

THE FUTURE OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED THIRTEENTH CONGRESS SECOND SESSION

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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, DC.

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.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

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 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:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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I yield the remainder of my time to Rep. _____.

Mr. PITTS. And I yield the remaining time to Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I appreciate you yielding the time. 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 provide 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.

Mr. 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 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.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

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, for having this hearing today, and I very much look forward to making progress toward 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.

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 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 appears at the conclusion of the hearing.]

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 [continuing]. 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.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

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 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 appears at the conclusion of the hearing.]

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.

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

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 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, in 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 XXI 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 CHIP 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 variation across CHIP programs. Currently, 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 in families with income greater than 250 percent of the federal poverty level, fiscal year 2013 administrative data show that CHIP enrollment is concentrated among families with annual incomes 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 a CHIP Medicaid expansion.

CHIP benefit coverage and cost-sharing rules depend on program design. CHIP Medicaid expansions must follow the federal Medicaid rules for benefits and cost sharing, which entitles CHIP en-

rollees to Early Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, effectively eliminating any state-defined limits on the amount, duration, and scope of any benefit listed in Medicaid statute, and exempts the 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 parity 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 resulting in coverage for targeted low-income children that are eligible for the current CHIP program.

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

[The prepared statement of Ms. Baumrucker follows:]



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**Oral Statement of Evelyne P. Baumrucker
Analyst in Health Care Financing
Congressional Research Service**

Before

**House Energy and Commerce Committee, Subcommittee on Health
U.S. House of Representatives**

December 3, 2014

“CHIP: An Overview”

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 am here to provide an overview of the State Children’s Health Insurance Program (CHIP). My colleague, Alison Mitchell, will address CHIP financing and the Patient Protection and Affordable Care Act (ACA) maintenance of effort (MOE) for children.

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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 variation across CHIP programs. Currently, state upper-income eligibility limits for children range from a low of 175% of the federal poverty level to a high of 405% of FPL (in FY2013, 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 in families with annual income greater than 250% FPL, FY2013 administrative data show that CHIP enrollment is concentrated among families with annual income at lower levels. Almost 90% of CHIP child enrollees were in families with annual income at or below 200% FPL.

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

Mr. PITTS. Chair thanks the gentlelady.
Now recognize Ms. Mitchell 5 minutes for an opening statement.

STATEMENT OF ALISON MITCHELL

Ms. MITCHELL. 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 E-FMAP rate, and this is calculated annually and varies according to each state's per capita income.

In fiscal year 2015, the E-FMAP rates range from 65 percent in 13 states, to 82 percent in Mississippi. The ACA included a provision to increase the E-FMAP 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 E-FMAP 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, 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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**Oral Statement of Alison Mitchell
Analyst in Health Care Financing
Congressional Research Service**

Before

**House Energy and Commerce Committee, Subcommittee on Health
U.S. House of Representatives**

December 3, 2014

on

“CHIP Financing and the ACA MOE”

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, my name is Alison Mitchell. I am an Analyst in Health Care Financing with the Congressional Research Service. Thank you for the opportunity to appear before you today to provide an overview of the State Children’s Health Insurance Program (CHIP) financing and the Patient Protection and Affordable Care Act (ACA) maintenance of effort (MOE) for children.

CHIP Financing

The federal government and the states jointly finance CHIP with the federal government paying about 70% of CHIP expenditures. The federal government reimburses states for a portion of every dollar they spend on CHIP up to state-specific limits called allotments.

Federal Matching Rate

The federal matching rate for states’ CHIP expenditures is determined by the enhanced federal medical assistance percentage (E-FMAP) rate, which is calculated annually and varies according to each state’s per capita income. In FY2015, the E-FMAP (or federal matching rate) ranges from 65% (in 13 states) to 82% (in Mississippi).

The ACA included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019. With this 23 percentage point increase, states would be expected to spend through their CHIP allotments faster.

State Allotments

State allotments are the federal funds allocated to each state for the federal share of their CHIP expenditures. Allotments are provided to states annually, but the allotment funds are available to states for two years. This means that even though FY2015 is the last year states receive CHIP allotments, states could still receive federal CHIP funding in FY2016.

There are two formulas for determining state allotments: an even year formula and an odd year formula. In even years, state CHIP allotments are based on each state's previous year allotment, and in odd years, state's allotments are based on each state's previous year spending. Every year, states' CHIP allotments are adjusted for health care inflation and child population growth.

Maintenance of Effort (MOE)

The ACA extended and expanded the MOE provision in the American Recovery and Reinvestment Act. The ACA MOE for children requires states to maintain their eligibility standards, methodologies, and procedures for Medicaid and CHIP children from the date of enactment (which was March 23, 2010) until September 30, 2019.

The MOE for children applies to both Medicaid and CHIP even though federal CHIP funding is not provided after FY2015. The penalty for not complying with any of these MOE provisions is the loss of all federal Medicaid matching funds. Together, these MOE requirements for Medicaid and CHIP impact CHIP Medicaid expansion programs and separate CHIP programs differently.

CHIP Medicaid Expansion Programs

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 state's financing for these children switches from CHIP to Medicaid. This switch would cause the state share of covering these children to increase because the federal matching rate for Medicaid is less than the E-FMAP rate.

Separate CHIP Programs

For separate CHIP programs, only the CHIP-specific provisions of the ACA MOE requirements are applicable. These provisions contain a couple of exceptions to the MOE:

1. states may impose waiting lists or enrollment caps in order to limit CHIP expenditures or
2. after September 1, 2015, states may enroll CHIP-eligible children into 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, in the event that a state's CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen CHIP-eligible children for Medicaid eligibility. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP-eligible children in qualified health plans offered 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. Under these ACA MOE provisions, states are only required to establish procedures to enroll 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.

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 federal CHIP funding is exhausted, CHIP children in CHIP Medicaid expansion programs would continue to receive coverage under the Medicaid program through at least FY2019, due to the ACA MOE. However, coverage of CHIP children in separate CHIP programs, who are not eligible for Medicaid, depends on the availability of qualified health plans that are certified by the Secretary to be “at least comparable” to CHIP in terms of benefits and cost sharing unless states decide to provide state-funded coverage.

This concludes my statement. I would be happy to answer any questions you may have at the appropriate time.

Mr. PITTS. Chair thanks the gentlelady.
Now recognize Ms. Yocom 5 minutes for an opening statement.

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 five 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, 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 were covered by private insurance. However, access to specialty care in 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:]

United States Government Accountability Office



Testimony
Before the Subcommittee on Health,
Committee on Energy and Commerce,
House of Representatives

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CHILDREN'S HEALTH INSURANCE

Cost, Coverage, and Access Considerations for Extending Federal Funding

Statement of Carolyn L. Yocom
Director, Health Care

GAO Highlights

Highlights of GAO-15-268T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses. As such, Congress faces important decisions about the future of CHIP. PPACA extended federal funding for CHIP through fiscal year 2015, and Congress will be deciding whether to act to extend that funding.

States can operate CHIP as a separate program, include CHIP-eligible children in their Medicaid programs, or use a combination of the two approaches. If funding for CHIP runs out after 2015, children in CHIP-funded Medicaid programs will remain in Medicaid. For the 5.3 million children in separate CHIP programs, beginning in October 2015, PPACA requires that if a state's CHIP funding is insufficient to cover all CHIP-eligible children, the state must establish procedures to ensure that they are screened for Medicaid eligibility, and, if not eligible, enroll them in QHPs certified as comparable to CHIP.

This testimony is based on prior work conducted from February 2011 through November 2013, and highlights relevant GAO findings on cost, coverage, and access in CHIP.

View GAO-15-268T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

December 3, 2014

CHILDREN'S HEALTH INSURANCE

Cost, Coverage, and Access Considerations for Extending Federal Funding

What GAO Found

Over the last 17 years, the State Children's Health Insurance Program (CHIP)—a federal-state program that provides coverage to about 8 million low-income children—has played an important role in providing health insurance coverage for children who would otherwise be uninsured. The Patient Protection and Affordable Care Act (PPACA) created alternative coverage options with the establishment of subsidized coverage—through a premium tax credit and cost-sharing subsidies—offered through health insurance exchanges, however, there remain important considerations related to cost, coverage, and access when determining the ongoing need for the CHIP program.

- Cost.** In 2013, GAO found that consumer costs in CHIP plans were lower than under the benchmark plans selected by states as models for the benefits that would be offered by qualified health plans (QHP) through exchanges in 2014. For example, when comparing CHIP plans in five states with separate CHIP programs to state benchmark plans, GAO found that the CHIP plan in the states typically did not require the payment of deductibles, while all five states' benchmark plans did. Similarly, the amount of any applicable cost-sharing was almost always less for CHIP plans and the difference was particularly pronounced for physician visits, prescription drugs, and outpatient therapies. PPACA provisions, which seek to standardize QHP costs and reduce cost-sharing for certain individuals, could narrow the cost gap. GAO's work also suggests that some children transitioning out of CHIP would not be eligible for the premium tax credit because they have a parent with employer-sponsored health coverage that is considered affordable under Internal Revenue Service regulations.
- Coverage.** GAO's prior work from 2013 found that coverage was generally similar in separate CHIP and benchmark plans, though some variation exists. GAO also found that in contrast to CHIP plans where dental benefits are included, in some states, dental coverage is optional through exchanges and may be offered as a stand-alone dental plan. GAO found that families choosing such coverage could face higher costs. Further, in the current landscape of coverage options, many children eligible for CHIP, Medicaid, or the premium tax credit will have different eligibility than their parents, which can create complex scenarios of coverage for families. In 2012, GAO estimated that 21 percent of children eligible for CHIP, Medicaid, or the premium tax credit under PPACA would have different eligibility than their parents.
- Access.** GAO's prior work found that CHIP enrollees generally reported having access to health care at rates comparable to children with private insurance, with some exceptions. In 2013, GAO's analysis of national survey data indicated that CHIP enrollees reported positive responses regarding their ability to obtain care, and the proportion of positive responses was generally comparable to those with Medicaid or with private insurance.

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 State Children's Health Insurance Program (CHIP). Established in 1997, CHIP finances health insurance for over 8 million children whose household incomes are above the threshold for Medicaid eligibility.¹ Since the inception of this joint federal-state program, the percentage of uninsured children nationwide has fallen by half, although the uninsured rate for children varies considerably among states.² Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses. The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) oversees CHIP, while states design, manage, and administer the operations of their individual CHIP programs. States administer CHIP under broad federal requirements, and the programs vary, for example, in the services covered, costs to individuals and families, and eligibility requirements.

Congress faces important decisions about the future of CHIP. Congress has appropriated federal CHIP funding at various times since the creation of the program. Most recently, the Patient Protection and Affordable Care Act (PPACA) appropriated federal CHIP funding through federal fiscal year 2015.³ Congress will decide whether to act to extend funding in the future. In the near term, PPACA requires that, if CHIP funding for a state is insufficient to cover all CHIP-eligible children, beginning in October 2015—the month after which federal funding for CHIP is scheduled to

¹Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of lower-income individuals, including children. Most states' CHIP eligibility levels are between 200 and 300 percent of the federal poverty level (FPL), with the highest eligibility level being 400 percent of the FPL.

²The percent of uninsured children was 13.9 in 1997 and 6.6 percent in the first three months of 2014. See Cohen, R.A., Martinez, M.E. *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2014*. National Center for Health Statistics. (September 2014). Available from: <http://www.cdc.gov/nchs/nhis/releases.htm>.

³Pub. L. No. 111-148, § 10203, 124 Stat. 119, 927 (2010). In this testimony, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), unless otherwise indicated.

end—the state must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility.⁴ If ineligible for Medicaid, children are to be enrolled in a qualified health plan (QHP), which are plans offered by private issuers through health insurance exchanges established as required by PPACA.⁵ While all QHPs must meet certain requirements related to what services are covered and the value of coverage, the QHPs for children transitioning out of CHIP must be certified by the Secretary of HHS as offering benefits and imposing cost-sharing for children in a manner that is at least comparable to the covered services and cost-sharing protections provided under the state's CHIP plan. If the Secretary finds that no exchange plans are comparable to CHIP, states are not required to seamlessly transition children from CHIP to exchange coverage, though families may obtain such coverage on their own. Children transitioning from CHIP to exchange coverage may be eligible for the advance health insurance premium tax credit (referred to as the premium tax credit) and for cost-sharing subsidies established through PPACA to offset the cost of insurance purchased through state exchanges by eligible families.⁶ Over the longer term, PPACA also requires states to maintain eligibility levels for children in CHIP and Medicaid. That requirement ends after fiscal year 2019, which means that under current law, in fiscal year 2020, some states could choose to eliminate their programs even if federal funds were available.

My statement today will draw from past GAO work examining the Medicaid and CHIP programs to identify important issues regarding

⁴Although federal appropriations for the program will end on September 30, 2015, any unexpended amounts allotted to the states in fiscal year 2015 will be available for expenditure through September 30, 2016.

⁵PPACA requires the establishment of health insurance exchanges (referred to as exchanges) in each state—marketplaces where eligible individuals can compare and select among QHPs offered by participating private issuers of health coverage. QHPs provide a package of essential health benefits—including coverage for specific service categories, such as ambulatory care, prescription drugs, and hospitalization.

⁶Eligibility for the premium tax credit is limited to individuals with household incomes between 100 and 400 percent FPL. In addition, to be eligible for the premium tax credit, an individual cannot have access to public insurance such as Medicaid or CHIP (except for a child in a state with insufficient CHIP funds for eligible children) or to affordable employer-sponsored health insurance that provides a minimum value. Eligibility for the cost-sharing subsidies, which aim to reduce out-of-pocket costs for deductibles, co-payments, and other costs, is for individuals and families with household incomes of up through 250 percent FPL.

whether to extend federal funding for CHIP beyond fiscal year 2015. In particular, my remarks will address considerations related to cost, coverage, and access in CHIP.

My statement is based on reports we issued from February 2011 through November 2013.⁷ For this work, to compare costs and coverage for consumers in separate CHIP plans and the benchmark plans that serve as models for QHP benefits,⁸ we reviewed Evidence of Coverage documents from separate CHIP plans and benchmark plans from five states. To describe access to care for children in CHIP compared to others with Medicaid, private insurance, or without insurance, we analyzed nationwide data from HHS's Medical Expenditure Panel Survey (MEPs) from 2007 through 2010. The reports cited in this statement each provide detailed information on our scope and methodology. The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

With CHIP programs, states cover children in families whose household incomes are too high to qualify for Medicaid. Most states' CHIP eligibility levels are between 200 and 300 percent of the federal poverty level (FPL). States typically cover a broad array of services in their CHIP

⁷See GAO, *Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families*, GAO-11-264 (Washington, D.C.: Feb. 4, 2011); *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624 (Washington, D.C.: June 30, 2011); *Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance*, GAO-12-648 (Washington, D.C.: June 22, 2012); and *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, GAO-14-40 (Washington, D.C.: Nov. 21, 2013).

⁸To prepare for the offering of QHPs through exchanges in 2014, HHS asked states to select benchmark health plans—plans intended as models for the benefits that would be offered through QHPs—by December 26, 2012. To offer coverage starting in 2014, individual market and small group market insurance plan issuers were required to offer QHPs that were substantially equal to their state's benchmark plan. We compared coverage under CHIP and benchmark plans to establish baseline information.

programs, for example, routine check-ups, immunizations, emergency services, and certain dental services. With respect to costs to consumers, CHIP premiums and cost-sharing may not exceed minimum amounts as defined by law. States may vary CHIP premiums and cost-sharing based on income and family size, as long as cost-sharing for higher-income children is not lower than for lower-income children. Federal laws and regulations also impose additional limits on premiums and cost-sharing for children in families with incomes at or below 150 percent FPL. In all cases, no cost-sharing can be required for preventive services—defined as well-baby and well-child care, including age-appropriate immunizations and pregnancy-related services. In addition, states may not impose premiums and cost-sharing, in the aggregate, that exceeds 5 percent of a family's total income for the length of the child's eligibility period in CHIP.⁹

States can operate CHIP as a separate program, include CHIP-eligible children in their Medicaid programs (referred to as a CHIP-funded Medicaid expansion), or use a combination of the two approaches. Eligible children in a CHIP-funded Medicaid expansion are entitled to coverage because Medicaid is an entitlement. There is no individual entitlement to coverage under separate CHIP programs. If funding for CHIP runs out after fiscal year 2015, those children enrolled in CHIP-funded Medicaid expansions—2.5 million children across 32 states and the District of Columbia in fiscal year 2013—will remain in Medicaid.¹⁰ For the 5.3 million children across 39 states in separate CHIP programs, PPACA requires that the state must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility and, if determined ineligible for Medicaid, are enrolled into a QHP in an exchange in that state that has been certified by the Secretary of HHS as comparable to CHIP.

⁹This annual cumulative cost-sharing maximum applies to all services with cost-sharing requirements, irrespective of the number of children in the family that are enrolled in CHIP.

¹⁰For children that remain in Medicaid, the state is to receive reimbursement based on the federal matching rate for the state's Medicaid program rather than the CHIP rate, which under PPACA is to increase by 23 percentage points to nearly 100 percent from fiscal years 2016 through 2019. The federal government matches state Medicaid service expenditures based on a statutory formula known as the Federal Medical Assistance Percentage (FMAP). The FMAP depends on each state's per capita income and may range from 50 to 83 percent.

Cost, Coverage, and Access Are Important to Consider in Deciding whether to Extend Federal CHIP Funding

Over the last 17 years, CHIP has played an important role in providing health insurance coverage for low-income children who would otherwise be uninsured. While the introduction of the premium tax credit and cost-sharing subsidies for coverage through health insurance exchanges could provide an alternative coverage option for some of these children, there are important considerations related to cost, coverage, and access when determining the ongoing need for the CHIP program.

Cost considerations

Our prior work suggests that consumer costs under state benchmark plans, which were used as models for QHP benefits, would be higher than in CHIP, due to higher cost sharing and premiums. For example, in 2013, when comparing CHIP plans in five states with separate CHIP programs to state benchmark plans, we found that the CHIP plan in the states we reviewed typically did not include deductibles, while all five states' benchmark plans did.¹¹ Similarly, when cost-sharing applied, the amount was almost always less for CHIP plans, and the cost difference was particularly pronounced for physician visits, prescription drugs, and outpatient therapies.¹² For example, depending on income, the copayment for primary care and specialist physician visits ranged from \$2 to \$10 per visit for one state's CHIP enrollees, but was \$30 and \$50 per visit, respectively, for benchmark plan enrollees. PPACA provisions, which seek to standardize QHP costs and reduce cost-sharing for certain individuals, could narrow the cost gap we identified, but will vary by consumers' income level and plan selection.¹³ Our analysis of premium data also suggested that CHIP premiums were likely lower than benchmark plans, with some enrollees in three states paying no premiums and most enrollees across all five states paying less than \$200 a year. For families that qualify for a premium tax credit, premium contributions for those covered under the QHP will be limited to anywhere from 2 percent to 9.5 percent of the family's annual income; we estimated

¹¹The five states were Colorado, Illinois, Kansas, New York, and Utah. See GAO-14-40.

¹²We have work underway that is examining a comparison of costs and coverage in separate CHIP plans and QHPs in selected states.

¹³Effective January 1, 2014, PPACA provides for cost-sharing subsidies for individuals and families with household incomes up through 250 percent of FPL to reduce out-of-pocket costs for deductibles, co-payments, and other costs.

that in 2014 those premium contributions would range from \$471 to \$8,949 for a family of four.

Further, our work suggests that some children transitioning out of CHIP would not be eligible for the premium tax credit because they have a parent with employer-sponsored health coverage that is considered affordable under Internal Revenue Service (IRS) regulations. With regard to affordability, IRS standards consider the cost of self-only coverage offered by the employer rather than the cost of family coverage. In 2012, we estimated that about a half million uninsured low-income children would be ineligible for the premium tax credit under these IRS standards, because they had access to affordable employer-sponsored coverage.¹⁴ Further, we estimated that without CHIP-funded Medicaid expansion or separate CHIP programs, an additional 1.9 million children who would otherwise be eligible for CHIP would be considered to have access to affordable insurance under the IRS standards for affordability.¹⁵

Coverage considerations

Our prior work suggests that coverage was generally similar in CHIP and benchmark plans, though some variation exists. In 2013, we found that the separate CHIP and benchmark plans we reviewed in five states were generally similar in terms of the services on which they imposed day, visit, or dollar limits.¹⁶ For example, the plans we reviewed were similar in that they typically did not impose any such limits on ambulatory patient services, emergency care, preventive care, or prescription drugs, but commonly did impose limits on outpatient therapies and pediatric dental, vision, and hearing services.¹⁷ One notable difference between CHIP and benchmark plans we reviewed was the frequency by which they limited home- and community-based health care services. While the benchmark plans in four states imposed day or visit limits on these services, only one state's CHIP plan did so.

¹⁴See GAO-12-648.

¹⁵Our analysis did not identify the percentage of these children estimated to be in CHIP-funded Medicaid expansions and separate CHIP programs.

¹⁶See GAO-14-40.

¹⁷One state's CHIP plan specified limits on rehabilitative services received in an inpatient setting, but not the number of days allowed for an inpatient admission.

Another consideration around coverage in CHIP and through exchanges is in coverage of dental services. CHIP covers dental services, but such coverage is optional for families seeking coverage on the exchange in some states. Families obtaining coverage through exchanges are provided a choice with regard to health plans, which may include some that cover pediatric dental and others that do not, along with the option to purchase a stand-alone dental plan. In 2013, before the exchanges were fully in place, we reported that exchange officials in three states told us that some families may face confusion in obtaining the appropriate amount of pediatric dental coverage. Now that exchanges are in place, our ongoing work is obtaining data on the types of plans in which families have enrolled, including stand-alone dental plans. As we found in 2013, a cost consideration for families is that stand-alone dental plans have out-of-pocket maximum costs that are in addition to the QHP maximum costs. For 2014, the out-of-pocket maximum costs for stand-alone dental plans offered in some states' exchanges were \$700 for a plan with one child or \$1,400 for a plan with two or more children. For example, a family with an annual income of \$53,663,¹⁸ that enrolls their two children in a stand-alone dental plan that is in addition to their QHP, would be subject to a total out-of-pocket maximum cost of \$11,800.

In the current landscape of coverage options, many children eligible for CHIP, Medicaid, or the premium tax credit will have different eligibility than their parents, which can create complex scenarios of coverage for families. Eligibility can vary within households because low- to moderate-income adults with household incomes greater than 133 percent of FPL will typically be ineligible for any assistance or will be eligible for the premium tax credit rather than Medicaid or CHIP, while children in some of these households will be eligible instead for Medicaid or CHIP. As one example, a family of three in Oregon could begin the year eligible for Medicaid. If the father gained part-time employment, the household income could increase such that the parents would no longer be eligible for Medicaid but would be eligible for the premium tax credit and cost-sharing subsidies and the child would become eligible for CHIP.

In 2012, we estimated that 21 percent of children eligible for Medicaid, CHIP, or the premium tax credit under PPACA would have different

¹⁸For a family of four in 2014, an annual income of \$53,663 equates to 225 percent of the FPL in the 48 contiguous states and the District of Columbia.

eligibility from their parents as of the beginning of the year, and an additional 9 percent would encounter that situation due to an income fluctuation during the course of the year.¹⁹ This could lead to breaks in children's coverage and, potentially, negative implications for health outcomes given the strong association between a parent's and a child's health insurance status. For example, in 2011, we found that children were more likely to be insured when their parents were insured, and that there is a strong association between a parent's health insurance status—whether they are privately insured, publicly insured, or uninsured—and a child's health insurance status.

Access considerations

Our prior work suggests that CHIP enrollees generally reported having access to care at rates comparable to children with private insurance, with some exceptions. In 2013, our analysis of national survey data indicated that CHIP enrollees reported positive responses regarding their ability to obtain care, and the proportion of positive responses was generally comparable to those with Medicaid or with private insurance.²⁰ For example, at least 88 percent of CHIP enrollees reported they had a usual source of care and usually or always got the care they needed. When compared with respondents with other sources of insurance, the proportion of CHIP enrollees with positive responses to these questions were, for most questions, comparable to respondents with Medicaid or with private insurance—that is, within 5 percentage points. In addition, in 2011, we found that most physicians were enrolled in Medicaid and CHIP and serving children covered by these programs. On the basis of our 2010 national survey of physicians, we estimated 78 percent of primary and specialty care physicians were enrolled as Medicaid and CHIP providers and serving children covered by these programs.²¹

Access to specialty care in CHIP may be more limited than in private insurance. In analyzing national survey data in 2013, we found that the proportion of CHIP enrollees with positive responses to the question

¹⁹A child's eligibility for CHIP, Medicaid, and the premium tax credit can change over time as his or her household income fluctuates. For example, a child who begins the year eligible for the premium tax credit may become eligible for CHIP if household income declines during the year. See GAO-12-648.

²⁰See GAO-14-40.

²¹See GAO-11-624.

about the ability to obtain specialty care was roughly comparable to respondents with private insurance.²² However, in 2011, we found that the physicians we surveyed experienced much greater difficulty referring children in Medicaid and CHIP to specialty care, compared to privately insured children. We also found that the percentage of specialty care physicians who accepted all new children with private insurance was about 30 percent higher than the percentage of those who accepted all children in Medicaid and CHIP.

The findings of our 2011 and 2013 studies predated the introduction of QHPs sold through exchanges. As such, little is known about the comparability of provider networks for CHIP versus QHPs purchased through exchanges and the effects on access to care. Knowing more about the potential differences in provider networks is important for understanding the possible disruptions in care that could lead to negative health outcomes for children moving from CHIP to QHPs.

In conclusion, Congress, HHS, and the states will be faced with making important decisions regarding the future of CHIP. In the short term, Congress will be deciding whether to extend federal funding for CHIP beyond fiscal year 2015. In the longer term, states and Congress will face decisions about the role of CHIP in covering children once states are no longer required to maintain eligibility standards in fiscal 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 that you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Susan Barnidge, Assistant Director; Priyanka Sethi Bansal; Sandra George; Drew Long; and Rachel Svoboda were key contributors to this statement.

²²About 81 percent of CHIP enrollees responded positively to the question about the ability to obtain specialty care compared to 87 percent of respondents with private insurance. We considered responses to be comparable if they were within 5 percentage points.

Related GAO Products

Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance. GAO-14-40. Washington, D.C.: November 21, 2013.

Medicaid and CHIP: Considerations for Express Lane Eligibility. GAO-13-178R. Washington, D.C.: December 5, 2012.

Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance. GAO-12-648. Washington, D.C.: June 22, 2012.

Pre-Existing Condition Insurance Plan: Comparison of Implementation and Early Enrollment with the Children's Health Insurance Program. GAO-12-62R. Washington, D.C.: November 10, 2011.

Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care. GAO-11-624. Washington, D.C.: June 30, 2011.

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Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs. GAO-10-258R. Washington, D.C.: January 19, 2010.

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Mr. PITTS. Chair thanks the gentlelady.
Now recognizes Dr. Schwartz 5 minutes for an opening statement.

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 in 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. It 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 appeared 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 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 policies 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:]



Statement of

Anne L. Schwartz, Ph.D., Executive Director

Medicaid and CHIP Payment and Access Commission

Before the

House Committee on Energy and Commerce

Subcommittee on Health

December 3, 2014

Summary

Since its enactment with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health care for tens of millions of low- and moderate-income children with incomes just above Medicaid eligibility levels. Lessons learned from CHIP should continue to inform public policy even as changes in coverage options dictate a re-examination of its role and purpose.

In its June 2014 report to the Congress, MACPAC recommended that the Congress extend federal CHIP funding for a transition period of two additional years during which time the 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 states after fiscal year 2015. It 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.

When the Commission made this recommendation, it noted that there was insufficient time between then and the end of FY 2015 to address all these issues, either in law or regulation. Under current law, states will run out of CHIP funding at various points during FY 2016 with more than half of states exhausting funds in the first two quarters. In the absence of federal CHIP funding, states with Medicaid-expansion CHIP programs must maintain their 2010 eligibility levels for children through FY 2019 at their regular Medicaid matching rate, meaning at increased state costs. States operating separate CHIP programs are not obligated to continue funding their programs if federal CHIP funding is exhausted and will most likely terminate such coverage.

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 under CHIP. In addition, congressional action is required so that states do not respond to uncertainty around CHIP's future by implementing policies that reduce children's access to services that support their healthy growth and development. Finally, MACPAC has stated that this transition period could be extended if the problems it has identified have not been addressed within that two-year period.

Statement of Anne L. Schwartz, Ph.D., Executive Director**Medicaid and CHIP Payment and Access Commission**

Good morning Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee on Health. I am Anne Schwartz, executive director of the Medicaid and CHIP Payment and Access Commission (MACPAC). 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 (HHS), 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 (GAO). While the insights and expertise I will share this morning build on the analyses conducted by MACPAC's 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 the State Children's Health Insurance Program (CHIP).

Since its enactment with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health care for tens of millions of low-income children with incomes just above Medicaid eligibility levels. Over this period, the share of uninsured children in the typical CHIP income range (those with family income above 100 percent but below 200 percent of the federal poverty level (FPL)) has fallen by more than half—from 22.8 percent in 1997 to 10.0 percent in 2013 (MACPAC 2014a). Over that time period, which included two recessions, private coverage for children in this income range also declined substantially—from 55 percent in 1997 to 27.1 percent in 2013 (Martinez and Cohen 2013, 2012).¹

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 since 1997. Subsidized exchange plans now potentially offer an alternative source of coverage to some children now covered by CHIP. Other policy changes included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) may also lead to additional enrollment of parents of those covered by CHIP in employer-sponsored coverage.

In addition to considering CHIP's future from the perspective of low-income children and families, the Commission has also examined issues in CHIP financing—in particular, how states will be affected if federal CHIP funding ends. MACPAC's most recent analyses focus on when, absent congressional action, states will run out of CHIP funds and how the requirement that states maintain coverage for children through FY 2019 will differentially affect states based on their decisions to run CHIP as a Medicaid expansion or a separate program.

In my testimony today, I will first present the rationale behind the recommendation, reached unanimously by Commission members, that CHIP funding be extended two years, as well as the evidence they considered in making that recommendation. I will then turn to financing issues.

Rationale for the Recommendation to Continue CHIP Funding for Two Years

In its June 2014 report to the Congress, MACPAC recommended that the Congress extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

The Congressional Budget Office (CBO) estimates that MACPAC's recommendation would increase net federal spending by \$0–5 billion above the agency's current law baseline. The federal costs of providing CHIP allotments for two more years would be largely offset by reductions in federal spending for Medicaid and subsidized exchange coverage—sources of federally subsidized coverage in which many children are assumed to enroll if CHIP funding were to be exhausted under current law. CBO's estimate also reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2015 at \$5.7 billion each year.²

In coming to this consensus recommendation, the Commission considered several options as it examined the role of CHIP given new coverage options for low-income families. The Commission considered what would happen under the current-law scenario, under which states would exhaust CHIP funding as FY 2016 begins. It found that many children now served by the program would not have a smooth transition to another source of coverage offering comparable benefits and cost sharing. The number of uninsured children would likely rise, and the cost sharing for children obtaining other coverage would often be significantly higher. Moreover, in the Commission's view, it is not clear that exchange plans are ready to serve as an adequate alternative for children now insured by CHIP in terms of covered benefits and provider networks.

The Commission also considered extending CHIP funding through FY 2019, consistent with the current law requirement that states maintain eligibility for children under Medicaid and CHIP through FY 2019. In addition to aligning coverage and financing policies, this approach would allow for completion and consideration of the Secretary's assessment of the comparability of CHIP and exchange coverage in terms of benefits and cost sharing, which I will discuss more in a moment.

Without question, CHIP has reduced the number of uninsured children, and lessons learned from that experience should continue to inform public policy. But the ACA transformed the policy context for CHIP such that CHIP-funded coverage now represents a small wedge among coverage options, potentially adding complexity for families and administrative costs for the states and the federal government. Thus, in the Commission's view, coverage for children under a separate CHIP authority should not be maintained indefinitely. The optimal outcome for children and families is to address affordability and adequacy so that low- and moderate-income children have affordable coverage that offers access to high-quality care, services that are critical to children's healthy development. They should also have smooth transitions to other sources of coverage, including Medicaid, exchange, and employer-sponsored coverage, as their family circumstances change.

When the Commission made this recommendation this past June, it noted that there was insufficient time between then and the end of FY 2015 to address all these issues, either in law or regulation. A time-limited extension of CHIP funding is needed to minimize coverage disruptions and provide for a thorough examination of the coverage options for children. The members of the Commission believe that these limitations must be addressed so as not to step backward from the relatively high level of good coverage children now have through CHIP.

MACPAC has stated that this transition period could be extended if the problems it has identified have not been addressed within the two-year period. However, the Commission also stated in the June report its view that the changes necessary to ensure that children have access to high-quality coverage can be accomplished during these two years.

Below, I describe in greater detail the Commission's three major concerns about an abrupt end to CHIP.

- The number of uninsured children would increase significantly. Not all children currently covered by CHIP would be eligible for subsidized exchange coverage. Among those whose

parents are enrolled in or who are eligible for employer-sponsored insurance, premiums for family coverage could be too high relative to families' ability to pay.

- Cost sharing for services would increase substantially for many families.
- It is unclear whether exchange plans are ready to serve as an adequate source of coverage (in terms of benefits and adequacy of provider networks) relative to CHIP.

Future Sources of Coverage for Children Now Enrolled in CHIP

If CHIP funding ends, the children now covered by the program will face different scenarios based on family circumstances (for example, whether a parent has access to employer-sponsored coverage) and the historical choices made by states to run their CHIP program as a Medicaid expansion or separate CHIP program.

Children in Medicaid-expansion CHIP programs. Of the 8.1 million children enrolled in CHIP in FY 2013, 30 percent were in Medicaid-expansion CHIP. Medicaid-expansion CHIP enrollment is expected to increase in part due to the transition in 19 states of children between 100 percent and 133 percent FPL from separate CHIP to Medicaid, so-called stairstep children. States' spending projections indicate that half of CHIP spending in FY 2015 will be for children in Medicaid-expansion CHIP.³ If CHIP funding runs out shortly after FY 2015, consistent with current law, these children would continue in Medicaid coverage but with federal funding from Medicaid at Medicaid's lower matching rate.⁴

Children age 0–18 in separate CHIP programs. Approximately two-thirds of children age 0–18 with CHIP coverage in FY 2013 were in separate CHIP programs. (Appendix Table 1-A-3 in MACPAC's June 2014 report details CHIP enrollment by state.) Separate CHIP programs generally operate under a set of federal rules that allow states to design benefit packages that look more like commercial insurance than Medicaid. States may also charge premiums, institute enrollment caps, create waiting periods, and brand and market their CHIP programs separately from Medicaid.

Although children in separate CHIP programs are generally in the income range to qualify for subsidized exchange coverage, in fact, such coverage is likely to be available to less than half of these children. One analysis estimated that the end of CHIP could lead to as many as 2 million more children becoming uninsured (Kenney et al. 2011).⁵

There are several reasons for this gap. First, children are generally only eligible for subsidized exchange coverage if a parent is not offered affordable employer-sponsored insurance. More than half (56 percent) of children have parents who report having access to employer-sponsored insurance—the vast majority of which would be considered affordable under the ACA definition, therefore disqualifying them from exchange subsidies. The ACA defines employer-sponsored coverage as affordable if an employee's out-of-pocket premiums for self-only coverage would account for no more than 9.5 percent of a family's income. This affordability test is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered.

For families not eligible for Medicaid, nearly all employer-sponsored coverage would be considered affordable based on the ACA's self-only coverage definition. Even at the 90th percentile of premiums for job-based coverage, the self-only premium paid by employees for a family of three at 138 percent FPL would comprise only 8.2 percent of income—still short of the 9.5 percent threshold to qualify for exchange subsidies (MACPAC 2013).⁶

Second, even among those children whose parents are not offered employer-sponsored insurance, and thus could qualify for subsidized exchange coverage, it is not clear how many would enroll due to higher cost sharing and premium payments associated with exchange coverage (MACPAC 2014a).

And finally, while the ACA requires states to develop procedures to automatically transition children from separate CHIP to exchange coverage as CHIP allotments run out (§2105(d)(3)(B) of the Social Security Act (the Act)), it also requires a special certification that sets a high bar for such transitions. By April 1, 2015, the Secretary of the U.S. Department of Health and Human Services (the Secretary) must certify plans that are “at least comparable to” CHIP programs with respect to benefits and cost sharing (§2105(d)(3)(C) of the Act). As I will discuss, while categories of covered benefits in separate CHIP and exchange coverage may be fairly comparable, cost sharing in exchange plans at current subsidy levels does not appear comparable to CHIP. If the Secretary finds that no exchange plans are comparable to CHIP, states are not required to seamlessly transition children from separate CHIP to exchange coverage, although families may obtain subsidized exchange coverage on their own.

MACPAC is currently working to develop projections using more recent data to determine how many children would become uninsured and how many children would enroll in employer-sponsored coverage if CHIP funding were exhausted. The analyses will also assess how changes in

the affordability test would affect the ability of families to obtain exchange subsidies. We look forward to sharing this information with the Congress in our 2015 report.

The Consequences for Children of Moving from CHIP to Exchange Coverage

If CHIP funding ends, those children shifting to exchange coverage are likely to face higher cost sharing, different benefits, and enrollment in plans with different provider networks. MACPAC's June 2014 report highlighted these concerns. Staff are now updating these analyses with more recent information that we anticipate including in the Commission's March 2015 report.

Higher cost sharing. Children moving from separate CHIP programs to exchange coverage would experience higher cost sharing in the form of deductibles, copays, and coinsurance. MACPAC compared the actuarial values of cost sharing in five separate CHIP programs to the actuarial values of exchange plans with cost-sharing reductions. Actuarial values measure the percentage of covered health care expenses that an insurer would pay, on average, for a typical enrollee population. The metal tiers for unsubsidized exchange plans are as follows:

- bronze: actuarial value of 60 percent,
- silver: actuarial value of 70 percent,
- gold: actuarial value of 80 percent, and
- platinum: actuarial value of 90 percent.

Exchange plans in the silver tier are required to provide cost-sharing reductions to qualifying enrollees with incomes below 250 percent FPL. Cost-sharing reductions must increase actuarial values as follows:

- for those with incomes up to 150 percent FPL: actuarial value of 94 percent,
- for those with incomes between 151 and 200 percent FPL: actuarial value of 87 percent, and
- for those with incomes between 201 and 250 percent FPL: actuarial value of 73 percent.

Because the medical benefits in separate CHIP and exchange coverage are largely consistent, the differences in actuarial values between exchange plans and separate CHIP programs in this analysis can largely be attributed to cost sharing.

To estimate actuarial values of separate CHIP programs, MACPAC used detailed cost-sharing information provided in a GAO study on the separate CHIP programs in five states—Colorado,

Illinois, Kansas, New York, and Utah (GAO 2013). To obtain actuarial values for the CHIP cost-sharing structure in these five states, MACPAC used the actuarial value calculator from the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS).⁷

With one exception, all of the states in the study at all income levels have actuarial values in their separate CHIP programs ranging from 97 to 100 percent (MACPAC 2014a). The one exception is for Utah's highest income range in its CHIP program (151 to 200 percent FPL), which has an actuarial value of 90 percent (MACPAC 2014a). Across income eligibility levels, the actuarial values of the five states' CHIP programs are consistently higher than the actuarial values prescribed for exchange plans with cost-sharing reductions. As a result, children moving from separate CHIP programs to exchange coverage would experience greater cost sharing.

Above 250 percent FPL, no cost-sharing reductions are available for exchange plans. Thus, above 250 percent FPL, individuals enrolled in a silver plan would have a 70 percent actuarial value. Above 250 percent FPL, the CHIP actuarial value is 97 percent in Illinois and 100 percent in New York; the other three states do not offer CHIP benefits at this income level (MACPAC 2014a).

Recent reports by the Wakely Consulting Group (Wakely) and the National Alliance to Advance Adolescent Health had similar findings regarding affordability. Wakely found that actuarial values for health plans in all 35 states with separate CHIP programs at both 160 and 210 percent FPL are higher than the actuarial values for the qualified health plans (QHPs) at the same income levels even after accounting for cost-sharing reductions available to lower-income enrollees in the exchanges (Bly et al. 2014).⁸ Researchers at the National Alliance to Advance Adolescent Health reported findings similar to those of the Wakely study, based on their analysis of cost sharing in separate CHIP programs and child-only exchange plans in five states. In general, CHIP programs do not require deductibles or coinsurance, while the child-only exchange plans do (McManus and Fox 2014).

In addition to cost sharing for services, premiums also affect CHIP's affordability. Based on policies in place in January 2013, MACPAC estimates that approximately 44 percent of children covered with CHIP funds (3.4 million) faced premiums in 33 states, including in some Medicaid-expansion states (MACPAC 2014b).

While CHIP and exchange coverage each have a statutory limit on premiums (combined with cost sharing in the case of CHIP) based on family income, neither takes into account the effect of premiums required by the other. In states charging premiums of CHIP enrollees, the combination, or stacking, of both CHIP and exchange premiums could be substantial for families. MACPAC recommended in March 2014 that, in order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums (MACPAC 2014b).

Differences in covered benefits. Exchange plans offer covered benefits that are largely consistent with separate CHIP coverage, but with a few differences. A GAO study comparing separate CHIP programs and essential health benefits (EHB) benchmarks in five states found that most benefit categories were covered in both programs. For example, benefits like inpatient and outpatient mental health services and chronic disease management services were covered in both separate CHIP programs and EHB benchmark plans in all five states. However, outpatient rehabilitative therapies and pediatric hearing services were covered inconsistently in separate CHIP programs and EHB benchmark plans (GAO 2013).⁹ The Wakely report's examination of covered benefits also found that many benefits such as physician services, inpatient services, radiology, and laboratory services are largely consistent between separate CHIP programs and QHPs. Other services—for example, eyeglasses, audiology, and applied behavioral analysis (ABA) services important to children with autism disorders—tend to be offered more often by CHIP programs than by QHPs and with fewer benefit limits. Moreover, coverage of these services is highly variable even among CHIP programs.

CHIP and QHPs also differ in their approach to providing pediatric dental coverage. Separate CHIP programs are required to provide coverage for dental services. Although pediatric oral health is an essential health benefit, exchange plans are not required to cover pediatric oral health benefits if stand-alone dental plans are available in an exchange (§1302(b)(4)(F) of the ACA).¹⁰ Thus some plans cover all 10 EHBs, including pediatric dental services, while others offer a stand-alone dental plan in addition to medical policies that exclude dental benefits.

When dental coverage is only available in an exchange as a stand-alone plan, families would need to purchase separate plans and pay two premiums.¹¹ Moreover, individuals and families are not required to purchase pediatric dental coverage when offered separately (unless required by state law).¹² Stand-alone dental plans may also establish separate cost sharing; in addition, there are no additional

subsidies for this coverage. Questions have been raised about the affordability of pediatric dental coverage and whether people will take up pediatric dental coverage in the absence of the requirement to do so (AAPD et al. 2013).

Network adequacy. The adequacy of provider networks is another key consideration in considering a shift for low- to moderate-income children from CHIP to exchange coverage. It is frequently assumed that CHIP networks are better than Medicaid and QHP networks because many CHIP networks mirror private plan networks or that CHIP networks are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, limited empirical information exists to support or refute this assertion. MACPAC recently held a roundtable discussion with diverse stakeholders including state officials, health plan executives, physicians, and beneficiary advocates to shed light on the extent to which such networks differ and to learn about how exchange plan networks are designed. Other organizations are also studying the composition of networks in different geographic areas and we look forward to examining more empirical information about network design to inform the Commission's deliberations. MACPAC is also exploring whether additional consumer protections might be needed to promote continuity of care and ease a transition from CHIP to other sources of coverage, when such transitions ultimately take place.

State Financing Issues

In addition to examining the future of CHIP from the perspective of children and families, MACPAC has also considered how different policy scenarios will affect states. Federal funding for CHIP is capped and is allotted to states annually based on a methodology that relies on each state's recent CHIP spending. States have two years to spend each allotment. If CHIP funding is allowed to end, the Congress will also have to consider the differential financial impact across states.

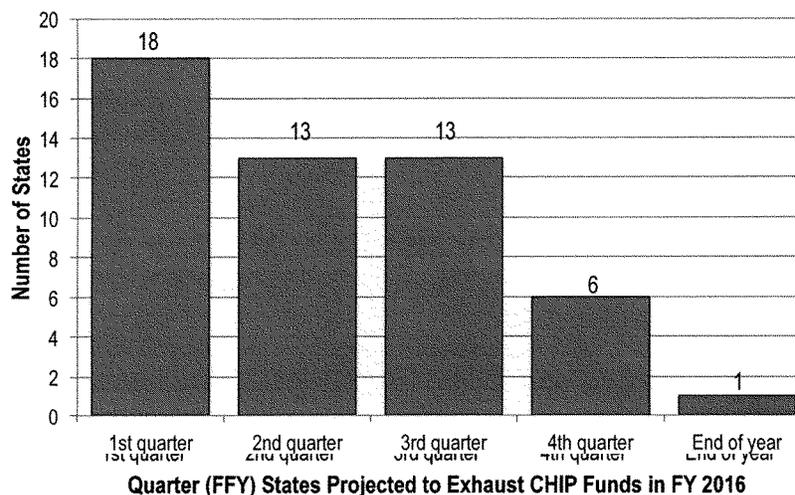
There are no new federal CHIP allotments after FY 2015. Under current law, states will run out of CHIP funding at various points during FY 2016, depending on a number of factors, with more than half of states exhausting funds in the first two quarters of the year (Figure 1).

The primary determinant of when states will exhaust their federal CHIP funds is how much of their FY 2015 allotment remains unspent at the beginning of FY 2016. Various federal policies would also affect when states run out of federal CHIP funds. For example, the ACA increases the federal matching rate for CHIP by 23 percentage points for FY 2016 through FY 2019. This will accelerate

the pace at which states will use any remaining federal CHIP funds in FY 2016. From the state perspective, states' current share of CHIP expenditures ranges by state from 17 to 35 percent; a 23-point increase in the federal share would reduce the state share to a range of 0 to 12 percent—as long as funds are available (MACPAC 2014a).

State policies may also affect when states exhaust their federal CHIP funding. For example, while the ACA's maintenance of effort (MOE) requirement generally prohibits reducing children's eligibility for CHIP, states are permitted to impose enrollment limits "in order to limit expenditures...to those for which Federal financial participation is available" (§2105(d)(3)(A)(iii) of the Act). States may also take other actions to reduce CHIP spending such as allowing CHIP waivers to expire and cutting payments to plans and providers.

Figure 1. States Will Exhaust CHIP Funds at Different Points in FY 2016



Note: FY 2016 spending is FY 2015's plus 5% and reflects 23-point increase in federal matching rate.

Source: Preliminary MACPAC analysis based on state FY 2014–2015 projections as of August 2014 on Form CMS-37.

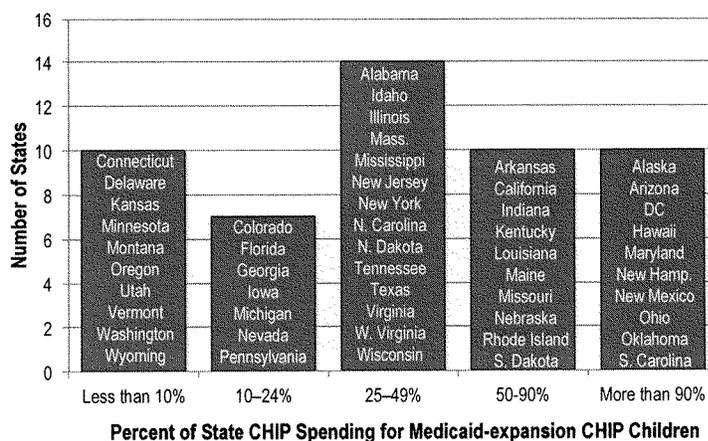
It is important to note that the exhaustion of CHIP funds has different implications for states depending upon whether children are enrolled in a Medicaid-expansion or separate CHIP program. If no new CHIP funds were made available, through FY 2019, states would be required to continue Medicaid-expansion CHIP coverage at their regular federal Medicaid matching rates, which are

significantly lower than those provided under CHIP. Approximately 3 million children enrolled in Medicaid-expansion CHIP would be protected with continued coverage.

Recall, however, that Medicaid's federal funding is open ended. Thus, for states relying on Medicaid expansions, there is no prospect of federal Medicaid funds running out, as with CHIP, but the state contribution would increase. A reduction from the CHIP matching rate—not including the 23-point increase for FY 2016—to Medicaid's traditional matching rate would generally increase state expenditures for those children by 43 percent (MACPAC 2014a).

While Medicaid-expansion CHIP accounts for half of projected CHIP spending nationally, that national number obscures the state variation and thus the differential effects on state budgets once CHIP funding is exhausted. In 10 states, Medicaid-expansion CHIP accounts for more than 90 percent of projected CHIP spending. Thus, once CHIP funding is exhausted, these 10 states must continue coverage at increased state cost for nearly all of their current CHIP population. At the other end of the spectrum, another 10 states have less than 10 percent of CHIP spending attributable to Medicaid expansions and thus would face little increased state spending if services are financed under the regular Medicaid match once CHIP funding is exhausted (Figure 2).

By contrast, states operating separate CHIP programs (now serving over 5 million children) are not subject to the maintenance of effort if CHIP funding is exhausted, and thus would have no legal obligation to continue financing coverage for these children. These states' only federal requirement would be to have procedures to enroll children in exchange plans that are certified as being comparable to CHIP, if available. Thus, states with a separate CHIP program could be released from any state spending and separate CHIP coverage would effectively end. Many of those affected children would become uninsured or face significantly higher cost sharing and potentially different benefits and provider networks in the exchange. For children who would qualify for subsidized exchange coverage if their CHIP coverage were to end, the cost of the subsidy would be entirely federal.

Figure 2. Percentage of States' CHIP Spending for Medicaid Expansions, FY 2015

Source: Preliminary MACPAC analysis based on state FY 2015 projections as of May 2014 on Form CMS-37.

MACPAC's analysis of state financing issues is ongoing. We expect to get new numbers on the final federal allotments later this month. Combined with relatively recent projections from states, we will soon have a clearer picture of how different states will be affected and we intend to share those analyses when complete.

Conclusion

CHIP has clearly played an important role in providing access to health care coverage to millions of low- to moderate-income children who would have otherwise been uninsured. In addition, some of CHIP's design features provided a platform for state innovations to improve take-up of public coverage among eligible but uninsured children. Many states branded their CHIP programs separately from Medicaid and launched targeted outreach and marketing efforts. These strategies increased enrollment of children in both CHIP and Medicaid, further reducing uninsurance rates among children. Outreach and enrollment techniques that often began as experiments in CHIP in individual states were subsequently identified as best practices and, in some cases, are now required in all states for both CHIP and Medicaid.

Even so, changes in the policy environment dictate a re-examination of CHIP's role and purpose. MACPAC has recommended a two-year extension of CHIP to provide the impetus to make the

legislative and regulatory changes necessary to smooth the transition and to make other coverage options work well for children now covered by CHIP. A short-term extension is also more fiscally prudent.

MACPAC's Commissioners urge the Congress act soon to extend CHIP so that states do not respond to uncertainty around CHIP's future by implementing policies that reduce children's access to needed health care services.

Thank you, members of the Subcommittee. I would be happy to answer any questions you may have.

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¹ This decline in private coverage could be the result of multiple factors. It could, for example, reflect a broader decline in the availability of employer-sponsored health insurance for adults and children. It could also reflect a degree of substitution of public coverage for available private coverage, which is frequently referred to as crowd-out. Researchers have struggled to answer the question of whether CHIP eligibility expansions caused crowd-out of private coverage or whether private coverage would have declined anyway, with CHIP preventing children from becoming uninsured.

² The Congressional Budget Office (CBO) makes unique assumptions regarding the future of CHIP, which will affect the projected federal cost of legislative proposals it examines. CBO is required to assume that CHIP and certain other expiring programs continue in perpetuity at the last appropriated level (2 USC 907(b)(2)(A)(i)). However, in order to reduce the long-term federal spending projected by CBO under these assumptions, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was worded so that the last appropriated level for CBO's purposes was \$5.7 billion in FY 2013 rather than the \$17.4 billion actually appropriated for FY 2013. In extending federal CHIP funding by two years, the ACA continued the use of this language so that the last appropriated level for CBO's purposes for CHIP past FY 2015 is \$5.7 billion rather than \$21.1 billion.

³ In FY 2013, at least 19 states reported enrollment of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs: Alabama, Arizona, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming.

⁴ Because the MOE is tied to eligibility policies in place on March 23, 2010, it is not clear whether states that elected to convert much of their population from separate CHIP to Medicaid-expansion coverage, such as California and New Hampshire, would be able to remove those children from Medicaid as CHIP funding is exhausted.

⁵ While ending CHIP would lead to some children being uninsured, the magnitude of the effect depends on a number of factors, many of which are difficult to model with precision. In addition, this estimate was modeled using data from several years ago and does not take into account that some states, most notably California, have transitioned the vast majority of their enrollees from separate CHIP to Medicaid-expansion CHIP coverage.

⁶ While 98 percent of employees who are eligible for their employers' coverage also have access to dependent coverage, that coverage may not be practically affordable.

⁷ MACPAC used the proposed 2015 Actuarial Value Calculator publicly available in February 2014. The calculator draws upon 2010 claims data from Health Intelligence Company, LLC, which is licensed by the Blue Cross and Blue Shield Association. The claims data are from 54 million adults and children in commercial insurance plans, representing group and individual health plans. The calculator determines actuarial values based on enrollees' cost-sharing information and a standard population representing "those likely to be covered in the individual and small group markets in 2014" (Knuth 2013).

⁸ Wakely estimated the AV of CHIP plans with cost sharing requirements using the Federal Actuarial Value Calculator for 2015.

⁹ In the study, the GAO compared the benefit categories offered by separate CHIP programs and the EHB benchmark definition in five states. The list of services available within each category may vary among separate CHIP and EHB benchmark definitions, and therefore coverage of a specific service may vary. EHB benchmark definitions establish a minimum standard that all exchange plans must meet in order to be certified. Issuers can provide additional services or establish higher benefit limits than those established in EHB definitions. When the GAO conducted its analysis, exchange plan details were not available. As a result, actual coverage may vary from the EHB benchmark used for comparison.

¹⁰ Stand-alone dental plans cover dental services only and must meet the state-defined pediatric oral services EHB standard (§1311(b)(2)(B)(ii) of the ACA).

¹¹ Individuals who purchase both separate medical and stand-alone dental plans face premium payments for each policy.

¹² Three states (Kentucky, Nevada, and Washington) require families and individuals to purchase dental coverage for children when it is not embedded within a QHP (Snyder et al. 2014).

Mr. PITTS. Chair thanks the gentlelady. Thanks to 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 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 E-FMAP 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. That's a very big bucket. If CHIP were fully funded, to speak to the 23 percentage point bump, 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 have a continued obligation to provide services for those children under the Medicaid program at their regular Medicaid match, which is lower, in the aggregate, about a 43 percent increase for states because of the difference between the two matching rates. It is different across different states because of the design decisions that they have made, and the extent of their enrollment that is enrolled in Medicaid expansion CHIP versus separate CHIP.

Mr. PITTS. OK. Ms. Baumrucker, there are nearly 270,000 children in Pennsylvania in CHIP. The Affordable Care Act required states to transition CHIP children aged 6 through 18, in families with annual incomes of less than 133 percent federal poverty level, to Medicaid beginning January 1 of this year. This was a big issue for people in my district in Pennsylvania. Nationally, do you know how many hundreds of thousands of children lost their CHIP coverage this year, and were instead enrolled into Medicaid as a result of the Affordable Care Act?

Ms. BAUMRUCKER. There was an estimate—there we go. There was an estimate that was done by the Georgetown Center for Children and Families in August of 2013 that suggested that 21 states were transitioning—were required to transition their separate CHIP program children into CHIP 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. OK. 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 reported 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, which 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 effect, 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 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 mic on, yes.

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 to others on the 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 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 status, 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.

Mr. 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. The survey data that we looked at that surveyed physicians, I believe we combined both Medicaid and CHIP together. In looking at the MEPS 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.

Mr. BURGESS. I will just—I practiced for a number of years in north Texas and my own experience was that it was hard to find specialty physicians, particularly in Medicaid because a larger pro-

portion of my patients—I was an OB/GYN—and a larger proportion of my patients were covered by Medicaid rather than SCHIP 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, 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 the paperwork and the requirements that are involved.

The thing that is always difficult in looking at the program is 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.

Mr. BURGESS. And, of course, it is just anecdotal, but I did hear from physicians who would tell me, OK, 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. 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.

Mr. BURGESS. Right.

Ms. YOCOM. So sometimes that is where some of those limits come in.

Mr. 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, these concerns surfaced, and our analyses primarily relied on GAO's work comparing benefits and cost sharing between separate CHIP programs and benchmarks for the design of exchange benefits.

We are now looking, now that there are real data on premiums, and real data on the benefits being offered by plans, we are trying 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.

Mr. 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 appears at the conclusion of the hearing.]

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 were more likely to be lower in CHIP. 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 who 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.

Mr. 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 separate CHIP 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—

Mr. 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—

Mr. 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 and 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 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 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

progress we have made since the beginning of the program, and cost to taxpayers would go up, since keeping kids in CHIP costs the Federal Government so much less than moving them to an exchange marketplace coverage.

So 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 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. Yes.

Ms. YOCOM [continuing]. Sorry, under the exchanges, and those were vision and dental—

Mrs. CAPPS. Yes.

Ms. YOCOM [continuing]. And some on rehabilitative services, but that was a bit more mixed. There were also CHIP plans that did not have rehabilitative 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 soon. 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 every state will run out by the end of 2016.

On the question of notice requirements, 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 recognizes 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 Investigations 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 began this fall a focused 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 or whether or not you have access to insurance coverage that is affordable, so whether you would 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. OK, 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. I would be happy for you to give me an answer. And I have 20 seconds left.

Ms. YOCOM. OK. No pressure. We did do some work on dental, and it is sort of a good-news, bad-news. The good news is dental coverage and 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. OK?

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 [continuing]. 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 appears at the conclusion of the hearing.]

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. 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 there are 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, OK, 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 chil-

dren 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. Some states have told us that it takes 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 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. OK, 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? Does the flexible benefit design help to control costs and increase outcomes in the program?

Ms. MITCHELL. Medicaid and CHIP are very different from a financial standpoint. They are both mandatory funding. CHIP has 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 E-FMAP rate that states receive for CHIP. In fact, it is—the E-FMAP 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 those two.

Mr. BILIRAKIS. OK, 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 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 attention that the Congress put on finding and enrolling uninsured children in the Medicaid program eligibility limits, and to try and bolster that lower income—those lower-income families over the CHIP 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-error program, an estimated 7 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. OK. Can you talk about some of GAO's Medicaid integrity recommendations, since some states run 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, 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 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 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 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. OK. Yes. 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 at 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. Yes.

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. Yes.

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 [continuing]. 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 [continuing]. 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. Yes.

Mr. MURPHY [continuing]. Because the committee—if funding for the 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 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? OK, 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 coverage—they're 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. OK. Mr. Chairman, I am going to yield back. I was one of the authors 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 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 state emphasized that the CHIP funding expires 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 and state of the children at the time. Therefore, would a compromise be made to continue the CHIP program with a greater financial contribution 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's perspective, increase 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. Yes. Yes.

Ms. SCHWARTZ [continuing]. 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. Yes.

Ms. SCHWARTZ [continuing]. Because of the service level cost sharing.

Mrs. ELLMERS. Yes.

Ms. SCHWARTZ. But that could be—what you suggest could be certainly one approach that we could look at.

Mrs. ELLMERS. OK. Also, as 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? 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.

Ms. SCHWARTZ. OK, 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. Yes.

Ms. SCHWARTZ [continuing]. 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. OK. Ms. Yocom, I have a 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. One of the things that happens with increasing that matching rate is the funds will disappear more quickly—

Mrs. ELLMERS. Yes.

Ms. YOCOM [continuing]. And that could lead to states struggling to continue to cover their—

Mrs. ELLMERS. Yes. But that hasn't necessarily been something that the GAO has already looked into?

Ms. YOCOM. It is not something we have looked at now.

Mrs. ELLMERS. OK. OK, 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. 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 subsidies are not available, that obviously—

Mr. LANCE. Yes.

Ms. SCHWARTZ [continuing]. 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. The savings do come from comparison to the alternative. That 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. Yes.

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, but 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 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 we will look into what we can provide the committee.

Mr. PALLONE. All right, I appreciate that. I just wanted to mention, 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, yes, taken together, the letters that we received 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 [continuing]. However you want to do it.

Mr. PITTS. Yes. 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. OK.

Ms. MITCHELL. That gets into sort of CBO's score—

Mr. GRIFFITH. But in basics, if you don't—

Ms. MITCHELL [continuing]. 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. OK.

Ms. MITCHELL [continuing]. 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. 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 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 to 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 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 term 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. OK. 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 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 en-

rollees 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. There is an assumption that CHIP networks work best for children because it is 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.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

CHIP is an important program that provides health coverage to children who might otherwise go uninsured and it has historically enjoyed bipartisan support. I am especially proud that because of this program, Michigan has one of the lowest rates of uninsured children in the nation. But funding for CHIP is set to end next year, and while I support extending that funding, it is important that we address several questions about the future of the program to ensure we continue to provide care for the nation's most vulnerable kids.

Much has changed in health care since CHIP was created back in 1997. While the rate of children without insurance has declined, health care costs have continued to grow.

In its repeated reauthorizations, the CHIP program has usually been extended in a bipartisan manner. Most recently, however, the Children's Health Insurance Program Reauthorization Act (CHIPRA) in 2009 and the Patient Protection and Affordable Care Act in 2010 made significant changes to the program. The president's health care law reauthorized CHIP through FY2019, but only provided funding for the program through September 30, 2015. This has effectively created a funding cliff raising questions about the future of CHIP.

First, we must consider cost. It's important to understand the cost of extending CHIP coverage and ensure that any additional federal spending is fully offset. CHIP is a good model of a program that provides coverage and flexibility while also providing budget discipline. We need to ensure that this remains the case.

Second, crowd-out must be considered. CHIP was designed to provide coverage for lower-income Americans. There is a legitimate policy concern that, if not properly focused, CHIP coverage may unduly crowd-out private health coverage. It is imperative that CHIP remain a program targeted to those who need it most.

A third area of concern is coverage. My colleagues and I who support extending CHIP funding do so because we believe in high quality, affordable coverage. As Congress considers the interactions between CHIP, employer-provided coverage, Medicaid, and exchange coverage, we need to carefully examine the benefits of different types of coverage. We need to examine what we know about cost, quality, outcomes, access to care, and other critical metrics.

Finally, we must consider the construction of the program. One of the great benefits of the way the CHIP program is designed is that it empowers states. We have heard recently from governors all across the country about the successes of the CHIP program. Michigan currently covers nearly 45,000 children and has provided services to over 300,000 since the program's inception. The Director of Michigan's Department of Community Health recently wrote, "We believe the flexibilities afforded by CHIP have contributed to our success." While states need to be accountable for the federal dollars they spend, we should maintain the CHIP program in a manner that provides states like Michigan with appropriate tools to oversee and operate their programs, enabling them to build upon past success. This means policies that enhance program integrity, state flexibility, and other factors should be a priority.

I want to thank the Congressional Research Service, Government Accountability Office, and Medicaid and CHIP Payment and Access Commission (MACPAC) for their testimony. I look forward to working across the aisle to adopt common-sense policies that keep the CHIP program strong for the future and provide needed coverage to millions of kids.



December 1, 2014

United States House of Representatives
Washington, D.C. 20515

Dear Representative:

As Congress returns to legislative session, **we urge you to enact a four year funding extension for the Children's Health Insurance Program (CHIP) this year.** While the CHIP program was reauthorized through 2019, the funding is currently set to expire in 2015 unless Congress approves its extension thereby continuing health care coverage for our nation's children.

The United States Conference of Catholic Bishops, Catholic Charities USA, and the Catholic Health Association have a long tradition of working toward affordable and accessible health care for all, especially the most vulnerable members of our society, our children. The Catholic community is the largest nongovernmental provider of health care and human services in the nation. We serve those in need in our emergency rooms, hospitals, and clinics, and in our soup kitchens, shelters, and Catholic Charities agencies. One out of six patients in our country is cared for in a Catholic hospital. Our faith and our history call us to provide services, including accessible and affordable health care, to those who need it most and we continue to answer that call.

Since its bipartisan inception in 1997, CHIP has garnered widespread support from both parties and from an overwhelming majority of the nation's governors and state legislatures. CHIP has been a reliable source of coverage for low-income children in working families whose parents earn too much to qualify for Medicaid, but too little to afford private health insurance.

Nearly 90 percent of the over 8 million children enrolled in the CHIP program in 2013 were in families with annual incomes at or below 200 percent of the federal poverty level (\$39,060 for a family of three). If CHIP funding is not renewed, coverage for millions of children will be disrupted and as many as 2 million could become uninsured because employer-sponsored family coverage is unaffordable. We believe CHIP must be extended through the FY 2019 authorization period in order to ensure adequate, affordable coverage and a responsible transition for children to family coverage.

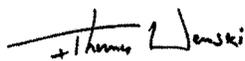
As Catholic organizations united by our common faith and committed to the principles of Catholic social teaching, we recognize and affirm the sanctity of human life from conception to natural death and the inherent dignity of every human being. We consider access to adequate health care to be a basic human right, necessary for the development and maintenance of life and for the ability of human beings to realize the fullness of their dignity. A just society is one that protects and promotes fundamental human rights and dignity, with special attention to meeting

the basic needs of children and the vulnerable, including the need for safe and affordable health care. This is an important moral measure of our society and of this Congress.

We firmly believe that there is no reason why any child in our nation should go without access to health care, a basic right that is critically important to the well-being and development of children. Almost 93 percent of children have health coverage today and these incredible gains are in part because of the role of CHIP in covering millions of children nationwide. Extending funding for the CHIP program gives Congress a great opportunity to ensure a healthy start in the lives of our nation's children.

We urge Congress to take action as it is critical that you provide certainty on the future of the CHIP program *this year*, without delay. If we can be of further assistance on this vital issue, please do not hesitate to contact us.

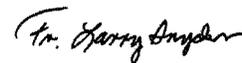
Sincerely,



Most Rev. Thomas G. Wenski
Archbishop of Miami
Chairman, Committee on Domestic
Justice and Human Development
United States Conference of
Catholic Bishops



Sr. Carol Keehan, DC
President and CEO
Catholic Health Association
of the United States



Rev. Larry Snyder
President
Catholic Charities USA

Statement for the Record
House Energy and Commerce Committee
Health Subcommittee Hearing
“The Future of the Children’s Health Insurance Program”
Senator John D. Rockefeller IV
December 3, 2014

Thank you, Chairman Pitts, for holding this important hearing today. I also want to thank Ranking Member Henry Waxman for submitting this statement to the record on my behalf. Congressman Waxman has been a leader in children’s access to health care for more than forty years, including his work to create the program under discussion today.

2014 marks the 17th anniversary of one of the most successful programs for improving children’s health in the United States: the Children’s Health Insurance Program—more commonly referred to as “CHIP.”

Eight million American children and families look to CHIP for comprehensive and affordable health coverage, including 40,000 children in my home state of West Virginia. CHIP’s success has played an essential role in cutting the number of uninsured children in half over the past 15 years.

This kind of progress is something we should celebrate. But, we must continue to invest in CHIP so that we can celebrate many more of the program's milestones.

Without Congressional action, CHIP will run out of funding next fall, placing at risk the well-being of millions of children and pregnant women. I hope that the members of this committee will not let that happen.

CHIP is a game-changer for so many children. No other form of coverage provides the same level of specific care and comprehensive pediatric networks at an affordable cost for working families.

The challenges many children face today are still too similar to the ones I saw firsthand in rural Emmons, West Virginia 50 years ago. It was in Emmons where I witnessed the struggles that families go through when they can't afford health care for their children.

I thought to myself then, as I still do now, that no parent should have to carry the stress of knowing you cannot afford health care for your child if something goes wrong. I'm proud to say that ever since CHIP's inception, the program has consistently enjoyed bipartisan, bicameral support. I am also proud to say, as a former Governor, that the support for the program is, if anything, even

greater in the states.

The letters requested by the Senate Finance and House Energy and Commerce Committees have been overwhelmingly supportive of the Children's Health Insurance Program. This support is reflective of the efficacy and quality of the program in its current form, as well as the vital role it plays at the state level. Without CHIP in its current form, Governors across the country would face not only a significant step backwards in children's health coverage but also unexpected challenges to state budgets.

For as long as I can recall, Congress has been able to put aside its differences and come together when it's called upon to do what's right for America's children. And that time has come again.

CHIP is currently at a crossroads. Funding for CHIP must be reauthorized soon; otherwise, the program as we know it will come to an end. As many as two million children could lose their insurance coverage altogether.

This would threaten their health and well-being, not to mention the significant gains we've made over the past 17 years to reduce the number of uninsured children and youth in this country. We simply cannot afford to take this

major step backwards and jeopardize our future generations by allowing CHIP to expire.

Furthermore, states have been budgeting and planning under the assumption that Congress will extend funding for another four years. They simply are not prepared to rapidly develop and implement plans to transition millions of children into other forms of coverage. In short, state legislatures and budget offices are relying on us to act now.

As I said in September when I chaired a hearing in the Senate Finance Committee about the future of CHIP – today's hearing is an opportunity to show the American people that Congress is committed to the health and well-being of our youngest generation by extending the Children's Health Insurance Program.

March of Dimes Foundation
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**Statement Submitted for the Hearing Record
by the March of Dimes**

**Committee on Energy and Commerce
Subcommittee on Health**

***The Future of the Children's Health Insurance Program*
Wednesday, December 3, 2014**

The March of Dimes, a unique partnership of scientists, clinicians, parents, members of the business community and other volunteers affiliated with chapters in every state, the District of Columbia and Puerto Rico, appreciates this opportunity to submit testimony expressing our strong support for the Children's Health Insurance Program (CHIP) and efforts to extend CHIP funding until at least 2019. As an organization committed to the health and wellbeing of women, infants, children, and families, the March of Dimes considers CHIP to be a vital source of health care coverage for children and pregnant women.

CHIP is a critical safety net program for children and pregnant women who earn too much to be eligible for the Medicaid program, but struggle to afford purchasing health coverage in the private market. CHIP was originally established in 1997 as a federal-state health insurance program; since then it has proven to be a key tool for states' mission to increase the rate of insurance coverage among children and thereby improve child health. The program is designed as a block grant, offering states broad flexibility to set their own eligibility, benefits, and enrollment criteria. The CHIP federal match rate for the states is higher than Medicaid's, averaging 70%, giving states an additional incentive to make a comparatively modest investment of state dollars.

Coverage for Children

Through the combination of CHIP and Medicaid, states have been able to reduce substantially the number of uninsured children in our nation. In fact, since Congress created CHIP, the number of uninsured children has fallen by half—from 14% in 1997 to



7% in 2012¹—and the population of uninsured children now stands at just over seven million. In 2013, CHIP provided health coverage for eight million children. CHIP provides families with access to affordable care for their children with low cost-sharing, given that out-of-pocket costs are capped at a maximum of 5% of income. In fact, many states impose no cost-sharing or premiums at all. CHIP's benefit package is uniquely designed to meet the needs of children, including pediatric dental and vision care, hearing and habilitative services, and more. States have also been given the flexibility to adapt their CHIP programs over time to respond to specific health issues as they arise. Children enrolled in CHIP are able to access a full range of primary, specialty, and pediatric providers who provide developmentally-appropriate care. In sum, CHIP's comprehensive coverage offers children the care they need when they need it most, improving their health and offering families peace of mind.

Coverage for Pregnant Women

While CHIP's importance for children is widely known, its coverage of pregnant women is also essential. While all states use CHIP funding to offer coverage to children, 18 states also provide access to care for pregnant women through their CHIP programs. Each year, approximately 370,000 pregnant women receive coverage through CHIP.² CHIP's affordable coverage effectively removes barriers to pregnancy services and prenatal care. It is also important to note that since CHIP does not restrict its enrollment period, it provides a vital opportunity for many uninsured pregnant women to obtain coverage outside of an open enrollment period. Research by the March of Dimes and others has demonstrated that access to health care services for women across the income spectrum has a significant positive effect, helping ensure healthier pregnancies, healthier deliveries, and healthier babies. Women who receive prenatal care are more likely to have access to preventive services, such as screening and diagnostic tests; services to manage developing and existing health issues; and education, counseling and referral to reduce high risk behaviors like poor nutrition or substance abuse. Financial barriers, including uninsurance and underinsurance, are major reasons women do not receive adequate prenatal care,³ and CHIP provides a critical pathway for accessing prenatal care for pregnant women. Further, access to early prenatal care is associated with reduced birth complications among high-risk pregnancies, which ultimately saves money due to reduced hospital and NICU admissions among infants.^{4,5}

¹ Rudowitz R, Artiga S, Arguello R, *Children's Health Coverage: Medicaid, CHIP and the ACA*. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2014) Accessed 9/16/2014 at: <http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicare-chip-and-the-aca>.

² March of Dimes Issue Brief, *CHIP Coverage for Pregnant Women*. 2014.

³ Kitsantas P, Gaffney KF, Cheema J. Life stressors and barriers to timely prenatal care for women with high-risk pregnancies residing in rural and nonrural areas. *Women's Health Issues*. 2012;22(5):e455-60.

⁴ Reece EA, Lequizon G, Silva J, Whiteman V, Smith D. Intensive interventional maternity care reduced infant morbidity and hospital costs. *J Matern Fetal Neonatal Med*. 2002;Mar11(3):204-210.

⁵ Ross MG, Sandhu M, Bernis R, et al. The West Los Angeles preterm birth prevention project II. Cost-effectiveness analysis of high risk pregnancy interventions. *Obstet Gynecol*. 1994;83(4):506-511.

CHIP provides coverage for pregnant women up to at least 185% of the federal poverty level, though most states cover women up to higher income levels.⁶ States have flexibility in the mechanism they choose to offer this coverage to pregnant women, as well as flexibility in designing their benefit packages. Twelve of 18 states who cover pregnant women through CHIP require no copays, premiums, or other cost-sharing. The remaining states only require copayments or premiums for higher-income pregnant women. States may offer either a full scope of comprehensive health care benefits or more limited coverage specific to services that are pregnancy-related—including those services that could result in pregnancy complications if not treated. All 18 of these states cover prescription drug services, and most cover other services such as mental health and emergency care. In addition, nearly all of these states offer a limited period of post-partum transition care.⁷ States like California have seen a significant reduction in statewide preterm birth rates in recent years, and it is thought that their efforts to provide prenatal care through multiple programs, including CHIP, have been an important contributing factor. Again, CHIP plays a key role in states' strategy to ensure healthier babies and mothers.

CHIP Extension

While CHIP's authorization period extends through 2019, the program's funding only extends through September 2015. Congress must act as soon as possible to ensure seamless coverage for families, as well as certainty for states' budget processes. If CHIP funding expires, some children and pregnant women will be able to gain coverage through states' Medicaid expansion programs or the Affordable Care Act Marketplace. But recent projections show that many could be left without any affordable options.⁸ Our nation must not allow the rate of uninsured children to climb again to pre-CHIP levels when we have the tools at our disposal to keep children healthy. CHIP has proven to play a critical role in our nation's effort to provide access to quality, affordable care for children and pregnant women. Given the demonstrated benefit of CHIP for children and pregnant women, the March of Dimes strongly urges Congress to extend funding through 2019.

Once again, the March of Dimes appreciates this opportunity to express our strong support for the Children's Health Insurance Program and efforts to extend funding for it. If we may provide further information or otherwise be of assistance, please contact Cynthia Pellegrini, Senior Vice President for Public Policy and Government Affairs, at our Office of Government Affairs at 202/659-1800.

⁶ March of Dimes Issue Brief, *CHIP Coverage for Pregnant Women*. 2014.

⁷ March of Dimes Issue Brief, *CHIP Coverage for Pregnant Women*. 2014.

⁸ First Focus, *Comparing Affordability and Benefits between CHIP and Qualified Health Plans in 35 States: Which Coverage is Best for Kids?* 2014. <http://firstfocus.net/resources/fact-sheet/comparingaffordability-benefits-chip-qualified-health-plans-35-states-coverage-best-kids/>



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“The Future of Children’s Health Insurance Program”

The U.S. House of Representatives Committee on Energy and Commerce

Subcommittee on Health

December 3, 2014

Submitted for the Hearing Record by the

National Association of Pediatric Nurse Practitioners

Mary L. Chesney, PhD, RN, CPNP, President

Chairman Pitts, Congressman Pallone and distinguished members of the Subcommittee:

On behalf of 7,800 pediatric nurse practitioners (PNPs) committed to providing optimal health care to children, the National Association of Pediatric Nurse Practitioners (NAPNAP) thanks you for holding this important and timely hearing on the future of the Children's Health Insurance Program. We join our colleagues and children's health advocates everywhere in recognizing Congressman Henry Waxman for his years of tireless service and commitment to improving the health of all Americans – particularly the millions of children who have been the beneficiaries of his leadership in creating the CHIP program.

Pediatric nurse practitioners are licensed advanced practice nurses who have enhanced education in pediatric health care and extensive practice and policy experience with both the Medicaid and Children's Health Insurance Program (CHIP). PNPs have been providing quality primary care, specialty, and acute care to children and families for more than 40 years in an extensive range of practice settings such as pediatric offices, schools and hospitals – reaching millions of patients across the country each year. PNPs provide care to newborns, infants, children, adolescents and young adults that includes health and developmental screening, managing acute and chronic conditions, ordering and interpreting diagnostic tests, prescribing medications, administering immunizations, coordinating care across the health care continuum and making referrals to other professionals as appropriate.

PNPs know first-hand how important the CHIP program is to the health of children in our country. CHIP has become a dependable source of coverage for low-income children in working families whose parents earn too much to qualify for Medicaid but too little to afford private health insurance. Since 1997 when CHIP was enacted with strong bipartisan support, it has helped to cut the number of low-income, uninsured children across the country by an amazing 50 percent – from 25 percent in 1997 to 13 percent in 2012 – while improving health outcomes and access to care for children and pregnant women. More than 8 million children across the country were insured through CHIP in 2012 – an all-time high.

The services that CHIP helps to provide are crucial for children's health. Uninsured children are three times more likely than those with insurance to lack needed medication and five times more likely to have an unmet health care need, including significantly lower rates of preventive care. Children enrolled in CHIP have access to a full range of primary, specialty and ancillary pediatric providers, including pediatric nurse practitioners, to ensure they receive comprehensive medically and developmentally appropriate care.

The CHIP program helps to ensure that low-income families have access to affordable care by limiting their out-of-pocket costs to no more than 5 percent of family income. In addition, many states provide children enrolled in CHIP with Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, a strong set of pediatric-specific benefits that provides comprehensive care based on children's unique needs, including appropriate preventive, dental, mental health, and developmental, and specialty services.

As you know, one of the strengths of the CHIP program is a structure that gives states flexibility to design a program that meets the needs of their distinct populations. This design has helped states tackle the costs of uncompensated care while reducing the numbers of uninsured children and pregnant women. The number of children eligible for but not enrolled in Medicaid and CHIP dropped by 18 percent between 2008 and 2011 – thanks largely to flexible state options created by Congress to improve enrollment strategies, such as express lane eligibility and 12-month continuous eligibility, when the CHIP program was last reauthorized in 2009. At the same time, because CHIP is a program devised specifically for children, its benefit design and provider networks are tailored to meet their special needs.

NAPNAP believes that continued federal funding for CHIP is essential to maintain these gains in health care coverage for children. As you are well aware, although Congress has authorized the program itself through federal fiscal year 2019, federal funding for the program will expire on October 1, 2015 unless Congress takes action to extend it. NAPNAP supports the committee's desire to conduct a thorough examination of the CHIP program, its current performance and its direction for the future. However, at a time when states are still adjusting to numerous changes in health care coverage, PNP's believe it is essential that Congress secure the federal government's financial commitment to CHIP as quickly as possible, so that states will be able to operate their programs without disruption.

The timing is crucial: state legislatures will soon convene to begin drafting and enacting their budgets for 2015. If it is unclear whether the federal government will continue to provide adequate resources to sustain the CHIP program, states will face difficult decision on cutting funding from other priorities to pay for CHIP coverage or reducing their children's health coverage. With some state legislatures in regular session only through March, it would be impossible for Congress to conduct a thorough review of the program and approve an extension of funding in time to give states the assurance they need.

Without CHIP, the uninsured rate would increase significantly and the health of children and families would be jeopardized. The Congressional Budget Office recently estimated that 12.7 million children projected to be enrolled in fiscal year 2015 are at risk of losing their CHIP coverage in 2016 if the program is not reauthorized. Likewise, pregnant women enrolled in CHIP could be left without other sources of prenatal care, jeopardizing the health of their newborns.

CHIP typically provides more comprehensive benefits designed to meet children's needs than plans offered in health insurance marketplaces. At least half of the states have chosen as their benchmark the "largest small business plan" primarily designed for adults. In nearly all instances, CHIP is substantially more affordable than current marketplace policies and provides better coverage for children. Finally, the so-called "family glitch" means that families that include as many as 2 million children who would otherwise be eligible will not be able to obtain premium tax credits to purchase affordable marketplace health coverage.

NAPNAP is grateful to Congressmen Pallone and Waxman for introducing the "CHIP Extension and Improvement Act of 2014" (H.R. 5346) to provide a starting point for the committee's deliberations on the future of the CHIP program. We thank Chairman Pitts and Chairman Upton for convening this hearing and for directly soliciting the input of governors and other stakeholders to begin this critically important discussion on finding a bipartisan approach to preserving and improving children's health care by continuing the Children's Health Insurance Program. Pediatric nurse practitioners look forward to working with you and your colleagues to facilitate prompt action to extend funding for the CHIP program as quickly as possible to provide sufficient time for thoughtful discussions about the program's long-term future.

Congress of the United States
Washington, DC 20515

January 8, 2015

Ms. Evelyne Baumrucker
Health Care Financing Analyst
Congressional Research Service
The Library of Congress
Washington, D.C. 20540

Dear Ms. Baumrucker:

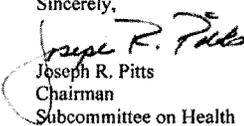
Thank you for appearing before the Subcommittee on Health on Wednesday, December 3, 2014, to testify at the hearing entitled "The Future of the Children's Health Insurance Program."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, January 22, 2015. Your responses should be mailed to Adrianna Simonelli, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Adrianna.Simonelli@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Congress of the United States
Washington, DC 20515

January 8, 2015

Ms. Alison Mitchell
Health Care Financing Analyst
Congressional Research Service
The Library of Congress
Washington, D.C. 20540

Dear Ms. Mitchell:

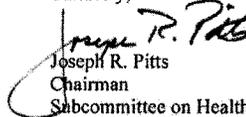
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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment



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MEMORANDUM

January 22, 2015

To: Subcommittee on Health, Committee on Energy and Commerce, House of Representatives
Attention: The Honorable Joseph R. Pitts
The Honorable Frank Pallone, Jr.

From: Evelyne P. Baumrucker, Analyst in Health Care Financing, 7-8913
Alison Mitchell, Analyst in Health Care Financing, 7-0152

Subject: Responses to Questions for the Record from the December 3, 2014 Hearing, "The Future of the Children's Health Insurance Program"

This memorandum was prepared in response to questions for the record from the December 3, 2014 Hearing, "The Future of the Children's Health Insurance Program" before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives. Responses to questions from the Honorable Joseph R. Pitts begin on page 1, and responses to the Honorable Frank Pallone Jr. begin on page 19.

Questions from the Honorable Joseph R. Pitts:

1. To date, two bills have been introduced to extend CHIP – Senator Rockefeller's CHIP Extension Act of 2014 (S. 2461) and Representative Pallone's CHIP Extension and Improvement Act of 2014 (H.R. 5364). Does either of these bills currently include offsets? If they were enacted in their current form, what impact would these bills have on the federal deficit?

Two bills were introduced in the 113th Congress that would have extended the federal funding for CHIP, among other things. Senator John D. Rockefeller introduced the CHIP Extension Act of 2014 (S. 2461) on June 11, 2014, and the CHIP Extension and Improvement Act of 2014 (H.R. 5364) was introduced by Representative Frank Pallone Jr. on July 31, 2014.

Brief Comparison of Bill Provisions

The two bills have a number of comparable provisions that make changes to both Medicaid and CHIP, but each bill has at least a couple of provisions that are not included in the other bill. The following is a brief overview of the provisions in each of the two bills grouped by these topics: CHIP financing, coverage, cost sharing, benefits, pediatric quality measures, and miscellaneous.

CHIP Financing

Both bills would have funded CHIP through FY2019 with the same funding levels and allotment formulas. In addition, both bills would have extended the Child Enrollment Performance Bonus Payments through FY2019, and the bills would have similar but varying mechanisms for providing shortfall funding to states for FY2016 through FY2019.

Coverage

With regard to eligibility, the Senate bill would have extended CHIP eligibility to certain medically frail individuals under the age of 26. Among the coverage-related provisions, both bills addressed the Secretary's benefit comparability review of CHIP and the qualified health plans (QHPs) in the health insurance exchanges, as well as benefit coverage during transitions between Medicaid, CHIP, and QHPs. Both bills had identical provisions that would have modified the Internal Revenue Service rules regarding the ACA's individual mandate so CHIP pregnancy assistance would *not* be considered minimum essential coverage. Both bills would have broadened the Medicaid eligibility requirements for former foster care youth.

With regard to provisions that address outreach and enrollment facilitation, both bills would have eliminated the sunset date for the "Express Lane" eligibility state plan option under Medicaid and CHIP, however, each bill would have extended this state plan option to different populations. Both bills added federal appropriations to the CHIP outreach and enrollment grants for FY2016 and each fiscal year thereafter. Both bills would have added requirements around language and interpretation services in Medicaid and CHIP. While the Senate bill included an increased federal medical assistance percentage (FMAP) rate for language and interpretation services, the House bill did not. In addition, the House bill would have extended the populations for whom 12 months of continuous enrollment in Medicaid would apply and would have eliminated CHIP waiting lists and enrollment caps.

Cost Sharing

With regard to beneficiary cost sharing, both bills made changes to CHIP cost-sharing requirements and the aggregate cap on out-of-pocket costs for an individual or family. The Senate bill made additional changes to Medicaid cost-sharing requirements.

Benefits

Both bills would have added preventive services to the list of mandatory benefits under Medicaid and CHIP, but the details of the preventive services benefit coverage differed. Cost sharing for these preventive services would have been prohibited under both bills for Medicaid, but only the Senate bill prohibited cost sharing for these preventive services under CHIP. The bills made similar (but not identical) modifications to the Vaccines for Children program.

Pediatric Quality Measures

With respect to the pediatric quality measures, both the Senate and House bills would have: 1) extended funding for the pediatric quality measures program broadly; 2) awarded grants and contracts to enhance the pediatric measures program and publish recommended changes to the core set of measures; 3) required additional information in the existing state-specific annual reports; 4) required a report to Congress on child health quality priorities and the convening of an expert advisory panel on child health quality; and 5) extended funding for both the child health quality demonstration program and the childhood obesity demonstration program. The House bill would have made additional changes, including: 1) an enhanced FMAP for the development and modification of systems necessary to collect

and report the child health measures; 2) the provision of technical assistance to states for adopting and using the pediatric quality measures; and 3) a requirement that states report on the full set of pediatric quality measures within five years after enactment.

Miscellaneous

In the miscellaneous provisions, both bills would have extended the Maternal, Infant, and Early Childhood Home Visiting Program through FY2019. The Senate bill included a provision that would have directed the Government Accountability Office (GAO) to conduct an analysis of states that provide Medicaid or CHIP coverage through QHPs or employer-sponsored insurance. The House bill would have extended the increase to Medicaid primary care rates and the Pediatric Accountable Care Organization Demonstration Project. In addition, the House bill would have added therapeutic foster care as a Medicaid covered benefit and modified language around special needs trusts for non-elderly disabled individuals.

Offsets

Neither of the two bills introduced in the 113th Congress included revenue provisions or provisions that would have offset federal collections or receipts. When CHIP was last reauthorized in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), the law included a few revenue provisions. The following is a list of the revenue provisions in CHIPRA.¹

- Increased excise tax rate on tobacco products, such as cigarettes, cigars, tobacco, and cigarette papers and tubes;
- Expanded the scope of penalties for not paying the tobacco-related tax, clarified the statute of limitations, and mandated a study of tobacco smuggling;
- Adjusted the portion of corporate estimated taxes due from July through September 2013; and,
- Made changes to employer-sponsored health insurance coverage that were estimated to affect both on-budget (Medicare) and off-budget (Social Security) payroll taxes.

Impact on Federal Budget

The Congressional Research Service (CRS) is not able to provide a cost estimate of the two bills introduced in the 113th Congress that would extend federal CHIP funding because cost estimates are the purview of the Congressional Budget Office (CBO). There are not any current publicly available CBO cost estimates for the provisions in the two bills. A few of the provisions have previously received a cost estimate from CBO in other contexts, such as when the provision was established or previously extended of provisions. However, these cost estimates should be considered with care for a number of reasons, including the assumptions may have changed since the cost estimates were done; the estimates were conducted prior to the implementation of dynamic scoring, the provisions may not comparable, etc.

While CBO has not estimated the cost of these two bills that would have extended CHIP for four years with a number of programmatic changes to both Medicaid and CHIP, CBO did estimate the cost of a clean

¹ For more information about these provisions, see CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker, Elicia J. Herz, and Jane G. Gravelle and Congressional Budget Office, *Cost Estimate: H.R. 2 Children's Health Insurance Program Reauthorization Act of 2009*, February 11, 2009.

(i.e., no programmatic changes) two year extension of federal CHIP funding for the Medicaid and CHIP Payment and Access Commission (MACPAC). In the estimate for MACPAC, CBO calculated that providing federal CHIP funding for FY2016 and FY2017 would increase net federal spending by \$0 to \$5 billion above CBO's current law baseline as of June 2014. In CBO's estimation, the federal costs of providing federal CHIP funding for two more years would be largely offset by reductions in federal spending for Medicaid and subsidized coverage in the health insurance exchanges.²

CBO's estimate also reflects the rules that govern CBO's baseline projections for expiring programs. For expiring mandatory programs, baseline rules established by the Deficit Control Act call for extrapolating the program's funding for the last six months of its authorization for the remainder of the baseline projection period.³ Under current law, funding for CHIP in FY2015 (the last year CHIP is to receive federal funding) consists of two semiannual allotments of \$2.85 billion—amounts that are much smaller than the allotments made in the four preceding years. The first semiannual allotment in FY2015 will be supplemented by \$15.4 billion in one-time funding for the program. Following the rules prescribed by the Deficit Control Act, CBO extrapolates the \$2.85 billion provided for the second half of the year to arrive at projected annual funding of \$5.7 billion.⁴ Since the baseline projections assume \$5.7 billion in federal CHIP spending for FY2016 and subsequent years within the budget window, CBO's estimated cost of extending federal CHIP funding is lower than it would have been without this assumption.

2. How many CHIP enrollees—either as a percentage or a total number—are from families with income above 200 percent of the federal poverty level (FPL), which equates to about \$47, 700 in annual income for a family of four? As a point of reference, the national median income for 2012 was \$53,046, according to the U.S. Census Bureau.

FY2013 CMS administrative data show that approximately 89% of the 8.4 million CHIP child enrollees were in families with annual income at or below 200% FPL, and approximately 97% of child enrollees were in families with annual income at or below 250% FPL. (See Table 1.)

Table 1. Number of Children in CHIP by Income Level
FY2013

Income Range (% FPL)	Ever Enrolled	Percentage
0-200	7,243,295	88.5%
201 - 250	724,785	8.9%
251 - 300	165,120	2.0%
301 & Higher	51,791	0.6%
Total	8,184,991	100.0%

Source: Centers for Medicare and Medicaid Services, Child Health Insurance Program Budget Report, based on Form 21E and 64.21E Combined, as of April 2014.

Notes: The enrollment figures reported in this response represent "ever enrolled" counts which measure the number of children covered by CHIP for any period of time during a given year. These

² Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014

³ Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2014*, February 2014.

⁴ Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2014*, February 2014.

enrollment counts differ significantly from estimates based on “point-in-time” or average annual enrollment measures.

CMS administrative data are from FY2013 and represent the most recent CMS administrative data available to date.

In FY2013, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$ 23,550, in Alaska \$ 29,440 and in Hawaii \$ 27,090. In FY2014, 200% of the federal poverty level for a family of 4 in the 48 contiguous states was \$47,100, in Alaska \$58,880 and in Hawaii \$54,180. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), *2013 Poverty Guidelines*, available at <http://aspe.hhs.gov/poverty/14poverty.cfm>.

FPL: Federal poverty level.

Title XXI of the Social Security Act (SSA) defines a targeted low-income child as one who is under age 19 with no health insurance,⁵ and who would not have been eligible for Medicaid under the federal and state rules in effect when CHIP was first initiated in 1997.^{6,7} States have broad discretion in setting their income eligibility standards, and eligibility varies across states. In FY2014, statewide upper income eligibility thresholds for CHIP-funded child coverage range from a low of 175% FPL to a high of 405% FPL.^{8,9,10} These thresholds represent the eligibility ceiling for CHIP children. As of January 2014:

- 18 states and the District of Columbia provide coverage above 301% FPL; of these, two states extend coverage above 400% FPL, including New York (405% FPL) and California (416% FPL¹¹ in one county);
- 9 states provide coverage between 251% FPL and 300% FPL;
- 20 states provide coverage between 201% FPL and 250% FPL; and
- 3 states extend coverage at levels less than 200% FPL, including Idaho (190% FPL), North Dakota (175% FPL), and Arizona (100%).¹²

⁵ States are permitted to require a period of uninsurance (i.e., waiting period) of up to 90 days before a child who is otherwise eligible is permitted to enroll in CHIP. See 78 *Federal Register* 42160, July 15, 2013.

⁶ Section 2110(b) of the Social Security Act.

⁷ Children who meet the CHIP eligibility requirements do not always enroll in the CHIP program. The enrollment figures reported in this response represent “ever enrolled” counts which measure the number of children covered by CHIP for any period of time during a given year. These enrollment counts differ significantly from estimates based on “point-in-time” or average annual enrollment measures.

⁸ In FY2014, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$23,850, in Alaska \$29,820 and in Hawaii \$27,430. In FY2014, 200% of the federal poverty level for a family of 4 in the 48 contiguous states was \$47,700, in Alaska \$56,640 and in Hawaii \$54, 860. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), *2014 Poverty Guidelines*, available at <http://aspe.hhs.gov/poverty/14poverty.cfm>.

⁹ Estimates of “real” median household income in 2013, the latest date for which these data are available, are \$51,939. Source: Carmen DeNavas-Walt and Bernadette D. Proctor, U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau; *Income and Poverty in the United States: 2013 Current Population Reports*; September 2014.

¹⁰ FY2014 CHIP upper income eligibility thresholds are from Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP, March 2014*, MACSTATS, Table 9.

¹¹ Most counties in California are in the state’s CHIP Medicaid expansion program which extends coverage up to 266% FPL. However, the state had a separate CHIP program that extended CHIP coverage up to 321% FPL in three counties, and up to 416% FPL in one county. During FY2013, children in the state’s separate CHIP program were transitioned to the state’s CHIP Medicaid expansion program.

¹² Federal authority for Arizona’s CHIP program to cover children in families with annual income above 100% FPL expired on January 31, 2014. As a result, children in families with income between 100-133% FPL transitioned to Medicaid effective (continued...)

Despite the fact that 27 states extend CHIP coverage to children in families with annual income greater than or equal to 251% FPL, CMS administrative data shows that CHIP enrollment is concentrated among families with annual income at lower levels.

3. The Affordable Care Act/Obamacare authorized CHIP through fiscal year 2019, but did not include funding for the program beyond 2015 even though the Act required a Maintenance of Effort for the program for these additional four years. Using CBO data, please provide an general sense of the possible increase of federal spending had the Act funded CHIP through fiscal year 2019.

As mentioned in Question #1, CRS is not able to provide a cost estimate of the impact on the federal budget if Congress had provided federal CHIP funding for FY2016 through FY2019 as part of the ACA because it is CBO's purview to provide cost estimates to Congress. Last year, CBO provided MACPAC with an estimate of the cost to provide federal CHIP funding for FY2016 and FY2017, and CBO estimated this clean two year extension would increase net federal spending by \$0–5 billion above CBO's current law baseline as of June 2014. See the response to question #1 for a more detailed explanation of this estimate.

4. Your report titled *State Children's Health Insurance Program: An Overview* indicates that, in fiscal year 2013, approximately 84 percent of separate CHIP program enrollees received coverage under some form of managed care. Please describe the types of managed care arrangements used in CHIP. To what extent are CHIP enrollees covered by managed care plans that also offer coverage in the private market versus plans that predominately cover Medicaid and CHIP population?

A vast majority of CHIP children receive coverage through managed care, and most of these children receive this coverage through comprehensive risk-based managed care as opposed to primary care case management. Of the children receiving coverage through comprehensive risk-based managed care, most of them have coverage through a plan that covers exclusively or primarily public programs such as Medicaid and CHIP.

Types of Managed Care

In general, benefits are made available to CHIP children via two service delivery systems: fee for service or managed care. Under the "fee for service" (FFS) delivery system, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under the "managed care" delivery system, Medicaid enrollees get most or all of their services from an organization under contract with the state. There are two main types of managed care used for CHIP:

(...continued)

January 1, 2014. Children in families with income over 133% FPL were encouraged to apply for coverage through the health insurance exchange where premium subsidies are available for eligible households. While the state's CHIP program to extend coverage for CHIP-eligible children in families with annual income less than 100% FPL remains in effect, enrollment of new children has been frozen since January 1, 2010. As a result of the enrollment freeze, enrollment in Arizona's CHIP program has dropped from 45.8 thousand in January 2010 to approximately 2.3 thousand in February 2014. Source: Tricia Brooks, Martha Heberlein, and Joseph Fu, Georgetown University Health Policy Institute, Center for Children and Families, *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs*, May 2014.

- **Comprehensive risk-based managed care**—states contract with managed care plans to provide a comprehensive package of benefits to certain CHIP enrollees. States usually pay the managed care plans on a capitated basis, which means the states prospectively pay the managed care plans a fixed monthly rate per enrollee to provide or arrange for most health care services.
- **Primary care case management (PCCM)**—states contract with primary care providers to provide case management services to CHIP enrollees. Typically, under PCCM, the primary care provider receives a monthly case management fee per enrollee for coordination of care, but the provider continues to receive fee for service payments for the medical care services utilized by Medicaid enrollees.

A comparison of service delivery systems use in separate CHIP programs and CHIP Medicaid expansion programs from FY2010 showed that risk-based managed care was the predominant service delivery model for both separate CHIP and CHIP Medicaid expansion programs (Table 2). However, comprehensive risk-based managed care was more prevalent in separate CHIP programs than CHIP Medicaid expansion programs. In FY2010, separate CHIP programs used comprehensive risk-based managed care to cover 81% of the CHIP enrollees compared to 57% for CHIP Medicaid expansion programs.¹³ In the same year, PCCM was used to cover a larger percentage of children in CHIP Medicaid expansion programs than in separate CHIP programs with 22% of children in CHIP Medicaid expansion programs covered by PCCM and 5% of children in separate CHIP programs.¹⁴

Table 2. CHIP Enrollment, by Type of Program and Coverage
FY2010

	CHIP Medicaid Expansion Program		Separate CHIP Program		Total	
Comprehensive Risk-Based Managed Care	1,241,441	57%	4,503,711	81%	5,745,152	75%
Primary Care Case Management	450,253	21%	778,354	14%	1,228,607	16%
Fee for Service	474,256	22%	257,708	5%	731,964	9%
Total	2,165,950	100%	5,539,773	100%	7,705,723	100%

Source: Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2011, Table A-2.

An analysis by GAO about Medicaid managed care found a distinct difference between states that used the comprehensive risk-based managed care model as opposed to the PCCM model of managed care. GAO found that, in general, states with comprehensive risk-based managed care coverage had a higher concentration of low-income individuals living in urban areas, while states with greater PCCM coverage and no comprehensive risk-based managed care coverage generally had fewer individuals living in urban areas. GAO theorized that states with low concentration of low-income individuals living in urban areas

¹³ Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid*, June 2012.

¹⁴ *Ibid.*

may face challenges attracting comprehensive risk-based managed care plans due to concerns about establishing adequate provider networks or attracting sufficient enrollment. In addition, GAO found that states with a higher proportion of comprehensive risk-based managed care enrollment also typically had more managed care plans in the private market.¹⁵

Extent Managed Care Plans Offer Coverage in the Private Marketplace

States may design their CHIP programs in three ways: a CHIP Medicaid expansion program, a separate CHIP program, or a combination of both a CHIP Medicaid expansion program and a separate CHIP program. For CHIP Medicaid expansion programs, the CHIP children are covered in the same way as Medicaid children, while CHIP children in separate CHIP programs receive coverage different from children in Medicaid.

A survey of Medicaid programs found that 63% of Medicaid enrollees with comprehensive risk-based managed care coverage received that coverage through a plan that exclusively or primarily serves Medicaid enrollees (also known as a Medicaid-only plan) in FY2011.¹⁶ Of the 36 states that answered this question in the survey, 26 states had both Medicaid-only and mixed (i.e., a plan that serves both commercial and Medicaid populations) plans participating in their Medicaid managed care program. Five states had exclusively Medicaid-only plans and five states had exclusively mixed plans participating in their Medicaid managed care plans.¹⁷ Another study found that as of July 1, 2011, 43% of the comprehensive risk-based managed care plans participating in Medicaid were Medicaid-only plans.¹⁸

There is little information available on the managed care arrangements in separate CHIP programs, and few studies have researched how managed care operates in separate CHIP programs.¹⁹ However, one study researching Medicaid and CHIP managed care in 20 states focused on the types of managed care plans in the seven states in the study with CHIP comprehensive risk-based managed care programs that were part of separate CHIP programs. This study found that 57% of the plans participating in the separate CHIP programs for these seven states were comprehensive risk-based managed care plans that had public program enrollment only in 2010.²⁰

5. How does the current eligibility requirements of CHIP, Medicaid, and Exchange coverage affect whether or not parents and children have the same health coverage? Please provide illustrative examples of situations where a family may have members with different coverage, such as a child in CHIP and a parent with coverage in the Exchange.

¹⁵ Government Accountability Office, *Medicaid: States' use of managed care*, GAO-12-872R, August 17, 2012.

¹⁶ This figure includes total Medicaid enrollment not enrollment in CHIP Medicaid expansion programs. However, the same plans used for Medicaid are used for the CHIP Medicaid expansion programs.

¹⁷ Kathleen Gifford, Vernon K. Smith, and Dyke Snipes, et al., *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2011.

¹⁸ Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2013, Table 16.

¹⁹ Embry M. Howell, Ashley Palmer, and Fiona Adams, *Medicaid and CHIP Risk-Based Managed Care in 20 States*, Urban Institute, Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, July 2012; Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid*, June 2012.

²⁰ *Ibid.*

“Split-family” Coverage: Background

The ACA changed the health insurance coverage landscape through, among other things:

- the expansion of Medicaid up to 133% of the federal poverty level;²¹
- the creation of health insurance exchanges where certain individuals and businesses may purchase private health insurance;
- the creation of federal tax credits which eligible individuals may use towards paying premiums for insurance purchased through the exchanges;²²
- insurance market reforms; and
- the requirement that all individuals have minimum essential coverage whereby most individuals are required to maintain health insurance coverage or otherwise pay a penalty.²³

Within this new coverage landscape, there is the potential to provide a continuous source of subsidized coverage (of one sort or another) for lower-income individuals and families. However, in general, a person may be only eligible for one subsidized health coverage program (i.e., Medicaid, CHIP, or subsidized exchange coverage) at a time. As a result, it is possible for family members in the same household to be eligible for different health coverage programs (e.g., some in Medicaid, some in CHIP, and others in subsidized exchange coverage), and for their coverage to change over time. “Split-family” coverage, as it often called, is a result of different program eligibility requirements that take into account factors such as income, age, residency, disability status, immigration status, family composition, pregnancy status, duration of eligibility, other insurance coverage, and the availability of affordable employer-sponsored insurance for an individual and/or for his (or her) dependents. For example, children may be eligible for Medicaid or CHIP while their parents are not, because of different income eligibility thresholds for adults and children in a given state, or differences in citizenship status (e.g., all citizens, or a mix of citizens and noncitizens and citizens) among family members.

From the family’s perspective, “split family” coverage may mean that different family members will be subject to different plan coverage, provider networks, as well as benefit and cost structures.²⁴ Early work in this area (i.e., before the U. S. Supreme Court’s ruling in *National Federation of Independent Business v. Sebelius*) generated national estimates of the number of Medicaid or CHIP-eligible children with the potential for exchange-eligible parents.²⁵ Later estimates take into account state actions with regard to the

²¹ The ACA established 133% of the federal poverty level (FPL) (effectively 138% of FPL with an income disregard of 5% of FPL) as the new mandatory minimum Medicaid income eligibility level for most non-elderly individuals. On July 28, 2012, the U. S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for adults. For more information on the ACA Medicaid expansion, see CRS report R43564, *The ACA Medicaid Expansion*.

²² For a discussion about the premium credits and cost-sharing subsidies established under ACA, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

²³ For more information about the individual mandate, see CRS Report R41331, *Individual Mandate Under the ACA*.

²⁴ For example, families who are split between CHIP and exchange coverage would be subject to premiums and other cost-sharing associated with both programs. While each program has separate statutory limits on premiums based on family income and CHIP’s cost-sharing protections (i.e., aggregate cost-sharing under CHIP may not exceed 5% of annual family income) also take into consideration service-related cost-sharing, neither takes into account the effect of cost-sharing required by the other. This situation is often referred to as “premium stacking.”

²⁵ “In 2009, there were an estimated 15.7 million children living in this scenario. These children represent nearly 20 percent of all (continued...)”

take up of the ACA Medicaid expansion for non-elderly adults. According to GAO, “In 2012, we estimated that 21 percent of children eligible for Medicaid, CHIP, or the premium tax credit under PPACA would have different eligibility from their parents as of the beginning of the year, and an additional 9 percent would encounter that situation due to an income fluctuation during the course of the year.”²⁶

As per the Committee’s request, we are providing a description of key eligibility requirements across each of the ACA low-income subsidy programs (i.e., Medicaid, CHIP and subsidized exchange coverage), and examples of situations where a family is split across the ACA low-income subsidy programs. This response includes: (1) an example of what eligibility might look like for a family of four²⁷ with annual income at 150% of the federal poverty level based on the applicable eligibility rules across the low-income subsidy programs in 5 states (i.e., California, Louisiana, New Jersey, Pennsylvania, and Texas)²⁸ where *everyone* in the family *is* eligible for one of the ACA low-income subsidy programs in that state, and (2) two scenarios where given family members *do not* meet program eligibility requirements for one or more of the ACA low-income subsidy programs. In the later example, even though these individuals are in a family with annual income within the state’s income eligibility threshold for subsidized coverage—they cannot participate. These examples are not meant to be exhaustive, nor do they necessarily reflect the prevalence of these scenarios. They are intended to illustrate the impact that the program rules across the ACA low-income subsidy programs may have on a family in this income range.

Eligibility

Medicaid Eligibility

Eligibility for Medicaid is determined by both federal and state law, whereby states set individual eligibility criteria within federal standards. Individuals must meet both *categorical* (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain nonelderly childless adults) and *financial* (i.e., income and sometimes assets limits) criteria.²⁹ In addition, individuals need to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. States are permitted to apply to CMS for a waiver of federal law to expand health

(...continued)

U.S. children and more than one-third of Medicaid/CHIP eligible children.” Source: Stacey McMorrow, Genevive M. Kenny, and Christine Coyer, *Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas*; Urban Institute; May 2012.

²⁶ See U.S. Government Accountability Office (GAO); *Opportunities Exist for Improved Access to Affordable Insurance*; June 2012. See also, Carolyn L. Yocum, U.S. Government Accountability Office (GAO); *Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives; Children’s Health Insurance: Cost, Coverage and Access Considerations for Extended Federal Funding*, December 3, 2014.

²⁷ In this example, the family of four includes an infant, a non-disabled 8-year-old child, a pregnant mother and a father.

²⁸ These five states were chosen because their program eligibility policies represent a range of allowable policy options (e.g., decision to take up the ACA Medicaid expansion, diversity of upper income eligibility levels across programs and groups, differences in CHIP program design, differences in eligibility for pregnant women) that result in a diversity of outcomes in terms of the number of low-income subsidy programs that the family might be eligible for.

²⁹ Some groups, such as young people under the age of 26 who have aged out of foster care, are eligible for Medicaid coverage without regard to the youths’ income and assets.

coverage beyond the mandatory and optional groups listed in federal statute.³⁰ Medicaid eligibility must be redetermined at least annually.

If a state participates in Medicaid, the following are examples of groups that *must* be provided Medicaid coverage:

- low-income families that meet the financial requirements (based on family size) of the former Aid to Families with Dependent Children (AFDC) cash assistance program;
- pregnant women and children through age 18 with family income at or below 133% of the federal poverty level (FPL),³¹
- low-income individuals who are age 65 and older, or blind, or who are under age 65 and disabled who qualify for cash assistance under the Supplemental Security Income (SSI) program;
- recipients of adoption assistance and foster care (who are under age 18) under Title IV–E of the Social Security Act;
- certain individuals who age out of foster care, up to age 26, and do not qualify under other mandatory groups noted above; and
- certain groups of legal permanent resident immigrants (e.g., refugees for the first seven years after entry into the United States; asylees for the first seven years after asylum is granted; lawful permanent aliens with 40 quarters of creditable coverage under Social Security; immigrants who are honorably discharged U.S. military veterans) who meet all other financial and categorical Medicaid eligibility requirements.³²

Examples of groups that states *may* provide Medicaid to include:

- pregnant women and infants with family income between 133% and 185% of the FPL;

³⁰Under Section 1115 of the Social Security Act, the Secretary of HHS may waive Medicaid requirements contained in Section 1902 (including, but not limited to, what is known as “freedom of choice” of provider, “comparability” of services, and “statewide-ness”). States use this waiver authority to change eligibility criteria in order to offer coverage to new groups of people, to provide services that are not otherwise covered, to offer different service packages or a combination of services in different parts of the state, to cap program enrollment, and to implement innovative service delivery systems, among other purposes.

³¹The poverty guidelines (also referred to as the federal poverty level) are a version of the federal poverty measure. They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes—for instance, determining financial eligibility for certain federal programs. In FY2014, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$23,850, in Alaska \$29,820 and in Hawaii \$27,430. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), *2014 Poverty Guidelines*, available at <http://aspe.hhs.gov/poverty/14poverty.cfm>.

³²Prior to the enactment of the Children’s Health Insurance Act of 2009, (CHIPRA, P.L. 111-3), legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years in the United States. With the enactment of CHIPRA, states are permitted to waive the five-year bar to Medicaid or CHIP coverage for pregnant women and children who arrived in the United States after August 22, 1996 and who are (1) lawfully residing in the United States and (2) are otherwise eligible for such coverage when certain requirements are met. Twenty-five states have opted to cover otherwise five-year barred children, and 20 states have opted to cover five-year barred pregnant women. Source: Hasstedt, K.; Guttmacher Policy Review; *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*; vol. 16, no. 1; pp 2–8; 2013. For more recent information on state take up of the five-year bar state plan option, see Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates and Robin Rudowitz and Laura Snyder, Kaiser Family Foundation, *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, October 2014.

- certain individuals who qualify for nursing facility or other institutional care and have incomes up to 300% of SSI benefit level, referred to as “the 300 percent rule”;
- “medically needy” individuals who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability, or are in families with children), but do not meet the applicable income requirements and, in some instances, assets requirements for those eligibility pathways;³³
- working people with disabilities, and
- nonelderly adults who otherwise are not eligible for Medicaid with income at or below 133% of FPL (i.e., the ACA Medicaid expansion).

CHIP Eligibility

In general, CHIP extends coverage to certain low-income children and pregnant women without health insurance in families with annual family income too high to qualify them for Medicaid. Specifically, Title XXI of the SSA defines a targeted low-income child as one who is under age 19 with no health insurance,³⁴ and who would not have been eligible for Medicaid under the federal and state rules in effect when CHIP was first initiated in 1997.³⁵ States have broad discretion in setting their income eligibility standards, and eligibility varies across states.

Child Eligibility in CHIP Medicaid Expansion Programs

Because CHIP eligibility builds on top of Medicaid eligibility, the Medicaid child eligibility rules that were in effect when CHIP was established in 1997 represent the Medicaid eligibility ceiling for children.³⁶ States with CHIP Medicaid expansion programs may cover CHIP children by expanding their Medicaid programs in the following ways: (1) by establishing a new optional eligibility group for such children as authorized in Title XXI of SSA, and/or (2) by liberalizing the financial rules for any of several existing Medicaid eligibility categories.³⁷ Regardless of the state’s approach, CHIP children are an optional eligibility group in Medicaid and enrollees must be covered statewide.

Child Eligibility in Separate CHIP Programs

States are permitted to determine the eligibility criteria for the group of CHIP children who may enroll in separate CHIP programs.³⁸ Title XXI of the SSA allows states to use the following factors in determining eligibility: geography (e.g., sub-state areas or statewide), age (e.g., subgroups under 19), income,

³³ For these groups, states are required to allow individuals to spend down to the medically needy income standard by incurring and paying medical expenses.

³⁴ States are permitted to require a period of uninsurance (i.e., waiting period) of up to 90 days before a child who is otherwise eligible is permitted to enroll in CHIP. See 78 *Federal Register* 42160, July 15, 2013.

³⁵ Section 2110(b) of the Social Security Act.

³⁶ Federal Medicaid statute establishes mandatory coverage floors (defined as a percentage of the federal poverty level) for its poverty-related pregnant women and children eligibility groups. States are permitted to extend coverage above these federal minimum thresholds which is why there is variability across states in terms of the income eligibility threshold at which CHIP begins.

³⁷ As of January 1, 2014, states are no longer permitted to expand eligibility standards to higher income levels through the adoption of income disregards. Section 1902(e)(14)(B) of the Social Security Act.

³⁸ Section 2102(b) of the Social Security Act.

residency, disability status (so long as any standard relating to disability status does not restrict eligibility),³⁹ access to or coverage under other health insurance (to establish whether such access/coverage precludes CHIP eligibility),⁴⁰ and duration of CHIP eligibility (states must re-determine eligibility at least annually).⁴¹

States can set the upper income level for CHIP children up to 200% of the federal poverty level (FPL), or 50 percentage points above the applicable pre-CHIP Medicaid income level. However, prior to January 1, 2014, states were able to use income disregards,⁴² which effectively permitted states to expand eligibility to children under age 19 at whatever level they chose. Two states, New Jersey, and New York, plus one California county used this income-counting methodology⁴³ to expand their CHIP programs to 355% FPL, 405% FPL, and 416% FPL, respectively.⁴⁴ The income-disregard option was eliminated under the ACA.⁴⁵ Under the ACA, states are permitted to use CHIP federal matching funds to cover children who lose Medicaid eligibility as a result of the elimination of income disregards,⁴⁶ and the ACA required states to transition CHIP children ages 6 through 18 in families with annual income less than 133% FPL to Medicaid, beginning January 1, 2014—these children are often referred to as “stair step children.”⁴⁷ As a

³⁹ States are permitted to offer different benefit packages for children with special needs, as long as the eligibility criteria for that coverage comply with the Americans with Disabilities Act (ADA) requirements for non-discrimination. Source: *The Administration's Responses to Questions About the State Children's Health Insurance Program*, July 29, 1998, Fifth Set.

⁴⁰ A CHIP child must not be found eligible for Medicaid, or other group health coverage, for example. See 42 C.F.R. §457.310.

⁴¹ States are permitted to continue coverage for CHIP-eligible children for a period of 12 months regardless of changes in family composition or income that may otherwise affect their eligibility status. While no explicit statutory authority for 12 months of continuous coverage currently exists in CHIP statute, HHS reports that 33 states provided 12 months of continuous coverage to CHIP children in FY2012. Source: Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2013.

⁴² Income disregards (including block of income disregards) and deductions effectively increase the amount of income a child's family can have and still be eligible for coverage, as they serve to eliminate from a family's countable income certain expenses, costs or amounts of income.

⁴³ Medicaid and CHIP financial eligibility requirements place limits on the maximum amount of income (and sometimes assets) individuals may possess to become eligible (often referred to as standards or thresholds). Additional guidelines specify how states should calculate these amounts (i.e., counting methodologies).

⁴⁴ Under the State Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), new states (in addition to California, New Jersey, and New York) were discouraged from expanding CHIP income eligibility through a policy that required a reduction in federal CHIP payments for coverage of children in families with income above 300% FPL. CHIPRA also included other provisions to provide financial incentives to states to find and enroll Medicaid eligible children at lower income levels through the use of CHIP Performance Bonus Payments. These payments were directed at states that adopted 5 out of 8 enrollment facilitation strategies and that successfully enrolled Medicaid-eligible children over target enrollment levels. These bonus payments expired at the end of FY2013.

⁴⁵ The ACA required states to transition to a new income counting rule based on the IRS' Modified Adjusted Gross Income (MAGI). Under the transition to MAGI, states were given a limited opportunity to expand CHIP eligibility above 200% of the FPL (not to exceed 300% FPL) using the old income counting rules by submitting a state plan amendment (SPA) before December 31, 2014.

⁴⁶ States must provide coverage through a separate CHIP program to children who lose Medicaid as a result of the elimination of income disregards permitted under Section 2101(f) of the ACA. Coverage for this population will be paid for out of the state's CHIP allotment at the CHIP enhanced match rate and will cease when the last child protected has been afforded 12 months of coverage (expected to be no later than April 1, 2016). While coverage of children protected by 2101(f) is mandated through a separate CHIP program, states may instead continue to provide coverage of these children in the state's Medicaid program. However, if a state chooses the option to maintain Medicaid eligibility for such children, funds through Title XIX of SSA and regular FMAP rates will apply. Sources: Centers for Medicare and Medicaid Services, *Medicaid/CHIP Affordable Care Act Implementation: Children's Health Insurance Program (CHIP) coverage for children who lose Medicaid eligibility due to the elimination of income disregards as a result of the conversion to MAGI. Section 2101(f) of the Affordable Care Act: Answers to Frequently Asked Questions*; April 25, 2013; and CMS *Answers to Frequently Asked Questions: Telephonic Applications, Medicaid and CHIP Eligibility Policy and 75/25 Federal Matching Rate*, August 9, 2013, December 31, 2013.

⁴⁷ Coverage for such children will continue to be paid for out of the state's CHIP annual allotment at the enhanced CHIP (continued...)

result of these CHIP program eligibility rules, statewide upper income eligibility thresholds for CHIP-funded child coverage vary substantially across states, ranging from a low of 175% FPL to a high of 405% FPL.

CHIP Eligibility for Pregnant Women and Unborn Children

In FY2014, nineteen states provided coverage to pregnant women under CHIP. The three main ways that states may extend CHIP coverage to pregnant women (regardless of their age) are through (1) the state plan option for pregnant women; (2) the Section 1115 waiver authority and/or (3) the unborn child pathway.⁴⁸ The latter is the predominant pathway used by states for this purpose. As of January 2014, four states (Colorado, New Jersey, Oregon, and Rhode Island) extended coverage to pregnant women under Section 1115 waiver authority or the CHIP pregnant women state plan option.⁴⁹ Under CHIPRA, states are permitted to cover pregnant women through a state plan amendment when certain conditions are met (e.g., the Medicaid income standard for pregnant women must be at least 185% FPL but in no case lower than the percentage level in effect on July 1, 2008; no preexisting conditions or waiting periods may be imposed; and CHIP cost-sharing protections apply). The period of coverage associated with the state plan option includes pregnancy through the postpartum period (roughly through 60 days postpartum). Infants born to such pregnant women are deemed eligible for Medicaid or CHIP, as appropriate, and are covered up to age one year.

Eligibility for Subsidized Exchange Coverage

Health insurance exchanges operate in every state and the District of Columbia (DC), per the ACA statute.⁵⁰ Exchanges are not insurance companies; rather, they are “marketplaces” that offer private health plans to qualified individuals⁵¹ and small businesses.⁵² Given that ACA specifically requires exchanges to

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matching rate.

⁴⁸ Prior to the enactment of CHIPRA, legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years in the United States. With the enactment of CHIPRA, states are permitted to waive the five-year bar to Medicaid or CHIP coverage for pregnant women and children who arrived in the United States after August 22, 1996 and who are (1) lawfully residing in the United States and (2) are otherwise eligible for such coverage when certain requirements are met. Twenty-five states have opted to cover otherwise five-year barred children, and 20 states have opted to cover five-year barred pregnant women. Source: Hasstedt, K.; Guttmacher Policy Review; *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*; vol. 16, no. 1; pp 2–8; 2013. For more recent information on state take up of the five-year bar state plan option, see Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates and Robin Rudowitz and Laura Snyder, Kaiser Family Foundation, *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, October 2014.

⁴⁹ Medicaid and CHIP Payment and Access Commission, Report to Congress on Medicaid and CHIP, March 2014, Table 9, pp 80-82.

⁵⁰ See Kaiser Family Foundation, *State Health Insurance Marketplace Decisions*, January 27, 2014, at <http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/>. ACA §1323 allowed U.S. territories to choose to either establish an exchange or not; as of the date of this response, no territory opted to establish an exchange.

⁵¹ Enrollment in an exchange plan is voluntary; see §1312(d)(3) of ACA. The voluntary nature of exchange enrollment also applies to Members of Congress and their personal staff, who may be offered by the federal government only coverage created under the ACA or offered through an exchange, per ACA §1312(d)(3)(D). In other words, although the federal government may make only certain health coverage available to applicable Members and staff, such individuals retain their right to enroll in any coverage that may be available to them (e.g., a private employer’s health plan offered to the Member’s spouse). For a comprehensive discussion about these issues, see CRS Report R43194, *Health Benefits for Members of Congress and Certain Congressional Staff*.

offer insurance options to individuals and small businesses, exchanges are structured to assist these two different types of “customers.” Consequently, there is an exchange to serve individuals and families, and another to serve small businesses (“SHOP exchanges”), within each state.⁵³

Certain enrollees in the *individual* exchanges are eligible for premium assistance in the form of federal tax credits.⁵⁴ Such credits are not provided through the SHOP exchanges. The premium credit is an advanceable, refundable tax credit, meaning tax filers need not wait until the end of the tax year to benefit from the credit, and they may claim the full credit amount even if they have little or no federal income tax liability.

To be eligible for a premium credit through an individual exchange, a person (or family) must:

- have a household income (based on Modified Adjusted Gross Income (MAGI) between 100%⁵⁵ and 400% of the federal poverty level (FPL), with an exception,⁵⁶
- *not* be eligible for “minimum essential coverage”⁵⁷ (such as Medicaid,⁵⁸ Medicare, or an employer-sponsored plan that meets certain requirements),⁵⁹ other than through the individual health insurance market;
- be enrolled in an exchange plan; and
- be part of a tax-filing unit.⁶⁰

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⁵² Before 2016, states will have the option to define “small employers” either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, large groups may participate in exchanges, at state option.

⁵³ ACA gives states the option to merge both exchanges and operate them under one structure.

⁵⁴ For additional information about ACA’s premium tax credits, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

⁵⁵ Given that the ACA Medicaid expansion is a state option, it leaves open the possibility that, as of 2014, certain individuals with incomes less than 100% FPL will not be eligible for either Medicaid or premium credits.

⁵⁶ An exception is made for lawfully present aliens with income below 100% FPL who are ineligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% FPL for purposes of the premium credit.

⁵⁷ The definition of minimum essential coverage is broad. It generally includes Medicare Part A; Medicaid; the State Children’s Health Insurance Program (CHIP); TRICARE; the TRICARE for Life program, a health care program administered by the Department of Veteran’s Affairs; the Peace Corps program; a government plan (local, state, federal), including the Federal Employees Health Benefits Program (FEHBP); any plan established by an Indian tribal government; any plan offered in the individual, small-group, or large-group market; a grandfathered health plan; and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.

⁵⁸ Certain individuals are eligible only for limited benefits under Medicaid. The IRS has promulgated regulations on whether or not it treats limited benefit Medicaid coverage as minimum essential coverage (MEC). (For a list of Medicaid limited benefits identified in relevant IRS rules, see the Appendix in CRS Report R41331, *Individual Mandate Under ACA*.) In the final regulation on non-compliance with ACA’s individual mandate, the IRS stated that certain limited benefit coverage under Medicaid would not be considered MEC in 2014 (78 *Federal Register* 53646, August 30, 2013). Individuals eligible for such coverage may still be able to access premium tax credits, assuming they meet all other eligibility requirements. Moreover, the IRS issued a proposed rule on MEC which identified other limited benefit Medicaid coverage as not meeting the definition of MEC (78 *Federal Register* 4302, January 27, 2014).

⁵⁹ Individuals who are offered health coverage through an employer may be eligible for the premium tax credit if the employer coverage does not meet affordability (employer-sponsored insurance is considered affordable if employees’ premiums contributions for self-only coverage comprise less than 9.5% of family income) and adequacy (standards). For a discussion of those standards, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*.

The Individual Mandate

Beginning in 2014, ACA requires most individuals to maintain health insurance coverage that meets a minimum set of standards or otherwise pay a penalty.⁶¹ Certain individuals are exempt from the individual mandate. For example, individuals with qualifying religious exemptions and those for whom health insurance coverage is “unaffordable” will not be subject to the mandate or its associated penalty. Individuals who do not maintain health insurance coverage and are not exempt from the mandate will have to pay a penalty for each month of noncompliance. The penalty is assessed through the federal tax filing process; any penalty that taxpayers are required to pay for themselves or their dependents must be included in their return for that taxable year.

Examples of “Split Family” Coverage

As per the Committee’s request, we were asked to provide illustrative examples of situations where a family may have members with different coverage. What follows are examples of what eligibility might look like for a family of four (i.e., an infant, a non-disabled 8-year-old child, a pregnant mother, and a father) with annual income at 150% of the federal poverty level in each of 5 states, including California, Louisiana, New Jersey, Pennsylvania, and Texas.⁶² In the first example, we assume that each family member meets the applicable eligibility requirements for the relevant ACA low-income subsidy program. This assumption allows us to examine how eligibility may change based on the applicable upper income eligibility levels across the low-income subsidy programs in these 5 states.

In a second example, we provide two scenarios where a given family member (or members) *does (do) not* meet program eligibility requirements for one (or more) of the low-income subsidy programs, and thus even though the family has annual income that is generally within the range of subsidized coverage—the individual cannot participate. Families at this income range are less likely to have access to employer-sponsored insurance, and thus this (these) individual(s) may be uninsured.⁶³ These examples are not meant to be exhaustive, nor do they necessarily reflect the prevalence of these scenarios. They are intended to illustrate the impact that the program rules across the ACA low-income subsidy programs may have on a family in this income range.

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⁶⁰Since the premium tax credits are administered through the individual income tax filing process, credit recipients are required to file federal tax returns, even if they do not have federal tax liability.

⁶¹For more information about the individual mandate, see CRS Report R41331, *Individual Mandate Under the ACA*.

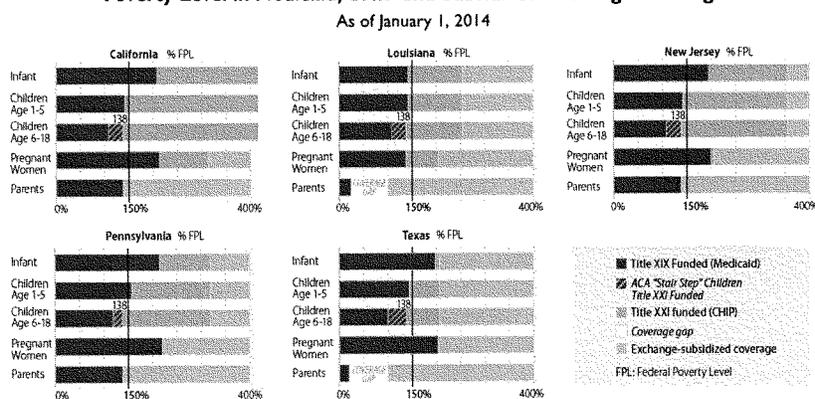
⁶²These five states were chosen because their program eligibility policies represent a range of allowable policy options (e.g., decision to take up the ACA Medicaid expansion, diversity of upper income eligibility levels across programs and groups, differences in CHIP program design, differences in eligibility for pregnant women) that result in a diversity of outcomes in terms of the number of low-income subsidy programs that the family might be eligible for. For example, California, New Jersey and Pennsylvania have taken up the ACA Medicaid expansion, and Louisiana and Texas have not.

⁶³For more information on the access to private insurance coverage among low-income children in CHIP, see Mathematica Policy Research, *CHIPRA Mandated Evaluation of the Children’s Health Insurance Program: Final Findings*, August 1, 2014.

Example 1: All Family Members are Eligible for at Least One Low-Income Subsidy Program

Figure 1 shows upper income eligibility levels for infants, children age 1 through 5, children age 6 through 18, pregnant women and parents in Medicaid, CHIP, and subsidized exchange coverage in 5 states (California, Louisiana, New Jersey, Pennsylvania, and Texas), as of January 1, 2014.⁶⁴

Figure 1. Selected Upper Income Eligibility Levels for Infants, Children Age 1 through 5, Children Age 6 through 18, Pregnant Women, and Parents as a Percentage of the Federal Poverty Level in Medicaid, CHIP and Subsidized Exchange Coverage



Source: CRS figure based on Medicaid and CHIP Payment and Access Commission; *Report to Congress on Medicaid and CHIP, March 2014*; MACStats; Tables 9 and 10.

Notes: Upper income levels (%FPL) represent the highest income eligibility threshold available in the state, and include the 5% disregard (which the law provides as a standard disregard).

It is important to note that CHIP coverage is limited to uninsured children, so children who have health insurance coverage and fall into the income eligibility range shown for CHIP are nonetheless not CHIP eligible due to their insurance status.

"Stair-step" children refer to children age 6 through 18 who were transitioned from separate CHIP programs to Medicaid under the ACA. Such children are considered Medicaid eligible, although their coverage is paid for out of the state's CHIP annual allotment and matched at the CHIP enhanced FMAP (E-FMAP) rate.

In one county in California, CHIP coverage for children extends to a higher income eligibility threshold than subsidized exchange coverage (i.e., 416% of FPL).

Pennsylvania implemented the ACA Medicaid expansion for non-elderly adults up to 133% FPL (effectively 138% FPL with the 5% income disregard that the law allows). Medicaid eligibility rules for the parent coverage expansion have been added here to reflect this recent state action.

⁶⁴ Pennsylvania implemented its ACA Medicaid expansion for non-disabled adults as of January 1, 2015. The state's ACA Medicaid expansion is shown in Figure 1.

In FY2014, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$23,850, in Alaska \$29,820 and in Hawaii \$27,430. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), 2014 Poverty Guidelines, available at: <http://aspe.hhs.gov/poverty/14poverty.cfm>.

FPL: Federal Poverty Level

In general, variability exists in the income eligibility ranges (i.e., income eligibility floors and ceilings) associated with each of the ACA low-income subsidy programs. The federal Medicaid statute establishes mandatory coverage floors (defined as a percentage of the federal poverty level) for its poverty-related pregnant women and children eligibility pathways. However, states are permitted to extend Medicaid coverage above these federal minimum levels; this is why there is variability across states in terms of the income eligibility levels at which CHIP begins. For example, the state of New Jersey extends Medicaid eligibility to infants in families with annual income less than or equal to 194% FPL, while the state of Pennsylvania extends Medicaid eligibility to infants in families with annual income less than or equal to 215% FPL. In another example, CHIP coverage for children extends to a higher income eligibility threshold than subsidized health insurance exchange coverage in one county in California (i.e., 416% FPL).

Figure 1 shows both the range of CHIP income eligibility relative to the other programs, and how the programs are envisioned to work together in extending coverage to low-income children and families. CHIP in Texas, for example, covers a relatively small segment of the income eligibility continuum while CHIP in California, New Jersey and Pennsylvania cover a larger segment of the continuum.⁶⁵ This is particularly true for infants and pregnant woman. In general, states have used the optional Medicaid eligibility pathways to set higher Medicaid income eligibility levels for infants and pregnant women relative to older children. As a result, CHIP has been used to provide health coverage to older uninsured children to a greater extent.

The vertical purple line in **Figure 1** represents 150% of the federal poverty level, and shows what eligibility across low-income subsidy programs might look like for a family of four with annual income at this level in each of the 5 states. In this example, the family of four includes an infant, a non-disabled 8-year-old child, a pregnant mother, and a father, all of whom otherwise meet the applicable eligibility requirements for the relevant ACA low-income subsidy program in that state.

Based on this example, in California, Pennsylvania and Texas family coverage would be similarly split across three low-income subsidy programs (i.e., Medicaid for the infant and pregnant mother, CHIP for the non-disabled 8-year-old child, and subsidized exchange coverage for the father). In Louisiana, family coverage would be split across two low-income subsidy programs (i.e., CHIP for the children and pregnant mother, and subsidized exchange coverage for the father). In New Jersey, family coverage would also be split across three low-income subsidy programs, however, CHIP would cover two of these individuals (i.e., Medicaid for the infant, CHIP for the non-disabled 8-year-old and pregnant mom, and subsidized exchange coverage for the father).

⁶⁵ This figure, however, is not weighted to reflect program enrollment by state. For example, it is possible that a state with a large uninsured child population but a CHIP program with a relatively narrow income eligibility range may result in a much larger number of CHIP program enrollees than a state with a relatively small uninsured child population and a CHIP program with a much broader income eligibility range. For example, in Texas, the CHIP eligibility range appears small by comparison to the CHIP eligibility range in Louisiana. However, in FY2013, CMS administrative data show CHIP child enrollment totaling approximately 1 million in Texas as compared to approximately 150,000 in Louisiana.

Example 2: At Least One Family Member is Ineligible for one of the Low-Income Subsidy Programs

It is important to note that not all individuals with family income within the ranges covered by the ACA low-income subsidy programs are eligible due to program rules that differ for each of these programs. For instance, CHIP is only available to uninsured children, subsidized exchange coverage is generally not available to individuals with access to minimum essential coverage, and insurance status is not considered when determining Medicaid eligibility. The following scenarios provide examples where a given family member (or members) in our family of four does (do) not meet program eligibility requirements for one (or more) of the low-income subsidy programs, and thus even though the family has annual income that is generally within the income eligibility thresholds for subsidized coverage—the individual cannot participate.

Scenario 1: Mix of Citizenship Status across Family Members

In this scenario, the infant in our family of four with annual income at 150% of the federal poverty level was born in the United States, the 8-year-old nondisabled child and pregnant mother are considered to be lawfully residing in the United States within the 5-year bar, and the father is undocumented. Based on the eligibility rules associated with citizenship status⁶⁶ in each of California, Louisiana, New Jersey, Pennsylvania, and Texas, the family would likely be split across two low-income subsidy programs, with one (or more) family members ineligible for at least one program depending on the state. In California and Pennsylvania, the infant and the pregnant mother would be eligible for Medicaid, the 8-year-old would be eligible for CHIP, and the father would be ineligible for coverage under any of the ACA low-income subsidy programs. In Louisiana, the infant and the pregnant mother (through the CHIP unborn child pathway) would be eligible for CHIP, but the 8-year old child and father would be ineligible for coverage under any ACA low-income subsidy programs. In New Jersey and Texas, the infant would be eligible for Medicaid, and the 8-year old child and pregnant mother would be eligible for CHIP (via the 5-year bar state plan option in New Jersey and the unborn child pathway in Texas), and the father would be ineligible for coverage under any ACA low-income subsidy programs.

Scenario 2:

In this scenario, our family of four has the same make up of an infant, an 8 year-old nondisabled, child, a pregnant mother, and a father, but the family's annual income is 95% of the federal poverty level. Under this scenario, the state's take up of the ACA Medicaid expansion becomes relevant because, in general, individuals are only eligible for subsidized exchange coverage if they have annual income between 100% and 400% of the federal poverty level (FPL).

Based on this scenario, in California, New Jersey and Pennsylvania the entire family would be eligible for the Medicaid program. In Louisiana and Texas, everyone but the father would be eligible for Medicaid. In these states, the father may be uninsured because he is not eligible for Medicaid and/or subsidized coverage under the exchanges, and purchase of private health insurance coverage through the exchange or otherwise would likely be very costly relative to family income.

⁶⁶ Hasstedt, K.; Guttmacher Policy Review; *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*; vol. 16, no. 1; pp 2–8; 2013.

Questions from the Honorable Frank Pallone, Jr.:

1. Sometimes we hear people criticize Medicaid and even CHIP, as being a “government run” program. While the federal government provides financial support and broad parameters, states have a lot of flexibility to design their programs. Do you agree?

States have a fair amount of flexibility to design their Medicaid and CHIP programs. First, participation in both programs is voluntary. However, all states, the District of Columbia, and the territories participate. Both programs are federal and state matching programs. States must follow broad federal rules in order to receive federal matching funds, but have flexibility to design their own version of Medicaid and CHIP within the federal statute’s basic framework. This flexibility results in variability across state Medicaid and CHIP programs.

Each state has a Medicaid and CHIP state plan that describes how the state will administer its programs. States submit these state plans to the federal Centers for Medicare & Medicaid Services (CMS) for approval. States that wish to go beyond what the law allows must seek approval from the Secretary of Health and Human Services under various waiver authorities.⁶⁷

While program flexibilities exist, some state health officials have the view that more flexibility is required. One common argument is that, under the current Medicaid financing structure it is difficult to control program costs especially during times of economic constraint when states typically see increases in program enrollment at the same time they see decreases in state revenues. Others suggest that states have less flexibility then it would appear since some of Medicaid’s optional services (e.g., prescription drug coverage) are not really optional in today’s world of medicine.

Table 3 summarizes some of the key program features that shape these programs, and highlights some of the flexibilities that states have in designing Medicaid and CHIP.

⁶⁷ The Social Security Act authorizes several waiver and demonstration authorities to provide states with the flexibility to operate their Medicaid programs. Each waiver authority has a distinct purpose and specific requirements. Under the various waiver authorities, states may try new or different approaches to the delivery of health care services or adapt their programs to the special needs of particular geographic areas or groups of Medicaid enrollees. The primary Medicaid waiver authorities include: Section 1115 Research and Demonstration Projects; Section 1915(b) Managed Care/Freedom of Choice Waivers; Section 1915(c) Home- and Community-Based Services Waivers (HCBS); and Section 1915(b) and (c) Waivers. The Section 1115 waiver authority also applies to CHIP.

Table 3. Flexibility Available to States Across Selected Program Features Between Medicaid, CHIP Medicaid Expansion Programs, and Separate CHIP Programs

Program Feature	CHIP		
	Medicaid	Medicaid Expansion	Separate Program
Program Design			
		States may cover eligible children under their Medicaid programs, create a separate CHIP program, or adopt a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. State choices for program design impact the coverage that enrollees receive.	
Eligibility	Medicaid rules (Title XIX of SSA) typically apply.	Medicaid rules (Title XIX of SSA)	Title XXI of SSA rules typically apply.
Who is eligible?	Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain nonelderly childless adults) and financial (i.e., income and sometimes assets limits) criteria. In addition, individuals need to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. In general, Medicaid eligibility groups must be covered statewide.	CHIP extends coverage to certain low-income children and pregnant women without health insurance in families with annual family income too high to qualify them for Medicaid.	CHIP children are an optional eligibility group in Medicaid and enrollees must be covered statewide.
Entitlement nature	Individual entitlement.	Individual entitlement.	Not an individual entitlement.

CHIP		
Program Feature	Medicaid	Medicaid Expansion
Implications of the ACA child maintenance of effort (MOE) requirement	States must maintain their child eligibility standards, methodologies, and procedures through September 30, 2019.	When federal CHIP funding is exhausted, CHIP Medicaid expansion children must continue to be enrolled in Medicaid through September 30, 2019, but the financing switches from CHIP to Medicaid.
		Separate Program
		States with separate CHIP programs are provided with exceptions to the MOE. When federal CHIP funding is exhausted, states must establish procedures to screen and enroll eligible children in Medicaid. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the Secretary of Health and Human Services to be "at least comparable" to CHIP in terms of benefits and cost sharing. If there are no certified plans, the MOE does not obligate states to provide coverage to these children.
Benefits		
	Benefits vary by population group and include a wide range of primary, preventive, and acute medical services as well as long-term services and supports (LTSS).	Regardless of program design, states must cover emergency services, well baby and well child care, including age appropriate immunizations, and dental services. If offered, mental health services must meet federal mental health parity requirements.

CHIP		
Program Feature	Medicaid	Separate Program
	<p>States define the specific features of each covered benefit within broad federal guidelines.</p> <p>Each service must be sufficient in "amount, duration, and scope" to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity.</p> <p>Within a state, services available to the various categorically needy groups must be equal in amount, duration, and scope (i.e., the "comparability" rule).</p> <p>With certain exceptions, the amount, duration, and scope of benefits must be the same statewide. (i.e., the "statewide" rule).</p> <p>With certain exceptions, enrollees must have "freedom of choice" among health care providers or managed care entities participating in Medicaid.</p> <p>States are required to cover certain mandatory benefits (e.g., inpatient hospital services, physician services, EPSDT for children <21); others (e.g., prescribed drugs and clinic services) are available at state option.</p>	<p>Follows Medicaid program rules. CHIP children are entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage, which effectively eliminates any state-defined limits on the amount, duration, and scope of any benefit listed in Medicaid statute.</p> <p>States have more latitude in designing their benefit coverage. States are permitted to elect any of three benefit options: Benchmark benefit package, Benchmark-equivalent coverage, or Secretary-approved coverage.</p>
Traditional Medicaid	<p>Must provide the full range of mandatory Medicaid benefits, as well as all optional services that the state chooses to cover as specified in their state Medicaid plans.</p> <p>NA</p>	NA

CHIP		
Program Feature	Medicaid	Medicaid Expansion Separate Program
Alternative Benefit Plans (ABPs)	ABPs must cover 10 essential health benefits that include preventive care, mental health services, prescribed drugs, rehabilitative services, FQHC services, EPSDT for children <21, family planning services and supplies, and non-emergency medical transportation.	ABP coverage available at state option and must follow the requirements specified under the Medicaid program.
Cost-sharing		
	In general, premiums and enrollment fees are often prohibited. However, premiums may be imposed on certain enrollees, such as individuals with incomes above 150% of FPL, certain working people with disabilities, and certain children with disabilities. States can impose service-related cost-sharing such as copayments on most Medicaid-covered benefits up to federal limits that vary by income. Some subgroups of beneficiaries are exempt from cost sharing (e.g., children under 18 years of age and pregnant women). The aggregate cap on all out-of-pocket cost-sharing is generally up to 5% of monthly or quarterly income.	In general, premiums and cost-sharing may be imposed. Allowable amounts are dependent on annual family income and are subject to an out-of-pocket aggregate limit of 5% of annual family income.
Financing		
Entitlement Nature	Open-ended entitlement.	Capped entitlement to states appropriated through FY2015.
Federal matching rate	Based on Federal Medical Assistance Percentage (FMAP) Rate.	Based on Enhanced-Federal Medical Assistance Percentage (E-FMAP) Rate.

Sources: CRS analysis of Titles XIX and XXI of the Social Security Act.

2. Isn't it true that most of the coverage provided under both Medicaid and CHIP is provided through private insurance companies, either HMOs or some other arrangement?

Managed care is the predominant delivery model for both Medicaid and CHIP, especially for children. Most of this managed care covered is provided through comprehensive risk-based managed care, and under this model states contract with managed care plans (i.e., private health insurance companies) to provide a comprehensive package of benefits to Medicaid and CHIP enrollees. The primary reasons states provide for choosing managed care include promoting care management and care coordination, increasing cost-predictability, reducing costs, and improving access to care.⁶⁸

Managed Care in Medicaid

Traditionally, states provided Medicaid coverage on a fee for service basis, which means Medicaid enrollees independently identify health care providers that will accept Medicaid enrollees and the state pays the providers directly. Some states adopted Medicaid managed care during the early 1980s, but most states waited until the 1990s to use managed care for their Medicaid programs. Throughout the 1990s, managed care grew to become the dominant form of health care delivery for Medicaid.⁶⁹

The growth in Medicaid managed care enrollment has continued, and on July 1, 2011, almost 72% of Medicaid enrollees were covered by some type of managed care with 50% of Medicaid enrollees covered by comprehensive risk-based managed care.⁷⁰ As of FY2011, at least 36 states and the District of Columbia used comprehensive risk-based managed care in their Medicaid program.⁷¹ Twenty-six of these states and the District of Columbia had more than half of their Medicaid enrollees in comprehensive risk-based managed care in FY2011, and seven of these states had over 75% of their Medicaid population enrolled in comprehensive risk-based managed care.⁷²

Most states use managed care primarily for their non-disabled child and adult populations. In FY2011, just over 63% of all Medicaid children had coverage through comprehensive risk-based managed care, and 11 states and the District of Columbia had over 90% of their Medicaid children covered through comprehensive risk-based managed care.⁷³ While managed care has largely been used for Medicaid subgroups that do not have chronic health care needs, some states are turning to this type of service delivery system for the elderly and individuals with disabilities.

While over two-thirds of Medicaid enrollees are covered by managed care, Medicaid expenditures for managed care account for only 20% of total Medicaid expenditures. Managed care expenditures account

⁶⁸ Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid*, June 2012; Embry M. Howell, Ashley Palmer, and Fiona Adams, *Medicaid and CHIP Risk-Based Managed Care in 20 States*, Urban Institute, Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, July 2012.

⁶⁹ Embry M. Howell, Ashley Palmer, and Fiona Adams, *Medicaid and CHIP Risk-Based Managed Care in 20 States*, Urban Institute, Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, July 2012.

⁷⁰ Under comprehensive risk-based managed care, states contract with managed care plans to provide a comprehensive package of benefits to certain enrollees. States usually pay the managed care plans on a capitated basis, which means the states prospectively pay the managed care plans a fixed monthly rate per enrollee to provide or arrange for most health care services.

⁷¹ Data was not reported for Maine, Tennessee, and Vermont. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.)

⁷² *Ibid.*

⁷³ *Ibid.*

for such a small share of total Medicaid spending because Medicaid managed care enrollment is dominated by families and children who tend to have lower health care costs, while the highest-cost Medicaid enrollees (i.e., the elderly and disabled populations) generally receive FFS coverage.⁷⁴

Managed Care in CHIP

CHIP was established in the Balanced Budget Act of 1997 (P.L. 105-33) at a time when states' use of managed care for Medicaid was growing significantly. As a result, many states used comprehensive risk-based managed care as primary delivery model for their CHIP programs. States had the choice of establishing their CHIP program in one of three ways: CHIP Medicaid expansion, separate CHIP program, or adopt a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. In FY2013, the bulk of CHIP program enrollees received coverage through separate CHIP programs (approximately 70%). The remainder (approximately 30%) received coverage through a CHIP Medicaid expansion.

When states provide Medicaid coverage to CHIP children (i.e., CHIP Medicaid expansion), their states' Medicaid rules typically apply and CHIP children in CHIP Medicaid expansion programs are covered by managed care in the same manner as Medicaid children in their state. There isn't any current state-by-state information about managed care coverage for children in CHIP Medicaid expansion, but since the Medicaid structures and rules apply to CHIP Medicaid expansion programs, states' coverage of managed care in their Medicaid program can provide information about managed care coverage in CHIP Medicaid expansion programs.

Two of the CHIP Medicaid expansion states (Alaska and New Hampshire) did not use any comprehensive risk-based managed care in their Medicaid programs in FY2011, which means the CHIP children in these states would not receive comprehensive risk-based managed care coverage.⁷⁵ Three of the other six states (Hawaii, Maryland, and Ohio) and District of Columbia that operate their CHIP program as a full CHIP Medicaid expansion program use comprehensive risk-based managed care to cover over 90% of their Medicaid children, which means most of the CHIP children in these states would also have comprehensive risk-based managed care coverage.⁷⁶

Twenty-nine states operate their CHIP program as a combination of CHIP Medicaid expansion programs and separate CHIP programs.⁷⁷ Four of these states (Delaware, Florida, Indiana, and Wisconsin) covered more than 90% of their Medicaid children with comprehensive risk-based managed care in FY2011, which means most of the CHIP children in the CHIP Medicaid expansion portion of these states' CHIP programs would be covered by comprehensive risk-based managed care. However, eight⁷⁸ of these states did not cover any of their Medicaid children with comprehensive risk-based managed care in FY2011.⁷⁹

⁷⁴ Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: Key Data, Trends, and Issues*, Publication #8046, February 2010.

⁷⁵ Vermont operates their CHIP programs as a CHIP Medicaid expansion program, and there isn't managed care data in the Medicaid and CHIP Payment and Access Commission report for Vermont. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.)

⁷⁶ Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.

⁷⁷ Centers for Medicare and Medicaid Services (CMS), *Children's Health Insurance Program Plan Activity*, as of July 1, 2014.

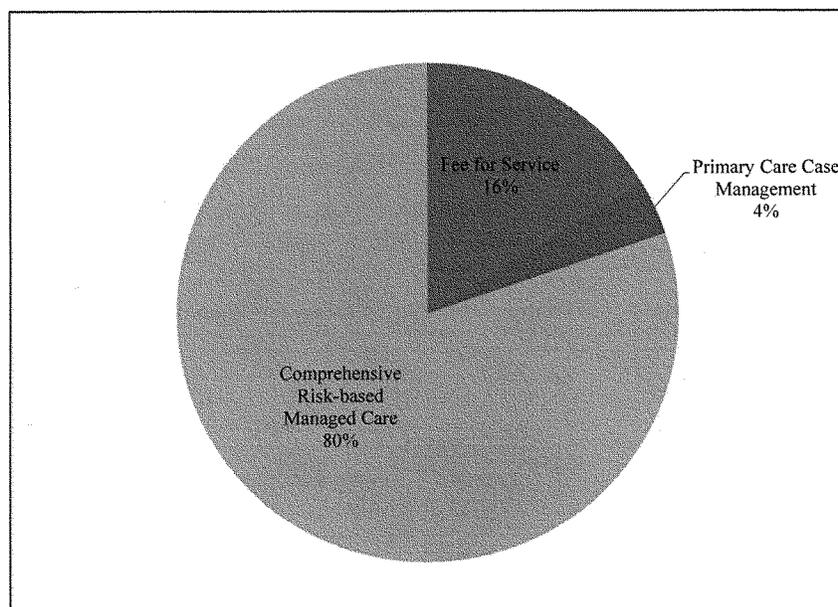
⁷⁸ The eight states are Arkansas, Idaho, Iowa, Louisiana, Montana, North Carolina, Oklahoma, and South Dakota. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.)

⁷⁹ Maine and Tennessee both operate their CHIP programs as a combination of a CHIP Medicaid expansion program and a separate CHIP program, and neither of these two states have managed care data in the Medicaid and CHIP Payment and Access Commission report. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June (continued...))

There is data from FY2013 for managed care coverage in separate CHIP programs, which includes states with full separate CHIP programs and combination programs. In FY2013, managed care was the predominant delivery system for separate CHIP programs. As shown in **Figure 2**, most (80%) of children in separate CHIP programs were covered by comprehensive risk-based managed care.⁸⁰ Of the 43 states with a separate CHIP programs, thirty-one used comprehensive risk-based managed care in their separate CHIP program. Of the states that used comprehensive risk-based managed care, 23 states covered more than 80% of the CHIP children in their separate CHIP program with comprehensive risk-based managed care, and eight of these states had all of the children in their separate CHIP program covered by comprehensive risk-based managed care.⁸¹

Figure 2. Children in Separate CHIP Programs, by Type of Delivery System

FY2013



Source: Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2014, Table 5, which is based on data from the CHIP Statistical Enrollment Data System (SEDS) as of March 4, 2014.

Notes: This figure does not include children in CHIP Medicaid expansion programs.

(...continued)

2014, Table 14.)

⁸⁰ Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2014, Table 5.

⁸¹ *Ibid.*

3. What Medicaid and CHIP do guarantee, however, is coverage that is child-appropriate. In Medicaid, and in CHIP programs provided through Medicaid, children are guaranteed the Early Periodic Screening Detection and Treatment (EPSDT) benefit. Could you discuss what EPSDT provides that is critical for children?

The EPSDT program is a required benefit for nearly all children (under age 21) who are enrolled in Medicaid (whether through traditional state plan coverage or otherwise), including CHIP Medicaid expansion programs.⁸² EPSDT covers health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services. The screenings and services must be provided at regular intervals that meet "reasonable" medical or dental practice standards.⁸³ States are required to provide all federally allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state's Medicaid plan. EPSDT sets Medicaid benefit coverage for children (including CHIP Medicaid expansion children) apart from other sources of health insurance in that it permits coverage of all services listed in Medicaid statute (regardless of whether a given benefit is covered in the state plan) and it effectively eliminates any state-defined limits on the amount, duration, and scope of this benefit.

While not required under separate CHIP programs, data from a 2013 study⁸⁴ that looked at benefit coverage in 42 separate CHIP programs (in 38 states) indicate that benefits offered under separate CHIP programs ranged from benefit coverage modeled after the state's Medicaid plan to more limited benefit coverage available through the commercial market. Of the 25 states with Secretary-approved coverage in 2013, 14 states modeled their coverage after the state's Medicaid program, and 11 of these 14 states offered EPSDT as a part of the state's separate CHIP program benefits.

Tracking receipt of EPSDT covered services is complicated by the diverse range of licensed providers (e.g., medical doctor, nurse practitioner, dentists, and others) that may offer the services, as well as the wide range of locations in which the screenings or other services may be provided (ranging from well-child clinics to Head Start programs and many other locations).⁸⁵ Further, the primary data source on use of EPSDT services is separate from the overall Medicaid claims data reported to CMS and does not include information received by specific eligibility groups.⁸⁶

At the same time, available information indicates receipt of EPSDT services by Medicaid children, is not always complete. In 2010, the Health and Human Services (HHS) Office of Inspector General (OIG)

⁸² EPSDT is not a mandatory benefit for the medically needy, although states that choose to extend EPSDT to their medically needy population must make the benefit available to all Medicaid-eligible individuals under age 21. Section 1905(r) of the Social Security Act Section and Section 1902(a)(43) of the Social Security Act.

⁸³ Section 1905(r) of the Social Security Act.

⁸⁴ Anita Cardwell, et al., National Academy for State Health Policy and Georgetown University Health Policy Institute, Center for Children and Families; *Benefits and Cost Sharing in Separate CHIP Programs*, May 2014.

⁸⁵ Eligible EPSDT providers and service locations are detailed in CMS, *State Medicaid Manual: Part 5: Early and Periodic Screening Diagnostic and Treatment Services*, Section 5124, pp. 5-19.

⁸⁶ States use CMS Form 416 to report annual aggregate data on the number of children (by age group) who are eligible for EPSDT services and have received certain services. See FY2013 data available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. Beginning, July 1, 2014 states must submit Medicaid program and financial data through the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS will replace CMS Form 416 data and will eventually allow for more detailed analysis of EPSDT service use.

reported that many Medicaid-eligible children did not receive all required EPSDT services.⁸⁷ In a follow up study conducted in 2013, the HHS OIG found that CMS had taken steps to encourage greater participation in EPSDT screenings and treatments. However, citing data that showed a national participation rate for EPSDT screenings of 63% in FY2013 (well below the HHS goal of 80% participation), it stated that the “underutilization of medical screenings is an ongoing concern.”⁸⁸

4. In the responses from governors that the Committee received to its July 2014 letter on the CHIP program, most governors expressed interest that Congress should act quickly to extend CHIP funding. I strongly agree that we need to act quickly. Please share some of the administrative and operational challenges that states would face if Congress were to delay acting on this issue.

Without Congressional action regarding the extension of federal CHIP funding, many states will be putting together their state fiscal year (SFY) 2016 budget with uncertainty about whether federal CHIP funding will be extended and at what level. In addition, for separate CHIP programs, if federal CHIP funding is *not* extended, these states need time to provide CHIP enrollees with “sufficient notice” of coverage termination.

State Budget Uncertainty

State governments do not know for certain whether federal CHIP funds will be extended past September 30, 2015, and if federal funding is extended, states do not know at what level the program will be funded. A vast majority of states will be developing their SFY2016 budgets between January and June 2015 with their SFY2016 beginning on July 1, 2015.⁸⁹ As a result, states will determine their SFY2016 budgets and putting together state legislation before knowing whether states will be receiving FY2016 CHIP allotments or the amount of those potential allotments.

In their responses to the committees request for information about CHIP, the governors from Alabama, Rhode Island, and Texas stated that their SFY2016 budget process would be complicated due to the uncertainty about the future of federal CHIP funding.⁹⁰ For instance, if federal CHIP funding is not extended, states with CHIP Medicaid expansion programs will need to continue covering the CHIP children in these programs at the lower Medicaid matching rate due to the ACA maintenance of effort (MOE) (see the following section for more information about the ACA MOE), and these states would need to budget for this increased expense.

⁸⁷ HHS, Office of the Inspector General (OIG), *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*, May 2010 (OEI-05-08-00520), <http://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf>. The report cited a need for improved documentation of certain screenings as well as better provider knowledge of what a screening entails (among other things) as ways to improve services. In December 2010, CMS convened a National EPSDT Improvement Workgroup to help identify areas to improve EPSDT and to work at the federal level and with states to improve children’s access to EPSDT services and the quality of the data reporting on receipt of those services.

⁸⁸ HHS, OIG, “Recommendation Follow-up Memorandum Report: *CMS Needs to Do More to Improve Medicaid Children’s Utilization of Preventive Screening Services* OEI-05-13-00690,” November 12, 2014. Available at <http://oig.hhs.gov/oei/reports/oei-05-13-00690.pdf>.

⁸⁹ National Conference of State Legislatures, *Budget Cycles*, December 2008.

⁹⁰ Responses to Bipartisan, Bicameral Letters to Governors Regarding CHIP, December 3, 2014, <http://energycommerce.house.gov/letter/responses-bipartisan-bicameral-letters-governors-regarding-chip>.

Starting in FY2016, under current law, the enhanced federal medical assistance percentage (E-FMAP or federal matching rate) for CHIP is to increase by 23 percentage points (not to exceed 100%) for most CHIP expenditures. This would increase the statutory range of the E-FMAP rate from 65% through 85% to 88% through 100%. With this 23 percentage point increase, the federal share of CHIP expenditures will be significantly higher. In formulating their SFY2016 budgets, states are uncertain whether to include this 23 percentage point increase or not.

Adequate Time to Notify Enrollees

If federal CHIP funding is not extended, states need sufficient lead time to make contingency plans and notify enrollees of coverage terminations. Due to the ACA maintenance of effort (MOE), only enrollees in separate CHIP programs might lose coverage if federal CHIP funding expired. The ACA MOE requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving payments under Medicaid.⁹¹

For states to continue to receive federal Medicaid funds, the ACA child MOE provisions require that CHIP-eligible children in CHIP Medicaid expansion programs must continue to be eligible for Medicaid through September 30, 2019.⁹² When a state's federal CHIP funding is exhausted, the state's financing for these children switches from CHIP to Medicaid. This switch would cause the state share of covering these children to increase because the federal matching rate for Medicaid is less than the E-FMAP rate. In the responses from governors, a few states mentioned the additional cost of the CHIP Medicaid expansion portion of their program if federal CHIP funding is not extended. The letter from New Hampshire said this increased cost "...would need to be offset by other Medicaid cuts at a time we are developing a new system of care."

For separate CHIP programs, only the CHIP-specific provisions of the ACA MOE requirements are applicable. These provisions contain a couple of exceptions:

- states may impose waiting lists or enrollment caps in order to limit CHIP expenditures or
- after September 1, 2015, states may enroll CHIP-eligible children into 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, in the event that a state's CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen CHIP-eligible children for Medicaid eligibility,⁹³ and enroll those who are eligible in Medicaid.

For children not eligible for Medicaid, the state must establish procedures to enroll CHIP-eligible children in qualified health plans offered in the health insurance exchanges that have been certified by the Secretary of Health and Human Services (HHS) to be "at least comparable" to CHIP in terms of benefits

⁹¹ Section 2105(d)(3) of the Social Security Act.

⁹² Both the CHIP child MOE and the Medicaid child MOE concurrently apply to the CHIP Medicaid expansion programs. CHIP children covered under CHIP Medicaid expansion programs are an optional eligibility group under Medicaid. However, because the Medicaid MOE for children extends through FY2019, states are not permitted to roll back Medicaid eligibility for these children without the loss of all Medicaid federal matching funds.

⁹³ States must conduct eligibility redeterminations for Medicaid and CHIP at least annually. Due to fluctuations in income among the CHIP target population, it is possible that a former CHIP-eligible child may meet the state's Medicaid eligibility standard due to a change in annual income that may not have been taken into consideration until the enrollee's next regularly scheduled eligibility redetermination.

and cost sharing. Under these ACA MOE requirements, states are only required to establish procedures to enroll children in qualified health plans certified by the Secretary. If there are no certified plans, the MOE does not obligate states to provide coverage to these children. Even when there are certified plans, not all CHIP children may be eligible for subsidized exchange coverage due to the “family glitch”⁹⁴ among other reasons.

Without an extension of federal CHIP funding, children in separate CHIP programs would be expected to lose CHIP coverage unless the state decides to extend the program with state funding. There are laws and regulations pertaining to states’ termination of CHIP-financed coverage. None of the federal rules address terminating coverage as a result of the absence of federal funding, and HHS may issue guidance for states about the termination of coverage due to the absence of federal funding. Federal regulations require states to provide “sufficient notice” of CHIP eligibility suspension or termination “...to enable the child’s parent or caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.”⁹⁵ Neither federal statute nor regulations provides a specific length of time for “sufficient notice” to affected families. Aside from the federal requirements about notifying CHIP enrollees of eligibility termination, states may want to inform enrollees, and in the responses from governors, the letter from New York mentioned that “...states would need at least twelve months of lead time in order to plan for, notify, and efficiently transition children to other programs.”

Also, it is important to note that no federal statute or regulation prohibits states from continuing to operate their CHIP programs using state funding with the potential to receive future federal CHIP matching funds. A state may make claims for federal payment based on expenditures incurred by the state prior to or during the period of availability related to that fiscal year.⁹⁶

⁹⁴ Subsidized coverage in the health insurance exchanges is not available to individuals with access to affordable health insurance. The “family glitch” results from the definition of affordable coverage. Under the ACA, employer-sponsored insurance is considered affordable if an employee’s premium contributions for self-only coverage (not family coverage) comprise less than 9.5% of household income. However, there is no affordability limit on the employees’ share of premiums for family coverage. Due to the “family glitch,” some of the current CHIP enrollees would *not* be eligible for subsidized coverage in the health insurance exchanges based on a parent’s access to “affordable” employer-sponsored insurance. For more information about subsidized coverage in the health insurance exchanges, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

⁹⁵ 42 C.F.R. § 457.340(e)(2). It is unclear how this federal regulation may interact with the ACA MOE requirements.

⁹⁶ 42 C.F.R. § 457.614(a).

Congress of the United States
Washington, DC 20515

January 8, 2015

Ms. Carolyn Yocom
Director
Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Ms. Yocom:

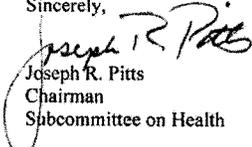
Thank you for appearing before the Subcommittee on Health on Wednesday, December 3, 2014, to testify at the hearing entitled "The Future of the Children's Health Insurance Program."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, January 22, 2015. Your responses should be mailed to Adrianna Simonelli, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Adrianna.Simonelli@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

January 22, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This letter responds to your request that we address questions submitted for the record related to the December 3, 2014 hearing entitled *The Future of the Children's Health Insurance Program*. GAO's responses to these questions are enclosed and are based on previous work related to the areas addressed.

If you have any questions about these responses or need additional information, please contact Carolyn L. Yocom at yocomc@gao.gov or call (202) 512-7114.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Carolyn L. Yocom".

Carolyn L. Yocom
Director, Health Care

Enclosure

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Post-Hearing Questions for the Record
Submitted to Carolyn Yocom
From the Honorable Joseph R. Pitts and the Honorable Frank Pallone, Jr.

“The Future of the Children’s Health Insurance Program”

December 3, 2014

The Honorable Joseph R. Pitts

1. **Under the Affordable Care Act/Obamacare, states are only permitted to use a waiting period of up to 90 days before a child who is otherwise eligible is permitted to enroll in CHIP. Before Obamacare, states could require waiting periods of up to a year. This was designed to ensure that CHIP coverage does not crowd out private coverage. What, if any, concerns does the removal of state options for implementing longer waiting periods raise and to what extent does this needlessly increase federal spending?**

Our prior work suggests that it is unclear whether having required waiting periods for CHIP, and the length of those periods, affect crowd-out, i.e., the substitution of public health coverage through CHIP for private health insurance. In 2009, we reported that 39 states used waiting periods to minimize crowd-out, with 16 of those states requiring periods of 3 months or less, 20 states requiring 4 months or longer (generally 4 to 6 months), and 3 states requiring different periods for different situations, such as different income levels.¹ All 39 states included exemptions designed to account for instances where a child involuntarily lost private health insurance. The studies GAO identified that focused on the effects of waiting periods and cost sharing requirements found that such requirements can have a negative effect on individuals’ participation in CHIP. These studies also suggested that policies to minimize crowd-out may deter CHIP enrollment by eligible uninsured children at a faster rate than they deter use by individuals who have private coverage. We found that little is known about the effects of the different lengths of waiting periods on minimizing crowd-out.

2. **Express Lane Eligibility allows states to determine eligibility for children in Medicaid or CHIP by using certain information, such as information from other public-assistance programs that enroll children. While express lane eligibility can result in administrative simplification, what, if any, concerns does this initiative raise for CHIP program integrity?**

Our prior work suggests that express lane eligibility (ELE) could result in administrative savings and have beneficial effects on enrollment.² However, we also reported that

¹See GAO, *State Children’s Health Insurance Program: CMS Should Improve Efforts to Assess Whether SCHIP is Substituting for Private Insurance*, GAO-09-252 (Washington, D.C.: Feb. 20, 2009).

²See GAO, *Medicaid and CHIP: Considerations for Express Lane Eligibility*, GAO-13-178R (Washington, D.C.: Dec. 5, 2012).

whether states' use of ELE has resulted in erroneous excess payments would be another key consideration when deciding whether to extend the option. We reported in December 2012 that the extent to which erroneous payments had been made as a result of ELE was not known. Though CHIPRA requires states to compute error rates related to ELE and report those to CMS annually, CMS had begun discussions about payment error rates internally and with states and was not planning to issue rules or guidance to states in the near future. We reported that if ELE was extended beyond its original expiration date of September 30, 2013, it would be particularly important that CMS place a higher priority on clarifying how states should determine ELE error rates and collect information on these erroneous excess payments. Congress most recently extended ELE through September 30, 2015. A recent evaluation of ELE for the Department of Health and Human Services (HHS) that focused on implementation in Louisiana included the state's overall payment error rate for Medicaid but did not include an error rate specific to those enrolled through ELE.

3. **With all of the outreach that has occurred under the current CHIP program and given the amount of federal dollars spent on outreach to encourage consumers to get enrolled in health coverage related to the Affordable Care Act/Obamacare, what, if any, policy rationale is there for continued federal funding of CHIP performance bonuses? Given GAO's historic concerns regarding possible duplication, isn't this a role a state could fund and perform if the state deemed it necessary or useful?**

We have not done any work assessing the effects of CHIP performance bonuses or the interaction of these financial incentives with other federal funds for outreach related to the new coverage options through health insurance exchanges.

4. **Under HHS rules, states are permitted to continue coverage for CHIP-eligible children for a period of 12 months regardless of changes in family composition or income that may otherwise affect their eligibility status. This means that a child could be eligible in January, become ineligible in February, and still be on the CHIP rolls using services through the end of the year. What concerns does such a policy raise about the appropriate use and safeguards of federal dollars?**

In states electing the option to grant 12-month continuous eligibility for children in CHIP, a child remains eligible for coverage regardless of a change in family income that may otherwise affect their eligibility. Thus, a child enrolled in January who experiences, for example, an increase in income in February that exceeds the income requirements for the program, would remain eligible for CHIP coverage. As an eligible enrollee, any payments made on behalf of that individual would be consistent with program regulations. Providing 12-month continuous eligibility potentially results in higher costs associated with higher-income enrollees remaining in CHIP. However, it also avoids additional administrative costs related to more frequent eligibility determinations, and minimizes individuals moving in and out of the CHIP program, which has the potential to improve continuity of care. GAO has not done studies aimed at examining these trade-offs.

5. **States have told us that, as a result of the modified-adjusted gross income (MAGI) calculation's treatment of lump sum payments, lottery winners are 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. This includes at least one individual who won more than \$25 million. Since CHIP uses MAGI calculations as well, is it possible that CHIP is providing coverage for lottery winners? Please explain how lump sum payments such as lottery winnings are treated under the MAGI calculation? Does GAO have an opinion on whether or not it is an appropriate use of federal dollars to provide Medicaid coverage to multi-million dollar lottery winners?**

Under the MAGI methodology, income received as a lump sum, such as lottery winnings, is counted as income in the month that the payment was received. Assets, including savings, are not considered for individuals whose eligibility for Medicaid or CHIP is determined using the MAGI methodology, although any interest earned on savings or other assets would be considered.³ Therefore, it is possible that children in families with lottery winnings could be eligible and enrolled in CHIP. Prior to the implementation of MAGI, almost all states did not consider or had reduced consideration of assets when determining eligibility for CHIP.⁴ As a result, it is not clear that the MAGI changes have affected the extent to which individuals with large lump payments might qualify for CHIP.

6. **GAO recently issued a report raising concerns about gaps in state and federal efforts to ensure Medicaid managed care program integrity. According to CRS, in fiscal year 2013, approximately 84 percent of separate CHIP program enrollees received coverage under some form of managed care. Do these same gaps in program integrity issues exist in CHIP? What efforts exist to ensure the integrity of the CHIP program?**

In our recent work on Medicaid program integrity, we found that managed care presents a gap in Medicaid program integrity efforts—as state and federal program integrity officials primarily focus on fee-for-service claims rather than Medicaid managed care payments.⁵ We also found that federal entities have taken few steps to address Medicaid managed care program integrity. We recommended that CMS increase its oversight of Medicaid managed care program integrity through a number of mechanisms, including requiring states to audit payments to and by Medicaid managed care plans. We did not assess the extent to which these gaps in program integrity efforts exist in separate CHIP programs. If similar gaps exist in CHIP program integrity efforts,

³The MAGI methodology does not apply to certain eligibility groups, including the aged, blind, or disabled, and individuals seeking coverage for long-term services and supports.

⁴See GAO, *Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance*, GAO-12-648 (Washington, D.C.: June 22, 2012).

⁵See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014).

our recommendations would be relevant for CHIP as well, given the prevalence of managed care coverage in separate CHIP programs.

7. As Congress moves to probably extend CHIP funding in some form, does GAO have relevant Medicaid or CHIP policies which you would recommend Congress consider that might either be targeted offsets or common-sense program integrity policies to include in legislation extending CHIP funding?

GAO has several open agency recommendations related to Medicaid program integrity, but we have not been asked to conduct work assessing CHIP program integrity issues. Our Medicaid program integrity recommendations include suggestions for CMS to strengthen the Medicaid Integrity Program, eliminate duplication, and more efficiently use audit resources;⁶ strengthen oversight of program integrity for Medicaid managed care;⁷ and increase efforts to ensure that states are correctly reporting overpayments.⁸ GAO also has an open matter for Congressional consideration regarding improving the transparency of and accountability for Medicaid non-disproportionate share hospital (DSH) supplemental payments. In November 2012, we reported that Congress should consider requiring the Administrator of CMS to require states to 1) improve state reporting of non-DSH supplemental payments, 2) clarify permissible methods for calculating such payments, and 3) submit an annual independent certified audit verifying state compliance with permissible methods for calculating non-DSH supplemental payments.⁹

The Honorable Frank Pallone, Jr.

1. Sometimes we hear people criticize Medicaid, and even CHIP, as being a “government-run” program. While the federal government provides financial support and broad parameters, states have a lot of flexibility to design their programs. Do you agree?

We have reported in prior work that the federal-state CHIP partnership has provided an important opportunity for innovation on the part of states for the overall benefit of children’s health.¹⁰ Providing three design choices—states may create a separate CHIP program, provide coverage to CHIP-eligible children through their Medicaid programs, or

⁶See GAO, *Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, GAO-13-50 (Washington, D.C.: Nov. 13, 2012).

⁷See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014).

⁸See GAO, *Medicaid: CMS Should Ensure that States Clearly Report Overpayments*, GAO-14-25 (Washington, D.C.: Dec. 6, 2013).

⁹See GAO, *Medicaid: More Transparency and Accountability for Supplemental Payments are Needed*, GAO-13-48 (Washington, D.C.: Nov. 6, 2012).

¹⁰See GAO, *Children’s Health Insurance: States’ SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization*, GAO-07-558T (Washington, D.C.: Mar. 1, 2007).

use a combination of these two approaches—allows states to focus on their unique needs and specific priorities. For example, provision of coverage through Medicaid (referred to as a CHIP-funded Medicaid expansion) offers Medicaid's comprehensive benefits and administrative structures and ensure children's coverage if states exhaust the CHIP allotments. In contrast, separate CHIP programs offer the state more flexibility in designing the program and may allow the state to better control program spending than when coverage is provided through a CHIP-funded Medicaid expansion.

2. Isn't it true that most of the coverage provided under both Medicaid and CHIP is provided through private insurance companies, either HMOs or some other arrangement?

We have not been asked to conduct any work looking at the use of managed care in CHIP. However, data indicate that the use of managed care in Medicaid and CHIP is substantial. According to statistics developed by MACPAC, about 80 percent of enrollees in states with separate CHIP programs were enrolled in managed care in fiscal year 2013.¹¹ Though we did not identify comparable data for children in CHIP-funded Medicaid expansion programs, the most recent data for Medicaid managed care enrollment show that about 63 percent of Medicaid children were enrolled in comprehensive managed care in fiscal year 2011.

3. What Medicaid and CHIP do guarantee, however, is coverage that is child-appropriate. In Medicaid, and in CHIP programs provided through Medicaid, children are guaranteed the Early Periodic Screening Detection and Treatment (EPSDT) benefit. Could you discuss what EPSDT provides that is critical for children?

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit entitles children in Medicaid to receive age-appropriate periodic screening services that include a comprehensive health and developmental history, a comprehensive physical exam, appropriate immunizations, laboratory tests, and health education. EPSDT also covers dental, vision, and hearing services and other necessary health care services, such as diagnostic follow up tests when concerns are identified, as well as the services necessary to control, correct, or reduce health conditions discovered through screenings and diagnostic tests, regardless of whether these services are typically covered by the state's Medicaid plan for other beneficiaries. Separate CHIP programs are not required to provide full EPSDT services but some separate CHIP programs do so.

4. In the responses from Governors that the Committee received to its July 2014 letter on the CHIP program, most governors expressed interest that Congress should act quickly to extend CHIP funding. I strongly agree that we need to act quickly. Please share some of the administrative and operational challenges that states would face if Congress were to delay acting on this issue?

We have not done work to assess how the timing of an extension of CHIP funding could affect states. However, states are likely to face challenges if Congress ultimately decides

¹¹As of fiscal year 2013, 5.3 million children across 39 states were enrolled in separate CHIP programs, and 2.5 million children across 32 states were enrolled in CHIP-funded Medicaid expansions.

not to extend funding. For example, states may not be prepared to seamlessly transition children to coverage in qualified health plans (QHP) offered through health insurance exchanges. As we noted in my testimony before the Committee, if CHIP funding is not extended, PPACA requires that beginning in October 2015 states must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility. If ineligible for Medicaid, children are to be enrolled in a QHP.¹² For states with CHIP-funded Medicaid expansions, children would remain in Medicaid in the absence of CHIP funds, but the state would receive a lower federal matching rate, increasing state costs.

5. In terms of physician access, I understand 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?

In 2013, we reported that our review of survey data indicated that most CHIP enrollees reported positive responses regarding their ability to obtain care, and the proportion of positive respondents was generally comparable to those with Medicaid or with private insurance.¹³ While over 88 percent of CHIP enrollees reported that they had a usual source of care and always or almost always got the care they needed, it is likely that some proportion of children with each type of coverage experience challenges in accessing care. Our prior work suggests that any access issues may be more pronounced for children in CHIP or Medicaid. For example, physicians we surveyed in 2010 experienced much greater difficulty referring children in Medicaid and CHIP to specialty care compared to privately insured children.¹⁴ These studies relied on survey information collected prior to many of the changes required under PPACA, which could have affected children's access to care in all markets.

¹²The QHPs for children transitioning out of CHIP must be certified by the Secretary of HHS as offering benefits and imposing cost-sharing for children in a manner that is at least comparable to the covered services and cost-sharing protections under the state's CHIP plan.

¹³See GAO, *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, GAO-14-40 (Washington, D.C.: Nov. 21, 2013).

¹⁴See GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624 (Washington, D.C.: June 30, 2011).

Congress of the United States
Washington, DC 20515

January 8, 2015

Dr. Anne L. Schwartz
Executive Director
Medicaid and CHIP Payment and Access Commission
1800 M Street, N.W., Suite 650 South
Washington, D.C. 20036

Dear Dr. Schwartz:

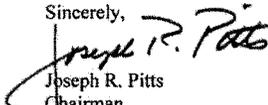
Thank you for appearing before the Subcommittee on Health on Wednesday, December 3, 2014, to testify at the hearing entitled "The Future of the Children's Health Insurance Program."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, January 22, 2015. Your responses should be mailed to Adrianna Simonelli, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Adrianna.Simonelli@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment



January 21, 2015

The Honorable Joseph R. Pitts
Chairman, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2223A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone:

Thank you for the opportunity to testify on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC) before the Energy and Commerce Committee's Subcommittee on Health on Wednesday, December 3, 2014 regarding the future of the State Children's Health Insurance Program.

I am pleased to have the opportunity to respond to the additional questions for the record you forwarded to me. Please do not hesitate to contact me if you or your staff have additional questions, or if MACPAC staff can be of further assistance.

Sincerely,

Anne L. Schwartz, PhD
Executive Director

Enclosure

Questions for the Record from the Honorable Joseph R. Pitts
Hearing on “The Future of the Children’s Health Insurance Program”
December 3, 2014
Anne L. Schwartz, PhD
Medicaid and CHIP Payment and Access Commission

Q1: What are the current estimates (CBO’s and/or MACPAC’s estimates) regarding the coverage effects on current CHIP enrollees if Federal CHIP funding is or is not extended? Specifically, what proportion of CHIP enrollees are expected to obtain coverage from Medicaid, the exchange, or employer-sponsored insurance, and what proportion are expected to become uninsured?

A1: Under current law, states and territories will exhaust their last remaining federal funding for the State Children’s Health Insurance Program (CHIP) during fiscal year (FY) 2016, which begins October 1, 2015. States will exhaust their remaining CHIP allotments at various points throughout FY 2016.

The maintenance of effort (MOE), which was included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), requires states to continue Medicaid and CHIP coverage at current eligibility levels for children at least through FY 2019. Because children enrolled in Medicaid-expansion CHIP are considered Medicaid-enrolled children who happen to be financed by CHIP (as long as such funds exist), the MOE applies regardless of the availability of federal CHIP funds. Thus, those children’s Medicaid coverage must continue (at least through FY 2019), although at a federal matching rate lower than CHIP’s. Without federal CHIP funding, states with children in CHIP programs separate from Medicaid may terminate that coverage.

For projections of the sources of coverage children would receive if separate CHIP coverage ended, MACPAC turned to the Urban Institute and its Health Insurance Policy Simulation Model-American Community Survey (HIPSMA-ACS). A preliminary analysis for MACPAC projects that if federal funding for CHIP is exhausted in 2016, 1.1 million children who would have been enrolled in separate CHIP programs would become uninsured. This is nearly one-third of the 3.7 million children (age 0–18) who would need to find other sources of coverage if their separate CHIP coverage ends. The remaining two-thirds are projected to enroll in subsidized exchange coverage (1.4 million) or job-based insurance (1.2 million).

The core data for this model are from the Census Bureau’s American Community Survey (ACS), which is an annual, state, and nationally representative survey of 3 million U.S. residents. National and state eligibility rules and out-of-pocket costs for Medicaid, CHIP, and exchange coverage were used to simulate eligibility and enrollment in these programs. The costs and eligibility for job-based coverage were also included. With this information, projections were produced as to who is eligible for coverage, how much would it cost, and who would enroll or be uninsured, based on various assumptions.

There are a number of caveats that need to be considered in any such modeling effort. First, there is uncertainty in the model’s assumptions about the rate of participation in employer-sponsored and subsidized exchange coverage. Sensitivity analyses are underway to test how much various assumptions would affect the projected number of uninsured. Second, in forecasting to 2016, the analysis assumes that the economic picture and the structure of employer-sponsored coverage remains constant, which may not be the case. Third, income, insurance coverage, premiums, health status, and other factors reported by or projected for CHIP-eligible children are subject to measurement and reporting errors.

Q2: Many of the members from both sides of the aisle at the December 3rd hearing, as well as health care providers and children’s advocates, have praised CHIP as a program that is currently successful. Can you confirm that if Congress were to eliminate the 23 percent increase to the EFMAP in current law, CBO projects that extending CHIP for two years could save federal money/reduce the deficit?

A2: In the spring of 2014, CBO estimated that MACPAC's recommendation to extend CHIP by two additional years (to provide federal CHIP allotments for FY 2016 through 2017) would increase net federal spending by \$0-5 billion above the current law baseline. This recommendation assumed no changes in any other aspect of CHIP-funded coverage as it exists under current law, including the 23-percentage-point increase in the CHIP federal matching rate slated for FY 2016 through 2019.

At the same time, the Commission received from CBO an estimate of how much net federal spending would change if CHIP were extended by two years without the 23-percentage-point increase. In that case, CBO projected that net federal spending would decrease—from \$0-5 billion.

CBO's estimate reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2015 at \$5.7 billion each year.

Q3: As Congress moves to probably extend CHIP funding in some form, what offsets does the Commission recommend for our consideration? Will MACPAC commit to working to inform us on offsets for funding CHIP in a timely manner, similar to how MedPAC does for Medicare policies?

A3: MACPAC is committed to working with Congress to provide information on potential offsets and other financing considerations related to Medicaid and CHIP. With respect to the extension of CHIP funding, as noted in MACPAC's June 2014 Report to the Congress, the costs of extending CHIP would largely be offset by reductions in federal spending for Medicaid and subsidized exchange coverage - sources of federally subsidized coverage in which many children are assumed to enroll in if CHIP funding were to be exhausted under current law.

In addition, congressional budget rules require CBO to assume in its baseline that federal CHIP funding continues beyond FY 2015. Based on these assumptions, the CBO estimated that a two-year extension of CHIP would increase net federal spending by \$0-5 billion above the agency's current law baseline. This estimate assumes that the ACA's increase in the CHIP matching rate (23 percentage points) takes effect in FY 2016. Federal costs would be lower if CHIP matching rates remained at their current levels.

Q4: The bipartisan Rivlin-Domenici Debt Reduction Task Force - led by former Clinton White House OMB Director Alice Rivlin and Republican Senator Pete Domenici - warned that "the present debt trajectory of the United States federal government cannot be sustained and poses grave dangers to the American economy." They noted lawmakers "must make difficult decisions to get our fiscal house in order," acknowledging that "any realistic solution must include structural reforms to entitlements." Rivlin-Domenici noted that two of their operative principles were to (a) protect the truly disadvantaged to ensure a sustainable safety net while (b) making spending reductions and adopting policy reforms that focused benefits on those who need them most. When does MACPAC expect to recommend to Congress policies that will reduce Medicaid spending, while adhering to these sound principles?

A4: MACPAC strongly supports the principles of ensuring a sustainable safety net and adopting policy reforms that focus benefits on those who need them most. Throughout its tenure, the Commission has worked to develop analyses that shed light on patterns of spending within Medicaid (for example, by eligibility group, type of service). Such analyses are critical to identifying both which enrollees are most vulnerable and where improvements could be made to ensure that the program operates efficiently.

An area where Congress can expect to hear more from the Commission in the coming months are analyses of state efforts to promote value-based purchasing. In particular, we are interested in sharing what we have learned about the design and effectiveness of payment and delivery system changes that promote positive health outcomes while incentivizing more rational use of health services. In addition, we will be further developing our work focused on high-cost, high-need populations, such as users of long-term services and

supports and those with behavioral health needs. Our goal in this work is to identify how best to meet the needs of these vulnerable enrollees in a manner that is consistent with goals of economy and efficiency. We have also been monitoring efforts by the Centers for Medicare & Medicaid Services (CMS) as it tests new approaches to program integrity.

Across all of these programmatic areas, MACPAC has identified the lack of consistent, complete data as a barrier to promoting program accountability, value to the taxpayer, and access to appropriate health services for Medicaid enrollees. We will continue to highlight where data improvements will be critical to the goals of moderating program spending and serving those most in need.

Q5: With all the outreach that has occurred under the current CHIP program and given the amount of federal dollars spent on outreach encouraging consumers to get enrolled in health coverage related to the health care law, what, if any, policy rationale is there for continued federal funding of CHIP performance bonuses? Do states already receive federal matching funds for outreach conducted?

A5: As the Committee is aware, funding for performance bonuses for enrollment and outreach to eligible but uninsured children has expired. States may receive federal matching funds for most separate CHIP outreach expenses at the CHIP enhanced federal medical assistance percentage (FMAP) rate. Translation and interpretation services are eligible for a higher matching rate of 75 percent, or the 5 percentage points above the state's CHIP enhanced matching rate, whichever is higher (see §2105(a)(1) of the Social Security Act). In addition, a total of \$126 million in outreach grants were made available from FY 2009 through FY 2015 for outreach and enrollment grants for states, local governments, Indian tribes, and community organizations. These grants can fund outreach activities, but they cannot be used to provide coverage.

In MACPAC's November 17, 2014 comment letter on the U.S. Department of Health and Human Services reports on adult and children's health care quality reports to the Congress (available at www.macpac.gov/comment-letters), MACPAC noted that any decision to extend bonus payments would require significant design decisions. Specifically, many eligibility simplifications incentivized by the performance bonus program are now statutory requirements under the ACA and the current formula for calculating performance bonus payment amounts relies on pre-ACA eligibility standards (see 2103(a)(3)(F)(i) of the Social Security Act).

Q6: The Affordable Care Act/Obamacare required states to use modified-adjusted gross income (MAGI) for CHIP eligibility. What, if any, income sources are excluded from the MAGI calculation as part of CHIP eligibility determination and what is the rationale for these exclusions?

A6: Modified adjusted gross income (MAGI) is calculated on IRS Form 1040 plus any foreign earned income excluded from taxes, any tax-exempt interest, and any tax-exempt Social Security income. This measure was intended to align income-counting methodologies across Medicaid, CHIP, and subsidized exchange coverage. Thus, MAGI has required some changes in how income is counted in Medicaid for certain eligibility pathways. There are some income sources previously counted that may no longer be factored into income determinations. These include example, veteran's benefits, child support that a family receives, as well as any pre-tax contributions households may make toward expenses like childcare costs and flexible spending accounts. In addition, while self-employment income will still be counted, the tax code allows for various deductions, such as depreciation, that were not typically allowed in Medicaid prior to the ACA.

Similarly, the move to MAGI has required changes in calculation of family size. For example, under MAGI, stepparents are included as part of a child's household and their income counts toward income eligibility for a child. Prior to the ACA, most states would disregard such income, as the stepparent is not legally responsible for the child.

Q7: States have told us that, as a result of the modified-adjusted gross income (MAGI) calculation's treatment of lump sum payments, lottery winners are 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. This includes at least one individual who won more than \$25 million. Since CHIP uses MAGI calculations as well, is it possible that CHIP is providing coverage for lottery winners? Please explain how lump sum payments such as lottery winnings are treated under the MAGI calculation? Does MACPAC believe it is appropriate for multi-million dollar lottery winners who may have bank accounts greater than some CEOs to receive Medicaid?

A7: MAGI requires the use of the latest income information and prohibits the use of asset tests. For CHIP eligibility purposes, a large amount of income (e.g., from lottery winnings, cashing out a 401(k), sale of a home or vehicle, earnings) may count as income generally in the year in which it was realized and make a family ineligible that year. In years that follow, however, any remaining funds are treated as assets and generally do not count as income (unless they are bearing interest or other realized income).

It should be noted that asset tests were rarely used in separate CHIP programs prior to the implementation of MAGI. For example, in January 2013, only two states used asset tests in their separate CHIP programs—Missouri for \$250,000 and Texas for \$10,000.¹ States that voluntarily eliminated their asset tests in CHIP did so for reasons such as:

- the administrative burden and costs of asset tests on states;
- relatively few families being determined ineligible because of asset tests; and
- many eligible families being dissuaded from applying because of the administrative and application burden of asset tests.²

MAGI has made the elimination of asset tests in CHIP (and for some populations in Medicaid) a national standard and removes a potential barrier to enrollment.

To address this particular situation, Congress could amend MAGI to account for lottery winnings that no longer count as income. Congress previously amended MAGI to allow counting of tax-exempt Social Security income count.³ The Commission expressed its support for congressional action in that case, noting that it was consistent with prior state practices and that it would avoid requiring states to calculate taxable versus tax-exempt Social Security income.⁴ However, the Commission has not recommended the reintroduction of CHIP asset tests, which the vast majority of states had voluntarily eliminated prior to the implementation of MAGI. The Commission will continue consideration of these issues as part of its ongoing monitoring of the implementation of MAGI and the ACA.

Q8: MACPAC has recommended creating a statutory option for states to implement 12-months continuous eligibility for children in CHIP. To what extent does a 12-month continuous eligibility option result in CHIP

¹ Table 6, M. Heberlein et al., *Getting into gear for 2014: Findings from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP, 2012-2013*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2013. <http://www.kff.org/medicaid/upload/8401.pdf>. In Missouri, this so-called net-worth test applied to children above 150 percent of the federal poverty level (FPL). Texas' asset test for separate CHIP children also applied only above 150 percent FPL.

² See, for example, V.K. Smith et al., *Eliminating the Medicaid asset test for families: A review of state experiences*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2001. <http://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf>.

³ §401 of P.L. 112-56, enacted November 21, 2011.

⁴ Medicaid and CHIP Payment and Access Commission (MACPAC), letter to HHS Secretary Kathleen Sebelius regarding CMS-2349-P "Eligibility Changes Under the Affordable Care Act of 2010," October 2011, http://www.macpac.gov/comment-letters/MACPAC_Comments-CMS_Eligibility_Rule_Oct2011.pdf.

coverage for individuals from families with incomes above the CHIP eligibility thresholds? How does a 12-month continuous eligibility policy affect the required premiums and cost sharing for an enrollee? Could it result in an enrollee paying more or less than required based on their current income?

A8: In its March 2013 report, MACPAC recommended that 12-month continuous eligibility be made statutorily available for children in CHIP, at state option, as is the case for children in Medicaid. At the time, 33 states were using 12-month continuous eligibility in their separate CHIP programs. However, because of the implementation of MAGI, it was unclear whether or not CMS would continue to permit 12-month continuous eligibility for children in CHIP. Since then, in May 2013, CMS clarified that states may continue offering 12-month continuous eligibility as a state plan option for children in CHIP.⁵

In considering the merits of continuous eligibility, it is important to note the frequent income fluctuations, potentially affecting Medicaid and CHIP eligibility, that are typical in the low-income population. Historical research has shown that, depending on the state and the size of its program, between 11 and 67 percent of children who were enrolled in a separate CHIP program at any point during the year were also enrolled in Medicaid-financed coverage at some time during the same year.⁶ With the addition of subsidized exchange coverage and the requirement that intra-year income changes be reported in Medicaid and CHIP, churning between programs may be more prevalent than churning off of coverage altogether.⁷

The amount that families pay depends upon the coverage source to which they churn. If they churn Medicaid, they may see a decline in out-of-pocket premiums and cost sharing relative to CHIP.⁸ If they move to subsidized exchange coverage, they may see an increase in out-of-pocket payments. In CHIP, total out-of-pocket payments for premiums and cost sharing are limited to 5 percent of family income, although most states have lower limits. For out-of-pocket premiums alone, subsidized exchange coverage generally requires 3 to 9.5 percent of family income in the typical CHIP income range. In no state are the cost-sharing protections for children in subsidized exchange coverage comparable to those of CHIP.⁹

MACPAC will be monitoring this issue as enrollment data become available for 2014.

Q9: How does the current eligibility requirements of CHIP, Medicaid, and the Exchange coverage affect whether or not parents and children have the same health coverage? Please provide illustrative examples of situations where a family may have member with different coverage, such as a child in CHIP and parent with coverage on the exchange.

A9: Medicaid, CHIP, and exchanges have different income eligibility rules for coverage or available subsidies, which can affect whether parents and children have the same coverage. The ACA set the minimum Medicaid income eligibility level for children at 138 percent of the federal poverty level (FPL), but many states provide Medicaid coverage to children in families with higher incomes. Under the ACA, states may also choose to

⁵ Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, letter from Cindy Mann to State Health Officials and State Medicaid Directors regarding "Facilitating Medicaid and CHIP enrollment and renewal in 2014," May 17, 2013, <http://www.medicare.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>.

⁶ J.L. Czajka, *Movement of children between Medicaid and CHIP, 2005–2007*, MAX Medicaid policy brief no. 4. Princeton, NJ: Mathematica Policy Research, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/Medicaid_and_CHIP_Transitions.pdf.

⁷ 42 CFR 435.916(c).

⁸ Even in a state with 12-month continuous eligibility, children would be moved from CHIP to Medicaid if a decline in income is reported during the year that would make them eligible for a more generous program or cost-sharing protections. In a state with continuous eligibility, it is not clear the extent to which families would continue to report such declines in income.

⁹ A. Bly et al. *Comparison of benefits and cost sharing in Children's Health Insurance Programs to qualified health plans*. Englewood, CO: Wakely Consulting Group, 2014, <http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf>.

cover eligible adults under age 65 in Medicaid with incomes at or below 138 percent FPL. As of January 16, 2015, 28 states are expanding coverage to this adult population (NASHP 2015).¹⁰

In addition, some parents are eligible for Medicaid through pathways other than the new adult group. Federal Medicaid rules in place prior to enactment of the ACA require states to cover parents with dependent children who would have been eligible for cash assistance under program rules in place prior to 1996 (when welfare reform was enacted), on average, 41 percent FPL (CMS 2015). States also may cover parents at higher income levels. Of the states not expanding Medicaid to the new adult group, 14 cover parents with income less than 50 percent FPL, 5 cover parents with income between 50 and 100 percent FPL, and 4 cover parents with income greater than 100 percent FPL (Brooks et al. 2015).

CHIP was designed to provide health insurance to low-income uninsured children above 1997 Medicaid eligibility levels and has also been used to fund coverage of pregnant women and other adults on a limited basis. While Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no mandatory income level up to which CHIP programs must extend coverage. Under the ACA, however, states must maintain their 2010 eligibility levels for children in both Medicaid and CHIP through FY 2019. States' upper limits for children's CHIP eligibility range from 175 percent to 405 percent FPL. It is worth noting, however, that 89 percent of the children enrolled in CHIP-financed coverage had incomes at or below 200 percent FPL in FY 2013 and 97 percent were at or below 250 percent FPL (MACPAC 2014a).

While there are no income limits on who can purchase coverage on exchanges, eligibility for subsidies is based on income. Premium tax credits may be available to those with incomes between 100 and 400 percent FPL and cost sharing reductions to those with incomes between 100 and 250 percent FPL, if they do not otherwise have access to affordable coverage.

Depending on the state, family income, and age of children, family members could be enrolled in different coverage sources. For example, consider two families both with two children aged 10 months and 8 years, at two income levels: 135 percent FPL and 200 percent FPL. The chart below provides examples of how members of a family could have different sources of coverage.

Sources of Coverage for Families at 135% of the Federal Poverty Level (FPL) and 200% FPL in Three States

State	135% FPL			200% FPL		
	Family member			Family member		
	10 month old	8 year old	Parents	10 month old	8 year old	Parents
California	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Exchange
Pennsylvania	Medicaid	Medicaid	Exchange	Medicaid	CHIP	Exchange
New Jersey	Medicaid	Medicaid	Medicaid	CHIP	CHIP	Exchange

Note: Based on state Medicaid and CHIP eligibility levels as of January 2014 and state Medicaid expansion decisions as of January 2015.

¹⁰ This includes five states (Arkansas, Iowa, Michigan, New Hampshire, and Pennsylvania) that are using an alternative to traditional expansion.

**Questions for the Record from the Honorable Frank Pallone, Jr.
Hearing on “The Future of the Children’s Health Insurance Program”
December 3, 2014
Anne L. Schwartz, PhD
Medicaid and CHIP Payment and Access Commission**

Q1: Sometimes we hear people criticize Medicaid, and even CHIP, as being a “government run” program. While the federal government provides financial support and broad parameters, states have a lot of flexibility to design their programs. Do you agree?

A1: Yes, states have broad flexibility in many aspects of Medicaid and CHIP programs including benefit design, payment policy, delivery system design, and the extent to which they cover certain populations.

States have more flexibility within CHIP than Medicaid to design their benefit packages and can model their benefits based on specific private insurance benchmarks, a package equivalent to one of those benchmarks, or Secretary-approved coverage. The most flexible of these options is Secretary-approved coverage, which is the most common approach.

States also have the flexibility under CHIP to charge premiums and cost sharing at levels generally not permitted by Medicaid (although limited in total to 5 percent of family income). In addition, states’ separate CHIP programs can rely on administrative structures and payment policies and rates that are distinct from those in Medicaid.

States set eligibility levels for Medicaid and CHIP, subject to certain minimums and limitations. For example, Medicaid coverage must be available to children up to 138 percent FPL. There is no minimum eligibility level for CHIP. However, the MOE requires states to maintain their eligibility levels for children in Medicaid and CHIP through FY 2019.

States also have broad flexibility in establishing their payment policies and delivery systems. For example, some states rely almost entirely on managed care plans, while others use state-administered fee-for-service programs. For payments to plans and providers, states set their rates within broad federal parameters. As a result, payment levels and policies vary substantially across states.

Q2: Isn’t it true that most of the coverage provided under both Medicaid and CHIP is provided through private insurance companies, either HMOs or some other arrangement?

A2: The majority of children enrolled in Medicaid and CHIP are enrolled in some form of managed care, including through HMOs or other arrangements (primary care case management).¹¹ In fiscal year 2013, 44 states enrolled at least some of the children with separate CHIP program coverage in some form of managed care. Among children enrolled in separate CHIP programs, 80.2 percent received care through a managed care plan, such as an HMO and 3.6 percent were enrolled in primary care case management (MACPAC 2014a). In fiscal year 2011, 46 states enrolled at least some of the children enrolled in Medicaid in some form of managed care. Of these children, 63.3 percent are enrolled in comprehensive, risk-based managed care and 18.7 percent were enrolled in primary care case management (MACPAC June 2014b).

Q3: What Medicaid and CHIP do guarantee, however, is coverage that is child-appropriate. In Medicaid, and in CHIP programs provided through Medicaid, children are guaranteed the Early, Periodic, Screening,

¹¹ Under primary care case management, primary care providers receive a monthly fee to manage patients’ care.

Detection, and Treatment (EPSDT) benefit. Could you discuss what EPSDT provides that is critical for children?

A3: The Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services to all children under age 21 enrolled in Medicaid. States operating Medicaid-expansion CHIP programs must provide EPSDT to enrollees and although not required, 13 states operating separate CHIP programs also provide enrolled children EPSDT or EPSDT-like benefits (Cardwell et al. 2014).

Under EPSDT, states must screen children for and provide medically necessary services to treat physical, mental, vision, hearing, and dental problems or conditions. States must establish and adhere to a periodicity schedule based on professional guidelines that sets how often screenings for physical, mental, vision, hearing, and dental conditions occur. EPSDT requires that based on findings from the screening, states refer children in need of further evaluation and diagnosis to such services.

If a child requires medically necessary treatment or services to maintain or improve their health condition, any such services that could be covered under Medicaid regardless of whether the services are covered in the state's Medicaid state plan, must be covered. For example, services that children could receive through EPSDT include mental health and substance abuse services, personal care services (for example, assistance with performing activities of daily living, such as dressing, eating, and bathing), dental services, vision services (including eyeglasses) and hearing services (including hearing aids).

Q4: In the responses from Governors that the Committee received to its July 2014 letter on the CHIP program, most governors expressed interest that Congress should act quickly to extend CHIP funding. I strongly agree that we need to act quickly. Please share some of the administrative and operational challenges that states would face if Congress were to delay acting on this issue?

A4: Most states have fiscal years that begin on July 1 and most have begun their legislative sessions.¹² As such, they are already planning for the budget year that includes September 2015, when CHIP funding is set to expire, and will need to make assumptions about whether or not federal financing will continue. States that do not budget for ongoing CHIP funding may need to revisit their budget to allocate the state share of the program should federal financing be extended. States assuming ongoing federal spending may face a shortfall if funding is extended, but after their current allotment expires. If funding is ultimately not extended, states will face the administrative challenge of dissolving their separate CHIP programs or the fiscal challenge of maintaining their CHIP-financed Medicaid expansions at the lower Medicaid matching rate.

There are at least four primary administrative and operational areas that states will need to consider:

1. States will decide the level at which they will continue their existing separate CHIP coverage. States could maintain coverage for current enrollees and freeze any new enrollment, disenroll current CHIP children, or continue to operate an open program while possibly incurring the full cost of coverage. The extent to which they maintain their separate CHIP program will likely depend in part upon how much they have in carryover funding and how much they may be willing to spend in state-only funds.
2. States will also need to notify families of the upcoming programmatic changes, allowing them to report any updates in family circumstances or additional information that may make their children eligible for Medicaid or exchange coverage. Additionally, consumer assistance and education will also be needed so that families understand the changes occurring in CHIP. Should the program reopen

¹² National Conference of State Legislatures (NCSL). 2015. 2015 state legislative session calendar. <http://www.ncsl.org/research/about-state-legislatures/session-calendar-2015.aspx>. and NCSL. 2012. Quick reference fiscal table. <http://www.ncsl.org/research/fiscal-policy/basic-information-about-which-states-have-major-ty.aspx>.

after funding is extended, states will need to conduct further outreach and education, with the understanding that freezes in enrollment often affect future program participation.¹³

3. Eligibility and enrollment systems (including the exchanges) will need to be updated to reflect new income thresholds and whether or not CHIP is open for enrollment. If a waiting list is established, a system will also need to be developed to track and possibly enroll applicants. States have established procedures for coordinating between the various health insurance affordability programs and children found eligible will need to be enrolled in a qualified health plan that has been certified as comparable to CHIP by the Secretary, a certification that needs to be completed by April 1, 2015.
4. CHIP is primarily operated through managed care organizations and state contracts with plans may include provisions regarding operations in the case of a funding lapse. This may require certain notice requirements and ongoing coverage through a period of time, which may come at the expense of the state. If the CHIP program is ceasing operations, states will need to work with plans to terminate the contract.

CMS has not released any details on the certification of comparability nor any guidance for states (beyond what is in statute) on the transition from CHIP to Medicaid or exchange coverage should funding cease. Additionally, there is little precedent for what the agency might require as states end their CHIP programs or state experience to serve as a guide, since Arizona is the only state to effectively end its CHIP program and it operated under a waiver.

Q5: The Affordable Care Act took many steps to simplify how CHIP and Medicaid are administered, to ensure greater coverage of children—one of these steps was to create a uniform income eligibility standard for siblings within families. Prior to this, because of differences in income eligibility limits based on age, there were families with children who would no longer be eligible for Medicaid when they turned six, even as their younger siblings remained on Medicaid. The ACA effectively moved some children from CHIP to Medicaid coverage. Some of my colleagues across the aisle talk about this like it's a bad thing, and that "millions" of children have been affected.

- a. Can you give us an estimate of how many children have been affected by this "stairstep" provision?
- b. Can you also discuss the benefits of the stairstep provision for children and for States?

A5: Section 2001(a)(5)(B) of the ACA increased the minimum eligibility threshold for children ages 6-18 from 100 percent FPL to 133 percent FPL. As a result, states covering older children up to 133 percent FPL in separate CHIP programs needed to transfer these children to Medicaid as of January 1, 2014. CMS gave a number of states permission to implement an alternative approach, such as coordinating the transition with regularly scheduled renewals.

At the time of the ACA's enactment, 21 states were affected by this provision. Two states, New York and Colorado, implemented an early transition of children from CHIP to Medicaid, while New Hampshire and California decided to move all their children in their separate CHIP programs to Medicaid. Although CMS has not published any data on the number of children transitioning, available estimates suggest that more than 540,000 children enrolled in the 17 remaining separate CHIP programs would move to Medicaid.¹⁴

¹³ Cohen Ross, D. and L. Cox. 2003. Out in the cold: Enrollment freezes in six State Children's Health Insurance Programs withhold coverage from eligible children. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/out-in-the-cold-enrollment-freezes-in-six-state-children-s-health-insurance-programs-withhold-coverage-from-eligible-children.pdf>.

¹⁴ Prater, W. and J. Alker. 2013. Aligning eligibility for children: Moving the stairstep kids to Medicaid. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8470-aligning-eligibility-for-children.pdf>.

This shift in coverage allows children in families to remain enrolled in the same program regardless of their age. Additionally, as these children are now Medicaid enrollees, they are provided the same benefits, cost sharing, and other protections as other children covered through Medicaid. For example:

- Stairstep children will have access to the full Medicaid benefit packaged, including the EPSDT benefit.
- Because states may not charge premiums and cost sharing to children covered through the mandatory Medicaid eligibility pathways (which now includes the stair-step children), children transitioning will not be charged for their coverage or care.
- Waiting periods are not permitted in Medicaid without a waiver, so children with income between 100 and 133 percent FPL who are newly eligible for Medicaid coverage will no longer have to wait to enroll.
- Since Medicaid is an entitlement, states cannot cap or freeze enrollment and any child who is found eligible must be enrolled.

There may also be disadvantages to moving from separate CHIP into Medicaid. For example, there are anecdotal concerns that children fare better in CHIP in terms of access to care. For states, the transition clearly required additional administrative efforts such as identifying affected children, transitioning them to a new source of coverage, and providing families with timely notice of the change. However, once this transfer has occurred, states may see the administrative burden lessen, as they are no longer moving children from Medicaid to CHIP when a child turns six. Additionally, states will continue to receive the higher CHIP matching rate for coverage of children who moved from CHIP to Medicaid as a result of this provision.¹⁵

Q6: When Congress passed the Affordable Care Act, it included a provision called the Maintenance of Effort that required states to maintain coverage levels for children in Medicaid through 2019. The intent of this provision was to ensure that millions of low to moderate income children currently covered under Medicaid did not find themselves suddenly uninsured or underinsured as new coverage options were coming available. While I am sure a very small handful of states, if given the opportunity would simply drop coverage and hope children found their way to Marketplace coverage, most states appreciate the value of Medicaid and CHIP for children and would not take such a step. In the CHIP arena, however, I have heard some complaints that it is unfair that States that operate separate CHIP programs could simply drop children's coverage if CHIP funding is not continued, while for States that have chosen to administer CHIP via their Medicaid program, they will have to continue to cover these children. However, while some states may not like that maintenance of effort requirement, some states have deliberately chosen the Medicaid-CHIP expansion route because the state is guaranteed continued federal support for covering these children even if CHIP money runs out. Isn't that correct?

A6: Years ago, states faced several trade-offs when designing their CHIP programs. By using a separate CHIP program, states could implement waiting lists and enrollment caps, with flexibility to charge premiums and cost sharing and offer benefits less generous than required in Medicaid. However, if federal CHIP funding were exhausted, there would be no fallback for federal funding of separate CHIP programs.

On the other hand, states that chose Medicaid-expansion CHIP programs often found implementation easier. These states draw down enhanced federal CHIP matching funds for children enrolled through a simple Medicaid expansion. In addition, if federal CHIP funding were ever exhausted, these states would have federal Medicaid funds to fall back on, although requiring a 43 percent higher state share than CHIP.

¹⁵ Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. CMS answers to frequently asked questions: Telephonic applications, Medicaid and CHIP eligibility policy and 75/25 federal matching rate. August 9. <http://www.medicaid.gov/federal-policy-guidance/downloads/faq-08-09-2013.pdf>.

While states' ability to revert to Medicaid funding may have been a consideration when deciding how to implement their CHIP programs, they may have chosen differently if they had known that CHIP funding would end and that the MOE would require them to maintain their Medicaid-expansion coverage beyond the exhaustion of federal CHIP funding. As you note, however, it is not clear how these states would respond in the absence of both the MOE and federal CHIP funding.

Q7: Can you please provide more details on the purpose of the Maintenance of Effort and how it will help to keep low-income children insured, which I believe is a goal that we all have on both sides of the aisle?

A7: For children, the MOE requires state Medicaid and CHIP programs to have, until October 1, 2019, eligibility standards, methodologies, and procedures in place that are no more restrictive than those in place at the enactment of the ACA (March 23, 2010).¹⁶ In short, states must continue to cover children with no more restrictions than they did before. However, this MOE does not obligate states to continue funding separate CHIP programs if federal CHIP funding is exhausted; a state may limit separate CHIP enrollment based on available federal CHIP funding.

While the exhaustion of federal CHIP funds under current law will result in children now covered by separate CHIP programs having to find other coverage or become uninsured, the MOE will ensure that those covered under the Medicaid expansion approach remain covered through at least FY 2019.

Q8: In fact, if we are worried about states with M-CHIP programs having to maintain their coverage while states with separate state programs can cut if CHIP funding does not get extended, shouldn't we just extend CHIP funding to ensure states have adequate fiscal support and that children won't lose coverage?

A8: As long as MOE is in effect, the continuation of federal CHIP funding treats separate CHIP states and Medicaid-expansion states equitably and ensures that CHIP enrolled children do not become uninsured.

Q9: Please expand on MACPAC's underlying intentions of their CHIP recommendations. Does MACPAC still recommend that Congress act on these previously recommended program improvements, or does the Commission now recommend that Congress simply fund CHIP for two more years?

A9: In its March 2014 report, MACPAC made two recommendations to Congress that would have an immediate effect on children's coverage through CHIP: (1) eliminate CHIP waiting periods, and (2) exempt families below 150 percent FPL from CHIP premiums.

In its June 2014 report, MACPAC followed up with a recommendation regarding the future of CHIP, recommending that federal CHIP funding be extended by an additional two years. This recommendation did not eliminate the need to make the program improvements called for in MACPAC's March 2014 report. On the contrary, the continuation of CHIP makes it even more important for Congress to eliminate CHIP waiting periods and premiums for families below 150 percent FPL.

The Commission cited four primary reasons to eliminate CHIP waiting periods. First, eliminating CHIP waiting periods will reduce uninsurance and improve the stability of coverage. Waiting periods cause children to move between 90 days or less of enrollment in exchange coverage, or uninsurance, before being eligible for CHIP. Second, eliminating CHIP waiting periods will reduce administrative burden and complexity for families, states, health plans, and providers as children move from short-term exchange coverage to CHIP. Because most of the states with CHIP waiting periods rely on the federally facilitated exchange, which is generally not able to do CHIP determinations where waiting periods exist, CHIP waiting periods are a barrier to streamlined, coordinated eligibility determinations. Third, although CHIP waiting periods were instituted

¹⁶ §§1902(gg) and 2105(d)(3) of the Social Security Act.

to deter crowd-out of private coverage, the limited research on CHIP waiting periods has reached contradictory conclusions, primarily driven by the different sources of data used by the researchers. Fourth, eliminating CHIP waiting periods is consistent with the goal of having more simplified and coordinated policies across various programs. Since neither exchanges nor Medicaid require waiting periods, eliminating CHIP waiting periods would make CHIP consistent with exchanges and Medicaid in this regard. In the past few years, most states have eliminated their CHIP waiting periods.

MACPAC called for the elimination of CHIP premiums below 150 percent FPL to prevent uninsurance and to align premium policies of separate CHIP programs with Medicaid. Above 150 percent FPL, premiums can be effective at preventing crowd-out with little increase in uninsurance, depending on the amount of the premiums; below 150 percent FPL, however, even small premiums can lead to significant increases in uninsurance among children.¹⁷ Only a handful of states continue to charge CHIP premiums below 150 percent FPL. The CHIP premiums charged in this income range, generally less than \$10 per month, are so small that they would not represent a significant revenue loss to states if they were eliminated—especially as this also removes states’ burden of collecting and administering these premiums. This recommendation did not call for any change to CHIP’s premium policies for families above 150 percent FPL, the income range for the vast majority of CHIP enrollees subject to premiums.

Q10: What are the key elements we should consider to determine whether CHIP is no longer necessary and children can be moved to other forms of equally comprehensive and affordable coverage?

A10: MACPAC called for federal CHIP funding to be extended by two additional years to allow time to make changes in public policy needed to ensure adequate and affordable coverage for low-income children, equitable treatment of states, appropriate use of public dollars when private dollars may be available (for example, through employer-sponsored coverage), and smooth transitions across sources of coverage. The Commission is at work on developing and analyzing policy options to address concerns about adequacy and affordability of children’s coverage.

Q11: Can you discuss issues that still need to be resolved with regard to network adequacy and access to pediatric services in Qualified Health Plans?

A11: There is an often-stated assumption that CHIP networks are better for children than those in exchange plans because CHIP is designed for children. There is little available evidence, however, to support this assumption. As such MACPAC has been exploring what policies might be needed to ensure that children who might move from CHIP to the exchanges have access to appropriate care. This is a complex issue requiring consideration of the effects of market conditions on issuers’ ability to create networks, how to ensure appropriate access to specialty care, measures of network adequacy, network transparency, and how plans and payers balance access, quality, and cost in network design.

Market conditions can affect plans’ ability to create networks. It may be difficult to contract with providers that are members of a relatively rare subspecialty or are the only facility of their type for a region, such as children’s hospitals. These providers can sometimes demand higher rates than plans are willing or able to pay. It can be challenging to connect children to needed specialty care. There are gaps in the supply of certain specialists at a population level, as well as gaps in certain geographic areas. Even if sufficient specialists exist, some may not wish to contract with plans, regardless of payer. The network adequacy challenges in dental care mirror those in medical care, including provider participation, network transparency, and affordability.

¹⁷ S. Abdus et al., “Children’s Health Insurance Program premiums adversely affect enrollment, especially among lower-income children,” *Health Affairs* 33(8): 1353–1360, August 2014. J.B. Herndon et al., “The effect of premium changes on SCHIP enrollment duration,” *Health Services Research* 43(2): 458–477, 2008.

Measuring network adequacy can be challenging because networks change frequently. In addition, those that are adequate for the majority of patients may not be adequate for those with special needs. While plans can be required to negotiate special arrangements in such circumstances, if the burden of arranging this care falls on families, it could present a major barrier to access. Network transparency is also important to consumers. While directories are currently the only source of provider participation information for consumers, they are not always accurate nor sufficiently detailed. A beneficiary may need to see a subspecialist with experience treating a specific condition, and that expertise is not likely to be reflected in directories.

Network design must balance two key factors: which providers are needed to ensure access for the insured population, and which providers are available and willing to serve enrollees. These factors affect a health plan's ability to create a network at a cost that is acceptable to both the plan and the providers. A plan's leverage to negotiate lower payment rates can be limited by low provider density (for example, in rural areas), low supply (for example, of children's hospitals and many pediatric specialists), or extensive regionalization of specific services (for example, children's hospitals). Narrow network designs also give issuers the opportunity to offer plans that include providers who meet specific access and quality benchmarks, although this does not currently seem to be a widespread practice (Corlette et al. 2014a, 2014b, Howard 2014).

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