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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

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December 1, 2014

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Subcommittee on Health Hearing entitled "The Future of the Children's Health Insurance Program"

The Subcommittee on Health will hold a hearing on Wednesday, December 3, 2014, at 10:15 a.m. in 2322 Rayburn House Office Building. The hearing is entitled "The Future of the Children's Health Insurance Program."

I. BACKGROUND

This hearing will examine the Children's Health Insurance Program (CHIP) which was enacted 17 years ago in the Balanced Budget Act of 1997[1] and currently provides health insurance coverage to more than 8.1 million children (as compared with 38.7 million children covered by Medicaid) and 10,000 pregnant women (in 4 states).[2] Through CHIP (Title XXI of the Social Security Act (SSA)), States can provide health insurance coverage to children under age 19 and pregnant women in low- and moderate-income families with incomes that are above Medicaid eligibility levels.[3] Unlike the Medicaid program, the CHIP program is a block grant, and while States receive enhanced federal matching funds (i.e., higher than the Medicaid match), States are limited to an annual federal allotment each year. CHIP and Medicaid together have brought coverage rates for children to a historic high of 92.9 percent nationally.[4]

[1] P.L. 105-33.

[2] See CHIP enrollment by State for fiscal year 2013 at Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Mar. 2014) (MACStats Table 3, page 68) (online at http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0).

[3] States can use CHIP funds to provide coverage to pregnant women and unborn children, but the majority of CHIP enrollees are children under age 19.

[4] U.S. Census Bureau, 2013 American Community Survey.

Initially $40 billion in Federal funding was authorized for the first 10 years of the CHIP program. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) increased CHIP appropriation levels to $68.9 billion over five years, and changed several aspects of the program, e.g., eligibility levels, benefit requirements, and the formula for allocating Federal funds to States.[5] The Patient Protection and Affordable Care Act (ACA) provided an additional two years of funding for CHIP, funding coverage through fiscal year (FY) 2015.[6] The ACA also provided that for 2015 through 2019 states will receive an additional 23 percent increase in federal support for the CHIP program. (For example, a state with a 65 percent CHIP match would see that match increase to 88 percent). As such, beginning in FY 2016, the federal CHIP matching rates will range from 88 percent to 100 percent, up from the current range of 65 percent to 83 percent. Separately under the ACA, States are required to maintain their Medicaid and CHIP eligibility levels through FY 2019—often referred to as a "maintenance of effort" requirement[7]—intended to prevent states from simply dropping existing health coverage in the face of new coverage availability through the Marketplace.

Below are key elements of CHIP program design, eligibility, coverage, and affordability. For more details, see two recent reports issued by two of the witnesses—Congressional Research Service, *State* Children's *Health Insurance Program: An Overview* (July 3, 2014); and Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, Chapter 1 (June 2014).

A. Program Design

States have flexibility in how they can design their CHIP programs—as an expansion of their Medicaid program, as a separate CHIP program, or a combination of these two approaches. Regardless of which approach a State takes, enhanced federal matching funds are available to pay for the costs for services provided to CHIP enrollees. If a State covers CHIP enrollees through its Medicaid program (i.e., CHIP Medicaid expansion), Medicaid rules (SSA Title XIX) apply. If a State creates a separate CHIP program, States may use alternate benefit and cost sharing approaches, including charging premiums. As of May 2014, 14 states had separate CHIP programs, seven states and the District of Columbia were using CHIP Medicaid expansions, and 29 states used a combination approach.[8]

Regardless of the approach chosen, all States retain the flexibility to deliver health benefits coverage through whatever arrangements are best suited for their state market, whether it is fee-for-service, managed care entities, new delivery reform models (such as medical homes), premium assistance for the purchase of private (including exchange) coverage, or combinations of the above.

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[5] P.L. 111-3.

[6] P.L. 111-148, as amended. The ACA authorized State CHIP allotments of $19 billion for FY 2014 and $21 billion for FY 2015.

[7] P.L. 111-148, as amended.

[8] Congressional Research Services, *State Children's Health Insurance Program: An Overview* (Jul. 3, 2014) (online at http://www.crs.gov/pages/Reports.aspx?PRODCODE=R43627&Source=search).

B. Eligibility

Beginning January 1, 2014, the ACA required States to use modified adjusted gross income (MAGI) rules when determining income eligibility for CHIP.[9] To do this, a State must compare an individual's MAGI minus a 5 percent disregard, with the State's income standards. The ACA also required States to transition CHIP children ages 6 through 18 in families with annual incomes less than 133 percent FPL—effectively 138 percent, with the 5 percent disregard—to Medicaid, in order to ensure uniform child coverage under Medicaid across all States up to 138 percent FPL.

Because of states' flexibility in designing their CHIP programs, as of January 1, 2014, CHIP income eligibility limits range from a low of 175 percent of the federal poverty level (FPL) to a high of 405 percent of FPL.[10]

Most CHIP enrollees are in families with relatively modest annual incomes. CRS reported that in FY 2013, the majority (89 percent) of CHIP child enrollees were in families with annual income at or below 200 percent FPL ($39,580 for a family of three), and almost all (97 percent) child enrollees were in families with annual income at or below 250 percent FPL. Retaining State flexibility in establishing income eligibility levels is important to allow States to account for the variation in cost of living across the United States.

C. Coverage

Under the CHIP program, States have a number of options for benefit package design. States choosing to operate a separate CHIP program may choose from either (1) a benchmark benefit package, e.g., Blue Cross Blue Shield preferred provider option offered under the Federal Employees Health Benefits Program; (2) benchmark-equivalent coverage, i.e., have the same actuarial value as one of the benchmark plans; (3) coverage approved by the Secretary of Health and Human Services; or (4) previously existing comprehensive state-based coverage (limited to certain states). While States have flexibility in determining specific benefit coverage, all States must cover emergency services, well-baby and well-child care including age-appropriate immunizations, and dental services.[11] States that provide CHIP coverage through a Medicaid expansion provide the Medicaid benefits package to CHIP enrollees, including the child-focused Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

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[9] The ACA also required States and the Federal government to use MAGI rules when determining income eligibility for most of Medicaid's nonelderly populations and subsidized exchange coverage.

[10] See CHIP income eligibility level by State as of January 2014 at Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Mar. 2014), (MACStats Table 9, page 80) (online at http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0).

[11] Congressional Research Services, *State Children's Health Insurance Program: An Overview* (Jul. 3, 2014) (online at http://www.crs.gov/pages/Reports.aspx?PRODCODE=R43627&Source=search).

D. Affordability

CHIP has been a critical coverage source for low- and moderate-income families who cannot access coverage for children as private insurance has been less attainable and more and more expensive. Premiums and out-of-pocket costs are significantly lower for families in CHIP as compared with private insurance, when available for dependents. While States choose the level of cost sharing and premiums, combined out-of-pocket expenses cannot exceed 5 percent of family income. The recent federally-mandated evaluation of CHIP re-confirmed that even when employer-sponsored insurance is offered for children, affordability is a major barrier for families.[12]

II. CHILDREN'S HEALTH INSURANCE IN THE NEW ACA LANDSCAPE

The health insurance market is very different today than from when CHIP was established. The ACA expanded the coverage options for children in families with incomes that exceeded CHIP and Medicaid eligibility levels by offering subsidized coverage in the health insurance exchanges. Because of the MOE requirement, if funding for CHIP is not extended, States with CHIP Medicaid programs must continue to cover current CHIP enrollees through their Medicaid programs through FY 2019, and be reimbursed at the lower Medicaid matching rate. However, States with separate CHIP programs will be able to limit enrollment based on the availability of Federal CHIP funds. Furthermore, CHIP programs typically provide more comprehensive benefits at better cost than plans offered in the Marketplace.

While exchange coverage might be available for some children, it will not be affordable for all of them. According to the Kaiser Family Foundation, in 2013, the average annual premium for employer-sponsored health insurance was $5,884 for individual coverage, compared to $16,351 for family coverage.[13] Because of the "Family Glitch", individuals are considered to have access to affordable coverage and are not able to access tax credits or subsidies for exchange plans if the premium for individual coverage is less than 9.5 percent of their income, but does not take into account the much higher cost of family coverage. Even with tax credits and other financial support available, both GAO and MACPAC concluded that in nearly all instances CHIP coverage will be more affordable than that offered in the Marketplace. According to MACPAC, if CHIP funding is not extended, many children moving from CHIP to Marketplace coverage would experience greater cost sharing.[14] According to GAO, many families, including up to 2 million children who would otherwise be eligible for Marketplace

[12] Mathematica Policy Research and Urban Institute, *CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings* (Aug. 1, 2014) (online at http://aspe.hhs.gov/health/reports/2014/CHIPevaluation/rpt_CHIPevaluation.pdf).

[13] Kaiser Family Foundation, *2013 Employer Health Benefits Survey* (Aug. 20, 2013) (online at http://kff.org/private-insurance/report/2013-employer-health-benefits/).

[14] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (June 2014) (online at http://www.macpac.gov/reports/2014-06-13_MACPAC_Report.pdf?attredirects=0).

coverage, will not be able to afford coverage and could end up uninsured.[15] The Wakely Consulting Group compared CHIP and Marketplace benefits and cost-sharing in 35 states, finding CHIP to be significantly more affordable for families than Marketplace plans.[16]

For those families that might be able to afford private insurance coverage, the coverage will likely not be as comprehensive for their children. CHIP programs were designed with children's needs in mind, while the Marketplace was focused on covering adults. A recent GAO study found that the range of benefit categories covered by five states' CHIP programs are similar to that in Marketplace benefit benchmarks, but the CHIP programs generally include fewer benefit limits than the Marketplace benchmark plans.[17] Furthermore, states designed CHIP benefits expressly for children and often include Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits and pediatric dental coverage. In a recent report, the National Academy for State Health Policy and Georgetown University Center for Children and Families stated that CHIP provides "robust coverage of benefits needed by children" with "substantial financial protection for families", thereby making CHIP a "strong model for ensuring comprehensive and affordable coverage for children".[18] Marketplace plans also may have narrower networks that exclude important pediatric providers, and the Marketplace plans are not required to cover out-of-network providers when the network is not adequate for a child's medical condition.

III. RECENT CONGRESSIONAL AND OTHER EFFORTS

A. Legislative Efforts

There have been two recent legislative proposals to extend funding for CHIP:

- *H.R. 5364 – CHIP Extension and Improvement Act of 2014 (Pallone).* This bill extends CHIP funding for four years (through FY 2019) and takes a number of steps to strengthen the program. It updates the performance incentive program that rewards States that succeed in exceeding children's enrollment targets; provides States with permanent flexibility to use express lane eligibility to enroll children and adults in

[15] Government Accountability Office, *Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance*, GAO-12-648 (June 22, 2012) (online at http://gao.gov/assets/600/591797.pdf).

[16] Wakely Consulting Group, *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans* (July 2014) (online at http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf).

[17] Government Accountability Office, *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 (Nov. 21, 2013) (online at http://www.gao.gov/assets/660/659180.pdf).

[18] National Academy for State Health Policy and Georgetown University Center for Children and Families, *Benefits and Cost Sharing in Separate CHIP Programs* (May 2014) (online at http://www.nashp.org/publication/benefits-and-cost-sharing-separate-chip-programs).

CHIP and Medicaid; and enhances and extends funding for the development and maintenance of pediatric quality measures in Medicaid and CHIP.

- *S. 2461 – CHIP Extension Act of 2014 (Rockefeller)*. This bill extends CHIP funding for four years (through FY 2019) and takes a number of steps to strengthen the program.

B. Other Congressional Efforts

In July 2014, Chairman Upton and Ranking Member Waxman, along with Chairman Wyden and Ranking Member Hatch of the Senate Finance Committee, sent a letter to the governors of all 50 states asking them whether CHIP should be extended and what, if any, policy changes should be made to the program. As of December 1, 2014, the Committees have received responses from 39 States. The vast majority of States support Congress continuing to fund the program.

C. MACPAC Recommendation

The Medicaid and CHIP Payment and Access Commission (MACPAC) recommended in its June 2014 that CHIP funding be extended for two years, through FY 2017, to give policymakers more time to address concerns about the affordability and adequacy of alternative coverage options.[19]

MACPAC also made three additional recommendations related to the CHIP program and children's coverage in its March 2014 report[20] and comment letters:

- To reduce complexity and to promote continuity of coverage for children, the Congress should eliminate waiting periods for CHIP.

- 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.

- The Congress should permanently extend express lane eligibility (ELE) authority to protect children's coverage gains in States that have employed the option it, as well as extend the ELE option to adults.[21]

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[19] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (June 2014).

[20] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (March 2014) (online at http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0).

[21] Letter from Medicaid and CHIP Payment and Access Commission to The Honorable Kathleen Sebelius et al. (Apr. 30, 2014) (online at https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/comment-letters/MACPAC%20Letter%20on%20ELE%20Report%20to%20Congress%2020140430.pdf?at

IV. CBO BUDGET ESTIMATES

CBO has informally estimated that extending funding for CHIP (in its current state) for four more years would cost approximately $5 billion to $10 billion; and extending funding for two more years would cost approximately $0 to $5 billion. If Congress were to repeal the 23 percent E-FMAP increase that is supposed to take effect in FY 2016, CBO estimates that extending funding for CHIP for two or four more years could potentially save up to $5 billion because of current CHIP enrollees shifting into Medicaid or Exchange coverage, or becoming uninsured (i.e., it costs the federal government less due to the federal Medicaid match and Marketplace exchange subsidies/tax credits being less than the federal CHIP match).

V. WITNESSES

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