

ONE HUNDRED THIRTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
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**Statement of Rep. Henry A. Waxman**  
**Ranking Member, Committee on Energy and Commerce**  
**Hearing on “The Extenders Policies: What Are They and How Should They Continue**  
**Under a Permanent SGR Repeal Landscape?”**  
**Subcommittee on Health**  
**January 9, 2014**

Thank you, Mr. Chairman.

This Congress seems to be, I hope, poised to eliminate the SGR and make it a program that will no longer be in existence so every year we don't have to go through the torture of trying to make sure that the harmful consequences of not extending it would be averted. All three committees, two in the House and one in the Senate, have voted – our Committee voted unanimously – on the SGR. I hope we can get it across the finish line and get this job done.

The SGR issue has often served as a vehicle to address Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and additional public health-related programs, which contain similar time-limits. These provisions have been collectively referred to as “extender” policies. When we permanently repeal and replace the Medicare SGR policy, we must also address these associated extender policies.

These policies seek to protect vulnerable patient populations and the providers and health programs that serve them. We cannot afford to leave them out in the cold and in jeopardy of being terminated.

In Medicare, we have policies that need to be extended relating to therapy caps and special needs plans. Those have been discussed; they are well known. There are six public health extenders, some which have a long history of bipartisan support. I am generally supportive of these public health programs, but I do want to note my reservations about extending the abstinence only program.

But I want to focus on the Medicaid and CHIP issues which are often overlooked. Those policies help secure affordable coverage, boost enrollment of eligible children, and streamline administrative processes for states. For example, the express lane program gives states the option of relying on income data already in use for other federal programs, helping reduce bureaucracy and lower state administrative costs. This should be a permanent option for the states.

The transitional medical assistance and qualified individual programs are indispensable for low income families. We must end the annual extender rollercoaster and ensure this coverage is secure going forward. The CHIP bonus payments have been successful at getting states to adopt simplifications and find ways to get kids enrolled. Twenty-three states, more than half of them with governors who are Republicans, have qualified under this program. We should continue it through the current CHIP reauthorization.

I have also heard a great deal from family doctors and pediatricians about the Medicaid primary care bonus. It is something that would provide stability and adequate payment for physicians comparable to what we do in Medicare. There is no better way to assure access and provide an alternative to the emergency room for care than making sure that doctors, especially family care and pediatricians, will have the extra payment to allow them to see these patients. I'm glad we're holding this hearing.