ALLIANCE FOR HEALTH REFORM

Children's Health Coverage: What You Need To Know
Kaiser Family Foundation
Alliance for Health Reform
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Ed Howard: Just wanted to let you know we are going to get started. Those of you who are still going through the line, feel free. Staff here will help you try to find a seat. We are always glad to have a big crowd but we are mindful that it presents to logistical difficulties so we will try to be respectful of that.

My name is Ed Howard. I am with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Blunt, our Board of Directors, I want to welcome you to this program on how kids, particularly low income and moderate income kids, get health insurance in the United States. And if you think that that is a simple scheme, you would be badly mistaken. There is private coverage, of course, mostly employer sponsored, and that covers about half of the children. But there are public programs that cost most of the other half, leaving only about one in fourteen kids uninsured. Not perfect but a big improvement over what it was just a few years ago.

Today, we are going to be focusing on those public programs and how they are working and on the challenges ahead to make sure children are going to get – will continue to get – affordable quality health coverage. You are going to hear a lot more from people who really understand this stuff than this but let me just sketch out the black letter of the law part of it. Medicaid, obviously, covers the biggest chunk of less well-off kids and then there is the Children's Health Insurance Program or CHIP. That is one acronym you are going to have to know to understand the conversation today. That was put in place in 1997; by the way, with leadership from founder and honorary Co-Chairman of the Alliance, Jay Rockefeller, to serve kids with family incomes too high for Medicaid but too low to afford private coverage. And then there are the subsidies available through the insurance marketplaces created in the Affordable Care Act.

Now how these components fit together – or do not – is one important aspect of today's discussion, as is a look at what is coming up in these programs and what benefits they might get or bestow under current law. Our partner and co-sponsor in this briefing, Kaiser Family Foundation, one of the Foundation's signature programs, the Kaiser Commission on Medicaid and the Uninsured has done tons of work – high quality work – on kids' coverage issues reflected in several pieces that are in your packets today. And we are pleased to have as co-moderate in today's discussion the founders – the Foundation's Executive Vice President, who is also the Commission's Executive Director, Diane Rowland. Diane?

Diane Rowland: Well, thank you, Ed, and thank you all for being here today. This is a continuation of our many briefings that we have done over time on how to assure high quality affordable coverage for the nation's children. And since 1997, which is a long time ago now, CHIP has really been there as one of the cornerstones of the way in which we provide high quality affordable care to children just above the Medicaid eligibility levels but still with need for some assistance. And clearly, one of the goals has always been to reduce the number of uninsured kids and CHIP has clearly contributed mightily to that. But it has also helped to lay the foundation for how to enroll and retain children in coverage, how to provide quality pediatric specialty care to children, and it has helped, obviously, connect millions of children over time with affordable coverage.

However, today's briefing is because the Affordable Care Act offers another vehicle for trying to provide coverage to children. And the role CHIP will play in the future of healthcare for children is very much the center of our discussion today and the center of the debate over how to assure the best quality affordable continuous coverage to children in the new world as the Affordable Care Act begins to provide other kinds of offerings.

So we have a terrific panel who can shed perspective both on the kind of cost considerations and what CBO's role is in trying to figure out the funding for the CHIP program, to look at the role CHIP has played in the past, and to look at some of the on the ground experiences from the State of Alabama, as well as some perspective on some of the future challenges of trying to merge CHIP forward into the new world. So I am looking forward to hearing a great discussion and I hope you all will enjoy it, as well.

Ed Howard: Thanks, Diane. By the way, the screen has the Twitter handles – is that the appropriate term? For all of those wonderful panelists that Diane was mentioning along with the hashtag that we are using for the briefing itself; that is kidscoverage. And you should feel free to tweet about the briefing as we go along here.

A couple of logistical items. You have materials including lots of biographical information on the folks who will be speaking and other materials – background materials – for this topic, along with a list of other materials that you can get to by going to the Alliance website at AllHealth.org. There will be a video recording of this briefing available in a couple of days, thanks to the Kaiser Family Foundation, on their website, KFF.org, and we will have a way to get to it on our website, as well. And a couple of days after that, we will have a transcript available for your perusal.

And I want to call your attention to the appropriate way to ask questions once we get to the Q&A portion of the program. You can use the green card in your materials to write a question and it will be handed forward. We have microphones at the sides – either side of the room – that you can use to ask it in person. And if you would like to, you can tweet a question. We will monitor the universe as we go forward and get those questions up front here, as well.

As Diane said, we have a terrific panel and we are going to get to it right now. Leading off on my far right is Robin Rudowitz, who is the Associate Director of the Kaiser Commission on Medicaid and the Uninsured, which is a major initiative of the Foundation. Robin has been with the Commission for almost ten years now focusing in large part on Medicaid financing issues. She has been involved in a whole range of policy issues involving low income populations. She has done it at the local level, at the state level, and at the federal level including stints at CBO and the House Ways and Means Committee. And I am pleased to say she has graced our platform on more than one occasion. Glad to have you back, Robin.

Robin Rudowitz: Thanks, Ed and Diane, and good afternoon to everyone. I am so glad to see so many people here. So my job is really to provide an overview of children's coverage and really set up the discussion for the other panelists and, of course, as the debate and discussion will continue on the future of the children's health insurance program.

So we all know that Medicaid and CHIP play a really significant role in providing coverage to kids today. So the two programs together cover more than one in three children and just nearly two out of three low income children in the United States. We know that also today, the median coverage level for children across states is two hundred and fifty-five percent of the federal poverty level. That is about sixty thousand dollars annually for a family of four. All states really provide coverage for kids that exceeds the federal minimum levels and there are nineteen states, including the District of Columbia, that provide coverage to children at or above three hundred percent of the total poverty level.

As Ed just mentioned, CHIP was enacted as part of the Balanced Budget Act in 1997 and it was really designed to build on children's coverage that was already being provided by the Medicaid program. So both Medicaid and CHIP are really state and federal partnerships to provide coverage to children but there are some key differences that I wanted to highlight in the programs. The first is around coverage. When CHIP was enacted, states were given the option about how to provide coverage for children so they could either expand their Medicaid programs or provide a separate program to cover kids or do a combination of these two approaches.

In terms of enrollment, it is also – again, as Ed mentioned – important to highlight and remind folks that Medicaid really provides significantly more coverage to children now, about five times more than provided through the Children's Health Insurance Program.

And there are some key differences around financing in the entitlement structure of these programs. So in Medicaid, the entitlement is to both states and to individuals, so any individual who is eligible for coverage is guaranteed to be able to enroll and that financing is guaranteed to states in terms of their matching dollars. On the CHIP program, it is a capped financing program though all the matching structure exists. Once states reach their cap, then that is the available financing for the state. So the entitlement is really to states in terms of financing.

Medicaid also provides a broader set of benefits to children compared to CHIP and the CHIP program allowed states a little bit more flexibility around premiums and cost sharing.

So that is some of the differences but really, the two programs together – and again, since the enactment of CHIP and really, with the reauthorization of CHIP through CHIPRA, there have been three main ways that CHIP and Medicaid have increased coverage to children. There was expanding eligibility so when CHIP was enacted, states really expanded the coverage levels. There was also a big push to simplify enrollment and renewal strategies. And certainly, as part of CHIP reauthorization, there were incentives for states to adopt additional simplifications to their eligibility and enrollment systems. And there was also a big push, particularly when CHIP was first enacted, to really do outreach and enrollment, which was new at the time – that there would be large efforts to increase outreach and enrollment. And really, the effect that that has had on children has really been increased coverage for those who became newly eligible. There was also a large increase in coverage for people who had previously been eligible for Medicaid but had not applied, because of all the new outreach. And again, because of some of these new simplifications that have been adopted over the course of time since CHIP was enacted, coverage for kids has become much more stable in terms of making sure kids both obtain coverage and stay enrolled in coverage. So overall,

this has really led to a lot more kids covered by these public programs and a large decline in the number of uninsured children. And that is pretty clear in this chart when you look at what has happened since 1997 when CHIP was enacted. The rate of uninsured kids has really been cut in half, so the results are pretty clear in that.

I think it is always also important to stop and say, "Why does this matter?" And this line clearly shows that it matters because kids who are enrolled in Medicaid and CHIP have much better access to health care services. So that is one of the primary objectives of the two programs.

I also want to highlight a few other effects of coverage that will be highlighted in a brief that we plan to post later this week that really looks at a lot of the evidence around what coverage has meant for children in terms of Medicaid and CHIP. There has been a reduction in racial and ethnic disparities among children. There have also been a number of studies that show and point to improved outcomes for children related to declines in hospitalizations. Big changes in terms of out-of-pocket expenses for families and children that need care. And there is also lots of evidence of broader benefits related to coverage so kids pay better attention in school, less absenteeism, etc. And this is, again, all highlighted in a brief that we will post later this week.

So there were a few changes that were part of the ACA that affected children that I wanted to highlight again in this overview. So the new efforts and requirements under the ACA for all states to really streamline and coordinate enrollment processes, as well as to do outreach for new coverage, is expected to really increase participation among children who are currently eligible. The eligibility levels did not really change for children under the ACA, but there is expected to be a large increase in the number of children who would participate. We also know from a number of studies and lots of research that coverage gains for parents will also effect increased coverage and enrollment for children.

The ACA made a few changes to eligibility levels for children. One was to better align coverage for kids. Prior to the ACA, children under poverty would be covered at only a hundred percent of the poverty level and children below six would be up to one thirty-three percent of the poverty level. So the ACA has requirements to align that coverage for children above six. And there is also a maintenance-of-eligibility requirement to maintain coverage levels for children through 2019.

In terms of financing, this will be the subject of much continued discussion on the panel. The ACA extended CHIP funding through 2015 and that is, of course, one of the big issues of why we are examining what will happen with CHIP because of the financing structure. And the law also includes an increase in the match rate for children through CHIP, an increase of twenty-three percentage points. In the ACA, there is also a number of children who will gain coverage through the new marketplaces, as well.

So then again, to just wrap up, I am going to leave some very hard questions for the rest of my panelists to ponder for the rest of the discussion. But I think we are going to want to discuss, you know, will Congress consider legislation, when will that legislation be considered to extend the funding for CHIP. There is going to be a lot of discussion about how long should the funding be extended and how much will all of that cost the federal government. If funding is not extended,

what happens? So what happens to current CHIP enrollees? How many would have other coverage? How many would be uninsured? Whoops, I did not mean to snap the slide so early. And we also want to know how CHIP compares to other coverage that might be available, so how would CHIP compare to other coverage in the marketplace in terms of cost sharing, premiums, networks, benefits, etc. And there has been a bunch of research to date on some of those topics that we will cover.

There are some other things that Congress might consider to improve children's coverage, including transitions between coverage through Medicaid, CHIP, and marketplaces. There are some issues around some families who might want a choice, so that will be a discussion of if they should be able to choose between CHIP and the marketplace. And then really looking more long-term, how does CHIP fit in with Medicaid and the ACA in this new world since it was enacted? So it is a whole slew of questions for the audience and the rest of the panel to chew on and we will get back on that.

Ed Howard: Great. Thanks very much, Robin. We have a panel who can respond to those questions and probably a bunch of others. And first up in that line is Joan Alker. Joan is the Executive Director of the Center for Children and Families at Georgetown University, where she is also an Associate Professor. The center of the Center's work is low-income families and children, and health coverage is Joan's specialty within that. She has been working on issues affecting low income Americans for more than twenty years and including recent reports on how we are doing in extending coverage to kids. So we are really pleased – and I cannot believe this is the first time – but we welcome you for the first time to an Alliance panel. Joan?

Joan Alker: Thanks so much, Ed. It is a pleasure to be here. I have enjoyed many a panel over the years. And I am going to really pick up on some of Robin's questions, expand on some of the changes she mentioned in the Affordable Care Act. But just to highlight, I think from the perspective of kids, as you saw from Robin's slides, it is important to enter into this discussion just recognizing that we have really, as a country, made enormous strides with respect to the coverage of children. We have seen that number go down by half since CHIP, working together with Medicaid, was first enacted. And I think that is a really important context because kids were very far ahead of where adults were and that is why the Affordable Care Act really focused more on adults with respect to coverage expansions. But it really recognized and built on the progress we have made for kids in Medicaid and CHIP by including a maintenance-of-effort requirement so that that coverage remains steady and extending the life of CHIP.

So as we like to say at CCF, we do not want to mess with success so we have got to approach this issue very carefully. A lot of complicated questions and nuances as we go forward, and I will try to talk about some of those for you now.

So as we think about what is different now as opposed to when last Congress was considering renewing CHIP, the obvious answer is the Affordable Care Act. And so the coverage landscape for kids, of course, is different, as well as the coverage landscape for their parents. And what this line is attempting to show you is that now, essentially, we have three primary sources of publicly funded coverage for kids. By far, the largest source of publicly funded coverage for kids is Medicaid. I do not think people often think of Medicaid as a kids' program but about half of Medicaid beneficiaries

are children and it is an absolutely essential program for their health coverage. And you see in this slide this little stairstep kid's bar in there. Robin mentioned that, and I am going to talk about them in a minute, so I will leave that to the side. But then on top of the Medicaid coverage levels, you have the CHIP coverage levels. And as Robin explained, states have a choice if they want to expand their Medicaid program or if they want to establish a separate state CHIP program. And so that CHIP bar encompasses both those kinds of programs, all with a higher match rate that comes with the CHIP kid as opposed to regular Medicaid kid. And then on top of that, depending on where your state is, of course, you will have some children who are eligible for subsidies in the exchange, with premiums, after reflecting those subsidies, on a sliding scale based on income.

So let's talk for a minute now about those stairstep kids. Those are the kids that Robin mentioned. The ACA, in an effort to simplify and align eligibility, established an across-the-board income eligibility level for Medicaid of 133% or 138% of poverty with the disregards. And the idea here was because sometimes you had kids in the same family in different programs. Once a child turned six, they might move into the separate state CHIP program and that did not make a lot of sense. And also, the idea was to align eligibility with their parents, assuming their parents would be part of the Medicaid expansion, of course. This was before the Supreme Court made that optional.

But this provision – and we did a report, actually, for the Kaiser Commission on, which is in your packet on this, affected over half a million children. About 28% of CHIP kids nationally did fall in this stairstep group and that is because a lot of the CHIP kids tend to cluster in at the lower income eligibility ranges. And there were 21 states affected by this change, which was to have been completed by January 1, 2014. But in fact, the vast majority of states have requested from CMS, and have gotten, some kind of extension of that provision and they are phasing that in. So you may hear about that going on in your state today. But after the next few months, all states should have transitioned all of those kids over to Medicaid. Now they are still CHIP kids, they still get the better match rate. But in some cases, this has meant a very sizeable chunk of kids from the separate state CHIP program has moved over to Medicaid.

So talking now for a minute about both the Congressional outlook and whether there are changes we see on the horizon for CHIP, I know this will be a source of further discussion on the panel and also, importantly, for you in the audience. But I just wanted to mention, as many of you know, that Senator Rockefeller, of course, a long-time champion for children in health policy and in health policy, in general, has introduced legislation to extend the CHIP program for four more years. I think Holly Glazier [PH] is here. I do not know where she is but she is really the lead on that bill so I am hoping she will pop up in the Q&A and share with us some more of the Senator's plans. But Senator Rockefeller, of course as you know, is retiring and so he very much would like to get this done before the end of the session. That is going to be, I think, difficult but hopefully, he can make that happen. On the House side, I know that Congressman Waxman and Congressman Pallone are looking at introducing similar legislation. They are in the process of drafting that legislation and hoping to introduce it before the August recess.

So let's just talk for a minute about what would happen if Congress did not act and funding ran out in 2015. And I think this speaks to one of the sort of fundamental questions folks have today about CHIP given that slide that I showed and given that now for parents and other adults, we have really

two coverage sources – Medicaid and Exchange. What is the role of the CHIP program in this new coverage landscape? Well, in fact, if CHIP funding ran out, kids would be in trouble for the following reasons. Some children would maintain coverage on Medicaid. So if they are a CHIP-financed Medicaid kid -- thoseare the other states that had chosen to expand Medicaid initially when CHIP came along, or the states that are moving their stairstep kids over that we just discussed -- they will continue to get coverage in the Medicaid program because it is an entitlement program, but the match rate for the state will go down.

For kids who were in separately state funded programs, essentially, the _____ [00:24:27] would no longer apply and those kids, in theory, could go into the Exchange. But we have a problem called the family glitch. And the family glitch, I am sure many of you have heard of, relates to the way the affordability of employer-sponsored coverage has been defined. I am not going to spend a lot of time on it, but just to say there are estimates ranging from about 500,000 to two million kids that would likely become uninsured if CHIP ran out. Because of the family glitch, their family would not be able to get subsidies and the Exchange coverage would be unaffordable for them.

Some families would be able to move to the Marketplace and get tax credits to help them pay for that coverage and some families might end up in other private coverage options, perhaps picking up their employer-sponsored insurance. But we do know, and I think more research is needed to really get a better handle on the number – but we do know that potentially millions of kids would become uninsured if CHIP funding were to run out.

So we have just done a preliminary analysis with the Center of Budget and Policy Priorities. We find that nearly four million children would lose CHIP coverage entirely if the CHIP funding runs out. These are kids who would not wind up in Medicaid, and many of these would likely become uninsured – we do not know how many. The state that would be most affected by this would be Texas, appropriately 900,000 of those kids are in Texas and another 900,000 of the kids are in New York and Florida combined.

So some might say, “Well, why don’t we just put the CHIP kids in the Exchange?” So there are a lot of complicated financing questions about that and we talked about the family glitch. Some would not be able to get there. But let’s just talk for a minute about how coverage would compare for kids, with respect to benefits and cost-sharing, if kids did wind up in the Exchange one way or the other.

So this is a study that is in your packet. We did it with the National Academy of State Health Policy, our colleagues there. And we essentially catalogued all of the CHIP benefits for separate state CHIP programs. Kids who are on CHIP-funded Medicaid, of course, received the EPSDT benefit, which is a very comprehensive benefit. But in fact, we found in our study that most states are using that Medicaid benefit either explicitly because they are doing a Medicaid expansion, or they started with the EPSDT and took a few things off. So while we have not done the full crosswalk – and this would be a very hard thing to do -- GAO tried to do it a little bit, where you crosswalk a CHIP benefits package with the essential health benefits package for a kid in that state. It is our sense that the CHIP benefits are going to be stronger for kids because the essential health benefits, the pediatric component of it, is not particularly strong. And I will just give one example,

which is the pediatric dental component of the essential health benefits package is really pretty weak. So that is one way we know in which CHIP would be a better benefit package for a kid.

And the other issue, affordability, I think there is widespread agreement that CHIP affordability protections are stronger than what families would experience in the Exchange. That is because CHIP has very strong affordability protections. We took a look at Arizona. Arizona is a state that, due to some quirks, is not actually subject to the maintenance-of-effort and actually got rid of most of their CHIP program earlier this year. So it gives us a little preview of what would happen if CHIP went away. And we compared three kids with different health scenarios, looked at actual qualified health plans in the Phoenix area that they could sign up for, compared them to what they would have paid under CHIP. And we found that in 17 out of 18 scenarios, the families did better, they ended up paying less when they were in CHIP. And we know that high copays and other barriers to care can really result in children not getting the care they need.

So with that, I will stop. I am out of time. We are doing a lot of work in this area so I really encourage you to follow us on Twitter. Our blog is extremely active on CHIP and other issues and, of course, our website. Thank you.

Ed Howard: And extremely well written, I might add. Can I trouble you for the slide deal? We are going to turn now to Rob Stewart. If you think that how we finance public health coverage for kids in America is fairly simple, you would also be fairly wide of the mark. You have heard a little bit about this from Robin. Medicaid and CHIP obviously play a part as do some aspects of the ACA subsidies for private coverage. But how they interact – and this is more important than most other aspects of that issue – how much CBO says changes to the current law will cost often shapes the course of legislative action. Fortunately, we have a panelist with expertise on these sometimes complicated matters, and that is Rob Stewart. He is the Principal Analyst at CBO. His area of expertise includes developing estimates for the costs of legislation affecting both Medicaid and CHIP. He has also looked at these issues from the executive branch standpoint, having been part of HHS' Office of Health Policy. Rob is also noted for his ability to speak an English version of budgetese and so we are really pleased that you could join us today.

Robert Stewart: Okay, thank you. I will try to live up to that billing. This can be a complicated topic so I will do my best to, in fact, speak English. My real mission is to try to answer what you could consider FAQs or Frequently Asked Questions about CBO's budgetary treatment for CHIP. I want to start, though, first with just the financing essentials, just to make sure we have a common base of understanding before we move forward to the more complicated stuff.

So as the slide says, for every fiscal year since the program's inception and through 2015, the statute has provided a total federal appropriation. That funding is known as budget authority or BA. The law also specifies a formula for annual allotments to states. The formula works like this. In even-numbered years – that is 2010, '12, '14 – in even-numbered years, the allotment to each state is based on the prior year's allotment, grown by two factors. One to account for the growth of national health expenditures, and one to account for growth in the number of children. In odd-numbered years – '09, '11, '13, '15 – the allotment to each state is based on prior year's spending grown by list of factors. So that is an important feature because it means that the amount of funding

that states receive in the allotment should very closely match the amount they actually need to operate their programs. It also means that the total amount of the federal appropriation does not necessarily get allotted to states, and you will see why that is important in just a moment. But I do want to mention that once states have an allotment, they have two years to spend it.

All right, so this table shows the Budget Authority versus the allotments. Do not memorize the numbers, look at the relative sizes of the darker blue and lighter blue columns. Budget Authority is the tall columns, the shorter columns are the allotments the states receive. So I just mentioned that because of the formula, not all of the national budget authority goes to states. You can see the difference. The thing to understand is that that extra amount of budget authority over and above the allotments does not get allotted and therefore, cannot be spent. And so that does lead to some questions for CBO about what could be done with an excess budget authority. You can test your budget knowledge, by the way, with these questions.

All right, question. If Congress rescinds or cancels some of this budget authority or all of this budget authority, would CBO estimate reductions in the deficit? So easy deficit reduction. No, no. There has been some confusion about this. Because that budget authority is not expected to be spent under current law, rescinding it would not be expected to affect spending orer deficit. Deficits result from a difference between outlays and revenues, not budget authority and revenues.

This pertains to appropriations. So current law includes annual caps on budget authority provided in Appropriations X. If Congress rescinds some or all of the excess budget authority, would that create room for an increase in appropriations for other programs under those caps? In this case, yes, so Congress could do that. Congress could basically reprogram that money as long as it was done in an appropriations bill.

All right, my favorite question. Could Congress provide a new purpose for the excess budget authority that results in new outlays without CBO estimating an increase in spending, because, after all, the funding has already been appropriated once before, right? Wrong. No, if this budget authority was made available for a new purpose that results in new outlays, CBO would have to estimate an increase in spending relative to current law. I think that is the very definition of what requires to estimate an increase in spending in current law. So a lot of confusion about that, as well.

So now, let's get onto talking about CBO's baseline after 2015. As you have heard today, I believe, from both of our prior speakers, CHIP has no funding after 2015. There is no new budget authority for 2015. But if you went to CBO's website and downloaded CBO's budget table for CHIP, you would see something that looks like this slide. If you can see the numbers in the slide, look at the budget authority row, you would notice that there are not zeroes after 2015. There are these $5.7 billion figures. And so you might wonder what these numbers are doing there and that would be a good question, and we are so glad you asked because we get asked that a lot. And you see, the law actually requires CBO to extend in the baseline any program that expires or loses its funding, if two conditions are met: 1) it outlays more than $50 million annually; and 2) it was enacted on or before the date of the Balanced Budget Act of 1997. CHIP was enacted in the Balanced Budget Act of 1997 so it qualifies for this budgetary treatment. So therefore, what CBO is supposed to do is extend CHIP in the baseline – this is the key phrase – as it operated immediately before its funding is

scheduled to end, alright? By the way, before I go to the next slide, if you are curious why this law was passed, I was told it was passed to deal with the Food Stamps program. The Food Stamps program, as some of you may know, is authorized four or five years at a time in the Farm Bill. And apparently at the time, Congress was concerned that CBO's overall baseline would look artificially low if at some point in a ten-year budget window, Food Stamps went to zero when nobody really thought it was going to go to zero.

So all that explains why CBO extends CHIP beyond 2015 on the baseline of the table. It does not explain those $5.7 billion figures yet. So to understand that, you would need to know that Congress did something for the 2015 appropriation that it did not do for other years. Congress divided the 2015 appropriation into three parts – a one-time appropriation, that is a, quote, one-time appropriation of $15.4 billion made in the first half of 2015, a $2.85 billion appropriation made in the first half of 2015, as well, and then another $2.85 billion made in the second half of 2015. So based on that statutory construction, CBO assumes that the semi-annual payment of $2.85 billion will be made after 2015, because that is how the program will operating, immediately before its funding is scheduled to end. So in other words, CBO looks back at the second six months of 2015, we see the $2.5 billion in appropriation made there. You annualize that and that is $5.7 billion.

Okay, so now that we have solved that mystery, there is something that is very important to understand about these $5.7 billion figures. They are not actual appropriations, okay? Nobody should leave here thinking, "Well, at least there is $5.7 billion after 2015." If Congress does not act, there is no BA after 2015, okay? However, because those amounts are in the baseline and CBO estimates proposals relative to a baseline, if there were legislation to extend the CHIP program beyond 2015, CBO would subtract the outlays that are estimated in the baseline and the cost of the CHIP legislation, making it essentially that much cheaper. So that clears that mystery up.

Last issue. Generate some questions. I believe others have mentioned the ACA added a provision to CHIP to increase the matching rate from 70% to 93% so I will not go into detail there. But the question we get is what effect does that have on the CHIP spending baseline? And it actually does not have an effect on the CHIP spending baseline, and that surprises people. But the reason for that is that we assume that all of the federal funding available after 2015 would be spent regardless of whether the matching rate is 70% or 93%. The federal funding may spend more quickly because the federal government is spending 93 cents on the dollar instead of 70 cents on the dollar. But the total amount would be the same. And again, just to be clear when I say the available funding after 2015, I am referring to some 2015 funding that remains unspent at the end of 2015 and bleeds over into 2016 that will not last states long. I am also referring to the $5.7 billion that I said is not actually available to states but is in the baseline. That again was _____ [00:39:14] the baseline.

All right, the last thing to know about this provision that increases the matching rate for CHIP is that if CHIP were extended such that it were fully funded to cover every child that is eligible and applies, that the cost of the CHIP program would be about one-third higher than it would have been in the absence of this provision. On the flip side, the cost of the states would be about 77% less. And in fact, I looked up Alabama's matching rate and for 2015, it is projected to be 78.29%, which means that the federal share for Alabama would be 100% if the CHIP program were extended

beyond 2015, which means the state's share would be zero. And I think that is a perfect segue to hand the mike over to Cathy. Thank you.

Ed Howard: Nicely done, Rob. As Rob said, the final speaker is Cathy Caldwell, who does not deal in only nationwide policy assessments, although she certainly is active in a number of national efforts to improve both the breadth and the quality of coverage available to low income kids. She directs Alabama's CHIP program, the Bureau of Children's Health Insurance, within the Department of Public Health. The Bureau's all kids program covers more than 85,000 children in the state. She has been with the Bureau for over 15 years. And I am pleased to say she also is a repeat offender as an Alliance panelist and we are very glad to have you back, Cathy.

Cathy Caldwell: So Rob, that is great news about the 100% if we get funded. And it is actually really, really difficult to explain because a lot of people in our state have done the math and so they will say, "Oh, wonderful. CHIP is funded at 100% federal after 2015." And in my mind, it is pretty much either zero or 100, you know, and so that is pretty hard to explain.

But I want to talk a little bit about the Alabama CHIP program just to put a state face on what we have been talking about today, touch on some of our successes, and touch a little bit on what may happen if CHIP funding goes away. So all of this from an Alabama perspective. ALL Kids is the name of our separate CHIP program. I believe Robin explained about how a state could either expand Medicaid or have a separate CHIP. We had an early Medicaid expansion that went away after a few years because the children were gradually transitioned into the regular Medicaid program. And so then for these 15, 16 years, we have only had the separate CHIP and it is a private model CHIP. It is in public health as opposed to the Medicaid agency. But we now have a Medicaid expansion also. We were one of the states that had the stairstep children and so, January 1, we transitioned about 23,000 children from our separate CHIP program to Medicaid. So they are still funded out of our federal CHIP allotment but they are enrolled in Medicaid.

So Alabama's program serves uninsured children above the Medicaid income level up to 300% of the federal poverty level, which is now being converted to 312% of the federal poverty level, which that is because of a provision in the Affordable Care Act. And our match rate is approximately 78% and we look forward to the day it is 100%.

CHIP covers approximately 84,000 children right now. They are not in ALL Kids. About 23,000 of them are now covered in Medicaid.

So this is my grandson and you can see that we take both sun protection and water safety very seriously. But just wanted to point out that we work very closely with Medicaid. We have a joint application, we always have, but now with the implementation of the Affordable Care Act, we have a joint application with Medicaid, CHIP, and the federally facilitated marketplace.

And I do not know this little girl. But the ALL Kids program is administered by the Alabama Department of Public Health, as I have noted. And we contract with Blue Cross and Blue Shield of Alabama for delivery of statewide benefits of all kids. We did not start with EPSDT program, but we took a very comprehensive benefit package and we enhanced it, particularly for services that are

needed by children with special health care needs. But we do utilize the Blue Cross preferred provider organization network and we pay off the commercial fee schedule.

So we are unique. There are not a lot of states structured just like we are. To be eligible, you must be an Alabama resident, US citizen or eligible immigrant, not institutionalized, and not covered by Medicaid or private insurance.

This is my grandson, as well. He got to take off his life jacket because he was about a quarter of a mile from water. But we have a comprehensive benefit package. We cover dental and vision, prescriptions, mental health and substance abuse services, hospital services, immunizations, well child checkups, so a very comprehensive benefit package. We have 12 months of continuous enrollment both in our CHIP and Medicaid programs. A child remains enrolled regardless of changes unless the child turns 19 during the year and then they go off CHIP at the end of their birth month. Also, if the child moves out of state, we will cancel. But otherwise, they stay on for 12 months.

Cost to parents, and I think this is usually important, and I think it was Joan that pointed out but it may have been Robin, as well, the difference in cost between CHIP and an Exchange plan. Everything that we have looked at shows that an Exchange plan would be substantially higher for a family, assuming that the child was eligible and able to enroll. We have premiums in Alabama, we actually have annual premiums and depending on family income, the premiums are either $52 or $104 per year with a max of three premiums per family.

We do use the five percent out-of-pocket cap, but we have probably less than five families a year actually hitting that cap. So what happens if the family does hit that cap? We then put them in the no-fee category. But over the 15 years I have been with the program, I truly have only seen a few hit that capability.

So as has already been mentioned, children with health insurance coverage are able to receive needed services, particularly dental and vision, that they may go without if they are uninsured, to get their needed immunizations. Able to get medical attention early so that maybe the condition can be treated before it becomes more acute or even in cases where it may become a chronic condition, and miss fewer days of school.

This is comparing CHIP versus Exchange plans and I have already touched on some of this. The Exchange plans are more geared towards adult, where CHIP is a child-specific benefit package. And certainly, I think one day maybe Exchange plans will be a good place for some of these children but, right now, I do not think they are there.

Affordability, as I have just pointed out, the Exchange plans, when we have looked at comparisons, are definitely much more expensive for families.

Provider networks. CHIP plans tend to have all of the children's providers in them. I mean, that is a huge focus, you know, to get all of the children's hospitals in the network, to get all of the pediatric

dentists in the network. So certainly, you are going to have in CHIP likely a more child-specific network than you are going to get with an Exchange plan.

And then, as already mentioned, the coverage issues. Here I call it the kid glitch. I think Joan called it the family glitch but we are talking about the exact same thing. There will be many children who are not eligible to be enrolled in an Exchange plan so they will likely become uninsured if CHIP goes away.

And we saw a slide earlier plotting the uninsurance rate of children since the beginning of CHIP. I think Alabama is right on with the national numbers we saw. Alabama's uninsurance rate for children was over 20% prior to CHIP and we are now down around 7%. So we still have uninsured children in our state and we continually try to get them all enrolled but we have drastically reduced that uninsurance rate.

So from my perspective, what do I think we need? I think we need a timely extension of CHIP, extension of funding, and I say timely because these are big programs with many families involved and it is hard to turn those large programs on a dime. So as state leaders are making decisions, it is really a tough place to be in when we are not certain about the future. So it is already causing a lot of anxiety in states and families.

So that is the Alabama story.

Ed Howard: That is great. Thank you so much, Cathy. And I should point out those numbers, getting down to the national average was a bigger accomplishment in Alabama because you started from a higher threshold. And I should say that the very first briefing that the Alliance did on the CHIP program back in the late 1990's featured the Director of the Department of Public Health from Alabama who was even then launching an aggressive program to try to get as many kids signed up as possible and they have been doing it ever since. So congratulations.

Now we get a chance to hear the questions and comments that you might have. As I mentioned, you can use one of the microphones that are at the sides of the room, you can fill out the green card in your packet and hold it up as the lady is doing right there, or you can tweet a question. Kidscoverage is the hashtag.

Let me just, if I can – and again, you should chip in, too – Cathy, you mentioned that you have moved a number of kids from CHIP to Medicaid as a result of the ACA changes. And I wonder in your specific case how smooth that transition has been, and I would ask Joan and Robin if they have any comments on the broader experience in the other states where that has happened.

Cathy Caldwell: Well, it was not the smoothest thing in the world but it actually worked out okay. We had a lot of anxiety because we do use two different networks. The Blue Cross network that the ALL Kids program uses is more comprehensive than the Medicaid network, particularly around things like dental and behavioral health. Since these children were in families with incomes right at the dividing line between Medicaid and CHIP, we learned that many of these families had

experience with Medicaid. So I do not think it was quite as hard a transition as it could have been and we did transition them all on January 1.

So truly, we have had very few comments from families objecting to the move or having a difficult time finding providers. We worked on it for about a year ahead of time. So I am not saying that it was perfect but I think when it was all said and done that it actually was okay.

Joan Alker: So just a couple comments on that. I think in any transition, there is always concern that some kids might get lost and what are the changes going to be. And certainly, the provider network issue has cropped up in some states. Just to mention in California, they actually shifted their entire separate CHIP program over to Medicaid and I know there were concerns there about provider capacity. But on the flip side, for many kids, this has meant an improvement in their benefits package. They have gotten the more comprehensive benefit package and also, sometimes their premiums have gone away. And just to mention Florida in that vein, for those kids, 100% to 133% of the federal poverty level, they were paying premiums in their CHIP program and now they are not. And Florida has seen quite a sharp uptick in enrollment in their kids' Medicaid. And I think folks think a lot of that is because those families were not able to pay the premium at that very low income level. And so it is probably going to help reduce the number of uninsured kids in Florida.

Diane Rowland: We have a question from Bill. What level of oversight does HHS provide over the CHIP programs in the states? Do they approve the benefit package and structure? And aren't they also responsible for approving and reviewing rather the CHIP plans meet the new Exchange plan?

Robin Rudowitz: Sure. I think similar to the Medicaid program, states need to submit a state plan amendment to describe how they are administering their CHIP program so that would describe what benchmark benefit plan they are intending to use. And CMS reviews and approves those state plan amendments.

As far as looking at comparability to coverage in the marketplace, the Secretary is required to release a report by April 2015 that looks at how comparable coverage is for kids from CHIP into the – relative to CHIP and in the new Marketplace in terms of benefits and cost-sharing. So that needs to be released to Congress in April 2015.

Diane Rowland: [Sound out]

Joan Alker: So Rob, I think, did a fantastic job actually talking about how the allocations are working in CHIP. And in the early years of CHIP, we had a fair amount of kind of mismatching going on and sometimes we had a few instances where states ran out of money. But we have not seen that in a while since we have moved to the new formula. So Rob, maybe you want to comment on that, too.

Robert Stewart: Yeah, sure. So prior to CHIP's reauthorization in 2009, the allotment formula was quite different and CHIP was a bit notorious for the disconnect between the amount that some states received and the amount that they actually need. And so there was – and there

actually still is – a provision in place in CHIP that if a state does not spend all of its allotment within two years, then it can be re-allotted – redistributed it is called – to other states. Because of the new formula, which much better matches the allotments a state needs, that no longer happens. Actually, there has not been a redistribution in years.

On the flip side, there is a provision in place in the current formula that I did not mention because it almost never happens, as well. But if a state actually ran out of allotments – all allotments – so it literally could not continue, there is a separate appropriation called the Contingency Fund that it can access to tide itself over. It is a limited pot, but as of today, I believe, one state has needed to use it for something like $20 million. So the formula is a much better match.

In terms of state performance goals, though, I am not aware of any, and I am going to harken back a bit to my HHS days. There are certain performance measures the state is supposed to report on. Cathy can probably speak to that. But I do not believe the funding is actually tied to it. I have never heard that any state was penalized or on the flip side, received any bonus based on their performance.

Joan Alker: I think the question might be referring to the performance bonus.

Robert Stewart: Oh, performance bonus.

Joan Alker: If states do certain things that simplify and streamline eligibility, they can get additional performance bonus for that.

Robert Stewart: I apologize. I was answering an entirely different question. Hopefully, what I said was somewhat useful anyway. So this is almost a briefing in and of itself, but I will do a short version. So there was something in CHIP called the Performance – well, there used to be something in CHIP called a Performance Bonus Fund. And it was added in the reauthorization of 2009. And the short version goes like this. If states adopted five of eight administrative procedures that tended to enhance enrollment to retention – things like continuous eligibility, removing assets tests – I do not remember all eight but there were eight of them. And you picked five of eight, they qualify to potentially receive a performance bonus. At that point, then they have to meet certain enrollment targets. And if they met certain enrollment targets, they would receive a performance bonus.

What has been interesting, though, is that this whole story that I told on my second slide about the mismatch between total budget authority and allotment, the difference used to go to the Performance Bonus Fund. And the Performance Bonus Fund at one point had many billions of dollars but the outlays from the Performance Bonus Fund, the bonuses that states actually earned, has been on the order of a $100 million, so I think the most recently was maybe around $300 million. So nowhere close to the amount of money that was actually sitting in the fund. So Congress has actually been rescinding the money. They have rescinded many billions of dollars in the last three years. So that is the one place where there are some performance measures.

Kelly Peuquet: Hi, my name is Kelly Peuquet. I am from the National Coalition on Healthcare. I would like to thank all the presenters for your presentations. The National Coalition on

Healthcare firmly believes that extending financing for CHIP is vital. Extending financing this year is vital to ensure that children in the United States continue to receive the health care that they need. My question for the panelists is what do you all believe are the largest barriers to successfully extending CHIP financing? And then, number two, what can organizations like the National Coalition and other advocacy organizations do to support extended financing?

Joan Alker: Okay, no one is chomping at the bit here. So I would say I am guardedly optimistic that CHIP funding will be extended. CHIP has been a very popular program. It has been a program with a lot of bipartisan support over the years both at the state and the federal level. And I think we all know that there is a lot of turnover here up on the Hill, particularly among the staff. And so I think it is really important now to be educating folks about the role that CHIP and Medicaid are playing for kids just as we have been doing here today and seeing what an amazing success they have been working together to reduce the number of uninsured kids. And I think because we face the prospect of potentially millions of kids becoming uninsured if CHIP were not to be funded that I do not see really either party wanting to make that happen. But perhaps I am overly optimistic. I mean, to state the obvious, the biggest barrier is probably that not a lot of things are getting done up here.

Diane Rowland: Well, the question here that follows up a little on that, though, is what additional funding is needed if CHIP is to be reauthorized? What level of funding are we talking about as a total per-year increase? And are any changes to the CHIP program also being seriously considered as part of extending the funding? CBO cannot answer that. They have not done the estimate yet.

Joan Alker: Okay, so – and I do not want to pitch it to you, Diane. I was just going to say a couple things, which is we did get some numbers from the MACPAC report. I do not know if, Diane, you want to talk about those. But we do not have an official score or estimate yet from CBO. I think recently, as many of you know, MACPAC made a recommendation to continue CHIP for two years with changes that need to be made to Marketplace coverage so before kids would get moved over there. And there are some numbers in that report. So can we talk about this?

Robert Stewart: I can talk about that, okay.

Diane Rowland: Actually, CBO did the estimate so they cannot talk about it.

Robert Stewart: Well, I can talk a little bit about what we did for MACPAC. But the original question in terms of how much is actually needed is not something we can really comment on at this point. I think it is way too soon in the process _____ [01:03:37] legislative language. Just so people here know who are not as familiar with the CBO's working, we have very strict confidentiality rules that we have to abide by. And so only at a certain point in the process are we allowed to share a topic publicly about legislative we have reviewed, estimates that we have done. So we have to be very guarded about what we can and cannot say.

However, MACPAC recently had – and I presume you all know Diane is the Chair of MACPAC – MACPAC recently recommended extending CHIP for two years to 2017. So far, so good. And it

basically gave us two specifications and only two specifications, which is extend it for two years and fully fund the program. We define "fully fund the program" to mean that, basically, every eligible child who applies can be covered. Because we only had two specifications and normally, when we are working with Hill staff, we are working with _____ [01:04:36] and eventually, of course, we are working with detailed legislative language. When we estimate for MACPAC, we do not actually put a point estimate on it. We usually give estimates on a range. So the cost that we estimated would be between $5 billion and something close to zero so between nothing and $5 billion would be the net cost of extending CHIP for two years. Now it is important to understand, I think, when we say that range, what we are talking about is the net cost of all the changes and all the programs that might be affected. That is not the cost of the amount of money that you have to add to a CHIP program in and of itself. So for example, I think it was Joan who mentioned that you have these children in CHIP who are essentially in Medicaid but paid for by CHIP. We call them the Medicaid CHIP kids or the CHIP Medicaid kids. Those kids, if CHIP went away, would end up in Medicaid, at regular Medicaid matching rates. So if you extend CHIP, the cost of covering those kids in CHIP is the cost of the CHIP coverage minus the savings from no longer having to cover them in Medicaid.

Same with the Exchange. You know, we have talked about the family glitch. Some kids will almost certainly end up in the Exchange. Not all kids will fall into that worst-case scenario. And it is the same dynamic. If you extend CHIP, then the cost of covering them is the cost of CHIP minus the savings from no longer having to cover them in the Exchange. So when we say five to zero, we are talking about on net, all of those different program flows.

Ed Howard: If I can just sort of stimulate Rob's thinking along these lines, I call your attention to one of the slides that you did use in which you estimate the outlays in 2015 at $12.5 billion under current law, right? And of that, $5.7 billion is in your baseline and would be the following year. Is that any guide to orders of magnitude that might occur if the extension were approved?

Robert Stewart: Well, okay. Can you put that slide back up [interruption]? It would be helpful.

Ed Howard: Once it comes up as a pack, you can advance it. There you go.

Robert Stewart: There we go. All right, so again, this looks something like CHIP's baseline table made to fit into a PowerPoint slide. So in 2015, you see the estimate of outlays is $12.5 billion. Now, that is an estimate and that does depend somewhat heavily on what happens to CHIP enrollment under the ACA. So there is a mandate, there is an employer mandate that eventually will be implemented. There is something that is called the No Wrong Door policy if people are familiar with that. It was no matter which eligibility office you walk into – Medicaid, CHIP, or an Exchange office – you eventually get to the right program. At the moment, that is not working well. But we do assume eventually it will work. The technical glitches that have been solved so far have not solved that but we presume at this point they eventually will.

So this assumes that eventually, we would have $12.5 billion. So if you were to extend CHIP, then I would say it is fairly reasonable to assume, if the program were fully funded, that you would see

$12.5 billion grown by some reasonable factor to account for health care cost growth and potentially, some more moments under the program as the ACA continues to phase in. But again, it is entirely too preliminary to put anything more precise in that. But to answer your question, that is a reasonable ballpark.

Diane Rowland: But I think it is important to recognize that in the future if you do not change the bump up in the matching rate that would give Alabama 100%, those dollars would be expended faster than under the current matching rate scenario.

Robert Stewart: That is correct.

Diane Rowland: So you would cover fewer kids.

Robert Stewart: You might not cover fewer kids. It depends how much you put in the allotments and how much – sorry, how much you put into the budget authority and then how much got distributed in the allotment formula. So that depends on the specifications.

But you are right. The prior comment about the program would cost one-third more within the presence of that _____ [01:09:23] increase still stands.

Bob Hall: Hi, I am Bob Hall with the American Academy of Pediatrics. Really great to have some of you folks here in the room and an amazing panel. Thank you guys so much for putting on this briefing. One of the things that we have always advocated for is for the Congress to know what they are buying when they are putting forward funding for issues. So whether in CHIPRA it was the creation of MACPAC or significant unprecedented new funding in quality improvement that came forward as part of CHIPRA. Wondering if you all have any perspective on whether or not some of that quality improvement funding might be extended or continued. And then if there are other good ideas that we might – for children, generally – that we might be able to put into reauthorization or refunding or whatever you want to put it, new ideas that might be on the table after the _____ [01:10:10] came forward.

Cathy Caldwell: Bob, I am not certain that I have a specific answer to your question but I agree with you completely that the quality measures. I think that has really helped us focus a lot more on quality, and they are voluntary right now. In Alabama, we are reporting on them for CHIP and trying to get numbers for Medicaid. So I would hope that emphasis continues and even broader, relate it to all children, not just Medicaid and CHIP. And that is really all I can think of right this minute.

Joan Alker: So I would just say a couple of things. I mean, one is to point out that I think last time when we did CHIP, its reauthorization, there were a lot of changes that were made, many which we thought were very beneficial. And I think there are certain issues that were raised like the quality measures, which as Cathy just mentioned, are optional. You know, we would love to pump that up to be mandatory. But it is important to recognize that we have to think about kids' coverage both in the context of the Affordable Care Act and essential health benefits. We feel like the

pediatric essential health benefit is kind of weak. It has not been implemented really as Congress intended. We would like to see that pumped up.

So there are some changes in CHIP but also, some bigger changes we would like to see. But just to note, I think it is important to stress, and I think that Robin mentioned this at the outset, that CHIP is actually permanently authorized. So we do not actually need to reauthorize, we just need to extend the funding. And I just mention that because given the complexity of life up here, I think extending the funding is a simpler task than what would be the better thing to do, obviously, would be to try to make improvements to the underlying programs.

Diane Rowland: This question is for you, Cathy. It is you mentioned that the current level of uninsured children in Alabama is 7%. What are you doing to target these kids? Are there specific enrollment strategies that you are trying to use to get them to enrolling in CHIP? And the second part of the same question is how does Alabama ensure that no family pays out-of-pocket expenses greater than five percent of family income?

Cathy Caldwell: So for the first question, I have to say this but we actually do less now than we used to do. We had always done a lot of outreach to uninsured children, targeting all uninsured children. And then they were enrolled in the program for which they were eligible, CHIP or Medicaid, and most of the uninsured children in our state are eligible for one of those programs. Because of state budget deficits, about two years ago, we stopped all of our outreach. We have seen a slight decline in enrollment because of that. A lot of our community partners stepped up and continued the activities that we used to do from a state perspective. Our goal is still to reach and enroll all the uninsured children. Just our tools in which to accomplish that have been limited the last few years. I, too, am an optimist and I think that that will get better. Our uninsurance rate is actually a little bit higher than it was. So I mean, because of the stopping of the outreach, I do think that we have lost a little bit of ground and I certainly hate to say that.

As far as the five percent, we do what CMS calls the shoebox method and we explain this in the benefit book and a lot of the materials that we send to families. But essentially, the family has to keep up with it. And so a combination of the premium and any copayments that the family pays, if it exceeds five percent of their income, they alert us. We do send them a letter with that five percent computed. So they are told in a letter upon enrollment what that dollar amount is so at least they do not have to do the math. Until this – this was a strategy to address our state budget shortfall. Until about two years ago – or maybe three or four years ago – we had a $500 cap. So that was well below five percent even of the lowest family income in our program. So we told families, "If you spend out-of-pocket more than $500, let us know and we will put you in the no-fee group." Even at $500, we only had a handful out of many, many years. So now, we do compute the five percent of family income and the family has to keep up with it. So that is how we do it and it is called the shoebox method.

Joan Alker: I just wanted to mention on the premium topic, you know, there are a number of issues that we have not talked about here today with respect to the interaction of the ACA and CHIP because they are sort of more complicated and maybe we can get into them at a future briefing. But for example, there is a problem now of premium-stacking where families may be paying premiums

for the parents who are a qualified health plan but they are not essentially getting credit for their CHIP premiums. So they are actually paying more than they should be. There are problems like waiting periods when CHIP programs still have waiting periods, a kid has to be uninsured, and that really does not make sense in a world of universal coverage. And keeping track of these kind of copays, I would hope that we could move to more automated methods.

So all of those are issues that are maybe good for a 201 session but things we should be thinking about in this new world where we have different coverage sources.

Diane Rowland: And actually, if you want more information on all of those topics, the March report from MACPAC dealt with the premium-stacking and the waiting period issues, as well as the June report, which recommended the two-year transitional extension of CHIP.

Joan, a question here is can you describe financially the impact on states if the federal funding expires? Have you talked with states or do you have any sense of what that impact would be?

Joan Alker: Yes. So we, too – I am going to ask Elizabeth Barak [PH] to raise her hand here. She has been responsible with the Center of Budget and Policy Priorities for our memo and we do have preliminary state estimates of how much funding they would lose. So we do not have it up on our website yet but if you would like to know what the answer is for your state, see Elizabeth after the briefing and we can share copies out with you and I can share the top-line numbers if I can find them. We estimated for 2016, depending on the match level if you have the current match level, for states that have Medicaid expansions, the range of funding loss for states would be between $1 billion and a little over $3 billion. For states with separate state CHIP programs, the loss in federal funding would be between $5 billion and $6.8 billion, depending on the match rate assumption. So again, see Elizabeth if you would like a copy of this memo.

Diane Rowland: For the federal government, may it cost more or less to cover a child through the Exchanges, with subsidies, through CHIP, or Medicaid? The answer does not have to be given but they want to know what resources could one look at and what are some of the complications of trying to make that comparison.

Robert Stewart: So I am not going to answer that but I will tell you why I am not going to answer that. It is hard to do an apples-to-apples comparison, particularly with respect to Exchange coverage versus public coverage. So it is really not the kind of thing that is easily responded to in a forum quite like this.

Diane Rowland: I think he is saying that the benefit packages, the provider reimbursements, there are lots of changes that go on into that calculation. Though when you take into account, as you said, whether children are covered by CHIP or whether they are covered in the Exchanges or in Medicaid, obviously, that is part of what CBO factors into its analysis.

The next question we have is really a different flip side of the CHIP debate and that is what would have to be done in the ACA to Exchange coverage to make it more palatable for coverage of children so that you could smooth some of these transitions?

Joan Alker: So just to pick up on a couple things I said in my presentation, I think we feel like the essential health benefits, the pediatric component of that benefit package, really needs to be strengthened. It is actually our hope that the administration has said that they will be taking another look at the essential health benefits for 2016, that they will look at this question. Because it is our sense that what the Congressional authors of the Affordable Care Act intended for that piece of the essential health benefits could have been implemented a little more robustly by the agency. So that is certainly something Congress could look at but it is also something, I think, the Administration has similarly, a way to look at it on their own.

But the other question, I think the affordability question is a more difficult one. And as I talked about in my presentation, I think there is fairly widespread agreement that the cost-sharing protections are stronger for kids in CHIP. And so that is something that potentially kids would go backwards on if CHIP were to end and they were to end up in the Exchange. So that is something certainly that Congress could take a look at.

Diane Rowland: And we have a question, too, about how interested parties could access reliable data sources to assess trends and apparent needs of children with disabilities and special health needs. And how does CHIP address that compared to Medicaid? Cathy?

Cathy Caldwell: As far as data, we conducted a study, and it has been several years ago now, looking at our CHIP enrollees, surveyed parents at the University of Alabama at Birmingham School of Public Health conducted a survey. And we found that the vast majority of needs of our enrollees with special health care needs were met in our benefit package. I mentioned a little while ago that we took a benchmark benefit plan and then we enhanced it, particularly for services for children with special healthcare needs. And we partnered with two state agencies, the Title V Children with Special Healthcare Needs entity and then our mental health agency.

So from an Alabama perspective, I am not saying that our CHIP covers everything that would be covered in EPSDT. But I am saying that for our enrollees, the vast majority of needs were met. Many of the children even that come through our program that do have needs beyond what CHIP offers, they become Social Security-eligible and end up enrolled in Medicaid, so we are certainly a partner in that.

From a national perspective, I am not sure where you could access those data. I would certainly be glad to share this study with you that we conducted in Alabama.

Diane Rowland: Is there any evidence of what CHIP has contributed in terms of the support for language access services for kids with limited English proficiency? And what role has that played in improving access to care for children?

Joan Alker: I am not sure about the language access. I am hoping Robin maybe is familiar with something. I was just going to make a quick point on the special needs kids. Two things – one is to say that in our report that we did with the National Academy of State Health Policy, we did look at things like habilitative benefits that are really important to kids with special needs so at least you

can get a sense of what is in the benefits package. A lot of times, it is hard to actually get good data for CHIP specifically that is not broken out from Medicaid with respect to kids with special needs.

So I think it is actually an area that we do not know as much as we would like to know but certainly, the kids who are the most severely disabled tend to wind up on Medicaid.

Robin Rudowitz: And I would just say that I am not sure about the language access piece but there is evidence that shows that shows that Medicaid and CHIP have played a significant role in reducing racial and ethnic disparities and access to care. So part of that is probably application and language access. That was part of that effort in expanding coverage.

Ed Howard: I just want to tell folks we are, you will recall, going to end the program in just a couple of minutes so we do not have for many more questions. While you are listening to this final exchange, maybe I could ask you to fill out the blue evaluation forms as you are listening to the Q&A. Diane, do you have one last question that you wanted to get in before we leave?

Diane Rowland: I think the final question goes to the heart of what we have discussed all day, which is does CHIP funding need to be maintained at its current levels or can it be adjusted as more and more families begin to purchase coverage through the Exchange? And I think the whole issue is how do you fit CHIP into the new world of the ACA and the Exchanges and the Medicaid changes and how does that differ, of course, by the expansions taken in non-expansion states? So that is the issue that we are giving back to Congress to deal with.

Ed Howard: Absolutely. It sounds like we have got right back to Robin's questions in her last slide and I suspect we will have to do a CHIP 201 if we are going to be able to address all of them. Well, want to chime in before we do that?

Robin Rudowitz: I think we will have to watch to see what evolves in the legislative debate around CHIP and see what happens with the bills that have been introduced and are being worked on and particularly, around the timing and if there is any debate or negotiation around those to see what ultimately happens.

Diane Rowland: I guess I would close by saying we also know that from a state planning perspective, knowing what the future looks like is very important. Because many of the states have either built into their budgets the expectation that CHIP is being extended or are actually having to make plans for what they would do if it is not.

Ed Howard: Pretty good description of what your duties are, those of you who are going back to your Congressional offices to take a look at these issues, read the background materials, and make use of the list of experts and sources that we have listed for you in the materials. Thank you very much for staying with us in what was a really complicated situation being described by lots of good folks. I will also ask you to join me in thanking not only the Kaiser Family Foundation, but our panelists, for bridging the gap between those complicated topics and our ability to understand them. Thanks very much. [Applause]