OFFICE OF THE GOVERNOR

ROBERT BENTLEY
GOVERNOR

STATE CAPITOL
MONTGOMERY, ALABAMA 36130

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STATE OF ALABAMA

November 6, 2014

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

The Honorable Ron Wyden
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

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

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

Thank you for seeking governors' input on the Children's Health Insurance Program (CHIP). This important state-federal partnership provides access to vital health care services for many Alabama children, and I encourage Congress to act soon to extend CHIP for four years.

CHIP in Alabama

As of June 2014, Alabama had 86,218 people enrolled in CHIP: 57,872 were enrolled in ALL Kids (Alabama's separate CHIP) and 28,346 were enrolled in the Medicaid portion of CHIP. Among Alabama's CHIP enrollees, 58 percent are 12 or younger and 42 percent are 13 to 18 years of age. Also, 49 percent are white, 25 percent are black and 26 percent are Hispanic or have other racial or ethnic backgrounds. In addition, 33 percent of our enrollees are in families with incomes of 100 to 141 percent of the federal poverty level, 43 percent are in families with incomes of 142 to 200 percent of the poverty level and 24 percent are in families with incomes of 201 to 312 percent of the poverty level.

Changes to CHIP as a Result of the Patient Protection and Affordable Care Act (PPACA)

Alabama's CHIP, at the federal government's direction, moved about 23,000 children to Medicaid on January 1, 2014. Medicaid provides the children with health care, but the care is funded by CHIP. Also, Alabama has built a new eligibility system to meet requirements of PPACA. The system has a rules-based engine for determining eligibility for both Medicaid and CHIP based on modified adjusted gross incomes. The system also interacts with the federally facilitated Marketplace, the Internal Revenue Service and the Federal Data Hub. In addition, Alabama's CHIP erased a three-month waiting period to comply with PPACA.

Unique Benefits in Alabama's CHIP

Alabama's CHIP provides nutritional counseling and extra primary care office visits for obese children. Also, Alabama's CHIP generally has lower copays than other insurance plans.

CHIP Extension

Congress should extend CHIP funding for four years to provide health care for many of our children. I ask that Congress act soon. We have started budgeting for the 2016 fiscal year, and CHIP's funding uncertainty complicates that task. The uncertainty of CHIP funding is also stressful for parents trying to make sure their children have health insurance.

Alabama does not have precise estimates of the number of children who would be uninsured without CHIP, but the number likely would be large. Many CHIP enrollees could have access to health insurance through a parent's employer, but the coverage almost certainly would cost more and might be unaffordable. Also, family coverage for policies bought on the Marketplace likely would be out of reach for many CHIP families. People cannot qualify for tax credits to lower the cost of Marketplace policies if single coverage available through an employer would cost 9.5 percent or less of household income. The tax credits are unavailable even if family coverage through an employer would cost 20 percent or more of household income. Without CHIP, many of our children will be uninsured.

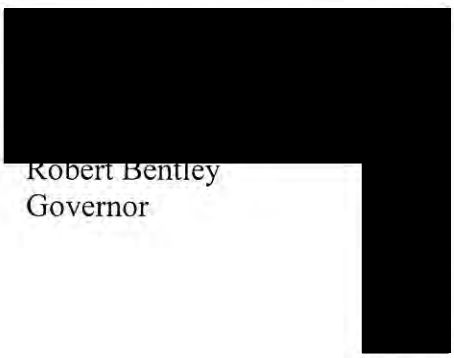
Unspent Allotments

Unspent federal allotments have not been a problem for Alabama. The funding formula, however, may need to be adjusted to ensure that Alabama and other states have adequate allotments to cover CHIP spending. Without carryover funds from 2010, funding provided to Alabama in the 2011 fiscal year would not have covered costs.

Uninsured Rate

Before CHIP, the uninsured rate for children in Alabama was 15 percent. In 2013, the uninsured rate for children in Alabama was 8.2 percent. That rate could fall even further if the Federal Medical Assistance Percentage for CHIP is raised by 23 percentage points as called for by PPACA starting in the 2016 fiscal year.

CHIP is successful. It was started to give kids access to health insurance. There is still a need for it. Through CHIP, Congress has provided routine care and life-saving care for our children. I ask you to extend CHIP funding for four years, and to do it soon. Thank you for giving me the chance to comment on this vital program. Please contact my office if we may assist you further.



Robert Bentley
Governor

THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health and Social Services
OFFICE OF THE COMMISSIONER

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October 23, 2014

The Honorable Fred Upton
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The Honorable Ron Wyden
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Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate
104 Hart Office Building
Washington, DC 20510

Dear Congressmen Upton and Waxman and Senators Wyden and Hatch,

In response to your letter to Governor Sean Parnell, dated July 29, 2014, regarding Children's Health Insurance Program (CHIP) funding and additional information that would be helpful as you work through the funding extension process, please find the following response to your 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)?

   - We had 10,725 children enrolled on the last day of the quarter ending September 30, 2013.
   - Our eligibility standards for the program are:
     - Ages 0 – 5: 160-203 percent of the federal poverty level
     - Ages 6 – 18: 125-203 percent of the federal poverty level
   - At the State level, the Medicaid Agency has demonstrated improvement in children's quality of care as shown through the 15 children's quality measures.

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?

    - There have been no substantive changes, with the exception of those due to modified adjusted gross income (MAGI) and the conversion to Survey of Income and Program Participation (SIPP) plus one percent standards required under the PPACA.
    - The MAGI SIPP conversion requirements are a direct impact of PPACA, as the law requires us to include income disregarded under prior law.

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.

    - The early periodic screening diagnosis and treatment (EPSDT) comprehensive child coverage is available to all children enrolled in Medicaid in Alaska. Therefore, the coverage available to the CHIP population is much more comprehensive than the coverage which is available in the Health Insurance Marketplace. Additionally, there is no cost sharing in Alaska's CHIP program. Some services that CHIP provides that private insurance may not are:
        - Inpatient and outpatient behavioral health services
        - Vision exams and corrective lenses
        - Hearing exams and hearing aids
        - Physical and occupational therapy
        - Services for speech, hearing, and language disorders
        - Durable Medical Equipment

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?

    - The State of Alaska recommends that CHIP funding be extended at least through September 30, 2019 to match the maintenance of eligibility requirements (MOE) under the PPACA.
    - Alaska is an M-CHIP state. We do not have a free-standing CHIP program, so the 10,725 enrolled children will have coverage through September 30, 2019.

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?

- Yes, the CHIPRA federal funding allotment formulas and methodologies have worked well for Alaska.
- States have two years to spend their allotments so the Fiscal Year 2015 allotment could go out through September 30, 2016. If Congress does not extend CHIP funding, the unspent allotments should be addressed.

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 the uninsured, and improve health outcomes for children in your state?

   - Yes, the federal government could assist in enrolling eligible children by continuing to support the express lane eligibility provision between child health and social/human service programs, and by working to standardize the basic eligibility requirements across all programs.
   - The quality improvement work under the CHIPRA children's quality demonstration grants has been very helpful to Alaska Medicaid/CHIP programs. We would recommend the continuation of the children's quality improvement work.

The State of Alaska supports the CHIP program, as it gives much needed coverage to approximately three million children nationwide. As stated earlier, the CHIP program in Alaska allows children to receive coverage for services that private health insurance and the Exchange may not cover.

If you need any additional information please feel free to contact me at [redacted] or by email at [redacted]

Sincerely,

[redacted]

William J. Streur
Commissioner
Alaska Department of Health and Social Services

STATE OF ARIZONA

JANICE K. BREWER
GOVERNOR

EXECUTIVE OFFICE

November 13, 2014

The Honorable Fred Upton
Chairman
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
House Committee on Energy & Commerce
2322A Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Upton:

This letter serves as Arizona's reply to your correspondence dated July 29, 2014 regarding the Children's Health Insurance Program (CHIP). KidsCare is Arizona's CHIP program.

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)?

   AZ Reply: KidsCare serves children in households between 133% of the federal poverty level (FPL) to 200% FPL. Parents have a monthly premium requirement that is assessed on a sliding scale based on income. In general, KidsCare members are healthier than the average Medicaid enrollee, with a per-member per-month cost of $206.

   As part of the Arizona's effort to address the fiscal challenges associated with the Great Recession, the State froze enrollment to KidsCare in January, 2010. To mitigate the impact of that enrollment freeze, Arizona had 1115 demonstration authority that allowed temporary KidsCare enrollment funded by political subdivisions. Under that demonstration, KidsCare enrollment reached 46,761 by the end of 2013 before federal authority expired. Subsequently, most enrolled children were transitioned to Medicaid, while 14,000 were transitioned to the Federally Facilitated Marketplace (Marketplace). Arizona does not have data on the Marketplace take up rate of those 14,000. The State agreed to provide data on the 14,000 to MACPAC (Medicaid and CHIP Payment and Access Commission) to match with Marketplace enrollment data, but the Marketplace declined MACPAC's request. Currently, there are 1,945 children enrolled in KidsCare.

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602-542-4331 • FAX 602-542-7602

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

   AZ Reply: Arizona has not made any changes to its KidsCare program as a result of PPACA.

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.

   AZ Reply: Arizona provides the full Medicaid benefit package to KidsCare members. The State selected its state employee benefit package as the benchmark for Marketplace coverage. Those benefits align fairly closely to the Medicaid benefits package. The primary difference for children is non-emergency medical transportation, which is not offered in the Marketplace. There also are some family supports and other behavioral health services that may not be offered on the Marketplace.

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?

   AZ Reply: Arizona led the nation in the percentage of children who enrolled in health care through the Marketplace with 21% of enrollees under age 18 (compared to the national average of 6%). KidsCare has been an incredible success in Arizona and served many families well. While there may be some differences between the Marketplace and KidsCare, especially related to out-of-pocket expenses and cost sharing, there is no reason to believe that a Marketplace option cannot be structured to meet the needs of children in this income range.

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?

   AZ Reply: Although Arizona's example presents some unique issues, it exemplifies the dynamic nature of health care. A five or six year formula struggles to address shifting state needs. In one instance, Arizona had an unspent allotment and just a couple of years

later, Arizona required an increase. Ideally, the formula allows for greater flexibility to keep pace with state needs.

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 uninsured, and improve health outcomes for children in your state?

   AZ Reply: Arizona has had tremendous success in enrolling eligible individuals through its public/private partnership that allows community organizations, providers, faith-based groups and others to be part of the application assistance team. These groups are trained by the State for use of the actual eligibility online system, known as Health-e-Arizona Plus. Over 100 organizations have agreements with the State as application assisters. Through those organizations, the State has trained over 2,000 non-State employees to provide application assistance in the community representing organizations all across the State. Moving away from a government-run model to one that is partnership focused has been a success.

Sincerely,

[redacted]

Janice K. Brewer
Governor

cc: Senator John McCain
Senator Jeff Flake
Representative Ann Kirkpatrick
Representative Ron Barber
Representative Raul Grijalva
Representative Paul Gosar
Representative Matt Salmon
Representative David Schweikert
Representative Ed Pastor
Representative Trent Franks
Representative Kyrsten Sinema

STATE OF ARKANSAS
MIKE BEEBE
GOVERNOR

October 21, 2014

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

Henry A. Waxman, Ranking Member
House Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, DC 20515

Ron Wyden, Chairman
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

Orrin G. Hatch, Ranking Member
Senate Finance Committee
104 Hart Office Building
Washington, DC 20510

Dear Chairmen Upton and Wyden, Ranking Members Waxman and Hatch:

In response to your letter of July 20, 2014, I have enclosed the requested information about the Arkansas Children's Health Insurance Program, compiled by my Medicaid Director Dawn Stehle. We have been able to significantly reduce the number of uninsured children in Arkansas and have been very pleased with the success of our program. Thank you for this opportunity to share our positive results with the House and Senate Committees.

Sincerely,

[redacted]

Mike Beebe

MB:jb

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

P.O. Box 1437, Slot S401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197

October 20 2014

Fred Upton, Chairman
House Committee on Energy and Commerce

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

Ron Wyden, Chairman
Senate Finance Committee

Orrin G. Hatch, Ranking Member
Senate Finance Committee

Congress of the United States
Washington, DC 20515

Dear Chairmen Upton and Wyden; Members Waxman and Hatch:

In response to your July 29, 2014 request for information from governors regarding the Children's Health Insurance Program (CHIP), I welcome this opportunity to provide information on Arkansas's successful CHIP program (ARKids-B and Unborn Child programs) and my thoughts regarding the future of the CHIP program.

The ARKids First program began in Arkansas in 1997. At that time, 22% of children in Arkansas lacked health coverage. ARKids First is made up of two programs. ARKids-A is traditional Medicaid for children and offers low-income families a comprehensive package of benefits. ARKids-B is funded by Title XXI (CHIP) and offers a similar benefit for families with higher incomes. The ARKids First program has played an important role in significantly dropping the percentage of children without access to coverage. Currently, 80,400 children in Arkansas are provided health coverage through the ARKids-B and Unborn Child programs of which the majority of children covered are in the ARKids-B program. .

The passage of the Patient Protection and Affordable Care Act (PPACA) has led to changes in the administration of the ARKids-B program. Specifically, Arkansas converted the state's existing income eligibility standards as required by the PPACA to a Modified Adjusted Gross Income (MAGI) equivalent standard. Additionally, as required by PPACA, Arkansas has transferred children ages six through eighteen with incomes above 100% of the federal poverty level (FPL) up to and including 133% FPL from the ARKids-B program into the ARKids-A program.

ARKids-B provides coverage for vision and dental services. These benefits have historically not been covered through the majority of employer sponsored health plans. In the Arkansas Health Insurance Marketplace, pediatric dental services are not required to be offered as a part of the package of benefits along with the other essential health benefits, if a stand-alone pediatric dental plan is offered on the Marketplace.

As previously mentioned, the CHIP program has worked well in Arkansas. The annual allotments have been adequate and the funding formula is working appropriately. Thus, we do not believe there is a need for Congress to address the issue of unspent allotments. Continuing to provide coverage for children in Arkansas is imperative. Thus far, our experience with the CHIP program in Arkansas has been overwhelmingly positive and successful and has led to a dramatic reduction in the percentage of uninsured children. Whether coverage remains to be provided through continued funding of CHIP or via an alternate mechanism (e.g. providing coverage through the Marketplace), ensuring that our state's children do not lose access to coverage is critical.

Thank you for the opportunity to comment on Arkansas's experience with the CHIP program and to provide input on this important policy debate.

Sincerely,

[redacted]

Dawn Stehle
Medicaid Director

11.10.14
CA
Attach
Trust
Resolution

EDMUND G. BROWN JR.
GOVERNOR

State of California
HEALTH AND HUMAN SERVICES AGENCY

DIANA S. DOOLEY
SECRETARY

Aging

Child Support Services

Community Services and Development

Developmental Services

Emergency Medical Services Authority

Health Care Services

Managed Health Care

Public Health

Rehabilitation

Social Services

State Hospitals

Statewide Health Planning and Development

October 30, 2014

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

The Honorable Ron Wyden, Chairman
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch, Ranking Member
Senate Finance Committee
104 Hart Senate Office Building
Washington, DC 20510

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

Dear Members of the United States Congress:

I strongly encourage Congress to act early and extend the Children's Health Insurance Program (CHIP) funding to the states beyond federal fiscal year 2015. Since California's enactment of this program in 1997, we have valued and relied upon federal CHIP funding to provide comprehensive, affordable health care, mental health, and substance use treatment coverage for children and pregnant women to ensure the best possible health care outcomes for children and infants.

By providing coverage for low to moderate income children and pregnant women through CHIP, cost-sharing is significantly lower than through other subsidized coverage, such as through California's state-based health benefit exchange, or private health plans. This ensures that cost-sharing requirements for these children and pregnant women is not an access barrier to care. Together, CHIP and Medi-Cal, California's Medicaid program, have cut the rate of uninsured children in California by half—from 10.3 percent in 2001 to 5.1 percent in 2011, according to the California Health Interview Survey by the University of California, Los Angeles, Center for Health Policy Research.

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If federal CHIP funds are not renewed for Federal Fiscal Year 2015, California could lose upwards of $533 million annually. Renewal of federal CHIP funding is extraordinarily important to California's fiscal stability and the ability to continue to offer cost-effective, affordable coverage for children and pregnant women. California makes every effort to maximize its federal CHIP allotments and fully expects to do the same with the enhanced federal matching rate as part of CHIP renewal. The enhanced federal CHIP funding supports a 23-percentage point increase (also known as the "CHIP bump") in the federal match rate for California. This is an important investment in children's health care. The loss of such funding would put gains in children and infants' health coverage at risk.

California recommends early approval of the extension of this funding to ensure no lapse in the California State Fiscal Year (FY) 2015/16 budgeting process for these important programs. CHIP renewal would encourage health coverage enrollment and positive health outcomes for children by generating permanent efficiencies in enrollment and renewal simplification processes, as well as improvements in the quality of pediatric health care delivery.

Enclosed with this letter are California's responses to questions outlined in your letter dated July 29, 2014. If you have additional questions or would like to discuss the responses further, please contact Mr. Toby Douglas, Director, California Department of Health Care Services, by telephone at [redacted]

Sincerely,

[redacted]

Diana S. Dooley
Secretary

Enclosure

ATTACHMENT

California is pleased to provide the following information to the Congressional committees with jurisdiction over the Children's Health Insurance Program (CHIP) regarding the extension of funding for CHIP beyond Federal Fiscal Year (FY) 2015.

California Background:

California has a robust CHIP program that is administered by the Department of Health Care Services (DHCS), the single state Medicaid agency (known as Medi-Cal in California). Prior to January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB), a state board separate from DHCS, administered the largest component of California's CHIP, previously known as the Healthy Families Program (HFP). HFP was transitioned to DHCS throughout Calendar Year 2013. Under this transition, children previously eligible for HFP, under a standalone CHIP, became Medi-Cal eligible under a new Medicaid expansion coverage group, known as the Optional Targeted Low Income Children's Program (OTLICP). The other transitioned CHIP programs now administered by DHCS are as follows:

- The Medi-Cal Access Program, (previously known as the Access for Infants and Mothers Program [AIM]) which provides comprehensive medically necessary services to pregnant women who are above the Medi-Cal income standard, up to and including 322 percent of the federal poverty level (FPL). Additionally, those infants born to women enrolled in the Medi-Cal Access Program with incomes above 266 percent (the OTLICP upper income limit) and up to and including 322 percent are also covered under this program for up to their first two years of life.
- The County Children's Health Initiative Matching (C-CHIP) Program, historically funded solely by local county and federal funds in three counties (San Francisco, San Mateo, and Santa Clara) that voluntarily chose to operate a C-CHIP program, offers comprehensive coverage to CHIP-eligible children who are above the applicable Medi-Cal/CHIP limits up to and including 322 percent. Today, as a result of the ACA maintenance of effort eligibility requirements, state and local county funds are used as the non-federal share to draw down unused federal State CHIP/Social Security Act Title XXI funds for CHIP-eligible children in these three counties.

How many individuals does your state's CHIP serve?

As of August 30, 2014, there are approximately 1,257,500 low-income children and pregnant women enrolled under California's CHIP programs in which Title XXI funds are used to support medically necessary health, mental health, and substance use disorder services. The CHIP funded programs are:

- Medicaid Expansion for Low-Income Children and Pregnant Women
- Optional Targeted Low Income Children's Program
- Medi-Cal Access Program for Pregnant Women and Infants
- County Children's Health Initiative Matching Program

What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

The following charts provide a summary of demographic characteristics of CHIP enrollees in California.

Chart 1: Medicaid Expansion Population	

Children under the age of 19
• FPL income level:
  o Children 1-6 up to and including 142 percent
  o Children 6-19 up to and including 133 percent
• Full scope Medi-Cal coverage
	Pregnant Women (Unborn Option)
	• FPL income level above 60 percent up to and including 208 percent
	• Pregnancy-related covered services

Chart 2A: CHIP Population		
OTLICP (Children under age 19 above traditional Medicaid income levels)	**Medi-Cal Access Program (Pregnant Women)**	**Medi-Cal Access Infant-Linked Program (Children under 2, born to mothers enrolled in Medi-Cal Access Program)**
FPL Income level • infants 0-1 above 208 percent up to and including 266 percent • 1-6 above 142 percent up to and including 266 percent • 6-19 above 133 percent up to and including 266 percent	FPL Income level • Above 208 percent and up to and including 322 percent	FPL Income level • Income above 266 percent up to and including 322 percent

• Subject to premiums when FPL >150 percent not to exceed the 5 percent limit on their monthly income
  o $13 per child up to a maximum of $39 per month for households with three or more children.
  o No copayments on covered services
• Native American/Alaskan Indian Exemption
	• No maternity insurance or have health insurance with a high (over $500) maternity-only deductible
	• Total cost for enrollment = 1.5 percent of family's adjusted annual household income after applying standard deduction
		• Enrolled in share-of-cost Medi-Cal
		• Subject to premiums based on income and household size
		  o $13 per child up to a maximum of $39 per month for households with three or more children
		• Native American/Alaskan Indian Exemption

Chart 2B: CHIP Population County Operated	
Santa Clara, San Francisco and San Mateo	Children under age of 19
	FPL Income level • Above 266 percent and up to and including 322 percent
	• Uninsured, or enrolled in share-of-cost Medi-Cal or Medi-Cal Access Infants Program • Subject to premiums based on income and household size
Santa Clara	• $4 to $21 per child monthly premium with maximum cost of $63 per family per month • No copayments for preventative services • $5 to $15 copayments for other medical, dental and vision services • Maximum of $250 in copayments per family in a Benefit Year, does not include copayments for dental and vision services
San Francisco	• $48 to $189 annual premium based on household income and family size • $5 and $10 copayments for most services
San Mateo	• $0 to $90 quarterly premium based on family income • No copayment for check-ups, immunizations, annual dental exams, and other preventative services • $5 to $15 copayments for most services

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

To ensure achievement of the overall purpose of the PPACA, California began with the enactment of Assembly Bill 1296 (Bonilla, Chapter 641, Statutes of 2011), which among other things required the development of a standardized single, accessible application form and renewal procedures for state insurance affordability programs.

Additionally, California transitioned the State's separate CHIP programs for children and pregnant women and their infants to DHCS administration, beginning in 2013. This has effectively resulted in the integration of the standalone CHIP and the Medicaid expansion under the Medi-Cal program. The goals in the transition of children and pregnant women to Medi-Cal under DHCS are to provide a uniform approach for potential beneficiaries applying for and obtaining health care coverage under applicable insurance affordability programs, to streamline eligibility and enrollment processes, and to broadly simplify coverage options for individuals under Medi-Cal and California's state-based health benefit exchange.

How has the implementation of the PPACA impacted the way your state administers CHIP?

As indicated above, the implementation of PPACA set in motion the creation of a Medicaid expansion for children by moving from a standalone CHIP to the movement of CHIP-eligible children under the Medi-Cal program. This integration has allowed California the ability to apply Medicaid cost sharing principles to CHIP-eligible children and to make available to these children the expanded benefit package of Medi-Cal as

described in the response on covered benefits. California also expanded coverage to children between the ages of 6 to 19 years of age with family income up to 133 percent.

Specifically, PPACA has influenced the way in which California administers CHIP-funded programs in the following ways:

- Implemented the use of streamlined eligibility processes and coverage options for children and adults seeking coverage under insurance affordability programs, including CHIP, using a federally-approved, single streamlined application.
- Established a "no wrong door" approach for enrollment. Individuals are first assessed for no-cost coverage under Medi-Cal/CHIP using one intake process before moving to programs that require cost-sharing or advanced premium tax credits. This approach allows consumers to obtain health insurance at the lowest cost with a streamlined application and provides the option for families with children to shop, compare, and select coverage under one health plan if available in their county of residence.
- Provided additional benefits and lowered costs for children at certain income levels.
- Gained overall administrative efficiencies and oversight, including more consistency in health plan contracting processes while increasing plan accountability for providing high-quality services to children.
- Provides the opportunity to standardize the existing administrative appeals process for consumers for initial eligibility or enrollment determinations and redeterminations for insurance affordability programs both Medicaid and CHIP funded, with procedures and timelines for hearings with the appeals entity with continuing eligibility for beneficiaries during the appeals process.
- Achieved operational efficiencies by consolidating administrative resources under one state agency

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.

Benefits

All children enrolled in the Medi-Cal program funded with Title XXI and Title XIX receive the same Medi-Cal benefits and use the same health care delivery systems. Through Medi-Cal, CHIP-eligible children have access to a more comprehensive coverage package at a lower cost to families than that which is available through private or state exchange coverage. Given the incorporation of CHIP-eligible children as a coverage group under the state plan, the funded services includes the comprehensive Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit which also has a more liberal standard for medical necessity and has been considered the gold standard for publically financed programs. Additionally, these children also receive dental and vision

benefits, mental health, and substance use disorder services. Comparatively, children enrolled through Covered California or employer-sponsored health plans receive the required ten essential health benefits but have higher out-of-pocket expenditures.

Pregnant women in the Medi-Cal Access Program receive the minimum essential health benefits from their health plan, which also includes the following services:

- Physician and Professional Services
- Mental health and substance use disorder services including behavioral health treatment
- Preventative and wellness services; and chronic disease management
- Maternity services
- Hospital care
- Prescription drugs
- Non-emergency medical transportation services
- Skilled Nursing Facility Services (91+ days) offered to pregnant women until the end of the woman's postpartum period if medically necessary
- Pediatric services for income-eligible children including oral and vision care

Cost-Sharing

Previously, families whose children enrolled in HFP paid a monthly premium amount based on income and family size with the state's program administrative vendor tracking the payments and cost sharing requirements. Families' premiums fluctuated based on a change in income level, much like Covered California coverage that is based on family size. Cost-sharing for the OTLICP under Medi-Cal is based upon a flat monthly rate established in state law. The state monitors the process for payment of premiums and cost-sharing. As a result of the change to premiums for children under Medi-Cal, families receive either a lower monthly premium or none at all. Medi-Cal does not require co-payments for children under the age of 19. These policies ensure that premiums, co-payments, and deductibles are not a barrier for children and pregnant women to access care. Retaining CHIP funding is critical for achieving affordable, comprehensive coverage for low-income children and their families.

The total cost-sharing for women enrolled in the Medi-Cal Access Program is 1.5 percent of the family's adjusted annual household income after applying the standard deduction. The cost sharing amount for pregnancy and post-partum can be divided into 12 monthly installments, but enrollees may choose to pay the entire 1.5 percent cost in one single payment including a $50 discount.

Covered California, which is California's state-based health benefit exchange, offers health plans with four major metal tiers: Bronze, Silver, Gold, and Platinum. Each health plan provides minimum essential coverage, but they differ in the cost sharing. Marketplaces also must make available minimum coverage plans, also referred to as catastrophic coverage plans, to people under age 30, as well as to individuals who are exempt from the mandate to purchase coverage because they have an affordability or

hardship exemption. A minimum coverage plan covers minimum essential coverage, but only after out-of-pocket cost sharing reaches a high deductible that will match the level of the PPACA's required out-of-pocket maximum. Out-of-pocket costs for Covered California plans typically include:

- Coinsurance
- Co-payments or similar charges
- Deductibles

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?

California believes the annual allotments received were sufficient. Since Federal Fiscal Years (FFY) 2011, California's CHIP expenditures have been approximately equal to California's annual allocation. However, current estimates of FFY 2015 and beyond show expenditures depleting the annual allocation and all available prior year allotments. California believes that the current safeguards for redistribution and contingency funding will be sufficient to meet our future funding.

California's CHIP expenditures have averaged $1.24 billion in federal funds annually since 2006 and estimate an increase in children covered with the implementation of PPACA. FFY 2014 expenditures are exceeded $1.4 billion in federal funds.

Without reauthorization, California will have several fiscal barriers:

1. Four of California's CHIP programs would lose $145 million in federal funding annually:
   a. Medi-Cal Access Program (Pregnant Women Unborn Option Coverage)
   b. Medi-Cal's Expansion Program for the Unborn Child Option
   c. Medi-Cal Access Infant-Linked Program
   d. C-CHIP
2. The remaining California CHIP programs would require coverage under Title XIX at a lower Federal Financial Participation and California would lose an additional $388 million in federal funds annually.

Additionally, the proposed PPACA Enhanced Funding for Children would enhance the CHIP federal matching rate by 23 percentage points beginning in October 2015. This enhancement would provide California with an additional $578 million in federal funds annually. However, an increase in the current allocation level would be required to maintain this enhanced level of funding through FY 2019.

Do you believe there is a need for Congress to further address the issue of unspent allotments?

ATTACHMENT

No, California believes states are in a better position to address the issue of unspent allotments. The current process provides State's with the flexibility necessary given changes in health care and the economy which impact our expenditures.

STATE OF COLORADO

OFFICE OF THE GOVERNOR

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October 31, 2014

John W. Hickenlooper
Governor

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee

The Honorable Ron Wyden
Chairman
Senate Finance Committee

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee

Dear Congressmen:

We are grateful for the opportunity to respond to your letter regarding continued federal funding for the Children's Health Insurance Program (CHIP), dated July 29, 2014.

As detailed in the enclosed pages, Colorado's CHIP program – known locally as the Child Health Plan *Plus* (CHP+) – is a critical component of Colorado's commitment to ensure access to affordable and comprehensive health insurance coverage. We are proud to have made substantial progress in reducing the number of uninsured children in Colorado in recent years, and CHP+ continues to be a key driver of that success.

In light of ongoing changes to the coverage landscape due to both state and federal health reforms, we strongly encourage Congress to continue funding CHIP through 2019. We believe that this continued funding period best aligns with existing CHIP policy and will provide states the opportunity to analyze data and evaluate long-term coverage strategies that ensure individuals and families continue to have access to coverage and access to care.

We would be happy to provide you with any additional information about Colorado's CHIP program. Should you have any further questions, please reach out to our Washington, D.C. Liaison, Jena Griswold, at 202.624.5278 or jena.griswold@state.co.us.

Regards,

[redacted]

John W. Hickenlooper
Governor

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).*

Colorado's CHIP program, the Colorado Child Health Plan *Plus* (CHP+), serves over 112,000 children and nearly 3,000 pregnant women living between 133% and 250% FPL – roughly $31,000 to $58,000 for a family of four, as detailed below. CHP+ is an HMO-model program administered by the Colorado Department of Health Care Policy and Financing, which also administers Colorado Medicaid and is the state's single state Medicaid agency. Core demographics for our CHP+ population are as follows:[1]

Distinct Clients FY 2013-14 July 2013 – June 2014	
Population	**Distinct Clients**
Children	112,395
Prenatal	2,853
Total	**115,248**

FY 2013-14 Distinct Client Ethnicity Distribution			
Race	**Children**	**Prenatal**	**Total**
American Indian	1.82%	1.37%	1.81%
Asian	2.71%	2.75%	2.71%
Black	5.64%	5.46%	5.63%
Native Hawaiian/Pacific Islander	0.44%	0.33%	0.43%
Other	7.68%	9.85%	7.73%
Other - White	32.40%	49.83%	32.84%
Spanish American	31.80%	21.30%	31.54%
Unknown	17.52%	9.11%	17.31%

FY 2013-14 Distinct Client Distribution by Income			
FPL	**Children**	**Prenatal**	**Total**
0%-100% FPL[2]	7.97%	17.06%	8.17%
101%-150% FPL[1]	22.67%	12.68%	22.45%
151%-200% FPL	34.47%	19.63%	34.14%
201%-205% FPL	4.47%	8.31%	4.55%
206%-250% FPL	22.60%	37.29%	22.92%
Blank	7.83%	5.02%	7.77%
Total	**100.00%**	**100.00%**	**100.00%**

[1] Colorado Department of Health Care Policy and Financing, 2014.

[2] Colorado expanded Medicaid to all individuals with incomes 0-133% FPL in January 2014, and began to use the Modified Adjusted Gross Income (MAGI) eligibility determination criteria in October 2013. Some individuals in the 0-133% FPL income range are listed here because the time period shown partially predates our MAGI implementation. Additional detail can be found in the response to Question 2.

Although our actuaries have access to beneficiaries' encounter data for rate setting purposes, Colorado does not directly collect information on CHP+ enrollees' health status. A sample of CHP+ beneficiaries' data provided by Colorado Access (the largest of our CHP+ carriers, with 37,000 members) indicates that 83 percent of the CHP+ insured population visited a primary care provider in the last year. Additionally, CHP+ children report better general health than uninsured and Medicaid populations, but worse health than commercially insured populations, as illustrated in the following table:

Self-Reported Health Status by Insurance Type, Children Ages 0-18, Colorado, 2013[3]

	CHP+	Medicaid	Commercial Insurance	Uninsured
General Health Status				
Excellent/Very Good/Good	97.0%	90.6%	98.1%	95.2%
Fair/Poor	3.0%	9.4%	1.9%	4.8%
Oral Health Status				
Excellent/Very Good/Good	87.2%	93.6%	95.7%	84.2%
Fair/Poor	12.8%	6.4%	4.3%	15.8%
Mental Health Status				
Less than 8 poor mental health days	88.6%	87.5%	94.7%	87.5%
8 or more poor mental health days	11.4%	12.5%	5.3%	12.5%

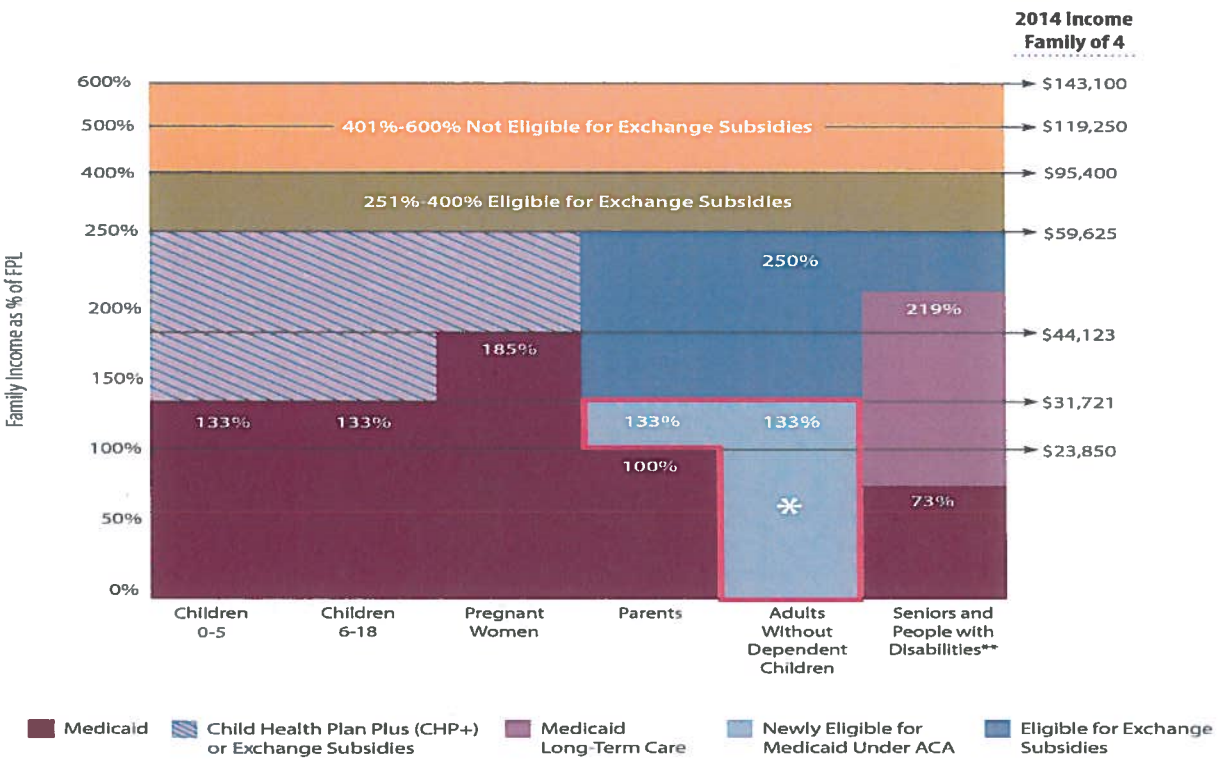
2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

Colorado has taken a measured, bipartisan approach to implementing the Patient Protection and Affordable Care Act (ACA). In doing so, we have built upon foundations that predate the ACA and passed bipartisan legislation that enabled us to expand Medicaid to 133% FPL and establish a state-based health insurance marketplace, Connect for Health Colorado (C4HC).[4] Pursuant to the ACA, HCPF began using Modified Adjusted Gross Income (MAGI) methodology to calculate eligibility for both Medicaid and CHP+. As part of that rule implementation, both programs use a 5 percent "income disregard" to assist families whose income is close to the eligibility cutoff under MAGI methodology. As such, we determine CHP+ eligibility for children and pregnant women if their income is less than 260% FPL.

[3] Colorado Health Institute analysis of the 2013 Colorado Health Access Survey, 2014.
[4] Senate Bill 13-200 and Senate Bill 11-200, respectively. Senate Bill 13-200 codified in pertinent part at 25.5-4-402.3; Senate Bill 11-200 codified at 10-22-101, et seq.

The following table provides an overview of coverage options for Coloradans at or below 400% FPL, as of January 2014: [5]

Eligibility Levels for Public Insurance Programs, by Population, Colorado, 2014



We have also taken steps to limit the impact of "churn" across various coverage programs to help improve continuity of care for Colorado individuals and families. For example, in March 2014, Colorado began providing twelve months of continuous eligibility for children in Medicaid and CHP+, even if the family experiences a change in circumstances that effect eligibility. This policy helps prevent lapses in continuity of care and is in place for 28 CHIP programs nationwide.[6] Although this was authorized by state law that predates the enactment or implementation of the Patient Protection and Affordable Care Act (ACA), implementation of the ACA resulted in changes to our financial models that enabled us to implement 12-month continuous eligibility for children.[7]

[5] Source: Colorado Health Institute, 2014.

[6] Kaiser Family Foundation, State Health Facts. Accessed October 20, 2014. Available at: http://kff.org/medicaid/state-indicator/12-mo-continuous-eligibilitymedichip/

[7] Colorado Health Care Affordability Act, House Bill 09-1293, codified in pertinent part at Colo. Rev. Stat. § 25.5-4-402.3.

3. *To the extent the following 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.*

Colorado strives to improve continuity of care, to align benefits across Medicaid, CHP+, and qualified health plans (QHPs) purchased through C4HC, and to ensure our system works seamlessly for families and children. While CHP+ and private market individual insurance coverage have very similar benefits, cost sharing differs significantly. Specifically, average annual cost sharing in a QHP can be roughly four times cost sharing for CHP+, even after cost sharing reduction subsidies are accounted for.[8] Additionally, although both CHP+ and QHPs establish an out-of-pocket maximum, Colorado's CHP+ program establishes this maximum at 5 percent of the enrollee's income. In contrast, the out-of-pocket maximum for QHPs is a fixed dollar amount adjusted for low-income populations, which could be as high as $5,200 for some CHP+ families. For additional information on differences in benefits and cost sharing based on analysis conducted by Wakely Consulting Group, please see Appendix A.

Colorado's CHP+ program has been a successful safety net coverage program since its inception. As a testament to its success, in 2012, advocates successfully lobbied to gain access to CHP+ for dependent children of state employees.

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 covered children by CHIP do you estimate would become uninsured in the absence of CHIP?*

We appreciate Congress' desire to assess whether federal CHIP funding should be renewed in light of new coverage options provided by the ACA. At the same time, we are still implementing key provisions of the ACA that may have significant market impacts over time and alter the value proposition for maintaining the CHP+ program. Ultimately, our goal is to continue reducing the number of uninsured Colorado children while ensuring that coverage options remain affordable for low-income populations.

At this time, Colorado recommends CHIP funding be reauthorized for another four years to align with CHIP's existing maintenance of effort requirements. Given the current coverage opportunities available to our CHP+ population and our commitment to maintain market stability as we implement the ACA, we firmly believe that discontinuing federal CHIP funding in any less than four years would eliminate CHP+ as a coverage option for Colorado families and create a significant financial hardship for low-income Coloradans.

In addition to providing alignment with existing CHIP policy, a four-year funding reauthorization will enable states to monitor coverage trends and engage stakeholders around coverage alternatives to CHIP in the event Congress determines the CHIP program should not be reauthorized in the future. Any long-term changes to CHIP at the federal level are likely to necessitate program, policy, and legislative changes at the state level for which states must be given the opportunity to prepare.

[8] Wakely Consulting Group, "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans," July 2014.

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?*

Since restructuring of the allotments occurred, Colorado has not utilized the full annual allotment of CHIP funding. Current funding levels have enabled us to achieve our CHP+ goal of providing coverage to pregnant women and children, and the funding that remains in Colorado's allotment provides a critical safety net for the CHP+ program, as it would provide a short-term funding source should Congress fail to reauthorize CHIP funding in 2015.

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 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?*

Implementation of the ACA has enabled Colorado to provide coverage options for nearly all children in our state. We are also proud to have received over $157 million in CHIPRA performance bonuses since 2010 for our efforts to insure Colorado kids. However, to continue reducing the uninsured rate and maintaining continuity of coverage and care among children in our state, we need to align eligibility and enrollment policies across a broader range of social services.

Last year, Colorado launched Colorado PEAK – the Program Eligibility and Application Kit – an online portal allowing consumers streamlined access to and application for a variety of state benefits and services. By the end of 2014, up to 20 programs will participate in PEAK, including child care, nutrition, and energy assistance programs. To better serve families in need, Congress should work with federal agencies and willing states to align eligibility, enrollment, and renewal policies across social support programs, including Medicaid, SNAP, TANF, National School Nutrition Programs, the Child Care Subsidy Program, and others. This would reduce the administrative burden on each program and, more importantly, provide a simpler and more holistic approach for families.

APPENDIX A: COLORADO CHP+/QHP BENEFIT & COST SHARING COMPARISON

Excerpt from "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans," Wakely Consulting Group, July 2014[9]

COLORADO

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	97.4%	86%-88%	95.3%	72%-74%
Enrollee Average Percent of Allowed Claims	2.6%	12%-14%	4.7%	26%-28%
Average Annual Cost Sharing	$90	$411 - $480	$161	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$925	$1,970
QHP	fixed dollar	$1,450	$4,750

[9] Full report available at: http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$5 copay	50% after deductible	$10 copay	50% after deductible
Eyeglasses Cost Sharing	No copay: $50-$150	50% after deductible	No copay: $50-$150	50% after deductible
Dental Checkup Cost Sharing	No copay	50% after deductible	No copay	50% after deductible

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

Type of Benefit	Total Benefits	CHIP			QHPs (Based on EHB)		
		Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	91%	9%	0%	91%	9%	0%
Child-Specific	14	36%	29%	36%	36%	29%	36%

The following table shows the coverage and limits for the core benefits.

Service	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	L$	Certain items subject to $2,000 annual limit	C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	L$	$600	C	
Dental - Orthodontics	U		U	
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	$50/year	C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	C		C	
ABA Therapy	U		LQ	550 sessions (age 0-8) 185 sessions (age 9-19) (25-minute session increments)
Autism - General	C		LQ	550 sessions (age 0-8) 185 sessions (age 9-19) (25-minute session increments)
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ	No limit (age 0-3) 30 visits/year (per diagnosis, age 3+)	LQ	20 visits/year (per type of therapy)
Podiatry	LC	Routine foot care not covered except for patients	U	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
		with diabetes		
Habilitation	C		LQ	20 visits/year (per type of therapy)
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

Dannel P. Malloy
GOVERNOR
STATE OF CONNECTICUT

October 30, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
104 Hart Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
United States House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
United States House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

Thank you for your letter of July 29, 2014, concerning the Children's Health Insurance Program (CHIP). I appreciate the opportunity to address the merits of and continued need for federal funding for this vital program.

Connecticut has made it a priority to ensure that all of its citizens have access to high quality and affordable health insurance. Connecticut's state-based health insurance exchange, Access Health CT, enrolled over 200,000 people during the first open enrollment period. This reduced Connecticut's rate of uninsured from 7.9 % in 2012 to 4% – one of the ten largest reductions in the country. Over 80% of these new enrollees qualified for Medicaid. Connecticut Medicaid is now serving almost 770,000 individuals, over 21% of the state population.

Connecticut's CHIP, which is known as HUSKY B, is an essential source of coverage for 14,119 children under age 19. Additionally, the program provides federal match for additional income-eligible children in Connecticut's coverage group for children and relative caregivers, which is known as HUSKY A. CHIP provides a broad range of preventative care, behavioral health, and dental services that support Connecticut children in early childhood development, school readiness and performance, and overall well-being.

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I have provided below our responses to the six questions that you raised 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)?**

Connecticut is currently covering 14,119 children in CHIP/HUSKY B. The PPACA Modified Adjusted Gross Income (MAGI) conversion increased the maximum income eligibility limit for HUSKY B from 300% to 323% of the Federal Poverty Level (FPL). Additionally, Connecticut permits families with income in excess of 323% of FPL to purchase coverage via monthly premiums. The distribution of participants across Connecticut's three "bands" of coverage is depicted below:

HUSKY B premium band	Annual income level as % of FPL	Annual income level in dollars (family of four)*	Premiums	Annual out-of pocket maximum	Number of participants
Band 1	201% to 254%	$47,938-$60,578	None	5% of gross income	8,941
Band 2	254% to 323%	$60,579-$77,035	Maximum $30 for one child, $50 for two or more children per month	5% of gross income	4,805
Band 3	Above 323%	Above $77,035	$314 per child per month	No cap	373

* As of July 1, 2014, Connecticut's annual poverty level for a family of four is $23,850. See: http://www.ct.gov/dss/lib/dss/PDFs/PovSMI.pdf.

This is the HUSKY B enrollment by band as reported by Xerox as of October 1, 2014:

	Band 1	Band 2	Band 3	Grand Total
Total Enrollment by Premium Band	8,941	4,805	373	14,119

HUSKY B coverage is contributing to significant improvements in health outcomes for enrolled children. Under Connecticut's unique, self-insured managed fee-for-service system, the following results were achieved for calendar year 2013:

- increased well-child visits in the first 15 months of life (six or more visits) by 13.5%;
- increased well-child visits in the third, fourth, fifth and sixth year of life by 4%;

- increased access to primary care practitioners for children age 12-24 months by 4% to 99.5%;
- increased access to primary care practitioners for children age 25 months to 6 years by 3% to 97%;
- increased immunization rate for adolescents (Tdap/Td Total) by 7%;
- increased lead screening in children by 21.5%; and
- increased number and percentage of children age 3 to 19 who received preventive dental care to 69% (HUSKY A) and 73% (HUSKY B).

The demographics of children served by CHIP/HUSKY B are as follows:

- 48.2% are female and 51.8% are male;
- 10.1% identify as African-American;
- 22.5% identify as Hispanic; and
- 70.6% identify as Non-Hispanic 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 CHIP?**

The PPACA Modified Adjusted Gross Income (MAGI) conversion increased the maximum income eligibility limit for HUSKY B from 300 to 323% of the Federal Poverty Level (FPL). Additionally, Connecticut availed itself of the option to eliminate the crowd-out for coverage.

3. **To the extent the following information is readily available and you believe that it is relevant, please describe the services and or benefit 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.**

CHIP/HUSKY B provides a much broader range of behavioral health benefits than do exchange and employer-sponsored health plans. Additionally, CHIP/HUSKY B covers dental services with among the best geo-access of Medicaid programs in the country. Dental services are only covered through the exchange through purchase of stand-alone plans, and are typically covered by employer-sponsored health plans on a much more limited basis. There are no monthly premiums and a limitation on annual out-of-pocket costs of 5% of gross income in Connecticut's Band 1 for CHIP coverage; and a modest monthly premium of $30 for one child and $50 for two or more children, and a limitation on annual out-of-pocket costs of 5% of gross income in Connecticut's Band 2. These modest cost-sharing obligations (low if any premium, no deductible, limitations on out-of-pocket costs) are substantially less than would be paid for a Connecticut Qualified Health Plan (QHP).

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 funding should be extended, what coverage (if any) do you believe that CHIP enrollees in your state would be able to obtain? How many children covered by CHIP would become uninsured in the absence of CHIP?**

CHIP funding should be made permanent. Over the course of its existence, CHIP has proved to be a critical source of support for hundreds of thousands of children nationwide. The current cost-sharing arrangement between the federal government and the states represents an appropriate balancing of interests in the health, safety, and well-being of our children.

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 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?**

Connecticut's current CHIP expenditures are at levels that will fully utilize an amount equal to our annual allotment of funding. This has been the case for the past several fiscal years. That said, there is also an ongoing balance of funds that have been carried forward from years prior that affects the manner in which Connecticut accesses its federal funds, resulting in a carry-forward from year to year.

To the extent that there are states that are unable to expend their allotments, Congress could adopt a distribution methodology that examines expenditures year over year and makes appropriate adjustments based on demonstrated need.

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 can 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?**

Connecticut has been demonstrably successful though both its CHIP/HUSKY B program and Access Health CT enrollment activities in reducing the incidence of uninsured children in Connecticut. With respect to CHIP, the single most effective support for enrollment and continuity of care for children served by CHIP will be extension of federal CHIP funding. Additionally, performance bonuses have effectively incented and rewarded states that have 1) met their target for enrollment; and 2) implemented at least five of eight identified policies that support timely access to and maintenance of CHIP coverage (12-month continuous coverage; either no asset test or simplified asset verification; no face-to-face interview requirement; joint application and consistent information verification processes

across Medicaid and CHIP; administrative or *ex parte* renewals; presumptive eligibility; express lane eligibility; and premium assistance option). Connecticut has qualified in Federal Fiscal Years 2011 ($5.2 million), 2012 ($3.0 million) and 2013 ($1.6 million) for CHIPRA performance bonuses. Over and above activities related to Medicaid, Congress could support access to and adequacy of coverage under QHPs by:

- examining the incidence of families affected by the "family glitch" and considering appropriate remedies;
- reviewing the cost effectiveness, network adequacy and scope of coverage of QHPs with respect to supporting the needs of children and families; and
- providing ongoing support for the in-person assister functions that have been funded under PPACA.

Thank you for the opportunity to share our perspective. Continued funding for CHIP is essential. Failure to preserve CHIP funding will jeopardize continued coverage for children in demonstrated need for these supports and necessarily expose states to significant budget constraints. I respectfully request that you make resolution of this pending issue a high priority.

Sincerely,

[redacted]

Governor

Delaware Health and Social Services

Office of the Secretary

1901 N. DUPONT HIGHWAY, NEW CASTLE, DE 19720 * TELEPHONE: 302-255-9040 FAX: 302-255-4429

November 3, 2014

The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
Congress of the United States
Washington, DC 20515

The Honorable Ron Wyden
Chairman
Senate Finance Committee
Congress of the United States
Washington, DC 20515

The Honorable Henry A. Waxman
Ranking Member
House Committee on Energy and Commerce
Congress of the United States
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
Congress of the United States
Washington, DC 20515

Thank you for the opportunity to comment on the Children's Health Insurance Program (CHIP) as you consider an extension of funding beyond FY 2015. CHIP has been an integral component of the health safety net for children in low-income families since its enactment in 1997.

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state?**

   14,612 children were enrolled in Delaware's CHIP program during State Fiscal Year 2014 (July 2013 – June 2014). This represents an unduplicated count of children who were enrolled at any point during the year.

   Demographic characteristics of the children can be found in the tables below.

	Number	Percent
Gender:		
Male	7,387	50.5%
Female	7,225	49.5%
Age:		
Under 5	2,677	18.3%
5-8	3,650	25.0%
9-12	3,530	24.2%
13-15	2,516	17.2%
16-18	2,239	15.3%

Income:		
100% - 150% FPL	7,958	54.5%
150% - 200% FPL	6,654	45.5%

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?**

   Very few substantive changes were made to the Delaware CHIP program as a result of PPACA. CHIP and Medicaid are administered by the same agency, the Division of Medicaid and Medical Assistance, and CHIP offers the full range of services covered under EPSDT. Eligibility and enrollment are integrated and children are served by the same Managed Care Organizations (MCOs).

   Changes made as a result of PPACA include adoption of MAGI eligibility rules and transition of children between 100%-133% of FPL from CHIP to Medicaid. Children who transitioned to Medicaid will no longer be subject to a monthly premium and will now have access to the non-emergency transportation benefit.

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.**

   Cost sharing for families of children enrolled in CHIP is very minimal. The maximum family premium is $25 per month. There are no additional co-pays with the exception of a $10 charge for non-emergency visits to the emergency department. Since the full range of EPSDT covered services is available to the CHIP population, these children also have access to dental and specialized services that might not be available in exchange or employer-sponsored health plans.

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 attain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

   Yes, CHIP continues to provide a critical health care safety net for children. Funding should be extended to align with the current authorization ending in 2019. Discontinuation of funding could result in various scenarios depending on the structure of a state's CHIP program. Delaware administers a combination CHIP program with both a Medicaid expansion component and a stand-alone component.

Children enrolled in the CHIP Medicaid Expansion would continue to receive services but the state would receive the lower Medicaid FMAP rather than the CHIP enhanced EFMAP. The state would be required to meet MOE requirements for the stand-alone component. Beyond that, without an infusion of state funds, families would need to purchase insurance through the marketplace. This would likely present a financial burden for some families. There is also the concern that some children would not be eligible for marketplace coverage due to the "family glitch" in the affordability test.

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?**

   Annual allotments have been sufficient to cover the federal portion of CHIP expenditures. It remains to be seen whether states will benefit from the PPACA FMAP increase without an extension of funding and review of the funding methodology.

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 uninsured, and improved health outcomes for children in your state?**

   Delaware is actively engaged in promoting health innovation and transformation. As these efforts roll out, it will be necessary to critically assess the roles and value of each program with the goal of greater integration and alignment. CHIP currently provides a critical bridge between Medicaid and the marketplace but that need may diminish over time. It is also essential to more seriously consider all factors which impact health outcomes for children, including social determinants of health. Increased coordination and alignment of eligibility policies between federal agencies would strengthen the financial, nutritional, housing, and social supports necessary for children in low-income families.

Thank you.

[redacted]

Rita M. Landgraf
Secretary

STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Nathan Deal
GOVERNOR

November 20, 2014

The Honorable Ron Wyden, Chairman
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Orrin G. Hatch, Ranking Member
Senate Finance Committee
104 Hart Senate Office Building
Washington, D.C. 20510

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

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

Dear Chairmen Wyden and Upton and Ranking Members Hatch and Waxman:

On behalf of the State of Georgia, I would like to thank you for the opportunity to provide state-level input as Congress considers the future of the Children's Health Insurance Program (CHIP). I am writing to respond to the questions outlined in your July 29, 2014 letter regarding the Children's Health Insurance Program in Georgia which is also known as PeachCare for Kids®. As a state-established program, funded jointly between federal and state governments, your request for input from the state of Georgia, on behalf of nearly 200,000 children this program covers in our state, is greatly appreciated.

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)?**

   Response: In August 2014, 196,996 children were enrolled in the PeachCare for Kids® program. As renewals are completed monthly, some children have been found to be eligible for the Medicaid program, and they have been transferred to the Title XIX program. We expect a monthly decrease of 3,000-4,000 children until December 2014.

In terms of demographics, the following tables depict race, gender, and household income data that you may find helpful.

Count of RACE

	F	M	Grand Total
AMERICAN_INDIAN_OR_ALASKA_NATIVE	107	94	201
ASIAN	4519	4736	9255
BLACK_OR_AFRICAN_AMERICAN	31198	31907	63105
HISPANIC_OR_LATINO	14477	15034	29512
NATIVE_HAWAIIAN_OR_OTHER_PACIFIC_ISLANDER	56	64	120
None	7974	8115	16089
NOT_SPECIFIED	77	80	157
OTHER	6536	6840	13376
WHITE	39342	42119	81461
Grand Total	**104286**	**108989**	**213276**

The household income breakdown for members enrolled in the Georgia CHIP program in June 2014 is included in the table below.

Yearly Household Income	Count
$0 - 10,000	97
$11,000 - 20,000	14,929
$21,000 - 30,000	44,448
$31,000 - 40,000	37,175
$41,000 - 50,000	17,446
$51,000 - 60,000	6,113
$61,000 - 70,000	1,452
$71,000 - 80,000	295
$81,000 - 90,000	69
$91,000 and up	59

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?**

Response: Georgia took several actions that were required as a result of the Affordable Care Act (ACA). Note that these changes required significant additional state resources and extensive modifications to existing computer systems.

a. Georgia was required to lower premiums due to the income/federal poverty level conversions required by the Act.
b. Georgia implemented a single application for Medicaid, PeachCare for Kids and other public assistance programs. Individuals wishing to apply may now apply through a single electronic portal. Should individuals choose to apply via paper, the paper application

now used by the program is based on the streamlined application created by the Centers for Medicare and Medicaid Services (CMS).

c. Georgia was required to remove the requirement that families returning to CHIP eligibility due to nonpayment of premiums pay back past due premiums in order to be eligible for CHIP.
d. As a result of ACA, we have begun and will continue the move of an estimated 58,000 children from CHIP to the Medicaid program through December 31, 2014. These are children who are between 100-133% of the federal poverty level.
e. The eligibility determination process for CHIP has been moved to a Modified Adjusted Gross Income (MAGI) methodology. States were required to adopt MAGI rules to determine income in order to align with rules used for premium tax credits available through the exchanges.
f. The CHIP program implemented a 45-day standard of promptness for completion of applications in order to align with the Medicaid program and comply with new regulations.
g. Consistent with Section 10203(b)(2)(D) of the Act, Georgia modified CHIP eligibility criteria to permit enrollment of low-income children of state employees who are otherwise eligible under the state employees' health insurance plan.

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.**

Response: Georgia has not completed a comparison of the services, benefits, or cost sharing available through our CHIP program to the exchange plans.

However, several organizations have completed reports that include a comparison of Georgia's CHIP program to Exchange plans.

The Robert Wood Johnson Foundation issued a report[1] in July 2014 that was completed by Wakely Consulting Group that included a comparison of Exchange plans available in Georgia to the PeachCare for Kids (CHIP) program. They concluded that the Actuarial value of Georgia's CHIP plan is 99.3% with an average annual cost sharing of $24.00 when compared at 160% and 210 % of the FPL.

The National Alliance to Adolescent Health also completed a study[2] that compared Georgia's plan to exchange plans. They concluded that Georgia's CHIP coverage is much more affordable and provides a broader set of benefits than subsidized silver plans sold in the federal exchange. For your comparison purposes, the premium cost per month for PeachCare for Kids® coverage is $0 to $35 for one child and a maximum of $70 for two or more children living in the same household. There is no cost for coverage for children under age 6. Additionally, co-pays range from $0 to $15.00 depending on the service provided and the age of the child. There are no copays for preventive care services, including well child visits. Federal requirements limit out of pocket costs for CHIP to be no more than 5% of household income, including premiums and co-pays.

The aforementioned studies, as previously noted, were completed by third party organizations and their findings have not been validated by the State of Georgia.

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?

Response: Children covered through CHIP could be enrolled in other insurance through the federal exchange. The exchange plan must be comparable to CHIP and be approved by the Secretary of Health and Human Services. To date, the Secretary has not certified such a plan. Also, the exchange is only an option if the child's parent does not have access to affordable employer-sponsored insurance.

Until such time that the Secretary identifies comparable plans, the disparity between the CHIP premiums and copayments and their impact on enrollment remains unknown. Therefore, an estimate of the number of children that would be uninsured is difficult to determine at this time. However, we do know that today some families have difficulty paying the relatively low cost-sharing for the CHIP program, and we project that approximately 170,000 children would lose CHIP coverage in Georgia if the program ended at this time.

The ACA required children 100%-138% of FPL to be covered by Medicaid. This population is sometimes referred to as "stair step kids." In Georgia, these children were previously covered under our CHIP program, PeachCare for Kids®. Though this is a mandatory expansion of Medicaid, CMS allowed states to continue to draw the enhanced CHIP federal match for the stair step population even though they are enrolled in Medicaid. The end result was that moving this population to Medicaid had no cost impact to the state.

If Congress were to discontinue the CHIP program, they would need to either: 1) remove the requirement that Medicaid cover kids up to 138% of FPL; or 2) continue the enhanced FMAP for the stair step population.

Consistent with the recommendations of the Medicaid and CHIP Payment Access Commission (MACPAC), an additional two (2) years of funding would provide benefits which include but may not be limited to: 1) ensuring continued access for children who may otherwise become uninsured due to increased premiums and/or patient co-payments; 2) providing sufficient marketplace experience with exchange plans delivery of healthcare services to children to assess comparability; and 3) give states adequate time to prepare for the ending of the program, and to assist with the transition of CHIP members to an exchange plan. A critically important factor Congress should consider is need for sufficient time for states to phase down the program and work toward a smooth transition for these children. Therefore, states need the earliest decision possible from Congress on the direction of this program.

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?**

Response: To date, the funding formula has worked appropriately for Georgia and we do not see a need for Congress to address the issue of unspent allotments at this time.

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?

Response: There are several federal policy changes that would be helpful.

A. **Permit individuals to seek coverage and subsidies on the exchange if the employer's offer of *family* coverage exceeds 9.5% of family income.** The ACA requires that premiums for *individual* coverage not exceed 9.5 percent of household income, but there is no limit on the employee's share of premiums for *family* coverage. Considering the cost of *family* coverage as a percentage of family income as criteria for accessing coverage through a subsidized plan via the exchange should be considered. Otherwise, the cost of family coverage may cause many to opt out of providing coverage for their children.

B. **Permit federal subsidies for people with incomes below 400 percent of the federal poverty level.** These subsidies are not currently available for anyone who receives an offer of insurance from an employer. That means workers who can't afford employer-offered premiums for family coverage now have nowhere to go except the Children's Health Insurance Programs (CHIP) or Medicaid, if they qualify. Congress should consider expanding Premium Assistance approaches to assist families in purchasing employer-sponsored coverage for children and their parents as an alternative to CHIP. We believe maintaining coverage as a family unit – rather than approaches that split parents and children – is a preferable approach and is beneficial to the family.

C. **Change *Vaccines for Children (VFC)* rules for CHIP to match Medicaid rules, so that they are the same for all CHIP and Medicaid programs.** Children enrolled in a stand-alone CHIP program are not eligible to receive VFC stock because the children are considered insured. Children enrolled in a Medicaid expansion CHIP model are eligible to receive VFC stock because they are considered to be Medicaid eligible. The current rule creates administrative and access barriers to vaccines while disadvantaging certain states like Georgia who have established separate CHIP programs

Again, Georgia appreciates the opportunity to provide our thoughts on the future direction of the CHIP program. As Congress evaluates various options going forward, please do not hesitate to let me know if you have any questions or concerns. For any follow up inquiries, please contact Clyde Reese, Commissioner, Department of Community Health, at [redacted].

Sincerely,

[redacted]

Nathan Deal

1. Wakely Consulting Group, A. B. (2014, July). Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans. Retrieved August 1, 2014, from Kaiser Health News: http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf

2. Fox, M. M. (2014, July). The National Alliance to Advance Adolescent Health. Retrieved August 7, 2014, from thenationalalliance.org: http://www.thenationalalliance.org/index.cfm

EXECUTIVE CHAMBERS

HONOLULU

NEIL ABERCROMBIE
GOVERNOR

October 10, 2014

The Honorable Fred Upton
The Honorable Henry A. Waxman
The Honorable Ron Wyden
The Honorable Orrin G. Hatch
2183 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Upton
Congressman Waxman
Senator Wyden
Senator Hatch:

This letter is in response to the questions posed regarding the Children's Health Insurance Program (CHIP) in your July 29, 2014 letter. CHIP is an immensely valuable program for reducing the rate of uninsured children. According to the U.S. Census Bureau Current Population Survey 2013 Annual Social and Economic Supplement, Hawaii had an uninsured children rate of 3.6%, one of the lowest in the nation. CHIP, which provides health care coverage to 28,230 children in Hawaii, plays an important role assuring access to health care for Hawaii's children.

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, 28,320 children, of which 88 were blind or disabled, benefited from Hawaii's CHIP program. The distribution of eligible children by island of residence is 57% Oahu, 18% Hawaii, 14% Maui, 9% Kauai, and 1% Molokai/Lanai. Of the eligible children statewide, 1% were age <1 year, 19% age 1-5 years, and 80% age 6-19 years. Distribution by household income is provided in the table.

% FPL	#	%
<150	575	2.0%
150 to <200	53	0.2%
200 to <250	21	0.1%
250 to <300	27671	97.7%
Total	28320	100.0%

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?**

   Hawaii has implemented CHIP as a Medicaid expansion program. As such, the two programs are fully integrated from an operational perspective. Hawaii has implemented changes specifically required under the ACA (e.g., provider enrollment and screening), and has successfully implemented a new eligibility system with online application capability and interface to the federal services data hub. The implementation of PPACA has otherwise not impacted Hawaii's administration of its CHIP program.

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 in Hawaii covered under CHIP receive full Medicaid state plan benefits, including EPSDT, which meet minimal essential coverage and are comparably or more available compared to commercial health plans available in the State. Hawaii's CHIP has no cost-sharing.

   I strongly support extending the enhanced reimbursement in Medicaid, expanding provider eligibility to other key specialties and provider types, and extending these initiatives to all of CHIP or at least to Medicaid expansion CHIP. Commercial health plans reimburse providers at a higher rate. The reimbursement enhancement to primary care providers in Medicaid has been valuable, but this provision did not extend to CHIP. This has been challenging in states, like Hawaii, that have implemented CHIP as a Medicaid expansion as it has been difficult to implement the enhancement for primary care providers but not for CHIP providers as Hawaii does not have a separate CHIP program.

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?**

   No child should be without health insurance, and I strongly recommend that CHIP funding be extended. To avoid any gap in program continuity and provide stability to states, funding should be established prior to expiration of the current funding and for a period of no less than two years, preferably ten years.

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 CHIP funding for Hawaii has 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 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?**

   Looking at the federal funding given to health insurance exchanges for outreach as precedent, providing 100% federal funding to states for outreach to identify and enroll uninsured children would be beneficial. For younger children, increased federal funding could be made available to public health agencies to incorporate health insurance tracking and application assistance with immunization efforts. For school age children, schools in receipt of federal funding could be required to verify that students have health insurance, and schools could be required and/or given the authority to submit an application for affordable health insurance on behalf of an uninsured student.

Thank you for the opportunity to communicate my complete support for continued funding for the CHIP program and for other efforts to reduce the rate of uninsured children. If you have any questions regarding these responses, please contact our State Medicaid Director, Dr. Kenneth Fink, by phone at [redacted].

[redacted]

NEIL ABERCROMBIE
Governor, State of Hawaii

cc: Patricia McManaman, (DHS, Director)
Kenneth S. Fink, MD, MGA, MPH, (DHS, MQDA)