



June 12, 2017

TO: Members, Subcommittee on Health
FROM: Committee Majority Staff
RE: Hearing: “Examining the Extension of Safety Net Health Programs”

I. INTRODUCTION

On Wednesday, June 14, 2017, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled “Examining the Extension of Safety Net Health Programs.”

II. WITNESSES

- Michael Holmes, Chief Executive Officer, Cook Area Health Services;
- Jami Snyder, Associate Commissioner for Medicaid/SCHIP Services, Health and Human Services Commission, State of Texas; and
- Cindy Mann, Partner, Manatt Health.

III. BACKGROUND

The purpose of this hearing is to examine the extension of funding for two federal safety net health programs that provide health care and coverage for low-income adults and children. Both programs have traditionally enjoyed strong bipartisan support in Congress and shown success in helping eligible low-income adults and children achieve better health outcomes.

A. Community Health Center Fund

Federally Qualified Health Centers (FQHCs) are community-based, patient-centered organizations that provide comprehensive health services to medically underserved populations. FQHCs receive higher Medicare and Medicaid reimbursement rates – this payment designation was originally created because FQHCs offer extra supportive services that are generally not reimbursed by insurance. The higher payment rates also help minimize the use of Health Center Program grant funds to subsidize Medicare and Medicaid patients.

The Health Resources and Services Administration’s (HRSA) Health Center Program, authorized under Section 330 of the Public Health Service Act, awards grants, to these outpatient clinics in order to enhance the provision of medical, dental, mental health and other primary care services. These Section 330 grants are used for broad purposes – such as expanding health services, supporting new health centers, hiring more staff, and maintaining/improving facilities.

Grant funds are also used to provide care to uninsured patients. As a condition of receiving a Section 330 grant, a health center is required to provide care to the entire population of their designated service area, regardless of an individuals' ability to pay, through sliding-scale fees determined by income and family size. According to HRSA, in 2015, community health centers employed nearly 190,000 people and served over 24 million patients. One in 13 people nationwide rely on a HRSA-funded health center for their health care needs.

The Health Center Program's annual funding has increased over time. The program is supported by discretionary appropriations and the Community Health Center Fund (CHCF), which is a mandatory multibillion-dollar fund established in the Affordable Care Act (ACA) available from fiscal year (FY) 2011 through FY 2017. The CHCF represents over 70 percent of the Health Center Program's FY 2016 funding, and it has partially supplanted annual discretionary appropriations. CHCF mandatory funding as a total percentage of federal funding for health centers has increased from 40 percent in FY 2011 to 72 percent in FY 2016. In the 114th Congress, H.R. 2, Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), extended the fund, providing \$3.6 billion for each of FY 2016 and FY 2017.

Although health centers leverage a variety of federal programs, receiving a Section 330 grant is invaluable because, in addition to the extra funding, a grant provides access to medical malpractice coverage under Federal Tort Claims Act (FTCA), the 340B Drug Pricing Program, the Vaccines for Children Program, and assistance in provider recruitment and retention through the National Health Service Corps (NHSC). It is important to note that the CHCF also provides mandatory funding for the NHSC program, which offers scholarships and loan repayments to certain health professionals in exchange for providing care in rural and underserved areas for a period of time. This program last received discretionary appropriations in FY 2011. Since that time, CHCF funds have been the sole source of NHSC funding. MACRA provided \$310 million for each of FY 2016 and FY 2017 for the NHSC.

B. The State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but have no health insurance.

SCHIP Financing

SCHIP is jointly financed by the federal government and states, and the states are responsible for administering SCHIP. In FY 2015, 8.4 million children received SCHIP-funded coverage. Spending for FY 2015 totaled \$13.7 billion (\$9.7 billion federal, \$4.0 billion state). State SCHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's. SCHIP's enhanced federal medical assistance percentage (E-FMAP) varies by state, historically ranging from 65 percent to 81 percent, compared to 50 percent to 73 percent for children in Medicaid. Federal SCHIP allotments are provided to states annually, with amounts based on each state's recent SCHIP spending increased by a growth factor. States have two years to spend each allotment, with unspent funds available for redistribution to other states. In addition to redistribution funds, federal SCHIP contingency funds are available to

qualifying states that exhaust their SCHIP allotments. (Unlike Medicaid, federal SCHIP funding is capped. States may exhaust all federal SCHIP funding, although this has not occurred since the enactment of the current allotment structure in the Children's Health Insurance Program Reauthorization Act of 2009.)

How the Affordable Care Act Impacts SCHIP

Section 2101 of the Affordable Care Act increased the SCHIP E-FMAP by 23 percent, from October 1, 2013 through September 30, 2019. Therefore, under current law, for fiscal years through 2019, the SCHIP matching rate ranges from 88 percent to 100 percent. In FY 2017, 12 states have E-FMAPs at 100 percent. However, the ACA did not include additional or extended funding for SCHIP, so Congress had to extend funding in MACRA. Thus, under current law, funding for SCHIP expires September 30, 2017. (If SCHIP funding were not extended, all states would be expected to exhaust their federal SCHIP funds during FY 2018; this includes unspent SCHIP funding from prior years. Four states and the District of Columbia would be projected to exhaust their funds by December 2017.) The ACA also required states to maintain income eligibility levels for SCHIP through September 30, 2019, as a condition for receiving payments under Medicaid (notwithstanding the lack of corresponding federal appropriations for FY 2018 and FY 2019). This provision is often referred to as the "Maintenance of Effort" (MOE) requirement.

SCHIP Eligibility

Under the SCHIP program, the federal government sets basic requirements for SCHIP, but states have the flexibility to design their own version of SCHIP within the federal government's basic framework. As a result, there is significant variation across SCHIP programs. Currently, state upper-income eligibility limits for children range from a low of 175 percent of the federal poverty level (FPL) to a high of 405 percent of FPL. States may also extend SCHIP coverage to pregnant women when certain conditions are met. While individuals who meet Medicaid program criteria (including the criteria for Medicaid-expansion SCHIP programs) are entitled to Medicaid coverage, there is no individual entitlement to coverage in separate SCHIP programs. Similarly, funding is not open-ended.

SCHIP Benefits

Separate SCHIP programs can model their benefits based on specific private insurance plans, a package equivalent to one of those benchmarks, or Secretary-approved coverage. Federal rules require that all separate SCHIP programs cover dental services, well-baby and well-child care (including age-appropriate immunizations), and emergency services.

SCHIP Program Design

SCHIP gives states flexibility to create their programs as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches. For example, some states use a Medicaid-expansion SCHIP program to cover younger or lower-income children and a separate SCHIP program for others. As of January 2016, nine states, including the

District of Columbia, and five territories ran SCHIP as a Medicaid expansion, two states operated separate SCHIP programs, and 40 states operated a combination of programs. When states use a Medicaid-expansion SCHIP program, federal Medicaid rules generally apply. Separate SCHIP programs generally operate under a separate set of federal rules that allow states to design benefit packages that look more like commercial insurance than Medicaid. States may also use separate SCHIP programs in order to charge premiums, to create waiting periods, and to brand and market their SCHIP programs separate from Medicaid.

Because there is no individual entitlement to SCHIP coverage, separate SCHIP programs may generally use strategies to limit enrollment such as waiting periods, which is the length of time that children must be without employer-sponsored insurance before enrolling in SCHIP. Separate SCHIP programs are also permitted to charge premiums and cost sharing, which is generally prohibited for children in Medicaid. Twenty-five separate SCHIP programs require cost sharing for at least some types of services. The most flexible benefit design option for separate SCHIP programs is Secretary-approved coverage, which is the most common approach. Children in Medicaid-expansion SCHIP programs are protected by federal Medicaid benefit requirements and cost-sharing limitations. They are entitled to all of Medicaid's mandatory services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, generally without any enrollee cost sharing.

There are a few additional provisions of law which will also expire under current law that relate to the SCHIP program.

Medicaid and SCHIP Express Lane Option

Under this Medicaid and SCHIP state plan option, states are permitted to rely on a finding from specified Express Lane agencies (e.g., agencies that administer programs such as State Temporary Assistance for Needy Families (TANF), Medicaid, SCHIP, and the Supplemental Nutrition Assistance Program) for (a) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility for Medicaid or SCHIP; (b) eligibility redeterminations for Medicaid or SCHIP; or (c) renewal of eligibility coverage under Medicaid or SCHIP. Express Lane was created by (CHIPRA) in 2009, and was most recently extended in MACRA through September 30, 2017. The Department of Health and Human Services (HHS) Office of the Inspector General has found some modest problems with errors under this program, so this may be an area for some targeted improvement if it is extended.

SCHIP Child Enrollment Contingency Funds

CHIPRA Section 103 established the Child Enrollment Contingency Fund and authorized the fund. The ACA extended it, and MACRA further extended it. If a state's SCHIP allotment for the current year, in addition to any allotment funds carried over from the prior year, is insufficient to cover the projected SCHIP expenditures for the current year, a few different shortfall funding sources are potentially available. These sources include Child Enrollment Contingency Fund payments, redistribution funds, and Medicaid funds. MACRA extended this through September 30, 2017.

SCHIP Qualifying State Option

Certain qualifying states that significantly expanded Medicaid eligibility for children prior to the enactment of SCHIP in 1997 are allowed to use federal SCHIP funding to finance Medicaid expenditures. These states can use their SCHIP allotment funds to fund the difference between the Medicaid and SCHIP matching rates to finance the cost for children above 133 percent of the federal poverty level in Medicaid. The following 11 states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. MACRA extended this through September 30, 2017.

SCHIP Outreach and Enrollment Grants

CHIPRA Section 201 appropriated \$100 million in outreach and enrollment grants for FY 2009 to FY 2013 to be used by eligible entities (e.g., states, local governments, community-based organizations, elementary or secondary schools) to conduct outreach and enrollment efforts that increase the participation of Medicaid and SCHIP-eligible children. Of the total appropriation, 10 percent is directed to a national campaign to improve the enrollment of underserved child populations, and 10 percent is targeted to outreach for Native American children. The remaining 80 percent is distributed among eligible entities for the purpose of conducting outreach campaigns, focusing on rural areas and underserved populations. Grant funds also are targeted at proposals that address cultural and linguistic barriers to enrollment. MACRA Section 303 appropriated \$40 million for FY 2016 and FY 2017 for outreach and enrollment grants.

The Budgetary and Coverage Effects of Extending Federal Funding for SCHIP

One of the important issues the Committee must consider in extending funding for SCHIP is not merely the length of an extension or the policies related to extension, but the federal cost of such a funding extension. A related consideration is which federal health care policies might be appropriate to reduce outlays in a manner to offset the cost of such an extension.

Initial conversations with the Congressional Budget Office (CBO) indicate their estimate of the budgetary effects of a SCHIP funding extension will be very similar to their most recent, previous estimate of extending SCHIP spending. Therefore, it is helpful to better understand CBO's previous score of extending SCHIP funding.

In the 114th Congress, MACRA provided \$39.7 billion in funding for the State Children's Health Insurance Program to extend the program through FY2016 and FY2017. At the time, the CBO and the Joint Committee on Taxation (JCT) estimated that enacting that provision would increase outlays by \$7.0 billion and revenues by \$1.4 billion, for a net cost of \$5.6 billion over the 2015 to 2025 period relative to CBO's baseline.¹

¹ <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr22.pdf>

In the 2015 analysis, CBO explained that the *net cost* for the extension of SCHIP funding in 2015 was substantially less than the *gross amount* of funding for SCHIP. CBO explained there were two reasons for this.

First, pursuant to the rules that govern CBO's baseline, certain expiring programs, such as SCHIP, are assumed to continue in the baseline beyond the scheduled expiration date. In accordance with those rules, CBO's most recent baseline projections reflect the assumption that funding in each year will be equal to a portion of the funding provided for SCHIP in 2017. CBO's estimate of spending under this bill is net of that spending already assumed in the baseline.

Second, the increase in spending for SCHIP would be partially offset by reductions in the net costs of federal subsidies provided for other forms of health insurance, including Medicaid, insurance purchased through the exchanges established under the Affordable Care Act, and employment-based health insurance. Those reductions would occur because most of the people who would receive coverage through SCHIP as a result extending SCHIP funding would otherwise have received coverage from one of those other sources.

The federal government's share of SCHIP expenditures (including both services and administration) is statutorily determined by the E-FMAP rate. This E-FMAP rate is based on a state's Medicaid FMAP rate.² The E-FMAP rate for SCHIP is calculated by reducing the state share under the regular FMAP rate by 30 percent. Statutorily, the E-FMAP (or federal matching rate) has historically ranged from 65 percent to 85 percent for SCHIP.

However, one issue that the Committee may wish to consider is whether or not to retain a provision from the Affordable Care Act which elevated federal SCHIP funding above its historical matching rate in statute. Section 2101 of the Affordable Care Act increased the SCHIP E-FMAP by 23 percentage points, for the period from October 1, 2013, through September 30, 2019. Therefore, under current law, for fiscal years through 2019, the SCHIP matching rate ranges from 88 percent to 100 percent – rather than the range of 65 percent to 85 percent matching rate, which has traditionally characterized the program. As a result, in FY 2017, 12 states have E-FMAPs at 100 percent. While states generally can be expected to welcome additional federal spending for SCHIP, there are at least three important federal concerns the Committee must consider regarding the impact of retaining the ACA E-FMAP for SCHIP.

First, the elevated federal spending upsets the federal-state partnership that has historically characterized a successful SCHIP program. The increased federal spending departs from long-standing precedent in SCHIP by effectively buying-out state contributions to the program. Elevated federal spending makes states more dependent upon federal funding and could also reduce state incentives for robust oversight of their SCHIP programs.

² The FMAP formula compares each state's average per capita income with average U.S. per capita income. The formula provides higher reimbursement to states with lower incomes (with a statutory maximum of 83 percent) and lower reimbursement to states with higher incomes (with a statutory minimum of 50 percent).

A second concern is that the elevated spending would cost federal taxpayers billions of additional dollars, but would result in no significant net increase in the number of children with health coverage. In March of 2016, CBO estimated a policy that would eliminate the E-FMAP for SCHIP.³ In that estimate, CBO estimated that the federal government would save billions of dollars, but CBO did not project that the bill would prompt any change in state rules for benefits or eligibility because current law prohibits states from implementing restrictions on their programs prior to 2020. It is CBO's estimate that extensions during the period in which the maintenance of effort is operative (through FY 2019) do not have a significant net effect on the number of children with insurance or who remain uninsured. In other words, a policy spending billions of additional federal dollars to retain the ACA's E-FMAP for SCHIP would not yield any notable increase on net in the number of children with health coverage.

A third concern with retaining the elevated spending attributable to the ACA E-FMAP is that retaining such a policy would increase the federal cost of extending SCHIP funding. This dynamic could make it more challenging for the Committee to extend SCHIP funding for as long of a period as some may desire because that would increase the cost of a longer extension. Also, retaining the elevated spending increases the scope of federal health care policies that would be needed for the Committee to adopt to reduce overall federal outlays in a manner sufficient to offset the cost of such an extension and not add to the national deficit.

If Congress were to eliminate this ACA policy and return state matching rates for SCHIP to their pre-ACA historic levels, there could be savings relative to CBO's baseline projections of current law. If this policy were advanced, federal savings could be used to offset the cost of extending funding for other federal health care programs, which have enjoyed strong bipartisan support—a number of which are facing the expiration of federal funding this year.

Based on recent conversations with CBO, below are preliminary estimates of options showing the approximate federal budgetary effects of policies extending SCHIP funding. Each estimate shows the net budgetary effect of extending SCHIP funding along with the effect of extending the qualifying state option and express lane eligibility.⁴ These illustrative options do not include the estimated budgetary effects of continuing the three grants programs that were included in MACRA. These grants programs (with the amounts provided in MACRA for a two-year extension) include: (1) funding for outreach and enrollment efforts (\$40 million); (2) funding for combatting childhood obesity (\$10 million); and (3) funding for pediatric quality measures (\$20 million).⁵

Illustrative Options

1. Extending SCHIP funding through FY 2019 years without retaining the ACA E-FMAP bump would have the effect of reducing the deficit by \$2 billion.

³ <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr4725.pdf>

⁴ While these policies examine the net impact to the deficit, absent offsetting policies, as a practical matter, the Committee notes that legislation extending SCHIP funding must be appropriately offset to secure strong bipartisan support in Congress.

⁵ These grants programs have historically enjoyed bipartisan support.

2. Extending SCHIP funding through FY 2021 without retaining the ACA E-FMAP bump would have the effect of reducing the deficit by \$1 billion.
3. Extending SCHIP funding through FY 2019 retaining the ACA E-FMAP bump through 2019 would have the effect of increasing by \$6 billion.
4. Extending SCHIP funding through FY 2021 retaining the ACA E-FMAP bump through 2019 would have the effect of increasing the deficit by \$7 billion.
5. Extending SCHIP funding through FY 2022 as follows:
 - Retain ACA E-FMAP in FY 2018
 - Adopt an 11 percent E-FMAP in FY 2019
 - Return to SCHIP's historic FMAP in FY 2020 to FY 2022This policy would have the effect of increasing the deficit by \$5.2 billion.
6. Extending SCHIP funding through FY 2022 retaining the ACA E-FMAP bump through 2019 would have the effect of increasing the deficit by \$7.2 billion

IV. STAFF CONTACTS

If you have any questions regarding the hearing, please contact Paul Edattel, Josh Trent or Kristen Shatynski of the Committee staff at (202) 225-2927.