State of Rhode Island and Providence Plantations
State House, Room 224
Providence, Rhode Island 02903
401-222-2080

Lincoln D. Chafee
Governor

October 28, 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

Dear Chairmen and Ranking Members:

I appreciate the opportunity to express my strongest support for the continuation of the Children's Health Insurance Program (CHIP). The CHIP has been instrumental in reducing the number of uninsured children and pregnant women in Rhode Island and assuring they have access to the high quality prenatal and pediatric services they need to start and stay healthy. Moreover, the CHIP has provided Rhode Island with the crucial resources necessary to sustain RIte Care, the state's nationally recognized, successful Medicaid managed care program for families with children.

The significant contributions the CHIP has made to children's health are not unique to the State of Rhode Island. The CHIP has played a similar role in ensuring access to care and better health outcomes for children in states all across the nation. Given the gains the CHIP has made, it is critical that Congress act to re-authorize the program for an additional four more years along with the already scheduled 23 percent increase in the CHIP federal match rate. Without decisive action to extend the CHIP by the end of this year, millions of children will lose access to cost-effective, high-value health coverage and we, as a nation, will be dealing with the consequences for generations to come. For states like Rhode Island which have emerged as leaders in children's health, the extension of the CHIP is critical not only for preserving the gains we have already made, but also for ensuring we have the resources necessary to continue to succeed in the years ahead.

As per your request, below are the responses to questions contained in your letter of inquiry pertaining to the scope and operations of the CHIP in Rhode Island:

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)?

Rhode Island operates a combined Medicaid/CHIP program for families, pregnant women, and children through its RIte Care managed care delivery system. RIte Care uses a medical home model centered on providing the best evidenced-based practices in primary care.

As of September 30, 2014, an average of 20,803 of the children and pregnant women enrolled in RIte Care received health coverage funded, in whole or in part, by the CHIP. As we administer a joint Medicaid/CHIP program, we use a single income eligibility for each RIte Care population regardless of funding source. The Modified Adjusted Gross Income (MAGI) eligibility limit for RIte Care children is at or below 261% of the federal poverty level (FPL); the MAGI limit for pregnant women is at or below 253% of the FPL.

Since RIte Care was established 30 years ago, we have been providing high-quality, affordable health care to Rhode Islanders who might otherwise be uninsured. The CHIP has enabled Rhode Island to maintain and, in some instances, expand RIte Care eligibility for children and pregnant women at risk for poor health outcomes from regions all across the state. On-going evaluations of RIte Care health plans show that they are achieving positive health and utilization outcomes ranging from low rates of emergency hospital admissions and preventable hospitalizations, to fewer high-risk pregnancies and infant deaths, declines in pregnant women who smoke and present with gestational diabetes, and healthier newborns, infants, and children overall.

Rhode Island has one of the lowest rates of uninsured children in the country (5.4% of children lacked insurance coverage in 2013). This low rate of uninsured children is due, in a large part, to Medicaid/CHIP-funded RIte Care coverage. Rhode Island's CHIP participation rate was 90.4% in 2012, higher than the national average of 88.1%. However, Rhode Island still has room to improve. Approximately 71% of the uninsured children in Rhode Island between 2010 and 2012 were eligible for RIte Care based on their family income, but were not enrolled. While some of these children mostly likely enrolled in 2014, we know that we still have uninsured children in the community and CHIP is key to helping us to finish the job of insuring kids.

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 several changes made to the RI CHIP as a result of the Patient Protection and Affordable Care Act (PPACA). Each is outlined below:

CHIP Claiming -- A major impact of the PPACA was the loss of the state's authority to claim CHIP funds for health coverage provided to RIte Care families with incomes under 133% FPL. The loss of revenue from that change forced the state, for financial reasons, to lower the Medicaid/CHIP eligibility of parents and caretakers from 175% to 133% of the FPL and shift them to our new health insurance marketplace -- HealthSource RI (HSRI). The state has offered these parents state-funded premium assistance to help pay for the federally subsidized qualified health plans (QHP) they can now purchase through HSRI.

MAGI Income Standard -- The PPACA required all states to use the MAGI methodology for determining income eligibility for Medicaid and CHIP coverage. Beginning in 2014, Rhode Island eligibility levels for the CHIP were revised upwards by 3 to 5% based on MAGI methodology.

Streamlined Access -- The PPACA required states to simplify the application process, coordinate enrollment between Medicaid/CHIP and QHP coverage, and implement an electronic verification process to ensure seamless access to coverage options. Rhode Island has made significant progress in improving access in all these areas through our new automated eligibility system. We now have a fully integrated and interoperable system which uses a single on-line application for making determinations for affordable coverage funded wholly or partially through Medicaid/CHIP, federal tax credits and cost sharing reductions, or employers.

Consumer Support -- Rhode Island implemented enhanced consumer support services as required by the PPACA in October of 2013. Implementation of these new services in conjunction with our new unified eligibility greatly improved RIte Care access and enrollment. For example, from October 2013 to March 2014, an additional 12,000 children and parents with CHIP-funded coverage enrolled in RIte Care managed care plans.

Elimination of Premiums -- The coordination between Medicaid/CHIP and QHP plans required by the PPACA posed operational and equity issues for continuing RIte Care premiums. The state opted to eliminate RIte Care premiums effective January 1, 2014 to: (1) reduce the likelihood of premium stacking; and (2) provide an incentives for parents of RIte Care eligible children to enroll in a QHP through HSRI if otherwise not qualified for Medicaid coverage.

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.

At present, there are no commercial QHPs available in Rhode Island that provide health care coverage comparable to the Medicaid/CHIP-funded RIte Care plans when taking into account differences in the scope, amount, and duration of benefits and cost-sharing obligations. RIte Care enrollees have no cost-sharing or out-of-pocket costs. Additionally, RIte Care plans provide a more extensive array of child-specific services with fewer limits than QHPs. For many families, especially those who have a child with disabilities, it is nearly impossible to obtain comparable coverage to RIte Care plans at an affordable cost even through subsidized HSRI plans.

There are two areas of coverage where the differences between RIte Care and QHP plans is most pronounced due in large part to federal Medicaid and/or CHIP requirements: RIte Care enrollees must have access to comprehensive pediatric dental coverage and any medically necessary services deemed warranted as a result of Early Periodic Screening Detection and Treatment (EPSDT) requirements. In Rhode Island, as in most states, pediatric dental coverage and many EPSDT services are either unavailable or unaffordable in the commercial health insurance marketplaces. We do not anticipate that commercial or employer-sponsored plans will provide coverage for these services for children in the near future: most enrollees in these plans purchase them out-of-pocket.

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?

As stated at the outset of this letter, Rhode Island strongly supports extending CHIP's funding and as soon as possible. The state is facing significant budget pressures in the year ahead and most likely will be unable to sustain Medicaid coverage at current eligibility levels for certain populations if the CHIP is not re-authorized. The sooner Congress passes legislation to extend CHIP funding, the less uncertainty there will be and the more time states will have to ensure critical coverage is not disrupted. Congress should also maintain the scheduled 23 percent federal matching rate increase that goes into effect next year. These enhanced matching funds will help states like Rhode Island continue to provide high quality children's health coverage, as they have since the CHIP was initially enacted. Rhode Island also recommends that Congress extend CHIP funding at least through 2019. The PPACA requires states to maintain current Medicaid and CHIP eligibility levels for children until 2019. This Maintenance of Effort (MOE) provision would apply to the nearly 20,000 RIte Care children currently funded through CHIP.

If CHIP funding is not renewed, Rhode Island would lose the enhanced CHIP match but still be required to maintain existing coverage levels at the lower Medicaid FMAP under the MOE. As a result, Rhode Island's federal financial support for coverage would decrease by the difference between the CHIP and Medicaid match rates. For FY2014, Rhode Island's CHIP-FMAP is 65.08 percent. The scheduled match increase would bring Rhode Island's CHIP-FMAP to 88.08 percent. In comparison, Rhode Island's FMAP for FY2014 is 50.11 percent.

It is essential that Congress act to reauthorize the CHIP in a timely manner that takes into consideration the imperatives of state budget cycles. If Congress delays taking action until FY 2016, states like Rhode Island face dire fiscal consequences: Rhode Island stands to lose an estimated $28.19 million of annual federal CHIP dollars. Covering any of this difference would be a challenge for our state, given current and projected deficits. As roll-backs in eligibility for children are not feasible, Rhode Island will have no option but to reduce access to Medicaid coverage for adults, vulnerable elders and persons with disabilities, most of whom will be unable to purchase comparable affordable coverage through HSRI.

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 allotment for Rhode Island has not been sufficient. We are among the states that regularly exhaust our CHIP allotment and receive additional dollars (a total of millions) from other states that have not done so. Although no new federal funds for allotments are slated for FY2016, Rhode Island will continue to be able to draw on unspent federal CHIP funds returned by other states, as long as they are available, unless Congress develops a new allotment formula. Congress may want to consider the option of increasing allotments to states like Rhode Island which not only consistently use their complete allotment, but achieve improvements in health access and outcomes that meet or exceed the goals of the CHIP.

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 improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

Although Rhode Island has had some success on the enrollment front, we are committed to providing every child in the state with access to high quality health care. There are several strategies and federal policies that could be implemented to facilitate access and improve health outcomes. For example, Congress could allocate more resources to expand services in high demand, such as pediatric dental coverage, by providing an enhanced federal match.

Congress may also want to consider providing states like Rhode Island that operate combined Medicaid/CHIP programs and/or utilize their full allotments with additional flexibility. Combined programs are bound to follow Medicaid rules and this prevents states from using the flexibility provided in the CHIP authorizing statute to tailor benefit packages to meet the changing needs of the children we enroll. In Rhode Island, additional flexibility would allow us to focus on high demand but short supply service areas like behavioral health and to develop new design, delivery and payment approaches that more effectively leverage and integrate federal and state dollars, promote population health, and recognize the whole range of social supports kids need to start and stay healthy – e.g., stable families, housing, food security, etc.

Conclusion

I urge you to extend CHIP funding as soon as possible. CHIP is essential to assuring that we do not lose ground on children's coverage in Rhode Island and as a nation.

Thank you for the opportunity to respond to these important questions. Please contact me or any member of my staff should you have any questions.

Sincerely,

[redacted]

Lincoln D. Chafee
Governor, State of Rhode Island

cc: Steven Costantino, Secretary, Executive Office of Health and Human Services
David Burnett, Deputy Director, Executive Office of Health and Human Services
Deidre Gifford, Medicaid Director, Executive Office of Health and Human Services
Deborah Florio, CHIP Director, Executive Office of Health and Human Services
Jacqueline Kelley, Esquire, Executive Office of Health and Human Services

STATE OF SOUTH DAKOTA
DENNIS DAUGAARD, GOVERNOR

October 28, 2014

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton,

Thank you for the opportunity to provide information about the Children's Health Insurance Program (CHIP) reauthorization. CHIP provides insurance coverage to over 12,500 low-income children in South Dakota, and I strongly support continued funding for this program.

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

   There were 12,519 children enrolled in the CHIP program during our State Fiscal Year 2014 (July 1, 2013-June 30, 2014). Eighty percent of the children are age six years or older. The vast majority of children are at lower incomes with 77%, with income less than 182% of the federal poverty level ($43,407 annually for a family of four).

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?

   South Dakota implemented the required PPACA changes including the federal poverty level conversion, modified adjusted gross income (MAGI) eligibility methodologies, use of the federally required streamlined application to include tax filer information for other Insurance Affordability programs and Qualified Health Plans, and telephonic application capability. Although CHIP funding expires in September 30, 2015, the CHIP program remains authorized and states may use unspent portions of their FFY15 allotments. In addition, the PPACA also increased the enhanced Federal Medical Assistance Percentage (FMAP) available to states for CHIP programs by 23% beginning in FFY16. Unless CHIP allotments are increased, this will speed up the rate at which states spend their allotments resulting in potential funding shortfalls. The PPACA also added a Maintenance of Effort (MOE) provision and states must maintain Medicaid and CHIP eligibility standards, methodologies, and procedures that are no more

restrictive than those in effect March 23, 2010. An exception to the MOE requirement includes the lack of federal CHIP funding.

Despite these changes, the Centers for Medicare and Medicaid Services (CMS) maintain the implementation of PPACA would not result in significant reductions to the CHIP program. However, South Dakota continues to experience a significant shift of children from the CHIP program where services are paid at the enhanced federal match rate to Medicaid where services are funded at the regular Federal Medical Assistance Percentage (FMAP). From December 2013 to August 2014, we saw a decrease of 1,833 children (-13.4%) in the CHIP program. During this same time period, our Title XIX children have increased by 2,647 (4.1%). This is the opposite trend we saw in the six months prior to PPACA implementation. From June 2013 to November 2013, we saw an increase of 604 (4.6%) CHIP recipients while our Title XIX children recipients were decreasing by 1,414 recipients (-2.1%).

South Dakota expressed concern with CMS in March 2013 when the poverty level conversions were first provided. We began to see a significant reduction to our CHIP program in January 2014 when the new federal poverty levels were implemented. At the end of April, we saw 19% fewer children enrolled in the CHIP program and an offsetting increase to children enrolled in Medicaid. In April, after continued discussions with CMS, CMS agreed to adjust the federal poverty levels by approximately 30%. While we were pleased with this adjustment, we continue to see a shift from CHIP to Medicaid for children. Our latest numbers through August 2014, after adjusting the federal poverty levels, reflect a 13.5% reduction in CHIP enrollment. The result is a cost shift from the federal government to our state. In addition, although the state has successfully been able to send and receive applications to and from the Federally Facilitated Marketplace (FFM), the FFM is unable to check for existing Medicaid/CHIP eligibility causing applications to be sent to the state to process even though the applicant is already eligible for Medicaid/CHIP. Significant administrative effort was expended in assisting individuals and families who were "stuck" in the FFM process. The MAGI methodologies, while simplified, also require increased effort to determine eligibility individually rather than a single determination per household. The PPACA related federal reporting requirements are yet to be determined.

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.

South Dakota operates CHIP as a Medicaid look-alike program, where all Medicaid benefits are extended to individuals eligible for CHIP. In addition to the essential health benefit offered through the marketplace plans, children eligible

for CHIP have access to the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit. The EPSDT benefit allows South Dakota to provide medically necessary services to children outside of the scope of the normal services under the Medicaid or CHIP State Plan and those offered through the marketplace plans. No similar benefit is available from private health plans where children are only eligible to receive services within the limits imposed by the plan.

Some of the children who would lose coverage if CHIP is not funded will not be eligible for tax credits through the federal marketplace because a parent may have access to employer sponsored coverage. However, the affordability test for employer coverage is based on a calculation of the individual coverage relative to a workers wages, not the cost of a family policy. This situation is referred to as the "family glitch" and could leave more children uninsured.

While families at or above 100% Federal Poverty Level (FPL) are eligible to apply for subsidies and enroll in health plans offered through the exchange, the cost sharing, premiums, and out of pocket costs for plans available through the marketplace are at levels most low-income families on the CHIP program cannot afford. For example, a family at 183% FPL ($43,656 annually for a family of four) would be eligible to apply for the average silver plan through the marketplace at an average net monthly cost after subsidy of $174 per month. Additional premiums ranging from $6 up to $38 per dependent would apply and the out of pocket costs for the family plan would double from $2,750 to $5,500 by adding additional dependents. In addition, if CHIP were eliminated, parents with employer sponsored health insurance with a cost under 9.5% of their income would not be eligible for subsidy and would bear the full cost of the premium. Because families are not required to pay a premium for CHIP coverage and children under age 21 in South Dakota are exempt from cost sharing, these increased costs may result in reduced access to essential healthcare services for children. Preventative care, including preventive oral
health care has direct impacts on longer term health and avoiding higher cost care.

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

   We recommend that the CHIP funding be extended indefinitely and Congress should act on the extension of the CHIP as soon as possible to ensure there are no gaps in federal funding for the program. The South Dakota legislature will act on my fiscal year 2016 recommended budget in March of 2015. The status of South Dakota's current $20.0 million dollar federal CHIP award is a critical

component of our Medicaid budget. Currently, South Dakota utilizes CHIP funding for Medicaid eligible children who are uninsured and whose income is between 111% and 182% of the federal poverty level (over 9,200 children). If CHIP funding ends, South Dakota will be required to cover these children at the regular FMAP rate at an additional cost of $3.0 million in state funds due. South Dakota also utilizes CHIP funding for uninsured children whose family income is between 182% FPL and 204% FPL (over 2,660 children). If CHIP funding ends, these children will lose coverage altogether as there is no Medicaid coverage group for them.

In addition to funding benefits, CHIP is used to fund $1.0 million annually in administrative costs, primarily for program eligibility determination staff. The loss of CHIP funding would result in an annual state general fund impact of $160,000.

5. In spite of 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 redistribution of CHIP funding in 2009 was critical for South Dakota. Prior to the redistribution, South Dakota's annual expenditures for children eligible for CHIP exceeded our CHIP allotment. The redistribution increased our allotment by $10.0 million, which aligned our award closer to our annual expenditures for children eligible for CHIP, avoiding a budget impact to the state or reducing eligibility levels for the program. The enhanced FMAP rates of 23% for CHIP under the PPACA will provide state general fund savings. However, if CHIP allotments are not increased, South Dakota will not have adequate CHIP federal funds to support annual expenditures, resulting in a shift of children to the Medicaid program at the regular FMAP rate. Congress should adjust CHIP federal allotments commensurate with the 23% enhanced matching rate for CHIP.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job of enrolling eligible children?

   South Dakota has a high penetration rate relative to CHIP and Medicaid coverage for children. Continued funding for the CHIP program offers a strong financial incentive for continued efforts to enroll children where services will be paid at a match rate almost 15% higher than South Dakota's regular FMAP rate.

7. 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?

   The ability of the Federally Facilitated Marketplace (FFM) to verify Medicaid and CHIP eligibility must be resolved to avoid children being "stuck" in the FFM process and unnecessary duplication of effort by state resources.

I encourage Congress to act quickly to appropriate funding for the CHIP program so that low-income children in South Dakota continue to have insurance coverage.

Sincerely,

Dennis Daugaard

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BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

October 31, 2014

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

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

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

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

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

The purpose of this letter is to respond to your questions regarding the reauthorization of the Children's Health Insurance Program (CHIP), for which funding ends at the end of Fiscal Year (FY) 2015.

CHIP is a successful program providing healthcare coverage for children, but as a result of the PPACA, CHIP reauthorization must now be considered carefully within the context of overlapping, government-subsidized healthcare coverage programs. The PPACA has increased health care coverage silos, which reduce efficiency, increase member churning across arbitrary eligibility boundaries, and cause families to be split across different plans due to the eligibility status of individual family members.

Tennessee is looking for opportunities to streamline and simplify eligibility. I believe children covered by the CHIP program will have access to alternative coverage options that offer comparable services in the future. However, I do not believe that there is enough time to adequately consider and implement policy changes before federal funding for the CHIP program ends next year. Therefore, I recommend CHIP financing be extended for at least two years, through Federal FY 2017. In addition, states' maintenance of effort requirement, currently in effect through September 30, 2019, should end if the current level of federal participation in CHIP ends.

Below are detailed responses to your July 29, 2014 letter regarding Tennessee's experiences with the CHIP program.

Sincerely,

[redacted]

Bill Haslam
Governor

cc: Darin Gordon, Deputy Commissioner Department of Finance and Administration
Brooks Daverman, Director of Strategic Planning and Innovation

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?**

   Tennessee's CHIP program is a "Combination" program with two components that provide coverage to approximately 88,000 children using Title XXI funds.

   Approximately 68,000 children are covered through Tennessee's stand-alone CHIP program called CoverKids. Of these, about 45 percent are below 150 percent FPL, 38 percent are between 150 and 200 percent FPL, and 18 percent are between 200 and 250 percent FPL. Over three-fourths of children in the CoverKids program are between the ages of six and 18. Less than five percent are unborn children.

   Approximately 20,000 CHIP enrollees are served through the TennCare program. Nearly nine out of 10 children in this group have incomes below 150 percent of the FPL. Over three-fourths are between the ages of six and 18. About 70 percent are White, while 13 percent are Hispanic and 12 percent are Black/African American.

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?**

   Tennessee has made a number of changes to its CHIP program as the result of the PPACA. These include the following:

   - Tennessee eliminated our state-funded "buy in" CHIP eligibility category for families over 250 percent of the federal poverty level as of January 1, 2014. This category included children with family incomes above the maximum set by CHIP in Tennessee. With the availability of subsidized insurance through the federal Marketplace, the state no longer needed to subsidize the coverage of children who were above the income level for CHIP in Tennessee.
   - Tennessee eliminated the three-month "go bare" period, requiring children to be uninsured for three months before becoming eligible for CHIP. As a result of the PPACA's guaranteed issue requirement, this policy was no longer relevant.

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.**

   While we do not have a detailed comparison of benefits for any particular plan, we know that the benefits offered by our CHIP program are roughly comparable to those offered by Qualified Health Plans (QHPs) in the federal Marketplace. However, cost sharing is lower in CHIP than in most, if not all, QHPs currently offered in the Marketplace. There are no premiums or deductibles required of CHIP children, as there are of individuals enrolled in a QHP, and CHIP copays are relatively modest. The actuarial value of Tennessee's CHIP plan is between 90 and 95 percent, which is slightly higher than a platinum level plan available in the Marketplace.

4. **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeline should Congress act upon an extension? If you do not believe that CHIP funding should be extended, what coverage (if any) do you believe CHIP**

enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

We recommend that CHIP financing be extended for at least two years until alternative policy options can be fully considered. One alternative for CHIP enrollees is subsidized coverage available through the federal Marketplace. Certain policy changes will need to take place before states can move freely in this direction.

Currently the rules of the Department of the Treasury do not allow the children of an employee to access the federal Advanced Premium Tax Credits if the employee is offered affordable employer-sponsored health insurance. However, the affordability test does not take into consideration the cost of family coverage, only individual coverage. Tennessee will be unable to support covering currently CHIP-eligible children through the federal Marketplace until the Department of the Treasury issues an update to the Health Insurance Premium Tax Credit final rule (2012) so that children can be eligible for federal premium assistance tax credits in families where affordable employer-sponsored coverage is available for only the employee.[1] A change to this rule would allow more families to stay on the same plan and receive subsidized private coverage through the federal Marketplace. We believe the Health Insurance Premium Tax Credit rule should be updated before funding for CHIP ends.

In addition, the PPACA's maintenance of effort requirement on states for their CHIP program needs to be modified to reflect any changes to the program. As long as the maintenance of effort requirement remains part of federal law, we cannot consider any changes that affect CHIP.[2] After these changes are made, states will be able to further consider policy options regarding the CHIP program.

If comparable, affordable QHP coverage is available for families in the Marketplace, we believe that the QHP coverage should be considered as a potential coverage option for uninsured children in the state if CHIP were not continued.

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?**

   We believe Tennessee's federal allotment for CHIP will be sufficient for FY 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 uninsured, and improve health outcomes for children in your state?**

   We believe that federal policies should be targeted to streamlining and simplifying the eligibility policies of various programs. CHIP, Medicaid, and the Health Insurance Marketplaces have been layered on top of each other, creating duplicative coverage silos, each with their own benefit and

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[1] 26 CFR §1.36B-2(c)(3)(v)(A)(2) *Eligibility for premium tax credit*
Federal Register Vol. 77, no. 100 http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/FR-2012-05-23.pdf

[2] PPACA; Public Law 11-148; 2101(b) *Additional federal financial participation for CHIP*

eligibility rules. Duplication of programs reduces efficiency, increases member confusion, and causes beneficiaries' to "churn" across arbitrary eligibility boundaries as their age and income change. Many families are now split among coverage programs, such as families with children in CHIP and adults covered on the Marketplace. In order to be more customer-focused and relevant to meeting the needs of low-income families, federal health policy and program eligibility must be simplified.

OFFICE OF THE GOVERNOR

RICK PERRY
GOVERNOR

October 31, 2014

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

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

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

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

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

I appreciate the opportunity to provide Congress with feedback regarding the Children's Health Insurance Program (CHIP), which provides health insurance coverage for certain uninsured children. States possess valuable insights on the efficacy and efficiency of CHIP, given that they implement the program and see firsthand the impact of the Affordable Care Act (Obamacare).

The Texas Legislature passed legislation in 1999 creating CHIP, separate from Medicaid. Texas provides services for children of families with income at or below 200 percent of federal poverty level (FPL). Figures provided by the Texas Health and Human Services Commission (HHSC) show that in FY 2014, Texas CHIP served 524,658 children. Of that:

- 60.9 percent of recipients are ages 6–14;
- 22.3 percent are ages 15–18;
- 16.7 percent are ages 1–5; and
- 0.1 percent of recipients are younger than one.

In terms of income in FY14:

- 55.9 percent have incomes between 100–150 percent FPL;
- 30.9 percent have incomes between 151–185 percent FPL;
- 6.7 percent have incomes between 186–200 percent FPL; and
- 6.5 percent of recipients have incomes below 100 percent FPL.

Texas CHIP provides a variety of services to its recipients, including preventive health, dental, vision, mental health and hospital services. Texas requires certain CHIP families to pay an annual enrollment fee to cover all children in the family. Qualifying families must also pay co-pays for doctor visits, prescription medications, inpatient hospital services and non-emergent services in an emergency room setting. Additional information can be found here: http://www.hhsc.state.tx.us/medicaid/about/PB/10_PB_9th_ed_Chapter9.pdf

As a consequence of Obamacare, Texas has seen a significant number of children moved from CHIP into Medicaid. Though Obamacare provides for enhanced matching rate for this CHIP-to-Medicaid population, these enhanced federal funds diminish over time — shifting costs to the states.

Moving additional people into Medicaid is particularly significant given that Obamacare exacerbates problems within a broken Medicaid program. For example, Obamacare prevents states from using common-sense tools, including asset testing, to ensure that Medicaid is preserved for those individuals most in need. Furthermore, Obamacare taxes Medicaid to help fund private insurance subsidies for individuals who earn more than Medicaid recipients. In other words, Obamacare makes it more expensive for both federal and state governments — and ultimately the American taxpayer — to operate Medicaid, providing absolutely no benefit to the program or its recipients. As I explained in a recent letter to Congressman Elijah Cummings, current state and federal Medicaid expenditures are unsustainable. Obamacare only compounds that problem.

Additionally, it's important to point out characteristics of CHIP that differentiate the program — for the better — from Medicaid. For example, states receive federal matching funds for CHIP through allocations that function in a manner very similar to block grants. States have considerably more flexibility in operating their CHIP programs than Medicaid programs. Such flexibility empowers states to better serve their unique CHIP populations. States have the ability to implement reasonable cost-sharing and enrollment measures that help ensure appropriate

utilization of services, emphasize preventive care and encourage active participation in health care decisions.

Absent much needed comprehensive Medicaid reform, Congress should implement in Medicaid those initiatives that have proven to be effective and beneficial CHIP and recipients.

As for the reauthorization of CHIP, given that there appears to be no immediately viable alternative proposed for covering existing CHIP recipients, Congress should act to reauthorize CHIP prior to the expiration of funding in 2015. The sooner action is taken, the more predictability and stability Congress will provide to state appropriators.

Please do not hesitate to contact my office or HHSC for any additional information.

Sincerely,

[redacted]

Rick Perry
Governor

RP:kkp

STATE OF UTAH

GARY R. HERBERT
GOVERNOR

OFFICE OF THE GOVERNOR
SALT LAKE CITY, UTAH
84114-2220

SPENCER J. COX
LIEUTENANT GOVERNOR

November 5, 2014

The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
United State House of Representatives
Washington, D.C. 20515

The Honorable Ron Wyden
Chairman
Senate Finance Committee
United State Senate
Washington, D.C. 20510

The Honorable Henry A. Waxman
Ranking Member
House Committee on Energy and Commerce
United State House of Representatives
Washington, D.C. 20515

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
United State Senate
Washington, D.C. 20510

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

I am grateful for the opportunity to provide you with feedback regarding Utah's position on funding for the Children's Health Insurance Program (CHIP). The bottom line is that the CHIP has decreased the number of uninsured children in our state and that there remains a need for the CHIP until low income working families have a viable alternative to providing care for their children. Furthermore, Americans would be well-served by a federal government that provides maximum flexibility to states to provide services to their residents in the most efficient and effective ways possible.

In an attempt to be responsive to your inquiry, I have asked Michael Hales, director of Medicaid and Health Financing in Utah, to answer your specific questions on our state's behalf. His response is attached.

Thank you for your attention to this important matter. We appreciate your outreach on the CHIP and any other issues that have a substantial impact on Utah.

[redacted]

Governor

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

November 5, 2014

The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
United State House of Representatives
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Washington, D.C. 20515

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
United State Senate
Washington, D.C. 20510

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

At the request of Governor Herbert, Utah's CHIP team has compiled the following information. We hope you find it responsive to your inquiries. We stand ready to provide any additional information that you may need. Thank you for your outreach and consideration of Utah's experience.

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)?**

Utah's Response: The implementation of PPACA had a significant impact on the CHIP in Utah. Utah was one of three states in the nation, which had an asset test for Medicaid eligibility for children ages 6-18 prior to 2014. PPACA not only raised the eligibility income level for Medicaid children but also required the elimination of any asset test for Medicaid children. Prior to the implementation of PPACA, Utah averaged about 34,000 children per month on CHIP. With the implementation of PPACA, the number of children on Utah's CHIP has dropped to an average of 15,000 per month and it continues to be an important program for the children of Utah.

Before implementation of PPACA, children with household incomes from 0 to 200 percent of the federal poverty level (FPL) could be eligible for Utah CHIP. The program was broken out into three plans: Plan A for family incomes between 0 -100 percent FPL, Plan B for family

incomes between 101-150 percent FPL, and Plan C for family incomes between 151-200 percent FPL. Plan A existed primarily because Utah had an asset test for Medicaid children ages 6 to 18, but did not have an asset test for CHIP. Consequently, children ages 6 to 18 with family incomes under the poverty level enrolled in CHIP, rather than Medicaid. It was not uncommon to have younger children (under age 6) on Medicaid and older children on CHIP in a single household. Since the implementation of PPACA earlier this year, Utah CHIP eligibility covers children in families whose income is between 133 percent FPL and 200 percent FPL. CHIP Plan A was eliminated—leaving a modified Plan B (133-150 percent FPL) and Plan C (151-200 percent FPL).

The majority of CHIP families have earned income. Children in these families are eligible for CHIP either because they have no health insurance coverage available through an employer or because the costs of the employee's share of coverage is unaffordable. Utah's CHIP applies a test of five percent of gross annual income to determine if the cost of coverage is reasonable.

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?**

Utah's Response: As indicated above, PPACA changed the eligibility income levels for Medicaid and removed the asset test for children. This resulted in a significant reduction in the number of children on the stand-alone CHIP in Utah. However, since the children who transferred from CHIP to Medicaid are still eligible for the enhanced FMAP available under CHIP, Utah has had to implement a more complex expenditure tracking model to claim the enhanced FMAP on the CHIP children who transferred to Medicaid. The implementation of PPACA required significant changes in eligibility requirements for both Medicaid and CHIP, taking away much of the flexibility Utah previously had in determining eligibility for CHIP. With regard to benefits and service delivery, Utah's process remains largely unchanged.

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

Utah's Response: By state law, Utah's CHIP benefit is benchmarked against the HMO with the largest commercial, non-Medicaid enrollment in the state. Therefore, the benefits available to Utah CHIP children are very much like benefits offered in a silver plan available in the commercial market with a couple of exceptions. Utah does not operate an individual plan exchange. Utah has an agreement with the federal government to operate a federally facilitated exchange for the private individual market in our state. In addition, Utah operates a small employer exchange, known as "Avenue H."

As a stand-alone program, CHIP cost sharing includes co-payments, coinsurance, and premiums and is limited to five percent of the family's annual gross income. Cost-sharing reductions for families on the exchange are limited to 94 percent actuarial value (AV) for 100-150 percent FPL and 87 percent AV for 150-200 percent FPL. Even though the cost-sharing reductions create a

plan that limits average out of pocket costs, the costs facing a family with a severe medical issue could easily exceed the CHIP five percent of income standard. If CHIP is eliminated, CHIP families will experience greater out-of-pocket costs in the marketplace.

Second, a significant number of Utah CHIP families work for small employers. Under PPACA, if the employee's share of premium for the employee's coverage (not family coverage) is less than 9.5 percent of the annual gross household income, the family is not eligible for advanced premium tax credits to purchase private coverage instead of getting coverage at work. This issue is commonly known as the "family glitch." If CHIP is no longer available, former Utah CHIP families will be subject to higher cost sharing, and many will likely not be eligible for tax credits to help defray the cost of family coverage.

4. **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon 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?**

Utah's Response: Any change to the existing CHIP will impact Utah's budget for state fiscal year 2016. State appropriations for this period will be determined by mid-March 2015. Therefore, it is imperative that Congress act soon to make a decision on this issue. Thousands of Utah children will be impacted. Utah and other states cannot wait until the last minute to transition these families or make substantive changes to Utah CHIP and the data systems that support this program. As mentioned earlier, Utah administers benefits for CHIP through contracts with private entities that will also be significantly impacted by any change. Most importantly, Utah children with chronic or emergent conditions could go without care because of a lack of action on this issue.

At a minimum, states must know whether or not the CHIP will continue, and whether or not changes will be made to the program or funding for the program at least six months in advance of any change. That being said, Utah supports extending the CHIP for at least two years, and preferably for four years, to allow time to address any outstanding issues with the federal market place and the availability of subsidies. In addition, other changes should be made to federal law to address state concerns.

Utah has identified the following issues of concern that need to be addressed in the CHIP:

1. Continuing issues with the Healthcare.gov web site and remaining issues with the interface between the federal government and the state need resolution.

2. Federal law should be changed to resolve the "family glitch."

3. The CHIP needs ongoing funding, or the federal law regarding the Maintenance of Effort (MOE) must be modified to delink the CHIP from Medicaid and provide states with flexibility on this issue.

4. Federal law should allow states to use the commercial market with the assistance of premium subsidies as the primary service delivery system for the CHIP.

Utah continues to have approximately 55,000 uninsured children, who appear to be eligible for public programs based on their income. It is difficult to determine exactly why these children remain uninsured. Some parents choose not to access public programs. Many do not seek coverage while their children are healthy. Others may be children of mixed immigration status households, which hesitate to seek assistance for other reasons. If the CHIP is eliminated, Utah anticipates the number of uninsured children in the state will increase.

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 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?

Utah's Response: Utah has no concerns with the CHIP allotments or the formula used to determine those amounts. We have been able to manage our program effectively under the current allotment formula.

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 changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured and improve the health outcomes for children in your state?

Utah's Response: We recognize that many changes were made in an effort to streamline eligibility for Medicaid and the CHIP. PPACA also intended to make the commercial market place more accessible to all. Unfortunately, many of the changes brought about by PPACA did anything but simplify the enrollment process. A part of the concern is the prescriptive nature of the law and the lack of flexibility for states. The issues with the federal marketplace are also well known.

In addition, there needs to be a more seamless way to address churn for lower income families. Relatively small, but often frequent, changes in income can cause these families to move from the market place to public programs and back again. Utah would like to see more flexibility in the CHIP to allow broad use of Title XXI funding to provide premium subsidies to families to keep them in the commercial marketplace, even when their income drops to CHIP income eligibility level. This not only allows families to stay in the same health plan together but it also allows families to stay with the same provider network, which minimizes disruption in services and promotes continuity of care.

It is imperative that Congress act quickly but thoughtfully on the determination of the future of the Children's Health Insurance Program. Thank you for consideration of our input. We look forward to continued dialogue on this issue.

Sincerely,

[redacted]

Michael Hales
Deputy Director, Department of Health
Director Medicaid and Health Financing

PETER SHUMLIN
Governor

State of Vermont
OFFICE OF THE GOVERNOR

October 14, 2014

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

The Honorable Ron Wyden
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

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

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

RE: Children's Health Insurance Program (CHIP) – Vermont

Dear Chairmen and Ranking Members:

In response to your recent inquiry, I have asked my Vermont Agency of Human Services to compile answers to your six questions regarding the Children's Health Insurance Program (CHIP), including an assessment of impact should federal funding for the program end at the close of the 2015 federal fiscal year. We appreciate the opportunity to provide Vermont's perspective. Please find our responses below.

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

   Vermont has a longstanding commitment to providing coverage for all children. In Vermont, CHIP is operated as part of Dr. Dynasaur, the umbrella name for state sponsored children's health insurance, which includes Medicaid and CHIP. In 1989, Dr. Dynasaur was created as a state-funded program that extended coverage for children under age 7 to 225% FPL. In 1992, coverage was expanded to children up to age 18.

   In 2013, CHIP served 7,393 children ages 0-19, with a family income between 237% and 312% of federal poverty level. Vermont is a rural state with 67% of the population living in rural areas. In the most rural areas of the state over 60% of the population is eligible for Medicaid. Vermont's population is 97% white, with 3% from a variety of racial and ethnic backgrounds.

The 2012 Vermont Household Health Insurance Survey reported that 51.0% of Vermont's 111,257 children under 18 had private insurance, 43.4% had coverage through Dr. Dynasaur (Medicaid/CHIP), and 2.5% were uninsured. The rate of uninsured children has steadily declined from 4.9% in 2005. Between December of 2013 and April of 2014, Vermont saw an increase of 3,655 children enrolling in Dr. Dynasaur.

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 the PPACA impacted the way your state administers CHIP?

   As a result of the PPACA, changes to CHIP in the state of Vermont include the transition to a modernized application process through Vermont's state-based insurance marketplace, Vermont Health Connect, and conversion of income eligibility to a simplified MAGI based methodology. In addition to PPACA requirements, Vermont took advantage of other provisions including moving the administration of the CHIP program under the Medicaid State Plan. Benefits through the CHIP program continue to be the same as those offered in Vermont's Medicaid 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 comparable available through your state's exchange or through the majority of employer sponsored health plans in your state.

   The services and benefits offered through the state's exchange are comparable to the CHIP benefit. Medicaid services include comparable essential health benefits. Vermont covers up to 138% FPL for adults under Medicaid and up to 312% for children in CHIP and in families with other insurance.

   The state of Vermont receives close to $8 million in federal funds annually to provide coverage for the CHIP population and to support Vermont's early expansion of Medicaid coverage for children. In the absence of federal funding for CHIP, Vermonters would face significant hardship, as the state would not be able to supplement the full loss of the enhanced federal match until the CHIP authorization ends in 2019. At that time states can maintain coverage or shift coverage to plans offered through the exchange. For a single parent with a child out of pocket costs on the exchange range from $180-$628 per month. This is a substantial increase from the $60 a month premium for CHIP.

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 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 Vermont strongly recommends that CHIP funding be extended through the federal Title XXI authorization period to 2019. Failure to extend CHIP funding would result in a significant financial burden to the State, could result in many children becoming uninsured and would increase the cost of coverage for many who would remain insured. Continued funding would also allow states time to plan for a transition if needed and to assure that children will receive continued coverage.

The elimination of CHIP funding in 2015, will have a financial burden to the state. CHIP authorization requires Medicaid Expansion states including Vermont, to maintain the current level of coverage through 2019. Even with unspent funds from prior years, federal estimates indicate that CHIP will run out of money early in FY2016. The state will have to subsidize the loss of enhanced match. As state budgets are increasingly tight, this could mean the elimination of services for state funded programs outside of CHIP. Vermont relies on the enhanced federal match to provide healthcare coverage for CHIP enrolled children.

Elimination of CHIP will also have a detrimental effect on coverage for children in 2019. CHIP is an extremely successful program significantly increasing children's coverage in Vermont and across the nation. In the absence of CHIP, enrollees could obtain coverage through the state's marketplace, Vermont Health Connect, however there is potential for over 7,000 children to become uninsured. Depending on the plan they choose, families would have to pay higher premiums, deductibles and co-pays. This places an increased financial hardship on families, regardless of whether or not they are eligible for a subsidy.

Nationally, CHIP covers more than 8 million low-income children, CHIP and Medicaid combined cover more than 1 in every 3 children in the United States. Research indicates that for families below 150% FPL a premium increase to $120 is associated with a 5% increase in uninsured children[1].

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 on 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 2009 restructuring and retargeting of allotments has improved the state of Vermont's ability to spend down the state's allocation. The formula change allows Vermont to receive full compensation based on funds expended. In FY 13, Vermont had less than 1% in unspent funds.

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[1] Salam Abdus, Julie Hudson, Steven C. Hill and Thomas M. Selden, *Children's Health Insurance Progrom Premiums Adversely Affect Enrollment, Especiolly Among Lower-Income Children,*
Health Affairs, 33, no.8 (2014):1353-1360.

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

   As state budgets are increasingly tight, there is no guarantee that states will be able to maintain coverage for children beyond 2019, without federal appropriation. Continued federal support that would increase enrollment includes augmenting the state's ability to identify and enroll children who are eligible for CHIP or Medicaid but have not enrolled through incentives and funding for outreach.

   Other policies to support health outcomes include providing incentives to states to increase evidence-based practices in primary care for children, supports for analyzing pediatric quality measures, and linking quality measures to clinical decision support. Federal policies requiring universal coverage for all children will insure that states can enroll children and reduce the number of uninsured. Vermont is moving in the direction of coverage through a publicly funded, universal health care system. Under this system, eligibility will be based on residency, which will guarantee that all children have access to coverage. If federal policy for universal coverage for all children is impracticable for all states, we feel strongly that Vermont should receive federal support for its health care reform efforts.

Please feel free to reach out should you need additional input or clarification regarding the contents of Vermont's responses.

Peter Shumlin
Governor

Cc: Senator Patrick Leahy
Senator Bernie Sanders
Congressman Peter Welch
Secretary Harry Chen, Vermont Agency of Human Services
Commissioner Mark Larson, Department of Vermont Health Access

COMMONWEALTH of VIRGINIA
Office of the Governor

Terence R. McAuliffe
Governor

October 23, 2014

VIA ELECTRONIC TRANSMISSION

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

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

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

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

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

I am writing in response to your July 29, 2014 letter to states requesting information about our Children's Health Insurance Program (CHIP) in the context of the funding reauthorization. Thank you for the opportunity to provide information about Virginia's very successful CHIP programs, called Family Access to Medical Insurance Security (FAMIS) that provide comprehensive health care coverage to approximately 200,000 children and pregnant women in Virginia's low-income working families. These families earn 200% or less of the Federal Poverty Level (FPL), or up to $39,580 a year for a family of three.

FAMIS has enjoyed bi-partisan support in Virginia and is viewed as a bridge program for families earning too much to qualify for Medicaid, but yet not enough to afford employer or Marketplace insurance. While the Marketplace provides new affordable health care options for

adults, there remain some significant concerns for children's coverage especially for those 200% or less of FPL. These concerns include barriers to affordable coverage because of the "family glitch" (determining affordability based on the cost of employee-only coverage instead of family coverage); lack of comparable child-specific benefit plans; exclusion of the cost of stand-alone pediatric dental plans in the calculation of subsidies; and annual out-of-pocket cost sharing that far exceeds the CHIP affordability limit (5% of income).

Attached are answers to your questions which outline the importance of our programs and the coverage they provide to the children and pregnant women in the Commonwealth. Without Congressional action, Virginia will not have enough federal carryover funding to continue the program in federal fiscal year 2016. I urge Congress to fund the CHIP program for an additional four years through 2019 at the enhanced 23 percentage point match rate , because Virginia, like many other states, has already budgeted for this enhanced funding established in the Affordable Care Act. The four years of CHIP funding will provide the needed time to evaluate coverage for children through the Marketplace while continuing to provide quality health care through a proven and effective program.

Please contact Linda Nablo with the Department of Medical Assistance Services (DMAS), at [redacted], for any additional questions about our programs.

Sincerely,

[redacted]

Terence R. McAuliffe

Attachment

Attachment

I. 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)?

Virginia has a combination CHIP program made up of two components that covered over 196,000 otherwise uninsured children during FFY2013:

1. A separate CHIP (S-CHIP) program called Family Access to Medical Insurance Security (FAMIS) covered over 104,000 children, ages 0-18, living in families with incomes between 134% FPL and 200% FPL in FFY13. *These FPL limits were converted to 144-200% during the Modified Adjusted Gross Income (MAGI) conversion at the beginning of FFY 2014*; and

2. An expansion of Medicaid paid for by CHIP funding (M-CHIP) covered approximately 92,000 additional children, ages 6-18, living in families with incomes between 100% and 133% FPL in FFY13. *These FPL limits were converted to 110-143% during the Modified Adjusted Gross Income (MAGI) conversion at the beginning of FFY 2014.*

Approximately forty-one percent (41%) of Virginia's CHIP enrollees are Caucasian; twenty-six percent (26%) are African American; nineteen percent (19%) are Hispanic; four percent (4%) are Asian; and the remaining ten percent (10%) identify themselves as a mixed race or another racial group. Forty-nine (49%) of the enrollees are female while fifty-one percent (51%) are male. Ninety percent (90%) of families report English as their primary language while nine percent (9%) report Spanish as their primary language.

About ninety-five percent (95%) of Virginia's CHIP enrollees are served through a managed care organization (MCO) delivery system for the majority of their health care needs. Virginia's contracted MCOs are required to obtain and maintain accreditation with the National Committee for Quality Assurance (NCQA). Quality outcomes are monitored by the state in part through Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. As compared to the benchmark of HEDIS® 2013 National Medicaid Managed Care 50th Percentile, the Virginia MCO average for services provided in 2012 met or exceeded the benchmark for the following measures:

- Six or more well-child visits in the first 15 months of life
- Annual well-child visits in the third, fourth, fifth, and sixth years of life
- Use of appropriate asthma medication (ages 5-11 and 12-18)

Key findings from Virginia's 2013 CAHPS survey of FAMIS enrollees show that more than eight in ten parents/guardians gave positive satisfaction ratings of their child's

Personal Doctor (89%), Specialist (85%), Health Care overall (85%) and Health Plan overall (84%); and for parents/guardians of children with chronic conditions more than eight in ten gave positive satisfaction ratings of their child's Personal Doctor (91%), Health Care overall (87%), Specialist (87%) and Health Plan overall (84%).
In addition, sixty-two percent (62%) of three to eighteen year olds enrolled in FAMIS received a dental service during the state fiscal year (SFY) 2013.

The Centers for Medicare and Medicaid Services (CMS) PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The National average PERM rate is 6.1%. For FY 2012, Virginia's most recent Managed Care program PERM rate was less than 1%.

Additionally, Virginia has an 1115 waiver through CHIP that provided prenatal care, delivery, and post-partum coverage to over 4,600 women over age 18 living in families with incomes between 134% FPL and 200% FPL in FFY 2013. Based on External Quality Review studies, low birth weight rates for Virginia's program have continued to improve during the three year period 2011-2013 and outperformed the Centers for Disease Control national benchmark for all three years. Virginia MCO HEDIS score for the first trimester prenatal care was 86%, exceeding the National HEDIS Medicaid average rate.

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?

To align with the Federal Marketplace's first open enrollment, Virginia was an early adopter of the new MAGI eligibility methodology which we began to use in October 2013 at the same time we launched our new Eligibility and Enrollment system that determines eligibility for both Medicaid and CHIP. In July of 2014, following the issuance of new regulations by CMS, we also removed the four month waiting period after dropping health insurance for S-CHIP applicants. In addition, we are currently in the process of submitting a state plan amendment to allow dependents of state employees to enroll in our S-CHIP program starting January 1, 2015 -- an option made available to states through the ACA.

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 arc not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Virginia's separate CHIP program, FAMIS, provides comprehensive health care benefits originally modeled after the state employee health insurance benefits, but tailored to meet the specific health care needs of children. These benefits are not limited to well and sick

care visits, prescriptions, hospitalization, and vision care, but include comprehensive dental coverage including medically-necessary orthodontia, Early Intervention services, school health services, and substance abuse treatment services as well as non-traditional behavioral and psychiatric services.

FAMIS has no monthly or annual premiums and very affordable co-pays. For most services under FAMIS, the co-pay is only $2 or $5 and there are no co-pays above $25. In addition to not charging co-pays for well child check-ups, there are no co-pays for dental care. Cost sharing cannot exceed $180 per family per calendar year if a family's gross income is less than 150 percent of the federal poverty level and $350 per family per calendar year if gross income is more than 150% of the federal poverty level. Based on the July 2014 *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans* prepared by the Wakely Consulting Group for the Robert Wood Johnson Foundation, FAMIS has much lower average annual cost sharing and out of pocket maximum than a silver qualified health plan (QHP):

Enrollees with family incomes of 160% FPL	FAMIS	QHP in Federal Exchange
Average Annual Cost Sharing	$89	$411-$480
Out of Pocket Maximum	$350	$1,500-$2,250

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?

Yes, we strongly recommend the funding for CHIP be aligned with the current authorization of the program through 2019 and should include the ACA authorized twenty-three percentage point increase in the Federal Financial Participation (FFP) match rate. While the Marketplace provides new affordable health care options for adults, there remain some significant concerns for children's coverage, especially for those under 200% FPL. These include barriers to affordable coverage because of the "family glitch;" lack of comparable child specific benefit plans; exclusion of the cost of stand-alone pediatric dental plans in the calculation of subsidies; and annual out-of-pocket cost sharing that far exceeds the 5% of income affordability limit of CHIP.

We do not have estimates for how many separate CHIP enrollees covered during the year would become uninsured if CHIP is not funded, but approximately 104,000 Virginia children would be in jeopardy of becoming uninsured. According to our projections submitted in our August 2014 CMS 37/21B report, we do not project a CHIP allotment carryover from FFY2015. Therefore, Virginia would have no federal funds available to continue coverage for these children into FFY2016.

We project that we will need $356,175,917 in total funds to continue our CHIP programs in FFY2016. For our S-CHIP program alone, Virginia expects to need $219,644,400 in total funds to continue the program. Eighty-eight percent (88%) of that or $193,287,072 is currently budgeted to come from the federal government due to the twenty-three point increase in the state's Federal Financial Participation (FFP) match rate starting with FFY 2016. While we believe that FAMIS is a successful and needed program, if CHIP is not funded, Virginia will not be able to absorb the federal share and continue the S-CHIP program with state funds only.

In addition to concerns about children in our separate CHIP program becoming uninsured if CHIP funding is not extended, Virginia also has serious concerns about funding the M-CHIP program. Without the expected CHIP funding at eighty-eight percent (88%) FFP match rate, our understanding is that we would be required to continue to cover these children under the Maintenance of Effort (MOE), but that our match rate for covering these children would fall to the regular Medicaid FFP match rate of fifty percent (50%), requiring an additional $51,881,977 in state funds for FFY 2016.

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 allotment process was greatly improved under the 2009 CHIPRA legislation and appears to be working appropriately.

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?

- Guarantee twelve months of continuous coverage for children
- Eliminate requirements to prevent substitution of coverage from the CHIP program to reduce coverage barriers and streamline administration of the program. CHIP is the only publically-funded health care program with this requirement.
- Allow coverage for dependents of public employees without additional qualifying steps
- Improve alignment of coverage with the Marketplace so that there is no gap in coverage when a child/family moves from CHIP or Medicaid coverage to the Marketplace
- Enhance the electronic verification systems available to states through the HUB to reduce the need to request paper verifications

- Allow coverage of medically-necessary Institution for Mental Diseases (IMD) placements for CHIP eligible children as is available to children covered by Medicaid
- Allow states to claim enhanced FFP for production of materials (brochures, posters, member handbooks, TV and radio ads, etc., as well as media buys) in languages other than English, not just the translation itself

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

October 6, 2014

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

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

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

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

Dear Senator's Wyden and Hatch and Representatives Upton and Waxman:

SUBJECT: Extending Funding of the Children's Health Insurance Program

Thank you for the opportunity to provide input as federal policymakers considers extending funding of the Children's Health Insurance program (CHIP). Washington State is supportive of extending funding of the CHIP program through 2019. Below we have provided responses to the questions posed. We hope our responses resonate with Congress and other states in continuing this popular and effective program for providing health care coverage for 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)?

   States response: *Washington State provides health care coverage for nearly fifty thousand low-income children each year under its stand-alone CHIP program. Average monthly enrollment exceeds 38,000. Coverage is provided to unborn children whose mothers do not qualify for Medicaid because of citizenship status, but family income is at or below 193 percent federal poverty level (FPL), and to children birth through age eighteen whose family income is at or below 312 percent FPL. Thirty-two percent of the children birth to age 19 served by Washington's CHIP are members of an ethnic minority. Eighty-five percent of the children enrolled in CHIP receive their coverage via a Managed Care Plan.*

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 the PPACA impacted the way your state administers CHIP?

   States response: *Over the last year, Washington State has implemented a highly successful state-based exchange – www.wahealthplanfinder.org. Through this exchange portal, individuals and families can apply for the full range of subsidized insurance options including Medicaid (Apple Health) and CHIP (Apple Health with premiums). Applicants who use the web portal receive an eligibility decision in "real-time" based on Modified Adjustable Growth Income. This has dramatically improved the timeliness of service delivery and reduced delays in accessing needed medical care.*

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

   States response: *The benefit package under CHIP is the same as that offered children under Medicaid, and has an actuarial value of 100 percent. This value is over 25 percent higher than the actuarial value of a subsidized silver level plan in the exchange. There is no cost-sharing for this coverage other than a nominal $20 - $30 per monthly premium based on income, applied to a maximum of two children each household. In addition, CHIP coverage offers a richer set of services beyond the ten essential health care benefits in the exchange plans, including Early Periodic Screening, Diagnosis and Treatment, Health Homes, Personal Care Services, Tobacco Cessation Counseling, Targeted Case Management, Nursing Facility – Long-Term Care, and Intermediate Care, Individuals with Intellectual Disabilities Facilities for the Developmentally Disabled.*

4. Do you recommend that 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?

   States response: *We strongly support Congress acting to extend funding of CHIP for a minimum of two years as recommended in the June, 2014 MACPAC report. We believe an additional two-year extension to 2019 will allow Congress and the states the necessary time for the exchanges and health care networks to mature without negative impacts to the health care of our nation's children. We believe CHIP has been instrumental in providing effective health care coverage for uninsured children for the last 15 years. We would urge Congress to act no later than March 2015 to extend funding for CHIP if the State is to avoid development costs associated with*

eliminating the program in fiscal year 2015. If funding for CHIP is not authorized in FY 2016, 12,000 unborn children annually will not have access to prenatal coverage.

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

   States response: *In recent years, Washington State's CHIP expenditures have met or exceeded the available allotment. Given the 20 percent increase in our CHIP enrollment over the last year, we would ask that Congress consider a formula for establishing Washington's annual allotment that recognizes our success in operating a state-based exchange. Washington occupies a unique niche as a §2105(g) qualifying state. If the allotment formula for our state is not substantially modified, we estimate a loss of federal revenue in excess of $50 million dollars. We would also recommend Congress address the issue of unspent allotments by extending the enrollment performance bonus authorized under the Children's Health Insurance Program Reauthorization Act (CHIPRA).*

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?

   States response: *We support Congress establishing a unified set of Pediatric Quality measures as described in CHIPRA. We believe Congress could encourage states to pursue improved health outcomes by supporting adoption of such quality measures with enhanced federal funding (similar to performance bonuses for enrollment). Further, we believe grant funds should continue to be designated for pediatric institutions to continue the study, development, and measurement of improved health outcomes for children and adolescents.*

Thank you for the opportunity to review your request and answer your questions.

Sincerely,

[redacted]

Dorothy F. Teeter, MHA
Director

STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
1900 KANAWHA BOULEVARD, EAST
CHARLESTON, WV 25305
(304) 558-2000

EARL RAY TOMBLIN
GOVERNOR

October 31, 2014

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

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

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

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

Dear Chairman Upton, Chairman Wyden, Ranking Member Waxman, Ranking Member Hatch, House Energy and Commerce and Senate Finance Committees:

Thank you for the opportunity to respond to your recent inquiries regarding policy considerations affecting the federal Children's Health Insurance Program (CHIP) and West Virginia's Children's Health Insurance Program (WVCHIP). Since launching WVCHIP in July 1998, we have provided coverage and access to health care services for more than 185,000 West Virginia children who were previously ineligible to receive insurance coverage through Medicaid or other insurance providers. For years, West Virginia has been a leader in reducing the number of uninsured children through WVCHIP's continued outreach efforts to protect and promote the health of West Virginia children by gradually expanding eligibility and health services to families in need.

As we continue to implement health care reform, our state's vision for CHIP services assumes enrollees would transition to receive services either through Medicaid expansion coverage or subsidized commercial plans that provide more affordable and robust coverage. As we prepare for the last year of CHIP funding, it is unlikely our vision will become a reality for significant number of West Virginia enrollees.

1) **Individuals Served:** In Federal Fiscal Year 2013 WVCHIP served an unduplicated 37,413 children. In FFY 2014, the unduplicated enrollment decreased to 33,767, a 9.7% decrease in part due to the Medicaid child eligibility expansion to 133% federal poverty level (FPL) income level. On December 31, 2013, WVCHIP monthly enrollment was 25,011, prior to the transition of all WVCHIP enrollees to Medicaid by December 31, 2014, at which date the WVCHIP enrollment is estimated to total 19,557.

   Since the creation of the WVCHIP program, the demographics of West Virginia children receiving available services have evolved. In 2000, WVCHIP expanded its eligibility income level in several phases from 200% FPL and again in 2011 to 300% FPL. On July 1, 2014, children of public employees also became eligible to receive WVCHIP coverage. A past comparison of non-disabled WVCHIP children and non-disabled Medicaid children showed the WVCHIP population were identified by higher risk adjustment factors (were sicker) than Medicaid children. Simply put, CHIP and WVCHIP are serving a population of our state's children that Medicaid is not.

2) **CHIP Changes under PPACA:** The most significant changes to CHIP operations resulting from PPACA include those policy changes requiring the MAGI income counting rules and implementing operational changes to the eligibility system and electronic claims systems. While these updates are necessary enhancements, they have required significant resources and commitment, by not only WVCHIP, but from all those systems which provide similar administrative functions for the State's Medicaid program.

3) **Premiums and Copayments:** WVCHIP currently applies both modest premiums and copayments to different income tiers as follows:

Premiums and Selected Cost Sharing in West Virginia's CHIP Program, 2014

Family Income Level	Premiums	Office Visits	Inpatient Services	Prescription Drugs
≤150% FPL	None	$5*	None	$0-$5
>150-211% FPL	None	$15-$25*	$25	$0-$10
>211% FPL	$35/$71 max**	$20-$25*	$25	$0-$15

*Waived when member has a designated medical home.
**There is a single child family rate vs. multi-child family rate.

NOTE: *Premiums and cost sharing are set within federal parameters, i.e., in total, any family contribution to the cost of coverage cannot exceed five percent of family income.*

WVCHIP currently collects more than $900,000 in premium payments each year from families with incomes over 200% up to 300% FPL level. In 2013, approximately one-third of these families fell behind on premium payments and/or cancelled their enrollment.

Lack of Affordable Options and Increase in Uninsured Children: If federal funding for CHIP is eliminated in 2015, current enrollees will be given the option to enroll in

Qualified Health Plans (QHP) in West Virginia's Marketplace. We expect more than half of WVCHIP enrollees would drop enrollment during the benefit year, as the affordability of premium levels for family coverage of four would be challenging, even with the tax subsidy. The average monthly premium cost for a silver plan in West Virginia's Marketplace covering a family of four at the 139% FPL level would be $354 with a $200 deductible. The same WVCHIP family now pays no monthly premium. The silver plan average monthly premium cost for a family of four at the 300% FPL would be $824 with a $9,500 deductible. The most affordable bronze plan for a family of four at the 139% FPL has an average monthly premium of $253 with a $10,000 deductible. This same plan for a family of four at the 300% FPL level would be an average monthly premium of $723 with a $10,000 deductible. Even if these families could afford the cost of premium, the deductibles are a significant access barrier to services offered to WVCHIP children. This is especially the case for dental services where families would bear a $350 deductible per child up to a $700 deductible per family for dental care. WVCHIP has some $25 copayments for a handful of lesser used services, but there are no deductibles for dental. This information is summarized in the chart below.

West Virginia Qualified Health Plans' Premiums and Deductibles

Family Size and Income	Silver Plan *Premiums*	Silver Plan *Family Deductible*	Bronze Plan *Premiums*	Bronze Plan *Family Deductible*
4 (139% FPL)	$354/month	$200	$253/month	$10,000
4 (300% FPL)	$824/month	$9,500	$723/month	$10,000

In addition to the substantial increase in cost sharing for families, children would not receive the same health services as QHPs in the Marketplace were not created with the unique needs of children in mind. An important value of a pediatric-centered benefit is to assure coverage and access of preventive services, which WVCHIP does with no copayments or deductibles. WVCHIP children between the ages of three years to six years accessed well child visits at a 77.4% rate last year and 76.4% the year before. We would expect to see this rate and other preventive services decrease for CHIP children if they are subject to copayments and deductibles.

4) **Recommended Extension for Four Years:** We recommend consideration of a four-year CHIP extension. This extension would allow for further market development and stabilization with potentially more affordable choices for more West Virginians. In 2014, the total percentage of children enrolled in QHP plans was quite low (less than 1%). It would take at least two or three more budget cycles to determine the participation rates for CHIP income populations in QHPs. To determine whether enrollees are better served in alternative Medicaid bridge plans or under a basic health plan option would require an extension.

QHP Non-Affordability for West Virginia CHIP Households: In the spring prior to the 2014 Marketplace enrollment, a survey of WVCHIP households was completed. The results found more than half of the surveyed households indicated they could pay only $50 per month in premiums for family coverage, considerably less than QHP premium

rates. Based on this survey and without an extension of CHIP funds, we believe children currently receiving WVCHIP coverage and benefits could potentially become uninsured, resulting in increased uncompensated care costs for providers and unmet healthcare needs for children. While our ultimate goal remains to achieve a better Marketplace/public coverage fit for these families in whatever means possible, not extending CHIP funds would be a significant step backward for the health of West Virginia children.

5) **The Allotment Formula:** WVCHIP has been managed through strong fiscal management efforts, and federal dollars have always been sufficient to meet the needs of those enrolled. Since the CHIP Reauthorization Act (CHIPRA) of 2009, the basic allotment funding formula has worked well to support our state's program even during phased in expansion periods. This has allowed West Virginia to continue to expand the program within the parameters of its budget and reduce the number of uninsured children. CHIPRA special contingency funds and bonus set aside for enrollment incentives were less effective due to the current successes in terms of increased enrollment for children in our state as well as the efficient implementation of streamlining enrollment changes. CHIP allotments must now be split between WVCHIP and Medicaid, which causes us great pause as CHIP funds may be used at a more rapid rate, potentially leading to federal funding shortfalls. If federal funding to support CHIP is not extended, WVCHIP will be terminated due to state statute requiring the elimination of the program if federal funds are no longer sufficient. Without the extension of CHIP federal funds, thousands of West Virginia children and families will be impacted.[1]

Federal Funds Shortfall Projection: WVCHIP's actuary currently projects the program could start to experience a funding shortfall as early as first quarter Federal Fiscal Year 2016 (December 2015) without additional federal appropriations after 2015.

The CHIP Allotment Post Federal Fiscal Year 2015

Currently no Title XXI funds are allotted for the program past federal fiscal year 2015. The "separate" CHIP has $41,806,543 in projected costs for 2016 based on current projected enrollment and trends. The "expansion" CHIP has projected 2016 costs of $22,900,000. If the "enhanced" federal matching percentage (FMAP) is increased by 23%, as stated in the ACA, and additional federal funding is allotted, the federal cost for CHIP in West Virginia would be $64,706,543. There would be no state share, as West Virginia's federal matching percentage would be 100% (2016 enhanced FMAP = 79.99% + 23% = 100% FMAP cap). If the 23% increase to the enhanced FMAP is disregarded, and sufficient funding is allotted at the federal level, the federal cost for CHIP in West Virginia would be $51,758,764, while the state cost would be $12,947,779. If no funding is allotted at the federal level post 2015, West Virginia would have state costs of $41,806,543 to continue the "separate" CHIP. The "expansion" CHIP would continue to be funded at the regular FMAP using Title XIX funds. The projected federal cost for the

[1] ***§5-16B-8. Termination and reauthorization.*** *(a) The program established in this article abrogates and shall be of no further force and effect, without further action by the Legislature, upon the occurrence of any of the following: (2) The effective date of any reduction in annual federal funding levels below the amounts allocated and/or projected in Title XXI of the Social Security Act of 1997.*

"expansion" CHIP in 2016 is $16,355,180 and state funding of $6,544,820 at the regular FMAP. This represents an additional state cost of $1,962,530 compared to the enhanced FMAP currently available or $6,544,820 compared to enhanced FMAP with the 23% increase. The unknown is the additional costs to families who move from CHIP coverage to the marketplace or from CHIP coverage to being uninsured because of rules regarding marketplace eligibility – most notably the "family glitch", or to affordability issues mentioned above. The state will also bear the uncompensated costs for those children who cannot enter the Marketplace.

Federal Budget Action Timeline: It is important to stress action must fall early within the 2015 current year's cycle, as the state would amend its State Plan by the second quarter in the 2015 calendar year to allow time to close enrollment six months in advance of the December 2015 date. If Congress were to delay a decision on a CHIP funding extension until late 2015 for the 2016 budget cycle, it could come too late to continue West Virginia's program.

6) **Furthering Children's Enrollment, Reductions in Uninsured Children:** West Virginia continues to streamline its enrollment processes, particularly re-enrollment so as to not eliminate coverage for children due to noncompliance for timely response. We know many children dropped from the rolls at renewal remain eligible, and children are re-enrolled as soon as they are sick or have coverage need. Policy changes such as including Express Lane Eligibility as a permanent option or incentivizing coverage renewal at the time of SNAP enrollment would minimize this administrative inefficiency and promote better continuity of care for children. These changes also help lower caseloads for a workforce that has been severely stretched since recessionary pressures caused spikes in enrollment of safety net programs. In considering further incentives, most states are likely to continue to streamline enrollment where possible. The most important incentive would be one which would address continued lowering of the children's uninsured rate.

Improving Health Outcomes: West Virginia has been a participant in a CHIPRA Pediatric Quality Demonstration grant concerning medical home and quality measurement – work that has been challenging and complex and is drawing to a conclusion this year. It is critical that states have such funds to work on quality changes and identify performance drivers in the health care delivery system with the child population as its main focus. While much of the focus for federal funding has been tailored toward the chronically ill adult population, in many cases it leaves the needs of children out of the equation or in a secondary place of consideration. The importance of continued use of CHIP federal funding allotment to incentivize states to continue children's quality work cannot and must not be understated.

In conclusion, West Virginia continues to face changing budgetary times. Without an extension of CHIP federal funding to help sustain child health care coverage while Marketplace options for children are evaluated and improved upon, we will not be able to provide the health care coverage our children need.

Sincerely,

[redacted]

Earl Ray Tomblin
Governor

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

September 2, 2014

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

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

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

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

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

Governor Walker asked me to respond to your recent letter asking for input on the Children's Health Insurance Program (CHIP).

In Wisconsin, CHIP funding is integrated with the state's Medicaid coverage for children and low income families, called BadgerCare Plus. Using the combination of federal Medicaid and CHIP funds and state match, Wisconsin provides health coverage to children up to 300% of federal poverty level (FPL).

The following are answers to your specific questions:

1. As of June 2014, Wisconsin had 38,652 children in CHIP. The populations served by the CHIP program in Wisconsin currently include:
   - Children aged 1 through 5 years with incomes between 185% and 300% of the FPL.
   - Children aged 6 through 18 years with incomes between 133% and 300% of the FPL
   - Unborn children of women not eligible for Medicaid with incomes up to 300% of the FPL

2. As required under the Patient Protection and Affordable Care Act (PPACA), the state has implemented modified adjusted gross income (MAGI) rules for CHIP funded children. Wisconsin has maintained income eligibility levels for all Medicaid and CHIP funded children. Effective April 1, 2014, the state began providing Medicaid Standard Plan benefits coverage to all adults and children in the Medicaid and BadgerCare Plus program, including CHIP funded children. Previously, children above 200% FPL were enrolled in a benchmark health plan, whose benefits were consistent with commercial insurance. In another change resulting from PPACA, the state has begun processing CHIP applications received from the federal health insurance exchange.

3. The Standard Plan offered to all Medicaid and CHIP funded individuals includes more generous dental, prescription drugs, mental health, transportation, and long term care benefits, as well as lower cost sharing requirements, than plans offered through the health insurance exchange or in other commercial coverage. A list of Standard Plan benefits is available at: http://badgercareplus.org/standard.htm.

4. Wisconsin recommends that CHIP funding be extended and that Congress act to do so before the expiration of the funding authorization at the end of federal fiscal year 2015. In FFY 14, Wisconsin's CHIP allotment was $109,462,826, representing an important component of funding the state devotes to health coverage for low income children. It is crucial for Congress to provide states with predictable funding levels in the coming years. Wisconsin recommends that CHIP be extended at least for the duration of the PPACA requirement that states maintain current eligibility levels for children. This requirement is in place through September 2019. As noted above, CHIP funding supports over 38,000 children in Wisconsin. Also Wisconsin receives the CHIP enhanced federal Medicaid matching rate for some children 6 to 18 years old who are between 100% and 133% of the FPL and children under age 6 with incomes over 133% of the FPL and below Medicaid income limits.

5. In general, the current allocation formula has been sufficient for Wisconsin. It is important for Wisconsin at minimum to keep its current allocation. Congress may wish to consider indexing states' allocations to reflect population growth or health care inflation.

6. The most useful thing the federal government can do is provide states with as much flexibility as possible to design programs to meet each state's unique needs for health coverage.

Thank you again for your letter. Please feel free to contact me or my staff if you need any additional information.

Sincerely,

[redacted]

Kitty Rhoades
Secretary

Response from the State of Wyoming

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)?

- 5220 average monthly enrollment, SFY 2014
    - Serve youth 0-19 years of age, with thirty-six (36%) of CHIP recipients being between seven (7) and eleven (11) years of age; only four percent (4%) between zero and two (2) years of age.
    - Even distribution of male and female youngsters.
    - Sixty-five percent (65%) of CHIP population live in seven (7) of the twenty-three (23) counties.
    - Sixty-four percent (64%) of CHIP families have incomes between 151%-200% FPL (prior to Jan. 2014); seventy-seven percent (77%) of CHIP families have incomes between 151%-200% FPL (post Jan. 2014)
- Seventy – one percent (71%) of all CHIP recipients utilized a medical benefit, including pharmacy, during a 12-month period of time.
    - Professional services such as diagnostic lab, x-ray, optical exams and urgent care services account for forty-four percent (44%) of delivered services.
    - Institutional services (inpatient) for treatment of ailments such as psychoses and depressive neuroses account for twenty-four percent (24%) of delivered services.
        - The catastropic claims classification ($50,000+) is comprised of twenty-two CHIP recipients, with eleven (11) of the twenty-two catastropic claims being for inpatient treatment of psychiatric disorders.
    - Institutional services (outpatient) for treatment of ailments such as abdominal pain, bone fracture, ear ache account for twenty-one percent (21%) of delivered services.
    - Prescription Drugs account for eleven percent (11%) of services.
        - Antiasthmatic, ADHD treatment, a variety of antibiotics and dermatological pharmaceuticals are the most prevelant.
- Fifty-three percent (53%) of all CHIP recipients utilize a dental benefit during a 12-month period of time.
    - Services such as sealants, fluoride, varnish, x-rays account for 54% of services delivered.
    - Services such as fillings and crowns account for 27% of services delivered.
    - Five hundred forty-four (544) youngsters received oral surgery services.
    - Orthodontic services are growing at a higher rate than other services.

Data indicates that overall the CHIP population is quite healthy, utilizing services to address health issues as they present, and are reactionary in nature. Preventive services, such as well-child and well-adolescent checks are not utilized as frequently even though there is no co-pay for preventive services. Limited data suggests an hourly wage parent/caregiver may consider it too costly to forego work in order to schedule a well-child exam.

Response from the State of Wyoming

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?

- CHIP enrollment processes are now conducted in a centralized Customer Service Center.
- CHIP eligibility is now determined by a new integrated eligibility system, the Wyoming Eligibility System (WES) that ascertains CHIP and Medicaid eligibility with a single, streamlined application.
- Implementation of the new Modified Adjusted Gross Income (MAGI) based income standard deemed approximately 1,251 CHIP enrollees Medicaid eligible. The identified youth were transitioned to Medicaid beginning January 1, 2014.
- Verification is now required for reported income. Previous to the ACA income amounts were provided via self declaration.
- Previous to the ACA, a social security number was not necessary for CHIP application. A social security number is now required for each individual on the application applying for CHIP enrollment.

The administration of the eligibility and enrollment elements of the program have shifted from in-house eligibility staff to a customer service center with the CHIP Eligibility Manager providing administrative oversight of the work conducted by the customer service center staff.

The administration of the Federal CHIP requirements including State Plan and Amendments, Federal Reporting, strategic planning, coverage and benefit requirements, outreach and education activity have remained as they were prior to the ACA for the CHIP Program Manager.

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.

Kid Care CHIP	Marketplace
Premium: None	Premium: $771/mo - $1,159/mo
Deductible: None	Deductible: $2,000/yr - $3,000/yr
Out of Pocket max: 5% annual gross income	Out of Pocket max: $3,000/yr - $12,700/yr
Dental benefits: included in benefit package	Additional deductible or separate policy

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 recommendation would be for the extension of CHIP beyond September 30, 2015. The principal rationale for the recommendation is the vast majority of youth currently enrolled in CHIP would not have any viable options in the Marketplace nor would they be eligible for Medicaid. In addition, it is unlikely the CHIP family would be eligible for a tax credit as the formula to determine tax credit eligibility is based on the employee's share of the premium exceeds 9.5% of the employee's adjusted gross income. The option of the State absorbing the 65% match currently provided at the Federal level is not probable. The result would be a significant number of children returning to the rolls of the uninsured, defeating one of the purposes of the Affordable Care Act (ACA).

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

The allotments we have received have been sufficient, and since 2009 unspent allotment monies have been returned for redistribution. Perhaps there is an opportunity for Congress to readdress the use of unspent allotment dollars as a means to transition CHIP programs in a seamless fashion, and avoid children returning to the rolls of the uninsured. Retention of unsued allotment monies would allow states to begin to develop options, such as subsidizing an affordable child only policy in the Marketplace.

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?

The CHIP program is a Federal and State partnership with each partner participating to the extent politically and economically feasible. To date numerous program options have been offered at the Federal level to State CHIP programs. Our State has embraced several of the program options, but not all options. There are currently no impediments to expanding the outreach and enrollment efforts from a federal level.