Improving Coverage Stability for Kids in Medicaid and SCHIP
Alliance for Health Reform
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ED HOWARD: I'm Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of our board, our Chairman J. Rockefeller and our Vice Chairman Bill Frist to this program is on instability in insurance coverage in children in both public and private programs. They're coming to take us away I guess. [Laughter] I thought we were going to have a program. Hundreds of thousands of kids every year lose their health insurance coverage, and most of them regain it at some point. It's called churning, an inelegant label for an undesirable phenomenon, I would say. Our partner in today's program, as a matter of fact, as it was on Monday's program that dealt, in effect, instability of coverage among older people, is the Commonwealth Fund. We are very pleased to have Sara Collins with the fund, who has been working on putting this program together, with us. I want to thank Karen Davis, Ann Gauthier and the rest of the folks at Commonwealth for both their interest in and their support of projects like this and programs like todays.

We're going to take a look today at how coverage gets disrupted for kids, what the consequences are, and what some possible remedies are. We have a couple of very insightful papers, and their authors, on hand to help us in our examination. Here's a couple of quick logistical points. We have lots of materials that you will find of interest in your

packets, including more extensive biographical information than you will hear from me about each of our speakers. Tomorrow morning, or I guess Monday morning, you will be able to view a webcast of this proceeding on KaiserNetwork.org and if you want to really have an exciting subway ride in, you can get a pod cast of this briefing and listen on the redline. There will be a transcript available, both on the Alliance Web site at AllHealth.org and on KaiserNetwork.org, in just a few days. I am sure you're going to make an effort to fill out that blue evaluation form before you check out, and there are green question cards for you to fill out for that part of the program when we get there. You will also have the opportunity to use the floor mikes as well.

As I said, we have a terrific group of speakers gathered to help us explore the issue of churning, and I want to get started on that right away. We are going to start with Laura Summer, who is a senior research scholar at Georgetown's Health Policy Institute where she concentrates on state activities in publicly run health and long-term care programs. I think she is a first-time Alliance panelist, but we have known her for a long time, particularly for her work Robert Freedland [misspelled?] at Georgetown's Center on an Aging Society. She is also, more relevantly, the author, with her Georgetown colleague Cindy Mann, of the thick paper in your packets that is the jumping-off point for most of

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

today's discussion on this phenomenon of coverage instability. Laura thanks for joining us. Let's get started.

LAURA SUMMER: Thank you, Ed. If my colleague, Cindy Mann, were here sitting at the end of the table, and I assure you that she will be here soon, she would join me in thanking the Alliance for the opportunity to be here, as well as thanking the Commonwealth Fund for their support of our project. As Ed says, the problem of churning, which is a particular type of insurance instability, is a particularly significant one in this country, and particularly in public programs such as the Medicaid and the CHIP program. It affects families and children and the type of care that they are able to receive. It also is costly; time and money is wasted because of churning, not only for the public programs, but also for the health plans and the healthcare providers who work with public programs. We think it is not an intractable problem. Our work shows that certain policies and practice changes in states can make a significant impact on the stability of public coverage. What we set out to do was to come up with some very practical recommendations to reduce churning in public programs. The approach that we used was to look specifically at operations in four states. Those states are Louisiana, Rhode Island, Washington and Virginia. They represent a variety of policies and a variety

of circumstances. They also are four states that were successful over the period that we studied, in that they had increased enrollment in their programs. But the fact is that enrollment is a function of the people coming into the program and the people leaving the program, so we were particularly interested in looking at those enrollment patterns, not the total numbers, but what was going on behind those numbers, why it was going on and what changes might be possible. As I noted, she would be here and she is.

The first thing that we did was talk with a variety of stakeholders across the country, but particularly in these four states, about the consequences of churning. What we heard over and over again was that administrative costs are higher because of churning. Perhaps the best indication of this comes from the fact that health plans and healthcare providers are willing to make significant investments in ensuring that people participating in the Medicaid and CHIP program stay enrolled. We heard, for example, from the Neighborhood Health Plan in Rhode Island that they spend about $100,000 each year on activities related to retention. We also heard from them, as well as a health plan in Virginia, that they spend between $200,000 and $300,000 a year on activities related to un-enrolling and re-enrolling families. So clearly there is a financial stake there. We also heard about delayed, inappropriate, or more costly care.

The community health centers, for example, told us that when patients don't have coverage, they don't stop coming to the centers; they still come and still receive primary care. The centers don't get reimbursed to the extent that they would if these families were covered, but when they're in their gap period without coverage, they get care. They get primary care; they don't necessarily get specialty care. If a referral has to be made, that is where a problem comes in. Also, if prescriptions are required, there just may not be funds there to pay for the drugs that are needed. Data from Rhode Island illustrates this. You can see that this represents the RightCare program enrollment over a year's period of time. The families that were enrolled continuously were less likely than the families that were enrolled intermittently to say that they had difficulty obtaining medical care. In fact, you can see those with intermittent coverage were four times as likely to say that they had difficulty.

What I would like to do next is discuss four specific recommendations that we would make to increase stability. The first recommendation concerns the renewal process. Many states have made changes in the renewal process to simplify it. They've shortened forms, they provide information in languages other than English, they provide assistance at the time of renewal, they streamline verification requirements,

and these are really important steps that these states have taken. But Louisiana has actually gone one step further. What Louisiana has done is do away with traditional renewals for a portion of their population; this slide shows that it is for almost two-thirds of their population of children who are eligible for renewal. What happens in Louisiana is if a child is up for renewal, the first thing that the eligibility worker does is check state records, information on hand such as food stamp records or employment records, to see if the family can potentially continue their coverage. If they're found to be financially eligible, coverage in continued, and they're simply informed that their coverage will continue. If there is some additional information that may be needed, a phone call can be made. As a result of these processes in place, only one-third of the children have to go through that traditional renewal process. As you can see from the next slide, this new way of doing business has really had an impact. The proportion of children that complete the renewal process successfully has increased from 72-percent to 92-percent over about a four-year period. At the same time, we heard from Louisiana that the administrative costs associated with renewal were decreasing.

Our second recommendation has to do with the frequency of renewal. It is illustrated pretty nicely here with this slide from Washington State. What happened in

Washington in July of 2003 is that, because of budget pressures, decisions were made to change the renewal period from a 12-month to a 6-month period. You can see pretty graphically that following that change, as well as a few other changes in the renewal process, enrollment dipped. Later in January of 2005 when a new governor came in and issued an administrative order to return to a 12-month period, the enrollment figures show pretty dramatically what happened; they went up.

Our third recommendation is for smooth transitions across public programs. By this we mean transitions between the Medicaid and CHIP programs in states that have both of those programs, or transitions when a family loses coverage through TANIF or food stamps, but remains eligible for Medicaid. This is a pretty straightforward recommendation. I don't think anybody would really argue with it. But we thought it was important to include it here, because when we looked at what was going on in the four states, we found that implementation was very difficult. As a result, the gaps that we were seeing and the extent of gaps in coverage also differed. So we would just stress the need for information systems that communicate well with each other for cooperation and coordination among division and departments in the state and for a process that is as automatic as possible.

The fourth recommendation is to consider the impact of premiums on churning and on the stability of coverage. You can see from this slide that, indeed, premiums do have a significant impact. What this slide shows is that 60-percent of the people who lost coverage in the RightCare program because of failure to pay premiums in the previous year, 60-percent of families, lost coverage but re-enrolled in the next year. This is a clear indication of churning. So our suggestions would be in addition to considering whether there should be premiums at all, it is important to also think about the affordability of the premium and about options that people may have for paying premiums. Most states collect premiums on a monthly basis, but some allow people to pay annual fees if that is more convenient. There is an option for payroll deduction for public insurance in Rhode Island, and there is some experimentation going on with allowing premiums to be paid at convenience stores and other places where families might be likely to be able to pay them.

One factor that is not part of our report because it didn't need to be part of our report at the time we were doing our research, but which I think is really important to mention, is the new rule for Medicaid applicants who are citizens to provide proof of citizenship, as well as for Medicaid enrollees to prove citizenship at the time of renewal. As I said, this was not relevant at the time we

were doing our research. I suspect that if we did the same research three months from now, after July 1 when the rule goes into place, that that particular factor would probably jump to the top of the list of factors that account for insurance instability.

This is the final slide. I wanted to end on a positive note. This comes from Louisiana. Each of these bars represents a two-year period. The initial period from January of 1999 through the next two years is the time that we followed children. We were looking at whether they had gaps in coverage over that two-year period, and 18-percent of them did. We excluded children who would age out of the program. We looked again over several periods of time and you can see by the last period of time, only 5-percent of the children had gaps in coverage. So I think this represents success. It also represents, I think, pretty clear evidence that a comprehensive, coordinated approach can be effective at increasing insurance stability. Louisiana had a lot of support from their leadership. They had a real commitment to making systemic changes. They did training across the state explaining to eligibility workers not only what the new procedures would be, but also why those new procedures were being put into place and what the new philosophy of the state was. Finally, in Louisiana they collected, they analyzed, and they used data to figure out what was working and what

was not working. We are fortunate to have it today to demonstrate that such efforts can work.

ED HOWARD: Excellent. Thank you, Laura. We turn next to Stan Dorn, who is a senior policy analyst at the Economic and Social Research Institute. Stan's focus at ESRI has been the uninsured, so we at the Alliance have been keeping pretty close watch on his work. His paper on automatic enrollment, which is what he wants to inform you about today, is in you packets. He has been on Alliance programs several times in the past. He is probably as knowledgeable as anybody in the country on, for example, the Trade Act tax credits for displaced workers. We're happy to have you back, Stan.

STAN DORN: Thank you so much, Ed. Republicans and Democrats in Washington, if they haven't been able to come together on anything, have been able to come together around children's health coverage. In 1997 when the State Children's Health Insurance Program, SCHIP, was enacted, it was very much as bipartisan affair. Today, Republicans and Democrats alike agree that a top priority needs to be insuring children who qualify for Medicaid and SCHIP, but are not enrolled. That is why I am excited to discuss with you today an innovative strategy for accomplishing that widely shared goal. I think this is an area where we could see some progress. I'm going to talk about three things today. First

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of all, we'll discuss who uninsured children are. Second, we'll talk about automatic enrollment and why it represents a very exciting possible new strategy. Third, we'll talk about ways in which federal policy makers could make it easier to pursue this approach. Before I say anything else, I would like to thank the Commonwealth Fund. Sara is here. I would also like to thank them for supporting the research that Genevieve, Kenny and I have done and thank the Alliance for letting us share this information with you.

So which children are insured? Well, soon after the SCHIP law passed, the country saw a dramatic reduction in the percentage of uninsured children, but for the past few years, the reductions have been small. Not 3 or 4-percent at a clip, but a tenth or two-tenths of a percent. As of three or four years ago, three-quarters of all eligible children were already enrolled in Medicaid and SCHIP. That represents a high watermark for traditional public benefit programs like EITC and Child Health; that's as high as it gets, as good as it gets. This raises the question about whether we need to go beyond the traditional public benefits model if we want to try to reach the remaining children. If three-quarters of eligible children are enrolled in Medicaid and SCHIP, that means that a quarter are not. You guys are math geniuses, I know you can figure that stuff out. That one-quarter of un-enrolled children comprises the majority of uninsured

children. In other words, most uninsured children today are eligible for Medicaid and SCHIP, but are not enrolled. That has been the case for a number of years. Why is that? Well, soon after the SCHIP law passed, there was a sea change in eligibility for kids. Before SCHIP, typically you had to be a poor child if you wanted to be subsidized. Within a few years after SCHIP, the vast majority of states raised eligibility all the way to 200-percent of the federal poverty level. Procedural simplifications took place. Not every simplification and not in every state, but soon after enactment of SCHIP, most state took significant steps forward in making it easier to get on the program. Just about every state in the country has conducted major outreach campaigns and shortened the application form for kids. In other words, the usual suspects have all been rounded up. There is room for more action at the state level, but in terms of national policy, we are unlikely to see major steps forward for children's health coverage, unless we do something qualitatively different than we have in the past.

That brings me to the discussion of auto-enrollment strategies. Now the basic power of auto-enrollments stems from the fact that it is in accord with one of the fundamental laws of the universe, articulated by Sir Isaac Newton centuries ago. It is his first law of motion, inertia. Among other things, it says that an object at rest

tends to continue at rest. This applies not just to planets, but to people as well. So let's talk about retirement savings accounts. If I have to go out and set up an IRA and I'm eligible, there is a 10-percent chance that I'll do it. If I start a new job and my employer says, "Stan, fill out this form and we'll put you into a 401k," there is a 33-percent chance that I'm going to do that. If I start a new job and my employer says, "Stan, we're putting you into a 401k, unless you fill out this form and turn it down," 90-percent of eligible individuals enroll. Auto-enrollment is powerful. Let's give a second example, Medicare. For well over a decade, we've had these things called MSPs. How many people know about the MSP programs? Raise you hand if you do. For the rest of you, this is an exciting moment. Any health policy presentation has to introduce you to new acronyms. You have to be able to be the first one back in your office or your neighborhood to say, "I know what MSPs are." So congratulations; we've now hit our milestone in this briefing. MSPs are the Medicare Savings Programs, the programs formerly known as QMB and SLMB. These are efforts to help low-income seniors by paying their Medicare premiums, paying deductibles and co-insurance amounts; they've been around for a while. Less than one-third of eligible seniors enroll in these programs. You have to go to the Medicaid office; you have to fill our forms. Less than one-third take

it up, even though it is very valuable. Look at Medicare Part B, by contrast. This is the part of the program that covers doctor visits and outpatient care. When you turn 65, Uncle Sam mails you a letter. Uncle says, “You know what? We’re going to put you in Medicare Part B, unless by date X you fill out this form and tell us you don’t want to be enrolled. And by the way, when we enroll you, we’re going to withhold your premium payments from your Social Security check.” Ninety-six-percent of eligible seniors sign up for Medicare Part B. Is there a way we can harness this auto-enrollment strategy to help uninsured children? Well, maybe there is. If there is a family that has already been found by another means-tested program to have low enough incomes that the kids ought to qualify for Medicaid or SCHIP, why not enroll those kids into Medicaid and SCHIP? Why force mom and dad to fill out a needless application when we know, thanks to Sir Isaac Newton, that most of them won’t or many of them won't? Why force state officials to spend scarce resources doing administrative re-determinations of kids who have already been found to be eligible?

How effective could such a strategy be? Well, what our paper found, and hooray for Jenny Kenny [misspelled?] of the Urban Institute who did the number-crunching here, that 71-percent of all low-income, uninsured kids live in families that benefit from means-tested nutrition assistance. In just

about every state in the country, the income thresholds for those means-tested nutrition programs are below Medicaid and SCHIP. In other words, those 71-percent are virtually all income-eligible for Medicaid and SCHIP. If we could simply take all those kids and put them into Medicaid and SCHIP without requiring applications, we would make a step forward in children's coverage that would be comparable, if not greater than, the step forward the country took soon after enactment of the SCHIP legislation. A number of states have tried to pursue experiments along these lines, and there have been isolated successes. The example we just saw about Louisiana is one such example, in the context of re-determination, but most of the state experiments have not been happy affairs. The reason why is that there are two obstacles that federal policy makers could overcome. There has been an absence of IT resources, and there have been some areas of inflexibility, in terms of federal Medicaid law. IT is critically important. You have eligibility data housed in different computers with different programs, and sometimes those computers don't talk to each other. That means that in some cases when states have tried to pursue this strategy, they've had to gather information about kids manually, calculate eligibility manually and enter the data manually into Medicaid and SCHIP. That is very expensive; that is ultimately unsustainable. Here is a second reason why IT is

important; most of these kids have health coverage already. That is true for American children in general; it is also true of children participating in these nutrition programs. If you took all the food stamp kids, if you took all the school lunch kids and put them into Medicaid and SCHIP, half of them are there already. You would be wasting a lot of time and money. One-quarter of those kids get employer-based coverage. It is illegal to provide SCHIP to kids with employer-based coverage. So you need an efficient means of identifying those children who already have coverage within the group who are receiving non-health means-tested programs. If you have to do it manually, “Forget about it,” says the famous New Jersey phrase; it ain’t gonna happen. You need to have some automated mechanism for identify in those kids. There is, in fact, enhanced federal match available under the Medicaid program for IT development, but a long-standing federal regulation for bids for such enhanced match from going to eligibility site improvements. One way that federal policy makers could help states pursue this kind of strategy would be to make clear that when it comes to this particular eligibility area, enhanced federal match is available. Similar results could be achieved without changed the rules for federal match by simply providing a targeted federal grant program, but either way, federal resources need to be on the table in a major way for information technology

development, or else states cannot pursue this promising strategy.

The second issue concern federal Medicaid law. What is important here is that there is a difference between eligibility standards and eligibility methodology. For example, in most of the country, food stamps and Medicaid both say that if you are a kid over age 6, and you have a net family income below the federal poverty level, you qualify. But the problem is that the two programs use different methodologies; they use different ways to figure out if a particular family is below or above 100-percent poverty. For example, they both define family differently. They both define income that gets subtracted from gross to reach net figures differently. So a kid who food stamps say is at 105-percent of poverty might be at 95-percent of poverty according to Medicaid and visa versa. As a result, states cannot simply say, “You know what? Food stamps and school lunch say you’re poor, therefore we’re going to accept that you’re poor.” Instead, Medicaid has to go and apply its own unique Medicaid eligibility methodology. What that means as a practical matter among other things is, for example, when Washington and California tried to enroll kids into Medicaid who the school lunch program had already found were poor, the Medicaid program could not make that determination using their normal methodology without asking the families to fill

out a form. Now the whole point of this strategy is to avoid the need for families to fill out a form. Remember Sir Isaac Newton. You will not be surprised to learn that in most cases the law of inertia was obtained and the forms were not completed, and most of those kids didn't get enroll in coverage because of this difference in eligibility methodology. That is something that federal policy makers could do something about. Federal policy makers could give states the option to grant Medicaid and SCHIP coverage based on the final income determinations of other means-tested programs and give states the option, if they want to, to disregard methodological differences. My friends, this has already happened in the context of Medicare prescription drugs. We talked about those MSP program; remember MSP now? Everybody knows MSP, right? If there is one thing you'll remember, it's MSP, Medicare Savings Programs, help for low-income seniors. Congress authorized the administration to do what I'm about to tell you about. The administration has done it, and I think it is to its credit. They've said that you are automatically enrolled in low-income subsidies for prescription drugs if you get MSP benefits. That is the case even though there are differences in methodologies; some state MSP program use different methods for counting eligibility. Not only that, friends, but there is a difference in standards. The low-income subsidies for MMA

are not available if you have assets over $10,000 per person, but five states disregard assets entirely in granting MSP eligibility. But federal policy makers, in what I think is their wisdom, have said, “You know what? Sure, there may be a couple of people here and there who are going to be treated differently, but 95-percent of the people affected by this policy are seniors who fully qualify, and we’re going to make sure they get enrolled.” Now that has been done for seniors and a question would be if there is any reason why that should be done for seniors, but not for low-income children who qualify for Medicaid and SCHIP, but are not enrolled?

You’ll notice here that there are a couple of bills that have already been introduced this session of Congress in both houses, with Republican and Democratic co-sponsorship, that would do exactly what I mentioned, that would give states the discretion to disregard methodological difference in granting eligibility based on the findings of other programs. This gives me reason to hope that once again, as it did in 1997, the Congress and the administration can come together in a bipartisan basis and take a huge step forward for America’s uninsured children. Thank you.

ED HOWARD: Thank you. I like the animation. Our final formal presentation is from Matt Salo of the National Governor’s Association, where he directs the Health and Human Services Committee. His understanding of Medicaid is

prodigious and we've been lucky enough to have had him on a number of Alliance programs over the years. By the way, I commend to you his written biographical sketch in the materials; above all the others you will see in there, even among all these distinguished analysts, Matt's biographical sketch is the one that you want to read, but not right now. Matt, thanks for coming.

MATT SALO: Thank you, Ed. I certainly appreciate the opportunity to be here. You've heard from a couple of people who, as Ed said, are insightful authors and who've put together some very interesting an informative stuff. Unfortunately, I'm neither and author, nor particularly insightful; I'm apparently only here because Ed likes by bio. [Laughter] But for the time being, you're stuck with me, so I'm going to talk a little bit about the sort of general reaction to the concepts we've heard. I do want to start off by saying that, by and large, I'm very proud and governors are very proud of all the advances that we've made in terms of enrolling kids into coverage. If you look at the history even beyond the past 10 years of the experience with SCHIP, if you look back in previous years with Medicaid, the advances that we've made in terms of healthcare coverage for kids has been phenomenal. Unfortunately, the reason why the number of, 45 million, people who are uninsured, a number of

which are kids, continues to be so large is that no matter how much progress states can make, whether through Medicaid or through SCHIP, the private sector or employer-based coverage is hemorrhaging some fast and eroding so quickly that it essentially eats up any progress that we've made. It gives me pause because, as Ed pointed out at the beginning, one of the things we want to talk about around coverage is what we need to do in terms of public and private coverage. I've noticed that this panel is focused solely on public coverage. While I think there is a lot that we can do and talk about in terms of public coverage, I do think it is a mistake not to think about what can be done from the private sector as well. That is a key component to this. Maybe we've decided that employer-based coverage or the cost of healthcare is too big of a problem for us to solve, and it may well be, but I hope that is not the case, and I think we need to devote as much effort to that as we do to public programs. Having said that, I think that clearly, as Stan mentioned, across party lines, coverage for kids is a critically important issue and everyone believes that kids should have healthcare coverage. However, that is not to say that everyone believes that all kids should have publically funded healthcare coverage. We can talk about where the dividing lines are, but that it a critical component. I think we certainly believe that to the extent possible, if

private sector coverage is available and relevant, we need to look into that as well. But we also believe that churning, as Laura talked about, where people are coming off and on coverage or coming from one source of coverage to another and trying to figure out, “Okay, who are my providers here? What are my co-pays here? What are the processes there?” It is very confusing and we should find ways to minimize the churning, especially as it relates to kids with special needs, whether they’re in the foster care system or kids with mental health issues or developmental or physical disabilities, the need to have those kids in coverage that remains constant and benefit rules that remain constant is absolutely key here.

Having said that, let’s sort of get now to a little bit of a reaction of what Stan and Laura have talked about. While it is, I think, important to look at renewal periods, documentation, and what kinds of forms you have to fill out, I do think it is important that we look at this as a balance between how easy we make it to get public coverage and how the programs were not set up, and I don’t know that society necessarily believes that public coverage is a permanent entitlement, such that once you become eligible for a public program, you should then be eligible for that for the rest of your life. Circumstances do change, and I think we need to at least acknowledge that. Whether it is a 6-month period or

a 12-month period, there needs to be some kind of an acknowledgment that there has to be some kind of a look at people whose circumstances do change, who do move up the income scale and who gain access to privately funded insurance. I think it is something that we need to keep in mind.

Having said that, I do think that the studies that Laura has done with respect to the four states are very insightful and can serve as very important best practices for other states that are going thought these types of issues. I would also caution that sort of the concept of churning is not a de facto reason to sort of dismiss the idea of looking at premiums or other cost sharing, especially with respect to kids or families who are at higher incomes. Certainly some experiences have been that an imposition of a premium will lead to some coverage loss, but I think that as you're moving up the income scale and as you're looking at the benefits that are being provided versus the relative cost of a premium, relatively high on the income scale, for families, I think you do start to get into issues of how people need to weigh the balance of personal responsibility and familial responsibility and engagement into the healthcare process itself. I'm certainly not advocating large premiums for kids below the poverty level, which is not even allowable under federal law, but I am just saying that by definition, we

shouldn’t say that because of churning, premiums as a philosophy or a concept are therefore bad. I just wanted to make that point.

Again, I think to Stan’s point about auto-enrollment and trying to find the kids who are eligible, but who are not enrolled, whether it’s through linking with federal program, he very astutely pointed out some of the technical problems that exist with federal law on that. I think it is important to look at that. I would just caution that, from the state perspective, while there is a very strong interest in getting kids coverage and making sure that our populations are healthy, if we look at going down the road of policies that suddenly mandate enrollment of millions more kids into a publically funded programs, that is not without a budgetary impact. The budgetary impact of that, I think, shouldn’t be taken lightly because, as you guys know, the issues and financial pressures that states are facing with respect to Medicaid, or state revenues in general, are very serious. Any time there is a massive influx or a massive enrollment growth or anything that drives Medicaid funding forward, it does force other types of decisions that have to be made at the state level. If you have a sort of zero sum Medicaid budget and cost pressures drive part of that up, generally you’re required to tamp them down somewhere else. That can mean dropping coverage for other optional populations, that

can mean dropping of benefits, or that can mean reducing provider payments. Or, on the other hand, if Medicaid costs go up, costs in other parts of the budget, such as in education, have to come down. I would just say keep that in mind when we talk about this. This is my concern, obviously from un-funded mandate perspective.

My last couple of thoughts are why is all this important? This is all important because of a couple big things that are happening now or that are going to start happening in the very near future. We're starting to see states step forward with attempts to try to create universal coverage plans. There has been a lot of talk about Massachusetts with that. There is a lot of new activity coming out of Vermont. I think there are a lot of other states that are interested in this. I think this is very relevant to those debates. One of the things that I personally think is very exciting about the Massachusetts plan, in the sense of lessons that can be learned in other parts of health reform, is that what they're trying to do is make healthcare coverage, whether you're getting it through Medicaid, SCHIP, an employer or the individual market as seamless as possible. They have this sort of intermediate called the Connector. It doesn't really necessarily matter where the funding is coming from, the access to your plan, your doctors, formularies and all that stuff is going to

remain fairly consistent. I think, ideally, that should reduce the problem of churning, although we are fairly early on in this process, so it is hard to say for sure.

The other big issue is going to be with SCHIP. As mentioned, SCHIP has been around about 10 years. It has been a fabulously successful program, in terms of getting kids healthcare coverage. The SCHIP program expires next year and Congress will need to reauthorize it. I know there is a lot of interest in the Senate Finance Committee and in the House Energy and Commerce Committee in looking at these issues now. I do think that it will have to get reauthorized next year. Something is going to have to happen even before then, because currently there are 18 states that are going to be facing about $800 million in shortfalls next year. That is going to have to be addressed. All of that is going to be in the context of reauthorization for the next 10 years. Congress put in $40 billion for the first 10 years; how much are they going to put in for the next 10? We don't know. Will there be enough? Will there have to be a sort of re-prioritization of who within the SCHIP program is getting coverage? Are kids at 350-percent of the federal poverty level going to be prioritized, or is it going to be just kids below 200-percent? What about parents? There are going to be some very interesting conversations going on over the next year. I think a lot of these conversations about churning

and what happens with kids who are coming on and off of SCHIP or Medicaid are going to be very, very relevant to that debate. I would say we should pay attention, and this stuff is going to be fun. With that, thank you.

ED HOWARD: Thanks very much, Matt. Now you will have a chance to ask question and make comments. There are three microphones set up for your use. If you have the green card in your packet, you can apply ink to it and hold it up and someone will magically snatch it from your hand and bring it forward. Let me read one of the questions that I have in my hand in advance. Laura Summer, the question here says that you talked about administrative savings; the question is whether it is true or not that despite those administrative savings, more enrollment is going to cost more than less enrollment?

LAURA SUMMER: Well, administrative savings are easy. We do have evidence that when eligibility workers spend less time and less energy on the administrative process, savings do occur. There is no question that if you're covering more people, there are going to be more costs associated with that. One of the interesting things that we heard about from health plans and providers, though, that I think is relevant to this discussion when we talk about how money should be spent and whether there are savings or not is this idea of inappropriate care or people not having access to care. We

have data from Washington State that shows that during that period of time when so many families were experiencing gaps in coverage, there was higher emergency room use. So that is something that needs to be taken into consideration. We also heard about plans that were implementing disease management programs. These are programs designed not only to improve the health of individuals, but also to result in savings over time when they don't need hospitalizations. If a family is in and out of coverage, they can't participate in a disease management program to the extent that they could if they had continuous coverage.

ED HOWARD: Let me just introduce Cindy Mann, who is joining us for the question and answer session. She is the Georgetown colleague of Laura Summer, and she is the co-author of the churning paper and with it, one of the country's top experts on children's health. In fact, she ran the SCHIP and Medicaid programs for kids for a couple of years in the Clinton Administration. So Cindy, we're happy to have you with us.

CINDY MANN: I'm happy to be here. I would agree with everything that Laura said and underscore it. There are other examples in our report about why it is penny-wise and pound-foolish to not provide stable coverage to kids. But I just want to step back and, in part, reflect on a couple of the different comments. What we're talking about here, both

in terms of Stan's proposals and the findings that we made in our churning report, is kids who are eligible for public coverage. We'd also like to talk about the commitment that we all made, the country as a whole, local communities and states for the past 10 years towards the goal of covering kids and the commitment that, as Matt talked about, more governors and state legislators are thinking about even strengthening as we go forward. So it seems that if we have a commitment in terms of covering kids, where we are right now is thinking about how to get to that finish line. We have made enormous progress. We have about one-third less uninsured, low-income children today than we had in 1997, thanks largely to Medicaid and also the SCHIP program. The lion's share of the new enrollment was in Medicaid. We can get to the finish line. Part of the goal is to cover eligible, but un-enrolled kids. So is it ever proper, or in what circumstances is it proper, to think about not taking every step possible, obviously that is reasonable, to ensure that kids who states have already determined ought to be enrolled actually get into the program? I just want to put the cost implications into the broader context of where we're trying to go as a nation.

ED HOWARD: Stan?

STAN DORN: Yeah, just one other comment along those lines. In terms of auto-enrollment, the problem is not that

states have these options and some are taking advantage and some aren't; the problem is when states try to do this, they're hamstrung. Federal law makes in difficult, and in some cases impossible, to do it. The absence of IT resources means it can't be done in an efficient way. I don't think anybody is talking about un-funded mandates. Rather the question is should federal policy makers give states the flexibility to be effective in doing what some of them have tried to do, but have not been able to do? That is a much easier question to answer, it seems to me, and that's why we see broad bipartisan co-sponsorship of proposals to give states these new options to, as Cindy says, really take in to the next level and fulfill the promises that we collectively made a decade ago.

ED HOWARD: Yes? And would you identify yourself?

OLGA PIERCE: Sure, I'm Olga Pierce with United Press International. At the MSP discussion, there was some talk of states almost having a disincentive to try to enroll more individuals because it just cost them more money. I'm wondering if that is a phenomenon that we see here as well; are states really trying as hard as they can to reach the last fraction of kids, or are they sort of letting things rest because of budgetary concerns?

ED HOWARD: Who would like to take a crack at that?

MATT SALO: I can get that. I guess I'll reflect first on your comment around the MSP programs. You're absolutely right in terms of the disincentives there. I think we've long felt that those particular programs are about as poorly structured government programs as you could find, in which you have determined that low-income seniors who are enrolled in Medicare are too poor to afford premiums, co-pays, et cetera; the federal government has determined that. The answer is not the waive them; the answer is to make them sign up for Medicaid and make the states pay for it. That just makes no sense whatsoever. So yeah, that's just really bad policy and something needs to be done about that.

On the other hand, there isn't an exact corollary in terms of kids' coverage, because it's not as if these kids who are eligible for Medicaid are going to be able to get into another program easily. There is always a financial impact on things that you do, and I think it is important keep in mind that states have to balance their budgets every single year. The federal government does not have to do that. When you have to do that, you have to prospectively account for all decisions that you make going forward, but then also at the end of the year, if things have happened that have increased expenditures more than you expected or decreased revenues more than you expected, there has to be a reconciliation. You have to figure out what you're going to

cut in order to make all of this work. It's out there, but I certainly don't think that's stopping people from trying to get kids enrolled, because there really isn't very many other places for them to go.

ED HOWARD: Cindy?

CINDY MANN: Well, I think we've seen in the past five years when every state was under extreme budget pressures a rollback of the simplification efforts that they took. In some states, just a stopping of moving forward, and a few states kept going. I think Laura's chart from Washington State really shows exactly that story. That is a state that had been ahead of the curve in terms of really trying to enroll eligible kids and expand coverage and for budget reasons it wasn't rejoicing to do this; it made a decision to make it more difficult for eligible kids to stay on the program. Then with a different governor and in a different fiscal situation, it reversed those actions and you saw the enrollment levels go back up again. So I think what we really need to think about, if we're honest about the goal of covering kids, if whether we ought to let these barriers creep in periodically as impediments for kids to get their eligible coverage. If we think that's not the right policy, than I think we should address frontally some of the issues that Matt raised, which are how do we finance this; how do we make sure that there is stable financing for the programs;

and that the answer to budget stresses isn't, "Let's create barriers so that children don't get the coverage to which they're eligible."

MATT SALO: At some point, if you want, you can look at slides eight and nine in my presentation, which give you some detail about what has happened in states. I think it is remarkable that during the economic slow-down, despite the great reduction in state revenue that happened, though thank God it's turned around now, and increases in cost, there was very little retrenchment in children's health coverage. Kids are cheap. They may be half the Medicaid program, but they're a teeny percentage of the cost. For example, from 2002 to 2005, the number states covering kids up to 200-percent of the federal poverty level went up from 40 to 41. If you look at procedural simplifications, instead of 50 states waiving the assets test in 2002, 49 waived it in 2005. Instead of 30 states doing 12 months of continuous eligibility, 27 did continuous eligibility. So the long and the short of it is that I think kids generally do pretty well in the states. Even when they're having some trouble, Republicans and Democrats can typically come together. I think we've really seen substantial progress that remained in place, despite harsh times economically.

ED HOWARD: Question, I guess, for any of the panelists. What is the tradeoff for program integrity in

some of the proposals being made today? How many ineligibles are okay to enroll as the price of signing up, how many eligibles? Go ahead, Laura.

LAURA SUMMER: That's a question that I welcome because I did hear a comment, though I can't remember who made it before, about signing up kids who aren't eligible. I don't think we're really talking so much about lack of integrity here; we're talking about a different process. When I talked about Louisiana, for example, they are checking information about all of the families; they're just checking it in a different way. They're taking it from records that the state already has. States are already obligated to make sure that the information that families provide to them, whether it's on a written form or some other way, is correct. They already are doing that kind of checking. I think our suggestions for changing processes are more suggestions for doing things more efficiently, rather than not checking.

STAN DORN: In terms of auto-enrollment, the school lunch program has a system of auto-enrollment called Direct Certification. If you're a kid who gets food stamps or cash assistance, you can be directly enrolled into a school lunch program without an application being filed. What schools have found is that not only does this increase the number of eligible kids who get services, it reduces the percentage of ineligible kids who get services. When you shift from an

applicant-driven enrollment system into a data-driven enrollment system, to a certain degree, you have the potential to overcome that tradeoff and have a system that at the same time increases the enrollment of the eligible and improves the percentage of right answers at the end of the eligibility process.

ED HOWARD: Yes, sir?

BRUCE GREENSTEIN: Bruce Greenstein. Matt, first of all, if you guys could pick up MSP reform that would be great if anybody understands it. My question is more for reaction. These proposals are to make things simpler and more effective. If you looked at healthcare outcomes, you'd never find anybody that would disagree that its better healthcare outcomes at the end. But I'm wondering if these proposals and the direction of these thoughts are entirely Pollyanna-ish. In the context of states looking at opportunities in the Deficit Reduction Act, focusing on personal responsibility, and creating more opportunities where, say, eligibility will be dropped based on certain behaviors or not fulfilling certain obligations; that's what states are interested in now. I'm wondering if you could just talk about that. It is certainly not all of the states, but some states have expressed their preferences in their realm.

LAURA SUMMER: Perhaps you're referring to the West Virginia plan, which would reduce children's benefits if the

child or the parent doesn't follow a certain membership agreement to engage in certain healthy behaviors. That's a new State Plan Amendment that has been approved under the recently enacted Deficit Reduction Act.

I think I would go back to Stan's comment a few minutes ago, which is that we certainly are seeing states go in many different directions. But I think we are overwhelmingly seeing states either holding on or looking to improve children's coverage. They're doing it in different ways and have different approaches, so we tend to get more headlines on some of the more extreme or unusual approaches, and less headlines on Louisiana figuring out how to not bother people with asking for information that they already have. I think that really the story that is emerging in the states now and that has pretty much been there over the last 10 years is that they are solidly for trying to maintain and even strengthen children's coverage and sometimes need help getting there. But that is more often their goal than not.

MATT SALO: I would prefer the term innovative to extreme.

LAURA SUMMER: [Laughter] Extremely innovative.

ED HOWARD: A friendly amendment. Yes, Margo?

MARGO EDMONDS: Margo Edmonds [misspelled?] with the Lewin Group. I have a question about premiums and copayments. Ten years ago when we were launching SCHIP at

the Children's [inaudible] Fund, we did some focus groups with parents of eligible, but not enrolled children. One of the things that we found that there were a significant minority of folks who really wanted to contribute; they wanted to make a copayment and do what everybody else did. They felt responsible for their children and wanted to be able to do that. There were very few states at that time who had any kind of sliding scale; I think Massachusetts did. I'm wondering, since I've been away from SCHIP for a while, what has happened with setting premiums and copayments; can you make any generalizations at all?

CINDY MANN: Well, there is a lot of literature on the impacts of premiums, in particular, and some state experiences. We cited two of the states that we looked at; Virginia and Rhode Island had specific direct experience with premiums. I think that what you find is that at a certain level of premium or co-pay and at a certain income level, it is simply unaffordable. At a certain level of income and premium, it is affordable. Looking for that magic line is always the challenge. I think what our study shows and tries to say is not that premiums or co-pays, per se, are necessarily leading to instability, but at some level of premium and income, the evidence is, in fact, that they have. Virginia decided that they would stop a planned termination as a result of premiums because they were going to lose tens

of thousands of children, and they thought it was a mistake. To their credit, the state that charged the premiums decided not to take the action and then reversed itself because it found that it was not where they wanted to go. I think families, like everybody else—low-income families, middle-income families, upper-income families—want to contribute and be part of it. I think that the rubber hits the road when you've got your childcare payments and your gas to fill up your tank and your rent and whether, in fact, that month you're actually able to pay the premium. It's not a question of people thinking it's inappropriate; it's a question of affordability.

LAURA SUMMER: Affordability changes from month to month because so many incomes are not stable.

CINDY MANN: One of the things that a couple of states have found is switching to a smaller enrollment fee. If you have an enrollment fee that is $1,000, it will be unaffordable; if you have a small enrollment fee and it's not a month-to-month charge and it's a reasonable amount, it sometimes sort of satisfies the sense that everybody has that families, at least at certain income levels, want to and ought to contribute, but it is not so burdensome on them or burdensome on the state in terms of monthly collections and dealing with the month-to-month changes that you raised.

ED HOWARD: As we go forward here, I don't want you to forget the evaluation form that we would love you to fill out before you leave. I've got a question for Matt Salo. You mentioned employer-based coverage, private coverage, how do you propose to improve that kind of coverage for children?

MATT SALO: I'd love to answer that. I think the first thing we have to do is figure out the big question, which is, is employer-sponsored coverage the future of healthcare in this country? That's a big one. It has been the case for a long time, but as I mentioned earlier, increasingly, that is becoming less and less true. It is not just employers saying they don't want to offer coverage anymore; it's due to a rather major restructuring of our economy, in the sense that employers and jobs that are being create now are in small businesses. We all know that small businesses have a much harder time than big businesses in affording healthcare. Jobs that are being created are being created in the service industry; service industries traditionally never offered health insurance. And then even the jobs that are being created in the big manufacturing companies, those companies have to compete globally with companies in Japan, Germany or what have you that have healthcare built into a sort of national plan. It does not come out of the company's bottom line and even they are having trouble affording it. So we have to figure out if

this trend, the trend line that's going down, is what we're going to stick with and try to fix, or are we going to scrap it? I don't know the answer to that. If we try to fix it, I think two things are important. One is that I think we need to do something more in terms of tax credits, providing tax credits not only for low-income or lower- to middle-income individuals to help purchase health insurance, but tax subsidies or tax credits for small businesses to help them keep their employees and their employees' families covered. If it comes down to a question of cost at the end of the day, and it is a simple business decision of employing 10 people with health insurance or employing 20 people without health insurance, I think we need to help people make those decisions and get coverage more broadly.

But I think also, if we can do something to reduce the cost of healthcare itself, than we will have benefitted all of us. That is not just a Medicaid or Medicare or private sector thing. We spend and waste and enormous amount of money on healthcare in this country, and pretty much everyone is to blame. The U.S. spends 16-percent of its gross domestic product on healthcare. The next largest country spends about 12-percent, and the average of all industrialized nations is around 8 to 10-percent. We're spending a lot of money. But if you look at the healthcare outcomes in this country, we should all be ashamed of

ourselves because we end up just with third-world developing nations in terms of life expectancy and low birth-weight babies and a number of other indicators; it's really, really shameful. We are spending a lot of money that we are not getting a very good impact on. We've got to do something about that. That has to do a lot of things. That's going to be healthcare information technology, electronic medical records, and e-prescribing so that the pharmacist and the doctor don't get things mixed up and so that we know when people are taking 10 different drugs, which of those are contraindicating. We need to focus on patient safety, and we need to focus on quality. I think that by-and-large we are starting to get there as a society, but we're not there yet. That will solve most, if not all, of our problems and it is easily done, too.

ED HOWARD: Remember, you heard it here first. Yes, sir?

VIC MILLER: I'm Vic Miller from Federal Funds Information for States. I track Medicaid and SCHIP and those kinds of spending pretty closely. Through yesterday, Medicaid spending was at about $2 billion less than last year. This may be the first time in the history of the program that Medicaid spending is actually less than the previous year, except in 1973 with a $1 million decline. Part of that is obviously Part D and the shift of costs onto

Medicare. Part of it is the reduction in the FMAP. I can come up with about seven or eight good explanations and one of those is the economy; the economy is going better than it was going last year and some people may not be eligible for Medicaid anymore. My question for you, for anybody here, in your judgment, is a growing economy kicking people off Medicaid, reducing coverage for children perhaps and is that something that we should be concerned about?

STAN DORN: We actually did a study looking at the question of the relationship between economic growth and Medicaid and questions about how to adjust the federal matching formula. Bo Garrett of the Urban Institute was my co-author on that, and he found that there is a clear, inverse relationship between unemployment and Medicaid enrollment. More people lose their jobs, more people go onto Medicaid; more people gain jobs, people come off Medicaid. As Matt points out, the employer-based system is degrading over time in terms of the coverage it offers, so that relationship is diminishing in magnitude, but it still exists.

ED HOWARD: Can I ask you Vic, whether your data indicates a decline in enrollment over the same period that you see the decline in costs?

VIC MILLER: At this point, there is only standing data; there is not enrollment data. As a matter of fact, you

don’t get this response from the states. The states are still saying that their spending levels are pretty high. But the actual outlays from the Federal Treasury are quite flat, down actually. It’s like tea leaves here trying to figure out what’s going on. It’s not the disabled, it’s not the elderly probably, other than the shift in Part D, so who are we talking about here? It’s the mothers and children primarily, and what is going on is the question. The answers are appreciated. My number is [laughter].

LAURA SUMMER: Let me just make two comments, if I could. One is what is the saying in Medicaid? There is not one Medicaid, there are 50 Medicaids, not counting the territories. I think it is just a very different story in lots of different states. Texas introduced a whole new system for enrolling people, and they’ve seen an enormous drop on the enrollment of kids. Not because anybody intended it to, but because the new system is dropping off a lot of kids. We see a bunch of states like Washington State where you have this experience of down, maybe up, maybe still down in terms of changes in procedures, and we have other states that are continuing to go upward in terms of their enrollment. So I think that whenever we look at the national numbers, it masks some very different stories state by state. I think by-and-large that while there is a very close connection between the economy and Medicaid, what we have

seen coming out of prior recessions and downturns is that it takes quite a while for that change to actually affect the Medicaid roles if it was a straight-on economic change. It is counterbalanced by some of the things that Matt mentioned. The employment, particularly the low-wage market, is shifting more to jobs that don't offer private health insurance, so you don't see that immediate turn where when somebody gets a job or their income goes up that suddenly they're going to get health insurance coverage.

The one thing I just want to add on public and private is that I think all of us understand the important role that private coverage plays and see that unless we can shore up and maintain that private coverage, we're going to be in an even sorrier state of affairs than we are not. That having been said, I think it is important not to think of public, particularly for children, as the exception or the anomaly. That is just not where we are right now. It is not where we're likely to go. We need to really think through that reality. The family coverage cost for private insurance is just way above what people can afford in low-wage jobs. The offer rate for people in low-wage jobs is really very, very different, much lower than for people in higher-wage jobs. The other thing that is important that our study talks about a little bit, at least in the introduction, is that issues that we're talking about here like churning are not

unique to public programs. I was just at a meeting in Ohio where we were trying to think about how to marry public and private dollars to stabilize private coverage. One of the employers there said that her workforce has 186-percent turnover in a year. There is a ton of churning in the low-wage labor market, so it is not like private coverage is also the answer the stability in coverage as well. We need to be creative about marrying the two, but not to be thinking that public is just there for a temporary period of time until we can fix private. There are some real reasons why we have a dual system, and we're going to have to think about how to make them both work well together.

ED HOWARD: Yes?

FRANKINA WRIGHT [MISSPELLED?]: Hi, Frankina Wright from D.C. Action for Children. I wanted to follow up with something you said about the Deficit Reduction Act; how do we advocate for auto-renewal, auto-enrollment policies in light of the new citizenship documentation requirement?

ED HOWARD: Someone who knows more about it than I ought to explain briefly that requirement. Laura?

LAURA SUMMER: Well, it is a new requirement for citizens, not non-citizens but citizens who apply for Medicaid benefits to show proof of citizenship. There are specific types of proof, and I don't know them well enough to be able to recite them, but certainly something like a

passport, for example, is fine. A birth certificate may be fine if it is the original, not the original, but an official copy and if it is accompanied by an identity card. So there are all kinds of rules and requirements for people who are applying for Medicaid or for people whose renewal comes up after July 1. As you might imagine, if you think about impediments to enrollment and impediments to renewal, the kinds of things we've all heard and probably have even experienced when we're not applying for low-income programs, when you have to find a piece of paper to show proof of something, that can pose some difficulties.

STAN DORN: I'm really worried about it. When you try to automate enrollment or renewals, you need to have some digitized form of information. So I think that tracking this, to the point Laura makes, is absolutely right. More broadly, the more you ask people to do, the fewer people who complete the task. So we will no doubt see people lose coverage, kids and adults alike, because of this requirement. My guess would be that most of them are eligible, but just aren't going to go through the procedural steps that are required. It is worth tracking this issue to see what sort of data is available to document satisfactory immigration status in the case of non-citizenship and citizenship. The tail shouldn't wag the dog here. Our desire for automated coverage for kids is not what is going to drive the issue of

digitizing citizenship and immigration status data. To the extent that data does get housed in a digital home, that will make it easier to prevent kids from slipping through the cracks.

LAURA SUMMER: We've seen with other requirements a lot of creativity and innovation on the parts of states, and so people are talking about faxing or being able to check internally. I think you'll see some of that. I think it is unfortunately that that is where resources have to go right now.

STAN DORN: With kids, the problem may not be as serious as with seniors. Maybe we can make some progress on the digital front.

ED HOWARD: Laura, you were talking about flexibility; let me just follow up by reading this question that picks up on your presentation. You mentioned a number of remedies like general simplification, continuous eligibility, smooth transitions, and reasonable premiums; are there federal barriers to states implementing any and all of those, or can they work within the existing framework and take significant steps to improve the stability of coverage?

LAURA SUMMER: I think that probably, I hate to keep repeating myself, but this new citizenship requirement is a federal barrier or will be a federal barrier. I think that we've seen, certainly in the four states that we looked at

and in experiences across the country that states do have a fair amount of leeway. There are a number of options that they can take, although not all states take them. Cindy may want to add to this, but at least when we're talking about what we looked at, we were finding that cooperation within a state was certainly extremely helpful and that there were some tools available for states to use.

SARA COLLINS: Hi, I'm Sara Collins from the Commonwealth Fund. I wanted to go back to the premium issues, but from a state financing perspective. One of the interesting findings in your report was that in Virginia, when they imposed the premium, their costs of collecting the premium actually exceeded the amount of the premium. I just wanted to pose that to the panel in terms of what this means in this new era as we go forward where states have more flexibility, whether they're going to look at evidence like this and maybe make a different decision.

MATT SALO: I guess my reaction to that is that doesn't necessarily surprise me. I don't know that all states that would look to enhance their co-pay options or create a premium would all necessarily be looking at that as a means to generate revenue. In fact, a lot of what is going on is a very philosophical difference about how you provide public health insurance. Do you provide a completely free public benefit to everyone who is on the Medicaid program,

or, at some level do you start requiring people to have some kind of contribution? If having that contribution, if having that individual personal buy-in, not be cost-neutral to the state, I think the philosophical benefit to that would clearly outweigh it.

CINDY MANN: I'm glad you raised that point, Sara. I think it is an important factor to consider as states go forward. We've heard from providers, too, that when they're collecting co-pays, sometimes the cost of collection is greater than receipt of the co-pay. I do think that certainly in Virginia the potential termination of children, as well as the cost, caused Virginia to totally change its policy. That having been said, we see in some other states those policies continue that sometimes produce savings, not because of the receipt of the premium itself, but because it results in lower caseloads because people can't sustain those premiums over time. One of our other study state, Rhode Island, sees a steady drop-off in enrollment each month due to the premiums, which is about 5-percent of income in that state, for the upper tier of its income range. So the savings come in different ways, and it is a question, too, of whether states are open to get savings by virtue of making it unaffordable, or whether their premiums are at a level that's affordable. I think that when the Congressional Budget Office reviewed the Deficit Reduction Act and looked at the

new premium and cost sharing provisions, the largest share of the savings from those provisions came from less utilization of services or less enrollment, not from actually collecting the co-pays or the premiums.

MATT SALO: I would also say, looking at the example in Rhode Island, that people who are at the upper tier of coverage in the Rhode Island program are fairly well off. They're covering what, 300-percent of coverage?

LAURA SUMMER: No, it is between 150 and 200-percent.

MATT SALO: Okay, that is still significantly higher than pretty much anyone else in the Medicaid program. At some level, people have to be responsible for making choices about their lives. Some of these people are clearly not valuing health insurance.

CINDY MANN: It's not a question of valuing health insurance. It is a question of whether than particular level of premium is affordable for a large number of people in that group. Again, I don't think there's a sense that premiums are always right or always wrong, it's a question of being very sensitive. That is what our research showed in the experiences in Rhode Island and Virginia. It is a question of the level of the premium is, what the level of income is for the family, and what the payment practices are.

ED HOWARD: Laura?

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

LAURA SUMMER: One small addition, another small finding. We actually talked to some community health centers in Rhode Island who told us that for some of their patients, they're paying the premiums. It's worth it to them to pay the premiums to keep their patients insured to ensure that those patients have continuity of care. These are patients who obviously do feel it is important to get healthcare and are thinking about these things, as well as providers who are working with them.

ED HOWARD: Stan?

STAN DORN: 150-percent of the federal poverty level is about $2,000 a month for a family of three. If you were to move to Providence, Rhode Island and then try to find a place to live and pay your gas bills and utility bills and so forth, I'm not sure there's going to be a lot of money left over in the budget to pay more than a nominal premium amount.

ED HOWARD: Let's move on. We've got a couple more questions. I'm alerting our panelists that they'll have the chance to give us the 45-second summary at the end of this discussion. Stan Dorn, this questioner notes, noted that financial incentives were needed to increase health IT use. One hospital proposes regulatory changes for the Stark anti-kickback laws. Are those adjustments suitable if financing doesn't come through? Can the financing and reduction of fraud and abuse rules work together? Interesting question.

STAN DORN: I can't say anything about the Stark anti-kickback laws because I really don’t know very much about them, but I can talk about fraud in this context. I briefly alluded to it when I responded to the trade-off between accurate determinations and reaching all eligible kids. The nice thing about data-driven enrollment and IT enhancements to let you do that is they let you enroll eligible kids, but they also let you identify more applicants who aren’t eligible, either because the family made a mistake or because somebody was trying to get something they shouldn’t have been getting. So this is that rare opportunity to serve both ends of the political spectrum at once it seems to me.

ED HOWARD: Stan, speaking of IT and auto-enrollment, if we don’t do questioner rights, administrative simplification or auto-enrollment, how do we pick up those 60 or 65-percent of uninsured kids who are already eligible?

STAN DORN: You can’t, unless you mandate it.

CINDY MANN: Stan is an old friend, but I want to just amend his statement. He started off by saying in his talk that states have done all the things that they need to do, so let’s look at the next step, which is some of the auto-enrollment ideas. I think, in fact, we know that states have not done all the things that they can do. In fact, some of the things that some of the states that we looked at have

done are not done in almost all states. So the benefit of the last five or 10 years is that states have experimented with a lot of different things, have learned from each other, and we've all been able to actually look at the impact on enrollment. We know what has a lot of bang for the buck and what has less impact, so there is a lot to be done. Even if we had auto-enrollment, which would be a great thing, we would still have kids being lost at renewals, so these proposals go hand-in-hand. You really need to move forward on all of them and make the programs simpler, whether it's creating better IT systems, which the federal policy makers can do, and making sure that states don't feel added pressure in terms of cutting back their Medicaid or the SCHIP funding so that they're not free to take the steps they need to take.

STAN DORN: We are old friends and love Cindy; she's my former lawyer and she's great. If I understood the question correctly, it was saying if you don't do either administrative simplification or auto-enrollment, how do we move forward in a big way with kids? That's what I thought the question was. You're absolutely right; at the state level, there is a lot more that can be done in terms of procedural streamlining. From the standpoint of national policy makers, like the folks in this room, with the current structure of the program, I don't know that one can predict a huge increase in the number of states doing things like

presumptive eligibility and self-verification of income, which is sort of the next frontier for procedural streamlining. So from a federal policy maker perspective, that is why I'm thinking about auto-enrollment, but you could also think about changing the financial incentives and making more money available to states to do things like that. I think we're in agreement, old friend.

ED HOWARD: One last written question; it is also for Stan. One difference between 401k plans and Medicare Part B plans—let me take some literary license here—on the one hand and SCHIP and Medicaid on the other, with respect to auto-enrollment, is that you can have a change of circumstances in the first programs and you're still not ineligibly. Is that a distinction or a difference?

STAN DORN: It's a distinction and a difference and a well-taken point. Another way of putting it is that these are means-tested programs, Medicaid and SCHIP, unlike Medicare Part B and unlike 401k accounts. So if you want to do this in a means-tested program, you have to do it a little bit differently. We're doing it with Medicare prescription drugs. Most of the low-income enrollees are automatically enrolled based on their participation in other programs. The question is absolutely right, circumstances do change. Whether it is a 6-month eligibility period or a 12-month eligibility period, at the end of that period or sometime

before that, you need to assess whether circumstances have changed. You can do that assessment by asking the family to fill out a form, in which case you know a lot of them won't do it, or you can do it the way Louisiana did and say, "Do we have other data available from which we can see if this family continues to qualify?" So I think the question is really well-taken; it means you have to work hard at coming up with a system that will be effective in the means-tested context. Medicare prescription drug coverage has taken on that challenge, and the question would be whether we should do it at the other end of life as well for uninsured kids, the millions of uninsured kids who qualify for Medicaid and SCHIP, but aren't enrolled?

ED HOWARD: Let me just offer the panel the chance to get one final word in. Maybe we can start with Cindy and work our way down.

CINDY MANN: Okay, I'll be brief and try to bring it back to a federal audience, in addition to thinking about different ways in which you would tinker with the system and make changes that would really provide states some new options to improve enrollment for kids. I think most important are two things. One is do no harm; let's not make the pressures that states have worse by withdrawing federal support for these two critical programs and, in particular, think ahead to SCHIP reauthorization, which, as Matt said, is

coming up next year. If we use that opportunity to step back and say what a success the two programs have been over the past 10 years and do what we can to strengthen them, as opposed to weakening them, than I think you would be doing a great service towards really getting to the finish line. It really is doable. It is astounding that it is doable. There is a lot of excitement about the Massachusetts program and how it is this and it is that and how it has 17,000 different pieces, but the centerpiece for children is public coverage, up to 300-percent of the poverty line for kids between Medicaid and SCHIP. So it is a centerpiece for every state having moved forward on kids and for every state moving forward more broadly.

ED HOWARD: Thank you. Matt?

MATT SALO: Healthcare coverage for kids good; churning bad. That reasons, the barriers and the solutions, however, are much, much bigger than Medicaid or SCHIP, although they are a part of it. We need to start thinking bigger than where we've been thinking, which is not to say that SCHIP reauthorization isn't critically important, it is. But my perspective is absent of SCHIP reauthorization, the only real things that are going to be happening in terms of kids coverage are going to be driven at the state level. What that means is that they're going to be driven by budgets

that have to be balanced every year, so it is critically important to also keep that in perspective.

ED HOWARD: Thank you. Laura?

LAURA SUMMER: Well, Matt has talked to the big picture; I want to bring it down to the smaller picture, perhaps the theme of today and just remind everyone that there is a lot that is wrong, but there is a lot that could happen right now to improve things for lots of kids, in terms of continuity of care in states and that could improve things for providers who could provide the kind of quality care that they want to provide and not have to be concerned with maintaining this continuity of care. I would just put in a final plug for comprehensive approaches in states. Certainly public programs are not the only places that we need to be concerned about churning, but, as we've demonstrated, they are places where there is opportunity right now.

ED HOWARD: Thank you. Stan?

STAN DORN: I wanted to go back to the comment made by the gentleman in the front on is this Pollyanna? Aren't states moving in the direction of imposing more personal responsibility? I'd point out what an enormous diversity of states we have in this country. One things for federal policy makers to consider as we move forward is do the states have the resources they need to accomplish the goals that some of them, but not all, have in mind for child health? In

Illinois they want to cover all kids. There are Republicans and Democrats around the country, California and Governor Schwartzenegger, which have made moving forward a priority. It is not a partisan issue, but it does vary by state. So the question is do the states have the resources they need to move forward; is the SCHIP money enough? Maybe a couple of billion dollars here and there could make a huge difference.

Second, do states have the flexibility they need to move forward and cover kids? At this point, I think the program needs some rethinking. There are some steps that we didn't think about back in 1997. Nobody was talking about auto-enrollment back in 1997, and now we need to think about it. I think there is room for federal policy makers to roll up their sleeves, put some intelligently targeted, limited amount of resources on the table for states and give them the authority to move forward in a very exciting way. I'm looking forward to seeing what you all do. Here it is late in the afternoon on a gorgeous Friday and you all are here; that speaks to me of the tremendous interest in the policy community and on the Hill for doing something for kids. That is a wonderful set of facts and optimistic ideas to keep in mind as we go forward. Hooray for all of you.

ED HOWARD: He's right, you know. That is part of my little close. Thank you for participating and attending. It has been a lively discussion. We are going to have more than

one session between now and the time when you're forced to deal with SCHIP reauthorization. Keep tuned and we'll try to pick up on some of the threads of the discussion that you've had today. I do want to thank the Commonwealth Fund for their interest in this issue in the first place and their support for this briefing in particular. So thank you to Sara Collins and her colleagues. Thanks to the Alliance staff that I think did such a marvelous job of pulling this off and also preparing some fabulous materials and, not to mentioned, helping to recruit the speakers. Of course, the speakers themselves deserve our gratitude for, I think, a very insightful and useful discussion this afternoon.

[Applause]

[END RECORDING]