



THE KAISER COMMISSION ON  
**Medicaid and the Uninsured**

**The State Children's Health Insurance Program:  
Lessons and Outlook**

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Before the  
Committee on Finance  
United States Senate

Billings, Montana  
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## **The State Children's Health Insurance Program**

Summary of Testimony by Barbara Lyons, Ph.D., Vice President and Deputy Director  
The Kaiser Commission on Medicaid and the Uninsured  
The Henry J. Kaiser Family Foundation  
Submitted to the Senate Committee on Finance  
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### **SCHIP has successfully worked together with Medicaid to provide health coverage to millions of low-income children.**

- SCHIP covers 6 million children today, building on Medicaid's coverage of 28 million children.
- Over the past decade, SCHIP and Medicaid together have reduced the uninsured rate among low-income children by one-third.
- Without SCHIP, millions more children in low-income working families would be uninsured.

### **Effective outreach, expanded eligibility, and streamlined enrollment and renewal are key elements of SCHIP's success.**

- SCHIP established a new paradigm in which priority is given to finding and enrolling eligible children in SCHIP and Medicaid.
- Experience has shown that increasing eligibility, simplifying the enrollment process, and providing 12 months of continuous eligibility boosts coverage of eligible children.
- Continuous outreach and broad messaging about the availability of health coverage create enthusiasm and spur enrollment in SCHIP.

### **Because of SCHIP, millions of children have better access to the care they need.**

- SCHIP and Medicaid increase the likelihood that children will have a medical home and lead to improvements in children's health, yielding benefits in school as well.
- Utilization of preventive and primary care services increases with SCHIP and Medicaid coverage to a level on par with private insurance.
- SCHIP and Medicaid have helped to narrow racial and ethnic disparities in access to health care.

### **Children's participation in SCHIP and Medicaid is high, but many uninsured children are missing out on the programs' important health benefits.**

- Children's participation in SCHIP and Medicaid is high, reflecting the value parents place on coverage and their positive experiences with the programs.
- Low-income parents are emphatic about the need for health insurance for their children, but many cannot afford to pay for it on their own.

- Parents of uninsured children often do not know that their children qualify for SCHIP or Medicaid, do not know how to apply, or have faced enrollment barriers.

**Financing issues have presented the biggest challenges for SCHIP.**

- The capped financing for SCHIP, set 10 years in advance, often has not aligned with program needs.
- As state programs have matured, state spending for SCHIP has exceeded federal allotments.
- The distribution of federal SCHIP dollars across states has left some states with inadequate funds to keep up with enrollment and spending, while other states have had more funds than they could spend.

**Decisions regarding the level and allocation of federal financing in SCHIP reauthorization will be pivotal to SCHIP's future success.**

- SCHIP works effectively when state and federal funds are available at the level necessary to finance coverage.
- The Congressional Budget Office estimates that SCHIP enrollment will fall significantly if there is not additional federal financing for the program.
- The level of federal funding and its allocation across the states will determine whether states are able to address their 2007 funding shortfalls, maintain current eligibility levels, cover those children who are eligible but not enrolled, or expand coverage to more children or other groups.

**The health and health coverage of millions of children depends on the reauthorization of SCHIP.**

- The SCHIP program will expire and no federal funds will be available to support the program if SCHIP is not reauthorized by the Congress by September 30, 2007.
- Without additional financing for SCHIP, more children will likely become uninsured, jeopardizing a decade of progress in covering children and improving their access to care.
- To build on SCHIP's success, more needs to be done to reach the 9 million uninsured children who are missing out on the important benefits of coverage.



Thank you for the opportunity to offer testimony this afternoon on the State Children's Health Insurance Program (SCHIP). I am Barbara Lyons, Vice President of the Henry J. Kaiser Family Foundation and Deputy Director of the Kaiser Commission on Medicaid and the Uninsured. The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

SCHIP was created nearly a decade ago as part of the Balanced Budget Act of 1997 (BBA). Together with Medicaid, SCHIP has helped to dramatically reduce the uninsured rate of low-income children by expanding eligibility and simplifying enrollment procedures. The gains in coverage have helped to increase access to health services for millions of children and provided greater financial security and peace of mind for their families. SCHIP must be reauthorized by the Congress for funding to continue beyond FY 2007. My statement today will highlight the lessons on covering children that have emerged from nearly 10 years of experience in the SCHIP program and lay out the major issues for SCHIP reauthorization.

### **Lessons from 10 Years of SCHIP**

#### **SCHIP has successfully worked together with Medicaid to provide health coverage to millions of low-income children.**

Together, SCHIP and Medicaid provide health coverage for one in four of our nation's children. Medicaid provides a base of coverage for 28 million poor and near-poor children in America. SCHIP targets low-income children who do not qualify for Medicaid and covers an additional 6 million low-income children (Figure 1). Annual growth in SCHIP enrollment averaged 10.4% from June 2000 to June 2006 nationally and by 14.6% in Montana. SCHIP and Medicaid have successfully reduced the rate of low-income uninsured children by one-third over the past decade (Figure 2). This decline is particularly noteworthy given the falling rates of employer-sponsored coverage over the period and the fiscal stress that states experienced during the economic downturn from 2001 to 2004.

SCHIP has been a critical source of health coverage for low-income children who do not qualify for Medicaid but whose families cannot obtain or afford private coverage. As health insurance premiums rose and the percent of firms offering health coverage declined between 2000 and 2005, the number of uninsured Americans rose by 6 million, with adults accounting for almost all of the growth. During this period, public coverage through SCHIP and Medicaid played a significant role in stemming increases in the rate of uninsured children. In contrast, the number of uninsured adults climbed steadily upward, reflecting their more limited access to public coverage. In 2005, SCHIP and Medicaid did not fully offset the loss of employer-sponsored coverage among children, and the uninsured rate for children increased for the first time since 1998.

Low-income families have been the hardest hit by the deteriorating employer-based health insurance market. The percentage of firms offering health coverage has been on a long-term steady decline and, today, fewer than half of firms that employ a large number of lower-wage workers offer coverage to their employees. Three-quarters of low-income uninsured working parents do not have access to employer-sponsored coverage.

Even when firms offer health insurance, low-income workers often have difficulty affording it. Since 2000, the average premium for family health coverage has risen more than four times faster than wages. The average family premium now exceeds the earnings of a full-time minimum wage worker. In addition, deductibles and cost-sharing have also increased, placing families at greater risk for high out-of-pocket expenses. The average low-income family spends 70% of its income on housing, food, and transportation, leaving little room for other important expenses, such as education, clothing, child care, and health care. SCHIP, because it is affordable, helps many low-income working families obtain health coverage for their children. Few children enrolled in SCHIP have access to affordable private coverage. Without SCHIP, millions more children would be uninsured.

A hallmark of SCHIP's success in covering low-income children has been the flexibility provided to states to determine the structure of and eligibility for their programs. States currently administer their SCHIP programs as Medicaid expansions, separate programs, or a combination of the two. SCHIP coverage levels vary by state, in part based on states' Medicaid eligibility levels prior to SCHIP's enactment. However, all states are prohibited from providing SCHIP to legal immigrants who have been here for less than 5 years, undocumented children, children of state employees, children over age 18, and children who have private coverage.

**Effective outreach, expanded eligibility, and streamlined enrollment and renewal are key elements of SCHIP's success.**

SCHIP established a new paradigm in which priority is given to finding eligible children and enrolling them in SCHIP and Medicaid. States have taken steps to improve outreach, expand eligibility, and streamline enrollment and renewal processes. Experience has shown that all these actions boost the enrollment of eligible children.

***Expanded Eligibility***

SCHIP provided an impetus for states to broaden eligibility to reach more low-income children. As of July 2006, 41 states including the District of Columbia had income eligibility levels in Medicaid and/or SCHIP at or above 200% of the federal poverty level (\$40,000 for a family of four) (Figure 3). The federal poverty level is uniform nationwide; however, the cost-of-living varies substantially across the country. For example, a family living in San Jose, California has about half the purchasing power of a family with the same income living in Durham, North Carolina. States with lower eligibility levels tend to be rural states where the cost-of-living is lower.

### ***Simplified Enrollment and Renewal***

The implementation of SCHIP spurred states to adopt a variety of strategies designed to simplify enrollment and renewal procedures to bring children into coverage and keep them covered. Many of the simplification measures adopted by SCHIP programs have been carried over into Medicaid, facilitating coverage for low-income children more broadly. Nearly all states have now eliminated asset tests and face-to-face interview requirements for children covered under either SCHIP or Medicaid. States have also reduced verification requirements and provided for presumptive eligibility and self-declaration of income. Twenty-five states have adopted 12-month continuous eligibility in SCHIP, modeled on private insurance practice, to prevent kids from churning on and off of coverage. Montana has implemented many of these simplifications in their separate SCHIP program, including no asset test or face-to-face interview requirement, permitting self-declaration of income, and using 12-month continuous eligibility.

One recent development runs counter to the many simplification efforts that have promoted enrollment. The Deficit Reduction Act of 2005 (DRA) included a provision that requires Medicaid applicants and beneficiaries to provide proof of citizenship and identity to obtain or retain coverage. While the DRA provision does not apply to SCHIP generally, it does apply in states that have used Medicaid expansions for SCHIP. The new requirements are creating barriers for Medicaid enrollees, and some states are already reporting significant negative impacts on enrollment, including both declines in enrollment and delays due to backlogs in processing applications.

### ***Family Coverage***

Research shows increased enrollment and improved access and utilization of health services among children when parents are also covered. Unfortunately, in most states, eligibility levels for parents are substantially lower than those for children, precluding family enrollment in all but the very poorest families. While coverage for children is typically at 200% of the federal poverty level, eligibility for parents is set at or below 65% of the federal poverty level in half the states (Figure 4). Under federal waivers, some states are permitted to use SCHIP funds to cover parents. As of January 2007, 11 states were using SCHIP waivers to cover parents, although some have very limited enrollment. As a condition of covering parents, the waivers require that states keep children's enrollment open and prioritize funds for children. In 2005, about 600,000 adults were enrolled in SCHIP, compared to 6.1 million children on the program.

### ***Continuous Outreach and Broad Messaging***

Outreach is an essential tool to find and enroll eligible children. SCHIP and Medicaid enrollment are supported by continuous outreach and broad messaging about the availability of health coverage. A number of states have initiated broader coverage strategies for children building on Medicaid and SCHIP. Illinois, Massachusetts, Pennsylvania, Tennessee and Washington have enacted plans to provide universal coverage for all children. The message that all children are eligible for coverage is simple

and powerful and, in Illinois, this message attracted a substantial number of children who qualified for existing programs, in addition to newly eligible children. Conveying this message can help to overcome misperceptions among eligible families that their children do not qualify for coverage. Coordination between SCHIP and Medicaid is also critical for conducting effective outreach campaigns, for successfully enrolling children in the appropriate program, and for maintaining health coverage of children. Information technology and data sharing across public programs hold considerable promise for improving outreach to families with uninsured children, getting them enrolled in Medicaid and SCHIP, and keeping them covered.

**Because of SCHIP, millions of children have better access to the care they need.**

### *Improved Access to Care*

The benefits of health coverage are widely known. Children enrolled in SCHIP and Medicaid have much better access to preventive and primary health care than uninsured children (Figure 5). Compared with uninsured children, children with public coverage are much more likely to have a usual source of care--an essential building block of continuity and quality of care. They are also significantly more likely than uninsured children to have seen a doctor or other health professional, to have had at least one well-child visit, and to have received dental care in the last 6 to 12 months.

Consistent with their better access, children with public coverage report lower rates of unmet needs for doctor and/or specialist care, prescription drugs, dental care, and hospital care than children who are uninsured. Findings that unmet needs decreased significantly in the year following the enrollment of uninsured children in Medicaid or SCHIP provide additional evidence of gains in access and care associated with these two public programs.

Children in Medicaid and SCHIP have access to preventive and primary care that is comparable to that of privately insured children; some research indicates that, among low-income children, those with public coverage fare better on key measures of access than those covered by private insurance. Although their coverage is financed publicly, children in Medicaid and SCHIP are often enrolled in the same managed care plans that serve the privately insured population.

### *Reduced Racial and Ethnic Disparities*

SCHIP and Medicaid are responsible for gains in both coverage and access for children in all racial and ethnic groups. Further, the two programs have helped to narrow racial/ethnic disparities in access to care among low-income children. The Congressionally mandated evaluation of SCHIP found that SCHIP reduced racial/ethnic disparities in numerous access measures, including having a usual source of care, unmet need, and continuity of care. In New York, following the enrollment of previously uninsured children in SCHIP, the rates of unmet needs fell among the children overall, and previously observed racial/ethnic disparities in unmet needs disappeared (Figure 6).

### *Improved Quality of Care*

Evidence that children enrolled in public coverage experience improved quality of care has also emerged. For example, a study of one state's SCHIP program found that after enrollment in SCHIP, children received a greater proportion of their health care visits at their usual source of care. Also, improvements in the quality of asthma care have been shown for children following their enrollment in SCHIP, with the greatest improvements for children who were previously uninsured. The parents of these children benefited too, as fewer worried about their child's health after enrollment. Adding to findings of improved quality of asthma care, other research shows improved health outcomes for children with asthma associated with coverage under Medicaid and SCHIP. These improvements include marked reductions in the average number of asthma visits and in the rate of asthma-related hospitalizations for children.

### *Improved Health Outcomes and School Performance*

Significant declines in infant mortality and childhood deaths, as well as a reduction in low birth weights, have been attributed directly to expansions in eligibility for Medicaid and SCHIP. State and national surveys of parents and caretakers indicate that after one year of enrollment in Medicaid or SCHIP, children are in better health. An important test of the impact of coverage is the experience of the children with the greatest health needs. A study of children enrolled in California's SCHIP program for two years found that those with the poorest health status had dramatic improvements after the first year, especially in physical and social health outcomes, and these improvements were sustained over time. Chronically ill children also showed gains in physical and social functioning after more than one year in the program.

Enrollment in public coverage also has been associated with improved school performance. Researchers have found increased school attendance, greater ability to pay attention in class, and increased ability to participate in school and normal childhood activities following enrollment.

### **Children's participation in SCHIP and Medicaid is high, but many uninsured children are missing out on the programs' important health benefits.**

Children's participation rates in SCHIP and Medicaid are high (about 75%) reflecting the value that parents place on the coverage and their positive experiences with the programs. Building on the success of SCHIP, more needs to be done to reach the 9 million children who remain uninsured. The uninsured rate among children varies dramatically across the country, ranging from 5.5% in Massachusetts to 20% in Texas (Figure 7). Generally, the south and the west have higher rates of uninsured children than other areas of the country. In Montana, the uninsured rate for children is 15%, somewhat higher than the national average of 11%.

About three-quarters of uninsured children are eligible for SCHIP or Medicaid (Figure 8). As states have expanded eligibility for low-income children, a larger pool of children

have become eligible for these programs. Almost all eligible but uninsured children live in families with income below 200% of the federal poverty level. These children typically live in working households that often have little contact with government assistance programs. The overwhelming majority (85%) are native citizens. Forty percent are Hispanic, reflecting the high uninsured rate in the nation's growing Hispanic population. An additional 900,000 uninsured children are not eligible for Medicaid or SCHIP, but live in families with income below 300% of the federal poverty level, where access to employer-sponsored coverage can be limited.

Low-income parents are emphatic about the need for health insurance for their children, but many cannot afford to pay for it on their own. Most parents of low-income uninsured children have positive perceptions of SCHIP and Medicaid, but do not think their children qualify, do not know how to apply, or have faced barriers in the enrollment process. Fiscal constraints resulting from the recent economic downturn led many states to curtail outreach and limit enrollment by freezing enrollment, increasing premiums in SCHIP, and reversing simplifications in enrollment procedures. These types of program changes are confusing to parents and complicate efforts to conduct outreach and enroll eligible children.

As national economic and state fiscal situations have improved, states have begun to invest once again in statewide and community-based outreach activities that target children who are eligible but not enrolled. However, outreach efforts can be undertaken only if state and federal financing is available to support actual coverage. The level of federal funding and allocations to states will determine whether children who are now enrolled do not lose coverage and whether additional uninsured children can be covered.

### **Financing issues have presented the biggest challenges for SCHIP.**

While SCHIP is widely hailed for its successes, financing issues present some of the biggest challenges for the program. The primary issues are the total amount of federal financing available and the distribution of the funds across states.

Under SCHIP, state spending for eligible beneficiaries and services is matched by the federal government. To encourage participation among the states, the federal government assumed a larger share of SCHIP financing by making enhanced (relative to Medicaid) matching payments. On average, the federal government's share of SCHIP spending is 70 percent, compared with 57 percent in Medicaid. However, federal funds for SCHIP are capped nationwide and allocated to the states according to a statutory formula. Thus, each state operates under an individual funding cap. This financing structure contrasts with Medicaid, where federal matching funds are guaranteed to the states, with no pre-set limits.

SCHIP was established as part of the Balanced Budget Act of 1997 and the legislation provided a total of \$40 billion for the program over 10 years. The use of a capped financing structure in SCHIP helped meet some of the larger spending targets in that bill and generate the political support needed for passage, but the funding levels that were set

for 10 years never matched program needs. In the early years of the program, as states were getting their programs off the ground, SCHIP spending was below total allotment levels. However, as the SCHIP programs matured and the statutorily set annual allotment levels fell from \$4.2 billion to \$3.1 billion in 2002, SCHIP spending began exceeding the annual allotment levels and has done so every year since (Figure 9).

In addition to the level of total funding, the distribution of funding across the states has been problematic. The distribution formula has left some states with more funds than they could spend and other states needing additional funds to keep up with program enrollment and costs. For some states that had already expanded Medicaid coverage for children prior to SCHIP's enactment, it was difficult to spend their SCHIP allotments, but other states with high numbers of uninsured left large amounts of federal money on the table, despite the enhanced matching rate.

Concerns also have been raised about the SCHIP distribution formula. The formula directs funds based on a states' relative share of the nation's low-income children and its share of low-income uninsured children. Some argue that by including a factor for uninsured children, the formula penalizes states that increase enrollment in SCHIP. Finally, the provisions in SCHIP law to "redistribute" SCHIP funds from states unable to spend their full allotments to states that exhaust their allotments have created complexity and unpredictability in the program's financing that have led to numerous legislative changes to redistribute unspent funds.

### **Looking Toward SCHIP Reauthorization**

As Congress prepares to reauthorize SCHIP, a number of issues will be discussed, including who can be covered and the level and distribution of federal financing. States attribute much of SCHIP's success to the flexibility they have had over eligibility, benefit design, and program structure. The primary challenges for SCHIP have related to the program's financing. SCHIP works effectively when state and federal financing is available to support coverage.

### **Decisions regarding the level of federal and allocation of federal financing in SCHIP reauthorization will be pivotal to SCHIP's future success.**

If the SCHIP program is not reauthorized by the Congress by September 30, 2007, no federal funds will be available and the program will expire. The program is currently financed at \$5 billion in federal funds annually. However, the Congressional Budget Office assumes that, due to increases in underlying health inflation, SCHIP enrollment will fall significantly, from 6.9 million in 2007 to 5.3 million in 2012, if federal funds available for the program do not increase (Figure 10). During the past decade of relatively flat (and even declining) federal SCHIP funding, per capita health spending nationally rose by roughly 85%.

As Congress engages in discussions over reauthorizing the SCHIP program, 14 states are facing federal financing shortfalls in FY 2007. Further, 37 states are spending more in

2007 than their allotments for that year (Figure 11). They are supporting their programs with carry-over funding from prior year allotments. Because these carry-over or “reserve” funds are increasingly scarce as health costs more generally continue to rise, even more states will face funding shortfalls if federal funding is not increased. The level of federal financing included in SCHIP reauthorization will determine whether states can address their funding shortfalls in FY 2007, maintain current eligibility levels, expand coverage to those who are eligible but not enrolled, or expand coverage to more children or other groups.

**The health and health coverage of millions of children depends on the reauthorization of SCHIP.**

Together with Medicaid, SCHIP has been regarded as a huge success in expanding coverage and reducing the uninsured rate among children. Low-income children who are enrolled in SCHIP and Medicaid have increased access to needed care and obtain more appropriate care. Evidence indicates that these children have better health quality and outcomes as a result. Without additional federal financing for SCHIP, progress will be reversed as more children, parents, and pregnant women will likely become uninsured.

As Congress debates SCHIP reauthorization, many states are moving forward with plans to expand health insurance coverage for children and more broadly. Montana is currently considering increasing the eligibility limit for its SCHIP program from 150% to 175% of the federal poverty level. States like Washington and Illinois are moving forward to cover all children and Massachusetts and Maine are implementing more comprehensive reform plans. A fundamental component of these plans is their reliance on SCHIP and Medicaid as building blocks to achieve broader coverage. Since most children who are eligible for publicly financed coverage are covered by Medicaid, the foundation upon which SCHIP is built, sustaining that program will also be of utmost importance. The outcome of the SCHIP reauthorization debate will be a key factor in determining the ability of states to move forward in their efforts to cover more of the uninsured.

Figure 1

## SCHIP Builds on Medicaid for Children's Coverage

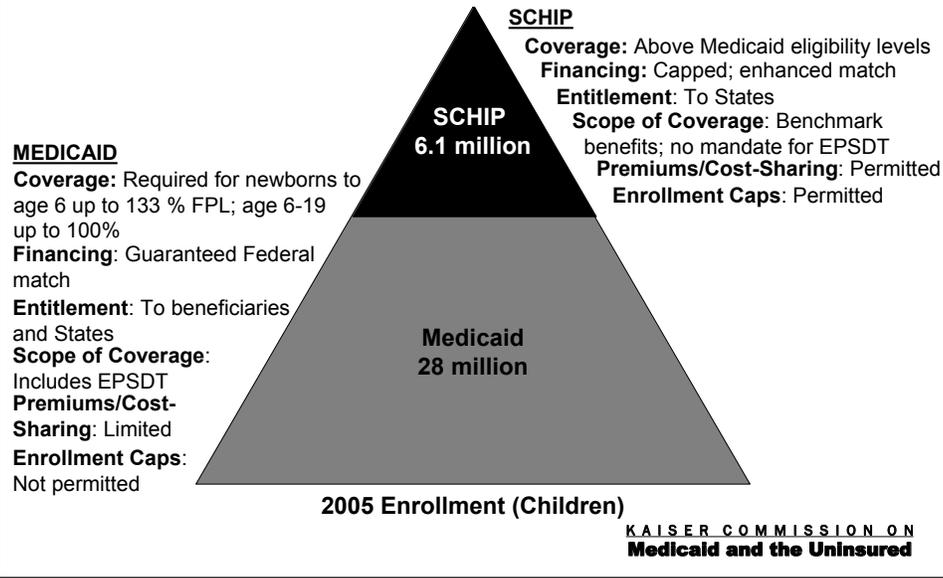
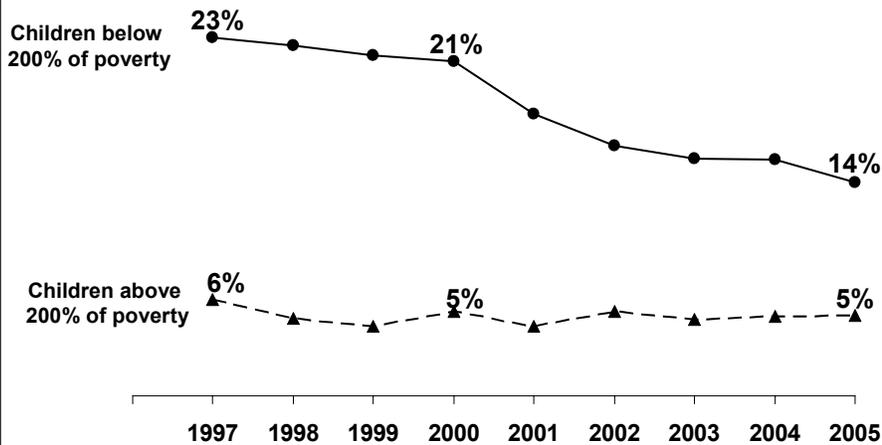
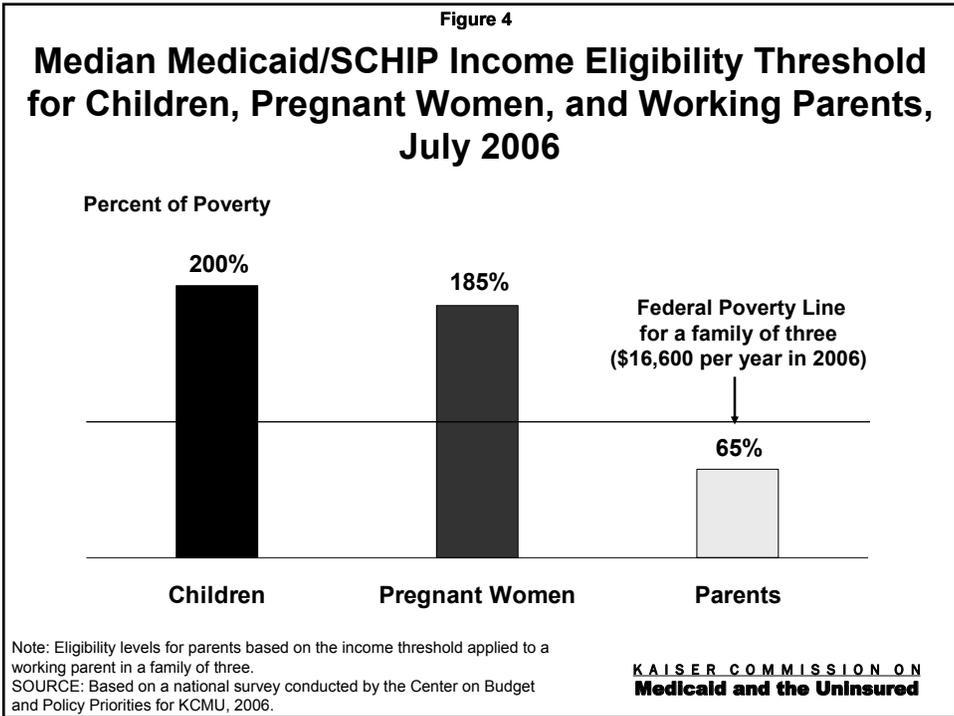
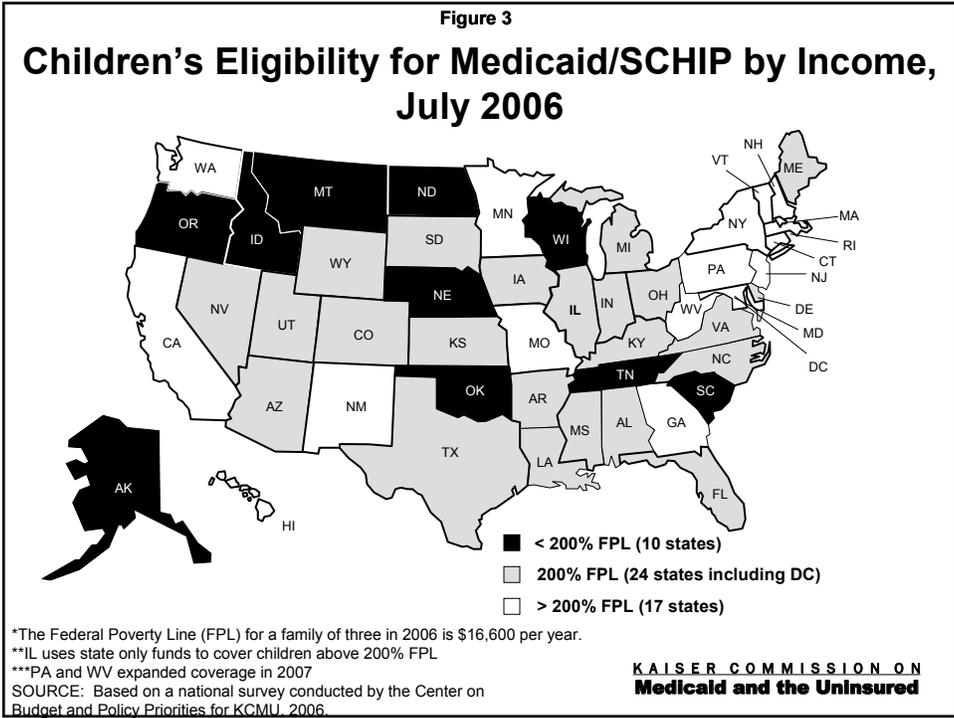


Figure 2

## Percentage of Children Without Health Insurance, By Poverty Level, 1997-2005



Source: L. Ku, "Medicaid: Improving Health, Saving Lives." Center on Budget and Policy **K A I S E R C O M M I S S I O N O N** Priorities analysis of National Health Interview Survey data, August 2005. **M e d i c a i d a n d t h e U n i n s u r e d**



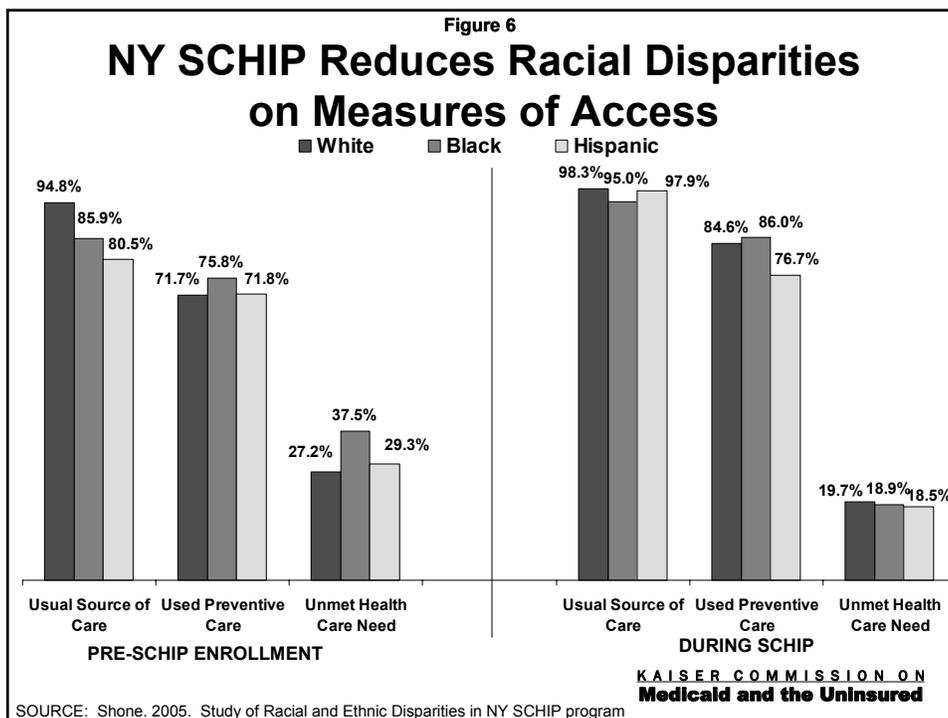
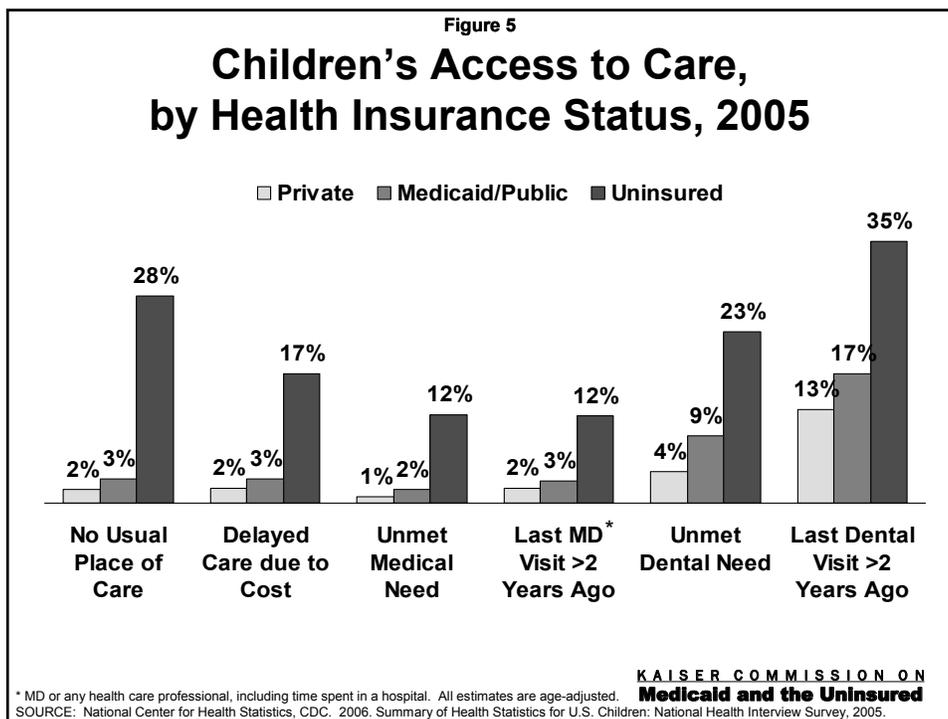
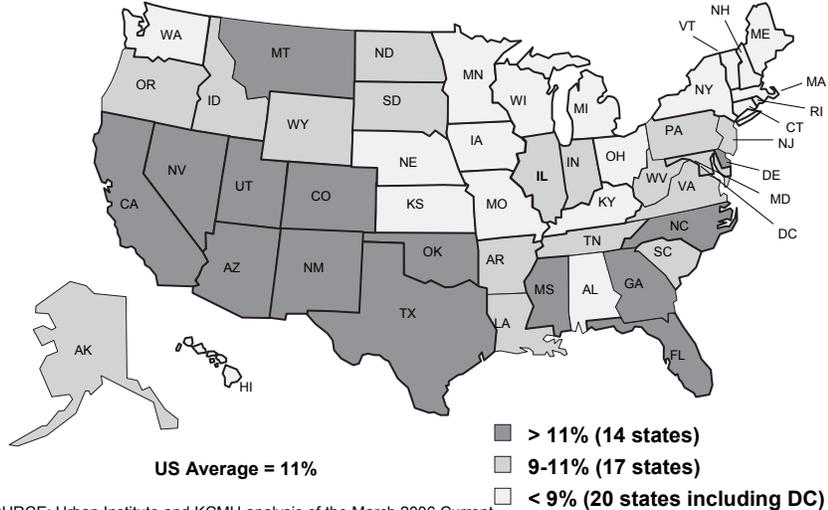


Figure 7

### Uninsured Rates for Children under 19, by State, 2004-2005

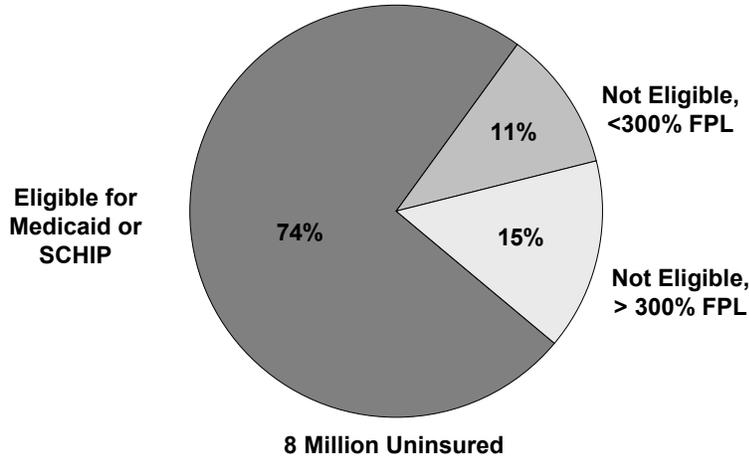


SOURCE: Urban Institute and KCMU analysis of the March 2006 Current Population Survey. Two-year pooled estimates for states and the US (2004-2005).

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Figure 8

### Distribution of Uninsured Children by Eligibility for Medicaid/SCHIP, 2004

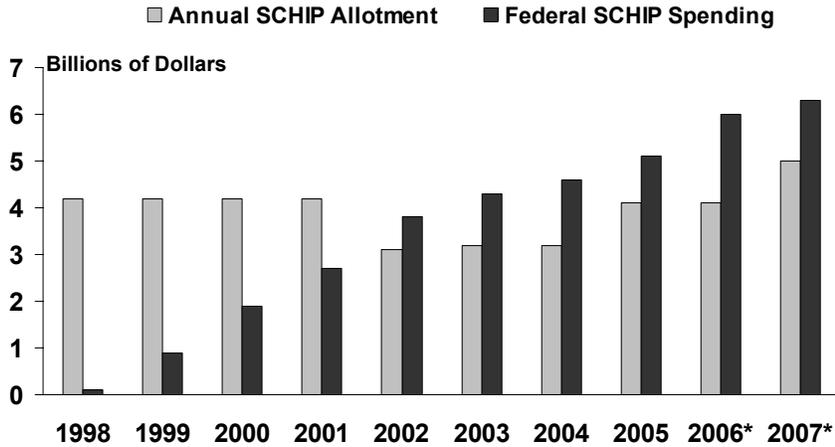


\*The Federal Poverty Level (FPL) for a family of three in 2004 if \$15,067 per year  
SOURCE: Urban Institute analysis of the 2005 Annual and Social Economic Supplements to the CPS for KCMU. Data has been adjusted for the Medicaid undercount. CPS does not fully account for immigration status so estimates in the eligible category potentially include some undocumented children.

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Figure 9

## Spending for SCHIP first outpaced SCHIP allotments in 2002



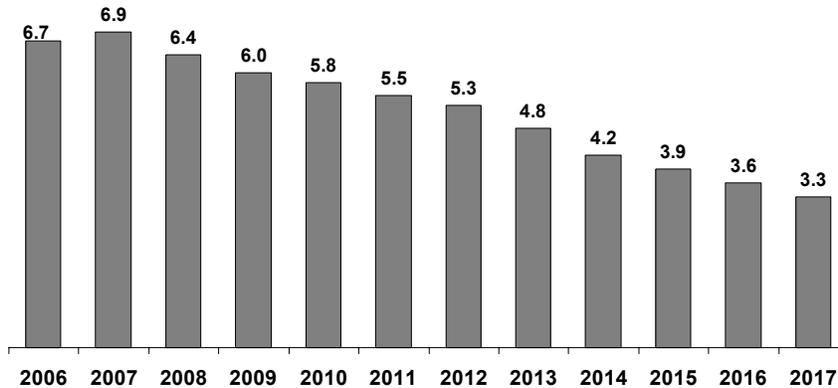
\* Projected spending

SOURCE: "SCHIP Original Allotments: Funding Formula Issues and Options, October 2006. Congressional Research Service.

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Figure 10

## SCHIP Enrollment Projections for Children if Federal Financing is Held Constant at \$5 Billion Annually

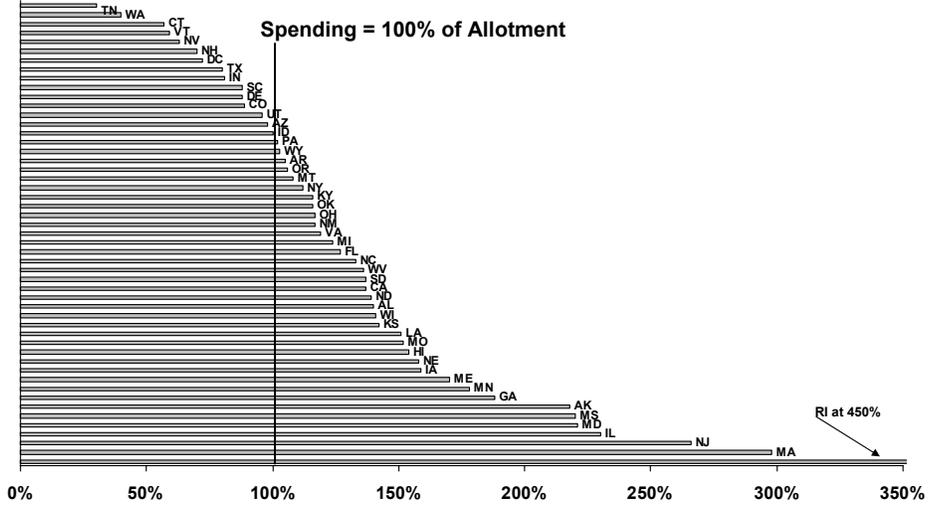


SOURCE: CBO March 2001 Baseline: SCHIP Fact Sheet, February 23, 2007

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Figure 11

### Spending Expected to Exceed Allotments in 37 States in FY 2007



SOURCE: Data on allotments and spending from CRS, State Children's Health Insurance Program: A Brief Overview. 10/12/2006. National average is 130%

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