Briefing: Outreach and Enrollment for Kids

March 23, 2005

[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.

[START RECORDING]

ED HOWARD: If we could get started, I think we're at about the hour. I want to thank you for braving the elements, the suddenly reinvigorated nasty elements for getting to this briefing, and I want to welcome you on behalf of Senator Rockefeller and Senator Frist and the rest of the leadership of the Alliance for Health Reform to this briefing that's aimed at trying to call some attention to the fact that millions of American kids are eligible for low-cost, free health insurance, but remain uninsured. And then, to look at some of the plans that are around to do something about that fact. Our partner in today's program is the Robert Wood Johnson Foundation, the largest philanthropy in the country dedicated to improving health and healthcare in America. It's also, by the way, a funder of substantial outreach efforts in every state on kids' coverage over the last few years. We're grateful for their support and their participation.

We're sorry that we don't have with us Stuart Schear, the Senior Communications Officer, who is involved in Covering Kids and Covering Kids and Families and the work of the Alliance. He's also involved in something called "Cover the Uninsured" Week, which is fast approaching, and he asked if he could get an excuse so that he could deal with the frenzied activities leading up to that set of events, which I believe is the first week of May.

Today's briefing examines an area of health policy that's usually marked by an unusual degree of bipartisan agreement, that of getting low and moderate-income children who are eligible for either Medicaid or the State Children's Health Insurance Program, the S-CHIP, actually enrolled. That's something certainly that Senators Frist and Rockefeller agree wholeheartedly on, and there are millions of kids in that category. One of the most important tools in working to enroll all those eligible kids is outreach. The Administration announced last fall, most of you know, and included in its fiscal 2006 Budget Request a major outreach initiative they call Covering the Kids. Stuart Schear wanted me to assure the Administration that they are not going to sue for copyright infringement, but Secretary Tommy Thompson, at the time, said that the goal of the initiative was, in his words, "to increase enrollment by providing families with more personal assistance and encouragement." The way he said that was going to happen was by enlisting "community groups, faith-based organizations, states and schools" to enroll these eligible kids. The President has asked for, I think it's a billion dollars or so for two years for that outreach component. This afternoon we get a chance to hear from the highest ranking official in charge of Medicaid and S-CHIP, Dennis Smith, to explain the Administration's thinking as this initiative gets debated. We

have commentary from others deeply involved in trying to get eligible kids covered as well.

Let me just handle a couple of logistics. Those of you who are veterans of Alliance briefings have heard this before, but consider me a flight attendant who has to make these announcements no matter what. In your packets you find a lot of good background information, including speaker bios for everyone except Dr. Nichols, who was a late entry. Those bio sketches are more extensive than the introductions I'm going to be able to give those folks, so take a look at them. There are hard copies of slides the speakers who have slides are going to be using as well, so make use of them. By the end of the day, you'll be able to view a webcast of this briefing on kaisernetworks.org. You'll find most of the materials in the kit and a few days from now a transcript on that website as well, and everything but the webcast on the Alliance website, which is allhealth.org. I just want to call your attention to the blue and the green. The blue evaluation forms that are in your kits, and the green question cards, which you can use to write a question on once we get to that part of the program, in addition to which, there are microphones in the front and the back, where you can ask your question directly.

Now, we have an excellent lineup of speakers with us today to help us examine this, what I consider to be a deceptively complicated question that seems simple on the

[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.

surface. I do commend to you the biographical information in the kits, but let me do a brief introduction.

Leading off is Dennis Smith, as I said, who's the Director of the Center for Medicaid and State Operations in the Centers for Medicare and Medicaid Services at HHS, so it's CMSO within CMS, within HHS. There's a quiz on this later. Dennis had headed CMSO for almost four years. This center has responsibility for not only Medicaid and S-CHIP, but also for all of CMS's relations with state and local governments and tribal organizations, among other things. Dennis served as the Bush-Cheney Transition Team's chief liaison to HHS. Before that he was Director of the Department of Medical Assistance in the Commonwealth of Virginia. I know some of you know him from that capacity. And of course, that department had authority over Medicaid and S-CHIP, among other programs, so, we're very pleased that Dennis has made time in his schedule to be on this program. It's the first time we've managed to get you down here, and we really appreciate you being here. Dennis?

DENNIS SMITH: Thank you very much, and it's a great pleasure to be with you this afternoon. I think that perhaps this panel might have the most in common in terms of, I think you'll hear the same message from all of us. I don't know if you try to go for controversy, but if you have, I think you've probably disappointed you today, because I think this is something we all probably pretty well passionately agree with

each other on, which is we know that there are still millions of children out there who are eligible for Medicaid and S-CHIP, and we need to go out and find them. That really is the long and the short of it in terms of the President's initiatives to put $1 billion, make that available for the communities, to schools, Native American organizations, faith-based organizations, the states, et cetera, to go out and find the kids who are eligible but not yet enrolled into Medicaid and S-CHIP.

I do want to step back a little bit. Sometimes in the success of programs like S-CHIP, and I think there again, there would probably be unanimous agreement that S-CHIP has been one of the most successful programs in recent memory, wildly successful for what it has done to enroll children, both into the new program—The Congress very deliberately and consciously created an option for the states to choose to set up new programs to expand Medicaid, or to do a combination of each, and I think to a large extent that flexibility is in many respects reason for the great success in the programs. As states really look to new ways of doing things, sometimes we forget how wildly successful that has been, because we haven't gone back sort of in the past to contrast the way enrollment was handled in the past. I had the honor of serving in Virginia as we were bringing up a new S-CHIP program, and at that point in time for a child to be enrolled in Medicaid, we

required a face-to-face interview at the local Department of Social Services and parents were faced with a 16-page application form. We have come a long ways. Again, I think that sometimes we forget the success of the program as being based on simplifying rules, simplifying the procedures from where states were locked into for decades, and taking the new approach is in large part responsible for the success of S-CHIP. Many states no longer have asset tests for children applying. In many states, you can get applications on the Web, you can do applications over the phone, all of these things that would not have been possible even ten years ago in the Medicaid program. So, I do every now and then like to remind us of the success that we have faced as we look forward to doing even more.

I think the President's budget issues in some respects a fresh opportunity to rejuvenate our efforts in outreach. Outreach is vitally important. First you have to make people aware of the existence of a new program such as this, and that was a challenge at the very beginning, to make certain that families understood that the families could in fact be working and the child still eligible for health insurance program. There was a long educational process at the outset.

In Virginia, we set up a broad coalition of many different interested parties from health insurance providers, employers, business groups, expanded beyond the traditional

outreach type of programs. We learned a great deal during that point in time. We learned what was successful in one part of the state differed from another. We were always interested in doing our county-by-county comparisons. Early on in the program, why were the rural counties sort of leading the pack? We were interested in finding out what that was all about, which again, wasn't perhaps the first assumption that you would make. The rural counties seemed to sort of jump out in front, and we went down and asked. In fact, local social services basically said, "Look, we had had the applications of families who had applied for Medicaid and they were turned down because their income exceeded the Medicaid limit, so we simply turned right around and contacted those families and asked them to apply again." In other parts of the state we couldn't figure out—we thought we had quite a challenge in the Tidewater area, which in the income standards, looked like we should have been enrolling more kids. Then we sort of probed behind the numbers and again find out, well, there are a lot of military families, so yes, they would be qualifying at the income level, but they're already insured. We went and made a special effort with the healthcare providers. It's always been of great interest to me as to why workers in the healthcare field itself we have a lot of workers who are not insured, which seems to be a bit ironic. So we started partnering with some of our nursing home and home health agencies to do special outreach to

their workers who were making, ten, twelve dollars an hour, and their kids could have been eligible for the program. What we learned from them as well was to say, “Well, what we’re interested in, we want to have the same health insurance package as the nurses and the administrator, et cetera.” So we’ve learned a great deal over the years. We learned some schools being very successful, and other schools, not quite as much success, but you always find, kind of the common element of that drive at the local level to make that personal contact, to make the personal touch. In northern Virginia, to where we have families speaking many different languages, our friends in Ron Carly, putting a special team together and doing outreach with the different ethnic groups, and again, knowing that it was going to take several contacts to actually get that family to fill out the application. One of our most successful outreach efforts on the local level was at the local church, to where, again, they were hearing from the pulpit about how important it was to get their children in health insurance, et cetera.

Again, today, we build on that success, build on that knowledge. I want to take it to the next level, and as I said to sort of refresh and rejuvenate our efforts to do outreach again. The President, in making it clear in his budget of really laying out a new challenge to say we want to do more. The issue of the uninsured in this country will take a variety

of different approaches. The President has put $125 billion in spending on the table to address the issue of the uninsured. It's gonna take several different approaches. It's gonna take several different ways to do it. As we found out in Virginia, in a single state, there was no simple one way to do it that worked everywhere. What worked in those local rural counties, versus what worked in northern Virginia were different approaches, and we understand that and recognize that. That's again why we want to take a variety of approaches with the outreach fund itself, making a variety of different groups eligible for that funding, to let them take their own models into the communities and successfully find the children who are eligible for S-CHIP or Medicaid and to get them enrolled in the program. We have had some discussions last year with Congressional Staff on what it might look like. We know Senator Frist and Senator Bingaman have been also working on a proposal that would achieve many of the same goals about outreach, so again, I think it's a great situation in which many people have different ideas, are willing to bring them to the tables and get together to work to accomplish the goal that we all share. As I said, creating S-CHIP, I think was greatly successful. It has achieved much of what we set out to do. There's more to be done, and we look forward to working with everyone in a way that, again, turns success into a greater success yet.

ED HOWARD: Thank you very much, Dennis. Next we're going to hear from Greg Martin, who is a Policy Associate with the Forum on State Health Policy Leadership at the National Conference of State Legislatures. [Clears throat] excuse me. Those of you who read and learn, as I do, from State Health Notes, have benefited from Greg's analytical writing and his design skill, I'm pleased to say. For the past five years he's been deeply involved in issues such as S-CHIP and substance abuse and health information technology at NCSL. State legislators around the country depend on the kind of information that's developed and laid out in such a clear and usable form by Greg and his colleagues on issues like outreach to the unenrolled eligible kids. We're very pleased to have you with us today.

GREG MARTIN: I'm really happy to be here. [Inaudible]. From the state perspective, there are a few key points to really consider. First off, is there going to be enough to go around? And as we start to ask this question, there are a few subpoints that we're going to need to consider that I'm going to try and go over here today.

First off, we need to look at what recent history has been for the state legislatures. We also need to look at what is the current state of S-CHIP, what lies ahead for S-CHIP, and my final point that I would like to look at is called, "Keeping Promises."

Now, recent history for the state legislatures, as I'm sure most of you have heard, has been a little tough in terms of budgets. It's been budget crisis after budget crisis for the past few years. Since fiscal year 2002, the states have closed a cumulative budget gap of $235 billion, with a "B". That's getting awful close to a quarter-trillion with a "T". So that's a lot of money that we closed out. There was nearly 80 billion of that that was closed in FY 2004, nearly 36 billion closed in FY '05. And of these worries, healthcare is always a major one. Up to 30 states have considered healthcare and Medicaid to be a top issue, because Medicaid keeps growing, and growing and growing. Now, over the last five years, through all these budget problems, they're made some cuts, they've made some trims, and everything has taken hits. All sorts of priorities, from transportation, to corrections, to policing to healthcare, everything has taken hits. But now the fiscal crisis is starting to level off a bit. Revenue streams are picking up a bit, and now the states get to brace for federal cutbacks. Even S-CHIP has taken hits through this period. S-CHIP in 13 states experienced enrollment declines or freezes or both. In two-thirds of the states, S-CHIP expenditures are now expected to exceed allotments in FY 2005. That's this year. Forty-one states will need redistributed federal funds by FY 2007, and only 135 million is going to be available in that pool to redistribute in that year.

In spite of these little factors, S-CHIP still remains a pretty hot and pretty popular program. It's popular with the public, with legislators, and with the people that are enrolled in the program. It's proven a very responsive and responsible program for states. It's flexible and it allows state to change it and tweak it as they need to as the times have changed. So through the budget crises, they've been able to tweak it as they need to. Most cuts have been easily reversible. We're looking at things like asset tests, income verification and trims to optional benefits and certain services. I think there are few programs out there that can make the same claim that they can change with the times so nimbly and easily.

So now, let's kind of start to look at where we're going. First off, the current formula for funding S-CHIP is broken. It was front-loaded in the early years to give a lot of startup money and states were just unable to spend that money. Then they were given a short time period to spend back allotments, and so, a lot of that money was originally scheduled to revert to the Treasury, but things like the BIVBA [misspelled?] and S-CHIP fix were able to keep those funds available for the states. But, now we're also looking at early reauthorization rumors, which could throw the whole thing into a new little problem, because rumors are making it hard for the states to plan for the future. Will the program be

restructured? Will it be restructured significantly? And if so, how? What will the program look like? And what effect is this going to have on the states' long-term goals for Covering Kids? And a lot of this is worrying states, because states that set and met bold enrollment and coverage goals are now getting worried because, are they going to be able to continue these goals? For example, Virginia is one of those states, I believe, that set bold enrollment goals and has met them, and now they're looking at possible cuts. States that had to cut their programs because of budget crises, now they're going to start getting worried about whether or not they're going to be able to retrench and rebuild. States that are coming out of the hole want to give coverage back to the kids, but they want to make sure there's enough funds available to do it. They don't want to revisit any of these fiscal crises.

And just when the state legislators thought it was safe to write their budgets, we start getting federal funding questions. If we can go back in time just a little just recently, we go back to September 2004 when $1.1 billion that were originally allotted to the S-CHIP program reverted to the federal treasury. Now, these were funds that were originally placed into the original S-CHIP authorization. They were there for the states to use, and if recent, even though it's a small program with a short history, but the tradition has been through BIVBA and the S-CHIP fix to keep those funds available

to the states to help over-spending states cover their kids. But they went back to the Treasury.

We're at a point now where more federal funds are being spent than allotted. States are starting to spend up more than their federal match, and federal funding is only going to be increasingly inadequate for an increasing number of states as we move towards the end of this initial authorization. What was the first federal funding answer to all this? Well, late last year, there was the Children's Health Protection and Improvement Act. What this act sought to do was prevent 1.1 billion that I just mentioned from reverting to the federal treasury. It was going to reallocate those saved funds among the 28 states that were projected to have inadequate federal funding. It was going to redistribute them to the states that needed them, and it was also going to adjust the federal funding formula slightly so that way, fewer and fewer states would need additional redistribution by the end of the program's initial authorization. However, the act did not pass, so those $1.1 billion went back to the federal treasury. So how much is left for us to look at now? Well, the reductions in the proposed FY 2006 budgets—that's the President's, the House and the Senate—they're shifting costs to the states across the board, from education to transportation, community policing, healthcare, across the board shifting costs. And this is leaving and restricting the states to

little flexibility for their budgets. If they want to maintain these programs, where's the money going to come from? And now the Administration is starting to offer plans to modernize Medicaid and S-CHIP, and it's worth noting that this will come at no extra cost to the federal government. So who's the cost going to come to? That's the question. Here's another answer, though. The President's FY 2006 has Medicaid and S-CHIP modernization. It's promising state flexibility in coverage and benefit structuring, but so far, it's raising for the states a few more questions than it's providing answers. For example, the notion of modeling Medicaid on S-CHIP. Is it S-CHIP's flexibility that's attractive, or the cap on funding? Or is it both? Are there other questions that are out there? And then we also get the Cover the Kids Initiative, and this is another federal funding answer.

So let's start looking at Cover the Kids now. What are the details? Well, that kind of depends on who you ask, because we haven't seen a firm plan in front of us quite yet. So far, what we kind of know about this nebulous plan is that it will provide approximately $1 billion for efforts to enroll and cover eligible children in S-CHIP, and $129 million of that, as I understand, come from the aforementioned $1.1 billion that reverted to the Treasury. This is going to be administered through performance grants, and will be available for two years to states, schools, community organizations and

faith-based groups, folks who the states are looking to as partners for efforts. Will this provide coverage for all comers? States, as I mentioned, are fresh out of fiscal crises, and they're going to be wary of expanding enrollment. Again, there's a little flexibility left in their budgets. It's worth noting that increased S-CHIP outreach is always going to yield the state more Medicaid enrollees, and while children are fairly cheap and easy to cover, Medicaid budgets, again, have been growing, and growing, and growing. So if we look at this plan for Cover the Kids, it raises the question, how much is for outreach and enrollment, and how much is for coverage? And if we don't have funds readily available for coverage, what are states' options going to be? We don't like waiting lists; we tried that. Are we going to cut benefits? Are we going to reduce eligibility? These are the options that are going to start popping up if there aren't enough funds for coverage. So what can you reasonably expect to hear from states? The states, I think, are going to say they have been covering the kids, to the best of their ability. States have proven effective at outreach and enrollment. However, they need to know that federal funds are secure and it's all about keeping promises to kids. The availability of funds for coverage is going to be a problem if we start increasing outreach and enrollment. State legislators, as appropriators, are going to be watching these developments closely, because

state legislators feel that at enrollment, they're making a promise to the kids of their state that they're going to cover them, and state legislators are serious about this promise, and they do intend to keep it. And in the long run, it's springtime now. It's kind of like saying, "You're all invited to a cookout. We're going to have a big barbecue. Everybody's going to come over. We're all going to have burgers." I don't know about y'all, but whenever I do a cookout, I like to make sure that I have enough burgers on the grill to go around. I'm not going to invite folks along if I don't have something to feed them. And I like to make sure I have a little extra there in case somebody's extra hungry and needs a bit more. It's all a question of, will there be enough to go around? And what are we going to get if there's not? I don't think state legislators are really going to be happy with the picture. So with that, I thank you for your time and your attention. If you'd like some more information, please visit our website. NCSL has a bunch of great resources on S-CHIP, and I turn it back over to Ed.

ED HOWARD: Thanks, Greg [applause]. It's not fair; he had cartoons. Just a point of clarification for those who don't follow S-CHIP as closely as the people in this panel: the reason the program can continue to function while the states are spending more than their allotment is that they have this overhang of money from previous years when they weren't

able to spend their full allotments. I just wanted to make sure we were on the same page here. Okay.

As I said, we have good biographical information on our speakers except for our next one. We recruited Sandra Nichols just in the nick of time, and so we're very pleased to have her with us, but she is a mystery to you, but not to us. She's the Chief Operating Officer and the Medical Director for Amerigroup, District of Columbia. Now, Amerigroup is what's called a Medicaid managed care organization. It covers over a million lives in seven states, including Maryland and DC. The company has what you might call an enlightened self-interest in making sure that kids and adults that are eligible for coverage actually get it. They've been active in trying to educate people about those opportunities. Now, Dr. Nichols has also been the Regional Medical Director for United Healthcare. She served under two different governors as Director of the Arkansas Department of Health in her earlier life. As I said, she has answered the call on extremely short notice, and we're deeply grateful for her coming to tell us a little about what health plans actually are doing and how they value outreach. Dr. Nichols?

DR. SANDRA NICHOLS: Thank you very much, Ed. I was wondering about that earlier life. I thought it was still in one life. It is an honor to share with this distinguished group a few comments on the role of health plans play in

reaching out to the S-CHIP population. I was honored, just as Dennis had mentioned, to be a part of the first rollout of S-CHIP when I served as State Health Officer in the State of Arkansas back in the 1990s.

Amerigroup is a multistate managed care company who's been in business for about ten years, and we only serve Medicaid population. I mentioned we have over ten years' experience in serving this population and that we coordinated healthcare services for this country and our most fundable citizens. Amerigroup is the country's first and largest company that focused solely in bringing healthcare to Americans enrolled in Medicaid and S-CHIP and other public health programs. We have found by putting in place, and not just Amerigroup, but other Medicaid companies, a preventive medicine and care management program, we can bring structure and consistency to a healthcare system that traditionally has disconnected parts and often failed at low-income citizens. We target and we help pregnant moms, we help children, and we particularly focus on disease management around this population, hence, one of the major reasons why Medicaid managed care works so well for this population. In addition to that, Amerigroup does some things around case management. We have an early case finding program. We have a state-of-the-art telecommunications program, and we do a lot of in person follow up with individuals around case managers. So again, that's

kind of the lay of the land around why managed care brings a uniqueness to this population and why the health plan has worked.

As a physician and as a former State Health Officer, it is my opinion that prior to managed care, there were a number of programs—in particular, the Medicaid program was an extremely inefficient program, and that was due to such things as, there were very few providers who wanted to participate in Medicaid. There was poor access to care. If you did not have a provider in your community who wanted to participate, then certainly that mom with that child who needed preventive services didn't have a place to go. There was lack of coordination of care. We offer what's called wrap-around services, just simple transportation. You'd be surprised at the number of moms who have five or six kids who cannot facilitate getting on a bus, and in a DC, of course, a train. And I'm from Arkansas, so there was no such thing as a train. Trying to get on the bus with six children was very difficult, so just coordinating that care by getting a van or something to pick this mom up with all of her children and get them to a hospital. We also saw higher ER utilization on the Medicaid program because again, we had a governmental entity who was just basically looking at a program and not coordinating care, and there was lack of quality indicators.

Since managed care companies have become involved, we have witnessed availability of care in the communities, so we have providers who never before wanted to take care of these children very anxious to be a part of the program. We have noted and are very excited about decreasing Emergency Room utilization. We see an increase in preventive care. If you don't get that child in for an immunization, guess what happens? As a physician, I've seen a number of kids with preventable diseases secondary to not getting immunization. Now that we have the program in place, those kids are getting in; they're getting their shots. A decrease in costs in the over all Medicaid program, and we've also seen expansion of eligibility to services up to 350 percent of the federal poverty level. As I mentioned, there are some other services that each of the managed care companies offer.

So now that you know a little bit about managed care and some things that we bring to the table, let me share with you the partnership we with managed care have in the states to increase enrollment in the S-CHIP program. From a marketing and outreach perspective, first of all, there are guidelines that are put in place from CMS, and there are also guidelines that are also in place from each individual state, so based upon some of those states, we have to look at the guidelines as to how we're going to interact with the members from an outreach perspective. For example, in the State of New York,

members can enroll on the spot, and the health plan can do the predetermination, which is very helpful to getting that child enrolled into the program almost immediately. In New Jersey, the health plan may assist in the enrolling process, but cannot enroll that child. In the State of Florida, the health plan may share information to educate a family, but you have to wait 24 hours, which is called a "cooling off period" before you can go back and work with that mom around enrolling her child or children into the program. If you look at Houston, the health plan can educate about the program, however, it cannot assist with the application. So I can walk up and tell you, "There's a program out there," but you can't do anything to help that mom get her children enrolled. And in the District of Columbia, which is where I work, we cannot approach a potential applicant, so I can be in a community—and we do a lot of community-based organization things—but I can't approach you. So I do unique things like having a bunny who sits beside me or that draws kids over. If you come and ask me why I'm sitting there, then I can tell you about the S-CHIP program. Isn't that amazing? And I can tell you how to enroll, but I can't tell you to enroll in Amerigroup. I can only tell you to enroll in the DC Healthy Family program. We see this being a very important role for us who are in part of this role in the healthcare industry and in the health plan industry. We not only have bunnies out there who are in outfits trying to get

the attention of families, we work with RVs in a lot of our communities where there are healthcare screenings occurring in these RVs.

By the way, we offer this service to all members in a community. It is not just explicit to one managed care organization. We are very close with DC community-based organizations, the faith-based organizations. We spend a lot of our time out interacting with those groups in order to make sure that they know that we're there, we're available and that S-CHIP is so important to that community. We've been known to give out food baskets and to have Christmas presents. I'll never forget one mom who was so thankful to get Christmas gifts for her 11 children and to have something to share with them, and they knew that they could come with us. We're a part of that community. We're available to try to meet some of the needs of that community, again, not just drawing attention to Amerigroup, but drawing attention to the fact that there's a managed care organization out there who cares, and there's a program called S-CHIP, and trying to make sure that those individuals that are eligible will enroll in those programs.

In addition to that, we have partnerships with schools and we give educational programs on health promotion, which are very important for that community. We also, in the District of Columbia, do things like trying to get our kids up and moving from a fitness perspective. We did a jamboree, which brought

us a lot of media attention because we taught the kids the techniques of cheerleading and football, and the techniques of getting out and moving, not just being in your home. Again, what we do with these programs is drawing the moms and the parents' attention to S-CHIP and looking at the fact that they could possibly be someone that could be eligible for S-CHIP. There are a number of studies out there that talk about the American families by the Urban Institution. One of them talks about all low-income uninsured children are eligible for coverage under Medicaid or CHIP. They're 80 percent of kids that are out there, but only 62 percent of those kids' parents know that they're eligible. And so in addition to doing a lot of community-based and faith-based things, we find ourselves interacting with business-to-business. There are a lot of businesses where they do not cover the families from an insurance perspective and those kids do qualify for S-CHIP, so we do find ourselves as a community partner with those businesses.

We also find very uniquely and very challenging sometimes the retention rate. I believe Donna's going to talk a little bit about the article she's written, but, from a retention perspective, one of the challenges we have in S-CHIP is that once you get these kids involved or get these parents enrolled, how do you keep them in the program? Amerigroup can boast of having a 6.4 percent national disenrollment rate. In

the District of Columbia, we personally have a 3.4 percent. That's still too high when you look at the fact that these kids are no longer getting the services that are provided. So when we look at, basically, some of the disenrollment, we think some of the things we're looking at and some of the things that are occurring throughout the country, and particularly here in the District of Columbia, is looking at the renewal policy. What's happening around that renewal policy? Are there very complicated applications for our members? And yes, there has been in the past. I'm happy to say, in the District of Columbia, they've streamlined that application process. Are there premium charges? Should there be premium charges? There are some discussions around whether or not premium charges will be helpful in making sure that the folks who need to be retained or who are part of the program will stay in the program.

We also see that a couple of studies in the District continue to talk about streamlining additionally the recertification process, and one of the things that we're doing in Amerigroup that I think is another very good outreach program is that we're now beginning to do some things around looking at that application form. What happens in a lot of the states, or at least in the District of Columbia and a lot of states, they either mail or try to interact with those folks who are already presently enrolled in the program about 90 days

before their eligibility is discontinued, but they'll send to that family a blank form and say to them, basically, "Fill out this form. It may be simple, but fill out this form so that we can reenroll you within the next 90 days." What we're doing with the District of Columbia Amerigroup, we are prepopulating that form, which means, we're putting in all the information that that mom will need to have, and we're writing it in for her, and we're saying to this mom or dad, "If this information isn't correct, strike through that information and put in the correct information." Within the District, they do not require for you to do income certification, but they do recommend that you put a pay stub with an application. And so we're looking at that and we follow up with the mom. We send an application out to them that's prepopulated, information filled in, and then we follow up with a phone call and say, "Mrs. Jones, Mary, whatever, have you filled out that form? Can we do anything to help you with this form? Do we need to come by and pick that up for you to get it over to where it needs to go?" We're seeing some success rates around that. We're seeing some folks who traditionally have not continued to have that form or have not recertified to go in for recertify. So the bottom line of that is to stay tuned. We're looking for opportunities to increase that membership from S-CHIP. We're looking for opportunities to continue to be partners, and we think the key to all of this is community and working very close with the

community and faith-based organizations and being partners with the state as well as CMS in order to get these parents in so that they can keep care for their children, and we can prevent preventable disease, and we can make sure that good healthcare is occurring in our country. Thank you.

ED HOWARD: Thanks very much, Dr. Nichols. Our final speaker is Donna Cohen Ross. She's Director of Outreach at the Center for Budget on Policy—I'll say it right.

DONNA COHEN ROSS: It's a mouthful. I'm sorry.

ED HOWARD: Easy for me to say! The Center on Budget and Policy Priorities. She's directed that center's outreach efforts, not just on health insurance, but other issues, notably the Earned Income Tax Credit, for which they are vastly famous at succeeding in getting people enrolled who are entitled to that provision of the law, and to ensure that low-income Americans generally actually benefit from the laws that are in place to help them. She's been directly involved in helping children for years, including efforts at the state and local level to improve early childhood education and healthcare, and we're very pleased, Donna, that you've cut short a business trip and got ready, and are here with us this afternoon.

DONNA COHEN ROSS: Thanks Ed. I'm very pleased to be here. I'd like to thank the Alliance and also Robert Wood Johnson. You mentioned earlier the Covering Kids Initiative,

and I've been privileged to work with the state and local groups involved in Covering Kids for some—gosh, I guess it's coming up on about eight years now. And I want to thank my fellow panelists, Dennis, Greg and Dr. Nichols. Your remarks have helped set me up for maybe building a little bit on what you've already said, but maybe I'll try to also summarize some of what we've heard.

I want to start by just bringing us back just a moment to talk about where we've come from, because I think it helps reiterate what Dennis described as the wild success of programs to cover children, to provide health insurance for children through Medicaid and CHIP. The strong support for reducing the number of uninsured children came from both the federal and state levels. The federal and state partnership, which is sort of the crux of both Medicaid and CHIP, was characterized by an enhanced federal matching arrangement for CHIP, and at the time that CHIP was enacted, of course there was a different economic picture than we see today. That robust economy made for very enthusiastic state participation in the program.

What I'm going to be focusing on, though, is the next point, and that there are really three ingredients that have made this enrollment boost so incredible in Medicaid and CHIP. The first part was expanding eligibility, but I think as everybody knows, if you expanded eligibility and didn't do anything else, some of the other things we've been talking

about, you probably wouldn't get quite as far as you needed to be. The other ingredients are critically important as well. Simplifying enrollment and renewal procedures. Greg mentioned those a little bit, as did Dennis. I'm going to spend a little bit more time on those. And also conducting outreach. I will say that some of these activities began even before CHIP with the Medicaid program, particularly for younger kids, but in fact they really did jump start, so to speak, with the advent of CHIP, with states looking at designing and redesigning programs to make them simpler. The Medicaid program was, to a large extent, brought along, and I would say, quite improved with respect to procedures and such, because of that effort. States made steady progress on reducing the number of uninsured children since the late 1990s, and I think we can just really look at what we have before us and say, in fact, Medicaid and CHIP are working. Again, you know, Medicaid and CHIP are doing the job that they were designed to do. In robust times, they've been helpful in getting more uninsured children insured, but also during the recent weak economic times, Medicaid and CHIP actually prevented millions of children from becoming uninsured and also buffered the effects of the erosion of employer-sponsored health insurance. So, in terms of being there as an important piece when families are experiencing financial strain, when they might be losing income or jobs or the health insurance associated with their jobs, Medicaid and

CHIP are also working in that context. My pictures aren't as nice as Greg's, but this one really just demonstrates what I've just said. In fact, this chart is based on CPS data and on some similar data from the CDC. A national health interview survey shows a more dramatic effect and that the percentage of low-income children without health insurance has fallen about one-third due to CHIP and Medicaid expansion. So again, we have a pretty successful program here.

I think we can see from our experience, certainly from the experience of the states and community groups that have been engaged in outreach, that the state and community efforts are both necessary to boost enrollment, that the simplification efforts and the outreach activities work in tandem to facilitate enrollment. Systems have to be simple and work smoothly in order for community-based outreach to even be feasible, and community-based outreach, especially application and renewal assistance, that direct assistance with families, is a very effective way to ensure applications are submitted and ready to be processed. Working together, states and community groups have created situations where getting into a program is easier for families, but also easier for the eligibility workers who are processing applications. I can give you many examples of where those two pieces have worked together quite effectively, and actually, community-based

organizations have helped to inform simplification efforts. So, the partnership is really very, very important.

The next two slides really just show you what happens when you have working together, those simplification efforts and also outreach. This was what we saw happen in Ohio. During June 1997 and June 2001 the state undertook various simplification efforts, also was conducting outreach, and you can see that enrollment improved. It's a very dramatic enrollment. The second picture is actually from Virginia, and looks at what had occurred in Virginia in terms of the boost in enrollment between September 2002 and June 2003. More recent data show that this is actually continued, but this is all that I could get my hands on for today. Some of the things that Virginia did had to do with reducing verification requirements, creating a "no wrong door" policy so whether a family submitted their application to the local social services agency or a central processing unit for CHIP, it didn't matter, the program was seamless, and a child could get into whichever coverage program was the appropriate for that child. The state continued to do additional simplification efforts, is now focusing a great deal of attention on that retention issue that we just heard about, so that once you have an eligible child enrolled, you do everything possible not to lose that child for continuity of care, certainly, but also so that you don't have this churning effect of kids being disenrolled and then coming

back into the program, spending that time and effort on reenrolling the child.

Despite all of this, in 2003 and 2004 we began to see the trend toward further simplification and outreach showing some signs of reversing. As some of you may know, the Center on Budget and Policy Priorities each year conducts a survey of the 50 states and District of Columbia. We do this survey for the Kaiser Commission on Medicaid and the uninsured. We have done the fourth in a series. We're gonna be getting ready soon to do the fifth, but in 2003 and 2004 we started to identify some new tensions that weren't there before. We began to observe that state budget pressures began to lead to some retractions of some of the simplified procedures and outreach efforts that had made such a difference in prior years. We saw enrollment decline in several states, and some states, as you've already heard, froze enrollment in CHIP.

I want to talk a little bit about some of these. I look at these simplification efforts as more than tweaks to the system. They really are very integral to making the system work, and so when we see them retracted, it is quite worrisome. Our latest survey—and you have the full report in your packet, and I thank the Alliance for sharing that—we found that nearly half the states, between April 2003 and July 2004 actually made it more difficult for families to secure and retain health coverage for their children and sometimes themselves. And if

you take a look at what they did, increasing premiums, reinstituting or creating procedural barriers, and also freezing children's enrollment. You see that a lot of these changes actually took place in the CHIP program, although the procedural barrier piece took place in both Medicaid and CHIP. One reason for that is that CHIP has the flexibility to do those kinds of retractions, whereas there are some beneficiary protections with Medicaid that made it not possible to do that. We also looked at over time what was happening, and found that in fact, when states had reverse simplifications, they stayed reversed. They didn't go back to where they had been, and that was troublesome as well. The map shows where states had frozen enrollment during this period of time. I will say that right now, we have a better picture than we're seeing right now in terms of most states having reopened enrollment. There are no longer eight states in this situation. In fact, only Florida and Utah are in this situation at this point, and in both states there are some efforts to open enrollment, and that's a good thing. But I will say that when a state closes CHIP enrollment, outreach becomes extremely tricky for them. First, attention needs to be paid to retention, because you don't want to lose a child during a frozen enrollment period, because then that child is locked out of coverage for a period of time, maybe indefinitely. Also, we can't forget that children eligible for Medicaid who are applying for the system can still

get covered, but it becomes a very tricky message to the public when you have closed enrollment in CHIP, you're still accepting applications so that a child can be assessed for Medicaid enrollment. This becomes very confusing and sometimes demoralizing to families, and that's a huge problem. We also found in our survey that many states scaled back outreach considerably, and they cited state budget shortfalls as the reason. Very few states had been spending up to the limits allowed by law on outreach to begin with. Many had curtailed their outreach spending, and some had reduced their outreach budgets to zero, and they had attributed these retractions to state budget pressures. It's worth noting that some states, Illinois, Louisiana, and Virginia among them had actually moved forward in this period, but most states we saw really cutting back. When we interviewed state officials, you can see what they said. I won't read these quotes to you except to point out that they all talked about the cost of outreach not being a problem. What they were really worried about was, if they brought children into the program, would they have the funds to support the coverage for those children? One even described it sort of false advertising, to attract kids to your program, but not be able to serve them, to perhaps have to freeze enrollment because you couldn't accommodate everybody. They're very concerned about this. I should say that when we did this survey, the issue was really state funding shortfalls, but now

some states are concerned about the adequacy of federal CHIP funding as well, and Greg talked about that. States are already reaching the limits of their federal CHIP allotments but by 2007, it looks like 19 states are projected to have federal funding shortfalls that could force them to reduce the number of children served, or cut CHIP spending in some other way. It appears that it will take new funds into the system to allow states to continue their programs and also to expand. At the same time, as Greg pointed out, there are budget proposals in the debate in Congress that make new outreach initiatives unlikely. The House Budget Resolution contains deep cuts in Medicaid, deeper in fact than those proposed by the Administration, and even if cuts were ultimately smaller than proposed, one would have to question where funds for new investments like children's outreach and coverage would come from. States are faced with a cost shift to the states. They're likely to cut back on coverage as a result, and so these are very tricky conditions to be talking about outreach and further enrollment. Again, just to reiterate, we're in this situation at a time when we can also say that we have programs like Medicaid and CHIP that have done a good job, and are working, and I think it does behoove us to find a way to make them work and to do what we have to do to make that happen.

ED HOWARD: Thank you, Donna. Now's your chance to get involved in this. I also invite our panelists to take this opportunity, while we're getting our act together to make any observations that might have been triggered by the things that they have heard. Dennis?

DENNIS SMITH: Oh, I might have a couple of things to say about what I heard, and I guess I would have to say I am a little bit surprised. I thought doing more outreach was something we could all agree upon. Let me go back a little bit in time and begin when we created S-CHIP and the issue of the 1.1 billion reverting to the Treasury, et cetera. One, S-CHIP was created in a legislative period. I believe we went to markup in Finance Committee in mid-June of '97, and we finished in early August in '97. We knew at the time that a number of decisions were made: How long should the allotments be the CHIP-dip itself, where funding was higher, and then it dipped down and then came back up again? Thankfully we are in the period where it has come back up again, et cetera. But one of the things—I think the Urban Institute actually did a report—we had actually put twice as much money into S–CHIP as what they had projected the demand would really be. But one of the complications that we were dealing with, again, trying to distribute funding among 50 states and the District of Columbia, trying to make assumptions about allotments based on uninsured kids, less than 200 percent of the poverty level, et

cetera. I think one of the things that we did assume—at least I assumed at the time was, we're getting it started, we've got a lot of money out there, and Congress will come back with a better way to do the data, refine the data, to sort of help do a better job on the allotments. Instead, we kind of got into the retention/redistribution formulas that in some respects, again, have an impact on the dollars themselves, when you look on a state-by-state basis. The $1.1 billion that went back to Treasury last year, it went back because Congress said it would go back, and the way we created the program in the first place, that a state would have three years to spend the allotment, some funds would be redistributed to other states, and if it wasn't used it would expire because it wasn't needed. Putting that $1.1 billion back in for the present fiscal year, which it would have done would not have resulted in one more child being covered. The states going into this fiscal year and the states coming out of this fiscal year, that $1.1 billion would have still been there. The formula that also, and again, people worked hard on it, and people of goodwill, trying to come up with a formula, but the formula itself didn't solve the problem for everybody either, in the short-term or the long-term, either. So, I do want to make sure we step back from any assumption that somehow if that had passed it would have solved all the problems. I don't think it would have.

In terms of the efforts that the states are facing now, again, we do have states that some are still building up surpluses while other states are facing pressures on their allotment. A number of the states that are facing pressures on the allotment have gone well above the 200 percent of poverty level. Some states that we actually helped as well have expanded to parents, expanded to other populations, as well. So there are different reasons why states are bumping up against allotments, and so, again, I want to caution about over-generalizing about what this issue is, and an approach to take. Again, as I said, I did want to step back and say, we knew that we were creating a great thing with S-CHIP. We didn't have any illusion that we were making it perfect in terms of the way the distribution and redistribution and the data that we were relying on was going to be perfect. I think efforts that we face, S-CHIP is a 70 percent match rate on a national basis, versus 57 percent on Medicaid. Again, it has still turned out to be a great deal for the states. Also, on the issue about what states have done, slowing down outreach or coming back again on doing twice-a-year enrollment periods or whatever, again, I don't want you to walk away with the mistaken idea that, as I said in my opening remarks, Medicaid in the not-to-distant past had 16-page application periods, asset tests, face-to-face interviews, all of which states could do again, if that's what they wanted to do. So, because

states have taken some steps doesn't mean that somehow states couldn't do those things in the Medicaid program to make them difficult as well.

ED HOWARD: Can I just interject that the first program we ever did on S-CHIP, which back in 1998 featured a presentation by the program director from California, who brought in their new redesigned application form, which allowed not only application to Medicaid but S-CHIP on the same form. It was color-coded, heavy with graphics, it was big type, easy to read and it was 24 pages long [chuckles]. She was accompanied by a woman from the advisory committee who said she couldn't understand what was in this application. I think we've made a lot of progress in that regard.

Those of you who know the drill, I didn't repeat it, but you've already done it. If you have questions, write them on a card, come to a microphone and/or we'll go forward from there. And I believe we have a person standing at the microphone back there, or just someone waving a card? We've got a couple of cards and a couple of these questions are pretty straightforward. Is there a timeline—and I assume this is for you, Dennis—Is there a timeline for more details on Cover the Kids concept? You noted the existence of other legislation in your remarks.

DENNIS SMITH: I don't have a specific timeline. We again, are sort of anticipating the usual legislative cycle,

committee hearings, et cetera. As I said, I think part of this is, we believe that this is something that would be broadly supported on a bipartisan basis, and we certainly would welcome the opportunity to work with folks to shape it.

ED HOWARD: To follow up with my own followup, is the Administration still expressing support for early reauthorization of the S-CHIP program itself, which runs through Fiscal ’07?

DENNIS SMITH: Yes. Again, I think that that is taking this on this year, in a year that’s not divisible by two. It’s probably a good idea.

ED HOWARD: Very good. Thank you. I should have noted at the beginning of the Q and A session the presence of both Najaf Ahmad, who works with Stuart Schear at the Robert Wood Johnson Foundation, and Kim Callanan [misspelled?] from the firm GM&B, who also works with Stuart on the Covering Kids and Families Initiative that’s been referred to a couple of times here, particularly their back-to-school campaign, so if you’ve got questions about that, we can draft Kim for an answer to that. Questions from the audience that I haven’t had a chance to read yet? A couple came in also before we came up here. One was directed, at, I would say, probably Donna. Shouldn’t advocates prefer waiting lists to no outreach, because that creates pressure to expand the program?

DONNA COHEN ROSS: Thanks Greg. I think in a situation where a state has capped or frozen enrollment in CHIP, I quite agree that a waiting list is preferable to what we've seen in, for example, Utah and Florida, where, if someone wants to apply for the program, they're told, "We're very sorry, but enrollment is closed right now. Check back with us at some future time to see if enrollment is open." I think that is a very difficult situation for family, whereas the waiting list situation at least allows two things: One, you get a place in line, and also, as we saw in, for example, Alabama, when they had a CHIP freeze for a period of time, they communicated with families on the waiting list periodically to let them know sort of what the status was to remind them that their child might be eligible for Medicaid if their income changed during the period of time that they were on the waiting list, so that was actually very, very helpful. I think if you have a freeze situation, I would agree with the person posing the question. I think the challenge is for us to figure out how not to have a situation where enrollment is frozen when we still have uninsured children who need to be covered.

ED HOWARD: The questioner writes, is it important to keep CHIP as a dedicated funding source in order to continue increasing enrollment? Has the enhanced matched dedicated funding been critical to the five million kids enrolled as opposed to state flexibility being the most important driver?

And I might point out, in your materials there is a very good article by Debbie Chang and Genevieve Kenney of the Urban Institute pointing out some of the issues that are going to have to be dealt with in the reauthorization, both the strengths and the weaknesses and the tradeoffs that were involved in the original decisions in that legislation, and it embodies the same question, as a matter of fact, which you may have forgotten. Anybody want to take a crack at that? What's more important—state flexibility of continuing to increase enrollment?

GREG MARTIN: I would actually say that they're probably both important. In terms of the initial run of S-CHIP the first few years, having dedicated funds was incredibly important, and the front-loaded nature of it did provide a lot of flexibility for states and a lot of room for them to grow. But also having that flexibility in terms of how you can structure your program is what I think has helped the program weather all these state fiscal crises. Having the flexibility to just nudge it a little bit in either direction has helped the state keep from having to make drastic cuts, which is why it's been able to weather the storm and as Donna mentioned, help keep many kids from feeling the same effects their parents have as employer sponsored insurance has declined.

ED HOWARD: Greg, there's another question that actually is related, and the other aspect of state flexibility

is that the S-CHIP money is in effect an entitlement to states and not to people, so that when you get to your cap you can stop, whether it's a waiting list or a freeze or whatever. The questioner asks quite simply, what would be the consequences of doing away with that cap and making it more like Medicaid so that you have an unlimited amount of ability to sign people up, and have the enriched federal match available for those kids?

GREG MARTIN: I think if we started making it an entitlement program, we'd start seeing what we have already with Medicaid, just all over again now with S-CHIP. That would be the short and simple answer.

ED HOWARD: It's a question for Kim at GM&B. The person wants to get some additional details on some of the aspects of Covering Kids and Families that the Robert Wood Johnson Foundation will be doing as part of your back-to-school initiative. How is it different, it asks, from the President's initiative?

KIM CALLANAN: Well, Covering Kids and Families has been around now for the past five years. The overall program does three things: We simplify outreach, and it's much of what Donna and Dennis talked about early on, where you saw application forms that were really long and they got condensed to shorter things. We work with states to do that. We help to coordinate between state agencies to make sure that food stamps and the Medicaid program and all of the different programs that

are enrolling kids that might be eligible for cross programs, that those agencies are talking together. And we do outreach, and the outreach piece of it each year is focused around the back-to-school time period. We do a big national launch event, and then it's a fully integrated communications campaign that includes public service announcements, earned media outreach, where we're reaching out to the press. There are activities and events taking place in all 50 states, and this is a campaign that we will continue doing. We always work very, very closely with the Department of Health and Human Services on these efforts, but they are two very separate and independent things. And if Cover the Kids were to come about as a national campaign, I'm sure the foundation and Cover the Kids would work together, but right at this point they're separate, and have always been separate. Any other questions? Great.

ED HOWARD: Dennis, a question occurred to me as you were talking about the Administration's initiative and that has been expressed in a couple of different questions, sort of at the margin of them. I'm reminded of, by the comparison to the Covering Kids as opposed to Cover the Kids, is that one of the requirements as I understand it, of the Robert Wood Johnson program was that state governments be at the table at whatever the coalition was that was put together, even if the money went directly to some sort of non-profit umbrella group. The question is whether you're going to try to build in some sort

of normative, or even require participation by state governments in whatever you put together for this new outreach initiative?

DENNIS SMITH: Thank you for the question, and again, I think that what we have been thinking about is to take a wide variety of approaches to get different partners involved in it, but certainly we want to, as it has been in the past, some support from the state government. We haven't gotten down into drafting those types of specifics to say exactly how it's going to work, but that partnership is very important across the board, and I think that that's one of the things that we need to continue to reinforce.

ED HOWARD: Donna?

DONNA COHEN ROSS: I just wanted to add my comment to that, and I think that's so right, Dennis. The experience of Covering Kids has really shown that partnership between the state administrators and the community-based organizations is so critical. In order for those simplifications to have happened to make outreach feasible for community groups to be able to use the mail in application, a simplified application, the state had to be involved. Where we've seen tremendous steps forward has been in states where they have used outreach money to do things like application assistance fees or small grants to organizations to enable them to help families directly with completing applications and renewal forms. That

doesn’t happen without the state folks training the community groups on how those applications are to be done completely and correctly, and we see in states like California, Illinois and New York some very significant steps in terms of those applications that come through when the family has been helped by an application assister, they come through more often complete, correct and approvable. And so, it just seems to me, that connection between the two is so critical, and I hope that as this proposal goes forward that those experiences will be considered.

DENNIS SMITH: If I can add another thing that just occurred to me in part of the discussions as well, I know we’ve been talking about S-CHIP specifically, but outreach brings in Medicaid eligible kids, also, and we’ve enrolled 5.8 million kids, even enrolled, according to the latest statistics in S-CHIP, so if you think of 1999 as being basically zero for kids in S-CHIP, to 5.8, well, the number of kids in Medicaid has increased by almost nine million kids. Again, all of these efforts in Medicaid, and you’re not talking about allotments, you’re not talking about the other things, so all of these outreaches are bringing kids in whether they’re eligible for either Medicaid or S-CHIP. I just wanted to make sure that I was clear that our goal is to reach a child to get them enrolled into whichever program they’re eligible for.

ED HOWARD: And I remember when the Clinton Administration said they were going to enroll five million kids in S-CHIP and everybody laughed. Where'd you get that number? So, they relied on the Bush Administration to fulfill the promise for them. I apologize to the folks standing at the microphone. I knew there was a microphone here and one there. I didn't know there was one there, and I thought you were just stretching. Identify yourself, if you would please.

CHRISTINA KEN [misspelled?]: Christina Ken. I'm with State Health Notes. Looking at Greg's slides reminds me of an old PR campaign which asked, where's the beef, which I need to ask you, Mr. Smith, because I don't understand how the Administration can propose on the one hand cutting funding for Medicaid by 45 billion over ten years and then propose a billion dollars over two years to improve and increase outreach. I mean, I think the points that Donna and Greg were making were that the states and the people who run these programs are worried that they'll enroll more people only to find that they can't provide the services.

DENNIS SMITH: Thanks for that opportunity to respond. Again, I would invite you to look at not just what's in the Medicaid budget, but the entire President's budget, where the President is proposing $125 billion to increase the number of people with health insurance. In terms of what's in the President's budget, again, the 45 is the net number between the

overall proposals that save money. A third of those savings also to save the states money, so we believe that especially in our discussions with secretaries, discussions with governors, governors are supportive of the $20 billion in proposals that save both the federal government and the states dollars. In terms of the other issues, again, to kind of put this into context, we're talking about over a ten-year period of time where Medicaid expenditures are going to be $5 trillion, and two-thirds of the savings proposals come in the second five-year period, so the vast majority of this is not even in the first five years. Secondly, the way those savings proposals are, again, we're talking about slowing the rate of growth, we're not talking about reductions in spending. We're talking about slowing the rate of growth from 7.6 to 7.3 percent annual, and again our discussion with governors, most governors are telling us they can't afford 7.3. And where Greg's pressures are coming from is to say they need relief on their side of the program. And the savings proposals also impact states differently. In terms of what we have proposed on assuring that the states are putting up their share of the match, if a state is not recycling funds, then there's no impact on the state for those proposals. So, again, I think when you look at the entire budget about increasing spending, increase more Americans with health insurance, and in many respects, those proposals are helping take the pressure off

states' Medicaid budgets, if we have expanded access to coverage in other ways.

JOY KAUFFMAN: My name is Joy Kauffman, and I'm formerly with HHS, and I guess this question is mostly directed to Mr. Smith, but, upon hearing of Governor Leavitt's confirmation to now be Secretary Leavitt, I had a flashback, and you may have to correct me if I'm wrong, but, I believe it was a waiver that was passed under your watch that allowed him as governor to disenroll approximately 20,000 disabled adults from Medicaid, reconstitute the program such that it eliminated hospitalization coverage and then open it up as if it were an expansion of Medicaid. I'm just wondering if these are the types of open-ended programs that can, I believe, completely compromise the integrity of the programs that are going to be considered modernizations?

ED HOWARD: Not exactly S-CHIP, but certainly on a lot of people's minds, if you don't mind answering.

DENNIS SMITH: I'd be happy to, and I think we are mixing a couple of different things. Let me say again at the outset, you don't need Medicaid modernization. You don't need that to reduce eligibility or reduce benefits, or to cut reimbursement to providers. You can do that now under Medicaid, and in terms of what we are trying to do, to give the states new tools to avoid making those decisions and trying to expand the tools that states would use to make decisions. In

terms of the Utah waiver, that was granting access to health insurance that people had nothing, and the state came forward with an idea of expanding coverage for physicians, prescription drugs. I don't remember what all was in the package of what they did. It was a limited benefit package for an expansion population that otherwise would not have received anything at all. Hospital care was not in the benefit package, but it was provided through agreement with the network of hospitals in the states that said that they would participate by providing individuals access to care. I think again, if you go back to when the state was developing the waiver at the time, you had seen broad support from a wide group of interested parties, including advocacy groups that participated in the development of that waiver, and were supportive, because you were giving access to a group of people that were otherwise uninsured.

I'm sorry. Before I call on Larry, let me just remind folks about the blue evaluation forms as we get near the end of this Q and A session. Yes, go ahead, Larry.

LARRY GREEN: Larry Green, physician in Denver, and work at a policy center here in DC. Another splendid program, Ed. Thank you very much. Do any of you know how much it costs us to enroll, reach out, reenroll, determine eligibility, redetermine eligibility over and over and over again per child enrolled? Secondly, help me understand why, as you have said, the policy objective is to cover the kids. You have said there

is bipartisan support. You've said there is state and federal support. You've said that children are relatively cheap and easy to cover, and I know that we're going to spend more than $6000 per capita this year on healthcare for everyone, whether they're a child and adult insured or not. Why are you not talking about automatic coverage for a child?

ED HOWARD: Larry, can I just ask you to take 20 seconds to clarify what you mean by automatic? Do you mean automatic enrollment, or do you mean automatic eligibility for every child?

LARRY GREEN: The latter. That's the policy objective, right? Did I miss-hear it? Is that not the policy objective?

DENNIS SMITH: I think you did hear the policy objective of insuring kids. Again, I think, where almost every state is now up to 200 percent of the federal poverty level, when you look at Medicaid and S-CHIP combined, I guess I'm not quite certain what you mean about being beyond that, in that I think the rate of uninsurance among children, although it is not as low as our senior citizens, who have Medicare, it is now in the single digits nationally. I'm not certain what else you mean of the efforts that we're making. I mean, are you suggesting they should be eligible for Medicaid or S-CHIP, that they should drop their private insurance coverage? I'm not quite certain what you mean.

LARRY GREEN: Does anyone know what it costs us to determine eligibility, enroll, reach out?

DENNIS SMITH: Well, nationally, it costs about $16 billion to administer the Medicaid program. About nine billion of that is basically for eligibility determination. Seventy five percent of that is for kids or parents in terms of what they are as a percentage of the Medicaid population. Disabled are about eight million people, elderly about four and a half. Generally the eligibility has been simplified for the kids and non-disabled adults. I haven't done the math real quickly, but that's a ballpark figure of what you're looking at on eligibility. Again, states themselves are the ones determining within federal guidelines how often a child or an individual is redetermined for eligibility, et cetera.

ED HOWARD: Donna your center does a lot of things with numbers. Have you done any calculations like that?

DONNA COHEN ROSS: [Laughing] I'm not the one who does. Actually, Sir, I don't have the specific answer to that, although I could point you to some local studies. For example, one in New York, some others that have looked at this question of enrollment and reenrollment, this phenomenon that sometimes is referred to as churning, where you have an eligible child who comes off the program and very quickly comes back on. What I will say about it, though, is that this phenomenon, which is arguably very wasteful and potentially harmful to a child,

particularly one with ongoing healthcare needs, this has been really a focus of efforts to get states to adopt options that they have, for example, 12-month continuous eligibility in Medicaid and CHIP for children so that you can guarantee coverage to a child for year. Regardless of fluctuations in the family circumstances you would be able to offer coverage to the child for the full year, and you wouldn't have that on-again, off-again situation, which again, is exacerbated by states sort of going back on some of the simplification efforts, which as we talked about earlier, states can retract simplifications that they've put in place. We've seen them do it, and we've seen, over the past year or so, where that's happened, very startling declines in enrollment, when it's just a matter of making a change like going from 12-month eligibility to six-month. In Washington State, for example, there was a dramatic drop in coverage because of that change pretty much on its own. We are already seeing some of that retraction, which can be quite disturbing.

ED HOWARD: Sandra?

DR. SANDRA NICHOLS: One thing we've seen, just wanted to add from the medical cost of that is, looking at the fact that that child was off services so, depending on the age of a child, they're not getting the preventive services that they need, EPS-DT immunization, dental screening. We're seeing those kids going back into the Emergency Room to get services

for chronic care in the District, asthmatic kids across the country, the chronic diseases that they have. So they're not getting preventive services, they're getting Emergency Room care, hence leading to higher hospitalization and certainly, we can't even begin to look at the cost of missing schools, et cetera. So certainly, their recertification from the medical impact on those children is very severe and very expensive, and just a poor way of managing preventive care for the children the program serves.

DENNIS SMITH: If I may, again, I think that far and away, the families who are participating in S-CHIP think it's a wonderful deal. It's great coverage. It's low-cost. It's affordable, et cetera, so again, in terms of the other end of it, in determining eligibility, the cost of doing that, again, states have lowered the cost of determining eligibility, when you're going to a two-page application over a 16-page application. You've lowered the cost of determining eligibility when you do it over the computer rather than requiring a face-to-face interview. I mean, again, I think that Congress and the American people would always expect us to make certain there's integrity in the program, that only people who are eligible for the program are actually being served, so there is a certain cost that is always going to be there. Any program has administrative costs. I think overall, if you compared the administrative costs to Medicaid and S-CHIP,

you're gonna find it a pretty good bargain when you compare it to a private plan as well. Again, everything is going to have costs to it in terms of administering eligibility. But I think we're getting a very good bargain.

ED HOWARD: Greg, you have a final comment?

GREG MARTIN: I guess I'd like to just go ahead and say that as Dennis pointed out, S-CHIP is indeed a small program compared to Medicaid, but it is also a very good program, a very popular program, and when you look at it, a very successful program. State legislators like this program. They want to keep this program. It's been a good program for them. To kind of just wrap things up a bit, it's good to remember also that state budgets are still stretched pretty thin. While revenues are on the up-tick, it's still not swimming in cash out there. They're still having to look at their budgets and having to watch where they're spending. When you take that into account with current budget proposals that are out there from the federal government, from the House, the Senate, the President, a lot of costs are being shifted to the states across the board, and these are things that they're going to have to look at and have to negotiate and have to hammer out in the coming year and on into the future.

To kind of respond to Dennis's point at the beginning of the question and answer period, taking one billion dollars out of a pot of money that was originally allotted to the

state, he mentioned that it wouldn't cover one extra child. I think I might agree with that. I think state legislators, given the flexibility with that money would be able to cover many more than one child with that money, and in terms of expanding Medicaid enrollment, I think we're also at a point where we're looking at a program that you've said is too expensive and growing too fast, and needs to have money cut out of it, and yet we're talking about adding more people into it. I think that's going to be putting states in a very tough position without extra funds available to them to help them provide this coverage, so that way they can keep their promise to the kids.

ED HOWARD: Go ahead, Donna.

DONNA COHEN ROSS: I would just want to end up my remarks by just again, reiterating as we heard from all of the speakers to remember that Medicaid and CHIP have been doing the job that they set out to do. They've been extremely successful programs, and I think certainly the people who have the coverage do want to be able to continue. As Dennis has said, families think that they're getting a pretty good package from Medicaid and CHIP. I would just say, you know, earlier, we talked about some pretty big numbers that are hard to wrap your head around. You know, our concern is, when you look at the House budget resolution that contains such deep cuts that the worry is that if that leads to further discussion of capping the program, the flexibility that states will have left is

flexibility to make the kind of cuts that could really be detrimental to the survival of the program and to people having those benefits that they need. So, as things go forward, I would just think that we need to be thinking about that.

ED HOWARD: Let me just clarify that the program you're talking about it Medicaid, and not necessarily S-CHIP.

DONNA COHEN ROSS: CHIP. I think that both are at risk.

ED HOWARD: Okay. Well.

DENNIS SMITH: If I may again, and back to this point, the states will end this fiscal year with still $5 billion in their allotments. And when you start the next fiscal year, you're going to add another $5 billion again, so my point was that it is where the money is in the aggregate versus the state specific, and simply putting another billion on top of nine nor ten billion wouldn't result in additional kids, was my point. In terms, again, of the budget resolution, et cetera, one of the things that we are missing here is the states themselves saying, "A rate of growth in excess of 7 percent is exceeding our revenue growth, is crowding out other items in state budgets, like education, et cetera," and people need to come together and start working on this and come up with solutions rather than just saying that it's an issue that people are unwilling to take on because of a budget number, et cetera. I think that there are lots of folks who can say we need to get

the growth of the Medicaid program to be more sustainable. I mean, we're hearing that from governors; we're hearing that from state legislators; we're hearing that from local government as well, and the sooner that folks are working on a solution rather than to say it's not a problem, then the sooner we'll find that solution and that's what we're all here for.

Just one final comment, and just reminding the panel and all of us, the partnership with the managed care organizations. Clearly that has brought some stability to the amount of budget funding that's being spent by the states because that is a negotiated arrangement, which allows for more children to be served, so again, as being partners at the table, we think we bring some solutions to some of the challenges we face around the budgetary constraints.

ED HOWARD: Quite good. Thank you all. I think despite some clear differences that are evident on some of these policy issues, there is, as Dennis had predicted, a whole lot of agreement on the need to keep S-CHIP working, to make it work better, and to get to the goal of covering all kids as quickly as we can.

By the way, we skirted several times on the underlying cause of the 7.7 or 7.2 or 7.5, whatever the growth rate might be, into the future, which is the growth in healthcare costs generally, not just in Medicaid, certainly not just in Medicare. Those of you who filled out our online survey told

us that the number one topic you wanted to focus on over the next year or so had to be healthcare costs, so we will be addressing that as we go forward, and if you have specific suggestions on aspects you'd like to see us take on, please let us know about that.

Let me take this opportunity to reiterate our thanks to the Robert Wood Johnson Foundation for its support in helping to shape this program as well, to you for being a big part of the way the discussion played forth, and certainly thanks to our panel, who I think gave us a lot of information to chew on about a program that seemed simple, but is a whole lot more complicated than we might have thought coming in. Thank you all very much, and thank you for being here [applause].

[END RECORDING]