to support new outreach efforts. There is a question as to whether performance incentives and rewarding states for achieving progress might be a tool that could be effective in increasing enrollment. I think there is growing recognition that the coverage problems facing low income parents may be having some spill-over effects on the participation of their children and their health care use.

Finally, I think a core issue is going to be whether quality and access gets more attention at reauthorization than it did in the original statute. The issues there are of a policy nature: what type of quality monitoring systems to recommend to states, how much to mandate, how much technical support states will need, how much federal funding, what kind of leadership the federal government will provide, whether there is a need for demonstrations in this area given that this is really a nascent area in terms of policy development. And while we don't have the specifics of legislative proposals for SCHIP, what is emerging is a pretty broad

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landscape in terms of different visions that run the gamut from really reducing the scope of SCHIP programs to cover just low income children, to expanding SCHIP to providing coverage for more uninsured children, either by increasing participation among the uninsured children who are already eligible for those programs or by further expanding eligibility to somewhat higher income levels where un-insurance rates are fairly high for children. There has even been interest expressed or suggested in viewing SCHIP as a model to provide coverage beyond meeting the needs of children and facing the broader coverage needs facing low income families and parents.

But let's first talk about what would be required to maintain the status quo. First, there is a short-term funding shortfall that could place programs, 14 to 17 programs in jeopardy in the coming months. But second, the longer term funding shortfalls are even more of a problem. The CBO baseline that's included for SCHIP includes an annual federal funding level of $5 billion. At that level, SCHIP enrollment is projected to fall by about a million and it's estimated that close to anywhere from $13 to $15 billion in additional funds would be required to maintain the programs at the current levels. But any additional funds beyond the CBO baseline are going to require offsetting savings

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elsewhere in the budget which raises all kinds of vexing issues in this budget climate. Now the President's proposal, from what can be gleaned from the budget and the public statements that have been made this week, really seems to put SCHIP on a more constrained track. As Senator Rockefeller indicates, it allocates less funding over the next five years than would be needed to keep the programs going in their current form and there seems an attempt to limit the program to low income children which raises a question about how do we define low income, what does that mean, how would the states that have already expanded coverage prior to the enactment in SCHIP be handled in this new vision. What would happen to the states that've been covering adults? And the best indications we have are with this type of approach, SCHIP programs would shrink and certainly not have the resources to make the aggressive outreach efforts and to bring more of the eligible but uninsured children into coverage.

The competing vision is to use SCHIP to cover more children. As all of us know, a growing number of states are viewing SCHIP as a piece of their plans to achieve universal coverage for children, and possibly universal coverage for all folks in their state. The reauthorization vehicle is being viewed as an opportunity to make more progress for

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children, to support state policies to increase participation and to improve quality. So I think what we're seeing are very different possibilities for the future of SCHIP at this point, but very important questions being raised. And fundamentally this will be a landmark piece of legislation in terms of whether the forward progress that we've seen in the last decade is built upon or whether we see retrenchment. Thank you.

SEN. JAY ROCKEFELLER: Thank you very much and Gayle Sandlin is, I have down here, "On the ground panelist." You're in the room. Isn't that the main thing? And you know what you're doing because you created the Alabama SCHIP program. It's called ALL Children – in capital letters, ALL. She oversees the development and the implementation of its $120 million budget. She's Director of the Alabama Department of Public Health and has over 30 years of state government service. So you've been through wars at the state level.

GAYLE LEES SANDLIN: Meaning wars.

SEN. JAY ROCKEFELLER: Yes.

GAYLE LEES SANDLIN: I want to say what a privilege it is to be here. I certainly want to start by thanking Senators Rockefeller and Collins for their leadership in moving us forward with this. I am just blown away to be up

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here on the panel with these folks. If you had told me ten years ago that this is where I'd be, I would never have believed it, and this is just a wonderful opportunity.

We have made some huge strides in Alabama covering our uninsured and that's what I want to tell you about today, what we were able to do with this legislation and how it's enabled us to move forward with covering our children in the state. You know, in Alabama we usually do social reforms through court orders or consent decrees. [Laughter] We've got them. We've got them in all kinds of areas, but this time we did something right in Alabama. There were a group of folk who were following this legislation as it was being passed at the national level and who saw what the opportunity could mean for our state. I want to tell you a little bit about that story and how we ended up where we are.

This is one true example of devolution where it's giving responsibility to the states to make the program meet the needs of the states. We were able to take into consideration in our state the political climate, the insurance market, health care providers system. In Alabama we have a unique relationship with our health care providers. Our Blue Cross Blue Shield insures about 82-percent of insured lives in our state. We only have a five-percent penetration of HMO in our state so it's very, very different.

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We were able to take that into consideration when we developed our program. We also took into consideration where it needed to be located and I'm going to tell you a little bit about that and a separate agency from our Medicaid. And we were able to design our eligibility criteria so that it fit our system.

I'm going to take a minute to show you how our program fits together, and when I speak to you today as the director of ALL Kids, I'm really describing experiences at various levels in most of the states throughout the country. Not that I speak for all the SCHIP directors, but I do want to give you general information so that you can see how the programs fit together. This is a schematic of our programs and how it exists. If you'll notice on the bottom of the chart, the gray area is where we were in coverage for temporary assistance for needy families. In Alabama, a whopping 13-percent of the federal poverty level — extremely low coverage. We are a state with very few resources. If you go across the bottom of the chart, zero to 19 is what the legislation enabled us to do and up to 200-percent of the federal poverty. In addition to that we had [inaudible] and Medicaid, and at the point that SCHIP legislation was passed, we were at the minimal level. So we took our SCHIP dollars and gave Medicaid coverage to the children 14 to 19 who were

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not already covered. That is now money that comes out of the Medicaid allocation. Our ALL Kids program sits on the top of Medicaid.

In addition to that, we were really fortunate to have our Blue Cross Blue Shield operate a Child Caring Foundation. They're in a number of states around the country. Ours continued to exist. They shut down in many countries. They had been trying to serve the children who ALL Kids now covers. We were fortunate in that they moved up to serve some children between 200 and 235-percent of the federal poverty level. I go into mentioning this because as I talk about some of our administrative principles, I want you to know and understand how the work that we've done affects children in all of these programs. We've taken the approach of trying to affect children, not just those who are eligible for the ALL Kids program.

This is an example or shows the growth in our program in our state. We've seen charts nationally as to how it’s worked. We're the same way. The gray is our growth in our Medicaid. Medicaid has been fairly stagnant up to the point SCHIP came along. I think we've got about 176,000 net growth in ALL Kids, Medicaid and the Child Caring Foundation. All of our programs have increased tremendously. Child Caring Foundation was running about 4,000 to 5,000 children before

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SCHIP. They're now up between 7,000 and 10,000 children. So everything has grown and we've done it together in a very, very collaborative fashion. We were able to do outreach to try to find children; this is the first time – before SCHIP came along, nobody out there was saying it was a good thing to get SCHIP kids enrolled in Medicaid. That was the first opportunity that was there. We did a joint application with all three of those programs. Many states have done that, so when a child applies for one program they're actually applying for all three. We built electronic capabilities between our agencies, using some Robert Wood Johnson Foundation money and SCHIP dollars, so that we could move our applications electronically between the agencies. Before that we had what I call the tote system. We used to put them in one of those post office boxes and tote them up the hill to the Medicaid agency. But now we move them electronically.

We have a seamless, family friendly enrollment and referral process. We achieve, try to achieve that. We were able to use – some states have used enrollment brokers. We have not done that and I'm going to show you our system that we've done, but we have procedures to keep children enrolled. We instituted a 12-month period of eligibility. Once we did that, Medicaid for children did the same thing. We have a renewal process where children can move between our agencies.

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Some other things that were there that I mentioned – we built a web-based application; we also have a mail-in application. We process applications centrally. Medicaid takes applications around the state. We feel that that complements each other. At our central location because of the outreach that we do, about 40-percent what comes through our office turns out to be Medicaid eligible. We think that's wonderful. The other thing that happened that surprised us all is that once we put our web-based application out there, 52-percent of the applications that came in turned out to be for children who were Medicaid eligible. That was a surprise for us that that many Medicaid recipients have access to computers and can use it. So all of those kinds of things have helped us increase the enrollment in the program.

One of the things that we did, instead of working with enrollment brokers we have something that I call teach the people who reach the people. We have spent some of our money on some fairly elaborate television and radio campaigns to get the word out there to market our brand to the people to know who we are. Then in addition to that, we hire our staff all over the state and their job is to be in touch with the folks who may be able to identify the uninsured. They are in touch with the doctors, the social service agencies,

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the hospitals, all the providers in the community because we know we're not able to find those children one-on-one, so what we do is get our information out to the people who touch the people and can help us find those who are uninsured. That, I think, all these things are examples of how even though the legislation, through compromise as I understand it, gave the flexibility to make the choices, those choices are what have made our programs so successful, I think, to be able to do it differently.

I want to touch on in these last few minutes some of what we believe are some of the crucial issues with re-authorizations. First of all, we want to make sure that the SCHIP program is funded at levels to support mature SCHIP programs. We've all grown. You've seen the charts. Alabama is right in there. We didn't spend our initial allocation, but we've ramped up; we're spending more than what we get in our allocation now. We want to see the enhanced match rate to continue to be put in place. That's enabled Alabama to take gigantic steps forward. We want to continue to encourage state flexibility. Senator Rockefeller talked about how initially they wanted a Medicaid expansion. We were given the option of doing a separate SCHIP program, out of compromise in the legislation from what I understand. That has been the backbone and the most significant thing

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that's enabled us to step outside those Medicaid boundaries, the negativity that was there, try some things differently to not only change ALL Kids, but also to change the Medicaid program and have a positive influence on that.

We'd like to see the prohibition in SCHIP programs removed that does not allow us to enroll children of state employees. There are many folks who actually work in our office under the state merit system who qualify for SCHIP but they are not able to enroll their children in the program because of the prohibition that’s there. We do not see that that is useful and would like to see that addressed in the re-authorization. We'd like to see some administratively simple processes to create some wrap-around programs for the SCHIP program. There are some families who do have limited insurance benefits but they're not complete. We'd like to be able to complement that and to help them. There is a process where you can do some things but it is extremely complicated that involves a lot of actuarial demands. We'd like to see that dropped and have it easier to operate.

In addition to that, we'd like to see some administratively simple processes where we can use SCHIP funds to help families move from SCHIP into private insurance. That is a big cliff for people to fall off of, when their income exceeds 200-percent of the federal poverty

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level and they need to move into the private insurance market. We'd like to see some graduated premiums or to be able to use SCHIP dollars to phase in to help families make that step into that. We'd like to see encouragement of Medicaid programs to be more aggressive in adapting family friendly processes for enrollment and renewal. We've been successful in Alabama because we adapted those in the SCHIP program. Our Medicaid program has stood fast in requiring documentation and putting in what we consider to be barriers. We'd like to see some of that addressed. We'd like to see it addressed on the Medicaid side so we can get children in there and improve their access to care. We'd also like to see PERM unfunded mandates addressed. PERM is a payment error rate measurement program which has to do with looking at the quality assurance and the error rate. Each state is required to have a 500 sample. For Alabama, we're right in the middle of the road. For California, that's a drop in the bucket. For some other states where they have a very, very small program, that is a huge percentage of administrative burden that they are having to put into that. We have to assume responsibility for that out of our 10-percent administrative funds. We'd like to see that addressed.

We'd also like to see established minimum coverage for states. Alabama is fortunate that we have been able to

achieve 200-percent of the federal poverty level. There are still ten states out there that haven't been able to do that. We'd like to see some encouragement. Let's bring it up to the minimum if we're going to do what we need for children.

And certainly not least but last, our motto is, let's leave no child behind. Thank you. [Applause]

SEN. JAY ROCKEFELLER: There are, I can see two microphones in the back and anybody is welcome to go to them. Cards have been collected so we're in motion. I think you have a question.

MARY AGNES CAREY: Yes, I'm Mary Agnes Carey with *Congressional Quarterly*. And my question was about adults being covered by SCHIP. I wonder if you could talk about the number of states, the number of adults that are covered. Was this allowed in the original law? Was it done by waivers from HHS? And if I understand the President's proposal correctly, they want to re-emphasize the program; they don't want the program to cover additional adults, but I'm not necessarily clear on that. If you could just explain the President's proposal and the impact it would have, as well as that background information.

DIANE ROWLAND, SC.D.: As I understand it, around 12 states now have waivers for the coverage of parents and six states for the coverage of childless adults. These were

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allowed as waivers under the SCHIP program. Congress has since said that the childless adults can no longer be covered utilizing the SCHIP funds. But around 600,000 adults, I believe, now get some coverage through these waivers of the SCHIP funds, but obviously quite small in comparison to the 6.1 million children that are covered.

We also know from some of the research that Genny and others have pointed out, that when you cover adults it helps to enroll families and to bring some of the children who are currently eligible but not enrolled into the program. Obviously from the perspective of getting a family covered, the children get access to care. When parents are covered, that promotes the chances of that.

GENEVIEVE KENNY: I would just add two things. One, new research that we've just done indicates that about 40-percent of all SCHIP enrollees have uninsured parents. And then second, the statute did allow for family coverage under the condition that it met a cost effectiveness test. That's not how the coverage to parents has been provided, but I think the statute did originally envision some type of parents being covered under SCHIP.

SEN. JAY ROCKEFELLER: All right. Is there any evidence to date about whether, one, Medicaid expansions, two, separate SCHIP programs, or three, combination programs

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are actually more effective than one another, separately, I guess. Is there an ideal model based upon your ten years of experience?

GAYLE LEES SANDLIN: I can address that. As far as any research, I'm not familiar with it, but having looked at other programs and talked with other folk; to me the benefit has been the flexibility of that program. What would have worked in our state would not have necessarily have worked in another state. In some states in made sense to do a Medicaid expansion; in Alabama, it did not. And I would like to encourage that flexibility to remain in the legislation in order to give us those abilities because one is not a better method than another. There are advantages and disadvantages in all of those. There are advantages in the Medicaid expansion program in that when you run out of your SCHIP dollars, you can flip into your Medicaid dollars. We cannot do that in a separate SCHIP program. However, we can step outside many of the Medicaid regulations in Alabama and have input into making some substantiative changes in our system that's there. Now Genevieve and Diane may know of some research that would document that, but it really is important, I think, to have that flexibility because what makes sense in one state may not make sense in another.

GENEVIEVE KENNY: And because states chose their

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programs, we don't know what the alternative would have been in terms of the gains in a given state from having chosen a different model, but we do know from the congressionally mandated study that included evidence from six separate programs, two combination programs and two Medicaid expansions is that all of them in all those states when you contrasted the experiences that children had before they enrolled in the program to those that they enjoyed while covered under the program, you see gains; you see comparable gains across the different programs. That's not to say that there aren't issues. For example, with special health care needs children, in some states with separate programs that have more limited benefit packages, but we don't have a good research basis for addressing that important question.

GAYLE LEES SANDLIN: While they're looking at another question, let me add something real quick. When we're talking about children with special health care needs, we had advocates at the table when we were developing our program. That was a huge concern. They felt like we were making the wrong decision by not doing a Medicaid expansion, that we were going to really leave children with special health care needs behind. We were committed to addressing that and when you look at improved access to care, in Alabama's SCHIP program children with special health care needs have actually

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had a higher increase in access to care than children without special health care needs. So we feel like even with our benefit package being a separate SCHIP program, we've been able to address that because we had the commitment to do that and to move forward with it. So it can present some barriers but we feel like we've overcome some of those.

FEMALE SPEAKER: The experience you're reflecting in Alabama is what we see nationally, that kids with special health care needs gain the most, but they still had the highest level of unmet needs of any children.

GAYLE LEES SANDLIN: Right.

FEMALE SPEAKER: So there are still issues there and that's not unique to SCHIP. That's true in Medicaid and it's true in private coverage.

GAYLE LEES SANDLIN: Yes. I know there's been some talk about including EPSDT, and again it addresses, I think, mostly children with special health care needs. We'd like to not see that burden. If it does make sense in a state to do that, let them do that, but we don't believe it makes sense in Alabama. It would be a huge administrative burden that would cost us a lot of money to do that when we believe we've already made those gains and that we're providing that for the children.

SEN. JAY ROCKEFELLER: Can you, because that was the

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question that I was going to ask. EPSDT is obviously the screening part, but there's also mental, dental, vision care, mental health therapies, personal care services, all kinds of things. So tell me again why that doesn't matter because you've got that covered in other ways in Alabama.

GAYLE LEES SANDLIN: We have. When the program was put in the Department of Public Health, the State Health Officer, Dr. Don Williamson said, "I want a good comprehensive benefit package. Not a Cadillac, but a Chevrolet." Kind of corny, but it made sense to us. And so what we did is we looked at our insurance benefits to make sure that children did have access to dental care, to vision, to all of those that are there. We do have some limitations on mental health benefits, but one of the things that we've done is we've put in place something called ALL Kids Plus, where we've contracted with state agencies and if a child runs up against the maximum benefits in our package, they can access, through the state agency putting up the match, additional benefits to receive mental health benefits for them. One of the things that we found in working with state agencies is most of them have not had to access that, that they've been able to get what the children need through our basic benefit package. So by having a truly across-the-board, comprehensive benefit package, we've been able to

address those needs of children.

SEN. JAY ROCKEFELLER: Let me press one point further. I think I read, I know I read in one of the papers this morning that there is some study out showing that one in every 150 children born in this country suffers from autism. How do you found that out in your program?

GAYLE LEES SANDLIN: Well, we haven't found it out yet. Within the last three months, we've been pulling together some autism experts because we have a mental health advisory council that meets with us at least quarterly. And through the meeting of that are providers and advocates and families that sit with us to look at our mental health benefits. They identified autism as an issue. So we brought people in to help us understand a little bit better. One of the things we're finding is when we carved out our mental health benefits to contract with United Behavioral Health, there was difficulty in knowing does autism fall under the medical side? Does it fall under the behavioral health side? What we're learning is it falls under both sides. That there are issues that need to be addressed, so we are trying desperately to make sure that we're not eliminating those services to those children. We're just in the process of trying to figure that out. We're not there quite yet.

SEN. JAY ROCKEFELLER: Okay. That's fairly

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incredible, isn't it, Diane?

DIANE ROWLAND, SC.D.: I think that the important thing here is what the scope of benefits is. What we see in the Medicaid program is obviously a comprehensive benefit package that requires a wrap-around for the EPSDT treatment benefit and very little cost-sharing so that it is sensitive to the incomes of the people that are on the program. And what we really need to look at in some of the SCHIP programs is to what extent is the benefit package sufficient, and that obviously varies across the states, and to what extent do the families that are low income but just above the Medicaid level have the ability to pay what is now being required in terms of some of the cost sharing. So I think there are a lot of issues in terms of looking at income and looking at scope of services to make sure that we're promoting access, and that's really where the difference comes in some states between the SCHIP program and Medicaid.

SEN. JAY ROCKEFELLER: Yes, sir.

AARON MCKEITHEN [MISSPELLED?]: Hi, I'm Aaron McKeithen from the Lewen Group. My understanding is that some SCHIP directors at the state level have expressed concern about the methods used to determine, I think, through the current population survey, used to determine the allotment each state will receive. I've heard a lot of

grumbling about that but I don't know what, if any, alternatives might exist and whether the re-authorization debate might include some of that. Can someone explain that?

GENEVIEVE KENNY: As an issue, that's bedeviled the program from the outset. The formula and the allocation was based on estimates from the current population survey originally of the number of low income uninsured children in every state. The sample frame is an issue. There are small samples in many states, and then there are measurement issues. Over time the formula is broadened to include a weighted average of the low income uninsured estimate and the number of low income children in the state.

If you think back at the outset, that might have been a good metric for gauging the need in the state for allocating dollars for this new program. But in this point in time, it doesn't bear that close a reality to the spending patterns and the enrollment levels. So I think this is very much an appropriate time to re-evaluate the federal funding formula and its allocation in terms of where we are now, 10 years later.

DIANE ROWLAND, SC.D.: It also points out that whenever you cap a program and have an allocation where states spend up to a level, you do get up into formula fights about which states get what amount of money, which obviously

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is not the case in the Medicaid program which does not have the capped entitlement. So it really is a difference in what you have to put on the table when you have to decide to allocate funds out across the states instead of matching spending on an open-ended basis.

GENEVIEVE KENNY: If I could just link that back to the earlier question on parents, many of the states were not in a position to use their allocations on low income children because they'd already expanded coverage to children prior to 1997. So the formula and their allocation bear no resemblance to their ability to provide coverage to low income children because they already were. So, in fact, many of the waivers grew out of the recognition that a number of states couldn't use those funds to cover low income children, but that they could use them to cover other groups that would serve that greater purpose.

GAYLE LEES SANDLIN: And CPS data is an issue, and it's an issue for Alabama with us having such a low sample size. However, we can't find anything else that's out there. We've reverted to that. We were successful in getting a grant to do a one-time survey of the uninsured in the state and it showed us that we were in the ballpark of what CPS was projecting with that. It's going to be an even larger issue, I think, in re-authorization if it's not addressed because

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one of the major pieces is looking at the number of uninsured children in the state. So those states like us that have made some tremendous progress aren't going to have as many uninsured children, but we're seeing a huge turning of children. Children moving from Medicaid to ALL Kids to private insurance, back to Medicaid and moving in between the programs that are there. It's going to have to be addressed at some point in the re-authorization.

FEMALE SPEAKER: My question is for Genevieve regarding the administration's budget proposal of $5 billion in funding for the program over five years. I understand that's about one-third of what's needed. I'm wondering about your estimate that only a million children will be cut from the program. I'm wondering how that will work since there are 6.2 million covered and yet the proposal is only for a third of what was supposedly needed. Does that assume states would pick up a lot more?

GENEVIEVE KENNY: The first thing is that there is already $25 billion in the CBO baseline. Then it's estimated that another $15 billion may be needed on top of that just to keep programs going as they are currently going. So the $15 billion is the relevant gauge for the $5 billion on a smaller base. That's the first thing. The second thing is we don't know how many children would lose coverage because there are

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a lot of things that that would hinge on. If state's could no longer use funds to cover adults at all that would free up some resources. If all the unspent resources of the funds that have accumulated could be reallocated automatically, that would free up some resources. But I think no matter, even if you make those assumptions, it's hard to see that there's enough resources there to cover the kids who are currently covered, let alone to bring in more of the uninsured kids who are eligible. But we're just dealing with very new budget information and the hard work of trying to sort out the enrollment implications has just begun.

GAYLE LEES SANDLIN: In some raw calculations for Alabama, it would reduce our program by about 25-percent. We would probably see more than 25-percent of the children reduced because you've got to maintain some level of administrative cost. It doesn't decrease proportionately with that. But that's just a raw calculation of 25-percent reduction.

DIANE ROWLAND, SC.D.: And just in terms of where states are today, the proposal the President has put forward talks about refocusing the program to children under 200-percent of poverty. Seventeen states already cover children above 200-percent, and in 19 additional states they're covering children at 200-percent of poverty, but the income

disregards they use effectively raise that income somewhat higher. So how the Congress deals with this proposal will really determine what its impact is on the current level of state efforts as well as on future efforts.

SEN. JAY ROCKEFELLER: All right, a question — just a moment, sir — a question here. Could Ms. Sandlin speak to the differences in provider payments on SCHIP versus Medicaid in Alabama?

GAYLE LEES SANDLIN: One of the interesting things that happened in Alabama, and I forgot to say we're the oldest living SCHIP directors around. It gets you in different places and you see a lot of stuff that's going on. One of the things that happened in Alabama, when we started and stepped outside the Medicaid system, we purchased the Blue Cross Blue Shield discounted PPO rate, is what we purchased when we put our program out for bid. It was different from the Medicaid reimbursement rate, but one of the things that happened is a lot of our providers and advocates then went back to our governor after they had done a survey with some of the pediatricians. Basically they said how does ALL Kids look and how is it working for you? How is Medicaid? You can guess what the results were that came back. It was that ALL Kids was wonderful. Medicaid really isn't wonderful. It's got big time problems. They took that

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to the governor and what we were able to do was to get the Medicaid reimbursement rates raised for children, so what we've been able to do — there's a bright spotlight that shines on SCHIP and instead of pitting SCHIP against Medicaid, we've tried to raise the floor of Medicaid, if that makes sense, rather than lower the floor of SCHIP. We've been able to do that so that the rates are fairly comparable.

The other issue with that is that there is more limited access to providers in Medicaid. There is stigma attached with that. One of the things we do a lot of times when families apply to ALL Kids is they end up being Medicaid eligible and they don't want to enroll in Medicaid because of the stigma. We've trained our staff to try to coax the families to understand that we know where they're coming from; we understand that stigma. If you put Medicaid to ALL Kids with EPSDT, you actually have a little bit more that you get through EPSDT than you do. We try to explain that to families. We also try to help them understand that this may be an opportunity if you're going to a pediatrician who has been accepting ALL Kids, perhaps they will take your Medicaid. We're slowly getting more pediatricians accepting Medicaid reimbursement and making a positive influence on that. There are differences but we've tried to, I kind of say, chip away at them. [Laughter] Anyway, it's kind of

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corny. We've got all kinds of corny things that we say down there. It keeps us pumped up. [Laughter] So we've tried to address it from that aspect that there were differences and rather than trying to lower the floor of SCHIP, we've tried to raise the ceiling of Medicaid. Or vice — however that works.

SEN. JAY ROCKEFELLER: Please.

MALE SPEAKER: Thank you for presenting as panelists and for taking questions. One concern of mine is the future of SCHIP. Even with some creative refinancing strategies and changing eligibility requirements, with a flat-lined budget perhaps with added, perhaps some congressional intervention in the years to come, it's still going to be very difficult to cover all children up to 200 FPL.

Now my question is this; in that context, there are a number of proposals on the table by presidential candidates and several states that have taken steps toward institutionalizing universal health insurance. How would SCHIP and how would this current congressional activity fit within a longer term scheme of generating sustainable insurance coverage for children, and for that matter, their families?

SEN. JAY ROCKEFELLER: Well, we don't talk any presidential politics in here, Diane, so you —

DIANE ROWLAND, SC.D.: We do clearly see when we look at Massachusetts, the California universal coverage proposal, the work going on in Illinois, now Pennsylvania, Senator Collins' home state of Maine, that the Medicaid program and the SCHIP program are really a fundamental part of any of the efforts to move toward more universal coverage at the state level. So I think there is a lot hinging in terms of whether the state efforts can move forward on what happens in the reauthorization process to the SCHIP funds. Because what we've seen, at least at the state level, is that governors understand that when you're low income, the best access to care, especially for children, is through the improvements in the public programs and they've been building on that. It would really be a step backward for many of the state reform efforts to not have the ability to build on their Medicaid and SCHIP base for not only children, but especially for parents. California has actually proposed in it's universal coverage proposal to cover everyone under poverty, childless adults, parents and children, under the Medicaid program and then build on that for SCHIP above that so that it is a fundamental building block and most of the states I think will get nowhere in terms of trying to achieve universal coverage if they have severe limits or cutbacks in what they're able to do with their public support.

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SEN. JAY ROCKEFELLER: I'd add a not necessarily very pleasant addendum to that. I think that this — and you did some of these polls — everybody who did polls back in the early '90s when the Clinton health care proposal was being developed. Almost all the polls showed that 72-percent of the American people would be willing to see their taxes increased if we could get universal health care. Now there was only one problem with that and that is they lied. [Laughter] It's one of those things that is easy to say in a poll, but people don't want to do that. So I think the more fundamental question is, how serious are we going to be about health care? Look, we've got a budget and we're discussing is it going to be $5 billion or $15 billion or something in between, and yet we've got a couple of wars going on which aren't included in the budget. If China decided to float it's currency for a week or so, a lot of America would kind of disappear, and I really mean that. They did that about three or four months ago and the world shook because they own so much of our expenses. Same thing with Japan; they are more stable that way. South Korea, we'll see.

But the Clinton health care, regardless of what one thinks about the substance of it, it took the wind out of bold thinking. And that's why, particularly to those of you who are working congressional offices with the people who we

most prize at these hearings, it's why it’s very difficult because people now are — we've decided that baby steps are acceptable and then we rationalize that baby steps lead to larger results, but that's all assuming that the baby steps grown. I just put this to you, that the Democrats now control the Congress and the all this that the Democrats have decided to be the pay-as-you-go party, and that's terrific for the budget and terrible for people, because it means that there really isn't virtually any money, and particularly if you told the truth about what's not in the budget, what's not included in the budget, we're in a very dire circumstance. I just say that out of frustration because that's why we have this alliance. That's why we've been doing this for 15 years. It just happens that during those 15 years, we've been through the roughest times in terms of the psychology and the drive for bold steps on health care. All these, not so much lack of ideas, but just that we don't have the money or we don't have this, we don’t have that. Pete Stark and I, I think for ten straight years have introduced what we both think is a terrific bill. We'd love to have a third person in the Congress think so. And that is, it's called MediKids and I believe in it; Diane, I bet you do too, if we could find the money. That is that just by virtue of being born, that any child is included in Medicaid regardless of

anything, and that they stay included until they graduate from college. Because as you know, college students don't tend to get health care, they don't seek that coverage. We think that if we could get that in place, it would be enormously expensive, it would change the dynamics, the psychology of the fight rather than in filling in the backboards. It would be a forward progress thing. There would be a mandate to fulfill it. It would make it to cover everybody. But that's not going to happen. See, that's not going to happen. And so I think that's one of our conundrums is that where do we get our will? Where do we get our courage? How do we do our priorities, tax cuts, wars, all the rest of it. How important really is health care. If we're now losing ground from where we were during the Clinton plan, when I think it was 37 million and now we're up to 46. Everything is getting worse constantly and will continue to do so. So that's the reason that we value your coming to these things because one of you is going to come up with an incredible idea of how to solve these problems. Aren't you?

Okay, I have a question. States that cover parents; do they cover both parents or only residential parents?

GENEVIEVE KENNY: It's residential parents.

SEN. JAY ROCKEFELLER: Okay. What is being done or considered to analyze long term health outcomes resulting

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from SCHIP coverage especially in terms of cost saving, which could help to undermine the cost of the program?

GAYLE LEES SANDLIN: I can address that from an Alabama standpoint. We've done extensive surveys since the beginning of our program and some of the claims analysis, ability through our office in looking at that, and we've seen tremendous progress. CMS and the legislation requires us to report on, I can't remember if it's three or four HETUS measures, to look at children having access to care and getting appropriate use of asthma medications, immunizations for two age groups, and I think there's a fourth one. I can't remember exactly what that is. But we're continuing to move in that direction and have seen that there has been a tremendous increase in the health care that's there. I know other states are involved in that as well. Genevieve, can you add to that?

GENEVIEVE KENNY: I would say that that's a whole, and it's a very difficult issue to address from a research standpoint, but it would be very valuable from a policy standpoint.

GAYLE LEES SANDLIN: In beginning to step in that direction. The other issue that I wanted to add based on what Senator Rockefeller was saying, while I understand the dilemma as far as the budgets and funding, those kinds of

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things. But I think we have to remember that children are our future and we've got to get them off from a good start. That's my public health training and experience that I have from that. I think some of the progress that we've made through SCHIP in making the programs administratively simple and stepping out of some of the Medicaid boundaries that are there, to make it simple to operate it and our error rates are no different than Medicaid error rates by having it done administratively simple. But children are cheap and if that's the direction then let's start there and begin to move forward.

ED HOWARD: Senator Rockefeller had to leave and we have about 15 minutes to go. He whispered in my ear as he left, "Have them fill out their evaluations." [Laughter] So if you would, in honor of Senator Rockefeller and Senator Collins, would you pull out those blue evaluation forms and fill them out as we wind down the question and answer period so that we can improve these programs for you.

I wanted to use some of the questions that you had submitted on cards. One related to something that Gayle addressed in a previous question, and it has to do with payment rates more generally. The questioner asserts that for most SCHIP providers, the rates fall far below Medicare. Some as low as 50-percent or 60-percent of Medicare, and the

question is in light of the other reimbursement issues that are facing physicians and other providers, what is being proposed to address those needs? Should SCHIP be expanded? And I might add, should SCHIP be kept even at its current level? Genny?

GENEVIEVE KENNY: I would just dovetail that with a discussion about the adequacy of our tracking and monitoring of quality and access under the program, under both Medicaid and SCHIP. So I think the provider reimbursement issue is one that could translate into access problems for particular groups of children, so that re-authorization is a time to evaluate whether we're getting the information that we need to assess whether the lower payment is translating into compromised access. But fundamentally, the federal funding level and how many resources are there are going to be key in determining not just whether states keep their current programs intact, but really how generously they pay providers. It's all a part of the same package.

DIANE ROWLAND, SC.D.: I would also say that previous legislation used to require studies of whether the Medicaid payment rates promoted access or not. Those have been repealed from the Medicaid statute, and maybe it's time to revisit putting back in an evaluation of the impact of the payment policies on access to care.

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ED HOWARD: Thank you. A rather simply stated question here. Why cover kids at 300-percent of the federal poverty level before we cover uninsured adults at under 100, or 13?

DIANE ROWLAND, SC.D.: I think that is a major question, and I think that when we look at the uninsured population, Gayle said, "Kids are cheap," and so one of the reasons that it has been easier to expand coverage to children is they're both cheap and popular in comparison to both their parents and especially to childless adults who aren't even eligible for coverage under Medicaid no matter how poor unless they become severely disabled. It really is, as the Senator put it, a question of priorities and a question of getting the funding, and it has in many places been an easier funding task to look at children than it has been to do comparable coverage for working parents and childless adults.

GAYLE LEES SANDLIN: I'll add from the standpoint that Alabama has not been able to move in the direction of improving the care to adults. One of the reasons is our resources are extremely limited. But this has enabled us to move forward with children, but I think we've got to look at the whole access to care, the whole arrangement as to where our priorities are and where to go from there. The current

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funding system really rewards states who are able to step out, who have other resources to be able to insure children at higher rates, and possibly adults, and move into that rather than helping poorer states, like us and some of the others, move the floor up higher. I hope that will get addressed as we go in having some requirements, particularly for children.

ED HOWARD: Yes.

FEMALE SPEAKER: Hi, I was wondering if —

ED HOWARD: Do you want to identify yourself, please?

ROCHELLE CARPENTER: Sure. I'm Rochelle Carpenter. I work at Summit Health Institute for Research and Education. I was wondering if the trends you see in racial and ethnic disparities, or access disparities in this case, are reduced solely by focusing on income and economics or if there are other strategies being employed.

GENEVIEVE KENNY: I want to make sure I understand the question. The point I was making is that when you look over time in the past decade, you've seen a narrowing in the gaps, racial and ethnic gaps, in insurance coverage and in access to care. You see Hispanic and other minority children just proportionately gaining because they're so much more likely to be low-income. So that was the point I was making. I think maybe you were addressing perhaps broader attempts to

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address these issues.

ROCHELLE CARPENTER: Right. I was just wondering if it did just have to do with the fact that they were more likely to be of low economic status. Thanks.

ED HOWARD: There is a question asking if the panelists could speak about funding ceilings and the extent to which ceilings enter into states' shortfalls; pretty straightforward.

DIANE ROWLAND, SC.D.: Clearly when you set a fixed amount and you allocate it out to each state, the components of how you decide what to allocate out, as we've talked about earlier, the data limitations mean that it's an imperfect match between what may be on the ground in terms of what a state has to deal with in terms of trying to address it's uninsured children. So the difference between a capped program is that you're going to allocate funds out, it's going to be imperfect and some states will face shortfalls while other states, like in the case now of Texas, will not spend their allocation. In the case of a program like Medicaid in which the dollars follow the beneficiaries, you have the matching funds available for everyone you enroll. In the case of SCHIP, you have matching funds up to an allocation which may be imperfect, and then either you have to spend fully out of state funds or you have to freeze

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enrollment or stop enrolling children. So there really is a difference between how an open-ended program of matching works compared to a capped program where you have both the issues of whether the allocation is fair and is justified to each state, and on what basis do you do the allocation.

GENEVIEVE KENNY: I think there is the cross-state allocation issue and then there is the extent to which that fundamental allocation level is appropriate to the economic times. We know that the business cycle has a profound affect on the number of kids who need public coverage. So to the extent that the block grant is not responsive to that, the core funding level leaves kids much more vulnerable during economic downturns through a block grant funding mechanism.

GAYLE LEES SANDLIN: One other point that I wanted to go back and reiterate that I covered in my slides is that separate SCHIP programs are prohibited from being able to draw down the Medicaid dollars for that. So the current funding mechanism, having SCHIP as a capped program really is to a disadvantage to separate programs and Medicaid expansions because you can flip those children into Medicaid to do that. So if we continue the flexibility of states being able to design the programs according to what meets their needs, then we need to look at that funding flexibility and being able to tap into some of those dollars as well.

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ED HOWARD: I think we may just have time for this last question. It's a fairly narrow one. All SCHIP programs now provide some dental benefits even though they are not required to provide them. Should the definition of well-child care, which is required, be expanded to include dental care and, alternatively, how else could erosion of dental benefits be prevented when states have funding shortfalls? I have to say we've done surveys over the years and many of you who have just filled one out on various topics that we had suggested, a lot of people in this town work on dental issues have asked us to do briefings. It's never gotten the kind of level of interest, but every time I read research or references to research, it is so connected to health, particularly for kids, that it is very hard for me to understand that. So I'm interested in our panelists' response.

DIANE ROWLAND, SC.D.: I wish Senator Rockefeller were still here since I remember at one hearing him asking about dental benefits, because as a Vista worker in West Virginia, he realized that one of the big barriers to the people he was working with getting jobs and being able to participate in the workforce was their total lack of dental care and that dental care was as important to the health and well-being of both children and adults as some of the medical

care that is delivered. So I think he would at least say dental care ought to clearly be continued to be part of the health benefit package. And we know that it is one of the real gaps, even in the Medicaid program, in terms of access to care. Dental benefits, while offered, are often very difficult to obtain because of low provider participation.

GENEVIEVE KENNY: While dental benefits are optional, they are the norm and it's the rare exception when states haven't offered them. But to link that up with something Gayle mentioned about the growing under-insurance problem facing low income families with private coverage, there are actually more issues with low income private families getting access to dental care than there is in Medicaid and SCHIP in this point in time.

GAYLE LEES SANDLIN: Just from our experience, we included dental benefits; the state health officer believed that that was very important because there is a direct connection to that. The first two years' operation of our program, 25-percent of what we paid out was for dental. We had a huge pin-up demand for that, children who had drastic problems. We do have a $1,000 maximum that we will pay. We've pulled the preventive services out of that max and we are still doing lots and lots of restorative work for our children. We will take children by exception though, and

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looking that if it's going to be a condition that's going to lead to higher expenses then we will approve and go beyond that $1,000 max in order to prevent additional work that is there.

Using our Blue Cross Blue Shield provider network, we've had pretty good access to dental care for that and Medicaid had an initiative at the same time and has been able to increase the dental providers in the Medicaid network mainly by raising the rates that they are paying for that. But it is still a huge issue. The other piece that I just happened — and I'll probably get in trouble for saying this, but I'm going to go ahead and say it — is that when we were starting our program, we didn't get a lot of help from the dentists themselves in improving that access. As a matter of fact, they fought some of what we were trying to do in giving children access to care and begged us to pull them outside the network, to not use the discounted rates, to do many kinds of things, but we've monitored it very closely and we've gotten some really good results with that. But it is critical and some states just haven't been able to address that. I think that is a big wrap-around issue that would be helpful to address.

ED HOWARD: I think we've just about come to the end of our time, and I want to say first of all that you ought to

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be congratulated for staying alert, showing up on time and not wandering in right now and wondering where lunch is. [Laughter] So thank you for coming and being such a good audience to this.

We mentioned a couple of times that this is the first of three programs that we hope to focus children's health coverage in. The next one is February 26, when we're going to try and take a closer look at those six, seven million of the nine million uninsured kids who are already eligible for one of these programs and are un-enrolled. Mark that on your calendars. Please fill out the blue evaluation forms.

I want to thank the Kaiser Family Foundation and the Commission on Medicaid and the Uninsured, not only for being involved in planning this program, but being so timely about it that we were able to put it together in a way that was useful in this process.

Finally, I just want to tell you before we thank the panel, how wonderful it feels not to have to welcome you on behalf of Senator Rockefeller and Senator Collins. This is a rare treat and I hope we're going to be repeating it over the course of the next year often enough. Yes, we did have wonderful explanations from our panelists and I would ask you to join me in thanking them for that. [Applause] And I'll bet you can find a better lunch yourself.

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