COVERING UNINSURED KIDS: REVERSING PROGRESS ALREADY MADE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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SUBMITTED MATERIAL

COVERING UNINSURED KIDS: REVERSING PROGRESS ALREADY MADE

TUESDAY, FEBRUARY 26, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:40 a.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman of the subcommittee) presiding.

Members present: Representatives Pallone, Waxman, Towns, Gordon, Eshoo, Green, DeGette, Capps, Schakowsky, Solis, Hooley, Matheson, Inslee, Markey, Dingell (ex officio), Deal, Wilson, Shadegg, Burgess, Blackburn and Barton (ex officio).

Staff present: Bridgett Taylor, Chief Health Finance Policy Advisor; Amy Hall, Professional Staff Member; Yvette Fontenot, Professional Staff Member; Hasan Sarsour, Legislative Clerk; Jodi Seth, Communications Director; Brin Frazier, Deputy Communications Director; Lauren Bloomberg, Press Assistant; Megan Mann, Staff Assistant; Ryan Long, Minority Chief Counsel; Brandon Clark, Minority Professional Staff Member; and Chad Grant, Minority Legislative Clerk.

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

Mr. PALLONE. The subcommittee is called to order.

The subcommittee is meeting today to discuss the reversal of progress made on covering uninsured children in America, and I will yield to myself for an opening statement initially.

First I want to welcome our illustrious panel here today. We have of course Governor Strickland, who was a member of this subcommittee and this Committee for many years. He used to sit with myself and Sherrod Brown, who is now our Senator from Ohio as well. So thank you in particular and thank all of you for being here today.

Last year should have been a landmark year for children's health. Within our reach was the opportunity to build upon the success of the previous 10 years in which millions of low-income children were provided access to healthcare coverage through the Children's Health Insurance Program, or CHIP. We sought to exceed that achievement by providing States with the resources they needed to maintain current enrollment as well as expand enrollment by 4 million additional children who are presently eligible but

don't participate. In spite of our extensive efforts to develop bipartisan bicameral legislation, that opportunity was lost, in my opinion to petty politics and ideological warfare waged by a President who has continually ignored the needs of hardworking American families. Instead of working with Congress to develop a compromise that would build CHIP up for future generations, he set out to unilaterally tear it down.

On August 17 of last year, the Administration issued a new directive to State CHIP officers that would seriously alter the way CHIP currently operates, essentially stripping States of the flexibility they have long enjoyed since the program's inception. Under the new directive, a State would have to prove that it has enrolled 95 percent of its CHIP and Medicaid-eligible children in families with incomes below 200 percent of the federal poverty level before providing coverage above 250 percent of the federal poverty level. By almost every account, there is no State that will be able to meet this requirement, and adding insult to injury, research suggests that CMS does not even have a methodology to measure State participation rates. There are equally egregious new policies imposed on the beneficiaries themselves such as a 12-month waiting period for a child who loses private coverage before he or she can enroll in CHIP, and I still have not found an answer for what that child is supposed to do for healthcare during those 12 months.

There is no doubt that if enforced this new directive would seriously constrain States who are trying to provide coverage to more kids. We have already seen some of the effects. New York planned to expand coverage from 250 to 400 percent of the federal poverty line but had its plan denied by CMS. That means approximately 47,000 fewer children in New York will have access to health coverage as a result of that denial. And while the Administration claims it will not expect any effect on current enrollees, I believe the policies put forth within that August directive could imperil the coverage of thousands of children in those States that already cover children above 250 percent of the federal poverty level.

Now, in addition to this August 17th directive, this Administration has issued a slew of Medicaid regulations that seriously jeopardize the healthcare of millions of low-income and disabled Americans of all ages. You have already talked about that at your governors' conference. What is on the chopping block? Funding for rehab services for those with disabilities, outreach, enrollment assistance and coordination of healthcare services for children with disabilities in school settings as well as payments for graduate medical education, which is an important revenue source for teaching hospitals around the country including in my home State of New Jersey, which is in desperate need of these funds to avoid further hospital closings. We had a hospital closing announced in my district just last Thursday. And most recently, CMS has proposed two new rules that would allow States to enroll Medicaid beneficiaries into benefit packages that offer fewer benefits as well as charge them higher premiums. If allowed to go into effect, these regulations would slash billions of dollars from State Medicaid programs, shifting costs to States at a time when many are strapped for cash. I know this to be true in my home State of New Jersey. Our governor couldn't appear today because he is delivering his

budget address that freezes State spending in order to close our budget shortfall. If New Jersey starts losing federal dollars for its Medicaid and CHIP programs, the State simply will not have enough money to make up the difference. Instead, it is more likely that enrollment will be curtailed and services will be cut.

Now, it is clear that the Administration is on the wrong side of history here. Everyone but the President seems to be working to expand health coverage, especially to our most vulnerable citizens. Because of the President's intransigence, we were unable to pass a robust CHIP reauthorization last year that would have helped move us towards covering all uninsured kids. Now he is clearly trying to move backwards from longstanding federal commitments by cutting federal dollars from our Nation's safety net programs at a time when States are talking about using these very programs to build the basis for universal coverage. How is a State like California, New Jersey or New York supposed to provide universal coverage without the Federal Government doing its part to help or how is a State like Massachusetts supposed to continue its current endeavor if the Administration is going to pull the rug out from under them?

As we see increasing signs that the U.S. economy is weakening and heading towards a recession, it is crucial now more than ever that we ensure that those hardworking American families who are negatively impacted by the economic downturn have a safety net to fall upon, and that is why myself, Chairman Dingell, Representatives Peter King and Tom Reynolds introduced H.R. 5268, legislation that would help protect access to health coverage through Medicaid during the economic downturn. It provides a temporary increase of the Federal Medical Assistance Percentage, or FMAP. During a time when the outlook for so many American families seems uncertain, we should be promoting policies with programs that provide States and beneficiaries with the relief they need. Temporarily increasing the federal matching payments in Medicaid is a proven strategy for stimulating the economy. Slashing billions of dollars from Medicaid through administrative fiat is not.

Now, we are going to hear from all of you today. I want to thank you all for being here. We are anxious to hear your testimony. I mentioned Ted Strickland, and we realize that you are taking time beyond the Governors' conference to be here today and we certainly appreciate that.

Mr. PALLONE. I now recognize our ranking member, Mr. Deal, for an opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. I thank you for holding this hearing on an important topic as we revisit the reauthorization of SCHIP and possible reforms to the program. We are indeed honored to have such a distinguished panel of witnesses, and I want to thank these governors for taking time out of their very busy schedules to be with us here today. States play a very integral part of making the SCHIP program work and your input is certainly appreciated.

At this point I think we all know that SCHIP was created to allow the States to cover targeted low-income children with federal matching funds with a capped allotment. Moreover, SCHIP has been remarkably successful at achieving its goals. Unfortunately, like any new program, there have been some abuses. Some States have covered more adults than children. Others have focused on covering children who are up the income scale while leaving the truly needy children from low-income families behind. Still others have failed to discourage families from dropping their private health insurance and replacing it with a government program.

It is these abuses which led to the August 17th guidance from CMS. I understand that many governors are concerned about the impact this guidance will have on their SCHIP programs and I am certainly willing to work with governors and my friends on the other side of the aisle to address this August 17th letter. But before we do so, we must ensure that the abuses within SCHIP are addressed so that poor children do come first. With reauthorization of SCHIP I believe we could craft a better solution than the August letter while addressing the other legitimate concerns about the current operation of the program.

I also hope the governors will take some time to shed light on what I believe is a major contradiction we are hearing from some governors lately. Recently due to slower economic growth, I believe the National Governors Association requested an increase in federal matching rate for Medicaid to meet the demands Medicaid places on State budgets. In this context, it is hard for me to understand how in the case of SCHIP States act as if they have ample resources to expand that program. It would seem to me that if States cannot afford to meet their obligation in Medicaid to the Nation's neediest citizens, they would not be able to expand eligibility of SCHIP to higher incomes.

Again, I want to thank each of you for taking time to be with us. We look forward to your testimony and welcome you to this hearing.

I yield back.

Mr. PALLONE. Thank you, Mr. Deal.

I recognize the chairman of the full Committee, Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy and I commend you for having this hearing. It will give us an opportunity to hear from a number of distinguished governors as to perspectives of themselves and their States with regard to current issues relating to children's health programs.

We are delighted to have before us five outstanding governors representing different regions and differing political perspectives. I want to express my thanks to each of you ladies and gentlemen for your presence here and your assistance. We know how busy you are and I am grateful to you for your kindness in this matter.

I am also pleased to welcome back a former member of this Committee, our good friend, Governor Strickland from Ohio. Welcome

back. This is a room that you will remember from other good days when you served here with such distinction.

The governors joining us today will provide enormously valuable insights into the importance of the State Children's Health Insurance Program and Medicaid and the efforts of several States to reduce the number of children who do not have health insurance. However, storm clouds threaten to undermine the progress the States have made in recent years. Over the past year, the Administration has taken a number of actions directly impeding State coverage efforts not only in SCHIP but also in Medicaid. The Administration's August 17th directive will affect at least 26 States by this summer, causing the States to roll back existing coverage and to stop planned expansions. While this directive is couched in rhetoric about helping the poorest first, the Administration's own actions make it clear that this is not the real intent. If this Administration were interested in helping those with the lowest incomes, the President would not have vetoed the bipartisan Children's Health Insurance Program Reauthorization Act that provided new incentives, new tools, bonus payments to make sure that the States had the funds to get the job done and the assistance of the Federal Government in doing so, and I will not mention the $35 million over the next 5 years that would have been made available to the States to make sure that they had sufficient funds to meet the growing need for SCHIP and for its beneficiaries. If the August 17th directive was not enough, the President's budget proposes to go one step further, stopping the States from covering children in families with annual incomes above $35,200.

As the infomercial would say, wait, there is more. The six Medicaid regulations the Administration has issued in the past year would cut more than $13 billion from Medicaid. These cuts would come from critical services for people with disabilities such as rehabilitation and case management services as well as from public institutions that serve as a safety net for our most vulnerable of our society. In the face of these cuts, many States will choose to do the right thing and use State-only funding to protect coverage of those in need. But States cannot and should not bear this burden alone, and there are many that cannot carry the kind of load that the Administration expects them to do.

When both Medicaid and SCHIP were created, the Federal Government was a full partner and it should remain so. Moreover, with the country facing an economic downturn, it is unclear how long States can sustain their commitment if the Administration continues to erode federal assistance to the States. This Congress will work to ensure and to restore the ability of the States to cover uninsured children in need. We will press forward with the good policies included in the SCHIP reauthorization vetoed by the President twice so that SCHIP is fully funded and the States have the resources to meet the growing need for coverage and we will work to stop this Administration's assault on healthcare coverage for children.

I look forward to today's witnesses' testimony, and I want to thank the governors for their presence here and their assistance to us. I look forward to working with them to protect SCHIP and the

Medicaid programs and to assist them in their difficult labors in this matter.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Dingell follows:]

STATEMENT OF HON. JOHN D. DINGELL

I thank Chairman Pallone for calling this hearing to provide the opportunity for the Committee to hear State perspectives on current issues relating to children's health programs.

We are pleased to have before us today five Governors representing different regions and political perspectives. I am especially pleased to welcome back a former member of this committee, Governor Strickland from Ohio.

The Governors joining us today will provide valuable insights into the importance of the State Children's Health Insurance Program (SCHIP) and Medicaid, and the efforts of their States to reduce the number of children who do not have health insurance.

However, storm clouds threaten to undermine the progress that States have made in recent years. The Administration has taken a number of actions over the last year that directly impede State coverage efforts.

The Administration's "August 17th directive" will affect at least 26 states by this summer, causing States to roll back existing coverage and stop planned expansions.

While this directive is couched in rhetoric about helping the poorest first, the Administration's own actions make clear that is not its real intent. If this Administration were interested in helping those with the lowest income, the President would not have vetoed the bipartisan Children's Health Insurance Program Reauthorization Act (CHIPRA) that provided new incentives, tools, and bonus payments to make sure States got the job done—not to mention $35 billion over the next 5 years to make sure that States had sufficient funding to meet the growing need for SCHIP.

And, if the August 17th directive wasn't enough, the President's budget proposes to go one step further, stopping States from covering children in families with annual incomes above $35,200.

As the infomercial would say, wait: there's more. The six Medicaid regulations the Administration has issued in the past year would cut more than $13 billion from Medicaid. These cuts would come from critical services for people with disabilities, such as rehabilitation and case management services, as well as from public institutions that serve as the safety net for the most vulnerable of our society.

In the face of these cuts, many States will choose to do the right thing, and use State-only funding to protect coverage for those in need. But, States cannot—and should not—bear this burden alone.

When both Medicaid and SCHIP were created, the Federal Government was a full partner, and it should remain so.

Moreover, with the country facing an economic downturn, it is unclear how long States can sustain their commitment if the Administration continues to erode Federal assistance to States.

This Congress will work to restore the ability of States to cover uninsured children in need. We will press forward with the good policies included in the SCHIP reauthorization vetoed by the President twice so that SCHIP is fully funded and States have the resources to meet the growing need for coverage. And we will work to stop this Administration's assault on health coverage for children.

I look forward to the testimony of today's witnesses and to working with the Governors to protect SCHIP and Medicaid programs.

Mr. PALLONE. Thank you, Chairman Dingell.

I recognize the gentlewoman from Tennessee, Ms. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Ms. BLACKBURN. Thank you, Mr. Chairman, and I want to welcome all of our governors who are here to talk with us about this. I appreciate that you would take the time away from your duties to be here and talk with us about SCHIP. It is an important pro-

gram to us and I certainly support SCHIP as it was originally created and support the goals of that program. Indeed, they are good goals. It is a worthy program and it fills such a need in our country.

This hearing and what we are going to talk about today is responsible guidance from CMS requiring States to ensure that SCHIP funds are targeted toward the low-income children before States spend money to expand coverage to wealthier populations and I appreciate the good government effort put forth by CMS to ensure that States cover 95 percent of their eligible low-income children first and reach those children first. In addition, we will also talk about procedures to address crowd-out.

Now, I come from Tennessee and we know a lot about crowd-out in Tennessee and we have a lot of experience in government taking over a majority of the healthcare market. We have seen it in our State with the TennCare program. I am certain some of you are aware of this and are aware of the TennCare program that we have had. So we know what happens when government overextends itself and when promises are made that cannot be kept or that are very difficult to be kept and the burden that this places on our citizens, so we are interested to hear what you have to say. We are interested in hearing how we address these issues, how we meet the needs of this population before we take any other steps, and we are looking forward to all the information that you will bring forward to us as we address the issues that we have with funding and with the budget and with other proposals that will come before us as we proceed through the years.

So welcome. We appreciate your taking the time to be with us, and Mr. Chairman, I yield back the balance of my time.

Mr. PALLONE. Thank you.

I now recognize the gentleman from California, Mr. Waxman.

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

Mr. WAXMAN. Thank you very much, Mr. Chairman. I want to welcome the Governors here as well. I want to thank my colleagues for allowing me to give an opening statement early because I have to run to chair my own hearing, so I won't be here to hear all of your testimony. But I think it is important we hold this hearing and I thank Chairman Pallone for convening us.

We need to look at a number of Medicaid issues. I know that a lot of the discussion this morning will be on the August 17th CMS letter, which as a practical matter eliminates State flexibility to extend SCHIP coverage to children in families with income above 250 percent of the federal poverty level. In my view, this policy doesn't make any sense. It doesn't have any basis in statute. This is clearly the province of the Congress, not the Executive Branch, and I will continue to work with my colleagues on both sides of the aisle to bar CMS from implementing this misguided and mean-spirited directive.

But I hope that in addition to the August 17th letter, we will also hear from the Governors about the State-specific impact on the Medicaid regulations CMS issued last year affecting payments to

government providers, payments for graduate medical education, provider taxes and coverage for outpatient hospital services, rehabilitative services, case management services and school administrative and transportation costs. The Federal Government is issuing regulations saying we know how better to handle all those things, we are not going to let the States decide these matters, we are going to tell you what to do.

Last November the Oversight Committee asked Mr. Smith, the principal author of these regulations, for a State-by-State analysis of their impact. Well, as the governors well understand, there are very great differences between States and the impact would differ from State to State. We asked for the impact, and last Friday we finally got a response from Mr. Smith.

Here is what he wrote: "With respect to your second request concerning State-specific impact analysis, I regret that we are unable to develop and report this information. While we share your interest in having State-specific impacts, it is not possible at this time to generate accurate assessments due to a variety of deficiencies in data collection including variation in State reporting, changes in State funding practices, current available data sources, information systems and resource levels."

Well, this is a pretty breathtaking response. The federal official in charge of Medicaid who has issued seven regulations that will reduce federal payments to the States by at least $15 billion over the next 5 years cannot tell us how any of these new policies will affect individual States.

Fortunately, we have the five of you here today to help us understand better what the effect of these regulations will be on coverage of low-income children. Will the regulations denying Medicaid payments to schools for outreach and enrollment activities result in a decline in Medicaid and SCHIP enrollment? Will the regulation narrowing Medicaid coverage for rehabilitative services result in the defunding of early childhood development programs for children from birth to 3? Will the cumulative loss of federal matching funds from all these regulations in a time of an economic downturn undercut the ability of States to finance their share of health coverage for children under Medicaid and SCHIP?

I hope the hearing can shed some State-specific light on these issues. This is a federal-State cooperative program and your federal partner is telling you we don't know what the impact will be on you. Maybe you can tell us what the impact will be before we allow these regulations to take effect.

Thank you. I yield back the balance of my time.

Mr. PALLONE. Thank you, Mr. Waxman.

Mr. Burgess of Texas.

Mr. BURGESS. Thank you, Mr. Chairman. It is an important hearing. In the interests of time, I am going to submit my opening statement for the record.

I just want to thank all of our witnesses for being here today. I do feel obligated to let you know there is a competing subcommittee hearing on food safety, and with all the attention that has been on food safety recently, it is not for lack of attention or for lack of desire that I have to divide my time between two subcommittees. I wish the subcommittees would work together in a

better fashion so that we didn't have these problems occur but such is life on this side of the dais.

Mr. Chairman, I would say this is an extremely important hearing and we are going to get some great information today. I am so pleased as we go through the process this year. I wish we have seen so this type of effort and attention last year when it was incumbent upon us to do the work of reauthorization of the State Children's Health Insurance Program. I hope that as we go forward, the importance of this subcommittee will be recognized. I realize process arguments aren't the kinds of things of which headlines are made and I am not supposed to talk about process, but in this subcommittee, process is important. I said it before and I will say it again: Some of the best legislative and scientific minds in the United States Congress, in the United States House of Representatives today are on this Committee, and Mr. Strickland, they were last year as well, but it is imperative that this committee weigh in on this important subject and we don't need a bill cut from whole cloth from the Speaker's office, air dropped into the full committee in the middle of the night. That is not the way to do it.

Mr. Chairman, I hope you will take your leadership and make certain that this subcommittee is able to do its work through the legislative hearings and the legislative markup that this subcommittee is supposed to conduct to get this vital legislation passed for the American people, and I will yield back.

Mr. PALLONE. Thank you.

I now recognize the gentlewoman from California, Ms. Eshoo.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Mr. Chairman, for holding today's hearing about healthcare for uninsured children in our country. Welcome to the governors and certainly to our colleague and our friend, always will be. You are an honorary member of this Committee, the full Committee and the House, Governor Strickland.

In the last several weeks the subcommittee has had much testimony from State Medicaid officials, from parents, from academics, from policy experts who testified about how we are losing ground in covering uninsured children in our country, so your presence here today is very important to 45 other States whose governors can't be here today. This is, I think, one of the better partnerships that the State and the Federal Government have for the children of our country, so your testimony is going to be really important to us.

With the economy on the verge of recession, many States including my home State of California are facing deep budget shortfalls. I think I am probably preaching to the choir when I say that to you, but it is a tough time, and families obviously are very concerned about their jobs and their healthcare coverage. Rather than providing security to these families the Administration diminished its commitment to low-income children by vetoing the expansion of SCHIP which would have covered an additional 4 million uninsured kids in our country. We thought that that was making

progress, which I think is synonymous with being an American, that that really signified real progress.

Now this is on the ropes but what has been added to the ropes is what the Administration came out with in their August 17th memo. Now, there are 43 governors of both parties that endorsed the legislation, so it was neither a partisan bill nor a bill that didn't enjoy important support from governors across the country. Among other things, the Administration's August 17th directive for SCHIP enrollment set nearly impossible goals for States to achieve before they can expand their program to cover uninsured kids and families earning up to $43,000 a year. Thousands of uninsured kids in States that plan to expand their programs have already seen this avenue to healthcare coverage closed as a result of the directive. Other States which already expanded have to come into compliance by this summer in order to maintain their plans, otherwise they are going to be forced to scale back the programs. Obviously as a result, it is more likely that we are going to see more children without healthcare and I think that is why several States, including Washington State, are suing over the directive. That is a major step for a State to take, to sue over this. Further undermining the program, the Administration's 2009 budget failed to propose funding sufficient to cover existing enrollment, so it is adding insult to injury.

In a letter to Oversight and Government Reform Committee Chairman Waxman, the Chief Deputy Director for the Health Programs for California wrote, "The reductions in federal funding as a result of regulatory proposals are likely to lead to destabilization of an already fragile healthcare safety net system in California which bears a heavy burden in rendering needed healthcare services to Medicaid beneficiaries and the uninsured." I think if we had children here testifying in the next panel, that a child might say what did I do to you, what did I do to you that you are doing this to us. In one of the issues relative to the guidance that was put out, it bars children from enrolling in the program until they have been without insurance for a full year, and as one of my colleagues said, and much sicker.

So Mr. Chairman, thank for you having the series of hearings. Thank you to the governors that are here today. You have tough jobs in tough atmospheres today, and we want to work with you to see that your hand can guide what your State chooses to do and that the Federal Government will be a fair and full partner in that. Thank you.

[The prepared statement of Ms. Eshoo follows:]

STATEMENT OF HON. ANNA G. ESHOO

Thank you, Mr. Chairman, for holding today's hearing about health care for uninsured children in our country.

In the last several weeks, the Subcommittee has heard testimony from state Medicaid officials, academics, policy experts and parents who have testified about how we're losing ground in covering uninsured kids. I'm pleased that we'll be hearing the perspective of five of our nation's governors today, including our former colleague, Ted Strickland.

With the economy on the verge of recession, many states, including my home state of California, are facing steep budget shortfalls. Families are concerned about their jobs and their healthcare coverage. Rather than providing security to these families, the Administration diminished its commitment to low-income children by vetoing

the expansion of the SCHIP which would have covered an additional 4 million uninsured kids. This was not a partisan or unreasonable bill: 43 of our nation's governors from both parties, including Governor Schwarzenegger, supported this legislation.

More than rejecting this opportunity to broaden coverage, the Administration has pushed forward a series of new rules and policy directives that are already reducing children's access to health care.

Among other things, the Administration's August 17, 2007, directive for SCHIP enrollment set nearly impossible goals for states to achieve before they can expand their programs to cover uninsured kids in families earning up to $43,000 a year. Thousands of uninsured kids in states that planned to expand their programs have already seen this avenue to health care coverage closed as a result of this directive. Other states which already expanded their programs, must come into compliance by this summer in order to maintain their programs, otherwise, they may be forced to scale back their programs. As a result, we're likely to see more children without healthcare. That's why several states including Washington State are suing over the directive.

Further undermining SCHIP, the Administration in its Fiscal Year 2009 budget failed to propose funding sufficient to cover existing enrollment.

The Administration has advanced six regulations that scale back Medicaid funding by $13 billion. Although many of these cuts have been temporarily set-aside by congressional moratoria, the moratoria will be expiring over the next few months. The implementation comes at worst time for states as they struggle to balance budgets in the face of cumulative budget deficits of more than $34 billion this year.

In a letter to Oversight and Government Reform Committee Chairman Waxman, the Chief Deputy Director for the Health Programs for the State of California wrote, "The reductions in federal funding [as a result of CMS's regulatory proposals] are likely to lead to destabilization of an already fragile health care safety-net system in California, which bears a heavy burden in rendering needed health care services to Medicaid beneficiaries and the uninsured."

I don't envy our governors for the position they are being put in. Most of all, the children of our country deserve so much better.

Mr. PALLONE. Thank you.

I recognize the ranking member of the full committee, Mr. Barton.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Thank you, Mr. Chairman.

I want to welcome our governors, especially Governor Strickland. It is unusual to see you sitting down there. I am used to having you up here. Of course, I kind of liked it when you called me Mr. Chairman. It is obvious that you are doing a great job for the great State of Ohio, and of course, our good friend Haley Barbour, who is no stranger to this committee, and the other governors also. We are very delighted that you are here.

I do want to thank Chairman Pallone for holding the hearing. I know that the focus theoretically on the hearing is on CMS's August 17th guidance letter, and I think that it is fair to have an open and vigorous debate about that, but I hope we can also get into some of the broader issues that deal with SCHIP and Medicaid, the component program with SCHIP. Several years ago we had in budget reconciliation a major review of Medicaid. We worked with the National Governors Association on a bipartisan basis. The two governors that led the taskforce were Governor Warner, a Democrat of Virginia, and believe it or not, Governor Huckabee, a Republican from Arkansas. They testified before this Committee several times, and Governor Warner on the record, and I quote, talked about Medicaid "being on the road to meltdown." I

couldn't agree more with that statement that Governor Warner made several years ago.

According to our latest CBO estimates, in the next 10 years Medicaid is going to spend $5.4 trillion—that is about a half a trillion dollars per year—and of that, the States are responsible for over $2 trillion, and I am sure that each of you governors is very well aware of that. It is an open question how we can afford on this one program, a State-federal program of Medicaid, to spend that much money and have all the other programs that each of you so well know your States work with the Federal Government to provide services and help to our less wealthy individuals at the State level.

Last year the former chairman of the subcommittee Deal and I put forward an SCHIP proposal that would have required that before States could go above 200 percent of poverty, they had to show 90 percent enrollment of their children between 100 and 200 percent of poverty. That is a little bit different than the guidance letter of 95 percent but it is close to it. It seems to me only fair before we go above the original intent of SCHIP in terms of enrollment of children at higher income levels, we really, really ought to try to get as many of our moderate low-income children in the program as is possible. It just doesn't seem fair that proposal that the Majority put on the Floor back in August would have let States go up to 400 percent of poverty, which would be over $80,000 per family and also cover adults. I just think that we should cover children first and of those we should cover the low-income children between 100 and 200 percent of poverty.

I know I am going to be stunned if each of you don't talk about State flexibility. I didn't reach your statements but I chaired enough of these things and I know enough about a governor, or governors, generically, that you all want State flexibility. That is why people like me support block grant programs so that we give you the flexibility to manage the programs at the State level that you think is best for your State. So I don't have a problem with requiring flexibility for SCHIP, but again, I think the basic guidepost should be, let us cover our moderately low-income children first.

I do appreciate you all being here, and I appreciate Mr. Pallone and Mr. Dingell for holding the hearing. I was one of the most vociferous objectors last year that we were legislating on the Floor without having hearings in committee, and I know there is a political element to this and there will be great gnashing of teeth and beating of breast and things like that as we go through today, but I do hope that we do focus on the policy underlying SCHIP, which is a State-federal partnership and it is designed to cover children between 100 and 200 percent of poverty.

I thank each of you governors for being here. I have another hearing going on in the Oversight Subcommittee so I am going to be shuttling back and forth, but I will try to listen to as much of your testimony as possible.

Thank you, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Barton.

The gentlewoman from California, Ms. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. CAPPS. Thank you, Chairman Pallone.

I am very much looking forward to hearing the particular perspectives of our esteemed witnesses today. Of course, I am going to add my congratulations and welcome back to our former colleague, Governor Strickland from Ohio, and really commend the five of you for taking the time from your very busy schedules to give us the perspective from the ground troops in your States, from the people who really see the issues we are discussing today face to face and know the families and know the people we are talking about. You are the ones struggling to cope with some very traumatic setbacks that the Bush Administration has proposed for SCHIP and Medicaid. I commend the National Governors Association for rightly standing up against these misguided rules and I am pleased to see attention drawn to your concerns on the front page of this past Sunday's New York Times. I think it is interesting to note that many of the prominent Republican governors are the loudest objectors.

Governor Perdue, we shook hands a few minutes ago and I want to put a quote into my statement from your commissioner of the Georgia Department of Community Health, Dr. Meadows. She said this: "These rules taken together would have a tremendous adverse impact. They would undermine the healthcare safety net for the entire State of Georgia." But Georgia is not the only one. Our own governor, those of us from California, Arnold Schwarzenegger, has estimated $12 billion in losses to California alone.

When we talk about these numbers, however, I think we lose sight of what these numbers really mean. The money isn't being taken away from Governor Schwarzenegger, his pockets or mine or yours. These are billions of dollars which represent lost services to our Nation's neediest families, to the children who will live lives compromised because of this lack of service. How insulting at the very time that we are experiencing an economic downturn when basically what the Bush Administration now has said through the SCHIP and Medicaid proposed rules is this: sorry, States, but we are reneging on the commitment we have made to work as partners in order to serve the needy families. What is also disturbing to me is the effect that this will have on public hospitals which are the backbone and the safety net in your communities, when they are being asked, when we rely on them. As President Bush has said, well, you can always go to the emergency room. They are going to be strapped for funds if we follow through with these rules and the hospitals they operate, we are going to see a domino effect as you know from where they will have to cut services in these very emergency rooms, in the trauma units and all of the services that your public demands and needs.

So I look forward to hearing from you today, and I look forward to a thoughtful discussion that we can have on how important it is we prevent these harmful rules from going into effect.

I yield back.

Mr. PALLONE. Thank you.

The gentleman from Arizona, Mr. Shadegg.

OPENING STATEMENT OF HON. JOHN B. SHADEGG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SHADEGG. Thank you, Mr. Chairman, and I thank you for holding this hearing. It is extremely important that we examine this issue.

I would like everybody to take one step back from the discussion of the SCHIP program and look at the broader issue of healthcare for Americans. I want to thank our witnesses. I think they are important players in this discussion and what we do. I would like to put my written statement into the record.

But in asking you to step back, I would like to ask you to not think about what role in this debate you play, whether you are a governor who would control some of those funds and run a program or whether you are a Congressman and would enact what we pass into law, but rather think about it from the standpoint of the patient. In this case, think about it in the standpoint of the child and of the child's parents. I would suggest we are at a watershed in healthcare in America. I would suggest that anyone who examines healthcare in America today will find very rapidly that one of the biggest problems we face is that the consumer of the healthcare product, the individual who is treated, is not put into a position to make decisions. If you examine healthcare in America today, too many decisions are made by third parties. They are made by your employer, they are made by the plan that your employer hired and they are made by the doctor that the plan hired by your employer. And so you don't get to make those decisions because your healthcare plan was picked by your employer, or in the case of government healthcare programs, you don't get to make the decisions because some bureaucrat made those decisions. I would argue that we have a crisis in the delivery of healthcare in America today because we are not putting the people who know the most, the consumer of the goods, in a position to make a decision.

I have introduced a bill every single year that I have been in this Congress since 1995 which would change that, which would say let us let individuals choose, let us say to an employer, you can buy a plan for your employees but you should also tell some of those employees that they have the right to go pick their own plan. I would suggest to you that with SCHIP, we can offer to the parents of the kids who need help a refundable tax credit, a block of money, and say to them, take this money and go buy health insurance coverage that meets your needs, a healthcare plan that you choose for your children, a healthcare plan that you pick with the doctors you like, and if you do not like how it performs, you can fire that plan. If you are not pleased with the way the doctors or the nurses or the labs or the hospitals treat you, you can get rid of that plan and do something else. We can do that. The bill I have proposed every year says we are going to give you a refundable tax credit to every single American. It would cover every single child in America and every single child in SCHIP and we can afford it because we are already spending that money in emergency rooms and in other clinics but the issue for America is, are we going to move toward more third-party control by employers or plans or the government or are we going to move toward patient-driven care?

I would suggest that this is the discussion we should be having, and I personally believe that if you put patients in charge of their own healthcare, then not only will costs come down because consumers buy the most efficient care they can afford but quality will go up, because if patients can fire a doctor that isn't doing a good job for them or a plan that isn't doing a good job for them or a lab that didn't get the answer back quick enough, if patients can hold the deliverer of that service to them accountable, then you will get better quality as well as lower prices, and I think that is what we ought to be talking about. That is the healthcare plan that as a Republican I favor and it ought to be funded by the government for everybody who can't get that care. I pushed it every year since I got here. It has largely been adopted by John McCain in his proposal, and I think we need to start looking at something broader than one more little program for one more little niche group that needs help, and we can help all Americans and certainly we can help all American children.

I thank the gentleman, and I yield back.

Mr. PALLONE. Thank you.

I recognize the gentlewoman from California, Ms. Solis.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Good morning, Mr. Chairman and to our witnesses, a very prestigious panel.

I happen to have a different take on what is occurring and what is being presented to us. I don't believe that the President is being very—how can I say—satisfactory, in my opinion, in his treatment of children. In fact, I think that his proposals that he is presenting are misguided. In my State of California, we are seeing that 6.7 million individuals who are currently on Medicaid may be affected by these proposals that he plans to implement. And in a district like mine in East Los Angeles and the San Gabriel Valley where 70 percent of the population are minorities, we have a very vast number of young children under the age of 6 that are currently not even enrolled in any form of healthcare coverage.

So I ask who is to care for our children? Who is to speak up for them? And last year, yes, we did discuss and debate a proposal that I was very much in favor of, the CHAMP Act, which I believe would have helped extend care to these vulnerable children in my district. Currently right now in my district, the SCHIP program serves 19,000 children. But 18,000 children in my district are still left without any form of healthcare. Look at those numbers. Those are things that I think the American public really wants to see us discuss. I believe that we should respect States' rights in the administration of these programs because there has to be flexibility provided for each States' goals and objectives. The goals of California may be very different from the goals of Washington State and Ohio. California certainly has its challenges, and I think that CMS' proposals are very cruel. I don't think that it is fair to punish children or individuals who are disabled. I don't think it is fair to punish children who are just starting out in their lives. We are trying to couple education with health. I would hope that the expan-

sion of the SCHIP program and Medicare programs will continue to grow. In a district like mine that is part of the L.A. Unified School District, which is the second largest school district in the country, we face many challenges. It is disheartening for many of us to have to go home and say that while we continue to try to speak up on behalf of our constituents, that somehow the President and his Administration don't think that it is appropriate to provide coverage for these vulnerable populations.

And in California, I would like to say we are a bit progressive. We like to provide incentives so that we can do more outreach to many of these vulnerable populations, but I see that my governor, Arnold Schwarzenegger, has his hands tied. He can't expand outreach. He can't reach the vulnerable populations that need assistance. So while yes, we want to provide coverage to all low income individuals, we don't even have half of the individuals in my own district currently enrolled, and I am sorry to say that more are going to be left out.

I will submit my statement for the record and really want to hear from our governors here because I think we should find a solution. I think we should put families and children first, and especially those that are disabled and need our assistance. I think that is what I was voted into office to do. I look forward to hearing your statements.

Thank you, and I yield back.

[The prepared statement of Ms. Solis follows:]

STATEMENT OF HON. HILDA L. SOLIS

Mr. Chairman, thank you for convening this hearing today.

Children face many barriers to health care.

Yet rather than increase coverage, President Bush continues to issue misguided policies that will result in more uninsured children and individuals with disabilities and overall reduction of access to care for vulnerable individuals enrolled in Medicaid.

CMS' ill-advised rules affect 6.7 million individuals in California's Medicaid program alone.

More than 170,000 individuals in my district are Medi-Cal beneficiaries and in East LA alone, at least 1 of every 4 persons received health coverage through the Medi-Cal program.

Despite Healthy Families (SCHIP in California), which serves more than 19,000 children in my district, 18,000 children are still uninsured!

CMS' regulations will reverse any progress that we have made and almost ensure these children and vulnerable populations do not receive care.

This is particularly troublesome for communities of color.

69% of Medi-Cal beneficiaries in my district are Latino and another 18% are Asian.

Congress must protect Medicaid and SCHIP.

We must also do better for children who are eligible for public programs.

7 in 10 uninsured Latino children are eligible for public programs such as Medi-Cal and Healthy Families, but language and cultural barriers may delay or block enrollment.

We must increase outreach and enrollment efforts, and one way to do this is to support community health workers, also known as promotoras.

They work in all communities and provide a wide array of services, such as health education, advocacy, and enrollment in health insurance programs.

However, the Administration is taking away funding for outreach and enrollment.

The Los Angeles Unified School District will likely lose at least $7 million in funding for outreach and enrollment activities and referral to Medi-Cal eligible services.

That is why my colleagues from the Congressional Hispanic Caucus and I sent a letter to the Administration on September 25, 2007 urging CMS to reconsider its August 17th directive.

We must also protect our safety-net hospitals and providers from CMS' cuts.

They provide essential care to individuals who have few options and train our future health professionals.

Unfortunately, with its regulations and directives, CMS is denying the wishes of states and barring families from health care.

I look forward to addressing these issues and to improving the health of our children, individuals with disabilities, their families, and our communities.

Mr. PALLONE. Thank you.

The gentlewoman from Colorado, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, Mr. Chairman. I want to add to the many plaudits being heaped on our former colleague and my former seatmate, Governor Strickland, who was sitting next to me in 1997 when we passed the first SCHIP bill out of this Committee, and at that time the SCHIP bill was really a bipartisan effort. We had President Clinton in the White House. We had Newt Gingrich as Speaker of the House. And the SCHIP bill was really an effort to help the States find state-based solutions to insuring children who were just above the level of poverty.

So imagine my surprise last year when we went to reauthorize the SCHIP program and it suddenly became a big political football with the White House and the Congress. Because in truth, the State-based solutions that we enacted in 1997 were solutions that worked for many years and all we really needed was a way to improve on the efficiency of the system and to give the States more resources so they could target those kids who needed it.

All of these horror stories that we heard about when we were doing the reauthorization were things that were mainly waivers that had been instituted by the Bush White House to allow States to cover these children.

And so we were really dismayed, everybody has talked about it, about this August 17th directive that limited States' ability to cover children in families above 250 percent of the federal poverty level, and you know, right now in Colorado we don't cover children above this level but I talked to some people about States that have a higher cost of living, like the Chairman's state, New Jersey, where in New Jersey and New York a family of four can often pay up to $20,000 in insurance premiums. So you tell me, if you have a family that is making $40,000, which is 250 percent of poverty, and they are paying half of that in insurance premiums, what choice are they going to make? The choice they are going to make is to go without insurance because they can't afford housing, food and insurance.

That is why we have to give the States flexibility on SCHIP and that is why in any reauthorization we need to make sure that we balance that. We don't want to be insuring rich children. Their parents should pay for their insurance. But we do need to make sure that of the 9 million kids in this country who are eligible for SCHIP right now under the current rules that we can cover all those kids because it is just like Congresswoman Eshoo said, how can I as a Member of Congress take two children who are in the

same economic situation and play God and say you get health insurance, you get well baby insurance but you have to go to the emergency room. It is unconscionable and we should not be doing this as the greatest country in the world.

Mr. PALLONE. Thank you.

I recognize the gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and I too want to welcome all of our governors here today. Governor Strickland, you know how these opening statements go. I am going to make mine as short as possible and speak on behalf of, although not authorized by my governor in Illinois, where we have a strong SCHIP and Medicaid program and he has fought to improve coverage in our State by increasing our income threshold and making healthcare affordable to every child in the State through his program. It covers immunizations and doctor visits and many other health services such as hospital stays and prescription drugs and vision care and dental care and important devices such as eyeglasses and asthma inhalers.

We have a really good program in Illinois. We are proud that we have so many children that are covered but its future is now threatened by these cruel and shortsighted regulations that will affect the health of thousands and thousands of Illinois children, and that is just the fact of this August 17th directive. It will force many, many children in our country to lose access to healthcare and undo State programs. That is just the fact of the matter. Under this directive, it is unbelievable to me that States would be required to let children who lose private coverage languish for an entire year before accessing public coverage. It would require States to cover 95 percent of children from families under 250 percent of the poverty level before meeting the needs of other children, and that may sound good on paper but actually that is a very unrealistic goal, and it is going to make it impossible to help other children who absolutely need the care.

And so I really look forward—I have read your testimony and I am also involved in this other hearing so I will be in and out but I appreciate the suggestions that you made and look forward to hearing your testimony.

Thank you. I yield back. And I would like to put the rest of my statement in the record.

[The prepared statement of Ms. Schakowsky follows:]

STATEMENT OF HON. JAN SCHAKOWSKY

Thank you, Mr. Chairman. I also want to thank each of the governors for being here today. We appreciate your time and your interest in this critical issue.

All of you know how important it is to provide children with quality health coverage and most of your testimonies will illustrate just how critical it is that we not undermine the State Children's Health Insurance Program. I strongly support SCHIP and Medicaid, as does my governor, Rod Blagojevich. He has fought to improve coverage in our state by increasing our income threshold and making healthcare affordable to every child in the state through his All Kids program.

Governor Blagojevich's All Kids program covers immunizations, doctor visits, and many other healthcare services such as hospital stays, prescription drugs, vision care, dental care, and important devices such as eyeglasses and asthma inhalers.

We have a good program in Illinois but its future is and the health of thousands of children are threatened by these cruel and short-sighted regulations.

Yet as we move forward in Illinois, this Administration seems bent not just on throwing up barriers but even on undoing some of the progress we have made. So now, rather than capitalizing on what we've already accomplished, we are spending valuable time defending these successful programs against the Administration's harmful regulatory cuts.

The August 17th directive will force children to lose access to healthcare and undo State's progress. As we head toward recession, families are going to have an even more difficult time getting medical care for their children. Employer coverage is declining, and premiums and out-of-pocket costs are rising. SCHIP and Medicaid are essential for filling in the gaps. Under this directive, states would be required to let children who lose private coverage languish for an entire year before accessing public coverage. It would also require states to cover 95% of children from families under 250% of the poverty level before meeting the needs of other children—an unrealistic goal.

The Administration claims that their objective is to reach the lowest-income children—but let me tell you what would truly accomplish that goal: the SCHIP legislation that was sent to the President's desk repeatedly—legislation that would have rewarded states for increasing their enrollment, not penalized them.

I look forward to confronting these issues and again thank our witnesses for being here.

Mr. PALLONE. So ordered.

Ms. Hooley.

OPENING STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Ms. HOOLEY. Thank you, Mr. Chair, and I thank our distinguished guests for being here today, one from a neighboring state and the other a member that I served with. Welcome to all of you.

The State Children's Health Insurance Program and Medicare and Medicaid play a vital role as a healthcare safety net for children and low-income families. As our economy continues to appear headed toward a recession, it is more critical than ever to ensure that the lifelines of coverage for our most vulnerable children continue to provide robust healthcare coverage. In Oregon, we have over 115,000 uninsured children. This is simply unacceptable in this day and age. Like every debate that costs money, it is all about how we want to spend our money, what are our priorities. And when I look at healthcare for children, it seems to me it has to come to the top of our list.

While a bipartisan coalition of colleagues in the House and the Senate passed multiple bills to expand SCHIP to 4 million more children, the President and a minority of the House blocked that commonsense legislation. Very disappointing. Oregonians and Americans across this country deserve better than stale, partisan warfare. Instead, the Administration has systematically sought to create barriers to coverage often defying bipartisan congressional opposition through its use of rulemaking authority. State flexibility—and I used to serve in the State legislature, I know how important that State flexibility is—has been I think a keystone of the success of SCHIP.

I am disappointed that the Center for Medicare and Medicaid Services directive severely limits States' ability to expand their SCHIP program and reverses gains in covering uninsured children already made. The directive establishes unattainable requirements for States that wish to cover children with family incomes above

250 percent of the federal poverty level. A State wishing to do so would have to enroll at least 95 percent of all children eligible for Medicaid and SCHIP under 200 percent of the federal poverty level. No means-tested programs like Medicaid or SCHIP have ever been able to achieve those unrealistically high targets. Great goals, just hard to achieve.

Unfortunately, the August 17th directive is only one of the problems States face as they fight to keep their children covered. The six Medicaid regulations that will cost States more than $13 billion over the next 5 years will have an equally devastating impact. Limitations on reimbursement for public providers and elimination of graduate medical education would have a devastating impact on Oregon Health and Science University. As Oregon's only medical school, OHSU would be forced to scale back its training of the next generation of physicians with the cuts to GME and public providers.

I am also concerned with significant new limitations on targeted case management. These services provide critical assistance in helping Medicaid beneficiaries meet their medical, social and educational needs. The meth epidemic in Oregon has produced an increased need for foster care because addicts often lose custody of their children. These children often face significant psychological trauma and need the types of services currently provided by targeted case management. If the interim final rule is implemented, these children will not receive the services that they so desperately need.

I look forward to learning more from the governors today about how the CMS directive and regulations will impact children in their States.

Thank you, Mr. Chair, for having this committee hearing.

Mr. PALLONE. Thank you.

The gentleman from Washington, Mr. Inslee.

OPENING STATEMENT OF HON. JAY INSLEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. INSLEE. Thank you. I would like to welcome my current governor, Governor Gregoire, and my former roommate, Ted Strickland, back to Congress. I have to say it has been kind of interesting listening to this lavish praise over my former roommate, Governor Strickland. I am sure some of that is deserved, at least a portion, but I am proud that Ted has been a great governor of the State of Ohio. Ted, we really have enjoyed seeing you helping your folks in Ohio. We are proud of you.

Governor Gregoire, I want to thank you for coming here to continue your long career in children's health starting with your efforts to prevent kids from being addicted to tobacco and your great work as an attorney general, and now I want you to know we are going to continue every way we can to help you in our efforts with the problems we have had of not funding States that have moved forward as we have under your leadership and others. As you know, our bill did solve that problem. We had a total solution until the President vetoed this bill. We are going to make additional efforts to solve that problem and we will engage CMS in this latest battle and I hope we will succeed so that you can continue your

great career on this, and we look forward to your comments. Thanks for being here.

Mr. PALLONE. Thank you, and that concludes the opening statements by members of the subcommittee. So we will now turn to our panel, and they have been listening to us now for an hour. I want to welcome you again, and let me introduce the various members of the panel. Starting to my left is the Honorable Chris Gregoire, who is the Governor of Washington. And second is of course the Honorable Haley Barbour, the Governor of Mississippi. Third is Governor Deval Patrick, Governor of Massachusetts. And then we go to Governor Sonny Perdue from Georgia, and finally Governor Ted Strickland, former member of this Committee, the Governor of Ohio.

Now, the way our rules are, we have 5-minute opening statements that become part of the hearing record and each witness may in the discretion of the committee submit additional brief and pertinent statements in writing for inclusion in the record later. So I just want to begin with Governor Gregoire for an opening statement. Thank you for being here again.

STATEMENT OF CHRIS GREGOIRE, GOVERNOR OF WASHINGTON

Governor GREGOIRE. Thank you, Mr. Chair, for the opportunity to be here, and Ranking Member Deal and all the members of the Committee. I am honored to make our presentation on behalf of the people of the great State of Washington today.

In my home State of Washington, we set a goal. Our goal is all children covered by health insurance by the year 2010. We are well on our way but we cannot do it alone so I come before this Committee to ask you to work with us, to work with the governors of our respective States to provide healthcare to America's children. Covering children we believe is a moral imperative but it also brings with it very important societal benefits and it makes a strong economic case.

I chaired a Blue Ribbon Commission on Health Care Costs and Access in my home State. It was a bipartisan commission charged with delivering a 5-year plan to provide access to safe, high-quality, affordable healthcare to all Washingtonians. During that process we learned a lot about the healthcare system, its challenges, its opportunities, its people and its impact. We agreed that healthcare is a shared responsibility, virtually a three-legged stool balanced between government, business and individuals, and in the case of children, the parents.

First we learned that healthy children are far more likely to succeed in school and in life and that the health of the next generation is critically important to the future of our country. Healthy children learn better. They grow better and they have a better chance to succeed in life.

Second, we heard from practitioners, pediatricians at one of our country's first-class institutions in children's health, the Seattle Children's Hospital and Medical Center. Their testimony was made clear to us that it is far more costly to taxpayers for children to access routine medical care via the emergency room than having the kind of insurance that the SCHIP program provides.

Third, that by the time children receive care in the emergency room, it is often too late. Their healthcare conditions are more severe, the consequences to the child much more painful and the cost to society much greater. We also know that uninsured children sometimes can cause other children to get sick in the classroom they are in because their care has been delayed.

So what is Washington State doing? Last year I signed a comprehensive bill that truly lays a strong foundation to ensure that all children living in Washington State have health insurance coverage by the year 2010. We raised the eligibility rate for all children's programs to 250 percent of poverty and we anticipate enrolling half of the remaining uninsured under that limit this biennium. We allowed for an active outreach effort to ensure that over the next 18 months all eligible are contacted and cared for. We increased our reimbursement rates for pediatricians by nearly 50 percent on January 1, 2008, knowing full well that health insurance without providers is not going to make it happen so we want to make sure that they have access to providers. We intend to increase our eligibility rate for all children by legislation to 300 percent of poverty on January 1, 2009. We provided for a reimbursement system so that families above 300 percent of poverty who still cannot afford to purchase health insurance on the private market will be able to buy children's coverage from Medicaid at the State's full cost, that to go in effect January 1, 2009, and we established a framework and track measures to improve the healthcare system for children and tie future rate increases to providing a medical home for our children to improve their health status.

As I mentioned, our coverage is based on the three-legged stool. Dependent on eligibility levels in Washington, parents are participating in the cost of their child's care. For example, with respect to SCHIP, unlike Medicaid, SCHIP families pay a monthly premium, currently $15 a month for each child up to a maximum of three children, and when our eligibility level increases from 250 to 300 percent in January, the family participation rate will increase.

What Washington is achieving is really quite remarkable. Our uninsured rate for children has dropped significantly. Eighty-four thousand more children have access to healthcare today than they did in 2005. By our own State survey, we are covering 94 percent of our children below 200 percent of poverty today. While we may disagree with the Center for Medicare and Medicaid Services as to the data that they use, nonetheless, we have made extraordinary efforts to cover all children. Our State's insurance programs for children currently provide coverage to 583,000 children. Another 1.2 million are covered by private insurance, most employer plans. Despite that success, 70,000 children in our State are still without coverage.

Medicaid and SCHIP provide the backbone for covering uninsured children. To truly cover all those children and throughout the Nation, we need a partnership with the Federal Government and we need to ensure that that same unity of purpose as was passed in 1997 is present today. I want to thank my congressional delegation—Jay Inslee is here today—and through their attempts to reauthorize SCHIP, they have been stalwarts. Because we have been an early leader in healthcare for our children, one of the handful of

States to raise Medicaid eligibility to 200 percent prior to the enactment of SCHIP, we have been punished ever since by a longstanding inequity that prevented the State from using its full allotment of SCHIP funds. By delegation work, you cleared that problem up and I want to thank you for that.

Without SCHIP reauthorization, our partnership to achieve our goal will fail. We need that partnership. Based on the August 17th letter through CMS that was sent to State health officials announcing new requirements, those requirements which have been described to you today together with eight other States I am challenging that rule. If allowed to go forward, 8,100 children in Washington State will not receive coverage.

Why am I bringing legal action based on the rule? Picture a single mother with two children trying to make ends meet with an annual income of $45,000 a year, just over 250 percent of poverty, and imagine how she is going to pay in Seattle, Washington, for lodging, for food, for clothing, for transportation and still have 700 to 900 a month to buy health insurance. That is roughly one-fourth of her income. This problem does not go away if we go to 300 percent of poverty in Seattle or for that matter in eastern Washington. In fact, it even makes things more desperate. By CMS measurements, no State that I know of will comply with the August 17th guidance. The effect of the rule intended or otherwise is to preclude the States from covering these children in low-income households.

One of the justifications for the August 17th letter is known as crowd-out. The crowd-out argument suggests that by making public health coverage affordable, families will drop private insurance and enroll in SCHIP, but in our State we have structured a program to get at that very issue by creating an employer-sponsored insurance program. When cost-effective, we keep otherwise Medicaid-eligible families in private insurance, paying the premium assessments for parents' employer plans to keep those kids in their employer plans and avoid them having to come onto Medicaid and SCHIP.

In discussing the need for a stronger partnership between the States and the Federal Government, I would be remiss if I did not mention the frustration that my colleagues and I share with respect to a number of Medicaid regulations being pursued by the Administration around targeted case management, graduate medical school education, school-based services and coverage of rehabilitative services, to name a few. Joining as we did in our annual winter meeting just this past weekend, governors are showing a united front in our opposition to these CMS regulations that will cause significant harm to our children, our seniors, persons with disabilities while shifting greater and greater costs to the States, an estimated $15 billion over 5 years. States simply cannot shoulder these costs. I urge you to place a moratorium on these regulations.

As Governor, I face challenges like you do at the federal level in developing a budget. There is no question we are in struggling times and that we are having to absorb ever-increasing costs of healthcare, families, employers and government alike, but in Washington I want to let you know that we are driving down the cost of healthcare, driving up the quality. We are making the

healthcare system more affordable and accountable to improve results to actually improve the health and the health outcomes of all Washingtonians but kids come first. Washington State is committed to preparing them for the very best that they can be with the tools, the education and the health that they need to succeed and to be productive members of our society. We need your help. I would ask you to put a moratorium on the August 17th letter and to proceed with the reauthorization of SCHIP. Our children need you very much.

Thank you, Mr. Chair and members of the Committee.

[The prepared statement of Mr. Gregoire follows:]

Providing high quality, affordable health care for every child

Written testimony by the Honorable Chris Gregoire
Governor, Washington State
Before the U.S. House Energy & Commerce Committee
February 26, 2008

Chairman Pallone, Ranking Member Deal, and Members of the Committee: for the record, my name is Chris Gregoire, Governor of Washington. Thank you for the opportunity to discuss Washington State's work over the past several years to ensure that every child has access to health care in our state.

When I first came to office a little over three years ago, one of my very first acts as governor was to stop 19,000 children from being dropped from health care coverage by directing the then-Secretary of our Department of Social and Health Services to do two things: return us from 6-months eligibility reviews to 12-month eligibility reviews for children on our medical programs, and hold back the imposition of premiums for those families living below 200% of the federal poverty level.

That was a defining and moving moment for me – a realization of what I, as Governor, and what we, as public servants, can do on behalf of our communities.

It was also just the beginning – the beginning of my work on health care and, frankly, my understanding about the depth and complexity of our health care challenges.

In 2006, I chaired a Blue Ribbon Commission on Health Care Costs and Access in Washington State. This was a bipartisan commission charged with delivering a five-year plan to provide access to safe, high quality, affordable health care for all Washingtonians.

We learned an inordinate amount about our health care system through this Commission – its challenges, its opportunities, its people, its impact. We agreed that health care is a shared responsibility. It is a three legged stool between government, business and individuals (and in the case of children, their parents).

I also came to understand not only the moral imperative of covering children, but the economic and societal benefits of doing so, as well.

First, we learned that healthy children are *far* more likely to succeed in school and life – that the health of the next generation is critically important to the future of our country.

Second, we heard from pediatricians at one of the country's first class institutions in children's health, the Seattle's Children's Hospital and Medical Center. Their testimony made clear that it is far more costly to taxpayers for children to access care via the emergency room than through routine medical and preventative care.

Third, that by the time children receive care in the emergency room, it is often too late. Their health care conditions are more severe, the consequences to the child more painful, and the costs to society greater.

We also know that uninsured children can sometimes cause other children to get sick in the classroom because their care was delayed.

This is what we know. These are the realities we learned in Washington State.

And it is the reason why Covering All Kids has been a hallmark of my first term, and with bipartisan cooperation in my state, the Legislature has stood with me. It is why we have a comprehensive approach to health care for children.

Beginning in our 2005 legislative session and culminating in the 2007 session, on March 17, 2007, I signed a comprehensive bill that truly lays a strong foundation to ensure that all children living in Washington State have health insurance coverage by 2010.

In Washington State, we believe that providing health care coverage to all of our kids and making sure they have access to high quality, affordable health care is not only the right thing to do – it is a moral imperative. We know that access to routine and preventive health care services can profoundly affect a child's health and well-being and readiness for school. Healthy children learn better, grow better, and have a better chance of succeeding in life.

WHAT WASHINGTON STATE IS DOING

In the 2005 session, the Legislature codified the goal that all kids in the state of Washington have health care coverage by 2010.

With the legislation passed in 2007, the state is truly looking at children's health care in a comprehensive fashion. It's not just about an insurance card, it's about reimbursement for providers so that children can get in to see a provider. It's about promoting healthy food and physical activity in schools. It's about preventive services and making sure that children are receiving timely vaccinations. It's about ensuring all children have a medical home – in other words, one place that coordinates their care and anticipates their needs.

Specifically, the comprehensive legislation:

- Raised the eligibility rate for all children's programs to 250 percent of FPL, and we anticipate enrolling half of the remaining uninsured children under that limit this biennium.

- Allows for an active outreach effort over the next 18 months.

- Increased reimbursement rates for pediatricians by nearly 50 percent on January 1, 2008.

- Will increase the eligibility rate for all children to 300 percent FPL on January 1, 2009.

- Provides for designing a reimbursement system so that families above 300 percent of FPL, who still cannot afford to purchase health insurance on the private market, will be able to buy children's coverage from Medicaid at the state's full cost. That also will go into effect on January 1, 2009.

- Established a framework to develop and track measures to improve the health care system for children and tie future rate increases to providing a medical home for children and improving their health status.

Providing for our children also takes a partnership and a shared responsibility between government and the people it is intended to serve. The comprehensive legislation I signed made very clear that parents, as well as the government, have a responsibility to provide health care for our children.

A parent's first responsibility is to make sure that a child is healthy and safe; to pay for health insurance if they can afford it; to make sure their child's immunizations are up to date; to ensure that their kids have had their annual check up. And when parents can't afford it, the state will do what it can to help parents meet their responsibilities.

For example, with respect to SCHIP, unlike Medicaid, SCHIP families pay a monthly premium, which is currently $15 a month per child, with the cost capped at three children per family. The premium has not proven to be a barrier to access – in fact there are indications that it lets families demonstrate some responsibility and ownership in the health coverage of their children. And when our eligibility level increases from 250% FPL to 300% FPL in January, the family participation through the monthly premium will also increase on a sliding scale.

In three short years, what Washington has achieved is quite remarkable and results so far are very promising. Our uninsured rate for children has dropped significantly and 84,000 more children have access to health care today than had it in 2005. By our own state population survey, we are covering 94% of children below 200%FPL. (Centers for Medicare and Medicaid Services (CMS) national census data puts us at 91%.) Our state's insurance programs for children currently provide coverage for 583,000 children. Another 1.2 million children are covered by private insurance, most of it in employer plans.

In total, our state is providing subsidized health coverage for one in every three children in Washington. Medicaid also covers just under half of all the births in our state.

Despite these totals, we still have up to 70,000 children in our state without insurance coverage. These children are in families where an employer has cut back coverage or dropped it altogether. They are in self-employed families, which cannot possibly shoulder the cost of the individual market. And they are in families that might even qualify under current eligibility standards, but who do not realize it.

STATE HEALTH PROGRAMS

In Washington State, we have three programs that serve low-income familes:

- Our Title XIX-funded Medicaid program for children provides health coverage up to 200% of the Federal Poverty Level, or FPL.
- Our Title XXI SCHIP program provides coverage to children up to 250% of FPL
- Our recently re-implemented state-only funded Children's Health Program (CHP) with state-only resources provides coverage for non-citizen children up to 250% of FPL.

Just as we have taken a comprehensive approach to children's health, so, too, do we look comprehensively at how parents enroll their children in these programs. With an eye toward simplification, we have taken significant steps to streamline the way in which families enroll their children in state programs:

- We've consolidated the application forms so that one form applies to all three programs – no more worrying about whether you filled out the right form.

- In terms of benefit structure, all three of our children's medical programs have the same comprehensive health benefit package, based on full-scope Medicaid coverage. That avoids confusion – and it makes it easier to move from one program to another without redefining someone's benefits.

- Most importantly, the convergence of eligibility standards means that any child in a Washington State family that meets the 250 percent FPL guideline is eligible to receive medical assistance. State government will navigate through the complexities of program eligibility. The family doesn't have to.

- Except for SSI disabled children, Medicaid and SCHIP children receive coverage through our Healthy Options managed care program. Over time, we will consider having CHP children enroll in managed care, as well as pilots for SSI children.

STATE-FEDERAL PARTNERSHIP

Medicaid and SCHIP provide the backbone for covering uninsured children. To truly cover all children in Washington State – and throughout the nation – we need a partnership of shared responsibility between states and the federal government. It is vital that the federal government show the same unity in purpose as it did when it passed SCHIP in 1997 – with a Republican Congress and Democratic

President – and reauthorize SCHIP now, because it is critical to seeing that all children have access to health care.

I want to thank my Congressional delegation. Throughout the attempts to reauthorize SCHIP, they have been stalwarts. Because Washington State was an early leader in children's coverage, and one of a handful of states to raise Medicaid eligibility to 200 percent of FPL prior to the enactment of SCHIP in 1997, it has been punished ever since by a long-standing inequity that prevented the state from using its full allotment of SCHIP funds. My delegation worked with this committee and others and I want to thank you for including a fix in the SCHIP reauthorization packages sent to the President.

Without SCHIP reauthorization, our state-federal partnership fails to achieve its goal. Without a partnership with federal regulators, we fail again. It is vital that federal regulators stop creating onerous rules that serve only to bar states from carrying out the programs whose stated goals are to ensure access to coverage for children and youth.

In August of last year, the Centers for Medicare and Medicaid Services (CMS) announced that states would no longer be given waiver approval to raise SCHIP eligibility rates above 250 percent of FPL. Since Washington has laid the foundation to go to 300 percent of FPL on January 1, 2009, we are one of 9 states challenging that directive as exceeding their authority and failing to comply with the rule-making responsibility.

The reason my state is challenging CMS is this: Picture the single mother with two children, trying to make ends meet with an annual income of $45,000 a year – just over 250 percent of FPL under 2008 federal guidelines – and imagine how she will pay for lodging, food, clothing and transportation for the kids....and still have $700 to $900 a month left over so that she can buy health insurance. That's roughly one-fourth of her income. This problem does not even go away at 300 percent of FPL in Seattle or even parts of Eastern Washington. In fact, it often times gets more desperate.

Tied to the August 17 guidance letter to states, CMS is requiring that if states intend to increase SCHIP eligibility rates, they must first have to enroll at least 95 percent of the children in families with incomes of up to 200 percent of FPL. Many states have weighed in against this limit because by CMS measurement no state will comply. The effect of the rule intended or otherwise is to preclude the states from covering children in low-income households.

Ironically, Washington State should not be that far off the 95 percent mark. In fact, as mentioned earlier, by our own annual Population Survey, we show that 94 percent of all children in families below 200 percent of FPL have been enrolled in medical assistance programs.

But the CMS measurement will not be based on our state's more accurate measurement of insured rates. Instead, it will likely be drawn from national census figures, which are less accurate and show Washington's rate at closer to 90 percent. By these same measures, only one state to my knowledge does any better. Purportedly, the State of Vermont has a participation rate of 92 percent for its children below 200 % FPL. Again, the "rule" ensures that no state will qualify.

One of the justifications for these new federal limits on our ability to insure our own children is known as "crowd-out." The crowd-out argument suggests that by making public health coverage affordable, families would drop their private coverage and enroll in SCHIP.

In Washington State, we have structured a program to get at that very issue. In creating an Employer-Sponsored Insurance program, or ESI, we work with employer plans in those cases where it is cheaper for Medicaid to pay the premium assessments for parents' employer plans to keep kids in employer plans.

There are several advantages to the ESI program, including the fact that it saves money for the state. But more importantly, it puts a family on the same health plan and lets them form a relationship with a single primary care provider. That's where the concept of medical home takes over, as I mentioned earlier.

Remember. The families taking advantage of our ESI program are already Medicaid eligible. If not for ESI, they would be on the state's caseload. But as it is, the state and federal governments are saving money when we can contribute to the family's premium for ESI at a lower cost than what we would otherwise be paying if the family were still on the Medicaid rolls.

Having successfully identified a mechanism to deal with crowd-out in our Medicaid program, Washington State approached CMS to expand ESI into our SCHIP program. Unfortunately, within the last few weeks, we received a letter from CMS that apparently will veto our plan to add this ESI feature to our SCHIP children's coverage.

Incidentally, the SCHIP bills sent to the President would have kept the Employer-Sponsored Insurance door open for our SCHIP client families, allowing the state to partner with private employers when it saves money for the state.

In addition to requiring unachievable participation rates, the rule is wrong in requiring a child to go uninsured for one full year if that child has had employer sponsored coverage through his or her parent and then is dropped. An entire year before he or she can come onto a state program! Again, as opposed to my state's keen interest in routine and timely care, as well as saving taxpayer resources, this requirement is simply inviting poorer health and greater emergency room utilization.

Another federal barrier to carrying out health care programs in Washington State and the other states is citizenship verification requirements that were remedied in the reauthorization bill passed by Congress.

In 2006, the Deficit Reduction Act dropped an expensive requirement on states to document the citizenship of each Medicaid applicant, from newborn babies on up. Previously, Medicaid programs were allowed to use a sworn statement by applicants, under penalty of perjury, to verify citizenship – an approach the federal Inspector General had ruled to be adequate and workable.

Since the rule took effect, our state Department of Social and Health Services had to devote 38 full-time employees to go through all Medicaid clients currently on the state's rolls at the time of implementation and lay out a process for approving all new applicants at a cost to the state of close to $5 million dollars. In going through all clients on the rolls, I will tell you that out of the over 383,000 clients who had attested to being U.S. citizens, our staff identified only one person inappropriately enrolled in Medicaid – an elderly woman from British Columbia, Canada.

The SCHIP reauthorization bill would have given states the option to make citizenship documentation requirements much easier. Under that vetoed legislation, we would have been allowed to match applicants' Social Security numbers with the Social Security Administration, avoiding the time-consuming and expensive work of collecting original birth certificates and other documents.

The same bill also would allow our Tribes – and in Washington State, there are 29 federally recognized Tribes – to use their Bureau of Indian Affairs identity cards to verify citizenship.

In discussing the need for a stronger partnership between the states and federal government, I would be remiss if I did not mention the frustration that my colleagues and I share with respect to a number of Medicaid regulations being pursued by the Administration around targeted case management, graduate medical education, school-based services, and coverage of rehabilitative services, to name a few.

Joining as we did for our annual winter meeting just this past weekend, governors are united in our opposition to these CMS regulations that will cause significant harm to children, seniors and people with disabilities while shifting greater and greater costs to the states. Estimated to be $15 billion over five years, states simply cannot shoulder these costs and I urge you to delay the implementation of these regulations.

HIGHER QUALITY DRIVES LOWER COSTS

We must not shy away from doing the hard work of re-establishing our partnership to provide health care coverage for our country's children – because we save taxpayers dollars.

As Governor, I face the same challenges that you do at the federal level when it comes to developing a budget (although mine, constitutionally, has to be balanced). There is no question that we all struggle with how to absorb ever increasing costs of health care – families, employers, and government alike.

That is why my efforts in Washington State around children's health fit into a much larger agenda around health care. And that agenda centers on driving down the cost and driving up the quality of care. It's about making the system more affordable and accountable to improve results – to actually improve the health, and the health outcomes, of all Americans.

And that is why our state programs today are models of fiscal integrity and we are actively partnering with the private health industry on ways to share data, implement cost controls and squeeze out waste from existing expenditures. We are

pioneering evidence-based practices and health information technology, expanding chronic care management concepts and using predictive modeling while we integrate medical, mental health and chemical dependency services. We are continuing to look for new ways to bring faster, effective treatments to our clients...and to spend less in doing it.

But the kids come first. Washington State is committed to preparing them to be the very best they can be – with the tools, the education, and the health that they need to succeed and be productive members of our society.

Former U.S. Surgeon General Joycelyn Elders said that it is impossible to educate an unhealthy child, and it is impossible to keep an uneducated child healthy. Every teacher knows that a sick child is not ready to learn. And every parent knows a good basic education is among the best indicators of a healthy future.

Washington State is paving the way. We need your help, though, and continued partnership to make our vision of covering all children by 2010 a reality and I urge reauthorization.

I am attaching a history of medical assistance in Washington State in the event that some of these remarks need additional context.

Thank you for your time, and I look forward to any questions you may have.

ATTACHMENT to the remarks by the Honorable Chris Gregoire
Governor, Washington State
Before the U.S. House Energy & Commerce Committee
February 26, 2008

A history of medical assistance in Washington State

In 1989, Washington State adopted a series of reforms that put the state at the forefront of health-care reform. This was also the same period in which Washington adopted its Basic Health Plan, one of the first attempts in the country to provide health care at low cost to the working poor. It came at the urging of then State Sen. Jim McDermott, now Congressman McDermott, of Seattle.

In 1989, Washington also undertook our "First Steps Initiative," which was designed to improve the health of Washington's children. This included:

- Expanding health coverage for pregnant women and infants under the age of one in families with income up to 185% of the Federal Poverty Level (FPL).

- Implementing a major prenatal initiative to improve birth outcomes. This included identification of maternity-care distressed areas and development of case management networks to assist high-risk women to access appropriate services.

- Increasing Medicaid payment rates to ensure pregnant women had access to prenatal care and birth and delivery services.

In 1991, my state expanded health coverage for all children up to age 18 in families up to 100% of FPL. Coverage for citizen children up to age 19 was converted to Medicaid in 1992.

In 1994, Washington became one of only a handful of states to provide Medicaid to children in families with incomes up to 200% of FPL. As part of my state's coverage initiatives, we obtained a Medicaid waiver to allow us to provide coverage for children through our managed care program, called Healthy Options. This program was designed to provide a medical home for enrolled children, while ensuring more predictability in Medicaid expenditures. Currently, some 404,000 children are enrolled in Healthy Options.

At the time SCHIP was enacted in 1997, Washington was one of only four states that were already covering children up to the SCHIP target of 200% of FPL. After failing to obtain federal language to help the four states use a portion of their Title XXI allotment to help finance existing coverage, our state Legislature ultimately authorized coverage

of children in families up to 250% of FPL through SCHIP. Today, Washington is among a dozen states ranked at the top of the income-eligibility levels for SCHIP coverage.

In 1998, federal funding was made available for a major outreach initiative to inform and help families and children to access Medicaid coverage. Although this special funding ended in July 2002, school districts, health departments and tribes have continued outreach efforts through our Medicaid Administrative Match program.

At the same time we implemented Healthy Options statewide, we also implemented a collaborative children's program with our state's Basic Health Program. We call it BH-Plus. The Basic Health Program provides subsidized coverage for adults in households up to 200% of FPL. Meanwhile, the BH-Plus program covers the children in those families. This allows Medicaid-eligible children to belong to the same Basic Health managed-care plan as their parents, even though they are receiving full-scope Medicaid coverage without the Basic Health cost-sharing requirements. Currently, some 25,400 Medicaid children are in BH-Plus.

The benefit and managed-care designs are intended to create a seamless children's program. That allows continuity of care, regardless of changes in programs and funding sources, and it represents a convenience to both the programs and families when income levels change.

Another way Washington streamlined the process is that eligibility for Medicaid, SCHIP and CHP is handled by a single agency – DSHS. We have adopted simplified two-page applications that prevent unnecessary confusion or paperwork. Information on these documents can be used to determine eligibility for any of our children's programs. We also allow mail-in applications.

This seamless approach is also one of the advantages for Washington State providers. Since coverage is relatively easy to explain, providers do not have to keep consulting the playbook as different categories of public clients walk into their practices.

As mentioned earlier, Washington State had implemented 12-month continuous eligibility for children's medical programs as part of our efforts to ensure that children have access to insurance coverage. In 2003, the Legislature eliminated that concept and reduced the state's eligibility review period from 12 months of continuous coverage to six months. But the state switched back to annual eligibility for children two years later at my urging, as I was concerned that the more stringent reviews and the hassle of eligibility paperwork were encouraging parents to take their children out of the coverage.

Unlike Medicaid, SCHIP families pay a small monthly premium, which is currently $15 a month per child, with the cost capped at three children per family. The premium has not proven to be a barrier to access – in fact, there are indications that it lets families demonstrate some responsibility and ownership in the health coverage of their children.

SCHIP'S SUPPORT FOR WASHINGTON

As discussed above, Washington was one of four states that were already covering children at 200% of FPL when SCHIP was implemented. Ironically, other states were able to use SCHIP with its enhanced match to expand coverage to Washington's level, while the early states like Washington were forbidden to use SCHIP funds to replace existing Medicaid coverage. As a consequence, Washington has never been able to fully utilize its annual Title XXI Allotment (FFY 2006 allotment is $64.7 million and the FFY 2007 allotment is $79.9 million).

This requirement began to ease in recent years, allowing the state to replace some Medicaid spending with SCHIP funds. A complete fix was actually hammered together this fall in the SCHIP reauthorization bill. But the President's veto of that legislation and the failure of override attempts means the state must continue to wait.

On the other hand, Washington State has been able to take advantage of federal policy that allows states to use their Title XXI allotment to provide prenatal care and related health services to non-citizen pregnant women whose child upon birth will be eligible for Medicaid or SCHIP. Washington replaced its state-only coverage with Title XXI funds to be able to continue this cost-effective coverage. Washington is one of six states currently providing prenatal care and health coverage through SCHIP. Currently, about 8,000 pregnant women are being covered by this program in Washington State.

As part of my commitment to ensure that all children have access to health insurance coverage, we are continuing to examine why some eligible children in families up to 250% of FPL apparently remain uninsured. A Robert Wood Johnson study released earlier this month showed that 7.7 percent of the state's children were uninsured in 2003-2004. The same study indicated that the SCHIP era (1997-2007) has lowered the state's rate by 2.5 percent.

Washington State's latest Population Survey, widely considered the most accurate current data on state demographics, shows that 94 percent of the state's children were uninsured in families of up to 200 percent of the Federal Poverty Level.

As noted above, we have had outreach efforts in place since 1998, and the state is planning to expand those efforts later this year. Under that plan, the state wants to make another $1.9 million available in Title XXI funds for local governments and stakeholder groups to provide matching funds for targeted outreach efforts. Our goal is to further reduce the number of uninsured low-income children.

Research has shown that parent's access to health insurance improves the likelihood that their children will have insurance. The state Legislature has asked the state Department of Social and Health Services to explore obtaining a Title XXI HIFA to expand BHP coverage for parents.

As noted earlier, Washington and other states that were penalized by raising income eligibility prior to SCHIP's enactment have successfully rolled back some of the restrictions that followed our early efforts to cover children.

Federal legislation in recent years has allowed our states to use a portion of our Title XXI allotment to help finance Medicaid children's programs. In 2003, Congress enacted P.L. 108-74 and P.L. 108-127 provisions, which recognized this inequity by allowing Washington and 10 other states (Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, and Wisconsin) to use up to 20 percent of our FFY 1998-2001 SCHIP allotments to help pay for Medicaid eligible children above 150% of FPL.

The availability of these funds expired in FFY 2005. But Congress continued to acknowledge the needs of these states by enacting P.L.109-171 in 2006. It allowed the 11 states to use up to 20% of our FFY 2004 and 2005 allotments to finance Medicaid children's coverage.

It is my understanding that Washington – again a national leader – has accessed more Title XXI funds to help finance our Medicaid children's coverage than any other state. To date, we will have used $45.3 million in Title XXI to help sustain our state's commitment to provide access to coverage for all low-income children. Language in the ill-fated (for now) SCHIP reauthorization bill would have added another $29 million to this total.

HEALTH INSURANCE FOR ALL CHILDREN: Washington's Goal

I strongly believe that children's coverage is a long-term investment that is essential to the future of our state.

When children have access to cost-effective preventive and health care treatment it is not only an important step toward good health but guarantees they have the capacity to use their education to become productive adults in the 21st century.

Having access to health coverage means healthier kids; healthier kids mean healthier, more productive adults.

Together with the state Legislature, Washington is committed to developing public and private sector strategies that ensure all Washington's children will have access to affordable health coverage by 2010.

Our state's Medicaid children's program and SCHIP will play a key role in helping achieve this goal.

Mr. PALLONE. Thank you, Governor.
Next is Governor Haley Barbour. You are recognized.

STATEMENT OF HALEY BARBOUR, GOVERNOR OF MISSISSIPPI

Governor BARBOUR. Mr. Chairman, thank you and Congressman Deal, members of the committee. I am going to try to stay within the 5 minutes but remember, I talk slower than the rest of them.

Together between SCHIP and Medicaid, we have about 625,000 people in Mississippi that are served. SCHIP is a very important part of that. Our SCHIP program in Mississippi covers only children at or under 200 percent of the federal poverty level. It is built to the 1997 law and that is all that we cover, and that is one reason that we are very concerned about the bill that was passed last year and was vetoed. The current distribution formula for Mississippi consistently shortchanges our State. Even though we only cover children under 200 percent of poverty, the current formula doesn't provide enough money to pay the federal share for even half of the children in Mississippi who are under 200 percent of poverty.

Mississippi's total costs of covering 63,000 children in SCHIP is $133 million. Under the current law, the Federal Government pays 83 percent of that. We have the highest match rate in the country. Thank you very much. It means the Federal Government should be giving us $111 million to cover the federal share for SCHIP but our State's SCHIP allotment for fiscal year 2008 was $61.7 million, leaving us $50 million short of the full federal share, even for the children that are signed up and this has been the case from the beginning. The formula shortchanges us very badly. And for years Congress and members of our delegation and the Administration have allowed us to depend on redistributed funds from other States. These redistributions were possible because other States weren't spending their whole allocation on children under 200 percent of poverty. However, when those States starting getting waivers where they could cover adults and we have States where more than half the people covered under SCHIP are not children, that redistributed pool of money got soaked up. Thus far, because of a lot of hard work by a lot of people, even though we are tremendously shortchanged, we have been able to scramble around and get the federal money for the federal share to cover these children. We have never turned anybody away from SCHIP, even though we got shortchanged.

The bill that Congress sent to the President last fall wouldn't have funded Mississippi's SCHIP program at an amount adequate just cover the children under 200 percent of poverty. It would though have allowed other States to greatly expand coverage so here we are, the poorest State in the country, getting shortchanged. I can't support a bill that doesn't give Mississippi enough money to fulfill even the original intent of the program while other States get to expand their programs to cover higher income children and even adults who don't have children. Even with the additional money that Congress provided for SCHIP in last year's bill, under the proposed formula we would still be shortchanged. According to the U.S. Census Bureau 2006 survey, there are 71,851 children in

Mississippi under 200 percent of poverty that don't have healthcare coverage either from Medicaid or from SCHIP.

With few exceptions, these children are eligible for SCHIP. To cover them all, Mississippi should receive a federal allotment of $232 million a year. Last year's wouldn't have given us but $142 million, leaving us $90 million short, still nearly 40 percent shortchanged by the bill. Even if we got 100 percent from the Child Enrollment Contingency Fund, we would still be shortchanged by 27 percent to cover all our children.

Again, I can't support a bill that shortchanges my State, the children of my State under 200 percent of poverty. We are not talking about covering middle-class children. We are not talking about covering adults. I can't be for a bill that shortchanges us for doing the basics.

I would like to mention the big thing you all can do for us: fix the formula. Fix the formula where States like mine get enough money to pay for their poor children, for the under 200 percent of poverty.

I would like to mention the Medicaid rules. We think that the Medicaid rule for changing the definition of public hospital is a very bad idea. Our Medicaid program was crowding out spending on higher education when I became governor as was noted in a Brookings Institution study. We have gotten control of Medicaid spending. Our problem now is, every time we get control of spending, the Federal Government disallows part of our State share so we are $90 million in the hole, not because we haven't controlled spending. We are $90 million in the hole because they told us this won't count anymore, part of it because of public hospitals. So we don't like changing the public hospital definition, and for us also the idea that changing the rule for graduate medical education is not a Medicaid issue. It wouldn't hurt Medicaid. It would hurt our Medicaid program. Our University Hospital has about 200 residents a year. It is the biggest provider of healthcare to Medicaid and SCHIP beneficiaries in the State, and if you took that $15 million away from the medical center for graduate medical education, you would be taking away the people that provide care.

So I wanted to share our views on SCHIP. I don't know how many other States are like us. But I also did want to put my oar in the water that we appreciate you all putting a moratorium last year on reducing the provider—you know, they wanted to reduce the provider fee where it could be 6 percent and you all limited the reduction to 5½ percent. It would certainly suit us if you would do that for some of these changes and rules which we don't really think are necessary or well thought out.

Thank you, Mr. Chairman. I am sorry I ran over.

[The prepared statement of Mr. Barbour follows:]

STATEMENT OF GOVERNOR HALEY BARBOUR

Mr. Chairman, Congressman Deal, and members of the subcommittee:

I am happy to be before you today to discuss important issues surrounding the State Children's Health Insurance Program and Medicaid. Together, these two programs provide health coverage to approximately 626,000 Mississippians and they are an essential component of our health care safety net, especially for our most vulnerable children.

I thank you for your continued work on the reauthorization of the SCHIP program. As you proceed, I ask you to remember the intent of the SCHIP program: to cover low-income uninsured children.

That's what we are focused on in Mississippi. Our SCHIP program covers only children at under 200% of the Federal Poverty Level. For a family of four, this means an annual income of less than $42,400.

For several years, the current distribution formula has resulted in Mississippi being consistently shortchanged. Flaws in the formula have resulted in an inequitable distribution of funds and a redistribution allotment has been needed to cover costs. The current formula does not provide enough money for even half of the children in Mississippi below 200% of the federal poverty level.

In Mississippi, the total cost of covering the 63,000 kids in our SCHIP program is $133 million. According to current law, the federal government is supposed to pay 83% of these costs, which means the federal government should be giving us $111 million for SCHIP. But our state's SCHIP allotment for federal Fiscal Year 2008 is only $61,687,048, leaving us $50 million short.

In past years, to make up this difference, we have depended upon redistributed funds from other states. These redistributions from other states were possible because their allocation was more than they needed to run their SCHIP program.

Not surprisingly, instead of sending that money back to Washington, other states started expanding their SCHIP programs. Instead of covering low-income children, as Congress intended when you created the program, other states began covering adults, even adults that did not have any kids!

Since then, the pool of funds available to be redistributed to states such as mine has shrunk and we are faced with significant shortfalls and much uncertainty.

The bill Congress sent to the President last fall would not have funded Mississippi's SCHIP program at an amount adequate to cover all children at or below 200% of the federal poverty level, even though it would have allowed other states to expand coverage. I cannot support a bill that does not give Mississippi enough money to fulfill the original intent of the program while allowing other states the opportunity to expand their programs to cover higher-income children and adults who don't have any children.

Even with the additional money Congress proposed for SCHIP, the proposed formula still causes serious concern for those of us charged with actually administering the program. According to the U.S. Census Bureau 2006 survey, there are 71,851 children in Mississippi under 200% of the Federal Poverty Level who are uninsured. With rare exception, all of these children likely are eligible for Medicaid or SCHIP.

In order to cover all children under 200% of the federal poverty level eligible for SCHIP, Mississippi would require a federal allotment of $232 million. But under the proposed new formula, Mississippi's FY 2008 allotment would have been $142 million. In other words, our state would still be shortchanged by $90 million, or nearly 40%. Even the "Child Enrollment Contingency Fund" you included in the bill for states that significantly increase enrollment only would provide a maximum of an extra $28 million, leaving us 27% underfunded.

Again, I cannot support an SCHIP bill that shortchanges Mississippi to such a degree we cannot even provide insurance to all our children at 200% of federal poverty level, but that allows wealthy states to provide insurance under SCHIP to children in families with an income of $85,000/year.

To that end, I agree with the guidance issued by CMS on August 17, 2007, which will ensure that before states expand their SCHIP coverage beyond 250% of the Federal Poverty Level, they should have enrolled at least 95% of the eligible children in their state below 200% of the Federal Poverty Level in either Medicaid or SCHIP.

I urge you to enact an SCHIP reauthorization bill which will provide states like Mississippi the federal support necessary for us to enroll all of our eligible kids.

In addition to SCHIP, I am glad to have the opportunity today to visit with you about the status of our state's Medicaid program. Since I have been Governor, we have made significant progress in saving Medicaid for the nearly 600,000 Mississippians who rely on it. We have enacted reforms because we know it is wrong for a family to work hard at two or three jobs, to raise their kids and pay for their healthcare, and then have to turn around and pay extra taxes so others who are able to work and take care of themselves choose not to but instead get free healthcare at taxpayers' expense. That's not right.

Under my Administration, the Division of Medicaid checks people's eligibility face-to-face, and the Medicaid rolls have decreased. This drop is what you should expect when the number of people employed has increased by more than 50,000 as it has in the last four years in Mississippi.

We've changed our prescription drug program to better utilize generic drugs. That, along with Medicare Part D, is saving taxpayers tens of millions of dollars on pharmaceuticals with no negative effect on beneficiary health.

But even with these common-sense, successful savings efforts, our Medicaid budget faces a large shortfall this year. This is primarily because the federal government has forced us to stop using certain funds to cover the state Medicaid match requirement.

For example, we have to replace the $90 million of state match that was previously provided by public hospitals through an inter-governmental transfer program. Considering the fact that our state appropriation for Medicaid is $513 million for the current fiscal year, this is a significant budget challenge.

Now, CMS is proposing more changes to the state-federal relationship that will have additional fiscal consequences. Given the strait-jacket of federal rules on how we can run our Medicaid program, these changes, if allowed to proceed, will likely result in reduced reimbursement rates for providers or reduced services for the beneficiaries. This morning, I will highlight two rules changes that would be especially harmful to the Mississippi Medicaid program.

First, CMS has issued a rule which changes the definition of a public hospital, thereby putting new restrictions on payments to hospitals in my state. In effect, this rule change would eliminate hospitals from the governmental classification if they are non-profit corporations that receive a government appropriation. The result would be that our county-owned public hospitals, mostly in rural areas, would be negatively impacted. This would be another $90 million hit to our Medicaid program.

Congress has approved a moratorium that delays implementation of this rule until May 25, 2008. CMS should either reconsider this rule, or Congress should act again.

Secondly, CMS has proposed to eliminate Medicaid payments for Graduate Medical Education. In an attempt to justify this proposal, a CMS official testified on November 1, 2007, to the House Committee on Oversight and Government Reform that training doctors "is outside the scope of Medicaid's role, which is to provide medical care to low-income populations."

In the case of the University of Mississippi Medical Center, the GME program makes it possible to train 200 residents a year and it has proved to be an effective physician retention program. If a doctor does his or her residency in Mississippi, there is an 85% chance he or she will live and practice in Mississippi afterwards.

Having doctors in under-served rural areas is necessary for there to even be a Medicaid program. Enacting the CMS proposal would cost the University of Mississippi Medical Center $15 million in FY 09 and would threaten future access to care.

In addition, the University Medical Center is our state's largest Medicaid provider. If the GME program is eliminated, UMC's ability to provide care for our Medicaid beneficiaries will be threatened.

Thank you again for allowing me the opportunity to be here today. I look forward to any questions you may have.

Mr. PALLONE. Thank you, Governor.

Mr. Markey has asked to introduce the Governor of Massachusetts. Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman, very much.

Governor Deval Patrick of Massachusetts has dedicated himself and Massachusetts to the implementation of a universal health care system for our State. He is a visionary leader. It is our honor to have him before the Committee today. Welcome, Governor.

STATEMENT OF DEVAL L. PATRICK, GOVERNOR OF MASSACHUSETTS

Governor PATRICK. Thank you, Congressman Markey, and thank you for the honor of the introduction and your presence here, and thank you, Mr. Chairman and Congressman Deal and also to Chairman Dingell and Congressman Barton, I guess, who just had to step out, all the members of the Committee for convening today's hearing. This is an enormously important issue or Massachusetts

and for the Nation in terms of both our public health and our economy.

A child with quality healthcare is a child with a better chance in every aspect of life. The Rand Corporation's 2005 report entitled "Children at Risk" found, for example, that access to healthcare through regular well-child visits enables early developmental screenings and encourages parental behaviors to assist all facets of child development: physical, cognitive, emotional and social. Quality healthcare enables children to better engage as students and fosters better lifelong health outcomes. These differences can set the course for life.

That is why SCHIP is a national success story. It is an important tool for fulfilling a most fundamental responsibility for any civilized society: to help parents give every child the care and support they need to reach their highest potential. Though there are differences on just what shape reauthorization should take, I do want to acknowledge and thank you for the broad bipartisan support in the Congress for continuing the SCHIP program.

In Massachusetts, SCHIP also plays an important role in our Healthcare Reform Initiative, as Congressman Markey referred. Healthcare Reform in Massachusetts is a mosaic of approaches and programs and contributions: individual contributions, employer contributions. The State has stepped up its funding and its contribution, obviously the Medicaid waiver and SCHIP, and at the center of it all is the private insurance market. Though these are still early days, we are only in the early weeks of the second year of implementation. Our reform plan has already been very successful. Three hundred thousand adults and children who were uninsured last year are insured today, reducing our uninsured population by almost half. Free care utilization has dropped. Between federal fiscal years 2006 and 2007, our uncompensated care pool saw roughly 9 percent fewer inpatient discharges and 12 percent fewer outpatient visits. A recent report by the Massachusetts Hospital Association shows that a number of hospital low-income uncompensated care accounts has decreased by 28 percent since October 2004 and there are initial signs of a leveling off in overall system healthcare costs with premiums for subsidized programs increasing at an average of 5 percent, less than half what increases in the general market have been.

As part of our partnership with the Federal Government, SCHIP has been an indispensable part of our plan. The Centers for Medicare and Medicaid Services agreed to permit Massachusetts to expand SCHIP to children at or below 300 percent of the federal poverty level. I just want to pause here because that was an agreement we reached with CMS as a part of developing this mosaic for our own plan. As a result, Medicaid and SCHIP enrollment has grown by 40,000 children including 18,000 newly eligible because of the expansion from 200 to 300 percent of the federal poverty level. CMS's approval of the Massachusetts SCHIP rules 2 years ago was a crucial part of the success we are experiencing today and I am happy to add that we have achieved that success without having residents use SCHIP to substitute for private coverage. In other words, the anti-crowd-out provisions are working.

I am here to ask you not to undermine our success. That is why the August 17th CMS guidance letter is so troubling for my State and for our goals with healthcare reform. We are in the process of creating seamless, integrated, market-based coverage for all individuals and families across the Commonwealth. Our success depends on the stability and reliability of the commitments the Federal Government has made to us. A retreat in any of those commitments could have devastating effects on our progress, particularly our ability to cover families who have no affordable options in the unsubsidized private marketplace.

The August 17th CMS directive imposes new enrollment, administrative and procedural requirements that impair the Commonwealth's Medicaid and SCHIP programs. Though couched as guidance by CMS, there are in fact significantly new requirements for States like Massachusetts that cover children over 250 percent of the federal poverty level. They are particularly worrisome in our case because we have a specific agreement with CMS on which we relied in designing and implementing our reforms.

Specifically, the August 17th directive may prevent us from covering eligible children who are not yet enrolled. They will inevitably lead to delays in care for many children while eligibility nuances are worked out. Unless the Congress acts, many families will be discouraged from enrolling in SCHIP all together. More costly emergency rooms will replace the pediatrician's office for families in need of care for a sick child with the consequent upward pressure on overall system costs. Not only are these the very outcomes we are trying to avoid but they would represent a giant step backward in one of the most successful innovations in healthcare reform in the country today, if I may say so myself. Indeed, as a practical matter in Massachusetts, this directive would leave thousands of children between 250 and 300 percent of the federal poverty level uninsured while their parents are covered by other features of our federally approved healthcare reform. This inconsistency compromises an otherwise comprehensive coverage strategy.

So I want to be as clear as I can. Without continued federal support for and flexibility within the SCHIP program, healthcare reform in Massachusetts and I believe in other States is in jeopardy. Given the benefits to children, to families and to our economy, and the many salient lessons to be learned from Massachusetts and other States on solutions that could work nationally, it is hard for me to understand why we would seriously consider limiting or reducing the reach of either the Commonwealth agreements with CMS or the SCHIP program as a whole.

I ask you to give reauthorization of SCHIP another try before the end of this Congress. Our success in enrolling low-income children means our federal SCHIP allotments have not been sufficient and I am grateful that Congress has consistently addressed this shortfall issue for my State. However, the instability caused by the absence of a reauthorization bill creates problems in long-term planning for the program in Massachusetts and other States across the country, as I think you must appreciate.

At a minimum, I join my fellow governors here in asking you to rescind CMS's August 17th guidance letter on SCHIP.

And finally, I want to briefly make a point about several other CMS Medicaid regulations to which my colleagues have referred that have been put forth in the past year which will also affect healthcare reform in Massachusetts. CMS has issued seven new Medicaid regulations that will shift between $13 and $15 billion in costs from the Federal Government to the States, and we simply cannot afford it in Massachusetts.

The regulations restrict how Medicaid pays for hospital services and graduate medical education—we have very similar concerns in Massachusetts as Governor Barbour has expressed in Mississippi for those reasons—outpatient services, school-based health services, services for individuals with disabilities and case management services.

Congress has thankfully delayed some of these regulations but they will soon take effect if you do not overturn or further postpone them. Without your actions, States will be forced to make choices that are more than just unpleasant but wasteful, costly, impractical and ultimately harmful to our common interests and good personal and economic health. So while you are at it, I urge Congress to rescind CMS's new regulations on Medicaid as well.

I thank you very much for convening the hearing and for allowing me the extra time.

[The prepared statement of Mr. Patrick follows:]

STATEMENT OF GOVERNOR DEVAL L. PATRICK

Good morning. Thank you, Mr. Chairman, Congressman Deal, and all the Members of this Committee for convening today's hearing. This is an enormously important issue for Massachusetts and for the Nation in terms of both our public health and our economy.

A child with quality healthcare is a child with a better chance in every aspect of life. The Rand Corporation's 2005 report entitled "Children at Risk" found, for example, that access to health care through regular well-child visits enable early developmental screenings and encourage parental behaviors to assist all facets of child development: physical, cognitive, emotional and social. Quality healthcare enables children to better engage as students and fosters better lifelong health outcomes. These differences can set the course for a life.

This is why SCHIP is a national success story. It is an important tool for fulfilling a most fundamental responsibility for any civilized society: to help parents give every child the care and support they need to reach their highest potential. Though there are differences on just what shape reauthorization should take, I want to acknowledge and thank you for the broad, bipartisan support in the Congress for continuing the SCHIP program.

In Massachusetts, SCHIP also plays an important role in our Healthcare Reform initiative.

Healthcare Reform in Massachusetts is a mosaic of different programs, contributions and approaches. Though these are still early days (we are only in the early weeks of the second year of implementation), our reform plan has already been very successful. 300,000 adults and children who were uninsured just a year ago are insured today, reducing our uninsured population by about half. Free care utilization has dropped. Between federal fiscal years 2006 and 2007, our uncompensated care pool saw roughly 9% fewer inpatient discharges and 12% fewer outpatient visits. A recent report by the Massachusetts Hospital Association shows that the number of hospital low-income uncompensated care accounts has decreased by 28% since October 2004. And there are initial signs of a leveling off in health care costs, with premiums for subsidized programs increasing at an average of 5%, roughly half what increases in the general market have been.

As part of our partnership with the federal government, SCHIP has been an indispensable part of our plan. The Centers for Medicare & Medicaid Services (CMS) agreed to permit Massachusetts to expand SCHIP to children at or below 300% of the federal poverty level. As a result, Medicaid and SCHIP enrollment has grown by 40,000 children, including 18,000 newly eligible because of the expansion from

200% to 300% of the federal poverty level. CMS' approval of the Massachusetts SCHIP rules two years ago was a crucial part of the success we are experiencing today. And I am happy to add that we have achieved that success without having residents use SCHIP to substitute for private coverage. (The so-called "anti-crowd-out" provisions are working.)

I am here to ask you not to undermine this success. That's why the August 17th CMS guidance letter is so troubling for my state and for our goals with Healthcare Reform. We are in the process of creating seamless, integrated, market-based coverage for all individuals and families across the Commonwealth. Our success depends on the stability and reliability of the commitments the federal government has made to us. A retreat in any of those commitments could have devastating effects on our progress, particularly our ability to cover families who have no affordable options in the unsubsidized private marketplace.

The August 17th CMS directive imposes new enrollment, administrative and procedural requirements that impair the Commonwealth's Medicaid and SCHIP programs. Though couched as "guidance" by CMS, they are in fact significant new requirements for states, like Massachusetts, that cover children over 250% of the federal poverty level. They are particularly worrisome in our case, because we have a specific agreement with CMS on which we relied in designing and implementing our reforms.

Specifically, the August 17th directive may prevent us from covering eligible children who are not yet enrolled. They will inevitably lead to delays in care for many children while eligibility nuances are worked through. Unless the Congress acts, many families will be discouraged from enrolling in SCHIP altogether. More costly emergency rooms will replace the pediatrician's office for families in need of care for a sick child—with the consequent upward pressure on overall system costs. Not only are these the very outcomes we are trying to avoid; but they would represent a giant step backward in one of the most successful innovations in healthcare reform in the country today. Indeed, as a practical matter in Massachusetts, this directive would leave thousands of children between 250% and 300% of the federal poverty level uninsured while their parents are covered by other features of our federally-approved Healthcare Reform. This inconsistency compromises an otherwise comprehensive coverage strategy.

So, I want to be as clear as I can be. Without continued federal support for and flexibility within the SCHIP program, Healthcare Reform in Massachusetts and elsewhere is in jeopardy. Given the benefits to children, to families and to our economy, and the many salient lessons to be learned from Massachusetts and other states on solutions that could work nationally, it is hard for me to understand why we would seriously consider limiting or reducing the reach of either the Commonwealth's agreements with CMS or the SCHIP program as a whole.

I ask you to give reauthorization of SCHIP another try before the end of this Congress. Our success in enrolling low-income children means our federal SCHIP allotments have not been sufficient. I'm grateful that Congress has consistently addressed this short-fall issue for my state. However, the instability caused by the absence of a reauthorization bill creates problems in long-term planning for the program in Massachusetts and other states across the country.

At a minimum, I join my fellow governors here in asking you to rescind CMS' August 17th guidance letter on SCHIP.

Finally, I want briefly to make a point about several other CMS Medicaid regulations that have been put forth in the past year which will also affect Healthcare Reform in Massachusetts. CMS has issued seven new Medicaid regulations that will shift $15 billion in costs from the federal government to states. We simply cannot afford it.

The regulations restrict how Medicaid pays for hospital services, graduate medical education, outpatient services, school-based health services, services for individuals with disabilities, and case management services.

Congress has delayed some of the regulations, but they will soon take effect if you do not act to overturn or further postpone them. Without your action, states will be forced to make choices that are more than just unpleasant, but wasteful, costly, impractical and ultimately harmful to our common interests in good personal and economic health.

So, while you are at it, I urge Congress to rescind CMS' new regulations on Medicaid as well.

Thank you again for convening today's hearing and for the opportunity to offer our views. I am happy to try to address any questions you may have.

Mr. PALLONE. Thank you, Governor Patrick.

Mr. Deal would like to introduce the governor of Georgia.

Mr. DEAL. Thank you, Mr. Chairman.

I am indeed pleased to have my governor, Governor Sonny Perdue, and our First Lady, Mary Perdue, with us today. I had the great honor of serving with Governor Perdue when we were both State senators in the Georgia legislature. He rose through the ranks of leadership there and is now serving his second term as the governor of our State as I believe his colleague Mr. Barbour is serving his second term as governor of his State. So we are pleased to have him here today. Our legislature is in session so I don't know whether he is just relieved that we got him out of town or whether he is anxious to return, but I do appreciate him taking the time to be with us on this very important issue. We welcome you.

STATEMENT OF SONNY PERDUE, GOVERNOR OF GEORGIA

Governor PERDUE. Thank you and good morning, Mr. Chairman and to my Congressman, Mr. Deal, and other members of the committee. Thank you very much for the opportunity to come before you today to discuss the progress that I believe we have made in Georgia in covering our State's uninsured children and more specifically the reauthorization of the State Children's Health Insurance Program nationally.

As most of you know, SCHIP is an issue about which I have been very vocal. I have been vocal because in Georgia this is a program that has worked. Ten years ago Congress made the health of our children a priority. A Republican Congress and a Democratic President worked together to create SCHIP, a federal-State partnership that would offer the children of low-income, hardworking parents the healthy start in life that they deserve.

I have been vocal because SCHIP is a success. I think nationally and I know in Georgia it works. It works because it promotes shared responsibility, shared between a family doing what it can and a compassionate public. SCHIP is not simply a government handout. It is not for unemployed families on welfare. It helps the children of working parents who not only pay their taxes but also pay premiums for the insurance that these children receive.

In Georgia, we have maintained that shared responsibility and integrity in our program by verifying income and citizenship for each of our applicants. We require monthly premiums for coverage, and yes, like anything else in life, there are consequences for failing to pay premiums.

I have been vocal because I know that the families who buy coverage through SCHIP want for their children what we all want for our children. They simply want them to have an annual checkup, to get basic immunizations, get regular screenings just like your children receive and my children receive.

In Georgia, we have been successful in providing basic preventative treatment. Roughly 90 percent of our young children enrolled in Georgia's SCHIP program—we call it PeachCare for Kids—for at least 10 months received the immunizations to prevent debilitating diseases and over 80 percent had a medical home, a family primary care doctor.

I have been vocal because it is a program that works, a program that has a 10-year record of proven success and faces extinction be-

cause we cannot agree on how to continue. I believe if SCHIP were a snail darter or a purple bank climbing mussel, we would be suing the Federal Government under the Endangered Species Act. In the last 2 years, a growing number of States have been forced to appeal to our federal partners to fund the federal share just so that we could continue through the end of the year. Watching this, wondering how they will afford the rising costs of healthcare, are the working parents of millions of our Nation's children.

Georgia has done very well in implementing SCHIP. In fact, we have done too well. In fact, we have been penalized for it as Governor Barbour indicated in Mississippi. We have enrolled so many children in SCHIP that our percentage of uninsured children has dropped dramatically. And because of this flawed funding model that partially bases States' allotments on the number of uninsured children, Georgia along with our neighbors in Mississippi and North Carolina, are facing growing shortfalls.

Think of this: the better you are at implementing SCHIP, the less funding you receive. If our State was 100 percent successful and reached all uninsured children, the funding next year would be drastically cut because no children would be uninsured. Imagine if we used the same logic on our education system. A school that was tasked with reducing the dropout rate and who achieved their goal of graduating 100 percent of their students would be rewarded with significantly less funding the next year. That just doesn't make sense.

The current funding formula is also flawed because it hurts fast-growing States like Georgia by lagging behind in factoring quickly changing population numbers.

In our 2007 fiscal year, the Federal Government was using population numbers from 2004, 2003 and as far back as 2002. Ladies and gentlemen, Georgia has grown by almost 1 million people since 2002. We need data that is reflective of the actual population and need.

I have been vocal about SCHIP because this formula flaw threatens the great progress that we have made. I want to thank my good friend, Congressman Nathan Deal, and others for their efforts along with Congress for addressing the funding shortfall while discussions continue on reauthorization of this important program. These debates give you the opportunity to revisit issues like this flawed formula, and I ask that you address it in any new bill signed into law.

I have been disappointed that the ongoing debate in Congress over the size of the program has completely overshadowed the great success that the last 10 years have seen. Equally overshadowed is our opportunity to recalibrate the program to better target funding to States and programs that need it. There are several lessons and principles I would like to share with you as your discussions continue.

The key principle of SCHIP is that children should always be the top priority. Our resources must focus first on children. This is not the case in every State right now. Some States have expanded their programs to include health insurance for other groups, even childless adults, but the goal of this program all along was to provide

an answer to an insurance need for our most vulnerable population: low-income children.

It is a grave mistake to expand taxpayer-funded insurance to a level that undermines personal responsibility for those who are able to purchase private insurance on their own. By focusing funding and enrollment efforts on low-income children, we are reaching those most in need and those who have no other options. There is a point of diminishing returns when you create a program that becomes so large that States can't afford to participate.

As governor of a State with a constitutional requirement for a balanced budget, I recognize that we simply do not have unlimited funds for SCHIP. Today we are in an uncertain economic environment where some States face daunting revenue shortfalls. Balancing State budgets means not everyone can continue to enroll uninsured children, and a program expansion will only cause less participation, enrollment caps or benefit reductions.

With a balanced budget on a yearly basis, a growing State match in a year of revenue shortfalls means cutting funding elsewhere. Additionally, knowing that States including our State of Georgia have had to struggle to anxiously persuade Congress to fund the program as originally conceived, how can we be confident that the money will be available to match an expanded program. While Georgia stood ready to meet our State obligations, we ran out of federal funds. What do you think happened then? The citizens of Georgia turned to us and the State to insure that PeachCare would continue to cover their children. We had made a promise together and Georgia was left to keep it alone, borrowing funds from other sources to continue our program's operation while Congress and the Administration debate it.

Reauthorization of SCHIP allows us to revisit a program that is a nationwide success. It allows us to reevaluate what has worked well and what has not. It gives us an opportunity to update an over a decade-old formula that we as a Nation have outgrown, and to make sure that we do not forget the mandate of the program: to ensure the health of our Nation's low-income children.

Is more funding needed? Yes. Both Congress and the Administration recognize that. But I am very concerned that the vast unsustainable expansions will harm the long-term viability of the good program we have now. By focusing funding on low-income children and retargeting a distribution formula that has not changed in a decade, States will continue to make progress in reaching and insuring our children.

As I have said many times, I am grateful that America is a very compassionate Nation. We must continue to take care of our most vulnerable citizens. SCHIP is a success story. It is a program that has proven to work. The proof is in the millions of children who would not have otherwise had vaccinations, would go without treatment for earaches and sore throats, without diagnosis of chronic diseases such as diabetes and asthma.

I have been vocal because there is no doubt in my mind that this is a program that must be preserved with its original intent in mind.

Thank you again for giving us the opportunity to testify, and I will be happy to address any questions you have.

[The prepared statement of Mr. Perdue follows:]

STATEMENT OF GOVERNOR SONNY PERDUE

Good morning, Mr. Chairman, and members of the Committee. Thank you for the opportunity to come before you today to discuss the progress we have made covering our nation's uninsured children—more specifically, reauthorization of the State Children's Health Insurance Program (SCHIP).

As most of you know, SCHIP is an issue about which I have been very vocal. I have been vocal because this is a program that works.

Ten years ago Congress made the health of our children a priority. A Republican Congress and a Democratic President worked together to create SCHIP, a federal-state partnership that would offer the children of low-income, hard-working parents the healthy start in life they deserve.

I have been vocal because SCHIP is a success. It works. And it works because it promotes shared responsibility—shared between a family doing what it can and a compassionate public.

SCHIP is not a government handout. It is not for unemployed families on welfare. It helps the children of working parents who not only pay their taxes, but who also pay premiums for the insurance their children receive.

In Georgia we've maintained that shared responsibility and integrity in our program by verifying income and citizenship for each of our applicants. We require monthly premiums for coverage. And like anything else in life, there are consequences for failing to pay premiums.

I have been vocal because I know that families who buy coverage through SCHIP want for their children what we all want for our children. They simply want to have an annual check-up, to get basic immunizations, and to get regular screenings, just like my children received and your children received.

In Georgia, we've been successful in providing basic preventative treatment: roughly 90% of our young children enrolled in Georgia's SCHIP Program-PeachCare for Kids-for at least 10 months received the immunizations they needed to prevent debilitating diseases, and over 80% had a primary care doctor.

I have been vocal because a program that works, a program that has a ten year record of proven success, faces extinction because we can't agree on how to continue.

If SCHIP were a snail darter or a purple bank climbing mussel, we would be suing the federal government under the Endangered Species Act!

In the last two years a growing number of states have been forced to appeal to our federal partners to fund their share—just so that we could continue through the end of the year. Watching this, wondering how they will afford the rising costs of health care, are the working parents of millions of our nation's children.

Georgia has done well in implementing SCHIP. We've done too well—in fact, we've been penalized for it. We've enrolled so many kids in SCHIP that our percentage of uninsured children has dropped dramatically.

And because of a flawed funding model that partially bases states' allotments on the number of uninsured children, Georgia, along with our neighbors like Mississippi and North Carolina, are facing growing shortfalls.

The better you are at implementing SCHIP, the less funding you receive. If a state was 100% successful and reached all eligible uninsured children, its funding the next year would be drastically cut—because no children would be uninsured.

Imagine if we used this same logic in our education system: a school that was tasked with reducing their drop-out rate and who achieved their goal of graduating 100% of their students would be rewarded with significantly less funding the following year. This just doesn't make sense.

The current funding formula is also flawed because it hurts fast-growing states, like Georgia, by lagging behind in factoring quickly-changing population numbers.

In our 2007 fiscal year, the federal government was using population numbers from 2004, 2003 and as far back as 2002. Folks, Georgia has grown by almost a million people since 2002! We need data that is reflective of the actual population and need.

I have been vocal about SCHIP because this formula flaw threatens the great progress we have made. I thank my good friend Congressman Nathan Deal for his efforts, along with Congress for addressing the funding shortfall while discussions continue on reauthorization of the program.

These debates give you the opportunity to revisit issues like this flawed formula, and I ask you now to address it in any bill signed into law.

I have been disappointed that the ongoing debate in Congress over the size of the program has completely overshadowed the great success the last ten years have seen.

Equally overshadowed is our opportunity to re-calibrate the program, to better target funding to states and programs that need it. There are several lessons and principles I would like to share with you as your discussions continue.

The key principle of SCHIP is that children should always be top priority. Our resources must focus first on children. This is not the case in every state right now.

Some states have expanded their programs to include health insurance for other groups, even childless adults. But the goal of this program all along was to provide an answer to an insurance need for our most vulnerable population: low income children.

It is a grave mistake to expand taxpayer funded insurance to a level that undermines personal responsibility for those who are able to purchase private insurance on their own. By focusing funding and enrollment efforts on low income children, we are reaching those most in need, those who have no other options.

There is a point of diminishing returns when you create a program that becomes so large that states can't afford to participate. As Governor of a state with a constitutional requirement for a balanced budget, I recognize that we simply do not have unlimited funds for SCHIP.

Today we are in an uncertain economic environment where some states face daunting revenue shortfalls. Balancing state budgets means not everyone can continue to enroll uninsured children and a program expansion will only cause less participation, enrollment caps or benefit reductions.

With a budget balanced on a yearly basis, a growing state match in a year of revenue shortfalls means cutting funding elsewhere.

Additionally, knowing that states, including our state of Georgia, have had to struggle anxiously to persuade Congress to fund the program as originally conceived. How can we be confident that money will be available to match an expanded program?

While Georgia stood ready to meet our state obligations, we ran out of federal funds. What do you think happened then? The citizens of Georgia turned to us to ensure that Peach Care would continue to cover their children.

We had made a promise together, and Georgia was left to keep it alone; we were borrowing funding from other sources to continue our programs operation while Congress and the administration debated.

Reauthorization of SCHIP allows us to revisit a program that is a nationwide success. It allows us to reevaluate what has worked well and what has not.

It gives us an opportunity to update the over a decade-old formula that we as a nation have outgrown, and to make sure we do not forget the mandate of the program—to ensure the health of our nation's low-income children.

Is more funding needed? Yes. Both Congress and the administration recognize that. But I am very concerned that vast, unsustainable expansions will harm the long term viability of the good program we have now. By focusing funding on low income children and re-targeting a distribution formula that has not changed in a decade, states will continue to make progress in reaching and insuring our children.

As I have said many times, America is a compassionate nation. We must continue to take care of our most vulnerable citizens.

SCHIP is a success story. It's a program that is proven to work. The proof is in the millions of American children who would have otherwise gone without vaccinations, without treatment for earaches and sore throats, without diagnosis of chronic diseases such as diabetes and asthma.

I have been vocal because there is no doubt in my mind that this program must be preserved with its original intent in mind. Thank you again for giving me the opportunity to testify. I am happy to address any questions you may have.

Mr. PALLONE. Thank you, Governor.

I was going to look around for somebody from Ohio to introduce you but after you and Sherrod left we couldn't find anybody of your caliber on the Committee, so we just have to go without it. I recognize the governor, Governor Strickland.

STATEMENT OF HON. TED STRICKLAND, GOVERNOR OF OHIO

Governor STRICKLAND. Thank you, Mr. Chairman and Ranking Member Deal and all of my former colleagues on this great Sub-

committee on Health. I am here today to talk about SCHIP, Medicaid and the unfortunate failed partnership between CMS and the States, especially the State of Ohio. But first I would like to thank you and others on this committee for the bipartisan work you have done to give those least among us access to healthcare. Your work on SCHIP is greatly appreciated, and I hope that we can continue to work together to get this vital program reauthorized.

Last spring in Ohio, I as a Democratic governor joined with Ohio's Republican House and Senate and we passed a budget that passed through both chambers and the conference committee processes almost unanimously. No dissenting votes in the Senate and only one dissenting vote in the House of Representatives. And in that bipartisan budget, we agreed that a priority of our State was to ensure that all of Ohio's uninsured children had access to healthcare. Therefore, we funded SCHIP coverage from 200 to 300 percent of the federal poverty level and also we authorized a State-only program to allow children above 300 percent of the federal poverty level to buy into an insurance program. I signed that budget on June 30, but then came the memo on August 17, not a new law or a new rule but a memo from CMS that severely limited what States could do under SCHIP, and because of that memo, the provisions in Ohio's historic bipartisan budget that were consistent with the Bush Administration's previous SCHIP and Medicaid policy came to a halt, and at that moment 20,000 children in Ohio between 200 and 300 percent of the federal poverty level were doomed to remain uninsured and they remain that way today.

This memo I believe is a true violation of the State-federal partnership that is SCHIP. We had no warning and there was no process to debate the impact of this major change that so negatively affects uninsured children in States like Ohio where we have made them a priority. In fact, it is more than a violation of a partnership. I believe it is a violation of authority. CMS took this action unilaterally outside the normal rulemaking process, not only denying input from the States but also denying input from even you, the Members of Congress.

Knowing that CMS was now rejecting our State plan amendments that covered children up to 300 percent under SCHIP, we decided to take another route. If there was one thing I knew from serving on this committee, it was that there was flexibility for States when it came to Medicaid, and there were other States that have been able to cover kids up to 300 percent. So while we were forfeiting the enhanced federal match under SCHIP, we knew what we had to do to get these kids covered: apply for the expansion under Medicaid, and that is exactly what we did. But in December, we got a denial letter from CMS. We were the first State to be officially denied Medicaid coverage for children up to 300 percent of the poverty line. The stated reason given to us: that we didn't apply for the expansion under SCHIP. That was the stated reason. But we all knew what would have happened if we had applied under SCHIP. The reason we were denied was not based in law or administrative rule. I believe the real reason we were denied is that we had found a legal and a legitimate way around their August memo.

Unfortunately, this August memo isn't the only thing that CMS is doing that exceeds their authority. Because CMS wants to enact policies that are contrary to the will of this Congress, they are going around you and issuing other devastating rules and directives. I applaud you for placing a temporary moratorium on some of these lawless policy changes and I hope this moratorium will be extended. I would also ask that you pass language that would overturn the August 17th memo and expressly prohibit such significant unilateral policy changes in the first place.

Before I close, I would like to ask you to consider Medicaid fiscal relief for the States. Ohio is struggling with both increased unemployment and Medicaid caseloads. Though Ohio faces a budget shortfall, we have committed to living within our means and investing in what matters. In a bipartisan way, Ohio has clearly stated in our budget that the uninsured, especially uninsured children, matter. So they will continue to be our priority and I ask that the Medicaid recipients continue to be a priority of this Congress. I ask that you vote to supplement help for our States, Medicaid help, as you vote for the supplemental funding in Iraq and Afghanistan. I want you, when that bill passes to help Afghanistan and Iraq, to also include in that bill supplemental Medicaid spending for the States.

Mr. Chairman, I appreciate being here today, appearing before this, the greatest committee and the greatest subcommittee of the Congress. I look forward to working with you. It is good to see all of my former colleagues. I will be happy to answer any questions you may have of me.

[The prepared statement of Mr. Strickland follows:]

STATEMENT OF GOVERNOR TED STRICKLAND

Mr. Chairman, Ranking Member Deal, and my former colleagues of the Subcommittee on Health, it is my honor to be sitting on the other side of this committee room today to talk with you about the state-federal partnership that makes Medicaid and SCHIP. I want to begin by thanking many of you and the majority leadership of Congress who have worked on a bipartisan basis to reauthorize SCHIP. It is unfortunate that the President has twice vetoed these measures, but I hope that Congress will continue to press this issue until the program is reauthorized.

As Governor of the State of Ohio, I have come to know well how the administrative actions of a federal agency can scuttle the carefully developed and negotiated bipartisan agreements that state legislatures reach to provide health coverage for those who need it most. I am here today to talk about three major topics:

1. The Center on Medicare and Medicaid Services (CMS) August 17 directive is a blatant attempt to thwart the will of Congress and its apparent extension to Medicaid is without any basis in law. The result in Ohio is that 20,000 uninsured children with family incomes between 200 and 300 percent of the federal poverty level remain uninsured;

2. There is a clear need for a congressional prohibition on CMS regulations and directives that either exceed its authority or violate legislative intent. Recently the U.S. Department of Health and Human Services (HHS) has gone so far as to propose giving the Secretary of HHS authority to overrule any decision by its Departmental Appeals Board; and

3. The urgent need for Congress to enact legislation providing enhanced Federal matching funds to states such as Ohio that are experiencing both an economic slump and increasing Medicaid caseloads and to reject the President's ill-conceived Medicaid budget proposals.

Ohio is currently facing tough economic times and Ohio families are struggling with the increased costs of food, energy, and other everyday expenses. For many of these struggling families Medicaid or SCHIP provides a lifeline that most could not do without. That is why I believe that the President could not have picked a worse

time to propose cuts in Medicaid funding and to limit state flexibility to offer assistance to families and their children as well as others who depend on these vital programs. The improper denial of Ohio's bipartisan plan to cover more children under Medicaid, the failure to increase federal Medicaid matching funds during this economic downturn, the score of proposed CMS Medicaid regulations that violate legislative intent and the President's proposed federal budget will result in fewer children having access to health care coverage and to health care services. This is a tragedy for Ohio's uninsured children and their families, for the State of Ohio, and for this country. I believe that Congress must take action now to overturn policies that violate congressional intent and/or the law and should prohibit the administration from adopting similar policies or regulations going forward.

OHIO'S EXPERIENCE IN EXPANDING HEALTH CARE FOR UNINSURED CHILDREN

When I was elected Governor 16 months ago, I traveled across the State of Ohio and in the course of those travels I met scores of families who were without healthcare coverage. What was particularly disturbing to me was the fact that there were approximately 156,000 Ohio children without health insurance. I knew children without access to health care coverage were more likely to go without preventive care, and to face delays in getting treatment. I also understood that a lack of health care coverage could hamper a child's ability to get a good education.

I met a small business owner from Shelby County. I would not consider him poor by any means, but certainly not wealthy. His son was diagnosed with Leukemia when he was only 18 months old. Happily, this youngster was treated and is now ten years old. But because commercial health insurers are reluctant to cover children with a medical history of Leukemia or other serious diseases, this man cannot afford to buy insurance for his son.

I met a single mother from Van Wert, Ohio. Her two children are enrolled in Ohio's SCHIP program. She told me she refused a promotion at work because the extra salary will not be enough to buy health insurance for herself and her children. And the increase in salary will put her over the income limit for SCHIP coverage.

Numerous Ohio families find themselves in these same situations. These folks have done nothing wrong. They are just working and trying to get ahead. And yet, they are victims of a system that fails to meet their needs, is lacking in compassion, and defies common sense.

To address this, I worked with the Ohio General Assembly to enact a historic, bipartisan biennial budget that was passed with only one dissenting vote. This budget funded coverage under Ohio's State Children's Health Insurance Program to Ohio children whose parents make up to 300 percent of the federal poverty line. For a family of three, for example, that's an annual family income of about $52,800. We projected an additional 20,000 children would receive health care coverage under this initiative. Ohio acted in good faith and we believed our proposal was consistent with the Bush administration approach to Medicaid and SCHIP, an approach often touted by former Bush HHS Secretary Tommy Thompson who provided states with great flexibility in terms of deciding who got what benefits under Medicaid.

We were trying to help children like Emily Demko, a little 3-year-old girl in Albany, Ohio whose story we learned about through Voices for Ohio's Children. Margaret Demko and her husband, of Albany, Ohio (near Athens) waited a long time to become parents—nine and a half years of hoping and undergoing fertility treatments. Finally, in 2004, Margaret gave birth to Emily by emergency C-section after 36 hours of labor. The couple had no idea that their baby would be born with any difficulties, but nine hours after birth, Emily was transferred from the regional hospital where she was born to Columbus Children's Hospital. Doctors suspected a congenital heart defect, respiratory problems and Down Syndrome.

After six days in the Neonatal Intensive Care Unit, the final diagnosis was Down Syndrome. And so Emily, whom her mother describes as "a happy, healthy little girl with some extra chromosomal material," was sent home. The couple rapidly decided that Emily's special needs and a lack of appropriate child care in Athens County meant that it would be best for their family if Margaret stayed home to care for Emily. She left her job, and that ended the family's health coverage. Margaret's husband, a self-employed contractor with fluctuating income, has no access to employer-based insurance.

Being without health coverage "took awhile to sink in," Margaret says, especially while adjusting to life with a new baby and learning everything she could about Down Syndrome. But when it did, Margaret applied for Medicaid for Emily; she received coverage beginning in the fall of 2005. Emily began speech, physical and occupational therapy at Columbus Children's Hospital and made great progress. "Therapy helped Emily learn to walk before the age of 2," reports Margaret, "which

is unusual for a child with Down Syndrome. Her manual dexterity is almost age-appropriate and she has recovered from other issues typical for children with Down Syndrome."

But in early 2007, Emily's Medicaid coverage was up for redetermination, according to Margaret, and she was told by a new case worker that her husband's income was $300/year over the limit for Emily's coverage to continue. And so, in March 2007, Emily became uninsured. "Emily needs insurance to cover her therapy," says Margaret, "and for the ordinary care that all children need. Her therapy costs $479 each week, and it helps foster the skills that will give Emily the best ability she can develop. I want my daughter to become a self-sufficient, productive member of society—she, and other people with Down Syndrome, is capable of that. Therapy helps make that happen, but we need health insurance to help pay for it."

When I was in these esteemed halls and on this committee, we debated numerous times the need for uninsured children like Emily Demko to have access to health care coverage. It was this committee that served as a driving force behind enacting the original State Children's Health Insurance Program (SCHIP) legislation in 1997. I am proud to have supported a policy change resulting in millions of uninsured children having access to well child visits, immunizations, doctor visits, and hospital stays. Without SCHIP, many working parents would not be able to afford health care services for their children. So after garnering virtually unanimous and bipartisan support of the Ohio General Assembly to expand Ohio's Medicaid/SCHIP program to serve children with incomes between 200 and 300 percent, I fully expected that CMS would quickly approve Ohio's state plan amendment to accomplish this. But I was wrong, just a few months after we passed our budget the federal government would unilaterally change the rules of the game.

We submitted our state plan amendment to the CMS on September 28, 2007 and asked for approval of our plan to expand Medicaid eligibility for children with incomes between 200 and 300 percent of the federal poverty level. On December 20, we received a letter from the CMS turning down our request to expand eligibility. The stated reason for the denial was that we had not requested the enhanced SCHIP match rate for our expansion. Put another way, we had not asked the federal government for enough money. Now I have only been Governor of the State of the Ohio for a little over a year, and I have to tell you this is the first and only time we have been told by the federal government that the reason they are saying "no" is that we have not asked them for enough money.

But this clever bureaucratic maneuver was really just an attempt to apply the August 17 SCHIP guidance to Ohio even though we were applying under Medicaid and not SCHIP. Because CMS knew that if we had applied for the same expansion under SCHIP at the higher federal match rate, they would have also turned us down, and it would not be because we did not ask them for the right amount of money, it would have been because neither Ohio nor any other state can meet the August guidance. To this day, Ohio has seen nothing in federal law that would prevent us from covering children in Medicaid at any income level using the 1902 (r)(2) income disregards as long as we are willing to provide the requisite state match. So while the bureaucrats may have congratulated themselves on their clever maneuver, nearly 20,000 children remain uninsured and 3-year-old Emily Demko is still without health insurance.

Of course, the State of Ohio has not stood still as a result of this federal rejection. I have met personally with HHS Secretary Michael Leavitt to make our case and our staff within the Ohio Department of Job and Family Services have worked with CMS to recently submit a state plan amendment under SCHIP to cover children with incomes between 200 and 250 percent of the federal poverty level. We have not received word yet from CMS whether or not this plan will be approved. At the same time, we are consulting with Ohio's legislative leadership regarding how we can offer coverage to those children with incomes between 250 and 300 percent of the federal poverty level. Emily Demko fits in this category.

Ohio has filed an administrative appeal of the CMS denial of our original proposal to extend Medicaid coverage to children between 200 and 300 percent of the federal poverty level. At the same time, we have not ruled out further legal action pending the outcome of the administrative appeal.

A much better alternative would be for Congress to legislate a prohibition on enforcement of the August 17 guidance until larger SCHIP reauthorization issues are settled. Congress has already wisely approved moratoriums on other proposed CMS regulations, but any effort to extend those moratoriums should be expanded to include a moratorium on the August 17 guidance. Congress thought they were maintaining the status quo on SCHIP when they passed the extension last year, but CMS' denial of Ohio's expansion shows it is not interested in maintaining the status quo and as a result, we are in danger of seeing the unraveling of state Medicaid

and SCHIP coverage for children. In addition, the President's Medicaid budget proposals show the administration wants to further expand the number of children covered by the guidance to those with incomes between 200 and 250 percent of the federal poverty level. Such an approach could prevent Ohio and other states from offering access to coverage to thousands of uninsured children.

PROPOSED CMS REGULATIONS WILL WEAKEN OHIO'S HEALTH CARE SYSTEM

In 2007 the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services issued a number of Medicaid regulations that have enormous consequences for states and millions of Americans served by the Medicaid program. Many of these regulations alter long-standing Medicaid policy, but they have been proposed without any corresponding legislative action. CMS estimated just six of these regulations could result in an estimated $12 billion reduction in federal Medicaid spending over the next five years. In our view these are really budget cuts disguised as regulations.

We applaud Congress for wisely implementing a moratorium on several of these regulations that CMS has attempted to implement. We believe Congress must now act quickly to expressly prohibit implementation of these burdensome and ill thought out regulations. Without such action, costs will simply be shifted to states and local governments that are already being hard pressed by a weakened economy. It is not just state Medicaid programs that will be affected by these cuts. The impact will be felt by our schools, child welfare agencies, colleges and universities, and many others.

For example, one of these regulations deals with the issue of targeted case management.

The Deficit Reduction Act (DRA) of 2005 contained a section to clarify the Medicaid definition of case management when covered as a Medicaid state plan service. This clarification intended to curb improper billing of non-Medicaid services to the Medicaid program. CMS issued an Interim Final Rule (IFR), effective on March 3, 2008, to implement this section of the DRA. Ohio is concerned CMS is using this IFR as a vehicle to eliminate administrative case management as an option for the 1915(c) Home and Community-Based Services (HCBS) waiver programs through which states provide less-expensive community care as an alternative to more expensive institutional care. Waiver case managers are key to assuring waiver consumer health and safety, and cost-effective community service delivery. The elimination of administrative case management goes well beyond the congressional intent of the DRA and will have a devastating impact on several of Ohio's 1915c HCBS waivers.

Though the proposed rules do not specifically address HCBS waivers, CMS has gone on record stating their intention that states will no longer be permitted to choose to provide case management as an administrative activity under an HCBS waiver. Historically, administrative case management combined what the IFR now defines as case management, such as designing and coordinating service plans, with certain Medicaid administrative activities, sometimes referred to as gate keeping activities. Gate keeping includes such activities as pre-admission review, prior authorization and eligibility determination. Ohio questions CMS' authority to extend the provisions for state plan services as contained in the Deficit Reduction Act to other forms of case management, including case management services provided through a 1915(c) waiver or under an administrative reimbursement mechanism.

CMS is differentiating case management from administrative activities, and indicating any willing, qualified provider may furnish case management, whereas only the state Medicaid agency can perform administrative activities. The provision prohibiting case managers from serving as gatekeepers will limit their ability to effectively coordinate services and manage program costs, especially as part of an HCBS waiver program. Limiting administrative functions such as level of care determinations, service plan approval and prior authorization of waiver services to only Medicaid state agency staff will have a major impact on access, efficiency and cost.

An advantage of administrative case management is the state's ability to limit providers to entities having expertise in serving an HCBS waiver's target population. For instance, in Ohio's PASSPORT HCBS Waiver that serves more than 27,000 elderly consumers, a network of 13 PASSPORT Administrative Agencies (PAAs), located in the state's 12 Area Agencies on Aging as well as one not for profit agency, operate the program regionally and provide administrative case management to PASSPORT waiver consumers. Ohio has used administrative case management in the PASSPORT waiver for 24 years with approval from CMS. The PAAs currently employ approximately 550 licensed social workers and registered nurses to perform the case management function. If CMS eliminates the option of adminis-

trative case management, the PAAs will be forced to lay off their current case managers.

The IFR requires a consumer have only one Medicaid case manager, and most individuals in Ohio's Medicaid HCBS system have only one. However, Ohio's system also supports the use of an inter-disciplinary approach, when consumer needs cross delivery systems. Requiring a consumer to have only one Medicaid-funded case manager may result in an individual receiving case management services from a case manager inexperienced in serving certain populations or needs. Case managers will need to expand their expertise and devote extra time to manage across all service delivery systems and providers. This will result in the need for smaller case loads to accommodate an increase in case management intensity, which will lead to increased program operation, costs.

The IFR allows individuals to decline case management services in contradiction to CMS' HCBS waiver program requirements. HCBS waiver provisions require each participant receive services furnished under a comprehensive plan of care clearly delineating the consumers' needs. Creating such a plan is a case management function under a HCBS waiver. If the case manager has no role in developing, coordinating and monitoring a comprehensive plan of care, Ohio can neither responsibly manage waiver program costs nor assure participating consumers' health and safety.

Historically, to avert the possibility of conflict of interest, Ohio has prohibited direct care service providers from also providing case management. The IFR allows direct service providers to also furnish case management, inviting the possibility of self-dealing.

Ohio also is concerned about the new 60-day limitation introduced in the IFR on coverage of community transition coordination, a state plan case management service component, consisting of all the tasks involved in helping an institutionalized individual relocate to the community. Currently, Ohio's MR/DD targeted case management service, provided as a state plan service and not as an HCBS waiver service, covers community transition during the last one hundred eighty days (180) of an individual's stay in an institution. This amount of coverage is consistent with CMS policies issued in response to the Olmstead court decision. In some cases, 180 days is not enough time to put into place all the necessary community supports to effectively transition an individual from an institution to a community setting. Moreover, the IFR requirement that FFP is not available until the consumer leaves the institution and is receiving medically necessary services coordinated by a community case management provider, coupled with the IFR requirement that a consumer can decline case management services, creates a disincentive for community-based case management providers to deinstitutionalize individuals.

CMS projects the IFR will produce Medicaid cost savings. With potentially many new agencies and individuals providing case management and with the loss of key oversight for Medicaid waiver spending, it is simply not possible to achieve the savings CMS assumes in its impact statement. This is even more evident by the fact that if administrative case management is eliminated in favor of targeted case management, states like Ohio will be able to bill case management at the higher FMAP rate. Ohio projects an increase in CMS expenditures of $5 Million from this change alone. Ohio believes the changes will result in an additional increase in costs due to increased staffing needs, decreased controls, and significant changes to information technology systems to accommodate a fifteen minute billing unit, newly introduced in the IFR. For example, for Ohio's waiver for the elderly, such changes may result in increased costs of over $6.1 million (all funds) to accommodate the regulatory provisions.

CMS indicates the only entity impacted by the proposed regulations is the state. In Ohio, these regulations, especially if applied to 1915(c) waivers, impact local entities currently responsible for case management activities whether the activity is currently conducted as an administrative function or as a service.

As I mentioned at the beginning of my testimony, we are also concerned about proposed HHS/CMS regulations published in the Federal Register on December 28, 2007 entitled Revisions to the Procedures for the Departmental Appeals Board and Other Departmental Hearings which would significantly weaken the Departmental Appeals Board (DAB) and cause a wholesale revision of the current method of resolving disputes between states and the federal government. Congress commissioned the DAB to give states a method of seeking review of Secretarial decisions and made a conscious decision not to give the Secretary the authority to review any decision by the DAB. The regulations seek to undo current practice and propose to give the Secretary the power to overturn decisions by the DAB. In this instance the Secretary is asking to be both the judge and the jury. The proposed regulations go even further by forbidding the DAB from invalidating any federal decision if such a decision runs contrary to published or even unpublished guidance. This means that

states could be held accountable to follow rules or guidance that was never properly released or were released without any proper notice. This is yet another example of HHS and CMS seeking to act in a way that is contrary to the law, and to well established notions of due process and fair play.

Another area of concern is the administration's regulations that would wipe out Medicaid reimbursements for Graduate Medical Education (GME). The regulations declare that state Medicaid programs "must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system." The Association of American Medical Colleges (AAMC) has filed comments that the rules "represent a major and abrupt reversal of long standing Medicaid policy." They also contend the rules could have a negative impact on the health care system. According to the AAMC, teaching hospitals represent 20 percent of all hospitals, and 42 percent of all Medicaid discharges. Ohio's teaching hospitals will lose millions of dollars if these regulations and or proposals are allowed to proceed and it will undercut their ability to train the next generation of physicians who will be called upon to treat our Medicaid consumers.

Other regulations of concern include those on rehabilitation services, school-based services, hospital cost limits, and provider taxes. Each of them has the potential to undermine the state's health care system and limit access to health care.

Federal Fiscal Relief Needed To Avert Medicaid Cuts

It is clear to me that Ohio's economy is struggling, with both unemployment and Medicaid caseloads increasing. As of December 2007, our Medicaid caseloads were 22,821 over our budgeted projections and there is every reason to believe that our Medicaid caseloads will continue to exceed budgeted levels. When we started to see these caseload numbers rise we delayed planned increases in the Medicaid rates for community providers and hospitals, and also delayed restoration of adult dental benefits, which was eliminated by my predecessor. Since that time, we have decided to proceed with the planned rate increase for community providers and to restore adult dental benefits, but we were unable to afford a planned rate increase for hospitals. Even though Ohio faces a biennial budget shortfall of $733.4 million we are committed to living within our means and investing in what matters to Ohio, and what matters in this instance is access to health care coverage for children and other vulnerable populations.

Bush Medicaid Budget Puts Children, Families, and Persons with Disabilities At Risk

According to the American Public Human Service Association, the budget submitted by President George Bush seeks to cut Medicaid spending by $17.3 billion over the next five years, and over half of these cuts are the result of simply reducing the federal financial participation in Medicaid expenditures. The administration is proposing to reduce federal financial participation for the following activities:

- Compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency;
- Preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility;
- Survey and certification of nursing facilities;
- Operation of an approved Medicaid Management Information System (MMIS) for claims and information processing;
- Performance of medical and utilization review activities or external independent review of managed care activities;
- Operation of a state Medicaid fraud control unit (MFCU);
- Family planning services;
- Targeted case management; and
- Medicare Part B Premium Costs (Q1 Program Match Rate).

There is no justification for these proposals, and many of them defy common sense. The federal government should be encouraging states to do more in areas like fraud prevention, preadmission screening for nursing facilities, automation, and health information technology, not less.

Another area of concern in the President's Medicaid budget is the proposal to extend the August 17 guidance to children whose families have incomes between 200 and 250 percent of the federal poverty level. States would be required to enroll 95 percent of their eligible Medicaid and SCHIP child populations with annual family income less than 200 percent of the federal poverty level. States failing to comply, and we do not know of any state that could comply with this standard, are subject to a 1% reduction in their federal financial participation rate.

We are also opposed to another apparent proposal placing new limits on how states calculate a family's income for purposes of qualifying for Medicaid or SCHIP. Most states, including Ohio, determine family income by deducting a certain portion of income (through earned income disregards) to account for work related expenses and child care. If these new budget provisions/rules are allowed to go into effect, it is virtually certain many Ohio children who are eligible today would no longer be eligible for our state children's health insurance program and would find themselves uninsured.

Finally, it is not clear to us the President's budget contains sufficient funding to either expand the program to serve additional eligible children in Ohio or to even serve all the Ohio children who currently depend upon the program.

In closing, I want to end my testimony where I started, by calling on Congress to assert its rightful authority over the Medicaid and SCHIP programs and to prohibit CMS from enforcing the August 17 directive; to prohibit CMS from promulgating regulations, directives or guidance that either exceed their authority or violate legislative intent; and to immediately pass legislation providing enhanced Federal matching funds to states such as Ohio that are experiencing both an economic slump and increasing Medicaid caseloads and finally to reject the Presidents Medicaid budget proposals which, if passed, would have the effect of reducing access to health care for thousands of Ohioans.

Thank you again for the opportunity to testify I would welcome any questions that you may have.

Mr. PALLONE. Thank you, Governor Strickland. Thank you to all of you. We are now going to take some questions from the Members of Congress, and I will recognize myself initially for 5 minutes.

I wanted to ask Governor Gregoire, I know that some governors have raised the concern that if CMS lets States like Washington cover uninsured children in families with incomes above $35,200, or 200 percent of the federal poverty level, that other States won't have enough money for their own programs. That is the concern. But in my view, a robust SCHIP reauthorization would solve that problem. The bill that the President vetoed, the Children's Health Insurance Program Reauthorization Act—we call that CHIPRA—not only fully funded every State's SCHIP needs but provided additional payments when States enrolled additional eligible but uninsured children. Now, I know that Governor Barbour and I may disagree on how our formula would have worked and I hope that maybe we can have a later discussion to clear that up, Governor, but the purpose of these SCHIP changes was to ensure that States didn't have to fight with each other for money to help children in need and that children in one State didn't have to hope that another State's children remain uninsured to get help. So I just wondered if you could, Governor Gregoire, to comment on those issues.

Governor GREGOIRE. Thank you, Mr. Chair, and what you just said is the absolute impression that I have of the bill that was put before the President. We are a contributing State to the likes of Mississippi because we have been penalized since the inception of SCHIP in 1997 because we already were covering children within 200 percent of poverty. So we have never expended our allotment for SCHIP funds. Those funds have gone elsewhere. So what you did in your reauthorization in my opinion is, addressed the issues that have been raised here this morning to include my State where the formula was a penalty to us and to address the issues that my colleagues have raised where they weren't sufficient in their allotment.

I would encourage Congress to yet again pass the reauthorization of SCHIP. It allowed the States to do what these children abso-

lutely needed, gave us the necessary flexibility but most importantly, Mr. Chair, I believe it adequately funded what is called for in SCHIP throughout the country.

Mr. PALLONE. Well, I know that the Administration is proposing essentially capping the program so that States can't cover uninsured children and families with incomes above the $35,000 a year, and then simply taking money away from States who can't meet arbitrary targets. But how does that compare with the CHIPRA bill? Which approach is better for States who wish to cover children and the children who remain uninsured, in your opinion?

Governor GREGOIRE. We again believe that the idea of covering children under 200 percent with the August 17th letter is a means by which we will not be able to raise our coverage above that threshold to 250 and hopefully ultimately to 300 percent. And while the Nation has dramatic differences in terms of income levels, depending upon where you live, yes, in New Jersey and New York and California but also I will tell you in a State like Washington State, we are being penalized by uninsured children who are absolutely low income. Their families are struggling so again what has come forward to us through that August 17th letter is virtually a guarantee that we can't move forward. The participation rate that has been called for there, to this day we do not have adequate information as to how that is to be addressed. We believe we meet it but we have no indication. New York met it by CMS standards and then was denied because it didn't meet it. So that is why the rulemaking process is so important, which was avoided here, and that is why we brought suit. But again, what you did and what you put before the President, in our estimation, was the exact right thing for the States.

Mr. PALLONE. Well, thank you.

You know, Governor Strickland, you mentioned the possibility of increasing the federal share of Medicaid funding. I think you know that in 2003 Congress enacted a stimulus package that provided States fiscal relief to help with their budget shortfalls, and one of those was an increase in the federal share of Medicaid funding for States that didn't roll back Medicaid coverage during the downturn, and we know that that assistance did help protect health coverage and assisted in the States' economy. I think I mentioned in my opening statement that myself, Mr. Dingell, Peter King and others on a bipartisan basis, we recently introduced a bill to provide a temporary increase in Medicaid funds to States during this current recession, and I just wanted you to comment, not just yourself but anybody on the panel, whether you believe that that State fiscal relief is important and how a temporary boost in Medicaid funding would help your State. You don't all have to comment but if anyone would like to. I will start with Governor Strickland since you mentioned it.

Governor STRICKLAND. Well, thank you, Mr. Chairman, and we have already—I have already reduced State spending by $730 million due to the economy and budget shortfall in Ohio, and we face a possible shortfall over the 2-year period of $1.9 billion. So we are taking drastic steps to try to keep our budget in balance as my friend, Sonny Perdue, indicated that he must do as well.

Before the first stimulus package was enacted by this Congress, I called the leadership of both parties and I called the leadership in the Congress from Ohio. I talked to Mr. Boehner, and at that time I urged him to make Medicaid relief a part of the stimulus package in an effort to help the States. He indicated to me that he did not think that would be a part of the initial stimulus package but he also indicated to me that he thought this body would rather soon be dealing with a supplemental bill to provide the funding for Iraq and Afghanistan, and he said perhaps—no commitment but perhaps what I was asking for would be considered as a part of that supplemental measure. I would certainly hope so. The people of Ohio and of America are suffering greatly because of the current state of the economy, and as this body considers additional financial support for Iraq and Afghanistan, it seems hugely appropriate to me that they would also consider the needs of the American people and the needs that the States are facing and grant us some relief by increasing the FMAP allotment.

Mr. PALLONE. Thank you. My time has run out but I don't want to preclude if anybody else wants to comment on that, you can. If not, we will—go ahead, Governor.

Governor BARBOUR. Thank you, Mr. Chairman. It happens that I became governor in 2004, the year after the FMAP was plussed up, and of course, I can tell you, if you all got some extra money lying around, we would like to have it. But I will tell you the unintended consequence is that my predecessor took $200 million and spent it on Medicaid recurring expenses with that one-time money and the next year we had to figure out how we were going to replace that $200 million. So we are not ever going to look a gift horse in the mouth but it is a little bit of moral hazard if you spend the money on recurring expenses and the economy doesn't come back the next year.

Mr. PALLONE. Thank you.

I will move on to Mr. Deal. Oh, I am sorry. Mr. Barton is recognized for questions.

Mr. BARTON. Thank you, Mr. Chairman. I am a little bit surprised but I would be happy if Mr. Deal wants to.

My questions are more generic. I mean, I respect these governors and what you have to do. My first question is, I assume that each of you operate under a balanced budget. Is that correct? So we have a little bit different system up here, as Governor Strickland knows. We have been working to try to hold our deficit down but CBO projects that this year is going to go back up. So even though Governor Barbour says if you have any money laying around, send it to Mississippi, our problem is how to distribute the money that we have. So my generic question is, what is wrong with the basic premise that SCHIP, one, should be a State-federal partnership, and two, should be for children between 100 and 200 percent of poverty? And why should we go above that? I understand the governor of Washington stated that you need better data. You might quibble with 95 percent but why shouldn't we try to cover with whatever money we have those children in that bracket before we go above that? What is wrong with that?

Governor BARBOUR. Well, Mr. Chairman, obviously in my State, we don't try to cover anybody above 200 percent of poverty but we

don't get enough money to cover the ones under 200 percent of poverty, and I will say it is hard for us to understand why the formula would give us half of what it takes to cover all the eligible children and other States, wealthier States, in fact, can go up the ladder, cover a lot of adults, even adults without children. I came to just share my information with you but we focus on exclusively people under 200 percent of poverty, children.

Mr. BARTON. I understand the formula fight. We have formula fights on this committee all the time. I could say, if I wanted to be mean to you, that Congressman Pickering just hasn't done a very good job of fighting your fight, but I am not going to do that because he is retiring and he is a good man. So I understand that the big States and the industrialized States have a different idea what the formula ought to be than the rural States and the small States but I want to try to pin down this what is wrong before we go above 200 percent that we have some criteria to cover people, children in this case, between that 100 and 200 percent. And then as Governor Strickland points out, if a State wants to go above that, apparently his State did and found funding for it, and I don't have any problem if people in the Buckeye State want to do it on their own but why should we give federal dollars until every child in America or 90 or 95 percent of them are covered?

Governor STRICKLAND. I think you ask a legitimate question, but I think there are just practical considerations. There is a reason why apparently no State meets the current expectations of CMS, and so I think that indicates that it is not because the States aren't reaching out and aren't trying to enroll these kids, and I guess the answer that I would give to your question is that every child without health insurance that cannot achieve it or attain it because of costs or because of family income, every child is deserving of healthcare coverage, and so simply because States may not be able to reach the criteria that has been set by CMS does not mean that the children that the States are trying to reach and cover are not worthy of this coverage.

Mr. BARTON. What is the reason, Governor? Why can't a State reach 95 percent or 90 percent? What is the structural reason that that is not an achievable goal?

Governor STRICKLAND. Well, I think there are many reasons that may differ from State to State but I don't believe that the fact that not a single State to my knowledge has reached this criteria means that the States aren't trying to do this outreach and to reach these children. But the fact remains that even the children that we are wanting to provide coverage to are needy kids. I mean, they are kids without health insurance, and they are from families that are working families but for a variety of reasons just simply cannot afford the coverage. So I don't see a legitimate way to make a distinction between one child's need of health insurance coverage and another child's need of health insurance coverage if both of those children or all those children are without coverage and it is through no fault of their parents but simply because they can't afford it.

Mr. BARTON. Governor Patrick, did you want to comment?

Governor PATRICK. I just wanted to make a couple comments about our experience in Massachusetts. First of all, 96 percent of the children we cover are at 200 percent or below. There is a slid-

ing scale of subsidy for kids at 200—between 200 and 300 percent, and I want to make a point about process here because as we were developing—and I say we meaning my Republican predecessor and in partnership with the Democratic legislature—these health reform components, we reached agreement with CMS on this structure. So the August 17th guidance takes that element of the agreement on which we relied away, and that is very, very troubling for us in terms of being able to sustain——

Mr. BARTON. But you said you got 96 percent covered so why would CMS not approve Massachusetts' petition if you are at 96 percent?

Governor PATRICK. Well, you should talk to CMS about that, and if CMS is here, I hope you will, but if the August 17th guidance stands, then we have about a $19 million bill that we weren't expecting based on the agreements that we have been living with. I would just make one other broad point. We are all of us sensitive to your premise of the question about having to—because we have to balance budgets every year. We are all sensitive to the fact that there is not a lot of money lying around, but I do ask that the Congress and the committee consider what I have been asking our own legislature to consider, which is the cost of inaction. There are costs associated by not doing these things, and one of the costs in Massachusetts, one that we have begun to moderate down, is the systemwide impact of having primary care delivered in emergency rooms rather than in a pediatrician's office, and I know you appreciate that.

Mr. PALLONE. Please go ahead, but we do have to keep going because I don't think you can stay here all day, but go ahead.

Governor PERDUE. To briefly answer Mr. Barton's question, this is a voluntary program. You cannot force parents to participate. We have—we are at 235 percent. We have—most of our population is under 200 percent of poverty. But even with a modest premium, as long as parents have a culture that they can walk into any emergency room when they need care and get it, then they won't even pay a modest premium to cover their insurance. They don't value it the way we value it.

Mr. BARTON. So——

Mr. PALLONE. Thank you. I am sorry.

Mr. BARTON. I will yield back. So if we adopted a rule that if coverage is offered and the family rejects it, say in writing, that would count as an attempt. I mean, if we took who is actually covered plus the parents who refuse coverage and add those numbers, that would satisfy the rule.

Mr. PALLONE. I have got to move on. I am sorry. Because I know all of you can't stay.

Mr. Dingell is recognized.

Mr. DINGELL. Thank you.

I would like to commend the governors for their very fine statements and tell them how much I appreciated their presence and their assistance to the Committee.

This first question is to Governor Barbour. Your comment at page 4 at the top of the page, "The better you are at implementing SCHIP, the less funding you receive. If a State is 100 percent successful and reached all eligible uninsured children, its funding next

year would be drastically cut because no children would be uninsured." Governor, that is a very legitimate complaint and I want to commend you for it. I would note here that your concerns I think were met by the bill which the committee reported out and which passed the House on several occasions. First of all, it increased the total funding from $25 billion by adding an additional $35 billion so it went up to $60 billion. Second, it would more than double the current allotment to Mississippi by giving them a $235 million increase. Third, it would give bonus payments to your State for enrolling new and low-income children. Four, it would make contingency payments available to your State where you would enroll more uninsured children and exceeded your allotment of children to be reached. And last, it would give rebasing, which appears to be a very major concern of yours, by having every 2 years the States' number be based on actual spending so that if Mississippi enrolls all of those uninsured kids, their allotment will be rebased on a higher number and that will help you to account for more children and to provide better services to your people. Does that address the concerns that you have expressed to us?

Governor BARBOUR. Mr. Chairman, let me first of all say they retyped this with bigger type so I could read it so the pagination that you gave me, I couldn't—it isn't on the top of page 4 on this old eyes copy. But to answer your question, what you all have proposed is certainly an improvement over where we are now but we don't turn away any child that shows up and wants to sign up for SCHIP who is eligible but we don't go out and try to recruit them because today we don't get enough money to pay for the new ones.

Mr. DINGELL. Your complaint about today, Governor, is a very legitimate one. I am talking about the future and the changes that we were trying to make in the bill which was vetoed by the President. I want to address your concerns and I want to make sure, Governor, that we have done so.

Governor BARBOUR. It certainly is an improvement, Mr. Chairman. We believe at the end of the day we would still be shorted 27 percent. I would be glad for my staff to sit down with your staff and crunch those numbers but that is what we believe, that at the end of the day it would be a shortfall of 27 percent even if we stay at nothing but children under 200 percent of poverty.

Mr. DINGELL. Governor, thank you.

Governor BARBOUR. Thank you, sir.

Mr. DINGELL. These questions are to Governor Strickland. Governor, you have talked about CMS and its directives that were made. First of all, the first of them says that the Federal Government should no longer help States pay for the cost of Medicaid outreach and enrollment activities by school employees, particularly when States have found this to be a very effective way to find and enroll uninsured children. The directive also said that the Federal Government should no longer pay States for the costs of services to children and adults with mental illness, even if the States believe these services would help reduce unnecessary institutionalization. And last of all, their directive says the Federal Government should no longer pay States for the salaries of interns and residents in teaching hospitals that serve the States' Medicaid patients. Do you favor those actions, Governor?

Governor STRICKLAND. Mr. Dingell, I think those actions are outrageous. I have heard from our hospitals. I have especially heard from our children's hospitals. Ohio is a state with just marvelous children's hospitals and they are very concerned about the graduate medical education issue. That is why we are asking and we have asked unanimously—I think there has been one dissenting vote among the National Governors Association of both political parties—that a moratorium be placed on these decisions. It is estimated that they could cost the States $13 billion over 5 years. The States I can tell you simply cannot tolerate that kind of financial burden and so it is our hope—and I think I am speaking unanimously here for the governors of both parties that it is our hope that a moratorium will be placed on these changes and that they will not be allowed to go into effect.

Mr. DINGELL. Those concerns are set forth in the letter of September 17 by Governor Spitzer and Governor Schwarzenegger of New York and California and also the one on February 26 by the National Governors Association signed by Governors Pawlenty and Rendell and Corzine and Douglas. Is that right?

Governor STRICKLAND. That is right, Mr. Chairman, and if it has not already happened, I would ask unanimous consent that this—that these letters you referred to be made a part of the permanent record.

Mr. DINGELL. You beat me to it. I ask unanimous consent that those be inserted into the record.

Mr. PALLONE. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. DINGELL. You know how this place works. My time has expired, Mr. Chairman. I thank you.

Mr. PALLONE. Thank you, Mr. Chairman. So ordered.

Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

First of all, I would like to ask—because there is confusion as to what the August 17th letter actually does, I would like to insert a response letter from Dennis Smith from CMS to Ranking Member Mr. Barton dated January 22 that I think does help clarify some of the ambiguity that may have existed.

Mr. PALLONE. So ordered.

[This information was unavailable at the time of printing.]

Mr. DEAL. Mr. Chairman, before I ask a question, let me sort of set the stage for it because I think that one of the great opportunities we have is when a piece of legislation has a sunset date such as SCHIP did that we have an opportunity to review it and its 10-year history and decide what things about it need to be changed. I think we have had one in particular that has been highlighted by Governor Barbour and by Governor Perdue in particular and that is the formula problem. It is the ultimate catch-22 where a child who would have been uninsured but for being enrolled in SCHIP no longer counts in your formula for the allocation. That is just something that definitely has to be addressed.

The other problem we have is data, that is, Governor Perdue alluded to the fact that we are being counted against 2002 data. We need a data system and I think all the governors would agree that we need a data system. The governor from Washington has indi-

cated that her statistics indicate one thing, federals don't. We need some consolidated way, a legitimate way to measure how many children are uninsured. Now, assuming we can get that reliable data for the measurement, I think the basic question that comes back to is this on the funding. We ought not to penalize States that have done a good job of enrolling the children that were the targets. Assuming we can correct that, then the question becomes, well, how do you allocate the money under this SCHIP program so that we don't create a situation of having rich States that can do things that poor States can't do. That is one of the fears that I have. One of my concerns about the formula that was in the bill that we were presented with is that you start as a baseline the amount of money you spent last year when we had some States who their baseline, 74 percent of their enrollees were childless adults, but that becomes your baseline on which you build for the future. To me, that is a crumbling foundation. It should not be the foundation for a formula.

So let me go back to basics on that. Are there any of you who disagree with the concept that a State's allocation under SCHIP should be based on the number of children who are below 200 percent of poverty, assuming that we get the numbers right about who those are? Do any of you disagree with that proposition, and if so, why?

Mr. PALLONE. Governor Patrick?

Governor PATRICK. No, Congressman, I don't disagree with the premise as the starting premise. It is just that that is not where I think we should stop. I am with you in terms of focusing on the poorest children first and on children rather than adults, as we do in Massachusetts. I know there are other arguments for that in other States. I am with you there. In our own situation, as you know, and I just want to come back to it, we have agreements we worked with CMS in order to make our healthcare reform work and so we want to make sure those agreements are honored in order to continue to make that healthcare reform.

Mr. DEAL. And I understand, Governor Gregoire, your concern that you were being penalized because you had already gone with the 200 percent. I think all of us agree, that needs to be fixed. Let me tell you why I think this is critical, because if we let the formula go up the economic chain and the allocation is based on, let us say, 300 percent of poverty, I don't think Mississippi and Georgia will be able to come up with the money at the State level even with the enhanced FMAP to meet their State's portion to be able take advantage of going to 300 percent. Is that a concern?

Governor PERDUE. Well, it is a concern, as I indicated in my testimony, Congressman Deal, that under a vastly expanded program, we may not be able to find the money to match, and frankly, based on our last experience of running out of federal money, I would be very anxious if we expanded that we would be left out to dry again from a funding perspective. So I agree that States like Washington, I think Minnesota was one, that may have expanded these populations probably ought to be rectified. They ought to be looking initially at those children under 200 percent and they ought to get credit for that in their allocation. I have got a little problem with my friend from Massachusetts in that we applied for these waivers

as well and the spigot was turned off. So not all States are being treated equally in the waiver program and I feel very strongly about commitments as he does but this has been very much an ad hoc position on the waiver process. We tried and we have been denied.

Mr. DEAL. Right.

Governor Strickland?

Governor STRICKLAND. Yes. I don't think any of us would say that the formulas that may injure some States unintentionally need to be readjusted and I think my friend from Georgia is correct. These waivers have been either approved or disapproved indiscriminately and so it is probably appropriate that we look at the funding allocations, that we look at a consistency across the states but I would hope that we wouldn't remove the flexibility that I think we need to have because all of our States are different and it is important that we maintain a level of flexibility that gives us the ability——

Mr. DEAL. I agree with that, and from a very fundamental point of view, if the funding is the same basis for determining the formula for every State, if it is the same, and I realize waivers have caused all sorts of distortions there, but if the funding formula for a State is basically the same funding formula, you know, from my point of view, if the State wants to do more, then fine. If they have got some money left over that they want to do more with, that ought to be their flexibility. But it ought not to be the flexibility that every State doesn't have the option of taking advantage of is the point I am making.

My time is expired. I realize that.

Mr. PALLONE. Thank you, Mr. Deal.

The gentlewoman from California, Ms. Solis.

Ms. SOLIS. Thank you, Mr. Chairman.

I would like to direct my question to Governor Gregoire, and I want to thank you for your earlier comments. We didn't get to hear your testimony regarding the DRA, the Deficit Reduction Act, and I noticed some of the problems that your State faced in trying to implement the documentation requirements. If you could explain what the cost was and if it was worth it?

Governor GREGOIRE. Yes. Thank you very much for the question. As a result of the requirements that were put in place, we hired a significant number of employees. We went through thousands of people to make sure that we were meeting the requirements for citizenship and at the end of the day, after looking at thousands and sending millions of dollars for employees to do that, we found one person, one person only, a person who was from Canada who did not meet the citizenship requirement. So what you did in the SCHIP reauthorization is a matched capacity for us to look at Social Security numbers, which would cut back the cumbersome process and cut back the cost to the States dramatically. So that is again why we appreciated what you did in the reauthorization and would support it again because the strenuous kind of things that CMS has us going through are far too costly, the results showing virtually nothing.

Ms. SOLIS. And if you could use that money to provide more coverage, how many more children could you have served? You say in your testimony that it cost your state $5 million.

Governor GREGOIRE. That is again the problem. Washingtonians believe that you ought to put the money where its greatest need is and where you can get the results, and I can't answer the specific question of how many more children I could cover. The $5 million to us for those under 200 percent of poverty is a significant contribution to the cost of the program. Meanwhile, we are just going through bureaucratic procedures and being able to produce nothing other than one individual from Canada.

Ms. SOLIS. So in your case, it was more of an auditing exercise. It is actually costing you more money, which you could spend doing outreach. Could you use this money to provide assistance to children that are not currently insured?

Governor GREGOIRE. Absolutely, and again, in the reauthorization, you took care of this in a way that we think meets the criteria, and by the way, the way in which we were doing it previously had already been supported and said was sufficient and then along came the new regulation that made us go through a $5 million process with virtually no results. I would ask you again to allow us that flexibility in what was already approved or the requirements for matching Social Security number so we can put the $5 million into children's healthcare.

Ms. SOLIS. These requirements resulted in extra costs to many States that have beenare already overburdened. In fact, because some Members of Congress tried to weed out people that aren't eligible for coverage, they have actually kept people who are U.S. citizens from obtaining assistance. Many U.S. citizens weren't able to show original birth certificates, and we know in Katrina and Mississippi, there were a lot of folks that lost their possessions. Lost items also include documentation, and I would like to hear more about that from other governors.

My next question is for the governor from Massachusetts, Mr. Patrick. You spoke earlier about your State's efforts to increase the pool of people that are eligible and you have actually provided assistance to folks that make anywhere from $52,000, I believe. What would happen if the August 17 directive is made permanent? How many people are going to be taken out?

Governor PATRICK. Eighteen thousand children would be ineligible for benefits, and that is a—there are 6 million people in Massachusetts. There are 400,000—excuse me—40,000 children who are covered now under our Healthcare Reform Initiative and 18,000 of those children would come out, and there are costs associated with that.

Ms. SOLIS. When we talk about that particular ceiling that you have implemented, I know inflation and all that has been factored into cost of living. I believe your State has a higher cost-of-living than——

Governor PATRICK. It is a higher cost-of-living State. We are very careful to assure that we are not extending coverage to children whose parents have employer-based coverage. We are very sensitive to the crowd-out issues. We also don't provide the same level of public contribution to kids who are in the 250 to 300—in other

words, it is a sliding scale beyond that because with higher income, we expect the families to be able to make a greater contribution.

Ms. SOLIS. And lastly, for Governor Strickland, I really want to thank you for your pointing out that CMS is exceeding their authority. What would happen to Ohio if the August 17 directive is implemented?

Governor STRICKLAND. Well, at a minimum, 20,000 children would be excluded, and if I can just take a minute to say that I have talked with and tried to work with Secretary Leavitt, a very honorable person. He allowed me to come to D.C. to bring my legal counsel and my policy people. We sat around the table, and I asked him to give me what legal basis he had to deny Ohio doing what we chose to do in a bipartisan way, and I think he is unable to provide a legal basis for the decisions that he has made, and we are contemplating what actions may be available to us including legal action. Quite frankly, I don't want to do that. I don't think that kind of confrontation and that kind of approach is best but we believe we are asking to do something that we are entitled to do under the law, that the Secretary does not have a legal basis for preventing us from doing it, and so we may have no other course of action other than go to the courts because we think there is no legal basis for his decision making.

Ms. SOLIS. Thank you, Mr. Chairman. I know I have to yield back, but thank all of you for being here and testifying.

Mr. PALLONE. Thank you.

Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman. In my absence I know many of the members talked about the August 17th directive with all of you, and so I am not going to focus on that. Instead, what I would simply like to ask each of you starting with Governor Gregoire, if you could tell me which of the components of the previous SCHIP legislation that you think are important for your State to be able to continue to enroll as many of the kids as possible. Because one of our great frustrations in Congress is that we see 12 million kids right now in this country without health insurance. Nine million of them are probably eligible for some kind of government assistance. Part of the challenges that States have had, I think, is how do you reach out and get the kids enrolled who are not enrolled right now. Because with the first SCHIP program, we sort of got the low-hanging fruit. We got the kids that we could get into the system and some States have experimented with different—I mean, that is how adults got onto SCHIP because some States thought well, if we insure the parents we can get the kids in. That is how we were able to streamline some of the applications and conform them with the Medicaid application so you could have a joint application, and I am wondering if there is something we could do as we move forward with the SCHIP reauthorization to help you find these hard-to-enroll kids?

Governor GREGOIRE. Well, what we believe is necessary is a significant outreach program. We want to work through the schools, we want to work through social service agencies, so we have begun that process, which is probably why in our State we have a 94 percent participation rate. We don't nor have we ever put adults on SCHIP so this is strictly children, and that is why we have been

able to achieve those goals, those kind of results. But what we need is the ability to go out and reach out in a collaborative way with all of those groups to make sure that we can get parents who otherwise don't know about it, find it too cumbersome. The other thing we have done in our State is to make it very simple. You make one application. Whatever program, we will figure it out for you. We don't make it scary. We don't make it difficult and we make it convenient to people through the schools or through social service agencies.

Ms. DEGETTE. Governor, that is an interesting point you raised, and I will tell you why, because in the second SCHIP bill that we passed that the President vetoed, the bill eliminated all outreach and enrollment programs for SCHIP. So I guess my follow-up question—the theory was, well, if we give them Medicaid outreach and enrollment money, then that will be good enough. Do you think you need specific appropriations for SCHIP outreach and enrollment?

Governor GREGOIRE. Yes. The statement that was made by Governor Perdue earlier is to the point. It is a voluntary program. A lot of people don't know about it, are virtually afraid of it. You need to reach out to talk about what it means, how the children can get a medical home and how important it is. So outreach efforts are the only——

Ms. DEGETTE. For SCHIP?

Governor GREGOIRE. For SCHIP, are the only reason that we are at 94 percent today so CMS makes the requirement and then doesn't fund the outreach. It makes it unachievable.

Ms. DEGETTE. Governor Barbour?

Governor BARBOUR. Ma'am, I am in kind of the opposite position of Governor Gregoire in that one of my predecessors aggressively went out to sign up kids for SCHIP in the early days of the program, then found out that our formula shortchanges us so much that he had a bunch of people he couldn't pay for.

Ms. DEGETTE. So you don't think we should do outreach if we can't pay for it?

Governor BARBOUR. No, that is what I was going to say. For some reason in my State, according to the Census Bureau, more children who are eligible are not signed up than are signed up.

Ms. DEGETTE. Right.

Governor BARBOUR. But we don't have aggressive outreach programs because you all don't give us through the formula enough share to pay for the people that are on the program——

Ms. DEGETTE. Well——

Governor BARBOUR [continuing]. And you all pay for my healthcare budget. If I have to pay 5 times more for an SCHIP child, where does that put me in trying to deal with my other healthcare issues? Nathan Deal, if I could, said something and I want to—and I apologize, ma'am, for taking 30 seconds of your time. The first time I ever went to a meeting about Medicaid as a governor, I thought I was the only one who was drowning in Medicaid. And Tom Vilsack, who was an outstanding governor of Iowa, made the point to me, his biggest problem was he couldn't come up with enough money to pay the State share, and if I have to pay 5 times the State share for SCHIP, I really am in trouble.

Ms. DEGETTE. So it is not just outreach and enrollment, it is the money to——

Governor BARBOUR. Yes. If we had a good formula, we would be doing outreach.

Ms. DEGETTE. Mr. Chairman, I would ask unanimous consent to allow the rest of the governors to answer very briefly.

Mr. PALLONE. Proceed.

Governor PATRICK. I will be very brief because I think the point about the formula, need for formula reform and about outreach support is key. I also think flexibility is key. Each of us has different circumstances in our States and both fiscal and practical circumstances, and being able to work out within the confines of SCHIP, how to utilize SCHIP in our States and within the right—what parameters within the broad parameters are right for us have been enormously important for the success of healthcare reform in Massachusetts.

Ms. DEGETTE. Thank you.

Governor Perdue?

Governor PERDUE. Thank you, ma'am. Georgia has been an aggressive pursuer of these children ever since the program started. We are the ninth-largest State in population. We have got the fourth-largest SCHIP population. So we have aggressively pursued it through many outreaches but I can assure you, ma'am, that it is a disincentive, as Governor Barbour says. When there is not enough money to cover the ones that you have on there, it is much of a disincentive to try to go find more.

Ms. DEGETTE. You betcha.

Governor Strickland?

Governor STRICKLAND. And I can say that sitting here listening to Governor Barbour, he has caused me to feel sympathy for his circumstances, and if the formula does to him in his State what he describes, then that is a problem and it needs to be addressed, and I am very sympathetic to that concern. I wish we could come up with some way of enrolling children that was simplified and that perhaps could be referred to as the presumed or presumptive eligibility so that if a child was from a family with certain economic circumstances, that child would automatically be considered as enrolled, and I don't know if we could ever achieve that but I think that would be helpful to us in Ohio and probably helpful to other States. Certainly it would help us achieve the standard that CMS has put forth for us to meet.

Ms. DEGETTE. And, you know, many States have been successful with presumptive eligibility. I think we should look at that. I agree.

Thank you very much, Mr. Chairman.

Mr. PALLONE. Thank you.

I know Mr. Inslee wants to ask questions but we did promise you that you would be out of here by noon, so can we take another couple minutes? Is that all right? All right. Why don't you try to be quick? The gentleman from Washington.

Mr. INSLEE. Briefly. We have had difficulties with this Administration basically ignoring the restraints of the law when they became inconvenient, and I have to tell you that the CMS memo looks to me like it is a continuation of that pattern, and Governor Gregoire, you talked about challenging this on a legal basis. Put-

ting on your lawyer's hat for a moment, could you tell us the basis of that challenge and what you believe the law should be and is?

Governor GREGOIRE. Well, Congressman Inslee, there are two bases for the lawsuit, and let me just say, we don't lightly do this. We don't think this is a course of action that we would prefer at all and so we first sent a letter asking that they reconsider it and then there was a very bipartisan group of governors who sent a letter and there was no consideration, so we felt we were at wits end. The basis is, number one, it is a letter that has the force and effect of a rule without any rulemaking done whatsoever, and the second basis has to do with the authority of HHS and we believe they exceeded the authority granted by Congress and that these are issues better left to Congress rather than having them rulemaking beyond the authority that has been given them. Those are the bases. Right now we are in a motion status with regard to the matter. We have a motion for summary judgment. They have a motion to dismiss. But again, I regret having to take this action but we didn't feel we had any other course but we would really very much appreciate if Congress would have that August 17th letter set aside so that the States don't have to resort to litigation.

Mr. INSLEE. Thank you. Thank you all. Thank you, Governor Strickland, for being an advocate for the solution in the upcoming stimulus package. We are going to try to make that happen. Thank you.

Mr. PALLONE. Let me just thank all of you once again. I thought this was very helpful in terms of our efforts on SCHIP, Medicaid as well as the FMAP that we are proposing.

I just wanted to say in closing that members can submit additional questions for the record and ask you to answer those. They are supposed to do that within 10 days, just so you know, and the clerk would notify your offices if that occurs. But thank you again, and without objection, this hearing of the subcommittee is adjourned.

[Whereupon, at 12:08 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF HON. EDOLPHUS TOWNS

I want to thank the Chairman and Ranking Member for holding this hearing. Furthermore, I would like to extend a special thanks to the Governors that have come, today, to testify before this Committee, and provide the benefit of their unique insight on this important issue. Providing healthcare coverage to our nation's uninsured children has been the topic of numerous discussions in this Subcommittee, in the full Committee, and on the floor of the House. Despite these discussions, and the actions of this Committee and this Congress, our progress toward providing healthcare coverage to the millions of uninsured children in this country has been reversed through the opposition of the current administration.

This administration has twice vetoed Children's Health Insurance legislation; and allowed the Centers for Medicare and Medicaid Services to issue an August 17th directive which effectively imposes an income eligibility cap in the State Children's Health Insurance Program and Medicaid without authority. The administration's actions have had a particularly harsh effect on my state of New York, which no longer has the flexibility to adapt its Children's Health Insurance Program to account for our high cost of living, high cost of healthcare, and other income factors unique to New York relative to other states. I hope that the panel of Governors, before us today, can help us further articulate the issues faced by individual states in light of this administration's current policy.

Thank you, Mr. Chairman and Ranking Member for this opportunity.

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September 17, 2007

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Leavitt:

Governors are deeply troubled by new Centers for Medicare and Medicaid Services (CMS) mandates that limit state flexibility under the State Children's Health Insurance Program (SCHIP) for those states that provide SCHIP eligibility for children of families with income levels at or above 250 percent of the Federal poverty level (FPL). In fact one state has already been a victim of these new rules, which sets an unfortunate precedent that will negatively affect all states with existing programs or plans to expand coverage for children. Released as a measure to address the substitution of SCHIP for private insurance, the requirements amount to a unilateral restriction on state authority to provide health insurance coverage for children and undermine the foundation of the state-federal partnership upon which SCHIP was built.

The requirements articulated in the CMS letter of August 17, 2007, fundamentally alter the authority given to states under SCHIP to craft and operate health care programs that best serve their constituents. Flexibility to set coverage levels is a basic tenet of this vital and successful program and one repeatedly endorsed by this Administration when it granted permission to multiple states to expand their coverage options. The CMS clarification reverses this policy by mandating administrative requirements that could result in hundreds of thousands of children and tens of thousands of adults losing health insurance.

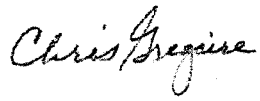
States stand at the forefront of policy innovation and governors are leading the way to create meaningful and sustainable coverage options for their uninsured populations. Governors have repeatedly called upon Congress and the Administration to reauthorize SCHIP before it expires in September. The CMS decision to limit coverage options for states and unilaterally alter existing state plans is contrary to our shared responsibility of working cooperatively to provide health coverage for uninsured children.

Governors call upon CMS to reiterate its commitment to the state-federal partnership under SCHIP by immediately rescinding its August 17, 2007, letter and joining governors in our efforts to reauthorize SCHIP this year.

Sincerely,

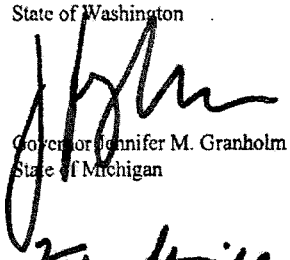
Governor Eliot Spitzer
State of New York

Governor Arnold Schwarzenegger
State of California

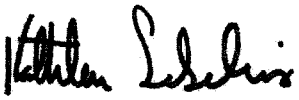


Governor Christine O. Gregoire
State of Washington

Governor Jon S. Corzine
State of New Jersey

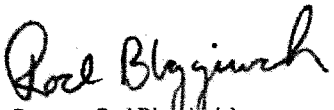


Governor Jennifer M. Granholm
State of Michigan

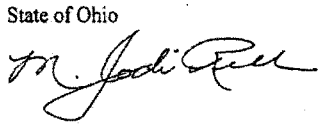


Governor Kathleen Sebelius
State of Kansas

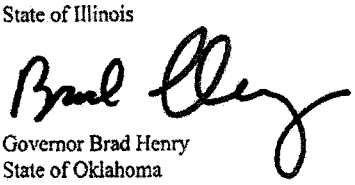
Governor Ted Strickland
State of Ohio



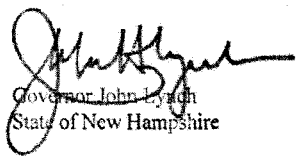
Governor Rod Blagojevich
State of Illinois



Governor M. Jodi Rell
State of Connecticut

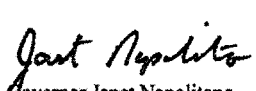


Governor Brad Henry
State of Oklahoma



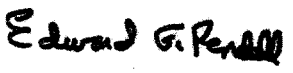
Governor John Lynch
State of New Hampshire

Governor Theodore R. Kulongoski
State of Oregon

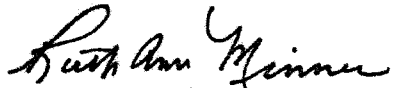


Governor Janet Napolitano
State of Arizona

Governor Bill Richardson
State of New Mexico



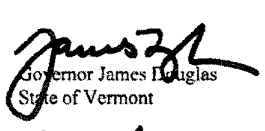
Governor Edward G. Rendell
Commonwealth of Pennsylvania



Governor Ruth Ann Minner
State of Delaware

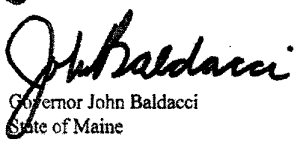
Governor Chester J. Culver
State of Iowa

Governor Kathleen Babineaux Blanco
State of Louisiana



Governor James Douglas
State of Vermont

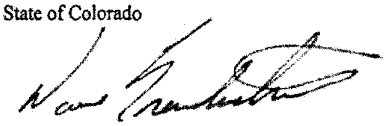
Governor Mike Beebe
State of Arkansas



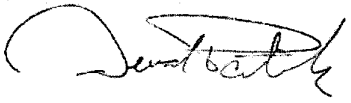
Governor John Baldacci
State of Maine

Governor Bill Ritter
State of Colorado

Governor M. Michael Rounds
State of South Dakota



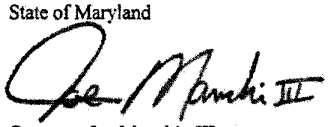
Governor Dave Freudenthal
State of Wyoming



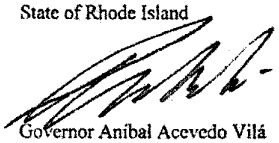
Governor Deval Patrick
Commonwealth of Massachusetts

Governor Martin O'Malley
State of Maryland

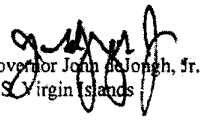
Governor Donald L. Carcieri
State of Rhode Island



Governor Joe Manchin III
State of West Virginia



Governor Aníbal Acevedo Vilá
Puerto Rico



Governor John deJongh, Jr.
U.S. Virgin Islands