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THE FUTURE OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

WEDNESDAY, DECEMBER 3, 2014

House of Representatives,

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:16 a.m., in Room 2322 of the Rayburn House Office Building, Hon. Joe Pitts [Chairman of the Subcommittee] presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Gingrey, McMorris Rodgers, Lance, Guthrie, Griffith, Bilirakis, Ellmers, Barton (ex officio), Pallone, Engel, Capps, Matheson, Green, Barrow, Castor, and Waxman (ex

officio).

Staff present: Sydne Harwick, Chief Counsel, Energy and Commerce; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Michelle Rasenberg, GAO Detailee; Ziky Ababiya, Democratic Staff Assistant; Kaycee Glavich, Democratic GAO Detailee; Amy Hall, Democratic Senior Professional Staff Member; Debbie Letter, Democratic Staff Assistant; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

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Mr. {Pitts.} The subcommittee will come to order. Chair will recognize himself for an opening statement.

In 1992, as a member of the state House of Representatives, I was proud to vote to create Pennsylvania's Children's Health Insurance Program, known as PA CHIP.

In 1997, Congress created the federal CHIP program, which was partially based on Pennsylvania's successful model. CHIP is a means-tested program designed to cover children and pregnant women who make too much to qualify for Medicaid, but may not have access to purchase affordable private health insurance.

Most recently, the Affordable Care Act reauthorized CHIP through fiscal year 2019, but the law only provided funding for the program through September 30, 2015.

CHIP has historically enjoyed bipartisan Congressional support, and it is widely seen as providing better care than many state Medicaid programs.

Moving forward, Congress should be thoughtful and data-driven in our approach. The last time Congress methodically reviewed the CHIP program was in 2009 with the Children's

Health Insurance Program Reauthorization Act, or CHIPRA. Clearly, since that time, the Affordable Care Act has changed the insurance landscape significantly. Provisions of the program which may have been made--which may have made sense prior to the ACA might no longer be necessary. Other changes may need to be made as well.

Like many of my colleagues, I believe we need to extend funding for this program in some fashion. If we do not, current enrollees will lose their CHIP coverage and many will end up in Medicaid and on the exchanges—programs which may offer poorer access to care or higher cost-sharing for lower-income families. Some will lose access to insurance altogether. At the same time, we should ensure the program complements, rather than crowds-out, private health insurance. We should also ensure CHIP is a benefit that is targeted to those who are most vulnerable, rather than one that effectively subsidizes coverage for upper-middle-class families.

It is important that we think carefully about this important program. While program funding does not run out until September 2015, governors and state legislatures across

the country will start to assemble their budgets as soon as January. Accordingly, the committee is very aware that states need certainty sooner rather than later in their budgetary planning process, and that is why Chairman Upton and Ranking Member Waxman, along with their Senate counterparts, engaged governors earlier this year to request their perspective on the program. And that is why we are hearing from witnesses in our hearing today.

So I look forward to hearing from our witnesses on the current state of CHIP as we consider the data they will provide, and evaluate proposals that will keep the program strong into the future.

[The prepared statement of Mr. Pitts follows:]

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Mr. {Pitts.} And I yield the remaining time to Dr. Burgess.

Dr. {Burgess.} Thank you, Mr. Chairman. I appreciate you yielding the time. And I--just before I deliver my opening statement, I want to say this may be my last time to serve as your vice chair of the subcommittee, and I have certainly enjoyed our time together the last two terms, and it has been a great honor of mine to have been of service to this subcommittee. I won't be leaving the subcommittee altogether, but I just won't be vice chairman in the upcoming term.

And I am happy to be here this morning to talk about the Children's Health Insurance Program. It is an important issue in our Nation's healthcare. It is probably one of the most important that we will take up over the next year, both nationally and in the individual states. I thank you for recognizing that states do have an obligation to generate their budgets early in the next calendar year, and Texas, in fact, will do a budget for the next 2 years, so they do one for the biennium, so it is important that they have the

availability of the information about this program going forward as they grapple with those budgetary issues.

One of the program's greatest strengths is it does provided needed flexibility to states, including program and benefit design and different levels of cost sharing. It has allowed for creativity and efficiency in the program, but it also means that each state will be affected differently if the program loses funding at the end of the fiscal year.

I think we can all agree that the health of our country's children requires our continuous attention, and in particular, kids with special needs. I am anxious to learn more about how this impacts Texas and my constituents. It is vital that we learn what the landscape for this program looks like in a post-ACA world. We need an accurate picture about the path forward for what CHIP might look like going forward, and ways that Congress can be helpful.

[The prepared statement of Dr. Burgess follows:]

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Dr. {Burgess.} And I will yield back to the chairman.

Mr. {Pitts.} And the chair thanks the gentleman, and again thanks him for his service to the subcommittee. We still have two more hearings--subcommittee hearings next week so I will keep you busy.

And with that, I would like to congratulate our ranking member, Mr. Pallone, for moving up to ranking member of the full committee. Looking forward to working with you in that regard, and appreciate having to have been work closely with you the last 4 years as ranking member.

So with that, Mr. Pallone, you are recognized for 5 minutes.

Mr. {Pallone.} Thank you, Chairman Pitts, and I certainly have appreciated working with you. It has been very easy to work with you on a bipartisan basis on so many initiatives that actually have been passed and been signed into law, and I actually asked Dr. Burgess yesterday if he was still going to be on the subcommittee, because I heard that he was going to be chairman of one of the other subcommittees, and he said, yes, he still expected to be on

the subcommittee. So I was glad to hear that as well.

I wanted to thank you, Chairman, also that--for having this hearing today, and I very much look forward to making progress towards ensuring the continued success of CHIP. It is a vital program that provides coverage to 8.1 million low-to-moderate-income children throughout the Nation who are unable to afford or not eligible for other forms of coverage. And without Congressional action, funding for the program will expire next year. This would inevitably lead to gaps in coverage for some, and lack of coverage for many others, so we must have a conversation now about providing funding as soon as possible.

In fact, I would urge my colleagues to consider an extension during the lame duck to ensure predictability to the many states that have come to rely and appreciate the CHIP program. I don't think any would argue that CHIP should not be extended, so let's just get it done.

Now, you said CHIP was created, it is true, in a Republican-controlled Congress in 1997 as a joint federal-state undertaking so that states could help determine how best to design and administer their own programs, and ever

since, it has traditionally enjoyed bipartisan support. And this historic support from both sides of the aisle was reflected in the responses to Chairman Upton and Ranking Member Waxman's recent letter to the Nations' governors, across red and blue states, including some that did and some that did not proactively implement the ACA, governors overwhelmingly support the extension of CHIP funding.

I have a Bill, H.R. 5364, the CHIP Extension and Improvement Act of 2014, that would achieve this purpose while also instituting reforms that would enable states to eliminate administrative burdens and increase the quality of care. By funding the program through 2019, we would provide states with more time to plan for the future, putting them in a better position to ensure that there are no disruptions, and affordance and comprehensive coverage for those families who depend on the program. Furthermore, the consequences of this coverage are far-flung. Not only do state governments depend on this funding, it would also support economic activities stemming from providers who provide care to children, as well as mothers who are able to keep themselves and their children health, and thus, won't need to take time

off from work in order to care for their sick children.

In New Jersey, over 800,000 children are served by New Jersey Family Care, which is funded by CHIP, and for these families, getting coverage on the private market is still out of reach, a sentiment that is supported by both the GAO and MACPAC, who have shown that even with cost-sharing, CHIP is the most affordable and comprehensive form of coverage for these children, especially those with complex health needs. And this is true for the millions of American families who rely on the program, so I hope that my colleagues will join me in supporting action this lame duck to fund CHIP for the next 4 years.

[The prepared statement of Mr. Pallone follows:]

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Mr. {Pallone.} Did anyone else want any time on our side, do we know? I guess not.

I yield back, Mr. Chairman. Thanks again.

Mr. {Pitts.} The chair thanks the gentleman.

Mr. {Pallone.} Mr. Chairman, can I ask unanimous consent to enter into the record written statements which I believe you have from Families USA and the American Academy of Pediatrics?

Mr. {Pitts.} All right, and I have--we have given this to you as well, a joint letter from the U.S. Conference of Catholic Bishops, Catholic Health Association of U.S.--Catholic Charities USA, to add to that UC request.

Without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} On our panel--and all Members' written opening statements are being made part of the record. On our panel today we have Ms. Evelyne Baumrucker, Analyst in Healthcare Financing, for the Congressional Research Service; Ms. Alison Mitchell, Analyst in Healthcare Financing, Congressional Research Service; Ms. Carolyn Yocom, Director, Health Care, U.S. Government Accountability Office; and Dr. Anne Schwartz, Executive Director, Medicaid and CHIP Payment and Access Commission, MACPAC.

Thank you for coming. You will each be given 5 minutes to summarize your testimony. Your written testimony will be placed in the record.

And, Ms. Baumrucker, we will start with you. You are recognized for 5 minutes for your opening statement.

Mr. {Waxman.} Mr. Chairman--

Mr. {Pitts.} I am sorry--

Mr. {Waxman.} Yes.

Mr. {Pitts.} --I didn't notice you come in. We have the ranking member, before you begin.

Chair recognizes the Ranking Member, Mr. Waxman, 5

minutes for his opening statement.

Mr. {Waxman.} Thank you very much, Mr. Chairman.

There is another subcommittee having a hearing at the same time as ours here, and so I am sorry I am late, but thank you for this courtesy to me.

Today's hearing is about the Children's Health Insurance Program. This is a rare program in Washington that has enjoyed bipartisan support since its inception in 1997, and I am pleased that the committee is again proceeding in a bipartisan fashion; first with our letter to the governors, and now with this hearing.

I strongly support an additional 4 years of funding for the CHIP program. The evidence both from the state letters and independent research shows that CHIP provides both benefit and cost-sharing protections that are critical for children, but are not guaranteed in the new health marketplaces or employer-sponsored coverage. For the peace of mind of families, and ease of administration and certainty for states, I believe that a longer period allows for needed stability. That is why I cosponsored Ranking Member Pallone's Bill, H.R. 5364, that would provide 4 years of

funding, and also give states flexibilities to make important program improvements, like making express lane eligibility a permanent option for states looking to reduce bureaucracy and improve the enrollment process. I hope that our colleagues on both sides of the committee--the aisle in this committee will give the Bill a serious look. It is balanced and fair, and there is a lot to look for both states and beneficiaries.

CHIP is only one piece of the healthcare system for children. Medicaid covers more than four times the number of children that CHIP does; 38 million in all, and with the new marketplaces and delivery system reform initiatives, such as medical homes, there are many positive developments to improve care for children.

We have reduced uninsurance to a record low among children, but there is more work to be done. No matter where a child receives coverage, we need to ensure that it is comprehensive, child-focused, and affordable for all families.

I want to also take a moment to honor one of the original authors of the CHIP program, Senator Jay Rockefeller, who is retiring this year. Senator Rockefeller

fought tirelessly to get the CHIP program established, he fought tirelessly again to defend the program, and strengthen it during its reauthorization. Millions of children have better lives because of his work, and I know that he hoped to see the program put on a stable funding path prior before-- prior to his retirement at the end of this Congress, and I would like to have his statement on the CHIP program inserted into the record for this hearing.

Mr. {Pitts.} And without objection, so ordered.

[The information follows:]

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Mr. {Waxman.} Thank you, Mr. Chairman. Yield back the balance of my time.

Mr. {Pitts.} Chair thanks the gentleman.

Now we will go to our witnesses, and we will start with Ms. Baumrucker, 5 minutes for an opening statement.

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^STATEMENTS OF EVELYNE BAUMRUCKER, HEALTH FINANCING ANALYST, CONGRESSIONAL RESEARCH SERVICE; ALISON MITCHELL, HEALTH CARE FINANCING ANALYST, CONGRESSIONAL RESEARCH SERVICE; CAROLYN YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND ANNE SCHWARTZ, PH.D., EXECUTIVE DIRECTOR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

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^STATEMENT OF EVELYNE BAUMRUCKER

} Ms. {Baumrucker.} Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for this opportunity to appear before you on behalf of the Congressional Research Service. My name is Evelyne Baumrucker, and I have--I am here to provide an overview of the State Children's Health Insurance Program. My colleague, Alison Mitchell, will address CHIP financing and the Patient Protection and Affordable Care Act Maintenance of Effort for Children.

CHIP is a means-tested program that provides health coverage to targeted low-income children and pregnant women,

and families that have annual income above Medicaid eligibility levels, but have no health insurance. CHIP is jointly financed by the Federal Government and the states, and is administered by the states. In fiscal year 2013, CHIP enrollment totaled 8.4 million, and federal and state expenditures totaled $13.2 billion. CHIP was established as a part of the Balanced Budget Act of 1997 under a new Title 21 of the Social Security Act. Since that time, other federal laws have provided additional funding and made significant changes to CHIP. Most notably, the Children's Health Insurance Program Reauthorization Act of 2009 increased appropriation levels, and changed the federal allotment formula, eligibility and benefit requirements.

The ACA largely maintains the current CHIP structure through fiscal year 2019, and requires states to maintain their Medicaid and child eligibility levels through this period as a condition of receiving Medicaid federal matching funds. However, the ACA does not provide federal CHIP appropriations beyond fiscal year 2015.

State participation in CHIP is voluntary, however, all states, the District of Columbia, and the territories,

participate. The Federal Government sets basic requirements for CHIP, but states have the flexibility to design their own version within the Federal Government's basic framework. As a result, there is significant variability and variation across CHIP programs. Current state upper income eligibility limits for children range from a low of 175 percent of the federal poverty level, to a high of 405 percent of FPL. In fiscal year 2013, the federal poverty level for a family of four was equal to $23,550. Despite the fact that 27 states extend CHIP coverage to children and families with income greater than 250 percent of the federal poverty level, fiscal year 2013 administrative data shows that CHIP enrollment is concentrated among families with annual incomes low--at lower levels. Almost 90 percent of child enrollees were in families with annual income at or below 200 percent of FPL.

States may design their CHIP programs in three ways; a CHIP Medicaid expansion, a separate CHIP program, or a combination approach where the state operates a CHIP Medicaid expansion, and one or more separate CHIP programs concurrently. As of May 2014, the territories, the District of Columbia, and seven states were using CHIP Medicaid

expansions, 14 states operated separate CHIP programs, and 29 states used a combination approach. In fiscal year 2013, approximately 70 percent of CHIP program enrollees received coverage through separate CHIP programs, and the remainder received their coverage through the CHIP Medicaid expansion programs.

CHIP benefit coverage and cost-sharing rules depend on program design. CHIP Medicaid expansions must follow the rules of the Medicaid program for benefits and cost sharing, which entitles CHIP enrollees to early periodic screening, diagnostic and treatment coverage, which effectively eliminates state-defined limits on the amount, duration and scope of any benefit listed in the Medicaid statute, and exempts a majority of children from any cost sharing. For separate CHIP programs, the benefits are permitted to look more like private health insurance, and states may impose cost sharing such as premiums or enrollment fees with a maximum allowable amount that is tied to family income. Aggregate cost sharing under CHIP may not exceed 5 percent of annual family income. Regardless of the choice of program design, all states must cover emergency services, well baby,

and well childcare, including age-appropriate immunizations and dental services. If offered, mental health services must meet the federal mental health parody requirements.

As we begin the final year of federal CHIP funding under the CHIP statute, Congress has begun considering the future of the CHIP program, and exploring alternative policy options. The health insurance market is far different today than when CHIP was established. CHIP was designed to work in coordination with Medicaid to provide health insurance to low-income children. Before CHIP was established, no federal program provided health coverage to children with family annual incomes above Medicaid eligibility levels. The ACA further expanded options for some children in low-income families with incomes at or above CHIP-eligibility levels by offering subsidized coverage for insurance purchased through the health insurance exchanges. Congress' action or inaction on the CHIP program may affect health insurance options, and result in coverage for targeted low-income children that are eligible for the current CHIP program.

This concludes my statement, and CRS is happy to answer your questions at the appropriate time.

[The prepared statement of Ms. Baumrucker follows:]

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Mr. {Pitts.} Chair thanks the gentlelady.

Now recognize Ms. Mitchell 5 minutes for an opening statement.

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^STATEMENT OF ALISON MITCHELL

} Ms. {Mitchell.} Thank--excuse me. Thank you for the opportunity to appear before you today on behalf of CRS to provide an overview of CHIP financing, and the ACA Maintenance of Effort for Children.

First, CHIP financing. The Federal Government and states jointly finance CHIP, with the Federal Government paying about 70 percent of CHIP expenditures. The Federal Government reimburses states for a portion of every dollar they spend on their CHIP program, up to state-specific limits called allotments. The federal matching rate for CHIP is determined according to the Enhanced Federal Medical Assistance Percentage, which is also the EFMAP rate, and this is calculated annually and varies according to each state's per capita income.

In fiscal year 2015, the EFMAP rates range from 65 percent in 13 states, to 82 percent in Mississippi. The ACA included a provision to increase the EFMAP rate by 23 percentage points, not to exceed 100 percent for most CHIP

expenditures from fiscal year 2016 through fiscal year 2019, and with this 23 percentage point increase, states are expected to spend through their CHIP allotments faster.

And these CHIP allotments are the federal funds allocated to each state for the federal share of their CHIP expenditures, and states receive a CHIP allotment annually, but the allotment funds are available to states for 2 years. This means that even though fiscal year 2015 is the last year states are to receive a CHIP allotment, states could receive federal CHIP funding in fiscal year 2016.

Moving on to the Maintenance of Effort, or MOE, the ACA MOE for children requires states to maintain eligibility standards, methodologies and procedures for Medicaid and CHIP children from the date of enactment, which was March 23, 2010, through September 30, 2019, and the penalty for not complying with the ACA MOE is the loss of all federal Medicaid matching funds. And the MOE impacts CHIP Medicaid expansion and separate CHIP programs differently. For CHIP Medicaid expansion programs, the Medicaid and CHIP MOE provisions apply concurrently. As a result, when a state's federal CHIP funding is exhausted, the financing for these

children switches from CHIP to Medicaid, and this would mean that the state's share of covering these children would increase because the federal matching rate for Medicaid is less than the EFMAP rate. For separate CHIP programs, only the CHIP-specific MOE provisions apply, and these provisions include a couple of exceptions to the MOE. First, states may impose waiting lists and enrollment caps, and second, after September 1, 2015, states may enroll CHIP-eligible children in qualified health plans in the health insurance exchanges that have been certified by the Secretary to be at least comparable to CHIP in terms of benefits and cost sharing.

In addition to these two exceptions, under the MOE, in the event that a state's CHIP allotment is insufficient, a state must establish procedures to screen children for Medicaid eligibility, and for children not Medicaid eligible, a state--the state must establish procedures to enroll these children in Secretary-certified qualified health plans. If there are no certified plans, the MOE does not obligate states to provide coverage to these children.

In conclusion, fiscal year 2015 is the last year federal CHIP funding is provided under current law. If no additional

federal CHIP funding is provided, once the funding is exhausted, children in CHIP Medicaid expansion programs would continue to receive coverage under Medicaid through at least fiscal year 2019, due to the ACA MOE, however, coverage for children in separate CHIP programs depends on the availability of Secretary-certified qualified health plans.

This concludes my statement, and I will take questions at the appropriate time.

[The prepared statement of Ms. Mitchell follows:]

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Mr. {Pitts.} Chair thanks the gentlelady.

Now recognize Ms. Yocom 5 minutes for an opening statement.

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^STATEMENT OF CAROLYN YOCOM

} Ms. {Yocom.} Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am pleased to be here today to discuss the extension of federal funding for the Children's Health Insurance Program, better known as CHIP. Congress faces important decisions about the future of CHIP. Absent the extension of federal funding, once a state's CHIP funding is insufficient to cover all eligible children, the state must establish procedures to ensure that those who are not covered are screened for Medicaid eligibility. In states that have used CHIP funds to expand Medicaid, children will be eligible to remain in Medicaid. Thus, approximately 2.5 million children will continue to receive coverage. However, for the over 5 million children who are in separate child health programs, their coverage options are different and less certain. These children may be eligible, but are not assured eligibility, for the premium tax credit and for cost-sharing subsidies established through the Affordable Care Act to subsidize coverage offered through health insurance

exchanges.

My statement today draws on past GAO work which suggests that there are important considerations related to cost, coverage and access when determining the ongoing need for the CHIP program. Cost: GAO compared separate health CHIP plans in 5 states with state benchmark plans, and these were intended as models of coverage offered by the qualified health plans through exchanges. Our studies suggest that CHIP consumers could face higher costs if shifted to qualified health plans. For example, the CHIP plans we reviewed typically did not include deductibles, while all five states' benchmark plans did. When cost sharing was applied, the amount was almost always less for CHIP plans, with the cost differences being particularly pronounced for physician visits, prescription drugs, and outpatient therapies. And lastly, CHIP premiums were almost always less than benchmark plans.

The cost gap GAO identified could be narrowed, as the Affordable Care Act has provisions that seek to standardize the costs of qualified health plans, and reduce cost sharing for some individuals. However, this will vary based on

consumers' income level and plan selection. Absent CHIP, we estimated that 1.9 million children may not be eligible for a premium tax credit, as they have a parent with employer-sponsored health coverage, defined as affordable under IRS regulations. The definition of affordability considers the cost of self-only coverage offered by the employer, rather than the cost of family coverage.

With regard to coverage, we found that most benefit categories were covered in separate CHIP and benchmark plans that we reviewed, with similarities in terms of the services in which they impose day visit or dollar limits. For example, the plans typically did not impose any such limits on ambulatory services, emergency care, preventive care, or prescription drugs, but did impose limits on outpatient therapies, and pediatric dental, vision and hearing services. We also identified differences in how dental services were covered under CHIP and benchmark plans; differences that raised the potential for confusion and higher costs for consumers.

With regard to access, our survey of national--our national survey data found that CHIP enrollees reported

positive responses regarding their ability to obtain care, and that this proportion of positive responses was generally comparable with those in Medicaid or those who are covered by private insurance. However, access to specialty care and CHIP may be more limited than in private insurance. In 2010, our survey of physicians reported experiencing greater difficulty referring children in Medicaid and CHIP to specialty care, compared with privately insured children. We also found that the percentage of specialty care physicians who accepted all new patients with private insurance was about 30 percent higher than the percentage of those who accepted all children in Medicaid and CHIP.

Over the last 17 years, CHIP has played an important role in providing health insurance coverage for low-income children who might otherwise be uninsured. In the short term, Congress will be deciding whether to extend federal funding for CHIP beyond 2015. In the longer term, states and the Congress will face decisions about the role of CHIP in covering children once states are no longer required to maintain eligibility standards in the year 2020.

Chairman Pitts, Ranking Member Pallone, and members of

the subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you might have.

[The prepared statement of Ms. Yocom follows:]

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Mr. {Pitts.} Chair thanks the gentlelady.

Now recognizes Dr. Schwartz 5 minutes for an opening statement.

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^STATEMENT OF ANNE SCHWARTZ, PH.D.

} Ms. {Schwartz.} Good morning, Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health. I am Anne Schwartz, Executive Director of MACPAC, the Medicaid and CHIP Payment and Access Commission.

As you know, MACPAC is a Congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies, and making recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on issues affecting these programs. Its 17 members, led by Chair Diane Rowland and Vice Chair David Sundwall, are appointed by the U.S. Government Accountability Office.

While the insights and expertise I will share this morning build on the analysis conducted by MACPAC staff, they are, in fact, the consensus views of the Commission itself. We appreciate the opportunity to share MACPAC's recommendations and work as this committee considers the future of CHIP.

Since its enactment, with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health services for tens of millions of low and moderate-income children with incomes just above Medicaid eligibility levels. Over this period, the share of uninsured children and the typical CHIP income range; those with family income above 100 percent, but below 200 percent of the federal poverty level, has fallen by more than half from 22.8 percent in 1997, to 10 percent in 2013. Given that the last federal CHIP allotments under current law are now being distributed to states, the Commission has focused considerable attention on CHIP over the past year in order to provide the Congress with expert advice about the program's future. This inquiry, which is ongoing, has considered the program in its new context, given the significant change in insurance options available to these families, including the exchanges and employer-sponsored coverage.

In its June 2014 report to the Congress, MACPAC recommended that the Congress extend federal CHIP funding for a transition period of 2 additional years, during which time

key issues regarding the affordability and adequacy of children's coverage can be addressed. In coming to this consensus recommendation, the Commission considered what would happen if no CHIP allotments were made to the states after fiscal year 2015. They found that many children now served by the program would not have a smooth transition to another source of coverage. The number of uninsured children would likely rise, cost sharing would often be significantly higher, and exchange plans appear unready to serve as an adequate alternative in terms of benefits and provider networks. My written testimony and the Commission's June report provide additional information about the nature and extent of these concerns. We are currently updating and extending our analyses of benefits, cost sharing, network adequacy, and coverage gaps for inclusion in our 2015 reports.

When the Commission made its recommendation to extend funding, it noted that there was insufficient time between then and the end of the current fiscal year to address all the issues it identified, either in law or regulation. In addition to examining CHIP from the perspective of children

and families, MACPAC has also considered the--how different policy scenarios affect the states. Under current law, states will run out of CHIP funding at various points during fiscal year 2016, with more than half of the states exhausting funds in the first two quarters. In the absence of federal CHIP funding, states with Medicaid expansion CHIP programs, which cover about 2.5 million children, must maintain their 2010 eligibility levels for children through fiscal year 2019 at the regular Medicaid matching rate, meaning at increased state cost. By contrast, states operating separate CHIP programs, now serving over 5 million children, are not obligated to continue funding their programs if federal CHIP funding is exhausted, and will most likely terminate such coverage.

MACPAC's commissioners feel strongly about the need to extend funding for CHIP. A time-limited extension of CHIP funding is needed to minimize coverage disruptions, and provide for a thorough examination of options addressing affordability, adequacy, and transitions to other sources of coverage. An abrupt end to CHIP would be a step backward from the progress that has been made over the past 15 years.

In addition, Congressional action is required so that states do not respond to uncertainty about CHIP's future by implementing policy that reduces children's access to services that support their healthy growth and development.

Finally, while MACPAC has recommended a 2-year extension, it has also stated that this transition period could be extended if the problems it has identified have not been addressed within the 2-year period.

Again, thank you for this opportunity to share the Commission's work, and I am happy to answer any questions.

[The prepared statement of Ms. Schwartz follows:]

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Mr. {Pitts.} Chair thanks the gentlelady. Thanks all the witnesses for your testimony.

We will now begin questioning, and I will recognize myself 5 minutes for that purpose.

Start with CRS and MACPAC. What is the impact on the federal budget if federal CHIP funding is or is not extended, and how does that differ based on whether the current match rate is increased or not, and whether or not it is a 2 or 4-year extension? Ms. Mitchell?

Ms. {Mitchell.} I can't tell you for sure, that is definitely a question for the Congressional Budget Office, but I can tell you that we, as we have said, the children in CHIP Medicaid expansion programs would continue to receive coverage at a lower federal matching rate through at least fiscal year 2019 due to the MOE. If CHIP funding ends, we know that at least some children will be covered under the qualified health plans in the health insurance exchanges with some--with subsidized coverage, and some children would be uninsured. And without--if there is no--you are talking about the 23 percentage point increase, if that is taken

away, then funding for the CHIP program would be less than under current law because we would maintain the current EFMAP rates, rather than the 23 percentage point increase.

Mr. {Pitts.} Dr. Schwartz?

Ms. {Schwartz.} Yes, we received a cost estimate from the Congressional Budget Office for MACPAC's recommendation, and for the 2-year extension CBO estimated that it would increase net federal spending by somewhere between $0 and $5 billion above the current law baseline. Very big bucket. If CHIP were fully funded, to speak to the 23 percentage point bump, if the--if CHIP were fully funded in fiscal year 2016, with the 23 percentage point bump, spending would be about $15 billion, without it spending would be $11.3 billion.

Mr. {Pitts.} All right, let us stay with you, Dr. Schwartz. What is the impact on states if CHIP funding is not extended?

Ms. {Schwartz.} The impact on states differs as to whether they operate their program as a Medicaid expansion CHIP program, in which case they are continued--have a continued obligation to provide services for those children under the Medicaid program at their regular Medicaid match,

694 which is lower, in the aggregate, about a 43 percent increase
695 for states because of the difference between the two matching
696 rates. The difference--it is different across different
697 states because of the design decisions that they have made,
698 and the extent of their enrollment that is enrolled in
699 Medicaid expansion CHIP versus separate CHIP.
700 Mr. {Pitts.} Okay. Ms. Baumrucker, there are nearly
701 270,000 children in Pennsylvania in CHIP. The Affordable
702 Care Act required states to transition CHIP children aged 6
703 through 18, in families with annual incomes of less than 133
704 percent federal poverty level, to Medicaid beginning January
705 1 of this year. This was a big issue for people in my
706 district in Pennsylvania. Nationally, do you know how many
707 hundreds of thousands of children lost their CHIP coverage
708 this year, and were instead enrolled into Medicaid as a
709 result of the Affordable Care Act?
710 Ms. {Baumrucker.} There was an estimate--there we go.
711 There was an estimate that was done by the Georgetown
712 Children and Families in August of 2013 that suggested that
713 21 states were transitioning--were required to transition
714 their CHIP separate state program children into the Medicaid

expansion programs as a result of the ACA eligibility changes, and according to Georgetown and Kaiser, this represented about 28 percent of CHIP enrollees, or approximately 562,000 children.

Mr. {Pitts.} Okay. Let's go back to MACPAC. In 2007, CBO wrote a paper saying the literature on crowd-out for CHIP children ranged from 25 to 50 percent. A 2012 report from the National Bureau of Economic Research found the upper bound of the rate of crowd-out to be 46 percent. What concerns does MACPAC have regarding to what extent this CHIP coverage crowds out private coverage?

Ms. {Schwartz.} Clearly, crowding out private coverage is not desirable, particularly in terms of federal spending. MACPAC has not done its own analyses of crowd-out, and we have cited the CBO report that you have cited. The Secretary's recent evaluation of the CHIP report--CHIP program has a much lower number. An article that came out in Health Affairs a couple of months ago, a much higher number. And I think that the experts are somewhat at a loss as to a point estimate.

We observe private coverage declining, we observe CHIP

coverage increasing, but it is very difficult to design a study that properly teases out the role of CHIP in that dynamic.

Mr. {Pitts.} Ms. Yocom, you want to comment on that question? What concerns does GAO have that might duplicate private--that this might duplicate private coverage and unnecessarily increase federal expenditures?

Ms. {Yocom.} Well, similar to what Dr. Schwartz said, there is always a concern if you are substituting federal dollars for private dollars. One issue with crowd-out is, it is extremely difficult to measure, and then even if measured, it is extremely difficult to think about causality and what happens with it.

One of the issues that we ran into in looking at this many years ago now, that I think is still relevant, is the fact that the insurance coverage available was not necessarily comparable to what was being offered. So while there was a substitution that could affect, you weren't substituting a similar type of coverage. Under the Affordable Care Act, there will be more standardization of what is a qualified health plan, and it may be a little bit

easier to take an analysis and look and see what types of substitution might be happening.

Mr. {Pitts.} Thank you.

Chair recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. {Pallone.} Thank you. I wanted to ask Ms.--Dr. Schwartz, in the CHIP reauthorization legislation in 2009, Congress gave states the new option to reduce bureaucracy and help make the Medicaid and CHIP enrollment process easier, called express lane eligibility. And this state option was only authorized on a temporary basis, but recently Congress acted to extend it through September of next year. This provision allows states to use family data from other programs like SNAP to determine Medicaid and/or CHIP eligibility, and it is a win for families that don't have to keep providing the same info twice, and it is a win for states who have demonstrated this approach saves administrative dollars.

It seems to make little sense that Congress would have to keep authorizing this commonsense provision. So, Ms. Schwartz, I believe that MACPAC has examined this issue, and

could you tell us what you have found, and also what the Commission recommends with respect to express lane eligibility?

Ms. {Schwartz.} Yes--

Mr. {Pallone.} You put the mike on, yeah.

Ms. {Schwartz.} One of our statutory requirements is to comment on reports of the Secretary to the Congress, and in April, MACPAC sent official comments to this committee and our--and to others on mandated evaluation of express lane eligibility by the department. In that letter, MACPAC noted its support for making express lane eligibility a permanent option, presuming that it does not result in incorrect eligibility determinations.

The Commission also recommended that express lane be extended to adults, which would be consistent with other actions that have been taken to simplify and streamline enrollment processes, and also would allow processing of the family as a unit, rather than processing parents and children separately.

The Commission also noted that it would allow states--the 13 states that have used express lane, that have invested

in this approach to continue to maintain the gains that they have seen, noting, for example, that the state of Louisiana told the Commission that they had reduced 200 eligibility worker positions as a result of adopting express lane.

And finally, in that letter the Commission noted the need for guidance from CMS to the states on how to measure the accuracy of eligibility determinations.

Mr. {Pallone.} Thank you. Let me ask, as you know, just having health insurance isn't enough; the coverage needs to be affordable, both when you go to the doctor, and also in the amount of money you have to pay to keep insured. And as you know, Medicaid includes important out-of-pocket cost protections for children with respect to premiums and copayments. And sometimes we hear that beneficiaries need to have more skin in the game, or states should be allowed to change--to charge beneficiaries more in the name of personal responsibility. I believe MACPAC has looked into the issue of how out-of-pocket costs like premiums affect access, and would have you found, and again, what did you recommend?

Ms. {Schwartz.} Yes, in the Commission's March 2014 report to the Congress, the Commission made a recommendation

to align premium policies in separate CHIP programs with those in Medicaid so that families with incomes below 150 percent of the federal poverty level should not be subject to CHIP premiums. The research shows that children and families at this low level of poverty are much more price-sensitive than higher income enrollees, and below 150 percent of the federal poverty level, premium requirements increased uninsurance substantially.

This recommendation would affect only eight states that continue to charge CHIP premiums below 150 percent of the federal poverty level.

Mr. {Pallone.} Well, thank you, Doctor. I hope we can see Congress implement this commonsense MACPAC recommendation and protect low-income children from losing coverage as a result of unaffordable premiums.

And again, I just wanted to ask you, I have heard some people argue that Medicaid is somehow harmful for patients, I am getting into Medicaid now, and that is because there is inconsistent quality or lack of information about quality, and somehow the program is bad for patients, but I wanted to ask you, do you think inconsistent quality or lack of quality

info is a problem unique to Medicaid, or is that something our health system as a whole struggles with? I was particularly interested in this recent study on the Oregon Medicaid program that shows that Medicaid really does make a difference. And if you could comment on that or any other states.

Ms. {Schwartz.} Yes. The Commission recently submitted a comment letter on the department's report on use of quality measures, the science of quality measurement, and the infrastructure for both measuring and holding health systems accountable for quality is growing. There is more work to be done. A very important factor to keep in mind when looking at differences in quality is an adjustment for health status because, clearly, individuals who are sicker to begin with tend to have poorer health outcomes. When the proper adjustments are done for health quality, Medicaid beneficiaries tend to do as well as others. Of course, there is room for improvement across the health system.

Mr. {Pallone.} All right, thank you very much.

Mr. {Pitts.} Chair now recognizes the vice chairman, Dr. Burgess, 5 minutes for questions.

Dr. {Burgess.} Thank you, Mr. Chairman. And I apologize for my absence. I am toggling between two subcommittee hearings this morning. It is always a challenge.

Let me ask Ms. Yocom, you were talking to the subcommittee chairman about the crowd-out issues. I am actually also interested in the provider update rates. We oftentimes hear SCHIP and Medicaid lumped in together, that a patient with a private insurance policy has about a 75 percent chance of a physician taking a new patient, whereas with Medicaid and SCHIP lumped together, it is under 50 percent. Do you have a sense as to where the actual CHIP program falls in that?

Ms. {Yocom.} We--the survey data that we looked at that surveyed physicians, I believe we combined both Medicaid and CHIP together. In looking at the MAPs data and the issues about referring to specialist care, which seems to be where the biggest access issue is, CHIP fared slightly better than Medicaid, and both programs fared significantly better than someone who was uninsured. There was a statistical difference between those who were privately insured, however.

There was better access for someone with private insurance in specialty care.

Dr. {Burgess.} I will just--you know, I practiced for a number of years in north Texas and I--my own experience was that it was hard to find specialty--

Ms. {Yocom.} Um-hum.

Dr. {Burgess.} --physicians, particularly in Medicaid because a larger proportion of my patients--I was an OB/GYN, and a larger proportion of my patients were covered by Medicaid rather than SCHIP--

Ms. {Yocom.} Right.

Dr. {Burgess.} --but it was difficult. And one of the obstacles always seemed to be the administrative barriers that were placed in front of the physician for either being enrolled in the program, difficulty getting paid, reimbursement rates are always an issue, but over and above that, it was--there was a hassle factor associated with, particularly Medicaid, but I suspect in both Medicaid and SCHIP.

Has GAO looked into that?

Ms. {Yocom.} Some of the studies we have done would

confirm that from the perspective of physicians, that it is not just about the payment, it certainly is also about sort of the paperwork and the requirements that are involved.

The thing that is always difficult in looking at the program is balancing--you know, balancing those requirements for documentation against some of the bad actors who are capitalizing on the services, and I think that is a constant struggle.

Dr. {Burgess.} And, of course, it is just anecdotal, but I did hear from physicians who would tell me, okay, I will see this patient because I like you and you are a friend. I am not going to submit anything for payment because it is just not worth my--I will pay more in having my office submit this for payment than I would ever be reimbursed. Is that just unique to north Texas, or have you heard that in other areas as well?

Ms. {Yocom.} You know, in the times that we have interviewed physician groups and things like that, that has come up. There is no way to quantify how big that is. I think many physicians do--they do want to help people who need care, and they can't--they also have to run a business.

Dr. {Burgess.} Right.

Ms. {Yocom.} So sometimes that is where some of those limits come in.

Dr. {Burgess.} Let me just ask a question generally, and really for anyone on the panel, but, Dr. Schwartz, it is particularly to you. We kind of heard during this subcommittee, during the passage of the Affordable Care Act, that once we were able to be in the elision fields of the ACA, programs like SCHIP wouldn't be necessary any longer. So is SCHIP still necessary with the full implementation of the Affordable Care Act?

Ms. {Schwartz.} I think when the Commission took a deep look last year at the coverage and the benefits and cost sharing that is available in the exchanges, there--these were--these concerns surfaced, and our analyses primarily relied on GAO's work comparing benefits and cost sharing.

We are now looking, now that there is real data on premiums, and there is real data on the benefits being offered by plans, to get a better sense of where those differences are and the magnitude of those differences. We have shared some of that information with the Commission, and

I would anticipate some recommendations coming from the Commission by our June report this year to address those issues around adequacy and affordability. But right now, the Commission's concern is that the changes are not ready for the CHIP kids, and that a significant number of kids with CHIP would not be able to afford the exchange coverage.

Dr. {Burgess.} Well, I appreciate that answer. And my time has expired, so I will leave it there, but I do just want to point out that June is great, but we will be talking reauthorization prior to June, so all of the, you know, expediting you can do with that report will be helpful to members of the subcommittee.

So thank you, Mr. Chairman. I will yield back.

Mr. {Pitts.} Chair thanks the gentleman.

The ranking member has a UC request.

Mr. {Pallone.} Mr. Chairman, I wanted to ask unanimous consent to submit for the record, on behalf of Congressman Lance, a statement submitted for the hearing by the March of Dimes.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

967 ********** COMMITTEE INSERT **********

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Mr. {Pitts.} And the chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. {Engel.} Thank you very much, Mr. Chairman. Thank you for holding today's hearing. Thank you, Mr. Pallone.

And let me first say, I have always been a strong supporter of CHIP. With funding for the program set to end in less than a year, I believe it is really imperative that Congress acts quickly to provide assurances to the states and the children served by this program, that their access to healthcare services will continue. It is absolutely imperative. It has been a tremendous success in my home state of New York. When CHIP was enacted, there were over 800,000 uninsured children living in New York. Now we are down to about 100,000 uninsured children, which represents a nearly 90 percent decline. Our program, titled Child Health Plus, is currently providing quality affordable healthcare to approximately 496,000 New York children. And after 2 decades of great success, I would like to see funding continue for this very important program, which is why I am pleased to be a cosponsor of Mr. Pallone's legislation, the CHIP Extension

and Improvement Act, and it is my hope that the committee will act quickly on this legislation.

Let me start with Dr. Schwartz. MACPAC unanimously represented that CHIP funding be extended for 2 years. Can you elaborate on what issues MACPAC recommends Congress, HHS and the states focus on in the intervening years to ensure that children maintain access to vital healthcare services?

Ms. {Schwartz.} Yes. The Commission's key concerns are the extent to which children will have an alternate source of coverage, the affordability of that coverage, the adequacy of the coverage in terms of the benefits that are covered, and the adequacy of the networks, and the differential impact on states. Those are the areas in which we are looking, and that is the reason for the 2-year recommendation for funding because those questions can't be solved quickly, but we believe that a 2-year time frame would provide the impetus to make those changes to a smooth transition to other sources of coverage.

Mr. {Engel.} Well, thank you. Let me also say, Dr. Schwartz, I couldn't agree more with the statement in your written testimony, and I am going to quote you when you said

``an abrupt end to CHIP would be a step backward from the progress that has been made under CHIP.'' And that is so true because the cost of living in my area of New York is quite high, and there is a significant difference in healthcare costs for those on CHIP, and the child-only policies available through our exchange, New York State of Health.

CHIP has been tremendously successful in providing lower-middle-income children with affordable health insurance, and for them to possibly lose that coverage would be very unfortunate.

So, Dr. Schwartz, we touched on it a little bit before in one of the questions, but can you or any of the other witnesses elaborate on the cost differences between CHIP and plans available in the various state health insurance exchanges that have been examined? Ms. Yocom?

Ms. {Yocom.} Sorry. Yes. We did find that cost was one of the areas where we could pretty consistently see that there was a difference between CHIP and the benchmark plans. There is a higher use of deductibles and larger deductibles. Premiums are much more of a share. And the other thing, of

course, is that CHIP is limited to 5 percent of a family's income. On the benchmark and qualified health plan side, there is a limit on premiums, but other costs are not necessarily counted in that limit. So it is a little more difficult to be sure that things remain affordable.

Mr. {Engel.} Thank you. Let me also ask anyone on the panel, if CHIP funding does not continue past this fiscal year, what will happen to the children in states that run separate CHIP programs, but do not have plans in place through their exchanges that are comparable to CHIP in benefits and cost sharing? And coupled with that is, do states have any obligation to help transition beneficiaries to affordable exchanges plans?

Ms. {Yocom.} The states' obligation is to take those children and screen them first for Medicaid eligibility, and then to consider them for coverage under the exchange. Our work identified about 1.9 million children that are likely not to qualify for the exchange because of having a parent that has employer-sponsored coverage. And affordability has been defined as a single, self-only coverage amount, and not a family coverage amount. That difference, in looking at

what the costs are, could place some people out of the market in terms of being able to afford--

Mr. {Engel.} And that just shows how imperative it is that CHIP funding continues past this fiscal year.

Thank you, Mr. Chairman.

Mr. {Pitts.} Chair thanks the gentleman.

We still have two more hearings next week in the Health Subcommittee, but let me just say in case I don't get to say it next week, we are going to be losing Dr. Gingrey, a very valued member of our Health Subcommittee, and I am pleased to recognize him for 5 minutes for questions at this time.

Dr. {Gingrey.} Chairman Pitts, thank you very much. I certainly appreciate that. I am going to miss you guys and gals on this great committee.

My question and comment will pertain to fiscal responsibility and, indeed, sanity. So before I get into that, I want to make sure everybody understands, my colleagues especially, that I think the Medicaid program is a great program, going back to 1965. And I think the CHIP program, in Georgia we call it Peach Care, I think it is a great program, going back to 1997 and 2009, and all that has

been discussed, but naturally, I am a fiscal conservative, and--as we all should be, and worried about the increased spending and responsibility, particularly to our states.

Obamacare included a provision which requires, as you know, the states to maintain income eligibility levels for CHIP and Medicaid through September 2019 as a condition of receiving payments under Medicaid and SCHIP, notwithstanding the lack of corresponding provision federal appropriations for fiscal year 2016 through 2019. This provision is often referred to, as has been mentioned, the Maintenance of Effort, or MOE, requirement.

While Medicaid and CHIP costs are increasing, is this effectively an unfunded mandate on states? And the last question, and more importantly, while a lot of states, a lot of states, have suggested extending the CHIP funding for these--that 4-year gap, is it fair to say that they are assuming that the MOE, Maintenance of Effort, remains, but they might feel differently if MOE was scraped. And I, indeed, have called many times since March of 2010 for eliminating that Maintenance of Effort requirement. I think if--you might have more states accepting Medicaid expansion

up to 133 percent of the federal poverty level if they could make sure that the people that were enrolled were indeed eligible, and doing that periodically, if it is every 1 or 2 or 3 years or whatever, because we want the money to go to those that really need it.

So any member really of the panel, and we can start with Ms. Baumgartner if you like. I know I mispronounced your name, but why don't you go ahead and respond to that for me, if you will?

Ms. {Baumrucker.} So I hear--there are a lot of issues that you discussed in the--in your question and in your comment about whether or not CHIP funding--what is the responsibility of states after the MOE--with the MOE in place. And so as we have discussed on the panel today, Medicaid expansion children continue to be enrolled in the Medicaid program, and are matched at the federal matching rate for the Medicaid program. The CHIP separate state children, if there are qualified health coverage through--if there are Secretary-certified plans available in the exchanges, separate state children would first be screened for Medicaid, and if they are eligible, they would be

enrolled there. Otherwise, the CHIP program requires them, under current law, to be--if there are certified coverage that--enrolled in that coverage. So if you remove the MOE requirements, then it would be up to states as to whether or not they would continue their child coverage going forward, but at this point, that 2019 requirement requires states to maintain Medicaid, and the CHIP question--

Dr. {Gingrey.} Well, Dr. Schwartz, would you like to respond to that as well?

Ms. {Schwartz.} I would just say that in talking with the folks who run CHIP programs in the states, that they are very concerned about needing to know what the future is for their state budgeting purposes, and concerned about what will happen to the kids that they are currently responsible for. And I believe that is well reflected in the letters from the governors--

Dr. {Gingrey.} Well, I am going to interrupt you just for a second. I apologize for that, because my time is running out and I wanted just to make a comment.

The question was brought up about the express lane process, and expanding that into the future. I am very

concerned about the express lane if people that are eligible, let's say, for the SNAP program are automatically eligible for Medicaid expansion or SCHIP, when there are some states, and we know this, who make people eligible for the SNAP program by virtue of the LIHEAP program, where they are giving them $1 a month to make them eligible, and then they are automatically eligible for SNAP. And now this express lane would make some of those people automatically eligible for the SCHIP program and Medicaid expansion. So it goes on and on and on. And we have a responsibility on this committee to make sure that we look at that problem and solve that before we go expanding coverage and appropriations for an additional 4 years.

So, Mr. Chairman, thanks for your indulgence, and I yield back.

Mr. {Pitts.} Again, the chair thanks the gentleman.

And now recognize the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. {Capps.} Thank you, Mr. Chairman, Ranking Member Pallone, for holding such an important hearing.

Since its inception, CHIP, or C-H-I-P, has been a

critical healthcare program for children. I think we all agree upon that. It has let parents rest easier, has shown the Nation what bipartisan support can do to make a real impact on each of our communities. And my background as a long-time school nurse, I can't impress upon my colleagues, and I know I have run this into the ground, but the importance of our children having a formal connection early on to the healthcare system, not for--just for when they get sick, but to keep them healthy, to keep them thriving and ready to learn.

The CHIP program is key to the health and economic security of all of our families, linking over 8 million of our Nation's children to care, and together with Medi-Cal, my state's Medicaid program, which we call CHGP in California, these programs have cut the rate of children's uninsurance by half. This is something that must be supported and continued.

And one thing I want to touch on briefly in response to a question earlier from our chairman, MACPAC does offer impressive coverage statistics for children over the history of CHIP. The share of near-poor children without health

insurance has dropped 22.8 percent in 1997, to 10.--10 percent in 2013, which is remarkable. Even while private coverage rates declined from 55 to 27.1 percent. Simply put, at a time when employer-sponsored coverage was declining, we still managed to bolster coverage for children.

Private coverage rate--rates also declined precipitously for near-poor adults, from 52.6 percent to 35.8 percent. So clearly, CHIP wasn't the reason why private rates declined, but it and Medicaid were the reason why children's coverage improved, despite an overall decline in private coverage.

Similarly, all of you--each of you has highlighted significant issues that could arise if the CHIP program is not funded for additional years. Children could become uninsured, eroding the process--progress we have made since the beginning of the program, and cost to taxpayers would go up, since keeping CHIP--kids in CHIP costs the Federal Government so much less than moving them to an exchange marketplace coverage.

So my question--my first question, just to get on the record, and I don't care who answers this, if CHIP funding is not extended, what would happen to the overall rate of

uninsured children? Anyone want to put that out?

Ms. {Schwartz.} I don't think we have calculated an overall rate of uninsured children, but the estimate that we have relied on to date is that about 2 million children would lose coverage. We are now doing additional analyses to get a better sense and more clarity around that number.

Mrs. {Capps.} Thank you. And that--I think that gives us the big picture of how important this program is.

And for those CHIP children who would become insured through the exchanges, how would this affect their level of appropriate age-specific benefits and the affordability of coverage? Again, sort of a generalized question for anyone. Thank you, Ms. Yocom.

Ms. {Yocom.} Sure. Affordability certainly would change, and costs would likely be higher for families who move from CHIP to the exchange. In terms of benefits, we identified a few benefits that were generally better under CHIP than under Medicaid--

Mrs. {Capps.} Um-hum.

Ms. {Yocom.} --sorry, under the exchanges, and those were vision and dental--

Mrs. {Capps.} Um-hum.

Ms. {Yocom.} --and some on habilitative services, but that was a bit more mixed. There were also CHIP plans that did not have habilitative services as well.

Mrs. {Capps.} I see. So, Dr. Schwartz, specifically for you, in terms of logistics, if CHIP funding is not extended, what are the implications for state legislatures?

Ms. {Schwartz.} State legislatures will begin meeting. Those that meet for less than the full year, in January, are very concerned about this issue, and need to have some kind of contingency plan if the federal funding runs out. The National Conference of State Legislatures have said that this is problematic for all state legislatures, whether they have a full-time legislature or one that meets every 2 years, or one that meets annually.

Mrs. {Capps.} Is there an estimate on when states would run out of CHIP money, and when families would have to be notified that they will no longer have coverage?

Ms. {Schwartz.} With regard to when the funding would run out, it is different in different states, as I mentioned in my testimony, but everyone--every state will run out by

the end of 2016.

On the question of notice requirement, there are notice requirements under current law. This is a somewhat unique situation, and so that would be an area where, certainly, we would like to get some clarity from CMS about what states would be required to do.

Mrs. {Capps.} I know I am over my time, but for our part, I don't believe we as a committee would allow that to happen, and that is why H.R. 5364, the CHIP Extension Improvement Act, is a good Bill to sign on to. Happy to have done that.

Thank you very much again for being here.

Mr. {Pallone.} [Presiding] Gentlelady's time has expired.

The chair now recognized the gentleman from Virginia, Mr. Griffith, 5 minutes for questions please.

Mr. {Griffith.} Thank you, Mr. Chairman.

And if anyone could respond to this, or all of you, in response to Chairman Upton and Ranking Member Waxman's letter and questions, Virginia Governor, Terry McAuliffe, raised the issue of allowing coverage of medically necessary institution

for mental disease, and the placements for CHIP-eligible children, which is currently available to children on Medicaid. Given the work that this committee has done on mental health under Chairman Murphy, or in the Oversight and Investigation Committee that Chairman Murphy chairs during this past year, and hearing that testimony, and, of course, being aware of the tragedies that took place, while it may not have been helped, at Virginia Tech and elsewhere in Virginia, I think this is something that ought to be considered.

Do any of you all have thoughts on whether or not CHIP should include providing this type of mental health coverage?

Ms. {Schwartz.} I would just say that MACPAC has, in the last--beginning this fall, has begun a focus inquiry on behavioral health services in Medicaid and CHIP. We are still learning and identifying the problems and the concerns. Coverage in institutions of mental diseases in Medicaid has certainly been a concern, and that will be an area where you will see more from us in the future.

Mr. {Griffith.} Because one of the areas--just to underline this for you all, one of the areas that we have

identified, and Chairman Murphy's hard work on this issue and those of us on that committee, is that so many young people, particularly young males between the ages of 14 and it goes over to like 28, which would not apply to CHIP, but particularly these 14-year-olds I am concerned about and up to the 18 age, they are not getting treatment. They know there is something wrong, the families know there is something wrong, but they are not even going in to get treatment for over a year before they begin, and that creates a lot of--or starts the process, and in a lot of cases it ends up in very tragic situations without getting that treatment.

All right, let us move on to other subjects while I still have some time.

The American Action Forum, run by former CBO Director, Doug Holtz-Eakin, estimated in September that 1.6 million children currently in CHIP would fall into the family glitch.

Ms. Baumrucker, can you explain for those who might be watching this hearing later or now, what is the family glitch and why is that of concern particularly related to CHIP?

Ms. {Baumrucker.} So under the regulation from CMS, or

IRS, affordability for whether or not you have access to insurance coverage that is affordable, so whether you would be--have access to subsidized coverage through the exchanges, is defined against an individual, not a full family. And so the idea behind families that would fall into that family coverage glitch is that they may have access to employer-sponsored insurance, but that that insurance coverage would be under the 9.5 percent of their annual family income, and so would be considered affordable, but may or may not be based on their income against poverty level.

Mr. {Griffith.} Okay, so if I can clarify, and I understand it but I want to make sure the public understands it as well. What you are talking about is, is that in order to be affordable, it has to be 9.5 percent of the individual's income or the family income, but that is determined against the individual employee's wages, and if they happen to have, particularly in a single-parent household and they have three or four children at home, when you add the cost of covering the children, it is no longer 9.5 percent or less of their income, it goes up above that, but for purposes--the Affordable Care Act did not take that

into calculation, or at least the regulations based upon the Affordable Care Act, did not take that into consideration, and so we have families out there who, notwithstanding the fact it is deemed affordable by the Internal Revenue Service, it may not be affordable. Is that a correct restatement of what you said?

Ms. {Baumrucker.} I would agree with that.

Mr. {Griffith.} I appreciate that. Thank you so much.

That being said, and I am going to have to truncate this a lot because I talk too much, which often happens. Dental insurance, there is a real concern there with the dental insurance aspects related to the Affordable Care Act, and of course, we know there was the double counting issue. Related to CHIP, what can you all tell me about how many children are currently getting dental services under CHIP, and how this may be impacted as well by the Affordable Care Act? And I saw Ms. Yocom nodding. You are--I would be happy for you to give me an answer. And I have 20 seconds left.

Ms. {Yocom.} Okay. No pressure. We did do some work on dental, and the--it is sort of a good-news-bad-news. The good news is dental coverage and dental--use of dental

services in Medicaid and CHIP has actually shown some improvement over the last few years. The bad news is it is still not on par with private insurance. Okay?

Mr. {Griffith.} I appreciate that.

And my time being up, I yield back. Thank you, Mr. Chairman.

Mr. {Pitts.} Chair thanks the gentleman. And--

Mrs. {Capps.} Mr. Chairman.

Ms. {Pitts.} --Mrs. Capps, you are recognized for a UC request.

Mrs. {Capps.} Yes. I apologize for not doing this on my time but I wanted to ask unanimous consent to insert into the record the statement from the National Association of Pediatric Nurse Practitioners in support of the Child Health and Disability Prevention Program, and swift passage of funding for this program. And I yield back.

Mr. {Pitts.} And without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} Ms. Castor, you are recognized for 5 minutes for questions.

Ms. {Castor.} Thank you, Mr. Chairman. And I want to thank you and Ranking Member Pallone for your leadership on SCHIP. And I would like to thank our witnesses who are here today for lending your expertise on the financing of SCHIP, and the impact of various policy decisions at the federal and state level.

I come from the state of Florida, and we take great pride that an early precursor to SCHIP was developed in the state of Florida, in the late '80s and early '90s. It was--I think it was very smart, they created insurance that is specific to children's needs, and they started with public school enrollment to create a large group that gave the state negotiation power to go out and get the best rates to cover children, and they used the data that they gathered there to demonstrate to other states that it is very cost-effective, that--compared to adults a lot of time, children are pretty inexpensive when it comes to taking care of their healthcare needs. So that allowed other states and the Federal

Government to say, hey, this is a smart policy to invest in children, negotiate lower rates for healthcare coverage.

So now, years later, it is widely embraced, and in response to the committee's July correspondence to states asking for their input, the overwhelming number of states have said, yes, Congress, please extend funding for State Children's Health Insurance Program. So we should do this as soon as possible, the Congress should act. First, it would give families the peace of mind that they need that their children are going to be able to get to the doctor's office, get the vaccination thingy, get the dental care that they need, but as Dr. Schwartz has pointed out, early in the new year, states are going to be putting their budgets together and they really need this information from the Congress and on the federal side of what the funding is going to be. So I would urge us to try to get this done in the lame duck to give that certainty, or at least in the early part of the new year tackle it and move it through as quickly as we can.

I would like to ask a couple of questions about who remains uninsured, and what the barriers are, because even with all of this progress over the past years, we still have-

-I don't know, Dr. Schwartz, did you say 10 percent uninsured? It varies state to state. In my State of Florida, we are still not doing all that we should.

What are the barriers today to getting children enrolled? Does it involve the waiting lists, and then I will have a couple of other questions to ask you.

Ms. {Schwartz.} Well, I think it is many different factors, and I am not going to be able to quantify how much each contributes to that amount. There are many children who are eligible for Medicaid and CHIP who are not enrolled because of lack of awareness or lack of understanding. Certainly, waiting periods for CHIP coverage do mean that those children remain uninsured in the period in which they have applied, but are not eligible for coverage. There are children as well whose immigration status does not permit them to be covered under Medicaid and CHIP.

Ms. {Castor.} So on the waiting list issue, the MACPAC has advised the Congress that one way to ensure that children get covered is to eliminate those waiting lists. And hasn't this been the trend in states over the past couple of years? I think I read that at least 20 states have eliminated that

waiting list. Unlike the State of Florida, unfortunately, I think they still say, okay, families and kids, you have to wait 2 months, which really doesn't seem to make a lot of sense when you acknowledge it is important for children to be healthy and ready to learn in the classroom. What is going on with the waiting list?

Ms. {Schwartz.} Yes, you are correct that states have been eliminating their waiting lists. The 37 states that began 2013 with CHIP waiting periods, by 2014, 16 had eliminated those. The Affordable Care Act also required states to limit waiting periods to 90 days. And as well, there are a number of exemptions to the waiting period which, for some states, we have heard them say it is a lot of work to go through and tick off all those exemptions, and it is just better to have no waiting period at all, and that was one of MACPAC's recommendations.

Ms. {Castor.} Great. Great. And then what role do you think the transition to Medicaid Managed Care has played in erecting barriers to children being covered, and the fact that many--that a number of states have not expanded Medicaid? Does that also play a role in creating a barrier

to enrollment?

Ms. {Schwartz.} The expansion of Medicaid that states have the option of taking, of course, applies to adults. It does not apply to children. Children are covered in every state. I am not aware of any research that shows that Managed Care is a barrier to insurance, and in fact, there are many who would argue that Managed Care provides a system of care for a child with someone--and an organization responsible for that care. So I am not able to provide an answer on that.

Ms. {Castor.} MACPAC has not examined that?

Ms. {Schwartz.} Not from that perspective.

Ms. {Castor.} Okay, thank you very much.

Mr. {Pitts.} Chair thanks the gentlelady.

And recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. {Bilirakis.} Thank you, Mr. Chairman. Appreciate it. Thanks for holding this hearing.

Ms. Mitchell, CHIP is a capped allotment and not mandatory spending like some other federal programs. Can you talk about how CHIP has provided more robust federal budget

discipline compared to Medicaid and Medicare--or Medicare? Does the flexible benefit design help to control costs and increase outcomes in the program reach?

Ms. {Mitchell.} Medicaid and CHIP are very difficult from a financial standpoint. They are both mandatory funding. CHIP has these--the capped allotments that states receive every year. Medicaid is open-ended. So for every dollar a state spends on their Medicaid program, they receive a portion of that back, according to their FMAP rate. And the FMAP rate for Medicaid is less than the EFMAP rate that states receive for CHIP. In fact, it is--the EFMAP rate is--for the states are 30 percent reduction in what states receive under the FMAP rate. So that is the difference between the financing on the--those two.

Mr. {Bilirakis.} Okay, thank you. Another question, under the President's healthcare law, about half the states have expanded Medicaid to cover childless adults, and again, this is for Ms. Mitchell. Yet, CHIP is facing a funding cliff. I am concerned that we could be subsidizing the care of able-bodied adults, and may have lost our focus on the poor and underserved children. That is what it was intended

to do, in my opinion.

When CHIP was initially passed, who was the target population, I want to hear, and under the broad eligibility provisions today, how has that eligibility income level shifted? This is for Ms. Mitchell.

Ms. {Mitchell.} When CHIP was passed in the--in '97--1997, the target population was targeted low-income children that did not have access to insurance. So that was the point of CHIP. Did you have anything to add to that?

Ms. {Baumrucker.} Sure. As part of the CHIP program, or CHIP Reauthorization Act, as well, there was an attention that the Congress put on finding and enrolling uninsured children of Medicaid eligibility limits, and to try and bolster that lower income--those lower-income families over the CHIP that covers children at higher income thresholds. So there is that target group. Without CHIP funding, there is a potential, as we have noted on the panel, that some could become uninsured going forward.

Mr. {Bilirakis.} Thank you. Thank you.

Ms. Yocom, OMB has labeled CHIP as a high area program, an estimated 77 percent improper payment rate. I know that

GAO has looked at program integrity within Medicaid, but have they looked at the CHIP program?

Ms. {Yocom.} We have not.

Mr. {Bilirakis.} Okay. Can you talk about some of GAO's Medicaid integrity recommendations, since some states run the CHIP inside the Medicaid program?

Ms. {Yocom.} Sure. Many of GAO's recommendations on program integrity and Medicaid relate to making sure that CMS and the states work together and collaborate on both information systems and oversight. We most recently have recommended that there be a more intensive look at Medicaid managed care, that--in our most recent study, we really found that CMS and the states, and even the Inspector Generals, were not spending time looking at whether payments made by managed care organizations and payments made to managed care organizations were done in a fiscally responsible way. So that is an area that--of significant need right now.

Mr. {Bilirakis.} Thank you very much.

Dr. Schwartz, has MACPAC looked at the feedback the governors provided about the current design of the CHIP program, and if so, can you talk about how this will factor

into their recommendations on MACPAC--what recommendations MACPAC may be making?

Ms. {Schwartz.} Yes. At the staff level we have seen some but not all of the letters that I believe have been sent to the committee. I understand the committee is releasing them and--in which case we will brief our commissioners at our meeting next week, and that will provide the strongest voice for the state perspective in MACPAC's deliberations, because our analyses and our recommendations focus on children, families, the Federal Government and the states. So we are very grateful to the committee for asking for those letters from the states because I think we will find them very useful.

Mr. {Bilirakis.} Very good. Thank you.

I yield back, Mr. Chairman.

Mr. {Pitts.} Chair thanks the gentleman.

Now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. {Murphy.} Thank you, Mr. Chairman.

Ms. Yocom, one of the concerns of Medicaid is that the program doesn't always provide good access to care, in part

due to the low reimbursement rates. And I believe in your report from GAO, the GAO report also says that the ways to improve access to providers is to change their reluctance to be part by changing what is basically low and delayed reimbursement and provider enrollment requirements. That is from the GAO report. So I understand that GAO did some work comparing Medicaid and CHIP kids' access to care in their--in that 2011 report. Can you talk a little bit about the findings of that report, what may be the difference in care for children in CHIP versus Medicaid?

Ms. {Yocom.} Okay. Yes. This--the report that you are referring to did not get to the point of what was the quality of care received. We did get to the point of looking at how much utilization occurred in each type of program, and whether or not there were perceptions of access with each of these programs. We did find that perceptions of access of the primary care level were equally strong across Medicaid, private insurance and CHIP. And in terms of utilization of primary care services, we didn't find a statistically significant difference in utilization across the private insurance, across Medicaid, and across CHIP.

Where we did find a significant difference was with specialty care, both in terms of physicians reporting difficulty referring individuals for specialty care, and then--in Medicaid and in CHIP, and then also with utilization rates of specialty care. Also perceptions of access for specialty services were also lower for Medicaid and for CHIP.

Mr. {Murphy.} Well, let me--they are lower for Medicaid and CHIP. One of the questions I have about access, and you heard Mr. Griffith make reference to the hearings we have had on mental health and mental illness, one of the barriers we find that the Federal Government has created under the Medicaid program is what is called the same-day billing rule. You can't see two doctors in the same day.

Ms. {Yocom.} Um-hum.

Mr. {Murphy.} Now, to me, that is an absurd barrier we have. Knowing that early symptoms of severe mental illness begin to appear, in 50 percent of cases, by age 14. Some may even appear earlier. And to have access to a pediatrician or a family physician might, say, Ms. Jones or Ms. Smith, your child is showing some problems here, we need to get them to see a psychiatrist/psychologist right away.

Ms. {Yocom.} Um-hum.

Mr. {Murphy.} Medicaid says, nope, you have to come back. When we know that they can be referred in the same day, compliance is very high when they have to come back, it is a problem. And there is an average of 112 weeks between the first symptoms and first professional involvement.

Does CHIP have the same barrier that Medicaid has, do you know--

Ms. {Yocom.} I--

Mr. {Murphy.} --or would anybody in the panel know about that?

Ms. {Yocom.} I don't believe so, but I don't know of any now.

Mr. {Murphy.} But that--because that is one of the critical barriers in terms of--

Ms. {Yocom.} Right.

Mr. {Murphy.} --access and quality if Medicaid--and I think one of the reasons there is stigma with mental illness is you can't get help.

Ms. {Yocom.} Right. And I--

Mr. {Murphy.} And so--

Ms. {Yocom.} I do know there are states and options that can allow you to bill two providers on the same day, and--by identifying the providers. So hopefully, not too similar to MACPAC, but we also are doing a look right now at behavioral health services and some of the issues related to obtaining access.

Mr. {Murphy.} I hope some of you can give me an answer to that question--

Ms. {Yocom.} Yeah.

Mr. {Murphy.} --because the committee--if funding for the CHIP is not--CHIP program is not extended, I am concerned that many kids are going to lose their coverage and be enrolled in the exchange under the Affordable Care Act, but what we have also heard from a number of employers and a number of families is what appears to be a lower cost is a very high deductible. And so basically now they are given catastrophic insurance where they are paying thousands of dollars as a deductible.

Now, in your testimony, you indicated that approximately 1.9 million children would not qualify for a subsidy in the marketplace due to the employer-based coverage being

available. Without CHIP, isn't it likely that many of these children are just going to go uninsured then, Ms. Yocom?

Ms. {Yocom.} I believe it is likely, yes, absent--

Mr. {Murphy.} And anybody else have a comment on that, would some of these kids just then go without care?

Ms. {Schwartz.} That is MACPAC's concern as well, and what we are trying to get better data on--at the moment are what the offers are for dependent coverage for the parents that have employer-sponsored coverage, and what the costs for that coverage look like.

Mr. {Murphy.} Well, I just want to say, and Mr. Pallone may be surprised to hear me say this, but there are some government programs that are doing pretty well, and I think in this one, CHIP has got some value, I know in Pennsylvania has a strong demonstrated value, and rather than cut something that is working, we should find a way of learning lessons of value from this and not making families go without insurance. So I thank you very much.

I yield back, Mr. Chairman.

Mr. {Pitts.} Chair thanks the gentleman.

Now recognize the chair emeritus of the full committee,

Mr. Barton, 5 minutes for questions.

Mr. {Barton.} Thank you, Mr. Chairman. I just got here. I am going to pass on questions. I--my--well, my--I guess I will ask one question just for the record.

In your opinion, if the next Congress significantly changes the Affordable Care Act, which I think we will, would you recommend that we maintain SCHIP as a separate program, or would it--would you recommend we fold it in with whatever we end up doing with the Affordable Care Act? And I will let anybody who wants to answer that.

Ms. {Schwartz.} It was MACPAC's--the Commission's intention in making its recommendation for a 2-year extension of CHIP funding to use that 2 years to find a way to make sure that there is integration of children into other forms of coverage, to ensure that that coverage works well for children, and that there is not loss of coverage for people.

Depending upon what the Congress does, the strategies for that integration might have to change, but that clearly is part of the intention behind the rationale behind the Commission's recommendation.

Mr. {Barton.} Anybody else? Okay, well, Mr. Chairman,

I am going to--Ms. Yocom, did you want to say something?

Ms. {Yocom.} I was going to point to one study that GAO did that looked at the association between parents and caretaker coverage with children's coverage, and we did find that there is a stronger--there is a strong association with parents who have--their far--their children are far more likely to be covered if they have coverage that is similar to their parents. When the coverage gets mixed, the likelihood of a child obtaining insurance is slightly lower. We did not find anything about utilization or access, however.

Mr. {Barton.} Okay. Mr. Chairman, I am going to yield back. I was one of the authored of the last reauthorization of the SCHIP program, so I am a supporter of it. I haven't studied the issue well enough to know where we are going to go in the next Congress, but I will definitely work with you and other members of this subcommittee to do that.

Mr. {Pitts.} The chair thanks the gentleman.

Now recognize the gentlelady from North Carolina, Ms. Ellmers, 5 minutes for questions.

Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you to our panel for being here today.

One of the issues that I have been working on that is very important to me is access to healthcare services for children with life-threatening illnesses. Congressman Moran and I have sponsored bipartisan legislation, the Children's Program of All-Inclusive Coordinated Care, or ChiPACC, Act of 2014, which is H.R. 4605. A little promotion there.

Basically, this is based on a collaborative model of care developed by Children's Hospice International. This model provides comprehensive and coordinated care for Medicaid-eligible children who suffer from life-threatening diseases. Currently, the ChiPACC program is operating in five waiver states. This legislation would allow states the flexibility to implement ChiPACC as a Medicaid state plan option. The program provides improved access to critical care services for this population of children , while resulting in cost savings through their state Medicaid program.

I would just ask that maybe you look into that piece of legislation because, again, we will be putting it forward into the new Congress.

My questions, starting off with Dr. Schwartz. When our

committee asked our state about CHIP funding, the North Carolina emphasized--the state emphasized that the CHIP funding expires families of, you know, qualified plans a federal facilitated marketplace could experience an increase in cost sharing by thousands of dollars per year. Of course, that depends on the number of children, health status, you know, state of the children at the time. Therefore, would a compromise be made to continue the CHIP program with a greater beneficiary financial contribution that is higher than the current 5 percent threshold, but lower than the cost sharing that would be incurred on the federally facilitated marketplace? In other words, how do we--from the beneficiary perspective, is there discussion about increasing their portion?

Ms. {Schwartz.} MACPAC is currently undertaking analyses to look at the impact of cost sharing, particularly in the exchanges on families--

Mrs. {Ellmers.} Um-hum. Um-hum.

Ms. {Schwartz.} --and that impact varies quite a bit based on the healthcare use of the children. So the children you are most concerned about stand to have the highest cost

sharing--

Mrs. {Ellmers.} Um-hum.

Ms. {Schwartz.} --because of the service level cost sharing.

Mrs. {Ellmers.} Um-hum.

Ms. {Schwartz.} But that could be--what you suggest could be certainly one approach that we could look at.

Mrs. {Ellmers.} Okay. Also, as kind of a follow-up to that, under current law for 2016, or will be implemented in 2016, the CHIP enhanced federal medical assistance percentage is scheduled to increase by 23 percent. Now, according to MACPAC or CBO estimates, will the additional billions of dollars that will be generated from that in federal funding result in more children receiving health coverage? Would--will there be an increase in the number? And I apologize if any of these questions have already been posed to you because I did come in late, so I apologize.

Ms. {Schwartz.} Okay, the increased funding results from when you have a higher matching rate, the states use the money more rapidly, and so to get through the same period of time with the same enrollment--

Mrs. {Ellmers.} Um-hum

Ms. {Schwartz.} --it requires more dollars. It is not based on a change in enrollment.

Mrs. {Ellmers.} So it won't increase the number of children receiving services?

Ms. {Schwartz.} That is affected by the eligibility level, not by the match rate.

Mrs. {Ellmers.} Okay. Ms. Yocom, I have a question--last question for you. How much money could Congress save in federal taxpayer dollars if the 23 percent increase were set aside or scraped?

Ms. {Yocom.} I am sorry, I don't think I can answer that. There--certainly, the--one of the things that happens with increasing that matching rate is the funds will disappear more quickly--

Mrs. {Ellmers.} Um-hum.

Ms. {Yocom.} --and that could lead to states struggling to, you know, continue to cover their--

Mrs. {Ellmers.} Um-hum. But that hasn't necessarily been something that the GAO has already--

Ms. {Yocom.} It is not something we have looked at now.

Mrs. {Ellmers.} Okay. Okay, well, thank you very much.

And, Mr. Chairman, I yield back the remainder of my time. Thank you.

Mr. {Pitts.} Chair thanks the gentlelady.

Now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. {Lance.} Thank you very much, and good morning to you all. I have been involved in another hearing. This is an incredibly important topic.

A number of members on the subcommittee, including me, are from states that extend CHIP coverage to pregnant women. As I understand it, it is estimated that about 370,000 pregnant women are covered each year in the 18 states that offer the coverage. Is there data to suggest that pregnant mothers have better health outcomes with CHIP as opposed to Medicaid? Whoever on the panel would be interested in responding to that.

Ms. {Yocom.} I am not aware of data that shows that, so no.

Mr. {Lance.} Anybody else? Regarding another aspect of this issue, Ms. Tavenner said to a senate committee that

existing CHIP regulations require assessment for all other insurance affordability programs, including Medicaid and the premium tax credit when CHIP eligibility for a child is ending. Can any of the distinguished members of the panel elaborate on what this assessment entails, or qualified health plans, for example, currently available that would be considered adequate for children leaving CHIP?

Ms. {Yocom.} Yes. Our--one of our more recent studies did take a look in five states. We looked at benchmark plans which were the basis for coverage under qualified health plans, and we have some ongoing work as well right now, but essentially we did find that costs would be higher, in some cases, particularly with vision and hearing services, that the coverage under the benchmark plans was not as robust as what is offered under CHIP.

Mr. {Lance.} Thank you. Others on the panel? Let me urge the distinguished members of the panel to consider the situation that was suggested by Chairman Emeritus Barton. The new Congress may very well try to amend the Affordable Care Act in significant ways. The President could sign that or veto that, but regardless of our action or his action, it

is my legal judgment that the Supreme Court may rule as not consistent with statutory law, current subsidies to the Federal Exchange. I think it is an extremely important case, and I think the Court could quite easily conclude that black letter law does not permit subsidies to the Federal Exchange.

If that were to occur then the Affordable Care Act might collapse under its own weight, and if that were to occur, then Congress will certainly have to address the CHIP issue separately and distinctly from the Affordable Care Act. And so I would encourage the panel to consider what actions we should take moving forward if that were to occur, and it is my legal judgment that it might very well occur.

Do any of the members of the panel have initial thoughts on what I am suggesting? Dr. Schwartz?

Ms. {Schwartz.} Only to say that to the extent that premium subsides are not available, that obviously--

Mr. {Lance.} Yes.

Ms. {Schwartz.} --changes the options for children significantly.

Mr. {Lance.} Yes.

Ms. {Schwartz.} And so it is always a question of CHIP

relative to what, and so I think your point is well taken and it is one that the Commission will be considering.

Mr. {Lance.} Thank you. There are pros and cons in having CHIP folded into the ACA, I understand that, but CHIP predates the ACA, there are many of us who support CHIP who certainly are vigorously in opposition to the ACA, and I hope that we cannot confuse the two or conflate the two. And the Supreme Court has granted certiorari in this case, well, there will be oral arguments in March, I suppose, and a decision by June, but I would encourage all on the panel to consider what might occur if what I suggest eventuates.

Thank you very much, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman.

That concludes this round of questioning. We will go to one follow-up per side.

I will recognize myself 5 minutes for that purpose.

And let me continue on Mrs. Ellmers' question. She asked it of GAO. Let me ask it of MACPAC. What many of the advocates and public health groups are saying is that CHIP is a success today under today's match rate. Can you confirm that if Congress were to scrap the 23 percent increased FMAP

in current law, and only extend CHIP for 2 years, the CBO's current projections are that extending CHIP for that time could save federal money, reduce the deficit. Dr. Schwartz?

Ms. {Schwartz.} This--the savings do come from comparison to the alternative, which is as long as states are putting in more money, the Federal Government is putting in less, and so yes, that would potentially result in savings.

Mr. {Pitts.} All right, let me continue with you. States have told us that under the MAGI, the Modified Adjusted Gross Income, calculations, there are lottery winners currently enrolled in Medicaid. In fact, in 2014, one state reported to us that roughly one in four of their lottery winners were enrolled in Medicaid, or had a family member in Medicaid. And this includes at least one individual who won more than $25 million, but still was receiving Medicaid services. Since CHIP uses MAGI calculations as well, is it possible that CHIP is providing coverage for lottery winners?

Ms. {Schwartz.} I am not familiar with the specific cases that you cite, but it would be my understanding that, to the extent that lottery winnings are considered taxable

income, that they would be taken into account in a MAGI calculation.

Mr. {Pitts.} Ms. Yocom, would you respond to that question?

Ms. {Yocom.} Yes. I can't do much more than echo what Dr. Schwartz just said. Yeah.

Mr. {Pitts.} Anyone else? All right, that concludes my questioning.

I will recognize the ranking member 5 minutes for a follow-up.

Mr. {Pallone.} Dr. Schwartz, let me ask you, I want to follow up on the earlier question relating to the transfer of children from CHIP to Medicaid. As you know, the Early Periodic Screening, Detection and Treatment benefit is available for all children in Medicaid, but not necessarily in CHIP. Do you have any estimate of the number of children of those 500,000 children who saw an improvement in coverage as a result, and do you have any estimate of the number of children who now benefit from reduced cost sharing as a result of the--that transfer?

Ms. {Schwartz.} That is a great question, and I don't

know--I don't think we have the data to answer that question.

Mr. {Pallone.} So you think you could get back to us, or you don't have sufficient data?

Ms. {Schwartz.} We would have to look at the states which were transitioning kids, and we would look--have to look at the difference between the benefit package in their CHIP program versus the Medicaid program. I would be hesitant to say that we could then say anything about their specific healthcare use, and so I--we will look into what we can provide the committee.

Mr. {Pallone.} All right, I appreciate that. I just wanted to mention, I don't--it is not a question, but I just wanted to mention that in formal responses to the Energy and Commerce Committee and the Senate Finance Committee, governors from 39 states expressed support for CHIP, and urged Congress to extend the program, and noted the role the program plays in providing affordable and comprehensive coverage to children. On July 29, the chairman and ranking members of both Energy and Commerce and Senate Finance sent letters to all 50 governors asking for their input to inform Congress' action on CHIP, and, yeah, the--taken together, the

letters that we received indicated, you know, from the governors, indicated support for extension of CHIP, and outlined a number of suggestions for program improvements that could accompany any funding reauthorization. And we do have that information on the committee's Web site. So I did want to mention that, Mr. Chairman.

And I yield back.

Mr. {Pitts.} Chair thanks the gentleman.

That concludes the questioning from the members. I am sure we will have more we will submit to you in writing. We ask that you please respond promptly. I remind Members that they have--I am sorry? Did you have a follow-up? I am sorry.

Mr. {Griffith.} I had some clean-up questions, Mr. Chairman, but it is up to you. I can submit them in writing or--

Mr. {Pitts.} Well--

Mr. {Griffith.} --however you want to do it.

Mr. {Pitts.} Yeah. Do you object or--go ahead. Mr. Pallone says it is all right.

Mr. {Griffith.} CBO's projections, Ms. Mitchell,

reflect what is effectively a grandfathered scoring provision, which assumes a $5.7 billion expenditure on CHIP in the baseline each year, however, since that is merely a budgetary assumption, is it fair to say that in reality, any additional funding is new funding which, if not offset, we probably ought to offset it, but if not offset, would increase the deficit?

Ms. {Mitchell.} I am not sure that I can answer that question.

Mr. {Griffith.} Okay.

Ms. {Mitchell.} That gets into sort of CBO's score--

Mr. {Griffith.} But in basics, if you don't--

Ms. {Mitchell.} --scoring--

Mr. {Griffith.} If you don't do an offset of something that has been built into the base, if you don't do the offset then you probably have an increase, wouldn't that be correct?

Ms. {Mitchell.} I think the $5.7 billion assumption in CBO sort of complicates this a little bit, so I would defer to them--

Mr. {Griffith.} Okay.

Ms. {Mitchell.} --for sure.

Mr. {Griffith.} I appreciate that.

CHIP was designed for lower-income children, yet today, some middle and even upper-middle-income families have members with CHIP coverage. For example, I note that one state, some enrollees are covered--the children are covered up to 350 percent of the federal poverty level. For a family of four, 350 percent is an income of $83,475, yet the median income in that particular state is $71,637.

So the question becomes, in some states, is CHIP subsidizing the upper-middle-class families in those particular states? Yes, ma'am?

Ms. {Ms. Baumrucker.} I am happy to take that question. So again, as a part of the CHIP Reauthorization Act of 2009, there were provisions that were put into place, into current law, to target the CHIP coverage to the Medicaid-eligible children first, and then also to limit coverage above 300 percent of federal poverty level by reducing the CHIP enhanced match rate to the Medicaid federal matching rate for new states expanding above that 300 percent level. So there was an attempt to ensure that the CHIP dollars were being spent on the lower income--or under 300 percent of FPL.

Mr. {Griffith.} And I guess where it gets confusing is the different states have different levels because that number is twice as much as the median income in my district, and so that makes it--that 350 percent of federal poverty level is about twice what the median household income is in my district.

MACPAC, if we find that we are subsidizing the middle-class, do you all think that is appropriate?

Ms. {Schwartz.} The Commission hasn't taken up the question of eligibility levels with within Medicaid--I mean within CHIP. I just would remind the committee that almost 90 percent of the kids now covered by CHIP are below 200 percent of poverty.

Mr. {Griffith.} And obviously, that is a good thing and we appreciate that.

Mr. Chairman, I appreciate your patience, and I yield back.

Mr. {Pitts.} Chair thanks the gentleman.

We have been joined by a gentleman from Texas, Mr. Green. You are recognized 5 minutes for questions.

Mr. {Green.} Thank you, Mr. Chairman, and ranking

member for--and for our witnesses for testifying today.

CHIP has been a critical source of health insurance coverage for millions of low and moderate-income families who cannot access affordable care for their children in the private insurance market. Recent evaluations of CHIP reiterated what we have long known, even when employer-sponsored insurance is offered for children, the affordability of such plans is a major barrier to many families. And I have a district that is an example of that.

There are a number of ways Congress can help to include and strengthen and improve CHIP and children's coverage. For example, my colleague and I, Joe Barton, have legislation that would provide for a 12-month continuous coverage under Medicaid and CHIP--SCHIP, because that would have that continuity. Most health insurance policies are a yearlong. Hopefully, that would be something we consider in the reauthorization.

People rarely lose their Medicaid and CHIP coverage because they become long-term ineligible for the program. Instead, people are often disenrolled due to bureaucratic problems or short change--time changes in income that have no

impact on their long-term eligibility for Medicaid and SCHIP. This disrupts that continuity of care and creates a bureaucratic chaos for hospitals and providers, and ends up costing the healthcare system much more.

While that legislation focuses on people who are removed--or lost their CHIP, the issue of churn exists between Medicaid, SCHIP and the marketplaces. Due to the small changes in income, an individual could switch from being eligible for Medicaid, to being eligible for subsidized coverage in the exchanges. Switching back and forth between insurance coverage can be changing benefits, changing in participating providers, pharmacies, changing out-of-pocket, not to mention administrative paperwork for the state or the insurance companies, and the doctor's office.

One program to help reduce that churn is the Transitional Medical Assistance, or TMA. Dr. Schwartz, I understand that MACPAC has recommended that Congress make TMA permanent, in part because of the churn factor. Can you elaborate?

Ms. {Schwartz.} Yes. MACPAC has recommended making TMA permanent, rather than having to consider it on an annual

basis. The Commission has also recommended and strongly supports policies of 12-month continuous eligibility for both children and adults as a way of minimizing disruptions in care, and also minimizing the bureaucratic aspects of churn.

Mr. {Green.} Okay. Some might say that we have exchanges, we do not need the TMA. I don't believe that because, simply, in Texas we don't have Medicaid expansion, which is, I think, a majority of the states. Why would we still need TMA even with the Affordable Care Act?

Ms. {Schwartz.} MACPAC has looked at that issue, and its recommendation was to make TMA optional in those states that have taken up the expansion for childless adults because that serves to cover that population without having a TMA program. Nonetheless, it stays relevant for those below the exchange eligibility level.

Mr. {Green.} You know, the goal of the SCHIP program is to get the most vulnerable population, and you are right, if a state did expand it, they don't need Medicaid expansion plus SCHIP, and we are not going to--they are not going to have two programs, but they need to be in one or the other. That is important.

Ms. Yocom, in terms of physician access, I understand that you and other researchers have reported that CHIP and Medicaid enrollees experience similar challenges as individuals covered by private insurance. Would you agree that issues with access experienced by families with children in CHIP reflect broader system-wide challenges, rather than problems with CHIP itself?

Ms. {Yocom.} There are certainly issues with access, particularly with mental health, with dental care, and with specialty services. I would agree that those issues that arise in CHIP appear to be similar for the private sector, but more intense for CHIP and for Medicaid.

Mr. {Green.} Ms. Schwartz, I only have a few seconds, but can you discuss the issues that still need to be resolved with regard to network adequacy and access to pediatric services and qualified health plans?

Ms. {Schwartz.} Yes. This is an area which we are looking into to ensure that there--I think there is an assumption that CHIP networks work best for children because it is a child--predominantly a child program. We convened a roundtable earlier this week, bringing together plans,

providers, state officials, federal officials, and beneficiaries, to kind of explore what some of the solutions might be, and you will be hearing more about that from us in the future.

Mr. {Green.} All right.

Mr. Chairman, thank you, and thank you again for having the hearing.

Mr. {Pitts.} Certainly. Thank you.

That concludes the questions from the Members. As I said, Members will have follow-up questions. We ask that you please respond promptly. And I will remind Members that they have 10 business days to submit questions for the record, and Members should submit their questions by the close of business on Wednesday, December 17.

Thank you very much for being here, for your patience, for all the good information. Look forward to working with you.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:13 p.m., the subcommittee was adjourned.]