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March 4, 2015

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
Washington, D.C. 20510

The Honorable Fred Upton
Chairman
House Energy and Commerce Committee
Washington, D.C. 20515

The Honorable Joe Pitts
Chairman, Health Subcommittee
Committee on Energy and Commerce
Washington, D.C. 20515

Dear Chairmen Hatch, Upton, and Pitts:

I am writing on behalf of the First Focus Campaign for Children (FFCC), a bipartisan advocacy organization committed to making children and their families a priority in federal policy and budget decisions, to thank you for your long-standing leadership in support of the Children's Health Insurance Program (CHIP) and for releasing the "discussion draft" to extend CHIP. We applaud you for your commitment to extend CHIP and ensure continuity of coverage for the over 8 million low-income children in working families who currently rely on CHIP for their health coverage.

Since its inception in 1997, CHIP has been a vital program for low-income children in working families whose parents earn too much to qualify for Medicaid but not enough to purchase private health insurance. By all accounts, CHIP has been a remarkable bipartisan, success story. According to the Centers for Disease Control and Prevention, since CHIP was established, the uninsured rate for children has been successfully cut by more than half - from 13.9 percent in 1997 to 6.6 percent in 2012.

CHIP has also played a critically improving health outcomes and access to care for children and pregnant women across the nation. In a congressionally mandated evaluation of the program by Mathematica Policy Research and the Urban Institute that was released this past August, the authors conclude, "CHIP succeeded in expanding health insurance coverage to the population it is intended to serve, particularly children who would otherwise be uninsured, increasing their access to needed health care, and reducing the financial burdens and stress on families associated with meeting children's health care needs."

Simply put, CHIP works. For example, in a recent 2014 Satisfaction Survey of Iowa parents whose children were enrolled in "hawk-i" (Iowa's CHIP program), an astounding 93.7 percent expressed satisfaction with the care received and less than 1 percent (or 0.7 percent) expressed dissatisfaction with the care their children received.

Knowing its value and importance to children across this country, just last week, we sent you a letter from over 1,500 national, state, local, and religious organizations that expressed their support for the extension of CHIP.

Furthermore, of the 42 governors who responded to your request for comments, none asked for CHIP to end. The governors, on a bipartisan basis, also highlighted the fact that CHIP provides stronger coverage to children than all possible alternatives. As a summary of the governors' letters by the United States Senate Finance and House Energy and Commerce Committees notes, "Governors reported that CHIP is more affordable to consumers than exchange or employer-sponsored coverage and generally has a richer benefit package. All 34 governors that mentioned the cost of care to consumers indicated that CHIP coverage is more affordable than private coverage, such as that offered on the exchanges or by employers."

The American people, across the political spectrum, also support CHIP. In a poll conducted by American Viewpoint, a Republican polling firm, last May, voters supported the extension of CHIP by a overwhelming 74-14 percent margin. Democrats, Republicans, Independents, and Tea Party supporters all overwhelming supported CHIP's extension. In fact, even voters that self-identified as supporters of the Tea Party said they favored CHIP's extension by a wide 66-18 percent margin.

And finally, the Medicaid and CHIP Payment and Access Commission (MACPAC), a non-partisan agency created by Congress to make policy recommendations to Congress, the Secretary of Health and Human Services (HHS), and the states on a wide range of issues related to Medicaid and CHIP, also recommends that CHIP be extended. In testimony before the U.S. House Energy and Commerce Committee, Anne Schwartz, MACPAC's Executive Director, warns that if CHIP were to expire, "Many of those affected children would become uninsured or face significantly higher cost sharing and potentially different benefits and provider networks in the exchange."

Fortunately, it is clear that you recognize just how much is at stake for children and the urgency with which Congress must act. As House Republican Energy and Commerce Committee Chairman Fred Upton said in a February 24th press release:

> At an Energy and Commerce Committee hearing last year, experts from the Congressional Research Service, Medicaid and CHIP Payment and Access Commission (MACPAC), and Government Accountability Office testified that hundreds of thousands of children could be uninsured, and millions could face higher cost-sharing in the health law's exchanges if Congress does not extend the program.

Chairman Upton added that the goal of Republican leaders is to "extend [CHIP] funding and sustain access to affordable health coverage for millions of children." We wholeheartedly agree.

Therefore, as Congress moves forward, we urge that a few overriding principles be adopted. The first principle should be that **children should not be left worse off**. With the success of CHIP, the important role it plays in the health and well-being of millions of America's children, and its overwhelming popularity, it would be a travesty to have children lose coverage or be left with inferior coverage by congressional action or inaction.

Another important and related principle should be that, because CHIP has been so successful and, by definition, focused on the specific needs of children, we urge the adoption of additional common sense principles of **do no harm** and **if it ain't broke, don't fix it**. Congress must be careful, as it proceeds, to **not gamble with the health care of children**.

As you know, without an extension of funding for CHIP beyond the current September 30, 2015 expiration date, between 1-2 million children who would lose CHIP coverage would become uninsured due to the "family glitch" in the Affordable Care Act (ACA).

Millions of other children currently enrolled in CHIP would possibly move into exchange coverage, but the Wakely Consulting Group has found, in an extensive study comparing CHIP coverage to that in ACA exchanges across the country, coverage in the exchanges to be inferior to that in CHIP. In fact, average out-of-pocket costs were estimated to be more than 900 percent higher and benefits more limited in exchange plans than CHIP, and yet, the Congressional Budget Office (CBO) estimates that CHIP coverage is less expensive. In makes little sense to move children to more costly, and yet, inferior coverage.

States are in session right now trying to finalize their budgets prior to the close of their legislative session. Therefore, legislation to secure CHIP's future is urgent if states are to continue to operate their programs without interruption. We are are committed to working with you to secure congressional action to extend CHIP funding as soon as possible and would like to offer the following comments to your "discussion draft."

CHIP Funding Extension

As a signee of the letter with over 1,500 organizations across the country, we are on record in support of a four-year extension of CHIP funding. Although MACPAC recommended a shorter two-year extension, their recommendation included a slew of changes to the ACA that would be necessary before Congress should consider moving children into exchanges. Bearing in mind that Congress is clearly not inclined to take up the variety of measures that would be necessary to make coverage for children comparable in the exchanges as that offered by CHIP, including elimination of the ACA's "family glitch," reducing cost sharing, improving pediatric and dental benefits of importance to children, improving pediatric provider networks, etc. in the exchanges, we believe that a four-year extension is more reasonable and would support an even longer period of time if Congress were inclined to do so.

In fact, until an alternative is in place that is clearly comparable or superior to the coverage that millions of children currently receive in CHIP and that also shows it can focus on and specifically address the special needs of children, we support the continuation of CHIP. The fact is that CHIP works well and is, by definition, child-specific. Per the principles mentioned before, children should not be left worse off, we should be careful to do no harm, and if it ain't broke, don't fix it.

We also support the summary's language that "[t]he bill would also preserve the current procedures for the redistribution of unused SCHIP allotments to shortfall states."

In addition, we would also urge the extension of the CHIP contingency fund beyond 2015. A failing of CHIP is that its financing structure is a block grant and fails to adjust for need. Congress cannot possibly anticipate potential future shortfalls in CHIP due to an unforeseen changes in need caused by the economy, natural disasters, etc. or in cost, such as changes in medical technology. Consequently, like the contingency fund that is included in TANF, we support the continuation of the contingency fund in CHIP.

Furthermore, states should not be penalized for being successful in enrolling eligible but unenrolled children and pregnant women into coverage. Without the contingency fund as a backup, states could be placed at risk of having inadequate funding to sustain coverage to children and pregnant women.

Elimination of the ACA's 23 Percentage Point Increase in the CHIP Match

The "discussion draft" calls for the elimination of the "23 percent increase in federal SCHIP matching funds over the current enhanced match for the children's health program." The summary continues, "CBO also estimates that no new net enrollment will result from maintaining the 23 percent funding increase. Therefore, there is no policy justification to continue to direct federal taxpayer dollars to efforts that do not impact coverage for low-income children."

As CHIP is a capped entitlement to states, an increase in the federal matching rate does not result in net new enrollment for children. In fact, if there is a higher federal matching rate, the federal allotments to states would be spent faster and so Congress would need to raise the allotments to states in an extension in order to maintain coverage for children.

If Congress chooses to maintain the scheduled 23 percentage point increase in the federal matching rate, we understand that the extension of CHIP funding would cost something like $5 billion over 2 years and $10 billion over 4 years. Although Congress rarely offsets other extenders, including numerous tax extenders or a recent Medicare sustainable growth rate (SGR) extension, or even new costly initiatives, such as tax cuts or the Medicare prescription drug benefit expansion, we would be extremely concerned about the need to find offsets for a CHIP extension.

Per your specific request, if the choice were to eliminate this provision or to come up with a specific package of Medicaid cuts, we would strongly oppose cutting Medicaid to pay for CHIP. If Congress were to eliminate the scheduled 23 percentage point increase in the federal matching rate and maintain the current matching rate, as the "discussion draft" proposes, we understand that CBO would score an extension as saving money.

However, we would highlight two major concerns that arise. First, states are currently setting their budgets and, according to a survey by the National Academy for State Health Policy (NASHP) of CHIP directors, some states are factoring an anticipated increase in the federal matching rate into their budget calculations. This points to the need for Congress to take action as soon as possible so that states can properly budget for their CHIP costs.

In addition, as we will point out below, we are strongly opposed to the proposal to eliminate the maintenance of effort (MOE) for a number of reasons. However, if Congress were to eliminate the MOE, a lower matching rate would create a financial incentive for states to eliminate CHIP in their states with the result that millions of children would either lose coverage entirely or be moved into inferior exchange coverage. Since we do not support providing states with a financial incentive to eliminate their CHIP programs, we would support 100 percent FMAP if the MOE were to be eliminated. We want to underscore that these provisions interact with one another in important ways that would potentially adjust our position in order to adhere to the principle that children should not be left worse off.

Elimination of the Maintenance of Effort

Congress has historically imposed a maintenance of effort (MOE) requirement when it passes new initiatives in a number of areas, including transportation, TANF, K-12 education, higher education, grants to non-profit groups, the Medicare prescription drug benefit, etc. The federal government does so to ensure the new initiatives actually serves the purpose they are intended to achieve rather than to simply supplant state or local funding. Without MOE's in a variety of programs, state and local governments could simply

eliminate their own effort and shift all of their spending on to the federal government with no or actual reduced benefit.

When Congress passed the ACA, the intent was to reduce the number of uninsured citizens in this country and not to simply take over the costs of current spending by states. Consequently, a MOE was included so that states would not shift current Medicaid and CHIP enrollees into the federal exchanges and actually leave their with higher cost sharing, weaker benefits, and at a higher cost to the federal government. We strongly oppose eliminating the MOE for those reasons.

In fact, the Congressional Budget Office (CBO) scored legislation in 2011, H.R. 1683, introduced by Rep. Phill Gingrey of Georgia, that would have eliminated the Medicaid and CHIP MOE requirement and found the bill would have the greatest negative impact on our nation's children. The reason is that CBO estimates the bulk of the impact would negatively impact CHIP.

In fact, although CBO estimated some impact to the Medicaid program, CBO estimates that "H.R. 1683 would have a significant impact on state CHIP programs" and that "by the end of 2016 half of the states would cease participating in the CHIP program."

The reason cited is that states will have a financial "incentive to reduce or eliminate CHIP" because, in the absence of CHIP, some children would be able to shift their coverage to the federal exchanges. As CBO notes, "Subsides for coverage provided through exchanges is funded completely by the federal government while states have to share in the cost of CHIP."

Other states may not cut children off outright, but they could use backdoor strategies, such as enrollment and administrative barriers, to keep children out of CHIP and simply shift health care costs to the federal government. Consequently, millions of children in working families will lose a trustworthy, proven, and popular source of coverage that allows them to get the medical treatment they need when they get sick.

And, as some states dropped CHIP, their members in Congress would be disinclined to support further extensions in CHIP for other states. Over time, CHIP would rapidly lose ground or whither away even in states that wanted to protect their children's health coverage.

As for the alternatives of coverage to kids, some children would lose health insurance entirely in large part due to the "family glitch" included in the ACA, millions of other children would move into inferior coverage in the ACA, and others would move into inferior private sector coverage. As a result, millions of children would be left worse off by such a change.

Therefore, the MOE is a critically important provision that is necessary to preserve and protect CHIP for millions of our nation's children. And frankly, it would be terribly ironic and harmful to children for this Congress to take action, even if unintentional, that would have the effect of creating financial incentives for states to move children from strong and popular CHIP coverage and move them into the ACA – a program that a number of Members of Congress have been trying to repeal.

Due to all of these reasons, FFCC would strongly oppose the elimination of the MOE, as it would undermine CHIP and Medicaid and negatively impact the health of millions of our nation's children. Again, Congress should not leave children worse off.

However, if for whatever reason, Congress is so inclined to eliminate a MOE provision so that states could supplant their spending with federal dollars, we would urge Congress to do so with respect to the Medicare prescription drug benefit instead. Unlike eliminating the Medicaid and CHIP MOE, elimination of the Medicare prescription drug MOE would not result in harm to anyone's health coverage.

Imposition of Coverage Limits and Restrictions

The "discussion draft" proposes to reduce the enhancing matching rate for CHIP coverage to children above 250 percent of poverty and eliminate it entirely for children above 300 percent of poverty. By definition, this provision to reduce the federal matching rate for some children or to eliminate it entirely for children would also violate the principle of ensuring that children are not left worse off. As such, FFCC would oppose its inclusion in a CHIP extension package.

As the "discussion draft" summary acknowledges, "Currently 18 states and the District of Columbia have upper income eligibility levels that exceed 300 percent federal poverty level (FPL)."

Moreover, if Congress were to reduce the enhanced match for children above 250 percent of poverty and eliminate it entirely for children above 300 percent of poverty, 27 states (Alabama, California, Colorado, Connecticut, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Washington, West Virginia, and Wisconsin) and the District of Columbia would have to increase their contribution of funding to maintain current levels of CHIP coverage or scale back their CHIP programs, which would leave children worse off. Again, some would lose coverage entirely and others would move into inferior coverage in the exchanges (only, of course, if *King v. Burwell* doesn't also eliminate subsidies in states that rely on the federal exchange).

One of the great strengths of CHIP is that states have been able to establish their CHIP programs with great flexibility in order to meet the needs of their specific populations. As a result, states have responded over the last 18 years, since CHIP's inception, to meet those needs in different ways. Consequently, it should not be surprising that states like New York or California cover children at a higher level of income than other states across the country where both the cost of living and health costs are significantly lower.

FFCC would strongly urge that Congress not add such a provision in a CHIP extension as it violates the principles stated previously. We urge you not to create financial incentives for states to either lose money or to end coverage to children currently enrolled in CHIP. These options would potentially leave over 200,000 children in 27 states worse off, as states would be put in the position of either losing federal financial assistance for covering children or causing states to end such coverage, which would move children to the ranks of the uninsured or into the ACA. In either case, this would, once again, violate the principle of ensuring that children are not left worse off.

Allow States to Impose Up to a 12-Month Waiting Period on Coverage

We oppose provisions that would allow states to require that children and pregnant women wait as long as a full year before eligible children could enroll in CHIP. Under current law, states cannot impose waiting periods of more than 90 days for coverage and 33 states have eliminated such waiting period entirely.

If a state adopted a 12-month waiting period, children who are eligible for CHIP might have to first enroll in coverage through the exchanges (only if they are not deemed ineligible for that coverage as well due to the family glitch). This would force a great deal of churning, changes in coverage, changes in providers, and

unnecessary bureaucratic expenses in the enrollment process. Consequently, this would violate the principle of not leaving children worse off.

Beyond children, this provision could also be applied to pregnant women, which is nonsensical. By definition, pregnant women cannot wait 12 months for health coverage. As such, we would urge that this provision not be added to any CHIP extension, and instead, encourage states to eliminate their waiting periods for children.

Outreach and Enrollment Grants

Although the "discussion draft" does not mention outreach and enrollment grants, we would urge the inclusion of such grants, particularly to community-based groups, in a CHIP extension package. Nearly two-thirds of the uninsured children in this country are eligible for but unenrolled in either Medicaid or CHIP, so there remain several million children that could benefit from health coverage that they are eligible to receive.

The initial idea of outreach and enrollment grants originally came from the Bush Administration, which initially proposed $1 billion for efforts to improve the enrollment rates of children. Republican Majority Leader Bill Frist then championed legislation called the "Covering Kids Act" that was ultimately incorporated in CHIPRA.

State Options for Coverage of Legal Immigrant Children and Immigrant Pregnant Women

The "discussion draft" does not mention and would seemingly leave in place the state options that allows states to provide Medicaid and CHIP coverage to legal immigrant children and pregnant women and to "unborn children". We would strongly support allowing these state options to continue.

Without the first option, legal immigrant children and pregnant women would be forced to wait five years to qualify for needed health coverage. For a child, this can be a lifetime. A child with cancer, in need of eyeglasses, or with asthma simply cannot wait for five years to get the health care they need. Moreover, asking a legal immigrant pregnant woman to wait five years to get health care is completely nonsensical.

Meanwhile, the "unborn child" definition in CHIP, which was pushed by the Bush Administration and adopted in CHIPRA, allows undocumented immigrant mothers to receive prenatal care coverage.

Considering that the United States has one of the highest infant mortality rates in the world, we should do everything possible, including maintaining these state options, so that our nation can continue its push to improve birth outcomes and reduce infant mortality across this country. Eliminating either of these options would leave infants worse off.

Reduce the Matching Rate for Certain Services for ESL Populations

We would oppose reducing the matching rate for translation and interpretation services provided to Medicaid and CHIP beneficiaries so that, as the Center on Budget and Policy Priorities (CBPP) recently wrote, "states have additional resources to ensure that language barriers do not prevent eligible children from enrolling." These services are also important for families to understand how to access coverage and benefits for their children.

The rules also allow states to use these dollars to translate and provide interpretation for hearing- and visually-impaired populations. Without these services, if states choose to drop or minimized the services, children may be forced to interpret medical information for their parents in medical settings.

Extend the Qualifying State Option

We support the provision in the "discussion draft" that extends the qualifying state option. This provision permits 11 early expansion "qualifying states" to use their CHIP funding to serve children who would otherwise be covered by CHIP in any other states above 133 percent of poverty. We urge the extension of the current law provision of this language, as states should not be penalized for having expanded coverage to children prior to the federal adoption of CHIP in 1997.

Give States Flexibility to Move Children Between 100-138% of Poverty Into CHIP

As the "discussion draft" summary notes, "ACA required states move children ages 6 to 18 in families with income between 100% and 133% of the federal poverty level (FPL) onto Medicaid. . . ." The rationale for this provision in the ACA was to simplify coverage for children, as the ACA requires states to provide Medicaid coverage to all children in families below 138% of the poverty line. This provision eliminated the situation in some states where families had children below the age of 6 enrolled in Medicaid and above the age of 6 in the state's separate CHIP program. It also eliminated the need for children to shift from one program to the other at age 6 even when the family's income had not changed.

In many cases, children were left better off with their transfer of coverage from CHIP to Medicaid, as Medicaid typically provides more comprehensive health benefits and lower out-of-pocket changes than that in separate state CHIP programs. On the other hand, others have argued that provider networks are sometimes stronger in CHIP so access to care may have dropped with the transfer.

On balance, we believe this change in the ACA was beneficial to children and families, although the outcome was likely different for children depending on the state or community in which they reside. If the Congress decides to include this provision, a possible way forward would be for a state to allow be allowed to take up this option if it demonstrates to the satisfaction of the Secretary that such a change would be meet the principle that children and families should not be left worse off by such a change.

Exempt State-Funded CHIP-Equivalent Coverage from the Individual Mandate

We support this provision.

Extend Express Lane Enrollment Option for States

Although the "discussion draft" doesn't mention it, we would strongly urge that the Express Lane Enrollment (ELE) option for states gives them the ability to coordinate coverage and enrollment data across programs and eliminate unnecessary bureaucracy, red tape, and administrative costs.

At a conference of families with children with special health care needs, discussion of this state option brought families to rise to their feet and give a standing ovation, as they are tired of having to provide proof of income, residence, immigration status, and other qualifying information to state agencies again and again – even though that very data is located within the agency's own computer system.

This common sense 21st century proposal allows states to use this option to utilize information technology for the purpose of improving and maximizing health coverage to children while minimizing the administrative costs and associated bureaucratic red tape found in many state's old eligibility systems. At present, 13 states have adopted this option and both the GAO and Mathematica have found in their evaluations of Express Lane that it has worked.

As Wendy Lazarus at the Children's Partnership recently said, "…implementing policies like Express Lane Eligibility that can help get those with limited resources access to health care in a streamlined and efficient way while generating administrative savings, well, that's a great thing."

Change of the Name of the Program from CHIP to SCHIP

In the 39 letters from our nation's governors, none of them requested that the name of the program be changed from the Children's Health Insurance Program (CHIP) to the State Children's Health Insurance Program (SCHIP). The reason is that the most common name for the program in states is "CHIP". Not even one state calls its own state program "SCHIP".

In the few years that Congress mandated that federal officials call the program by the name "SCHIP", this actually resulted in confusion in states. For example, in public forums in Colorado where they were attempting to help families understand the program and enroll their children in it, unnecessary confusion was created by federal officials referring to "SCHIP" while state and local officials spoke about "Child Health Plan Plus" or CHP+. Ironically, the state staff asked the federal official to stop calling in "SCHIP" but the federal official noted they couldn't because the law mandated they refer to the program as "SCHIP" even though the correct name in the state was and still is "CHP Plus". This was happening in a number of states across the country and the resulting unnecessary confusion led to the elimination of this requirement in CHIPRA.

Again, the fact is that most states refer to their own programs as "CHIP" and not a single one calls it "SCHIP and none of the governors asked for such a change. Consequently, under the "if it ain't broke, don't fix it" principle, this provision really doesn't add any value to a CHIP funding extension bill, and instead, would creates unnecessary confusion and conflict while relegating children to what appears to be a secondary focus.

Once again, we are grateful for your commitment to protecting the health of our nation's children, appreciate the opportunity to provide feedback to the "discussion draft," and thank you for taking the lead on legislation to make sure that CHIP continues into the future. We look forward to working with you to secure its enactment as soon as possible.

Sincerely,

Bruce Lesley
President