November 11, 2014

The Honorable John Boehner
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader
United States House of Representatives
Washington, DC 20515

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

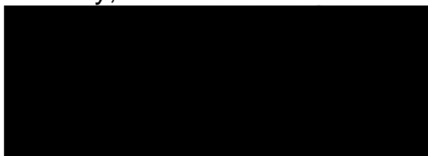
Dear Leaders of the House and Senate:

On behalf of the members of the Healthcare Leadership Council (HLC) – a coalition of chief executives from all disciplines of American healthcare – I am writing to urge you to consider and pass during the upcoming lame duck session of Congress a two-year reauthorization of the Children's Health Insurance Program (CHIP).

With many states not expanding Medicaid as originally envisioned under the Affordable Care Act (ACA), the Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended a two year extension of the CHIP program when it expires at the end of FY 2015. HLC supports MACPAC's recommendation of a two-year extension so that children with coverage are not displaced during this transition period. We would encourage Congress to establish a set schedule for analysis of coverage options, and of federal and state legal and regulatory barriers that may preclude a smooth transition for children and families to available coverage options at the conclusion of the CHIP extension.

Congress has an opportunity to act during the lame duck session of Congress to ensure that funding continues past FY 2015 and individuals with CHIP coverage do not become uninsured. We urge you to work together to pass two-year funding which would allow time to make policy changes to the ACA to better serve children. Please let us know if you have questions or need additional information.

Sincerely,



M
President

cc: Fred Upton, Chairman House Energy and Commerce Committee
Henry Waxman, Ranking Member House Energy and Commerce Committee
Ron Wyden, Chairman Senate Finance Committee
Orrin Hatch, Ranking Member Senate Finance Committee

C.L. "BUTCH" OTTER
GOVERNOR

November 10, 2014

Congressman Fred Upton
House Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Upton,

Thank you for your recent letter about the Children's Health Insurance Program (CHIP). Idaho has partnered with the Centers for Medicare and Medicaid Services (CMS) since 1997 to provide healthcare coverage for eligible Idaho children.

I am aware that the existing funding authority under CHIPRA for the CHIP Program is ending, and I appreciate your inquiry seeking specifics about our program here in Idaho. My responses are below.

(1) How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

*(a) Idaho had 25,518 children enrolled in our SCHIP program as of the end of FFY13.*
*(b) Idaho's CHIP income cap is 185 percent (plus 5-percent disregard) of the federal poverty guidelines. CHIP enrollees are primarily Caucasian, tend to live in the largest urban areas of Idaho and are of good health status.*

(2) What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

*(a) In accordance with the PPACA, Idaho changed our income and eligibility methodology to use the Modified Adjusted Gross Income (MAGI) basis and moved children to our Title XIX program, effective January 1, 2014.*

(b) *Idaho's administration of CHIP was impacted by the changes indicated above which required extensive modifications to our automated eligibility and claims systems. Idaho expects to exhaust all of our CHIP allotment this year.*

(3) To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

*Children enrolled in Idaho's CHIP program have the same benefits as children enrolled under the Idaho Medicaid State plan. Idaho's CHIP program provides some benefits typically not provided through exchange or Employer Sponsored Insurance (ESI) plans such as: disposable medical supplies, hospice, case management for children with special health care needs, dental care, Early Periodic Screening Diagnosis & Treatment services (EPSDT) and enabling services such as translation and medical transportation.*

*Idaho's CHIP children are subject to $3.65 copays for some, but not all services, which is about 60 percent less than co-pays provided through gold plans on our exchange or through ESI plans. Premiums for CHIP children are $15 or less per month. This also is significantly less expensive than exchange or ESI plans. CHIP children are not subject to deductibles, out of pocket maximums or lifetime benefit limitations, which are integral parts of exchange and employer sponsored plans.*

(4) Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what time frame should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

*Yes, I do recommend that CHIP funding be extended. Extending the funding through 2019 as a transition period would allow for key issues regarding the affordability and adequacy of children's coverage on the exchange to be addressed. Provisions in the current law that make it difficult for families to affordably maintain a single source of coverage should be addressed. We do not have a good estimate of the number that would become uninsured at this time.*

(5) In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

(a) *Yes, the annual allotment Idaho has been receiving in recent years has been sufficient to meet our needs.*

*(b) Yes. Adjusting to allow greater flexibility for states would be a positive measure to allow states to improve management and planning for their CHIP programs.*

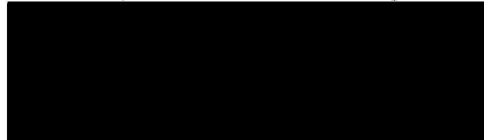
(6) Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been critical components of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

*Yes, there are federal policy changes that could assist Idaho families in providing health coverage for their families.*

- *Make CHIP look like an insurance plan (rather than an entitlement plan) by removing entitlement assurances like EPSDT and non-emergency medical transportation*
- *Allow parents to have the option of choosing between premium subsidies on the exchange or subsidies for ESI coverage. These changes would allow families to choose a family plan through the marketplace or ESI and would improve continuity of care for the entire family and would avoid placing family members on separate health plans with separate provider networks and/or cost sharing requirements. Traditional insurance plans can do a better job managing premium/co-pay requirements.*

Thank you for the opportunity to share the specific details of Idaho's CHIP program. If you need any additional information regarding our program, please contact my CHIP Director, Matt Wimmer, via phone at

As Always – Idaho, "Esto Perpetua"



CLO/tp

C. L. "Butch" Otter
Governor of Idaho

cc: Congressman Henry Waxman

STATE OF ILLINOIS
**OFFICE OF THE GOVERNOR**
SPRINGFIELD, ILLINOIS 62706

**Pat Quinn**
**GOVERNOR**

October 24, 2014

The Honorable Fred Upton
House Committee on Energy and Commerce

The Honorable Henry A. Waxman
House Committee on Energy and Commerce

The Honorable Ron Wyden
Senate Finance Committee

The Honorable Orrin G. Hatch
Senate Finance Committee

Re: Children's Health Insurance Program (CHIP)

Dear Honorable Members of Congress:

Thank you for offering this opportunity to express Illinois' strong support for the continuation of the federal Children's Health Insurance Program.

CHIP has played a key role in Illinois' efforts to provide health coverage to hundreds of thousands of children and pregnant women since the inception of our first expansion of coverage in 1998. Not only has CHIP enabled Illinois to expand coverage to children in families with income above our Medicaid income level, the outreach activities and streamlined application processes resulting from CHIP have had important spillover effects by facilitating enrollment of eligible children in Medicaid.

The close integration of CHIP funded coverage with Medicaid coverage has allowed Illinois to provide a safety net of health coverage to uninsured Illinois children for more than 15 years. Illinois was one of the first states to cover a broad demographic of uninsured children including non-citizen children and children in families at higher income levels. As a result of our approach, over the past five years Illinois has received over $60 million in bonus payments under the Children's Health Insurance Program Reauthorization Act of 2009. We understand we are one of only nine states to receive bonus payments for five consecutive years.

As a result of changes required by the Affordable Care Act and with CHIP and Medicaid support, Illinois now covers children with family income up to 318 percent of the federal poverty level guidelines.

Responses to your specific questions follow.

1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, demographics)?*

CHIP funding contributes to Illinois' coverage of approximately 219,000 children and pregnant women as of June 30, 2014.

Illinois uses the CHIP "unborn" group to cover pregnant women who are not eligible to enroll in Medicaid and their children for the first few months of the children's lives. The unborn group included a total of about 38,000 individuals on June 30, 2014: 12,000 pregnant women and 26,000 infants. All of these individuals live in families with income no greater than 213 percent of the Federal Poverty Level (FPL) guideline. They have no cost-sharing obligations for services.

Of the 181,000 children not in the unborn group, about 50 percent have family income falling into the lowest CHIP funded plan which is our Medicaid expansion. They have no cost sharing for services. Of the remaining 91,000 children, about 14 percent pay modest co-payments for most services not including well-child care and about 36 percent pay small monthly premiums in addition to co-payments for services.

Of the 207,000 CHIP-funded children enrolled in Illinois on June 30, 2014 (including the 26,000 infants mentioned above), 25 percent are age 5 or younger, 41 percent are ages 6 through 12 and 34 percent are ages 13 through 18.

The majority of enrollees, 73 percent, live in Cook County and the five counties neighboring Cook. About 10 percent live in the northwestern region of the state and about 17 percent live in central and southern Illinois.

Of those who reported their race, 48 percent self-identified as White of whom 26 percent reported Hispanic/Latino ethnicity; 10 percent self-identified as Black or African American of whom 2 percent reported Hispanic/Latino ethnicity; 5 percent self-identified as Asian of whom 2 percent reported Hispanic/Latino ethnicity; fewer than 1 percent self-identified as Hawaiian/Other Pacific Islander of whom 26 percent reported Hispanic/Latino ethnicity; fewer than 1 percent self-identified as American Indian/Alaska Native of whom 46 percent reported Hispanic/Latino ethnicity; and 1 percent self-identified as multiracial of whom 14 percent reported Hispanic/Latino ethnicity. Of the 35 percent of enrollees who did not answer the race question, 72 percent reported Hispanic/Latino ethnicity. Of the total population, 12 percent reported Hispanic/Latino Ethnicity. Eighteen percent of the population failed to report any race or ethnicity.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

While technically Illinois has implemented CHIP through a combination Medicaid expansion and separate CHIP program, the "separate" program is highly integrated with Medicaid and has been since its implementation in Illinois in 1998. Largely for that reason, Illinois had to make

few changes in the administration of CHIP as a result of enactment of the ACA. The most significant change required was the adoption of the Modified Adjusted Gross Income or "MAGI" methodology for determining eligibility. This required converting our CHIP income standards to eliminate the state specific income disregards that we had previously employed.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.*

Illinois' separate CHIP coverage is administered under the umbrella of All Kids, our array of plans for children. For CHIP eligible children, All Kids offers more robust benefits than those available through the Health Insurance Marketplace and All Kids' cost sharing requirements are more affordable.

The fundamental difference between services covered under All Kids and services covered by the benchmark plan for qualified health plans available through the Marketplace in Illinois is the availability of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits. Illinois has always offered our CHIP eligible children the same EPSDT services required for Medicaid eligible children. EPSDT coverage includes all screening, prevention and medically necessary diagnostic and treatment services falling within the federal definition of Medicaid. EPSDT benefits include dental, vision and hearing services. No similarly broad coverage is found within the Marketplace benchmark plan, nor are we are aware of any comparable coverage offered by employer-sponsored plans in Illinois.

Premium and cost sharing limits in Illinois' All Kids are much lower than what is allowed in the Marketplace plans at equivalent income levels. We believe the same holds for children enrolled in employer-sponsored plans. For children in All Kids whose services are funded with CHIP dollars, monthly premiums range from $0-40 per child with a maximum of $80 per month for two or more children, and cost sharing for office visits ranges from $3.90 - $15 per visit. Appropriate emergency room visits require no co-payment. On the Marketplace in 2014, the lowest cost bronze plan in Chicago for one child has a monthly premium of $76 per month and a $6,000 deductible. The lowest cost silver plan has a monthly premium of $105 per month, a $6,000 deductible, and a $30 co-pay for a primary care doctor, $50 co-pay for a specialist, and $500 co-pay for an emergency room visit. Similarly, in Peoria, the lowest cost bronze plan for one child has a monthly premium of $81 per month with a $6,300 deductible. The lowest-cost silver plan has a premium of $108 per month with a $3,750 deductible and a $10 co-pay for a primary care doctor, $75 co-pay for a specialist, and $500 co-pay for an emergency room visit.

Financial help is available on the Marketplace through premium tax credits and cost-sharing reductions, but All Kids is less expensive. For example, All Kids covers children in families with income up to 318 percent of the federal poverty level guidelines in Illinois. On the Marketplace at 300 percent FPL, families are expected to contribute 9.5 percent of their household income toward the benchmark plan's premium and no cost-sharing reductions are available. Even at 200 percent FPL on the Marketplace, the household is expected to contribute 6.3 percent of their household income toward the benchmark plan and, with cost-sharing reductions, a consumer has to cover 27 percent of the cost of benefits, on average.

Additionally, on the Marketplace, financial help is only available to consumers without alternative minimum essential coverage (MEC). Under IRS regulations, if an employee receives an affordable offer of coverage from their employer and even if the dependent coverage offered by the employer is unaffordable, all dependents are considered to have MEC. While CMS regulations provide dependents in this situation with an exemption from the individual responsibility penalty, the children still need health insurance. Without CHIP financing to support All Kids, households who face this "family glitch" are unlikely to have an affordable coverage option for their children.

Two recent articles appearing in *Health Affairs* that document the hit to children's coverage that would be experienced from ending CHIP support our analysis. Abdus[1] et al. used a carefully developed simulation model to estimate the impact on children's coverage of these kinds of changes (i.e. from CHIP to Marketplace) and found it would materially reduce coverage. McMorrow[2] et al. suggested that more than 50 percent of children currently on CHIP would not be eligible for the Marketplace because of parental access to other MEC. If insurance were purchased from this other source, it would materially increase premiums and other costs, resulting in the loss of coverage estimated by Abdus et al.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

We strongly recommend extending CHIP funding for five years. Because of the significantly lower amount of subsidy for Marketplace plans and the lack of any public subsidy for employer-sponsored plans, we believe a significant number of families would choose to forgo health coverage for their children should CHIP funded All Kids coverage be eliminated.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

The allotments have been sufficient for Illinois since 2009. At this time, we do not see a need to adjust the process for reallocating unspent funds. However, we strongly encourage the Congress to preserve the 23 percent increase in CHIP federal financial participation (FFP) scheduled for 2016 and also assure that state allotments are adequate to permit us to take full advantage of the increase in FFP.

6. *Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you*

[1] Abdus, S. et al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially among Lower-income Children," Health Affairs, (Vol 33, Num 8; August, 2014), pp. 1353-1360.

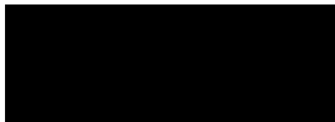
[2] McMorrow, S. et al., "Trade-Offs Between Public and Private Coverage for Low-Income Children Have Implications for Future Policy Debates," op. cit., pp. 1367-1374.

*believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?*

Illinois strongly recommends allowing states to use CHIP funds to cover undocumented children through age 18. Regardless of how they came to live in the United States, an investment in children is an investment in the future. For this reason, we work to promote the health of all children residing in Illinois and request federal funding to support this goal.

In closing, I must stress that preserving the support CHIP provides to states is critical to assuring we do not lose ground in our quest to give all of our children the health care they need to thrive.

Sincerely,



Pat Quinn, Governor of Illinois

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Robert Moser, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

Dear Chairmen and Ranking Members:

Thank you for your inquiry regarding the Children's Health Insurance Program (CHIP). I agree that it is crucial that Members of Congress seek insight and analysis on federal/state partnerships such as CHIP. I have considered each of your questions and provided the pertinent information and recommendations. I have included each of the questions from your initial correspondence for reference.

1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?*

   Concerning enrollment, 56,705 children were covered by CHIP as of June, 2014.
   Age groupings are less than 1% under age 1; 18.5% for ages 1-5; 47.4% for ages between 6 and 12; and 33.4% for teenagers.

   Concerning demographics, 67.3 % reside in an urban setting, 28.4% reside in a rural county and 4.3% live in a frontier community. 51.3% were male and 48.7% were females

   Concerning income characteristics, 53.3% belong to households with incomes less than 150% FPL, 34.3% belong to households with incomes between 150 and 200% FPL and 12.4% belong to households with incomes over 200% FPL

   Looking at Health Status information, claims/type of services rendered during FY 2013 and 2014, most services are associated with normal childhood illnesses (ear infections, flu, eye problems, other infections and childhood injuries). The large number of mental health services is also worth noting. Children meeting disability criteria are generally covered under Medicaid categories and are not covered by the CHIP program.

2. *What changes has your state made to its CHIP program as a result of the ACA? How has implementation of the ACA impacted the way your state administers CHIP?*

   Kansas has always operated an integrated Medicaid/CHIP program, so changes to CHIP have not been significant.

   Kansas has implemented:
   a. The new MAGI methodologies requiring the use of new household and income requirements
   b. The new 'm-chip' group (moving a group of children from CHIP into Medicaid) is mandated by the ACA.

c. The new Premium payment enforcement timeline- under previous policy, families who were delinquent on premium payments were not eligible until they became current on payments. We are now applying 3 months maximum non-payment penalty as mandated by the ACA and/or associated regulations.

d. Changes in the crowd-out. Crowd out occurs when someone voluntarily drops health insurance in order to be eligible for CHIP. Previously, Kansas had an 8 month waiting period from the date of voluntarily dropping coverage. As required by ACA, Kansas changed the look-back timeframe from 8 months to 3 months.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services and/or benefits and/or cost sharing that is currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer-sponsored health plans in your state.*

That information is as follows:

a. Cost sharing: The only cost sharing for CHIP in Kansas are premiums (see chart below) for some higher income families. There are no deductibles or co-pays. Here are the levels of premium obligations:

| FPL Percentage | Premium Amount |
|---|---|
| 167 – 191% | $20 |
| 192 – 218% | $30 |
| 219 – 242% | $50 |

b. Benefits: As indicated under Question 2, Kansas operates an integrated Medicaid/CHIP program. The benefit coverage is the same between programs including the Early Periodic Screening Diagnosis and Treatment provision. No commercial insurance has a benefit coverage as rich as the Medicaid/CHIP coverage.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon any extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

Yes, a 5 year extension to CHIP funding should be considered for budgeting and planning purposes. In the absence of CHIP, the only other options would be employer-sponsored coverage or coverage through the Exchange. Either option would have a less rich benefit package and higher cost sharing. It can be assumed that most of the non-premium paying children may become uninsured if CHIP is not extended.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting*

*in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

The annual allotment for Kansas has been sufficient. Additionally, the State of Kansas has not lapsed on any CHIP funding allotments.

6. *Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component to that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?*

   Give States more flexibility in program design allowing the States to design program models specific to their population mix and budget constraints.

   Relax Waiver red tape and encourage agility and flexibility in program development.

   Enact federal policy addressing beneficiary overpayments that include the ability to establish penalty periods for individuals who haven't accurately reported information.

   Allow options for repayment of overpayment, including the ability for states to utilize federal debt set-off for repayment of medical assistance claims attributed to beneficiary overpayments.

I appreciate the opportunity to answer your questions and provide these recommendations on improving CHIP. If you need additional information or have further questions, please contact me at [redacted]

Sincerely,

[redacted]

Susan Mosier, MD, MBA, FACS
Division Director and Medicaid Director
Division of Health Care Finance
Kansas Department of Health and Environment

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

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October 20, 2014

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Upton, Chairman Wyden, Ranking Member Waxman, and Ranking Member Hatch:

I am writing in response to your letter of July 29, 2014, seeking state input on the Children's Health Insurance Program (CHIP).

I am incredibly proud of the work we have done to provide access to affordable health insurance through kynect, the state's health insurance exchange, and the national attention we have received for so dramatically reducing our uninsured rate. However, before we began these efforts through kynect, I worked to greatly lower our rate of uninsured children. I strongly believe that it is shameful and shortsighted to deny children with the health care they need and deserve.

In 2008, I launched a plan through the Kentucky Children's Health Insurance Program (KCHIP) to dramatically cut the number of children without health coverage by removing barriers to enrollment, retaining more children once they are enrolled and significantly increasing education and outreach. The steps we took to get more eligible children enrolled in KCHIP were fiscally responsible, economically smart, and an unqualified success. Since the launch of our efforts, the number of Medicaid-covered children has increased by 97,251, a 22 percent increase, which includes an increase of 10,563 children in KCHIP. In addition, we eliminated a six-month waiting period to enroll in KCHIP that had been required for children whose private insurance was dropped voluntarily and whose family income was between 150 percent and 200 percent of the federal poverty level. Finally, earlier this year, we removed the five-year ban for lawfully present residents under the age of 18 to enroll in KCHIP.

KCHIP has been essential to ensuring that quality health coverage for Kentucky's children is affordable and accessible. As you know, children with health coverage have improved health outcomes throughout their childhood and are more likely to receive preventive care, treatment when they are ill and for recurring illnesses; get sick less frequently; have better attendance and performance at school; and have parents with better attendance and performance at work. Quite simply, KCHIP is a vital piece of the health care landscape for Kentucky's children and I urge its immediate reauthorization.

Below are answers to your specific questions:

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?**

Currently, 21,159 children are enrolled in the Medicaid Expansion portion of CHIP and 25,988 children are enrolled in the separate portion program.

As a result of the new MAGI income calculation methodology, children may be enrolled in KCHIP if household MAGI is at or below 159% of the federal poverty level (FPL), and they may enroll in the separate portion program at income levels up to 218% FPL. The previous thresholds were 150% and 200% respectively.

Children receiving disability benefits are not generally enrolled in KCHIP, but are eligible through programs for the disabled, though there may be some children with disabilities who do not qualify for disability payments that are enrolled in the program. Generally, both KCHIP and the separate portion program are comprised of children without disabilities.

The demographics of the combined group are below. These children are 51.08% male and 48.92% female (table 1). More than 97% of the children identify as non-Hispanic (table 2). Almost 60% do not list a standard federal racial category at the time of application, while 35% identify as white and 4.6% identify as black (Table 3). The enrollment by age group is shown in table 4.

**Table 1. KCHIP Enrollment by Gender**

| Gender | Percent |
|---|---|
| F | 48.92% |
| M | 51.08% |

**Table 2. KCHIP Enrollment by Ethnicity**

| Ethnicity | Percent |
|---|---|
| Hispanic | 2.23% |
| Non-Hispanic | 97.73% |
| Not Listed | 0.04% |

**Table 3. KCHIP Enrollment by Race**

| Race | Percent |
| --- | --- |
| E - Other Race or Ethnicity | 59.45% |
| O - White | 35.10% |
| B - Black | 4.62% |
| A - Asian or Pacific Islander | 0.50% |
| 7 - Not Provided | 0.04% |
| I - American Indian or Alaskan Native | 0.18% |
| J - Native Hawaiian | 0.11% |

**Table 4. KCHIP Enrollment by Age Group**

| Age Group | Percent |
| --- | --- |
| 0 – 5 | 20.95% |
| 6 – 12 | 43.54% |
| 13 – 18 | 35.51% |

2. **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?**

   As I mentioned above, Kentucky lifted the five-year waiting period for lawfully residing immigrant children. We have also added a substance use treatment benefit as a Medicaid covered service and amended cost-sharing requirements for children. Kentucky utilizes the existing Medicaid infrastructure to administer KCHIP; therefore, implementation of PPACA had a minimal impact on KCHIP, outside of the small impact of the MAGI calculation methodology on income thresholds.

3. **To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost-sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.**

   Kynect adopted the KCHIP vision and dental benefit package, which makes the two benefit packages more comparable. However, cost sharing in KCHIP is limited. Kentucky does not have a monthly premium or enrollment fee for KCHIP, while the monthly premiums, co-payments, deductibles, and cost-sharing in kynect are higher for families with children, depending on the income of the family.

4. **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

   CHIP funding must be extended until all Kentucky families' income no longer necessitates the need for this assistance. It is short-sighted to deny children health care coverage – sick children cannot be successful students; sick children cannot thrive in our workforce; and sick children will not lead the happy, productive lives that they deserve. I cannot urge strongly enough for you to continue funding for CHIP.

   If a decision is made NOT to fund CHIP after FY2015, as many as 50,000 Kentucky children will lose health care coverage.

5. **In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

   The restructuring and retargeting of allotments in 2009 have been adequate and sufficient for Kentucky; so far, Kentucky fully expends its annual CHIP allocation. Congress could easily address the issue of unspent allotments by reducing a state's next scheduled allotment by the unspent amount. The state would retain the unspent allotment from the previous period along with the modified new allocation, which would ensure the state retains the allotment necessary to maintain its CHIP program for the new period.

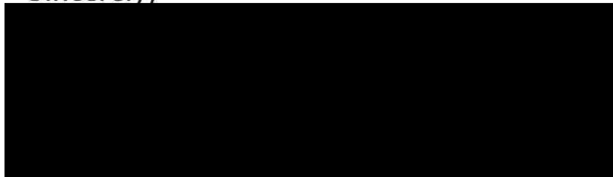
6. **Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?**

   KCHIP and PPACA have been instrumental in reducing the number of uninsured in Kentucky. As mentioned in the answer to question 4, CHIP serves as a vital transition point for children who may eventually move to a qualified health plan through kynect. Therefore, Kentucky recommends that the federal government fix the "family glitch" that exists in PPACA today. Since the affordability test for individuals who have access to other insurance is based on the cost of a single plan and not the cost of a family plan, the only options currently available to families who

cannot afford the cost of a family plan through their employer are either enrolling in CHIP or not insuring their entire family. This unfortunate glitch must be addressed.

I greatly appreciate the opportunity to provide my perspective on this critical program. Continued funding of this program is the right thing to do and Congress should view it as a moral obligation.

Sincerely,



Steven L. Beshear

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

September 4. 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Fred Upton
Chairman
House Energy and Commerce Committee
2125 Rayburn House Office Bldg.
Washington, DC 20515

The Honorable Henry A. Waxman
Ranking Member
House Energy and Commerce Committee
2322A Rayburn House Office Bldg.
Washington, DC 20515

Dear Chairman Wyden, Senator Hatch, Chairman Upton and Congressman Waxman:

Thank you for your letter to Governor O'Malley regarding funding for the Children's Health Insurance Program (CHIP) and to inquire about program data and policy changes as the program moves forward. The Governor received your letter and asked me to respond on his behalf.

Maryland operates a Medicaid expansion CHIP program called the Maryland Children's Health Program (MCHP). MCHP provides full health benefits for children up to age 19 who have household incomes below 300 percent of the federal poverty level (FPL) ($71,550 for a family of four); families between 200 percent and 300 percent FPL are required to pay a monthly premium. Benefits are obtained through the managed care organizations that participate in HealthChoice, Maryland's Medicaid managed care program. Benefits include, but are not limited to: doctor visits (well and sick care); hospitalization; lab work and tests; dental care; vision exams and corrective lenses; hearing exams and hearing aids; immunizations; prescription drugs; transportation to medical appointments; mental health services; inpatient and outpatient behavioral health services; physical and occupational therapy; services for speech, hearing and language disorders; and durable medical equipment.

Congress has not authorized funds for the CHIP program beyond Federal Fiscal Year (FFY) 2015. We strongly urge Congress to reauthorize the program and to make changes to the allotment formula to account for the enhanced FMAP slated to begin October 1, 2015. The Patient Protection and Affordable Care Act (PPACA) includes a provision for a 23 percentage point increase in Maryland's CHIP Federal Medical Assistance Percentage (FMAP) match rate effective October 1, 2015 (FFY 2016), which will enhance Maryland's FMAP from 65 percent to 88 percent. As a result, any funds carried over from the FFY 2015 authorization will be exhausted more quickly than in previous fiscal years. Without additional CHIP funding, once FFY 2015 funds are depleted, MCHP expenses will be subject to the regular Medicaid FMAP of 50 percent. With enrollment in MCHP and MCHP Premium likely to continue to increase due to PPACCA, this State fiscal impact has the potential to be even more significant.

Below are answers to the specific questions you posed in your letter:

1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?*

As of July 2014, 97,158 children are enrolled in MCHP. A total of 18,262 children in MCHP are enrolled in MCHP Premium.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

PPACA has had a modest impact on the way Maryland administers MCHP. MCHP eligibility determinations are now based on the applicant's modified adjusted gross income (MAGI), rather than the income disregard and asset rules used in the past. Maryland has not seen a decrease in enrollment due to this new eligibility determination method. PPACA has also opened up new avenues for Maryland families to apply for MCHP. Families can now apply for coverage by completing an application using Maryland's Marketplace, the Maryland Health Connection, by contacting the Maryland Health Connection Consumer Support Center, or by visiting a Connector Entity. Individuals also continue to be able to apply at Local Health Departments, Local Departments of Social Services, online using the Maryland SAIL application, and by mail.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services and/or benefits and/or cost-sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer-sponsored health plans in your state.*

Individuals enrolled in MCHP are exempt from cost-sharing requirements for all services and prescription costs. MCHP recipients also receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children enrolled in the program. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

Maryland strongly recommends that CHIP funding be extended. The State anticipates additional funding will be required in FFY 2016. However, for budgeting and planning purposes, an extension would ideally be granted prior to the commencement of the State Fiscal Year 2016 on July 1, 2015.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

Through FFY 2013, Maryland has been sufficiently funded for its CHIP expenditures, through a combination of "rollover" unused allotment from its prior Federal Fiscal Years(s) and the fresh allotments for each of its "current" Federal Fiscal Year(s). From most recent FFY 2014 actuals and projections, we expect to have ample allotment funding through FFY 2014, and we are reasonably comfortable with FFY 2015 projections.

However, we are keeping a close watch on recent increased expenditure trends due to CHIP enrollment growth (at least in part due to the impact of PPACA), and increased participation in CHIP administrative match due to additional claims from Maryland agencies that perform CHIP-related eligibility and other administrative functions: the Maryland Department of Human Resources (DHR), the Maryland Health Benefit Exchange (MHBE), and the University of Maryland School of Pharmacy Poison Control Center. This, in conjunction with the provision for a 23 percentage point increase in Maryland's CHIP FMAP match rate effective October 1, 2015 (FFY 2016), leaves us with a concern for how expanded allotment needs will be addressed in FFY 2016 and beyond. Maryland anticipates that the higher CHIP FMAP will result in available federal funding being depleted more quickly than in previous FFYs.

6. *Over the years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?*

- In FFY 2009 under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Congress appropriated funding for annual CHIP performance bonuses for states that were able to (1) increase child enrollment in Medicaid (not CHIP) by a certain amount and (2) implement at least five out of eight specific outreach and retention strategies that make it less difficult to enroll and retain eligible children in Medicaid and CHIP. Maryland was able to meet these requirements and to date, has received nearly $86.5 million in bonus payments. This federal payment is needed to help states maintain the increased enrollment levels that were achieved by meeting the standards that Congress established. Congress should continue to make these bonus payments available to states as part of any CHIP funding renewal legislation.

- Under CHIPRA, states are authorized to use eligibility information from other programs to streamline and simplify enrollment and renewals in Medicaid and CHIP. This process is known as Express Lane Eligibility. Express Lane Eligibility permits states to rely on findings, for things like income and household size, from certain designated programs. This enables states to avoid duplicative enrollment efforts and lowers administrative costs as a result. Congress should renew the Express Lane Eligibility provision.

- In FFY 2016, the FMAP for CHIP will increase by 23 percentage points, so that Maryland's FMAP will increase from 65 percent to 88 percent. The practical effect of this increase is that Maryland will exhaust its federal allotment for MCHP more quickly. Congress should maintain the enhanced FMAP increase and adjust the allotment formula accordingly so that state CHIP programs have a stable, predictable funding source.

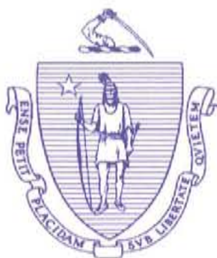
- Under current law, children enrolled in Medicaid-expansion CHIP programs (like Maryland's) are enrolled in Medicaid but funded by CHIP. The PPACA includes a maintenance of effort (MOE) requirement that states maintain their Medicaid and CHIP eligibility levels for children until September 30, 2019. When a state's CHIP funding is exhausted, these children will continue to be enrolled in Medicaid but will be funded at the state's regular Medicaid match rate instead of CHIP's enhanced FMAP levels, which will require significantly higher levels of state funding.

Thank you again for your inquiry. We look forward to working with our partners at the federal level to maintain this valuable resource for care that so many of Maryland's children have come to rely on. If you have questions or need more information on Maryland's CHIP program, please do not hesitate to contact Tricia Roddy, Director of Planning, Office of Health Care Financing, at

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

cc: The Honorable Martin O'Malley
Tricia Roddy

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**DEVAL L. PATRICK**
GOVERNOR

October 30, 2014

The Honorable Ron Wyden
Chairman, Senate Finance Committee

The Honorable Orrin G. Hatch
Ranking Member, Senate Finance Committee

The Honorable Fred Upton
Chairman, House Energy and Commerce Committee

The Honorable Henry A. Waxman
Ranking Member, House Energy and Commerce Committee

Dear Senator Wyden, Senator Hatch, Representative Upton and Representative Waxman:

I am pleased to provide response to your letter of July 29, 2014, regarding the operation of the Children's Health Insurance Program (CHIP) in Massachusetts.

Massachusetts has achieved near-universal coverage thanks in part to programs such as CHIP. Providing coverage reflects our values as a Commonwealth and helps keep families strong and children healthy. Massachusetts is a strong supporter of CHIP and below you will find responses to the specific questions in your July 29, 2014 letter.

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1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?*

   As of June 2014, there were 117,000 children enrolled in our CHIP program, including over 1,200 children with disabilities. Just over 95,000 have family income that is less than or equal to 200% of the Federal Poverty level. Of the children for whom we have race information, less than 1% are American Indian/Alaska Native, 2% are interracial, 9% are Asian/Pacific Islander, 14% are Black/Non-Hispanic, 25% are Hispanic and 50% are White.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHP?*

   Massachusetts has updated our CHIP policies to align with PPACA, including the use of Modified Adjusted Gross Income to determine eligibility and altered the residency and citizenship/non-citizen rules related to eligibility. We also updated the rules for children with unpaid premiums to allow the children to re-enroll in CHIP after a 90 day waiting period, even if the premiums remain unpaid.

   The Commonwealth has also extended the hospital presumptive eligibility available under PPACA to individuals eligible under the CHIP unborn child option.

   While this was not required under PPACA, Massachusetts eliminated the six month waiting period that was in place for CHIP children with income 200% to 300% FPL who were ineligible due to having dropped group health insurance coverage.

   Along with the other coverage and eligibility changes made under PPACA, Massachusetts replaced Healthy Start, our CHIP unborn child option program, which provided only pregnancy related services to pregnant women who were ineligible for the Medicaid (MassHealth) Standard program. These women are now provided with full MassHealth Standard benefits under CHIP.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services or benefits and/or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored plans in your state.*

   Massachusetts charges premiums to CHIP children on a sliding scale (ranging from $12 to $28 per child per month) and caps family premiums at $84 per month, with the result that CHIP premiums are much lower than those charged by private plans. CHIP children are also exempted from paying premiums if they have a parent enrolled in a Qualified Health Plan and receiving tax credits. There is no cost sharing for any services for CHIP children with direct coverage where private plans typically have deductibles and charge copays for most services.

   Also, our CHIP plan allows us to provide premium assistance to enable families to enroll their children in available employer-sponsored insurance that they would not otherwise be able to afford. This is not an option available to families in the exchange. Further, combined premiums and cost-sharing in our CHIP premium assistance program cannot exceed 5% of family income making this CHIP program too, like CHIP direct coverage, far more affordable than coverage through an exchange or unsubsidized employer coverage.

   In addition, there are some benefits available to children in our CHIP program that are generally not available through private plans, including those offered through the exchange or employer sponsored plans. The scope of benefits in our CHIP program was designed specifically to meet the needs of children. These benefits include eyeglasses, hearing instrument specialist services, diversionary behavioral health services, early intervention services, special education evaluation services, and child-specific screening and diagnostic services. Some of these services are of course available in private plans, but many may not be, particularly in the employer plans that are not subject to our state insurance laws. Our CHIP program also provides full dental benefits for children and while these benefits

may be purchased through the exchange as separate plans, a family purchasing dental benefits and medical benefits receives no higher tax credit than a family purchasing only medical benefits. Since dental coverage is not required to meet the individual mandate, it is likely some parents may forgo dental coverage for their children due to costs.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe that CHIP funded should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

   Massachusetts strongly supports the indefinite extension of CHIP funding as it is an integral part of ensuring that low income children have affordable, comprehensive insurance and provides federal financial support to states to help fund that coverage. While children in the Medicaid expansion portion of our CHIP program would be covered through Medicaid if CHIP funding is not extended, the state would no longer receive CHIP enhanced federal funding for their coverage.

   Given the differences in cost sharing between our CHIP program and private insurance plans, it is clear that children currently enrolled in our separate CHIP program would be negatively affected if CHIP funding is not extended. If their families are unable to afford the premiums and copays under private insurance, they may become uninsured. As noted above, they may also need benefits that are not generally provided by private insurance.

   In addition, many of these families may be impacted by the eligibility standards under the ACA for individuals who have an offer of private insurance through their employer. These standards only take into account the cost to purchase individual coverage through an employer, rather than the cost to purchase family coverage.

It is difficult to estimate the number of children who would become uninsured if CHIP funding is not extended but, given that over 27,000 of the children currently enrolled in our CHIP program have family income above Medicaid levels, but at or below 200% FPL, it is likely that a significant portion of that population would become uninsured if CHIP funding is not extended.

In addition, as you know, the ACA established Maintenance of Eligibility (MOE) requirements that prohibit states, until 2019, from imposing more restrictive eligibility and enrollment standards for children in Medicaid and CHIP. These mandates were effective as of March 23, 2010. We believe that this demonstrates strong legislative intent to continue CHIP program funding until at least 2019.

5. *In spite of the restructuring and reallocation of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received since 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

The annual CHIP allotments that we have received since 2009 have been sufficient.

6. *Over the past number of years, states have worked to reduce the number of uninsured children and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job of enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?*

Massachusetts has taken advantage of the Express Lane option in the 2009 CHIP Reauthorization bill and now uses Supplemental Nutrition Assistance Program (SNAP) information to automatically renew children with income up to 150% FPL. We recommend that any CHIP funding extension include additional administrative

simplification policies to help increase the number of eligible children in coverage.

Massachusetts also recommends that the Performance Bonus program included in the 2009 Reauthorization bill also be included in any funding extension. However, we recommend that the program be modified to allow bonuses to go to states with smaller percentages of growth but have the highest level of coverage for children as compared to when the 2009 baseline enrollments were calculated. The current program penalizes states, such as Massachusetts, that have traditionally had high levels of coverage and therefore cannot achieve the significant percentage gains in coverage necessary to qualify for a bonus.

The quality provisions included in the 2009 CHIP Reauthorization, including the establishment of a core set of children's health care quality measures and the CHIPRA Quality Demonstration grants have done much to advance the quality of care provided to children and we hope that any extension of CHIP funding would include a similar emphasis on quality of care. The quality funding in CHIPRA continues to improve the value of CHIP funded coverage and services. The investment has already advanced work on better quality measurement in pediatrics, spread of best practices in Patient Centered Medical Home service delivery, and the creation of a multi-stakeholder coalition to set improvement priorities and collaborative approaches to improvement in pediatric health care.

Finally, Massachusetts has found federal funding to support outreach to be extremely helpful as we try to find and enroll the remaining 1-2% of uninsured children in the state and hope that such funding will continue to be available in the future.

Thank you for your interest in the Commonwealth's CHIP program and for the opportunity for us to share our strong support for reauthorization of the CHIP program and for changes to improve and strengthen this valuable program. Please do not hesitate to contact me for any further information.

Sincerely,