

**THE CHILDREN'S HEALTH INSURANCE PROGRAM:
THE PATH FORWARD**

HEARING

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

—————
SEPTEMBER 7, 2017
—————



Printed for the use of the Committee on Finance

—————
U.S. GOVERNMENT PUBLISHING OFFICE

COMMITTEE ON FINANCE

ORRIN G. HATCH, Utah, *Chairman*

CHUCK GRASSLEY, Iowa	RON WYDEN, Oregon
MIKE CRAPO, Idaho	DEBBIE STABENOW, Michigan
PAT ROBERTS, Kansas	MARIA CANTWELL, Washington
MICHAEL B. ENZI, Wyoming	BILL NELSON, Florida
JOHN CORNYN, Texas	ROBERT MENENDEZ, New Jersey
JOHN THUNE, South Dakota	THOMAS R. CARPER, Delaware
RICHARD BURR, North Carolina	BENJAMIN L. CARDIN, Maryland
JOHNNY ISAKSON, Georgia	SHERROD BROWN, Ohio
ROB PORTMAN, Ohio	MICHAEL F. BENNET, Colorado
PATRICK J. TOOMEY, Pennsylvania	ROBERT P. CASEY, JR., Pennsylvania
DEAN HELLER, Nevada	MARK R. WARNER, Virginia
TIM SCOTT, South Carolina	CLAIRE MCCASKILL, Missouri
BILL CASSIDY, Louisiana	

A. JAY KHOSLA, *Staff Director*
JOSHUA SHEINKMAN, *Democratic Staff Director*

CONTENTS

OPENING STATEMENTS

	Page
Hatch, Hon. Orrin G., a U.S. Senator from Utah, chairman, Committee on Finance	1
Wyden, Hon. Ron, a U.S. Senator from Oregon	3
Burr, Hon. Richard, a U.S. Senator from North Carolina	5
Warner, Hon. Mark R., a U.S. Senator from Virginia	6

WITNESSES

George, Leanna, mother of a CHIP recipient, Johnston County, NC	6
Schwartz, Anne L., Ph.D., Executive Director, Medicaid and CHIP Payment and Access Commission, Washington, DC	8
Nablo, Linda, Chief Deputy Director, Virginia Department of Medical Assistance Services, Richmond, VA	10

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Bennet, Hon. Michael F.: Letter submitted by #FundCHIPColorado	39
Brown, Hon. Sherrod: Letters submitted by the Ohio Department of Medicaid and the Ohio Children's Hospital Association	42
Burr, Hon. Richard: Opening statement	5
George, Leanna: Testimony	6
Prepared statement	43
Hatch, Hon. Orrin G.: Opening statement	1
Prepared statement	45
Nablo, Linda: Testimony	10
Prepared statement	46
Schwartz, Anne L.: Testimony	8
Prepared statement	49
Warner, Hon. Mark R.: Opening statement	6
Wyden, Hon. Ron: Opening statement	3
Prepared statement	75

COMMUNICATIONS

AASA et al.	77
American Academy of Family Physicians (AAFP)	79
American College of Physicians (ACP)	81
Asian and Pacific Islander American Health Forum (APIAHF)	82
Campaign to End Obesity Action Fund (CEO-AF)	83
Children's Hospital Association	86
The Fed Is Best Foundation	87
Healthcare Leadership Council (HLC)	88

IV

	Page
National Child Health Organizations	89
Nemours Children's Health System	91
Oral Health America (OHA)	93
UnidosUS	94

THE CHILDREN'S HEALTH INSURANCE PROGRAM: THE PATH FORWARD

THURSDAY, SEPTEMBER 7, 2017

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Cornyn, Thune, Burr, Toomey, Heller, Scott, Wyden, Stabenow, Cantwell, Carper, Cardin, Brown, Bennet, Casey, Warner, and McCaskill.

Also present: Republican Staff: Jennifer Kuskowski, Health Policy Director; and Becky Shipp, Health Policy Advisor. Democratic Staff: Joshua Sheinkman, Staff Director; Elizabeth Jurinka, Chief Health Advisor; and Anne Dwyer, Health-care Counsel.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Let us call the meeting to order. But before we begin, I will take just a moment to say that our thoughts and prayers go out to those who have been impacted over the past few days by Hurricane Irma. Of course, we continue to keep those suffering from the effects of Hurricane Harvey in our thoughts and prayers as well.

These have truly been horrific events, and I hope and pray for the safety of everyone involved. I join with my colleagues in the commitment to doing all we can to assist our citizens who are in need at this extremely difficult time. And we will see what we can do to help alleviate some of the pain.

Now the hearing we are having today will come to order.

Twenty years ago, Senator Ted Kennedy and I came together to create the Children's Health Insurance Program, or CHIP, in order to provide health coverage for vulnerable children in families who were too poor to afford private coverage but still did not qualify for Medicaid. Twenty years ago, we were at something of a crossroads.

The year before CHIP was signed into law, a Republican Congress passed and a Democratic President signed a welfare reform bill which ended the entitlement to cash welfare. Welfare reform sought to replace a culture of dependency with an emphasis on work.

The emphasis was to move families off assistance and toward self-sufficiency. CHIP was needed to help many families make that transition. So we needed to be forward-thinking, taking into ac-

count the realities at that time with an eye toward future sustainability of the program.

Senator Kennedy and I worked in good faith for months to craft CHIP, and while neither of us got everything we wanted, the result was a dedicated funding stream for the program to help low-income families get good, reliable health insurance.

CHIP, from the outset, was a bipartisan program that enjoyed, and continues to enjoy, broad bipartisan support throughout the country and, I might add, here in Congress. While it is not perfect, and while, in my view, some of the subsequent changes to the program have been regrettable, I believe that, overall, people consider it to be a success.

Current law provides Federal CHIP funding through the end of fiscal year 2017. According to the Congressional Research Service, if Congress does not act to provide additional Federal funding, a number of children who would likely be eligible for CHIP will go uninsured once Federal funding is exhausted.

Additionally, inaction by Congress with regard to CHIP would cause another layer of unpredictability and anxiety for States that have to administer the program. Of course, this anxiety will pale in comparison to the uncertainty families who rely on CHIP will be faced with if Congress does not act.

As the committee contemplates the future of the CHIP program, there are several thresholds we will need to consider. The basic question is, does the committee want to reauthorize or merely extend CHIP?

Reauthorization would entail more extensive debate and consideration of potential policy changes to the underlying program. And as many of you know, in 2015, Congressman Fred Upton—who was then chairman of the House Energy and Commerce Committee—and I put forward a number of substantive policy recommendations for reforming CHIP, most of which were, admittedly, met with a mixed reaction from stakeholders.

While some policy changes are certainly in order for the program, some are justifiably concerned that, given the number of issues that are already before the committee, there may not be time to give full and fair consideration to CHIP reforms prior to the expiration of Federal funding at the end of the fiscal year. With these concerns in mind, some have suggested that, instead of reauthorizing the entire program, we simply act to extend CHIP funding.

Of course, that option comes with its own set of questions. For example, we will need to determine the appropriate length for the extension and whether to continue with the 23-percent increase in Federal matching for CHIP provided under the Affordable Care Act and extended in 2015.

I know some of our members have strong feelings about both of these questions. These are not particularly complicated issues, but they will require some deliberation among members of the committee.

Long story short, we have some difficult questions ahead of us. Whether we opt to reopen CHIP for reforms or simply provide another extension, the committee will need to invest significant time and effort to find answers to these questions.

Today, we will continue our discussion of these matters as we hear from witnesses who will testify to the importance of CHIP and the need for it to continue. I hope members will listen carefully to these witnesses, confer with their States, and let me know how they would prefer to proceed with regard to CHIP.

I look forward to working on a bipartisan basis with Ranking Member Wyden and all the members of the Senate Finance Committee to move forward on a bipartisan CHIP bill.

With that, let me now turn to my good friend, Senator Wyden, for his opening remarks.

[The prepared statement of Chairman Hatch appears in the appendix.]

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Mr. Chairman. And I just want—as we start this extraordinarily important effort, Mr. Chairman—to note your history with Senator Kennedy. The fact is, it was that bipartisan partnership that got this program off the ground and has significantly reduced the number of uninsured kids in America.

We are very appreciative that you set this in motion. I know all of the members on our side very much look forward to working with you to make sure that we get this reauthorized and done quickly.

The CHAIRMAN. Thank you, Senator.

Senator WYDEN. Colleagues, the fact is, it would be easy for those who are casual observers of political news to get lost right now in what is going on in Washington, DC. And there is an awful lot of Washington lingo that is just incomprehensible to people.

There is the continuing resolution, the debt ceiling, CSR payments, which is cost sharing, NDAA, which is the Defense Act, and I think all of us could go on and on with others.

Today we are talking about the Children's Health Insurance Program. It is CHIP, and it is the only health bill with a time stamp on it. The program is going to expire in a few weeks.

I think our message on this committee needs to be that we see our job as putting kids first. And that means that we are going to have to swing into action quickly here, because this program is a lifeline for almost 9 million vulnerable kids.

It is a source of profound relief for parents in Oregon and across the country. I want to talk about the kind of person who really sees this as the lifeline I have described.

We might be talking about a single mom who works multiple jobs, pays the bills, and handles all of what life throws at her all by herself. The last thing that single mom needs is a government letter stamped "notice of termination" explaining that her sick kids are on their own because CHIP funding has run out.

That single mom is already juggling an awful lot. I think it is fair to say she does not read page A17 of the morning newspaper every day, because she has too much going on to be able to do that and try to decode all of this Washington lingo to determine if the Congress is going to act.

That single mom sits in her kitchen, and if all she has is that scary termination letter, we are going to see a lot of single moms and families in a huge mess very quickly. That is the prospect families across the country face in a matter of weeks, and it is what they do not deserve.

Kids who desperately need care might not get it. States are going to be required to start planning for the worst. That means enrollment freezes, belt tightening, and emergency steps to try to preserve care for kids currently in the program.

But a vulnerable child not yet enrolled in CHIP might have to, in effect, wait until the Congress gets its act together. At best, that leaves families with a mountain of stress, anxiety, and heartache. At worst, it is a life-and-death proposition for a great many of some of the most vulnerable children in our country.

So today, the Finance Committee is going to discuss the leading health-care issue Congress has to address this fall. The Congress created CHIP with one goal in mind: that was to make sure that no American child falls through the cracks of our health-care system.

In the coming weeks, we have an opportunity, as Chairman Hatch just noted, to put together a strong bipartisan agreement that upholds CHIP's promise to families and gives those kids security for years to come.

I am beginning this discussion in an optimistic kind of way, because I have discussed this—as I know many of you have—with Chairman Hatch, and I know the history. In the decades since Chairman Hatch and Senator Kennedy led the Congress to create CHIP, the percentage of kids in America living without health coverage has fallen from nearly 14 percent to less than 5 percent.

So they gave us concrete proof, again, that you can have Senators who can have fierce disagreements on a variety of issues finding common ground when it comes to big challenges. And I submit—I have heard Senator Casey and others talk about this—it does not get any bigger than standing up for vulnerable children.

So it is important for the Congress to act soon. There is no kicking this can down the road with a short-term bill, and it cannot wait until December.

The States run their programs differently. Some are going to run out of funding earlier than others. In that time, no family ought to face the panic of being unable to get the care their sick child needs.

As I wrap up, one other point is to note how CHIP and Medicaid work hand-in-hand for American kids and families, particularly those families working hard every day to climb into the middle class. CHIP adds a level of security to the health care of that single mom and others above and beyond Medicaid. But CHIP can only work if Medicaid works. So we have hard work to do, colleagues, now, to uphold the Senate's promise to kids and families.

We are going to hear from a witness panel that I think it would be fair to say knows CHIP from A to Z: a mom whose child counts on this program, an official who assures CHIP runs smoothly in her State, and an independent expert who knows the program inside-out.

So I see this as an opportunity for all Senators on both sides of the aisle to learn about and discuss this critical program and set the stage for the work to come. I am confident that in short order Congress can pass a strong and bipartisan extension of CHIP that will last for many years. And this is exactly what the important work of the Finance Committee is all about.

[The prepared statement of Senator Wyden appears in the appendix.]

Senator WYDEN [presiding]. Now Chairman Hatch is going to have to do some juggling here. So I am going to call an audible, and I would like to welcome each of our three witnesses to our hearing today. Each of your perspectives is important with respect to CHIP.

First, we are going to hear from Leanna George, who will be introduced by our friend, Senator Burr.

**OPENING STATEMENT OF HON. RICHARD BURR,
A U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Thank you, Senator Wyden.

Welcome, Leanna. Leanna is a proud parent of two children. Is that Caleb behind you?

Ms. GEORGE. Yes, Sir.

Senator BURR. Caleb, wave at everybody. We are glad to have you.

Leanna's daughter is eligible for Medicaid because of her disability. Caleb, her son, is insured by the CHIP program.

Leanna serves as the beneficiary representative on the Medicaid and CHIP Payment and Access Commission. She is also a chairperson of the North Carolina Council on Educational Services for Exceptional Children and is the secretary of the Consumer Family Advocacy Committee for Johnston County Mental Health Center, the local management entity that connects Johnston County citizens with mental health, intellectual developmental disabilities, and substance abuse services.

She is not only a mom, she is an advocate in every sense of the word at every level. Leanna, we are just honored to have you here today. Welcome.

Senator WYDEN. Thank you very much, Senator Burr.

Second, we are going to hear from Dr. Anne L. Schwartz, the Executive Director of the Medicaid and CHIP Payment and Access Commission, commonly known in Washington lingo as MACPAC. MACPAC is the nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of Health and Human Services, and the States on a wide variety of issues affecting Medicaid and the State CHIP programs.

Dr. Schwartz previously served as deputy editor of the journal *Health Affairs*, vice president at Grant Makers in Health, and Special Assistant to the Executive Director and Senior Analyst at the Physician Payment Review Commission—another mouthful—a precursor to the Medicare Payment Advisory Commission. Dr. Schwartz has also held positions on committee and personal staff for the U.S. House of Representatives.

She holds a doctorate in health policy from the School of Hygiene and Public Health at the Johns Hopkins University.

Finally, we will hear from Ms. Linda Nablo, who is going to be introduced by our good friend, Senator Warner.

**OPENING STATEMENT OF HON. MARK R. WARNER,
A U.S. SENATOR FROM VIRGINIA**

Senator WARNER. Thank you, Senator Wyden.

I want to echo what both you and Chairman Hatch said about the importance of CHIP. It is a critically important program.

I would like to present to my colleagues my good friend Linda Nablo, who is now the Chief Deputy Director for the Commonwealth's Medicaid agency, the Virginia Department of Medical Assistance Services, or as we call them, Virginia DMAS.

Linda and I go back to the days when Bob Casey addressed me as his excellency, the Governor. Linda, at that point, was Director of the Division of Maternal and Child Health Services.

Our CHIP program back in the early 2000s was, frankly, a dreadful disaster. We were literally sending tens of millions of dollars back to the Federal Government because we did not appropriately sign up enough of our eligible children.

We came in, and with Linda's great help turned that program around, made it a much easier process to get through the sign-up process, and turned a multi-page application into a single-page application process. Linda and I traveled the State at clinics and other gatherings, and because of her good work and the work of a lot of folks at DMAS, we went from one of the bottom of the barrel programs to where we signed up 98 percent of our eligible children. Kaiser Foundation recognized us as one of the most effective CHIP programs in the country.

Linda went on to serve at CMS and now has come back to DMAS. She has a great, great expertise and a great heart for this program, and she should be a very valuable witness.

Thank you, Senator Wyden.

Senator WYDEN. Thank you, Senator Warner. So now we have gotten to the best part, and that is our witnesses. Why don't we begin with you, Ms. George? We will go right down the row.

It is a tradition in this committee if you could perhaps highlight your testimony in 5 minutes. We will make your prepared remarks a part of the record in full.

Please proceed, Ms. George.

**STATEMENT OF LEANNA GEORGE, MOTHER OF A CHIP
RECIPIENT, JOHNSTON COUNTY, NC**

Ms. GEORGE. Thank you very much.

Good morning. My name is Leanna George, and as Senator Burr indicated, I am from Johnston County, NC. It is a very small rural county.

Thank you for the opportunity to be here today to meet with you and to share my family's experience with the CHIP program and how it impacts families like mine throughout our great country.

I am married to a wonderful man named Jim. He is a Marine Corps vet, and he is in his third year of an electrician's training program to become a fully licensed electrician. As mentioned ear-

lier, I have two children: Serenity, who lives in a group home, and my great son, Caleb, behind me. Both of my children are on the autism spectrum.

Caleb has ADHD, Attention Deficit Hyperactivity Disorder, as well as a genetic neurological condition. And as you know, Serenity has Medicaid, and Caleb is insured by CHIP.

While I am not here to testify on behalf of MACPAC, it was not until I was appointed to the Commission that I realized that CHIP's future was so uncertain. As a parent of a child with extensive needs, my focus had been on advocating for home- and community-based service support waivers for children with developmental disabilities like my daughter. I was not aware that CHIP was in danger and that the children of working-class families like mine were in jeopardy of losing their health insurance.

As the Commission discussed the CHIP program, I began to wonder just how losing CHIP would impact my family. How would it affect the monthly premiums we pay for our insurance? Would Caleb have access to the services he needs? How much would it cost us?

With the current health insurance plan, there would be no increase to our premium because my husband's plan only covers employees or family-only coverage. There is no employee and spouse-only coverage. However, it has a very high deductible which already prevents my husband and I from accessing medical care that we need.

This, in short, means that the services that Caleb needs would be pretty much out of our financial reach to get for him without CHIP. These services include occupational therapy, which addresses fine motor challenges that impact his ability to write and perform basic self-care tasks like tying his shoes.

He receives periodic MRIs to mark the progression of his neurologic condition which allow us to be proactive in treatment, which results in better outcomes for our children. My son takes daily medication which helps him be able to focus in school, which impacts his grades and his ability to learn.

Over the years, the CHIP program has provided all of these services to us for little to no cost. Even in years when we have had cost-sharing, CHIP is still a tremendous value for my family. Without CHIP coverage, his access to services would be greatly diminished.

CHIP also provides families with financial security and moms like me with peace of mind. In January, my husband was laid off of work. That resulted in an insurance lapse for him and me. We worked hard to ensure that he continued his medication that he needed, but I was able to feel confident that Caleb had the services and supports he needed should he become sick. I am so thankful that I have never had to call his pediatrician and say, "I am going to have to cancel our appointment. We do not have insurance." I have never had to watch him lying in his bed with a fever and not been able to pursue medical intervention for him.

CHIP has allowed my son to continue to receive the services he needs without interruption, despite what challenges my husband and I were facing. If CHIP was to go away, families like mine would be forced to make many tough decisions for our children.

Monetary resources are already stretched thin. Families might have to ration medical care, which could result in something that appears minor right now progressing into a very serious condition. Other families may procrastinate on maintenance services on vehicles and housing, which could lead to tragic accidents occurring. If we were not able to afford my son's medication, I know his education would be severely affected.

Among sacrifices, we have to consider activities that our kids participate in. Caleb is a Boy Scout. He has been in scouting since he was in the first grade. He earned his Arrow of Light last year in Cub Scouts. His uncle and his cousin are both Eagles, and he is excited about earning his Eagle one day. And I want to see him grow into a young man who exhibits the 12 principles of the Boy Scout law.

While there is a lot of support for these great programs that teach leadership and discipline and promote active, physical, healthy lifestyles, losing CHIP can really put a hindrance on families being able to continue the support for these activities for their kids.

Some families would have to sacrifice the care they provide for others, their children, their parents who live in situations outside of the home. My daughter lives 4 hours away from us. I would like to go more often than I can, but without CHIP, we would be even more limited in our ability to monitor her needs from where we live.

There are 9 million children who receive CHIP. This program provides parents and families with peace of mind and financial security. Without CHIP, life would be a lot harder. I do not even want to picture or imagine it, but I know the impact is going to be on our kids for years to come.

I ask you today to continue funding CHIP. And I want to thank you for your time to determine the future of this great program. Thank you very much.

Senator WYDEN. Thank you, Ms. George. I know you speak for a lot of parents. We very much appreciate your being here.

[The prepared statement of Ms. George appears in the appendix.]
Senator WYDEN. Dr. Schwartz?

STATEMENT OF ANNE L. SCHWARTZ, Ph.D., EXECUTIVE DIRECTOR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, WASHINGTON, DC

Dr. SCHWARTZ. Good morning, Senator Wyden and members of the Finance Committee. I am Anne Schwartz, Executive Director of MACPAC, the Medicaid and CHIP Payment and Access Commission.

As Senator Wyden noted, MACPAC is a nonpartisan congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of HHS, and the States on issues affecting these programs. Its 17 members, led by chair Penny Thompson and vice chair Marsha Gold, are appointed by GAO.

While my statement builds on the analyses conducted by MACPAC staff, it reflects the views of the Commission itself. We appreciate the opportunity to share MACPAC's recommendations

at a time when there is a pressing need for congressional action and the consequences for children and their families are significant.

Since its enactment with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health care for millions of children with incomes just above Medicaid eligibility levels. Since 1997 to 2015, the share of uninsured children in the typical CHIP income range has fallen dramatically from 22.8 to 6.7 percent.

CHIP is State-administered within Federal parameters and jointly financed by the Federal Government and the States. Flexibility in program design is one of its hallmarks; some States run CHIP as an expansion of their Medicaid programs, and others operate entirely separate programs.

As you know, without congressional action, States will not receive any new Federal funds for CHIP beyond the end of this month. Our latest projection shows that 3 States and the District of Columbia will exhaust their CHIP funds by the end of 2017, and 27 States will do so by the end of the second quarter of fiscal year 2018.

In the face of uncertainty, many State administrators are already considering the numerous steps they will have to take to either freeze enrollment, scale back, or shut down programs. While they do not wish to alarm beneficiaries, States report that they cannot continue indefinitely with business as usual.

Mindful of this situation, the Commission issued its recommendations last January after devoting considerable attention over several years to CHIP's role in our health-care system and policy approaches for the future.

We reviewed available evidence about the quality and affordability of CHIP compared to other alternatives and focused attention on the implications of various policy approaches on children and their families, States, providers, plans, and the Federal Government. Based on this review, and in light of considerable uncertainty now facing health insurance markets, MACPAC recommends that Federal funding for CHIP be extended for 5 years.

If CHIP funding is not renewed, 1.2 million children covered under separate CHIP will lose their coverage. While some of these children may be eligible for coverage privately, they would have to pay considerably more than under CHIP, creating barriers to needed health and developmental services. In addition, they would lose access to services covered by CHIP that are not typically covered by other payers. Those covered by Medicaid expansion CHIP would not lose coverage, but there would be a significant shift in the funding obligation to the States.

The Commission also recommends extension of the current CHIP maintenance of effort requirement and the 23 percentage point increase in the Federal CHIP matching rate through fiscal year 2022.

These linked recommendations reflect the view that extension of the MOE—which it judged important to retaining gains in coverage—should be accompanied by an extension in enhanced funding. The higher CHIP matching rate is also thought to have influenced decisions in some States, including Florida, Utah, and Arizona, to expand coverage to previously uninsured children.

MACPAC's recommendations also look to a future in which a more seamless system of children's coverage can be created. Such a system would provide comprehensive and affordable coverage and remove gaps that occur when children transition among different sources of publicly and privately financed coverage.

Recognizing that States will be the drivers of such change, MACPAC recommends that demonstration grants be made available to States to develop and test new approaches.

Our other recommendations call for an extension of other child-focused programs that are typically reauthorized with CHIP.

CHIP has clearly played an important role in providing access to health care for millions of America's children. In addition, CHIP has provided a platform for State innovations to reach eligible but uninsured children, remove enrollment barriers, and focus on high-quality pediatric care.

Congress now faces an important decision regarding the future of CHIP during a period of great uncertainty affecting other health-care markets, including both Medicaid and the exchanges. MACPAC's recommendations provide guidance on how to ensure a stable source of affordable and comprehensive coverage for low- and moderate-income children amid such uncertainty. And the Commission urges Congress to act as soon as possible to extend CHIP, an action necessary to prevent children from losing coverage and access to care and to ensure that States have the necessary funds to provide people services.

Senator WYDEN. Dr. Schwartz, thank you very much.

[The prepared statement of Dr. Schwartz appears in the appendix.]

Senator WYDEN. Ms. Nablo, welcome.

**STATEMENT OF LINDA NABLO, CHIEF DEPUTY DIRECTOR,
VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES,
RICHMOND, VA**

Ms. NABLO. Thank you, Senator Wyden, for allowing me to speak to you today on the importance to States of continued funding for the Children's Health Insurance Program.

And thank you, Senator Warner. I remember well when you were Governor and enrolling every eligible child was your top priority. I particularly remember how you would ask every Friday—without fail—how many more children we had gotten covered that week.

So before you ask, let me say that in Virginia today there are 614,100 children covered through Medicaid and CHIP. These programs are the health insurance plan for almost one in three children in the Commonwealth, which is actually slightly below the national average.

However States have chosen to design their CHIP program, it plays a vital role for all of us in ensuring children have access to affordable and appropriate health care by building on top of the much larger Medicaid program. In fact, CHIP just turned 20. It is now a mature program that is woven deep into the fabric of health-care coverage in all States.

There are only two points I want to make with you today in my few minutes. First is that CHIP is vital to the health of children.

And second is that there are serious consequences looming if you delay reauthorization even for a few months.

In Virginia, as of September 1st, there are over 58,000 children enrolled in Medicaid, but funded by CHIP. There are 65,000-plus enrolled in our separate program we call "FAMIS." We also have a CHIP waiver to provide prenatal care to pregnant women, and about 1,100 are currently enrolled.

Virginia receives 88-percent Federal funding for this program. In the last two State fiscal years, this money has paid for hundreds of thousands of well-child visits and immunizations, over 21,000 pairs of glasses, and well over 367,000 visits to the dentist. But we have also paid for 258 heart surgeries, six brain cancer surgeries, two liver transplants, and one heart transplant. We have provided services for over 1,100 children diagnosed with cancer, 31 children living with HIV, and 32 babies born with neonatal abstinence syndrome.

Obviously, CHIP helps children lead healthy and normal lives. For example, they can play sports. You know you have to have insurance to play sports. They can control their asthma, they can see better in school, or get their teeth fixed.

For other children, CHIP has provided lifesaving treatments. This is true in my State and in yours. But without congressional action soon—as Senator Wyden clearly explained—States will be forced to start preparations to shut these programs down.

You have heard that most States will not actually run out of CHIP dollars until sometime in the second quarter of 2018. Some might believe you can safely delay action on CHIP while you deal with your very full calendar. But let me explain the reality for States.

According to all estimates, Virginia will run out of Federal CHIP dollars sometime in March. However, Virginia like many States, covers these children through managed-care plans. We pay those health plans a capitated rate retrospectively for the previous month's coverage. So in March, we will not have sufficient funds to pay for the month of February. We will, therefore, need to terminate our separate CHIP program at the end of January.

In order to give the families of those 65,000 children adequate notice, we will need to send them letters on or about December 1st. Before then, we will need to train eligibility workers, application assisters, call center operators, and others so they are able to answer questions and provide whatever assistance they can to these frightened families.

We will also need to inform providers and prepare to deal with their questions as well. We will need to expend CHIP funds to reprogram automated eligibility rules and to modify online and paper applications and notices. Countless other contracts, from managed care plans, prior authorization reviews, auditors, et cetera, will all need to be amended.

I suspect for States without a high degree of managed care, the situation will be even more precarious, as their costs are less predictable. And remember, Virginia is not one of the first States to run out of money. Please be aware that your State will soon be making difficult decisions about if and when to freeze enrollment so as to preserve current coverage as long as possible, and what to

tell families and when to tell them as the end of funding approaches.

Because we have come so dangerously close to the wire this time, States would be grateful for any quick extension of CHIP. But I do want to make the point that funding this program in one- or two-year increments can generate instability, dampen innovation, may limit State investment, and freeze programs where they are when the future is so uncertain. I hope at some point you are able to consider the recommendation of MACPAC and other organizations of reauthorizing and funding the program for at least 5 years.

Finally, please be aware that, for Virginia alone, if Congress reauthorizes CHIP by September 30th but reduces the Federal match rate to previous levels, we will experience over a \$57-million shortfall for the current State fiscal year which began in July, and an \$83-million shortfall in the next.

Senator Wyden and members of the committee, as you know, CHIP has always had strong bipartisan support. With all of the very difficult and complex decisions you have to make about health care in America, surely whether or not to extend CHIP is not one of the hard ones.

On behalf of States, I am here to ask you to please continue your support of children's health care by straightforward reauthorization for continued funding of CHIP at current levels. And please do it before we have to send those letters.

Thank you.

Senator WYDEN. Thank you, Ms. Nablo.

[The prepared statement of Ms. Nablo appears in the appendix.]

Senator WYDEN. Well said. And I also appreciated hearing how it was morning in Virginia when Mark Warner was Governor and everybody got their daily report on how many kids got covered. [Laughter.]

You all have been an excellent panel. Let me just start with a couple of questions.

Ms. George, I would like to hear what it really means in a parent's case, in terms of what they would give up if the program expires. For example, I think it would be helpful to know how you would pay for Caleb's medications, because it sounds like those are pretty pricey. And you talked to us about a whole variety of circumstances which obviously a parent cares about, but how would you pay for Caleb's medications?

Ms. GEORGE. Right now, I am not really 100-percent sure. I would probably be asking my mother for a lot more help than we already get. And right now Caleb and his father take a class called Tang Soo Do, a martial arts class that helps my husband with some arthritis challenges and helps Caleb immensely. But that would be one of the first things we would have to drop.

Right now we put aside money each month so that we can have money when the Boy Scouts go to summer camp, you know—that is another area. Because we are looking at \$3,600 a year that we have to find savings for, for his medications, and that is if they do not go up again.

And that is a third of our—is it a third of our income? No. It is not a third of our income. It is about a tenth of our income, actually, though.

And just trying to find that savings would be a challenge, because we can probably get half of it, as I said, through some of the martial arts classes that he takes, but the rest of it, I am not sure where it would come from.

Senator WYDEN. That was my sense. And I appreciate that, because you have described how, basically, every single month you are trying to watch how you allocate your dollars, and it is tight, but you get along. And you try to do, obviously, right by your kids.

I just kept looking at Caleb's medications, and I cannot figure out how you would be able to pick those up without some magical approach that we have not talked about. So I probably want to ask you some more about it.

Ms. Nablo, a question for you. You really gave us a very concrete and specific case about the kind of bedlam that we would see in the State of Virginia if this program was delayed.

Can you tell us—because you are an authority on this subject—what would happen in other States? In other words, based on your knowledge and your expertise about the program, tell us a little bit about whether what Virginia does is representative, and would other States have other problems, and just walk us through, if you would, some of the other States.

Ms. NABLO. I would say Virginia is probably somewhat fortunate in this situation in that the Federal funding does not run out until March, even though the program would have to close.

Senator WYDEN. So the problems you describe would, essentially, be worse elsewhere?

Ms. NABLO. Absolutely. Obviously, as has already been stated, there are several States that will run out of funding before the end of this year. They have really got to be thinking about notifying those families very soon.

In addition, I believe there are some States that actually have a State law that says if the funding level from the Federal Government is reduced or goes away, they have to shut down their programs. Every State is a little bit different, and every State program is constructed a little differently. There are some that I think are really kind of reaching the desperation point. Now, I suspect if they do not hear something in the matter of a couple of weeks, several States will be sending those letters, or being in the paper trying to warn parents.

Senator WYDEN. Your message—and that is particularly helpful—is that anybody who thinks they can wait around until December 15th to get serious about this—

Ms. NABLO. Has never shut down a program before.

Senator WYDEN. Okay. Well said. You are talking about people getting a signal in a couple of weeks. And if Congress plays stall ball on this, there are going to be real consequences.

Ms. NABLO. Absolutely. There would be very scared families, and our phones would ring off the hook in State offices and local offices.

Senator WYDEN. Very important to know.

One other really quick question. Dr. Schwartz, we feel very strongly that this program be multi-year, and we are going to push for the most generous funding that we can. I mean, obviously, we are going to have to have discussions back and forth on that, but that is my objective. That is our objective here.

What, in your view, is the value of a multi-year extension and why that is preferable? I mean, my sense is, that gives some certainty and predictability, but you are the expert on this.

Dr. SCHWARTZ. Certainly. The last time that MACPAC made a recommendation in advance of the extension that you passed in 2015—our recommendation was for 2 years. And at that point, there was some hopefulness that some of the uncertainty in health-care markets that were a feature in the congressional debate at that time would be solved. And it is clear that now, if anything, things are more uncertain. We are not sure about what sources of coverage would be available to kids going forward, with the uncertainty affecting Medicaid and the exchange market as well as privately sponsored coverage.

So it is the Commission's view that it is important to put kids in a safe space while these other bigger issues are debated and figured out. And that is why the Commission recommended a 5-year extension to ensure that families would have stability in insurance coverage, that States would not be in a situation where they were constantly having to sort of be in a groundhog day situation of going through the steps that they would have to take.

Senator WYDEN. Thank you. My time is expired.

Senator Heller?

Senator HELLER. I want to thank the ranking member and the chairman for holding this hearing today. It is a critical program, and it is a program that helps millions of children. So I want to thank Ms. George for being here and sharing your story with us, and the other witnesses for your help and support of this particular program.

In Nevada, CHIP provides medical coverage for roughly 25,000 children who otherwise might not get care. And over the years, this program has been responsible for increasing coverage for low-income children throughout my home State.

Nevada has made great strides when it comes to improving our uninsured rate, making sure that our kids have access to affordable health care. And this is something that both Governor Sandoval and myself are quite proud of. So it is my hope that Congress will act swiftly to reauthorize this program, give families in Nevada and across the Nation the certainty that they need when it comes to children's health care.

So with that, I would like to ask a question or two—specifically to you, Ms. Nablo, because of your background, expertise, and what you were able to accomplish in Virginia. I said 25,000 Nevada children now are covered. It is estimated that probably 9 million—I think, Ms. George, you said that—children across the country benefit from this program. But they also estimate that there are roughly 5 million children who remain uninsured today.

So with your expertise, your background, your knowledge of this program, can you share what some of the barriers are that would produce what we have today of 5 million uninsured children and their inability to get into a program like this?

Ms. NABLO. Certainly. I would say the first barrier is always awareness. It is amazing how many individuals still do not understand that this program actually can cover the children of working families, and there are many families who never in their life con-

sidered that they might be eligible for a publicly funded health-care program.

And someone loses their job, or their hours get cut back, and all of a sudden they are eligible. They have never paid attention to the ads before. So it is a constant need, a constant drumbeat, because there is always a new population. A plant closes, whatever, that creates a new population. That is one.

Plus, there are certain populations that have higher uninsurance rates that are more difficult to target, but States really need to make those efforts. Teenagers are much less insured than young children. Hispanics are classically underinsured.

So it takes special efforts, special outreach. And quite honestly, funding for outreach is one of the first things that goes when States get strapped. So that is a constant campaign to keep that up.

I think perhaps—and it may be MACPAC that has done some analysis of those 5 million children still uninsured—a good percentage of them, I think it is 60-some percent of them, would be eligible for CHIP or Medicaid if they would apply, if they were aware and took the action to apply.

Senator HELLER. Dr. Schwartz, could you add anything to that?

Dr. SCHWARTZ. Yes. I do not have those numbers at my fingertips, although we could get them for you.

I think, also, it is important that that number of children who remain uninsured includes undocumented children who would not be eligible for programs in different States.

Senator HELLER. Do you anticipate that this number is climbing, or is it actually getting better at this point?

Ms. NABLO. I think we have seen a consistent drop in the uninsured number for children going back to 1997, and that was the primary motivation for the Commission to recommend extension, wanting to secure those gains in coverage and make sure that the number of uninsured children does not go back to where it had been historically.

Senator HELLER. Yes.

Ms. Nablo, based on the barriers that you just spoke about, what can we be doing better here in Congress to address some of those issues?

Ms. NABLO. I think there is even a recommendation of MACPAC that money that is set aside, specifically targeted for outreach—right now States generally take that money out of their admin dollars that are allowable under the CHIP program. Those admin dollars get stretched to all kinds of other things.

So having a set-aside, if you will, that is meant to help States continuously promote this program, I think, would certainly be helpful.

There are some policy changes that could make it easier for people. There are some States that still have a required period of uninsurance before a child can become eligible for CHIP. That is my least favorite policy in the CHIP program.

Senator HELLER. Does the law allow any outreach in the CHIP program, in the funding the States receive?

Ms. NABLO. Does it allow it?

Senator HELLER. Yes.

Ms. NABLO. Yes. You can take it out of your admin dollars. Every State can spend up to 10 percent on admin of what they spend on medical care for kids.

So the bigger your program gets, the bigger your admin budget gets too. But that needs to pay for workers and IT systems and all of that kind of stuff as well.

But that is where most States are able to find some dollars for outreach.

Senator HELLER. Thank you very much, Mr. Chairman.

Senator WYDEN. Thank you, Senator Heller.

Senator Casey?

Senator CASEY. Thank you very much. I want to thank the ranking member for his leadership on this issue over many years. And of course, I want to thank Chairman Hatch for his work today as well as his leadership over many years in a bipartisan fashion.

This is an issue where we are particularly grateful our witnesses are here, but we are also grateful that you are here at this time, because we need your voice, we need your expertise, your advocacy, to inject a sense of urgency into a place where urgency is often not the order of the day.

I am going to start with Ms. George. We are particularly grateful that you are here to bring your own, not only expertise as all three members of the panel bring, but you bring a personal dimension. Your testimony has—I think in some ways—added value and significance on a day like today.

I was noting from your testimony all of the, not maybe an exhaustive list, but some of the services that you testify that Caleb benefits from. And I am looking at, I guess, the second page of testimony where you talk about weekly occupational therapy to address fine motor challenges that affect Caleb, periodic MRIs and ultrasounds to monitor the progression of his neurological condition, and daily medication which helps him stay focused on his schoolwork.

And you say, “The CHIP program has provided these services for little or no cost. CHIP is a tremendous value.” And you talk about financial security and peace of mind. All of that testimony is critically important to hear from you as a parent and hear from you as someone who is deeply concerned about your son.

I guess my first question would be, if you were to receive a termination of coverage notification, how would that affect your family?

Ms. GEORGE. Well, the first thing I would be looking for is a way to appeal the determination as an applicant.

Senator CASEY. Right.

Ms. GEORGE. But it would just be a challenge. I look at Caleb and his needs with education. His medication, primarily, is so important, because without his medication for ADHD, he could barely complete a half a worksheet in kindergarten. Within a week or two of having the medication, he is now completing two worksheets.

This medication allows him to stay focused. Without being able to focus on what you are doing, you cannot do more complex math. Right now, we are doing long division. When his meds wear out, put that aside, because it is too much involved in long division.

It is just so important that he keeps getting his medication. So that is the first thing. How are we going to pay for the medication? How are we going to address his penmanship?

We started occupational therapy over the summer, and he went from not being able to write legibly at all—I could not read it. He is homeschooled this year—now he writes fairly well. As long as we keep that up—and hopefully we can wean him off of the occupational therapy, but it is just so critical, that it is going to impact him not just today, but as he goes into high school, as he goes hopefully into college, into being an adult, that if he does not have these skills, then he is not going to be able to achieve as well as he could achieve.

That is why I think it is such a tremendous value, intervention. But as a family member, it would just be devastating to find out that all of these things that we have done to build him up, we are no longer going to have access to.

Senator CASEY. We are grateful for that testimony. I know if you just multiply that in just one State like, in my case, Pennsylvania—as of August we had over 176,000 children enrolled. And that number goes up and down depending on what day of the month it is or what time period, but lots of children benefit, I am sure, in the same way that Caleb does. So we are grateful for that testimony.

I am almost out of time, but, Dr. Schwartz, I wanted to ask you, has the risk to—I am sorry. I was going to ask Director Nablo this. Has the risk to CHIP funding already impacted your State in administering the program?

Ms. NABLO. I will say no. We have been very cautiously optimistic. And so we have not made any cutbacks.

I will say we just recently ended an outreach campaign. It ended this summer. It was the first media buy we have been able to do probably since the days when Senator Warner was Governor. And it did boost our enrollment again, but we have let that expire, I think, in part, because of funding, but the other part is, are we driving people to a program that is going to close soon?

I think there are other States that have had much more serious consequences. There are States that have prepared those notices, that are really actively engaged in shutting things down, are ready to pull the trigger.

Senator CASEY. Great. And I will have more.

Dr. Schwartz, I will send you one in writing. Thanks very much.

Senator WYDEN. Thank you, Senator Casey.

Senator Scott?

Senator SCOTT. Thank you, sir. And thank you to the panel for being here with us this morning.

Ms. George, thank you and your family for your service to the country. Your husband's service as a marine is greatly appreciated.

I will say that, as many of my colleagues know, I have a passion for helping our most vulnerable, our kids, access quality education, whether that is through school choice programs or youth apprenticeships. Anyone who has ever set foot in a classroom understands and appreciates the importance that health plays in the success of the child in the classroom and, by extension, in life.

For almost 9 million children across the country, including 80,000 in South Carolina, the CHIP plays a vital role in ensuring that our young folks are healthy enough to learn and thrive in school and in life. In considering the ways in which CHIP shapes education outcomes for many of our students, we need to look no further than the issue of asthma.

Asthma is the most common chronic condition among children, a leading cause of disability, and with bronchitis it is the leading cause of hospitalization among children in South Carolina. It is also one of the leading causes of absenteeism in schools and can increase the risk that that child will not reach their full potential educationally, and that, in turn, means in life.

Whether a child is struggling with asthma or another condition that impacts their ability to succeed at school, CHIP can help remove some barriers for families who are often up against a lot of other challenges. By producing healthier children, we also produce children who can be fully present in the classroom, fully invested in their studies, and fully prepared for a fruitful educational journey.

Shortchanging children's health produces a vicious cycle whereby poor health care leads to lower academic achievement, and poor academic outcomes, in turn, diminish long-term health.

Ms. GEORGE, first off, I want to say thank you again for the opportunity to listen to your story and to understand and appreciate that you are here not only as an advocate, but as a mother. Can you please talk with us as the chairperson of the Council on Educational Services for Exceptional Children about how you have seen the connection between health services that students with exceptional needs receive and the success that they are able to achieve in the classroom?

Ms. GEORGE. Well, as you know, through IDEA, public students have access through public education and their Individualized Education Programs for related services such as occupational therapy, physical therapy, speech therapy—the list goes on and on. And some of that is funded through public insurances, CHIP and Medicaid. A lot of students receive these services. It is very much beneficial to them.

Senator SCOTT. Excellent—excellent.

My second question for you, ma'am, is, as a mother, you have come before us, and I wanted to understand and appreciate—we certainly have heard Senator Warner and others talk about the importance of CHIP as it relates to your son. Can you perhaps expound upon the services and the way that they impact his academic achievements as well?

Ms. GEORGE. Well, with the occupational therapy, as I shared a little bit earlier, with his penmanship—he was completely illegible. We started homeschooling him in the fifth grade year, last year. We are in our second year of homeschooling.

We could not read his handwriting, despite having occupational therapy in the public school system. So we were able to get him private therapy, and he has made tremendous progress between that and constantly redoing it at home.

If you cannot read somebody's handwriting—you cannot write a letter, you cannot fill out a job application. Even in this technology-

based world, it is still a vital skill. As well as, with him, when doing multiplication and long division, when he was trying to line up and add his numbers, if he could not read the number he wrote, he would come up with the wrong answer.

Senator SCOTT. Yes, ma'am.

Ms. GEORGE. And once again, that impacts his education there. Yes.

Senator SCOTT. Thank you very much.

Senator WYDEN. Thank you, Senator Scott.

Senator Warner is next.

Senator WARNER. Thank you, Senator Wyden. Let me, again, thank all of our witnesses: Ms. George, Dr. Schwartz; Linda, it is great to see you again.

I am going to direct most of my questions, I hope appropriately, to Ms. George and Dr. Schwartz. And I also want to commend—

Senator BENNET. By the way, when you refer to the days that Mark Warner was Governor, did you mean the dark days for Virginia? [Laughter.]

Senator WARNER. They were already called the morning in Virginia, as Senator Wyden mentioned. [Laughter.]

One of the things that I hope, particularly, Ms. George will take back is, it is rare to have a program where people on both sides of this dais are all saying good things about the program. I hope it gives you a little more faith that we can get our act together and get this done in a timely way.

Dr. Schwartz, we appreciate all of the, kind of broader policy goals you have looked at, and the extension time you have set. Again, I think it is a 5-year extension at least.

One of the things I would like you to talk about—I do not want to be presumptuous and assume we are going to get it done in a timely way. But one of the things I recall in the past is, so many of these families, their incomes fluctuate so much month-to-month, and they may be Medicaid-eligible at one point and then CHIP-eligible at another point. On a going forward basis, are there better ways for us to make sure that people do not have to constantly re-apply, and can we streamline this, so people who fall within these eligibilities do not have to spend their time as they bounce from one program qualification to another?

Ms. NABLO. There is an option for States of making the Medicaid or the CHIP program for children—you would be continuously eligible for a 12-month period. So even though your income may fluctuate and you may drop down to Medicaid or go up to being not eligible for the program, you would not have to report a constantly changing income and your child would be covered for 1 year until their annual renewal date.

Not every State by far has adopted that policy. That would be wonderful if that was part of the law.

Senator WARNER. Would you keep that as an optional basis on reauthorization?

Ms. NABLO. Well, if we really truly wanted to address that concern, it would not be optional. It would be the way the program was structured.

In Virginia, we have a version of that. It does say that if your income goes up, you have to report that.

But you are absolutely right. People's income—there are a lot of seasonal workers here, there are a lot of people who get extra jobs over Christmas, and their income changes. You know, we have school teachers with children on CHIP.

So it is a constantly moving target and fluctuating environment for families. To realistically expect families, every time somebody works a few more hours, to report that and ask an eligibility worker to figure out if that makes a change or not is really not the smart way to have this coverage.

Senator WARNER. Right. There could be a retroactive look-back after a year or so, but this bouncing between income levels is really, I think, really important.

Ms. NABLO. Absolutely—absolutely. And in States where the benefits packages between CHIP and Medicaid are very different, that alone can cause problems. You may lose a provider. You may still be eligible for coverage in Medicaid, but perhaps your provider is not a Medicaid provider.

Senator WARNER. And I think we have heard from Senator Scott and others that, in terms of plain old business ROI, making sure that child—making sure Caleb—goes to school healthy and prepared is going to make him a better student.

Ms. NABLO. Sure.

Senator WARNER. That pays back enormous benefits.

Ms. NABLO. I think that is what you have to do. Hopefully you look at the long road, the long picture, and does it make sense that we have programs where families could potentially bounce back and forth almost month to month.

Senator WARNER. Talk to me a little bit about the importance of outreach, and particularly rural outreach, since there are so many communities. I know we have online signups. But the truth is, many families may not feel comfortable doing it online or going to a library and putting very personal data into a computer without an outreach worker. Talk about outreach, and more specifically, rural outreach.

Ms. NABLO. Certainly. Well, as you know very well, we—the State—employ a few outreach workers, and we do try to position them around the Commonwealth, but another thing that we do in Virginia is, we use some of our CHIP admin dollars to help support a project through the Virginia Health Care Foundation, of which you are the founding chairman. And that project—they also get a Federal grant to do the same. So their reach is more extensive across the Commonwealth in trying to help families.

And we do still, even in this day and age, we still get a healthy proportion of our applications on paper, even though the form is not particularly friendly. Really, it is shorter than it used to be, but you still have to answer all of those questions. So we still get a surprising number of people who submit on paper.

We have working families, working mothers, who cannot take off during their work hours and go to the local social services agency and sit across the desk from an eligibility worker to help complete that form or to follow it through. That is where the outreach workers come in. They will meet you at McDonalds; they will meet you at their home; they will meet you at your home; they will find a way to sit with you in a time and a place that works for you and

help you through that process, help you understand the questions and get the information in.

Then they will do the all-too-important follow-up on your behalf, because, as much as we would like to think we are all about helping people, we are still a bureaucracy, and it is not easy to deal with the system. So without that handholding, without that personal touch, especially in rural areas for families who have limited English capacity, it is absolutely essential, which is why we have still several million children who are eligible and not enrolled.

Senator WARNER. Thank all of you. Particularly, thank you, Linda, for your great work in the Commonwealth.

Senator WYDEN. Thank you, Senator Warner.

Next, it will be Senator McCaskill, Senator Bennet, and Senator Grassley. We will have to see what happens if others come.

Senator McCaskill?

Senator MCCASKILL. Thank you.

Senator Warner briefly talked about outreach. Ms. George, how did you find out about CHIP coverage?

Ms. GEORGE. When Caleb was born, he was qualified for Medicaid, and it was pretty much a seamless transfer over from Medicaid onto the CHIP program in North Carolina—

Senator MCCASKILL. Executive Director Schwartz, I am not sure you can talk about this countrywide, but I am really curious what kind of outreach is going on in these rural communities. Is there an aggressive outreach? I do not recall ever seeing anything, but maybe it is more targeted, the outreach. So in terms of radio or billboards or anything like that, I do not recall ever seeing anything talking about CHIP in my State.

Is it more targeted through the Medicaid population? But there are some children qualified for this in my State who would not qualify under Medicaid.

Dr. SCHWARTZ. As with all things CHIP and Medicaid, it definitely varies from State to State. States can use some of their administrative dollars for outreach and enrollment, as Linda mentioned. The Federal grants allow States to partner with community-based organizations, which could be churches, or a community organization, schools, and so it can range tremendously across States.

I do want to echo, obviously, the ad buys are the things that you and I would notice. We have heard quite a bit in Medicaid about people wanting that personal touch when signing up. Many people are very nervous in submitting an application, want to make sure everything is correct, and so that last touch with an outreach worker, it really gives them peace of mind that they have done everything properly to ensure that the enrollment goes through properly.

Senator MCCASKILL. That would be a role similar to the navigators in the ACA?

Dr. SCHWARTZ. It is very similar, very.

Senator MCCASKILL. Which, by the way—I would point out they have just cut the budget 40 percent for navigators, ACA, and the advertising budget by 90 percent, which is a real problem.

Could the two of you address what impact cuts to the Medicaid program would have on your work, assuming that there was success, which we hope there will not be, but if there were success in

cutting the Medicaid program as has been proposed a couple of different times in the context of an ACA replacement. What impact would that have on the CHIP program?

Dr. SCHWARTZ. Well, CHIP is separately funded from Medicaid, but in most States, the two programs work hand-in-hand.

The Medicaid proposals that have been considered over the past few months would put significant constraints on States, particularly going forward, on how they use those dollars. And presumably, if States had to make choices that would reduce eligibility levels in Medicaid, they would have to also reassess their CHIP programs.

It is very hard to predict how individual States would make those choices, but clearly, I think that is very much on the mind of State administrators.

Ms. NABLO. Absolutely. And I will just add Medicaid, obviously, takes care of the lower-income children. It also frequently takes care of the sicker children, waivers, disability waivers, et cetera. Oftentimes a child may well be in the CHIP income range or even the private insurance income range, but given medical expenses and the extent of their disability, they become eligible for Medicaid.

If Medicaid is curtailed, if enrollment has to be rolled back because of funding, if those children were to become eligible for the State's CHIP program, I think you would see us running through that funding much faster.

Senator MCCASKILL. So what would happen is, some of the sickest children potentially would be removed from the Medicaid rolls and put on the CHIP rolls, which would put incredible pressure on the funding levels of CHIP, which would squeeze out, at some point, people from coverage under the CHIP program?

Ms. NABLO. That would be my assumption, yes.

Senator MCCASKILL. That is the way that I think it has been looked at, that you cannot look at Medicaid cuts in isolation and assume other parts of the system are not going to be put under pressure, and ultimately folks end up in an emergency room uninjured, in the most expensive care possible, and all of those costs are passed on to us.

Thank you very much, Mr. Chairman.

Senator WYDEN. Thank you, Senator McCaskill.

The ever-gracious Michael Bennet.

Senator BENNET. Thank you, Mr. Chairman. And to add to that, let me say words that have not been said in the Senate before. My questions have been asked. [Laughter.]

Senator WYDEN. But not everyone has asked them. [Laughter.]

Senator BENNET. That is true. That is a habit I am trying to have us break.

But I have spent the morning in the HELP Committee, where we are trying to work on a bipartisan solution to our health-care issue. So I apologize to this very able panel. Your testimony was excellent, and it is really critical that we reauthorize this program.

CHIP has provided localized health insurance for about 90,000 kids who did not qualify for Medicaid in Colorado but are still unable to afford private health insurance. Colorado's working families have benefitted from CHIP by increasing coverage for kids, driving

the percent of uninsured children to an all-time low now of 2.5 percent.

On both sides of the aisle, everyone in this room certainly can agree that our children need to be covered and have access to quality health care, whether it is through CHIP or Medicaid, which covers over 400,000 children in my State of Colorado. CHIP also covers about 600 pregnant women in Colorado, and for these women, they have peace of mind knowing that they will have a provider to go to for maternity care.

Without reauthorization—as these witnesses have so ably stated—without reauthorization of the CHIP program this month, Colorado may stop enrolling new children as of October 1st. They would have to move forward with an emergency plan, and it would be a disaster for us.

So, Mr. Chairman, all I would like to do is, with your permission, submit for the record a letter from the Colorado CHIP Coalition, which includes over 70 organizations, asking for reauthorization of the program.

Senator WYDEN. Without objection, so ordered.

[The letter appears in the appendix on p. 39.]

Senator BENNET. Thank you, Mr. Chairman. Thank you to the panel.

Senator WYDEN. Thank you, Senator Bennet.

At this point, it is Senator Stabenow and then Senator Grassley.

Senator STABENOW. Well, thank you very much, Senator Wyden, for your leadership and for the chairman's leadership. This is an issue that has traditionally been bipartisan. I am very hopeful we are going to be able to continue with a long-term extension in a bipartisan way and do what children and families across Michigan and across the country are counting on us to do.

We know that before CHIP was created back in August 1997, millions of hardworking families could not take their children to the doctor and give them the care that they needed. Ms. George, thank you for speaking about your family and your experiences.

I can tell you in Michigan right now, the good news is that 97 percent of our children can go to the doctor. That is a very big deal. It is the highest percentage ever because of changes that we have made through the Affordable Care Act and through the Children's Health Insurance Plan. We want to make that 100 percent, but 97 percent is very good.

Unfortunately, as has been said—and, Ms. Nablo, you have been talking about the sense of urgency—we are about to see that health care go away. And we do not need a short-term extension. What we need is to fully fund the program and give States, and more importantly, families, the peace of mind of knowing that they can continue to take their child to the doctor and give them the certainty that they need.

So we need to act now. We need to act now, and I am hopeful that we are going to do that and do it in the right way for families.

I want to just share one story before asking questions. I have talked to so many people in Michigan, so many families who are so glad that they have the opportunity to not worry in the middle of the night what is going to happen if the kids get sick, but know

that they are going to have the confidence to be able to take them to the doctor and get the care they need.

One of my constituents, Jan, wrote me a letter saying, "From the time my daughter, Susie, was young, we knew she was going to need extra help. She was diagnosed in second grade with ADHD, and we proceeded to try a medical solution to her attention problems.

"As she got older, she was diagnosed as being bipolar and required a different approach to control her mood swings. Without having access to quality health care, we would have been lost. And thanks to MICHild, the Michigan CHIP program, with a premium of only \$10 a month, we were able to afford the help she so desperately needed.

"She is now a high school graduate with a goal of attending community college. And we are so grateful that we have been able to get the help necessary to help her get to this point."

So today's hearing is not about numbers. It is about people. It is about Susie. And I want to thank you, again, Ms. George, for coming today.

I want to take a moment—because my questions on the cost of prescription drugs were ably asked and answered by Senator Wyden's question, because that is such an important part of health care today and the drivers of health care.

But there is another piece that Senator Grassley and I have been working on that I think would be wonderful to add to CHIP in terms of quality measures for prenatal care and for making sure that we are providing, through CHIP and Medicaid, a set of maternity and infant quality measures that have not been there. And we have been working on this for some time together.

There is a broad coalition of organizations supporting this. There are so many that it is hard to know who to thank, but I want to thank the March of Dimes, in particular, for incredible advocacy on this.

But I want to ask, Dr. Schwartz, if you could speak to the desire, the need to have a set of measures as it relates to quality standards. I know that MACPAC recommended a 5-year extension of the Pediatric Quality Measures Program, which we are building off of.

So I wonder if you might indicate whether or not you agree there are gaps in the measures right now for labor and delivery, and could you discuss some potential quality measures and how they would benefit moms and babies?

Dr. SCHWARTZ. Certainly. I am not an expert on quality measurement for maternity. I would note that the Pediatric Quality Measures Program is intended to help fill gaps, and also to work with users of measures to make sure that measures are not some academic exercise but can actually work in terms of reporting and in their usefulness in providing feedback to plans and providers about the experience of care.

That work informs the inclusion of measures in the adult and child core set that CMS uses, and there are measures related to labor and delivery and prenatal care in both the adult and child core set. That is, obviously, a dynamic process, and over time measures have been introduced into the core set and taken out of the core set as our understanding increases.

I do think it is important. We talk about value to the beneficiary and value to the taxpayer of these programs, and certainly the availability of valid and reliable measures is an important part of that value equation.

Senator STABENOW. Senator Wyden, I want to thank you and the chairman for supporting our effort to report out of committee the Quality Care for Moms and Babies Act last year. It is strongly bipartisan. It is noncontroversial and would add to the strength and the quality of what is before us now, and I am hopeful we can include it in the final bill.

Senator WYDEN. I very much appreciate what Senator Stabenow and Senator Grassley are trying to do here. It has been supported in the committee, and I look forward to working with both of my colleagues.

Now at this point, the also-gracious Senator Cardin has said that, while he is next, it would be fine if Senator Grassley went. We appreciate Senator Cardin's courtesy, and I think Senator Grassley has—I think—a relatively short set of questions. But go ahead.

Senator GRASSLEY. And I appreciate Senator Cardin's—

Senator WYDEN. Everybody appreciates everybody. [Laughter.]

Senator GRASSLEY. I think I have a fairly easy question for Dr. Schwartz, but before I do that, I want to say that we have this program that is a CHIP program for my State of Iowa. It is called hawk-i, not exactly spelled the same way as the Hawkeye football team. It is the Healthy And Well Kids in Iowa program.

We had 83,400 Iowa children covered by hawk-i. It provides health insurance through commercial health insurance plans to kids of low-income Iowa households, up to 302 percent of FPL.

Because of this program, children can receive lifesaving vaccines, medicines, doctor visits. In addition, children are checked to make sure that they are developing appropriately.

This is a program that I have supported in the past, and I look forward to its reauthorization.

So to Dr. Schwartz, I want to ask you about children's access to care. As you may know, I have introduced S. 428, the Advancing Care for Exceptional Kids Act. We call that the ACE Kids for short. And I have introduced that with Senator Bennet, who has already spoken here.

The goal of this legislation is to ensure that sick kids have access to the very best care. However, there are some statutory and regulatory barriers which can require children's hospitals and specialized pediatric doctors additional work in order to care for these children.

My two questions: has your organization, MACPAC, done work on this issue, and are there potential solutions that maintain or even strengthen the program integrity but make caring for these children more streamlined?

Dr. SCHWARTZ. It is my understanding that the ACE Kids Act has evolved over a number of months, or perhaps maybe even longer than a year, in terms of its scope and size. We have not looked at it recently. It is something that we would be very willing to do, both at the staff level and the commission level, and would stand ready to provide any advice and feedback on that for you.

Senator GRASSLEY. Yes. Well what about just generally? Have you solutions that would strengthen program integrity and make caring for these children more streamlined, without looking at the bill I asked about?

Dr. SCHWARTZ. It is my understanding that the ACE Kids Act focuses on children who are extremely sick and tend to have quite a number of hospitalizations. It is a very small population that needs specialized care and often needs care outside of their community and maybe even in another State.

So that does create potential challenges for States that are very scrupulous in program integrity and knowledgeable about the providers in their State. So certainly that is a challenge when you have a kid who needs to have care across State lines. And as I said, we would be happy to look at any specific provisions and provide any guidance.

Senator GRASSLEY. Okay.

Well, is there any advice you can give about the bill—but also any consideration you can give, even without the legislation, would be very much appreciated.

I thank you and thank Senator Cardin.

Senator WYDEN. Thank you, Senator Grassley.

And now, the patient Senator Cardin.

Senator CARDIN. Thank you, Mr. Chairman. Everybody is thanking everyone else. I heard your opening statement, and I just identify with it and thank you for your leadership on the CHIP program.

Senator WYDEN. Thank you.

Senator CARDIN. I just really first want to underscore how important it is for us to timely reauthorize the CHIP program. There are 143,000 Marylanders who are covered under the CHIP program.

In this fiscal year, the cost is about \$275 million. Now, \$275 million is the total cost of the program. The Federal share is about \$241 million.

The Board of Public Works in Maryland just approved a budget cut mid-term because of budget deficits in our State. There is no conceivable, possible way that the State of Maryland can fill the gap under the CHIP program if it is not reauthorized in a timely way. So, if we do not reauthorize in a timely way, there are 143,000 Maryland children who are at risk. And I just really wanted to underscore that.

I was proud that in the 2009 reauthorization, an amendment I offered to include mandatory dental coverage was included under the CHIP program.

Now, Mr. Chairman, many of you have heard me talk about this before. This was as a result of a tragedy that took place in Maryland in 2007, 2 years before the reauthorization was enacted into law. And it occurred about 7 miles from here in Maryland. Deamonte Driver, a 12-year-old, died because he could not get access to dental care.

He had an abscessed tooth, needed to find a dentist who would provide about \$80 worth of dental care, and could not be seen. He ended up becoming abscess-infected in his brain. A couple of operations later, a quarter of a million dollars, and he lost his life.

That motivated the Congress to take action, and I was pleased that we did. And we recognized that tooth decay is the number one disease affecting children in this country, and it is preventable.

I went to many schools in Maryland and saw children and talked to teachers, learned exactly what oral health meant for the success of students in our schools. You cannot really learn if you have tooth problems and pain.

So we have made tremendous advancements in dealing with pediatric dental care as a result of coverage within the Children's Health Insurance Program. And I am proud of the progress that we made.

After we included dental under the CHIP program, we also included pediatric dental under the Affordable Care Act. So one might think, well, now if CHIP is not reauthorized, will we not still be protected under the Affordable Care Act? The answer is "yes," but not to the same extent that we have under the Children's Health Insurance Program because of the match, cost sharing, and the fact that States can put in caps, et cetera. So there is a significant difference for oral health for children if we do not timely reauthorize.

So I would just like to get the view of our distinguished panel of witnesses as to how important the CHIP program is for our children's dental care and what changes we have seen occur nationwide as a result of the coverage for dental care within the CHIP program.

Dr. Schwartz, would you—

Dr. SCHWARTZ. One of the areas for the Commission's analysis and consideration in thinking about the future for children's coverage was the availability of different types of benefits for children in CHIP versus other sources. And as you pointed out, pediatric dental is an essential health benefit, but the way the exchanges cover dental, it is often not included in a comprehensive package; it can be purchased separately, but the way the cost sharing works out, it is in fact more expensive.

So we did not find a tremendous number of differences between CHIP and exchange coverage, but audiology and dental were the two benefits that we called out just as you say.

Senator CARDIN. I would point out that I was proud of Maryland in that all of our carriers included pediatric dental within the prime contracts. We did not have to have a separate policy. But there are places in the country where you have to get a separate policy, and then you run into the cost sharings and the caps that can be different, which causes problems.

Ms. Nablo, would you want to comment?

Ms. NABLO. What occurred to me first, as you were speaking, was that we are always very cognizant when we do outreach for the CHIP program of highlighting that it involves dental care. That is extremely valuable to parents. And it is—I suspect it is—for parents who do not have a particularly sick child at this point, it is one of the big drivers that brings them to our door to apply for CHIP coverage, because it is not common with private insurance or exchange coverage for those children to have access to dental care.

Senator CARDIN. I would just point out, Mr. Chairman, in closing that one of the side benefits of the CHIP program and oral health

for children is that we now have dentist access in communities that did not have that access before. So it is not just coverage, it is also that providers are now in communities that they were not in before as a result of the CHIP program.

Thank you, Mr. Chairman.

Senator WYDEN. Thank you, Senator Cardin, and thank you for again highlighting the importance of dental care.

Now here is where we are in the order: Senator Thune, in order of appearance is next, Senator Cantwell, and then our friend from Delaware, if that is all right with colleagues.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman, for holding the hearing on the path forward for the Children's Health Insurance Program. Of course, I want to thank all of our witnesses for joining us as well, especially Ms. George, who has shared her family's personal experience with the CHIP program.

In my home State of South Dakota, CHIP serves more than 50,000 kids in a given month. And like many States, we run a combination program. And our State projects that if CHIP expires, nearly 12,000 kids would be shifted to Medicaid and more than 3,500 could lose coverage altogether.

I think we can all agree that this program has enjoyed broad bipartisan support over the years, and it is critical that we work together to ensure that kids across the country continue to have access to uninterrupted coverage.

And it sounds like this ground has been plowed a little bit already, but I want to—for purposes of my State's interest—ask the question of Ms. Nablo.

The administrators of CHIP in South Dakota have talked with us about the importance of maintaining State flexibility—which I think you have addressed on some level already—to determine benefit structure moving forward. You mentioned that in your testimony as well. From a State perspective, are there other areas where greater flexibility might be needed so that States can best meet the needs of their populations?

Ms. NABLO. I would say that the Virginia experience is one of continual change and continual improvement of the program to best meet the needs of families in our State. Certainly some flexibility in the benefit structure is helpful.

For example, Virginia just added a very robust package of substance use disorder benefits to help address the opioid epidemic. We added those for children in our CHIP program and for the pregnant women in our CHIP waiver.

So the ability to be able to do that was very helpful. The story in Virginia is, we started out with a very restrictive program. We had some of the most restrictive policies in the country.

For example, we started out with a 12-month forced period of uninsurance before a child could be found eligible for CHIP. That later went to 6 months, then went down to 4 months, and we have since abolished it. But that is within the ability of the State, given where the legislature is, what people learn as they go along with the program about what is needed and as they become more educated about families' needs. There is a constant and continual improvement to the program.

I think States probably appreciate the flexibility in CHIP a great deal. It is one of the most attractive features, probably originally, for States taking up this offer in the first place, and I think they would be very concerned if that flexibility went away.

Senator THUNE. Okay.

Dr. Schwartz, South Dakota also raised the importance of States' continued ability to carry over funds. You raised this issue in the context of how long States will be able to continue to run CHIP programs and also raised operational considerations associated with extending the program.

How quickly can States respond to congressional action? And I would also, I guess, direct the question to Ms. Nablo, if you would care to comment on how quickly you would expect Virginia to be able to respond.

Dr. Schwartz?

Dr. SCHWARTZ. When MACPAC made its recommendations, we set ourselves a deadline of having our recommendations available at the beginning of this Congress so that you could act quickly, to allow States to take the time to plan for the next fiscal year. Obviously, many months have elapsed since then. States have held off making changes to their programs, not wanting to alarm beneficiaries unduly and also to not cause disruption for the plans and providers.

I think that the clock really is very close to having run out.

The other point I want to make clear is that, while MACPAC has put out these figures noting when States will run out of money, that is not meant to say that Congress can wait until that deadline to make a decision.

It is really important for States to have the certainty right now so that they can plan appropriately so that these programs are run in a deliberate and professional manner.

Senator THUNE. Okay. Thank you.

Ms. Nablo, any response in terms of Virginia's—

Ms. NABLO. I would say the challenge is not so much how fast we can respond to any changes you would choose to make. I would say the challenge is much more, how long can we wait until you tell us with certainty that there will be funding for this program and what level it will be?

I think for some States we are weeks, a few weeks, maybe a couple of weeks away from having to take proactive measures to start shutting down. For Virginia, as I said earlier, I have a long "to do" list—I actually have it in my briefcase today—of things that will need to happen. And that "to do" list starts in October for us, with beginning to do the training, and the system changes, and all the things that will need to happen.

If the CHIP is authorized but the funding is reduced, that causes immediate budgetary problems in the State of Virginia. We have an immediate \$57-million shortfall in this State fiscal year. Our legislature comes to town on January 10th, and I guess that would be one of the very first problems they would have to face, what do we do with that kind of a hole in the budget, and it grows the next year.

So it is really more a matter of, we are waiting with bated breath to hear from Congress.

Senator THUNE. Okay. Thank you.

Thank you, Mr. Chairman.

Senator WYDEN. Thank you, Senator Thune.

We started, actually, a couple of hours ago with that question. And now as we move towards the end, I am glad you have highlighted that, because this is not something, where in the traditional Washington situation, you can have the amendment, the amendment to the amendment, and maybe it happens, and maybe it does not. Your question, again—Ms. Nablo highlighted that this morning—shows this has real consequences if there is delay. And I appreciate your bringing it up as we get to wrapping up.

Senator Cantwell?

Senator CANTWELL. Well that is definitely the line—thank you, Mr. Chairman—that I want to follow as well, because I am from Washington, and we like efficiency in our health-care delivery system no matter, whether it is talking about CHIP, adults, or what have you.

I do want to say, Ms. George, I so appreciate your testimony today. Being here, you really highlighted what this issue is all about, and it is about giving families the ability to take care of the needs of their families by making sure that they have coverage. And I so appreciate that your son, Caleb, is here as well.

And I wondered if we could just—I was so touched by your story about his Scouting awards. Is it okay if we give him a round of applause for his achievements?

[Applause.]

Senator CANTWELL. So I do not think we can ever forget the people who are affected by this program and what it means. And when I think about Ms. George and her family, what she has been able to accomplish, I think about the modernization of CHIP.

So in our State, we cover children up to 211 percent of poverty. And we cover up to 312 percent through CHIP, and yet we have families at a different level.

One thing that we have seen in New York, with the advent of the basic health plan, is a front door that allowed families in CHIP, no matter whatever the entry way was, to then get coverage. It also has driven down costs. It has driven down costs for everybody. It has driven down cost for the State. It has driven down cost for the Federal Government. It has made the program streamlined and efficient.

Do you think there is more to do, Dr. Schwartz or Ms. Nablo, in streamlining this program, thinking about both children and adults, making sure that there is coverage and cost savings in the administration side of this?

Dr. SCHWARTZ. There is certainly always work to do. One of the things that the Commission recommended was demonstration grants to States to try to think about how to better coordinate different sources of coverage. We know that the answer may be different in different States and wanted to provide an opportunity for States to experiment in how to smooth these transitions across coverage so you do not have situations where families lose coverage due to change in their life circumstances and lose continuity of care and have gaps in coverage.

So there is certainly more work to be done. MACPAC is meeting next week, and one of the things that we are taking up is a broader inquiry around Medicaid to assess where we are with streamlining eligibility, enrollment, and renewal processes to be able to see what we have accomplished and what more work needs to be done.

Ms. NABLO. I would agree with Dr. Schwartz. Both within the health-care arena and also just other Federal programs like SNAP and TANF, et cetera, there is a great deal of difficulty, disparity, differences in how those are administered and how you count income, et cetera, that is extremely confusing for families and very difficult to administer.

And even if you are successful in, for example, the health-care arena, moving from CHIP to Medicaid or back or if your family gets coverage on the exchange or whatever, the benefits can be very different. The doctors can be very different. The copayments and deductibles can be extremely different, and it just creates an extremely confusing atmosphere.

Senator CANTWELL. Well, I think it probably creates costs too.

Ms. NABLO. And costs.

Senator CANTWELL. And to me, streamlining that so there is a front door where families are covered and doing so in the most cost-effective way, considering they are likely getting coverage—it is just not in a uniformed way.

I, Mr. Chairman, regret that we—we identified this when we were doing the Affordable Care Act, but some of our colleagues were thinking more about CHIP at the time, less about this confluence that was going to happen. But I wish that then we would have offered some innovation to streamline, because I think we could have reduced costs, and I think we could have given more certainty to those families.

So I certainly hope we will take a look at that now, because I do think it is one of the keys to making this more affordable for everybody.

Thank you.

Senator WYDEN. Thank you, Senator Cantwell. And Oregon has always seen itself in a partnership with Washington State on these efficiencies.

And I think the point you made is extraordinarily important, because inefficiency wastes money. And if you waste money, you are not dealing with the scarce services, for example, that you talked about with respect to Caleb and the real consequences for people. So I thank my colleague.

Senator Carper?

Senator CARPER. I am not sure if Senator Brown was in line before me.

Senator WYDEN. You were here first.

Senator CARPER. Okay. Thanks.

To our colleagues here—the four Senators who are here in the room right now are all Democrats. I would just note that our chairman, one of his most important—he has a lot of important accomplishments in the time that he served here, but maybe none more important than his work, I think, with Senator Kennedy on the Children's Health Insurance Program.

I look forward to working with my colleagues who are here, but certainly with Senator Hatch, to extend funding to ensure that millions of kids, including about 18,000 in Delaware, continue receiving health insurance coverage under this program.

I was actually—as chairman of the National Governor’s Association—in the White House with President Clinton and Hillary Clinton on the day that this was rolled out at the White House. So this is one that has special meaning for me and for the people I am privileged to represent.

I have a couple of questions I would like to ask of our witnesses. Thank you so much for being here. Are you from Virginia? You work for the Governor there?

Ms. NABLO. Yes, I do.

Senator CARPER. Tell him a guy who grew up in Danville and Roanoke sends his best, please.

And they are building a ship in Newport News, VA today, a submarine called the *U.S.S. Delaware*, and we look forward to being back down there with Terry and to launching that with Joe Biden in several months.

CHIP serves millions of people in our country, some 18,000 kids in Delaware. Our neighboring State—I think Senator Cardin, when he was here, just said a few minutes ago about 143,000 kids in Maryland are covered.

But if we allow CHIP to expire at the end of this month, many of the children in our State, on Delmarva, and across the country are going to either become uninsured or maybe underinsured.

I am going to ask Dr. Schwartz, can you speak to whether other insurance coverage options for kids, including private insurance, would be able to provide for these children if CHIP expires, and how do these options compare in terms of cost sharing protections, in terms of pediatric benefits and pediatric networks, to CHIP?

Dr. SCHWARTZ. Certainly. Our analysis shows that if CHIP funding comes to an end, there are two different scenarios depending upon whether a child is covered under separate CHIP or a Medicaid expansion CHIP.

Separate CHIP funding programs would end. And we estimate that 1.2 million of those children would become uninsured.

All of those children would be eligible for either subsidized exchange coverage or employer-sponsored coverage, but for most of them, the cost of those, cost sharing, would be prohibitive, and that is why they would become uninsured.

For those who do enroll in exchange coverage and those who do enroll in employer-sponsored coverage, they would experience much higher cost sharing than they currently experience under CHIP.

And as I noted earlier, there would be some differences in benefits, most notably audiology and dental were the ones that we pointed out, and I think it is very likely as well that they would experience a change in provider in moving to a different plan.

Senator CARPER. Okay. Thanks.

Ms. Nablo, you mentioned the importance of CHIP for access to mental health services, for substance abuse treatments, for immunizations, basic health care, to help children be able to live a normal life. Could you describe for us the role that CHIP plays in treating mental health conditions as well as combating the opioid

epidemic and the improvements in public health that Virginia has experienced because of the CHIP program?

Ms. NABLO. CHIP in Virginia was originally designed based on the State employee health plan. Over the years, additional benefits have been added, bringing it much closer to the Medicaid package of benefits, but not the full range of Medicaid. For example, we do not cover EPSDT or we do not cover residential care in CHIP.

But it has become a very robust child-centered benefit package. So it includes many mental health benefits.

But in reaction to the—I will not say recent, but in the last several years—awareness of the opioid epidemic, Virginia has, under the leadership of Governor McAuliffe, taken a very aggressive stance to try to combat that epidemic. A big part of that initiative is to add addiction treatments that are evidence-based and recognized by national associations as being effective, to both Medicaid and to CHIP and to our pregnant women coverage in both of those programs as well.

We have just done that. Most of those benefits became effective April 1st. We just added another one as of July 1st. So it is, I think, a little too early to talk about the effect on individuals.

What we have seen—because along with adding those benefits, we also increased provider rates. So we have seen a significant growth in providers offering these evidence-based practices into the southwest of Virginia, Roanoke, and beyond. We are very excited about the growth in the provider network and believe that will carry over into improvement in outcomes.

Senator CARPER. Thank you.

Thanks so much. Thanks to each of you for the work you do. God bless.

Senator WYDEN. Thank you, Senator Carper.

Senator Brown?

Senator BROWN. Thank you, Mr. Chairman.

Today, first a “thank you” to the witnesses. I appreciate your being here and speaking out for one of the most important things that we should do this fall.

I would like to submit for the record two letters: one from Ohio’s Department of Medicaid Services Director, Barbara Sears; and one from the Ohio Children’s Hospital Association.

Senator WYDEN. Without objection, so ordered.

[The letters appear in the appendix beginning on p. 42.]

Senator BROWN. Thank you, Mr. Chairman.

I would add that Ohio has, I believe, still more free-standing children’s hospitals than any State in the country. I know that when my friend, the Senator from Oregon, was in Ohio, he met some of the people who work in some of these hospitals.

I would like to ask each of you about the importance of extending CHIP funding for more than 2 years. Dr. Schwartz, many advocates have written in support of a longer period, as much as 5 or more years.

When Secretary Price testified—Secretary-Designee Price—I asked him about the question of longer extension. I suggested 8 years. He concurred and said 8 years could make sense. MACPAC recommended we extend funding through fiscal year 2022.

Dr. Schwartz, explain briefly—and I need briefly, and I apologize. And you are probably tired of these questions anyway. So explain briefly why MACPAC recommends a 5-year extension?

Dr. SCHWARTZ. Yes, MACPAC's primary reason for the 5-year extension is the tremendous uncertainty in health insurance markets generally at this point, whether that relates to Medicaid or the exchange market, and certainly volatility of private coverage. And really it is important to secure the gains in coverage that CHIP has brought and to put kids in a place that is safe, where coverage is going to be available to them while all of these other problems are sorted out.

We have had quite long extensions of CHIP in the past. The first one was for 10 years. CHIPRA was from 2009 to 2013. So certainly there is a track record in the Congress for long-term extensions.

Senator BROWN. Thank you, Dr. Schwartz.

Ms. George, thank you for coming today. I understand your son, Caleb, is here, and he is aiming to become an Eagle Scout. I am an Eagle Scout, and I know the work that he will do to become an Eagle. I assume that his mother having the peace of mind knowing that CHIP will be there to raise her healthy young future Eagle Scout will be important. Talk to me about what extension means for peace of mind, what that means for a mother of a young man like Caleb.

Ms. GEORGE. Well, probably for me the biggest thing is knowing that he is covered. Right now, we had an insurance lapse a couple of months ago because of changing employers. He was not affected by that because he had CHIP.

Just that peace of mind knowing that no matter what happens to you, what happens to your loved ones, your child has the coverage that they need to be healthy, to have everything they need for school, for developing into the young man that they can become, is just tremendous. That is why it is so important for us.

Senator BROWN. Good luck.

Let me know when his court of honor is in "X" number of years.

Ms. GEORGE. Thank you. I sure will.

Senator BROWN. Ms. Nablo, my home State of Ohio has been a leader in innovating within CHIP and Medicaid. It is to lower costs and to improve outcomes—we still are embarrassingly awful in terms of infant mortality and some other indices. But CHIP has helped us be more than marginally better.

The Kasich administration tells me it is difficult to innovate when the future of the program is uncertain. Talk about what certainty means, in terms of stability, in terms of running a department, in terms of making this all work, especially in terms of innovation.

Ms. NABLO. Well, when you are looking at—we have come extremely close to the wire this time. So what does that mean for the future?

If there is a 1-year extension or a 2-year extension, what that is saying, I think, to States is, we are going to potentially be right back here 2 years from now, up against the wire again.

So the question you have to ask yourself, I think, as a State is, what kind of an investment are you going to make in this program? How much outreach are you going to do to drive children to this

program when it may not be there 2 years from now because it has come so close this time?

There is a feature in CHIP called a Health Services Initiative, HIS, where States that have sufficient admin funding can actually help support other programs like poison control centers. I understand there is one State that is now using some funding to help supply those kits that help somebody immediately recover from an overdose, to help pay for some of that for children.

So do you as a State begin to invest in something like that when by the time you get all of the paperwork done and the money flowing—

Senator BROWN. So it needs to be at least—it needs to be more than 2 years?

Ms. NABLO. I will take anything at this point.

Senator BROWN. Of course, of course.

Ms. NABLO. But I absolutely—

Senator BROWN. But I do not want you to have to come in here every year or two and say, I will take anything. I want you to—

Ms. NABLO. But absolutely, 5 years or longer would be a very welcome thing for States.

Senator BROWN. I will continue—and I know the chairman, I know Senator Wyden agrees with this. We will continue, at least many of us who care about this program, we will continue to advocate for at least 5 years.

So thank you all.

Senator WYDEN. Thank you, Senator Brown.

I want to just wrap up with a couple of thoughts, picking up on Senator Brown's really thoughtful case for how important a long-term extension is. And, Ms. Nablo, you have done an extraordinary job this morning laying this case out.

I have agreed with every single thought, save that one at the end about you will take anything. [Laughter.]

I want to leave this hearing saying that I think we all understand—and you did not mean it that way, of course—that kids deserve the very best.

I want to kind of recap a little bit on where we are on this issue. The Children's Health Insurance Program did not come about by osmosis. It did not just kind of magically show up in America and everybody said, hey, we are going to cut the rate of uninsured kids in America.

It happened because two very strong-willed United States Senators, the late Senator Kennedy and the chairman of this committee, acknowledged that they had plenty of differences on plenty of issues, but both said, we have got to do right by kids. We have got to step up.

And the reality is that without the two of them doing it, I do not see how it would have happened. So what we are talking about today is asking United States Senators to pick up on that extraordinary legacy of Chairman Hatch and Senator Kennedy and step up.

And you are going to hear a lot this fall about how there are all kinds of priorities on the Senate calendar. I listed some of them, and I am sure Caleb was not paying attention to all of the government lingo and all of the acronyms and all the initials.

But the real question behind our job going forward is to make sure that CHIP is way, way, way up that priority list so it does not get short shrift, it does not put us in a situation, as Ms. Nablo described very eloquently about this kind of parade of horrors—I do not know any other way to describe it—that kicks in if somehow everybody says, oh, we have other things to do and that sort of thing. And it starts to happen pretty darn soon if it does not get the attention that it is deserving.

Now, the last point I want to make is that I am sure we are going to have a discussion about costs. America has a lot of challenges in terms of the budget.

But I just hope what we say is, when people say, can we afford a generous funding package for CHIP, I hope that we say—on the basis of the really thoughtful comments that you all have made, and for Caleb sitting behind his mom—I hope we say America cannot afford not to cover CHIP in a generous kind of way, because we heard testimony about what it really means to be able to afford these skyrocketing medication prices.

I noticed your comment was, well, you know, we probably could figure out a way to do this. You said that as a mom. But you know, that is not considering all of the prospective price hikes.

So what we know is that, if you do not get there early for these children, you end up playing catchup for years and years to come. So we either get there for kids like Caleb and ensure that they can afford medications and spend a modest amount of money in order to get that coverage, or you basically say, oh, we are not going to do it, and we will pay, and pay, and pay some more in the years ahead as a result of that short-sighted thinking.

So we have a lot to do to talk about how we cannot afford not to do this. We have a lot to do to make sure that this gets up the priority list. We have a lot to do to show that this did not just come about by accident. It came about because of the extraordinary leadership of our chairman and the late Senator Kennedy.

The three of you have really given us sort of a road map on how the Congress ought to come together, and why it ought to come together. Each one of you brought a unique experience.

I have sat in on a fair number of hearings on this committee and have tried to specialize in health care since the days when I was director of the Gray Panthers back at home in Oregon. This has been one of the best health hearings that we have had in the Finance Committee. It is because the three of you laid the case out so well.

You could see the great interest among members on both sides of the aisle, and we are walking out of here today knowing that the job is going to be tough in the days ahead, but you have given us a path for the important work that has to be done.

I have one bit of business on behalf of the chairman. I wanted to make sure everybody understood he appreciates their attendance and that he feels that this is a very important conversation. He wants Senators to meet with him to talk through their ideas and suggestions. He believes that we are confident that we can get a meaningful and bipartisan solution.

And the last request of the chairman is that he would like to make clear that, for any members of the committee who have writ-

ten questions for the record, the chairman would request that those written questions be submitted by the close of business on September 14th.

With that, the Senate Finance Committee is adjourned.
[Whereupon, at 12 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

LETTER SUBMITTED BY HON. MICHAEL F. BENNET, A U.S. SENATOR FROM COLORADO

#FUNDCHIPCOLORADO

The Honorable Michael Bennet
U.S. Senate

The Honorable Cory Gardner
U.S. Senate

The Honorable Diana DeGette
U.S. House of Representatives

The Honorable Jared Polis
U.S. House of Representatives

The Honorable Scott Tipton
U.S. House of Representatives

The Honorable Ken Buck
U.S. House of Representatives

The Honorable Doug Lamborn
U.S. House of Representatives

The Honorable Mike Coffman
U.S. House of Representatives

The Honorable Ed Perlmutter
U.S. House of Representatives

Dear members of the Colorado congressional delegation:

We write to you today with an urgent issue to which we hope you will give your immediate attention and unwavering support. The Children's Health Insurance Program (CHIP) funding is set to expire on September 30, 2017. We urge you in the strongest terms to renew funding for this important program through 2022 at the currently established levels that enable Colorado to implement a successful program.

Our organizations represent a broad and diverse coalition of child health advocates, family doctors, pediatricians, community clinics, large and small hospitals and many others who have seen first-hand that CHIP, or CHP+ as Colorado's program is called, has made a genuine impact on thousands of Colorado kids and their families as well as the pregnant women the program serves. By bridging the gap for working families who wouldn't otherwise be able to afford private health insurance for their children, this program represents the difference between a healthy start and a childhood plagued with no preventive care, poor health, and poor performance in school.

CHIP has benefited Colorado's working families by ensuring their kids get the healthy start they need to reach their full potential. A failure to extend Federal funding for the program would jeopardize coverage for about 90,000 kids and pregnant women in Colorado.¹ Nationally, about 8.9 million kids and their families use CHIP for their health insurance. If financing is not extended, coverage losses will start in early 2018 according to the Colorado Department of Health Care Policy and Financing (HCPF). CHIP has been an integral part of Colorado's efforts to get kids covered, as well as national coverage gains, since its inception 20 years ago. A loss of the program would wipe out much of this progress Colorado and other States have achieved. CHIP, partnered with Medicaid, has given Colorado the two-pronged

¹ Roughly 90,000 kids and pregnant women had coverage in Colorado's CHIP program (CHP+) sometime during the 2015–2016 fiscal year. This number is slightly higher than HCPF's reported monthly caseload numbers, which use point-in-time estimates. Since some clients lose eligibility and others gain eligibility throughout the year, the number here is higher than the number of children being served during any one month during the year.

approach it needed to help increase coverage for kids, driving the percent of uninsured Colorado kids to an all-time low of only 2.5 percent.

Simply switching to private insurance isn't a solution for families who use this program. For example, the maximum annual enrollment fee for a family on CHIP is \$75 or about \$6.25 per month. The cheapest catastrophic health plan in Denver for a child is \$103 monthly—a 1,500 percent increase. That increase climbs to at least \$144 a month—a 2,200 percent jump—if you live in rural Chaffee County. And these catastrophic health plans would still expose families to very high out-of-pocket costs including large deductibles. In addition, recent studies have shown that out-of-pocket maximums for the working families using the program would skyrocket if the program goes away, jumping from an average of \$789 to as much as \$4,500 annually for a family of three living on \$32,484 a year.

Like all States that use the program, Colorado has set the rules for how it operates. Here, families buy into the program through an annual fee and pay co-pays for services, much like private insurance. Colorado has worked to ensure that the provider network for the program is pediatric-focused, which puts kids' health first and provides lower cost-sharing options than in private plans. The program includes important benefits, such as dental, that aren't often found in other plans. This attention to a pediatric-focused benefits package is particularly important to kids with chronic issues who often require specialty care. For kids with chronic illnesses and disabilities, CHIP is critical because it provides more benefits than private insurance.

We know that for all kids, their family's ability to access insurance for them matters. Kids with CHIP coverage are more likely to have a doctor that they see for regular care and less likely to be hospitalized for a condition that could have been treated at a primary care doctor visit. Kids with health coverage are less likely to drop out of high school, and more likely to graduate from college and have higher incomes as adults. An overwhelming amount of research tells us that healthy kids are better learners in school, have fewer absences from their educational experience and are better prepared when they enter adulthood.

From a Colorado budget perspective, our State stands to lose \$254 million annually in Federal funding if the program is ended. That's a hole in the State budget that Colorado won't be able to close due to constitutionally imposed tax and spending limitations. CHIP funding in Colorado provides support for both kids and pregnant women in Colorado's CHP+ program as well as certain kids enrolled in Medicaid. Colorado's budget for 2017–2018 is already set and includes Federal CHIP funding at current rates. Abruptly stopping the program does not allow State lawmakers to appropriately plan for dramatic changes to anticipated Federal revenue streams, does not give our State government time to implement thoughtful transitions, and does not give families the time they need to plan ahead. Extending funding for CHIP through 2022 will provide budget predictability as Colorado plans for the next fiscal year and beyond.

Across its nearly 20-year history, CHIP has enjoyed bi-partisan support because it increases health insurance for children and helps working families while operating more like a private insurance plan through membership fees and co-pays. Even in our current, deeply divisive political environment, there is no reason CHIP should not continue to enjoy this kind of support. It's a strong program with a track record that has proved its value to our country, our State, Colorado's working families and, most importantly, the children and pregnant women it serves. It deserves your attention and support.

Sincerely,

9to5 Colorado
 AFT Colorado
 All Families Deserve a Chance Coalition
 American Academy of Pediatrics—Colorado Chapter
 American Heart Association—Colorado
 American Liver Foundation, Rocky Mountain Division
 Boulder County Commissioners
 Boulder County Department of Housing and Human Services
 Bruce Doenecke, MD
 Center for Health Progress
 Children's Hospital Colorado
 Chronic Care Collaborative
 Colorado Academy of Family Physicians
 Colorado Access

Colorado Center on Law and Policy
 Colorado Chapter of the National Hemophilia Foundation
 Colorado Children's Healthcare Access Program
 Colorado Children's Campaign
 Colorado Coalition for the Homeless
 Colorado Community Health Network
 Colorado Consumer Health Initiative
 Colorado Covering Kids and Families
 Colorado Cross-Disability Coalition
 Colorado Dental Association
 Colorado Dental Hygienists' Association
 Colorado Fiscal Institute
 Colorado Gerontological Society
 Colorado Hospital Association
 Colorado Organization for Latina Opportunity and Reproductive Rights
 Colorado Public Health Association
 Colorado's Community Safety Net Clinics
 Delta Dental of Colorado
 Denver Health and Hospital Authority
 Early Milestones Colorado
 Epilepsy Foundation of Colorado
 Family Voices Colorado
 Farley Health Policy Center, University of Colorado School of Medicine
 Focus Points Family Resource Center
 Healthier Colorado
 Huerfano-Las Animas Counties Early Childhood Advisory Council
 Joanne Sprouse, Director, Division of Human Services, Summit County
 La Plata County Board of County Commissioners
 La Plata Family Centers Coalition
 Larimer County Department of Human Services
 Las Animas County Department of Human Services
 Leland Johnston, MD
 Mara S. Baer, Founder and President, AgoHealth, LLC
 Mental Health Colorado
 National Association of Social Workers, Colorado Chapter
 National Council of Jewish Women, Colorado Section
 National Stroke Association
 Nurse Advocate
 Oral Health Colorado
 Parkinson Association of the Rockies
 Peak Vista Community Health Centers
 Peter Dawson, MD, MPH
 Pitkin County Human Services
 Planned Parenthood of the Rocky Mountains
 ProgressNow Colorado
 Pueblo County Department of Social Services
 Rocky Mountain Health Plans
 Rural Communities Resource Center
 Senior Mobile Dental
 Stahlman Disability Consulting, LLC
 Steve Clifton, Director Fremont County Department of Human Services
 Steve Johnson, Larimer County Commissioner
 Sunrise Community Health
 Support Jeffco Kids
 The Arc Arapahoe and Douglas Counties
 The Bell Policy Center
 The Consortium
 Together Colorado
 Tri County Health Department
 Wendy Zerlin, MD, FAAP
 Women's Lobby of Colorado
 Yondorf and Associates
 Young Invincibles
 CC: Governor John Hickenlooper
 Sue Birch, Executive Director of the Department of Health Care Policy and
 Financing
 Gretchen Hammer, Medicaid Director

Senator Kent Lambert
Senator Kevin Lundberg
Senator Dominick Moreno
Representative Bob Rankin
Representative Millie Hamner
Representative Dave Young

LETTERS SUBMITTED BY HON. SHERROD BROWN, A U.S. SENATOR FROM OHIO

OHIO DEPARTMENT OF MEDICAID
50 W. Town Street, Suite 400
Columbus, Ohio 43215
<http://medicaid.ohio.gov/>

John R. Kasich, Governor
Barbara R. Sears, Director

September 6, 2017

The Honorable Rob Portman
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Bob Latta
2448 Rayburn House Office Building
Washington, DC 20515

The Honorable Sherrod Brown
713 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Johnson
1710 Longworth House Office Building
Washington, DC 20515

Re: CHIP Reauthorization

Dear Senators Portman and Brown and Congressmen Latta and Johnson:

I am writing today to urge your support of reauthorizing funding for the Children's Health Insurance Program (CHIP), which currently supports coverage for nearly 219,000 Ohio children as part of the Ohio Medicaid program. Retaining CHIP funding for services at its present 23-point enhanced match rate will provide Ohio with much needed stability as it faces challenges brought about by an already challenging State biennial budget.

Unless funding for CHIP is reauthorized, Ohio stands to exhaust CHIP funding by the close of calendar year 2017. Ohio provides CHIP coverage as an extension of its Medicaid program. Thus, as required by the Affordable Care Act's maintenance of effort provisions, Ohio will be compelled to continue coverage for these children at its regular Federal match rate, at an estimated cost of more than \$200 million over the next 2 years.

The Ohio Medicaid program is already successfully navigating an appropriations gap in the State's current budget. However, elimination of over \$200 million in CHIP funding would be a severe additional blow to the program and would likely require cuts in other services in order to support continued access to necessary health care for Ohio's Medicaid-eligible children.

For all of these reasons, I strongly urge your support for a measure that would reauthorize CHIP for at least the next 2 years. That said, a longer reauthorization period (5 to 10 years) would provide additional stability and avoid the cyclical uncertainty that has plagued this valuable resource over the last several years.

Thank you for your continued support for Ohio's most vulnerable citizens. If you need further information, please do not hesitate to contact me.

Sincerely,

Barbara R. Sears
Director

CC: Hon. Orrin G. Hatch, Chairman, Committee on Finance
Hon. Ron Wyden, Ranking Member, Committee on Finance
Hon. Greg Walden, Chairman, Energy and Commerce Committee
Hon. Frank Pallone, Ranking Member, Energy and Commerce Committee

OHIO CHILDREN'S HOSPITAL ASSOCIATION

September 6, 2017

The Honorable Orrin G. Hatch
 Chairman
 Committee on Finance
 U.S. Senate
 219 Dirksen Senate Office Building
 Washington, DC 20510

The Honorable Ron Wyden
 Ranking Member
 Committee on Finance
 U.S. Senate
 219 Dirksen Senate Office Building
 Washington, DC 20510

Re: Children's Health Insurance Program

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the 6 members of the Ohio Children's Hospital Association and the 1.3 million children who rely on Medicaid and CHIP in Ohio for their health insurance, we respectfully and strongly urge you to act quickly to provide a 5-year extension of funding for the Children's Health Insurance Program (CHIP), at the current enhanced match, to ensure kids continue to have access to quality health care.

As you know, CHIP provides coverage for children who fall above Medicaid eligibility levels but lack access to other options. CHIP covers children whose families earn too much to qualify for Medicaid, but who do not have access to adequate health insurance options. The parents of these families have jobs. In fact, 85 percent of the children in CHIP households have at least one parent working 50 weeks per year, according to numbers from the Medicaid and CHIP Payment and Access Commission.

CHIP was designed specifically for children and includes child-appropriate benefits, access to pediatric providers and cost sharing limits to protect vulnerable youth. In Ohio, the program extends as a complement to Medicaid, designed within the State's Department of Medicaid, and serves on average more than 200,000 children annually. Many of the children served by CHIP in Ohio also cycle back and forth between traditional Medicaid and CHIP.

Here in Ohio, Medicaid and CHIP serve the State's most vulnerable children, including 100% of all youth in foster care—many of whom are displaced due to the opioid epidemic. These programs also serve more than half of Ohio's newborns. Children need access to stable and predictable health care if they are to have an opportunity to grow and thrive.

With strong bipartisan support, an overwhelming majority of the U.S. Congress have consistently reauthorized this important program. Current Federal funding for CHIP expires at the end of Federal FY 2017. Because this program has not yet been reauthorized, State budgets have now been built on the assumption that CHIP dollars will be forthcoming. If Congress does not act before September 30, 2017, States will be forced to take action to fill those budget gaps by either disenrolling children, imposing lock-outs and waiting periods, winding down their programs altogether or cutting providers, in effort to recoup costs not covered with budgeted Federal dollars.

As always, we appreciate your commitment to support children and encourage your formal backing of a clean extension of CHIP. We look forward to working with you to ensure all Ohio children have access to the health care they need when they need it.

Sincerely,

Nick Lashutka
 President and CEO
 Ohio Children's Hospital Association

 PREPARED STATEMENT OF LEANNA GEORGE, MOTHER OF A CHIP RECIPIENT

Good morning. My name is Leanna George, and I live in Benson, NC. Thank you for the opportunity to meet with you and share my family's experience with the CHIP program and why this program is so important to working families. My husband and I have been married 16 years. We met when he was stationed at Marine Corps Base Camp LeJeune. After 7 years of service in the Marines, about a year after our daughter was born, he was honorably discharged. Currently he has completed 2 years of a 4 year apprenticeship training program to become a licensed elec-

trician. Together, we have 2 children: Serenity who is 15 years old and has severe Autism, Intellectual Disability, and resides in a group home; and 11-year old Caleb who has Autism, ADHD, and a genetic neurological condition. While Serenity has Medicaid, Caleb is insured by CHIP.

Although I'm not here testifying on behalf of MACPAC, it wasn't until I was appointed to the Commission that I realized that CHIP's future was so uncertain. As a parent of a child with extensive needs; the focus of my advocacy had been on increasing the availability of Medicaid waivers that provide home and community based supports for people like my daughter. While there is a need for that, I wasn't aware that basic coverage for children of the working poor was in jeopardy. As the Commission discussed the CHIP program, I began to wonder just how much losing CHIP would impact my family. How much would our premium cost if we added Caleb to our insurance? How would the change impact the services he's been receiving? How would we pay for it?

With our current health insurance plan, the monthly premiums would not increase if we added Caleb to our coverage as my husband's company only offers Employee Only or Family coverage levels. However, our insurance plan has a high deductible of \$6,000 which currently prevents my husband and me from accessing medical care. This deductible would put almost all of all of the services Caleb currently receives out of our financial reach. These services include weekly occupational therapy to address fine motor challenges that impact Caleb's ability to write legibly and perform basic self-care tasks such as tying his shoes. He receives periodic MRIs and ultrasounds to monitor the progression of his neurologic condition, which allow us to be proactive in treatment which results in better outcomes. My son also takes daily medication which helps him stay focused on his schoolwork; this medicine costs in excess of \$300 a month and requires at least biannual office visits for medication management. Over the years, the CHIP program has provided these services to us for little to no cost. Even with the cost sharing we've had in the past, CHIP is a tremendous value. Without CHIP coverage, Caleb's access to services would be greatly diminished and that would directly affect his ability to be successful in school. CHIP supports kids as they learn and grow; enabling them to be healthy and able to succeed at school which builds them as citizens and leaders for America's future.

CHIP also provides families with financial security and moms, like me, with peace of mind. In January of 2017, my husband was laid off. Thankfully he found employment a few weeks later. However, this short period of unemployment resulted in an insurance lapse for my husband and me. While we struggled to pay for my husband's medication, I was able to live my life with confidence knowing Caleb had access to care that he may need if he became sick or injured. I have never had to call the pediatrician and cancel a visit because of lack of insurance. I have never had to feel helpless and scared while watching him fight off illness without the benefit of medical intervention. CHIP has meant that my son has continued to receive the services and medical care he needs without interruption, despite the uncertainty his father and I have faced.

If the CHIP program was to go away, many families like mine would be forced to make tough choices between the immediate health of our children and the long-term well-being of the family unit. Monetary resources are already stretched for many families like mine. Families may have to ration medical care which could result in something that appears to be a minor medical issue going untreated and progressing into a more serious condition. Other families may procrastinate spending on maintenance services for vehicles or houses which can contribute to a tragic accident or expose the family to environmental health risks. If we were not able to find a way to afford my son's medication, his education would be severely impacted and that could impact his life well into adulthood.

Among the sacrifices families may consider are activities such as sports leagues, dance classes, and Scouting. These programs teach our young people so much in terms of teamwork, perseverance, discipline, and leadership while promoting physical activity and healthy lifestyles. Caleb has been active in Scouts ever since he was in the first grade. As a Cub Scout, he earned his Arrow of Light. He recently made Scout, the first rank in Boy Scouts. His uncle and cousin are both Eagle Scouts, and he aspires to earn his. I'm looking forward to seeing him enjoy similar experiences that I saw my brother participate in and to watch him grow into a young man who exhibits the 12 principles in the Boy Scout Law. While there is a lot of support for these excellent youth programs, they still require incredible investment of time and resources from the families of these youth. Losing CHIP coverage

can affect the availability of these family resources and limit the ability of children to participate in these life enriching programs.

Some families may even have to sacrifice some of the care and oversight they provide for loved ones like parents, siblings, or even their children who, because of their unique needs, may live in group homes, nursing homes, or are aging in place with support staff. My daughter lives in a group home that is more than a 4-hour drive from my home. While I wish I could travel to visit her monthly, the best I have been able to do is about bimonthly and sometimes it stretches to quarterly visits. The increased financial burdens my family will experience if CHIP is not funded will impact our ability to participate in our daughter's life and insure that her needs are being appropriately met.

There are approximately 9 million children who receive CHIP. This program provides parents with the security of knowing their children have high quality and reliable insurance coverage, no matter what challenges they face with their own health or employment. Losing CHIP would jeopardize the health of America's current workforce and the well-being of its future leaders. I ask you to extend funding for CHIP with the enhanced match rate for the next 5 years. Funding CHIP will contribute to the financial security of working middle class families like mine and ensure our children will continue to have access to exceptional medical care which impacts their quality of life well into adulthood. Thank you for the time you are investing in determining the future of the CHIP program.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing entitled “The Children’s Health Insurance Program: the Path Forward”:

Twenty years ago, Senator Ted Kennedy and I came together to create the Children’s Health Insurance Program, or CHIP, in order to provide health coverage for vulnerable children in families who were too poor to afford private coverage but still didn’t qualify for Medicaid.

Twenty years ago, we were at something of a crossroads.

The year before CHIP was signed into law, a Republican Congress passed and a Democratic President signed a welfare reform bill which ended the entitlement to cash welfare. Welfare reform sought to replace a culture of dependency with an emphasis on work. The emphasis was to move families off assistance and toward self-sufficiency. CHIP was needed to help many families make that transition.

So we needed to be forward-thinking, taking into account the realities at that time with an eye toward future sustainability of the program.

Senator Kennedy and I worked in good faith for months to craft CHIP, and while neither of us got everything we wanted, the result was a dedicated funding stream for the program to help low-income families get good, reliable health insurance.

CHIP, from the outset, was a bipartisan program that enjoyed, and continues to enjoy, broad support throughout the country and here in Congress. While it isn’t perfect, and while, in my view, some of the subsequent changes to the program have been regrettable, I believe that, overall, people consider it to be a success.

Current law provides Federal CHIP funding through the end of fiscal year 2017. According to the Congressional Research Service, if Congress doesn’t act to provide additional Federal funding, a number of children who would likely be eligible for CHIP will go uninsured once Federal funding is exhausted.

Additionally, inaction by Congress with regard to CHIP would cause another layer of unpredictability and anxiety for States that have to administer the program. Of course, this anxiety will pale in comparison to the uncertainty families who rely on CHIP will be faced with if Congress doesn’t act.

As the committee contemplates the future of the CHIP program, there are several thresholds we’ll need to consider.

The basic question is, does the committee want to reauthorize or merely extend CHIP?

Reauthorization would entail more extensive debate and the consideration of potential policy changes to the underlying program. As many of you know, in 2015, Congressman Fred Upton—who was then chairman of the House Energy and Commerce Committee—and I put forward a number of substantive policy recommendations for reforming CHIP, most of which were, admittedly, met with a mixed reaction from stakeholders.

While some policy changes are certainly in order for the program, some are justifiably concerned that, given the number of issues that are already before the committee, there may not be time to give full and fair consideration to CHIP reforms prior to the expiration of Federal funding at the end of the fiscal year. With these concerns in mind, some have suggested that, instead of reauthorizing the entire program, we simply act to extend CHIP funding.

Of course, that option comes with its own set of questions.

For example, we'll need to determine the appropriate length for the extension and whether to continue with the 23-percent increase in Federal matching for CHIP provided under the Affordable Care Act and extended in 2015.

I know some of our members have strong feelings about both of these questions. These are not particularly complicated issues, but they will require some deliberation among members of the committee.

Long story short, we have some difficult questions ahead of us. Whether we opt to reopen CHIP for reforms or simply provide another extension, the committee will need to invest significant time and effort to find answers to those questions.

Today, we will continue our discussion of these matters as we hear from witnesses who will testify to the importance of CHIP and the need for it to continue.

I hope members will listen carefully to these witnesses, confer with their States, and let me know how they would prefer to proceed with regard to CHIP. I look forward to working on a bipartisan basis with Ranking Member Wyden and all the members of the Senate Finance Committee to move forward on a bipartisan CHIP bill.

PREPARED STATEMENT OF LINDA NABLO, CHIEF DEPUTY DIRECTOR,
VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for allowing me to speak to you today on the importance to States of continued funding for the Children's Health Insurance Program.

And thank you, Senator Warner—I remember well when you were Governor and I was hired as the CHIP Director to help you improve Virginia's program and enroll every eligible child. I particularly remember how you would ask every Friday, without fail, how many more children we had gotten covered that week. So before you go there, I will say that Virginia currently has 614,100 children covered through Medicaid and CHIP. These programs are the health insurance plan for almost one in three children in the Commonwealth, or slightly less than the national average.

I was invited here today to give the State perspective on the importance of continued funding for CHIP. As Dr. Schwartz has explained, the authorizing CHIP legislation provided certain flexibilities to States in how to design their programs so there are differences across the country. Virginia, like most States has a combination program with some children enrolled in Medicaid but supported by CHIP funding and others covered in a separate program. But however States have chosen to administer this program, it plays a vital role for all of us in ensuring children have access to affordable and appropriate health-care coverage by building on top of the much larger Medicaid program. In fact, CHIP just turned 20—it is now a mature program that is woven deep into the fabric of health-care coverage in all States and is a key program protecting the health of children for all of us.

There are only two points I want to make in my 5 minutes today. First, that CHIP is vital to the health of children in Virginia and in each of the States you represent. By my quick calculation over 4 million children are covered by CHIP in just your States alone. Second, I want to make sure you understand that there are serious consequences looming if you delay reauthorization—even for a few months.

In Virginia, as of September 1st, there are 123,256 children receiving their health care through CHIP. Over 58,000 of them are enrolled in Medicaid and the other

65,000+ are enrolled in the separate program initially modeled after the State employee health plan. We call the separate program “FAMIS” and we call the Medicaid program for children “FAMIS Plus”; the plus is because Medicaid provides additional benefits.

In Virginia we cover children up to 200% of the poverty level. We do not charge premiums but we do charge modest co-payments for services and children are required to be served through one of our six managed care plans at an average per child monthly cost of \$160.

Virginia also has a CHIP waiver to provide prenatal care to pregnant women with incomes above the Medicaid limit up to 200% of the poverty level, and about 1,100 pregnant women are currently enrolled. We also have a small premium assistance program whereby families can choose to enroll their child in an employer’s health plan and we will help them cover the cost of the children’s coverage, as long as it is cost-effective to do so and certain benefits are included.

The separate CHIP benefit package is strong, and most recently, we have added new substance use treatments for CHIP children and pregnant women as part of Virginia’s effort to address the opioid epidemic.

Virginia receives 88% Federal funding for this program and to emphasize just how important this is to Virginia children, in the last 2 fiscal years this funding has paid for:

- 218,190 immunizations and 221,309 well-child checkups,
- 21,430 glasses/contact lenses, and
- 326,567 dental visits.

In addition to this more routine and preventive care, CHIP has covered:

- 258 heart surgeries,
- 6 brain cancer surgeries,
- 2 liver transplants, and
- 1 heart transplant.

We have provided services for:

- 1,118 children diagnosed with cancer,
- 31 children living with HIV, and
- 32 children born with neonatal abstinence syndrome.

You have heard today from Ms. George about the difference CHIP has made in her child’s life. There are thousands of stories in each of your States that would deliver the same message. In Virginia I could tell you stories of children who simply get to lead more normal lives because of CHIP; they can play sports (you know you need to have insurance to play sports), control their asthma, see better in school, or get their teeth fixed; and their families breathe easier. Some even avoid falling into poverty because they have ready access to good quality health care for their children. Or I could tell you stories of children with very serious illnesses that have received lifesaving treatments because of this program. I could talk about James who learned he needed heart surgery days before he was to turn 18. Everyone worked together to expedite his eligibility and schedule his surgery so it would be covered before he aged out of CHIP. We couldn’t pay for his considerable follow-up treatments but we could help fix his heart.

Or Nathan, a 15-year-old without health insurance who showed sudden symptoms of diabetes and was rushed to the local emergency room. On the cusp of entering a diabetic coma the staff transferred him to a nearby hospital better able to treat his health crisis. His mother was fortunate to connect with a Virginia Health Care Foundation outreach worker, an organization Senator Warner is very familiar with as he is the founding chairman, and that we help support with CHIP administrative dollars. The outreach worker quickly assessed that Nathan would be eligible for FAMIS and personally engaged the local department of social services to expedite his application and ensure receipt of life-saving care without delay. Like so many others, Nathan’s mother was amazed to find out that CHIP is designed to meet the needs of working families.

I hope you understand that CHIP is vital to the health of our children and therefore our Nation and it works. But without congressional action soon we will be forced to start preparations to shut it down, throwing families of over 60,000 children in Virginia, and millions across the country into a panic.

You have heard that most States will not actually run out of Federal CHIP dollars until sometime in the second quarter of FY 2018. Some might naively believe this

means you can safely delay any action on CHIP while you deal with your very full calendar. But let me explain how problematic that would be for States and how devastating for families.

The analysis from CMS and the MACPAC data shows that with some redistributed funds, Virginia will run out of Federal CHIP dollars sometime in March—and we agree. However, what that analysis does not take into account is that Virginia, like many States, covers these children through managed care plans. We pay those health plans a capitated rate retrospectively for the previous month's coverage. So in February 2018 we will pay the six health plans for the month of January—but in March we will not have sufficient funds to pay for the month of February. We will therefore need to terminate FAMIS coverage at the end of January.

In order to give families adequate notice, we will need to send them letters informing them of this alarming news at the end of November. To address the inevitable turmoil this will cause, in Virginia we will first need to train Eligibility Workers, advocates, application assistants, call center operators, and others before families receive those letters so they are able to answer questions and provide whatever assistance they can offer. In essence, we will need to mount a reverse outreach campaign. We will also need to inform providers along the same time frame and prepare to deal with their questions as well.

We will need to expend funds to modify IT systems as eligibility rules are now embedded into such systems across the country and to change online and paper applications and notices. Countless other contracts for managed care, prior authorization reviews, auditors, etc. will also need to be amended.

I suspect for States without a high degree of managed care the situation will be even more precarious. They will have to try and predict what CHIP claims will come in, and when, in order to shut down the program in time to cover unknown costs. This will be further complicated as parents who get that letter telling them their child's coverage will end soon will very likely rush their child to the doctor, dentist and eye doctor and fill any prescriptions to the maximum; thus driving up utilization and expending remaining dollars faster than anticipated.

Even if some States were able to continue a reduced level of coverage for a time—or move children in a separate program into Medicaid, it would take months to develop and implement new policies and change systems. In Virginia our legislators begin their regular session on January 10th, too late to begin any legislative debate of how to continue some form of coverage.

If the future of CHIP remains uncertain, States will soon need to make decisions about policies such as freezing enrollment so as to preserve current coverage as long as possible, and what to say to families and when to say it, as the end of funding approaches. I have a long "To Do" list of what will need to happen in Virginia and that list starts in October if CHIP is not reauthorized by September 30th.

While we have come so close to the wire this time that States would be grateful for any quick reauthorization, I do want to make the point that funding this program in 1- or 2-year increments breeds instability. It dampens innovation and probably limits State investment when the future is so uncertain. I absolutely endorse the MACPAC recommendation of reauthorizing and funding the program for 5 years.

Finally, I want to talk about the enhanced Federal match rate for CHIP. I understand there is some question of whether or not it will continue at the current rate or be reduced. Please be aware that for Virginia alone, we know that if Congress reauthorizes CHIP but reduces the Federal match rate to previous levels (65% for Virginia) we will experience an immediate \$56 million dollar shortfall in the current State fiscal year (July–June) and an \$83 million shortfall in the next. Virginia, like almost all States, has built the current biennial budget on current law with the higher CHIP match.

As the chairman knows better than anyone, CHIP has always had strong bipartisan support, and that is true at the State level as well. With all the very difficult and complex decisions you have to make about health care in America, surely whether or not to reauthorize CHIP is not one of them. On behalf of States I am here to ask you to please continue your strong support of children's health care with passage of a straightforward authorization for continued funding of CHIP, at current levels.

Thank you.

PREPARED STATEMENT OF ANNE L. SCHWARTZ, PH.D., EXECUTIVE DIRECTOR,
MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

Summary

Since its enactment with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health care for tens of millions of low- and moderate-income children with incomes just above Medicaid eligibility levels. Under current law, CHIP is funded through fiscal year (FY) 2017. The Commission urges Congress to act as soon as possible to avoid disruption for families, plans, providers, and States, and to ensure that children continue to have access to needed health-care services. Without congressional action, States will not receive new Federal funds for CHIP beyond the end of this month, and States will rapidly deplete available funding. MACPAC projects that four States will exhaust available Federal funds in the first quarter of FY 2018; another 27 will do so in the second quarter.

In January 2017, MACPAC recommended that Congress extend Federal CHIP funding for a transition period of 5 years, as well as extend the CHIP maintenance of effort requirement and 23 percentage point increase in the CHIP matching rate through FY 2022. The Commission's priority in making these recommendations was to ensure the stability of children's health coverage during a period of uncertainty as Congress debates the future of Medicaid and subsidized exchange markets.

In coming to these recommendations, the Commission considered what would happen if no CHIP allotments were available to States after FY 2017. Our most recent estimates are that, if CHIP funding is not renewed, 1.2 million children covered under separate CHIP will become uninsured. While others may transition to employer-sponsored or exchange coverage, it would cost considerably more, potentially creating barriers to obtaining needed health and developmental services. In addition they could lose access to needed services that these sources are less likely to cover, such as dental care or audiology services.

When the Commission made these recommendations, it noted that coverage under separate CHIP authority should not be maintained indefinitely but that more time is needed to address concerns related to the affordability and comprehensiveness of other sources of children's coverage. Health insurance markets may face substantial changes over the next few years; unless renewed, Federal funding for CHIP will be exhausted long before any such changes can be fully realized.

Although States can continue to use FY 2017 funds into FY 2018, they cannot do so indefinitely. Moreover, they have legal obligations to notify families, plans, and providers about future plans, which may include freezing enrollment, transitioning children to other sources of coverage, and making eligibility and enrollment systems changes. In some States (*e.g.*, Arizona and West Virginia), State law requires termination of CHIP if Federal funding is not available.

In the long term, a more seamless system of children's coverage needs to be developed. That is why the Commission made a number of recommendations for a more seamless system of children's coverage to accompany its recommendations for Federal CHIP funding. Such a system would provide comprehensive and affordable coverage to low- and moderate-income children and remove the potential gaps in coverage children may experience as they transition between publicly and privately financed health insurance.

Good morning, Chairman Hatch, Ranking Member Wyden, and members of the committee. I am Anne Schwartz, Executive Director of the Medicaid and CHIP Payment and Access Commission (MACPAC). As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the States on issues affecting these programs. Its 17 members, including Chair Penny Thompson and Vice Chair Marsha Gold, are appointed by the U.S. Government Accountability Office (GAO). While the insights and information I will share this morning build on the analyses conducted by MACPAC's staff, they are in fact the views of the Commission itself. We appreciate the opportunity to share MACPAC's recommendations and work as this committee considers the future of the State Children's Health Insurance Program (CHIP).

OVERVIEW OF CHIP

Since its enactment with strong bipartisan support in 1997, CHIP, a joint Federal-State program, has played an important role in providing insurance coverage and access to health care for millions of low-income children with incomes just above Medicaid eligibility levels. Over this period, the share of uninsured children in the typical CHIP income range (those with family income above 100 percent but below 200 percent of the Federal poverty level (FPL)) has fallen dramatically—from 22.8 percent in 1997 to 6.7 percent in 2015 (MACPAC 2017a). In contrast, during the same period, which included two recessions, private coverage for children in this income range declined substantially—from 55 percent in 1997 to 29.8 percent in 2015 (Martinez et al. 2017).

In fiscal year 2016, 8.9 million children were enrolled in CHIP-funded coverage (CMS 2017a). States have flexibility in designing CHIP. States can operate these programs either as an expansion of Medicaid, an entirely separate program, or a combination of both approaches. States with Medicaid-expansion CHIP must provide the full Medicaid benefit package, including early and periodic screening, diagnostic, and treatment services, and must follow Medicaid cost-sharing rules. States with separate CHIP provide comprehensive health-care services subject to the approval of the Secretary of the U.S. Department of Health and Human Services (the Secretary) or based on a benchmark benefit package. In separate CHIP, States may require premiums and cost sharing, such as copayments and deductibles (although not for preventive services), with a combined limit of 5 percent of income. States receive an enhanced Federal match for CHIP, subject to the cap on their allotments, and must contribute a State share to receive their Federal funding allotments.

BASIS FOR MACPAC RECOMMENDATIONS

Under current law, CHIP is funded through FY 2017, and without congressional action, States will not receive any new Federal funds for CHIP beyond September 30, 2017. Mindful of this date, the Commission devoted considerable attention over the past several years to CHIP's role in our health-care system and policy approaches for the future. We reviewed available evidence about the quality and affordability of CHIP compared to other alternatives, and focused attention on the implications of various policy approaches for children and their families, States, providers, health plans, and the Federal Government.

Based on this review, the Commission issued a report this past January recommending that Federal funding for CHIP be extended for 5 years. If CHIP funding is not renewed, many of the children covered under separate CHIP will lose their health coverage. While some of these children may be eligible for private coverage, their families would have to pay considerably more than under CHIP, potentially creating barriers to needed health and developmental services. In addition, they would lose access to services covered by CHIP that are not typically covered by other payers. Those covered by Medicaid-expansion CHIP would not lose coverage but there would be a significant shift in the funding obligation for their coverage to the States.

MACPAC has always looked at CHIP in its context, a relatively small public health coverage program in an evolving array of sources of coverage for children that includes Medicaid, publicly subsidized exchange coverage established by the Patient Protection and Affordable Care Act (ACA, Pub. L. 111–148, as amended), and employer-sponsored coverage. In the long term, the development of a more seamless system of children's coverage is needed. Such a system would provide comprehensive and affordable coverage to low- and moderate-income children, removing the potential gaps in coverage and care that can affect children as they transition among different sources of publicly and privately financed health insurance.

Moreover, the future of publicly financed health coverage markets currently is uncertain. Over the past few months, Congress has been debating reforms to both Medicaid and federally subsidized exchange coverage that would affect the available alternatives for children in the absence of CHIP. This uncertainty heightens the need for congressional action to extend CHIP.

In my testimony today, I will present the rationale behind the Commission's recommendations on the future of CHIP funding and children's coverage, as well as the evidence it considered in making its recommendations. I also will address CHIP financing; in particular, how States will be affected if Federal CHIP funding ends. MACPAC's most recent analyses focus on when States are projected to run out of CHIP funds and how the requirement that States maintain coverage for children

through fiscal year (FY) 2019 will affect States differentially based on their decisions to run CHIP as a Medicaid expansion or a separate program.

MACPAC's Recommendations on the Future of CHIP and Children's Coverage

In a January 2017 special report (made available in print in our March 2017 *Report to Congress on Medicaid and CHIP*), MACPAC made nine recommendations to Congress to fund and stabilize CHIP, and to move toward a more seamless system of affordable and comprehensive children coverage (Box 1).

STABILIZING CHILDREN'S HEALTH COVERAGE

In making its recommendations for CHIP funding, a key priority for the Commission was to ensure the stability of children's health coverage during this period of uncertainty about other sources of coverage. The Commission recommends that Congress extend Federal CHIP funding for a transitional period of 5 years through FY 2022. It also recommends extension of the current CHIP maintenance of effort (MOE) requirement and the 23 percentage point increase in the Federal CHIP matching rate through FY 2022.

Rationale. Extending CHIP for a transition period would ensure that low- and moderate-income children would retain access to affordable insurance coverage during a time of uncertainty for coverage markets. The transition period of 5 years would also provide time to address concerns with affordability and benefits of other coverage sources, which are described in greater detail below. In addition, this period would provide Federal and State policymakers time to plan and implement comprehensive children's coverage demonstrations, which the Commission also is recommending.

BOX 1. MACPAC Recommendations for the Future of CHIP and Children's Coverage

Recommendation 1.1

Congress should extend Federal CHIP funding for a transition period that would maintain a stable source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.

Recommendation 1.2

Congress should extend Federal CHIP funding for 5 years, through fiscal year 2022, to give Federal and State policymakers time to develop policies for, and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.

Recommendation 1.3

In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the Federal CHIP matching rate, currently in effect through FY 2019, for 3 additional years, through fiscal year 2022.

Recommendation 1.4

To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP.

Recommendation 1.5

In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the Federal poverty level not be subject to CHIP premiums.

Recommendation 1.6

Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support State efforts to develop, test, and implement approaches to providing, for CHIP-eligible children, seamless health coverage that is as comprehensive and affordable as CHIP.

Recommendation 1.7

Congress should permanently extend the authority for States to use Express Lane Eligibility for children in Medicaid and CHIP.

Recommendation 1.8

The Secretary of Health and Human Services, in consultation with the Secretaries of Agriculture and Education, should not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit States to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.

Recommendation 1.9

Congress should extend funding for 5 years for grants to support outreach and enrollment of Medicaid- and CHIP-eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures program, through fiscal year 2022.

To further stabilize children's coverage and prevent States from rolling back eligibility, the Commission recommends extending the CHIP MOE through FY 2022. The current MOE, which requires States to maintain the CHIP eligibility levels in place on March 23, 2010 through FY 2019, was established by the ACA (Appendix A). The MOE also prohibits States from adopting eligibility and enrollment standards or methodologies that are more restrictive than those in place prior to the enactment of the ACA (§ 2105(d)(3) of the Act).

MACPAC also recommends extending the 23 percentage point increase to the CHIP enhanced matching rate through FY 2022. This increase was enacted in the ACA for FYs 2016–2019. In the current fiscal year, 11 States and the District of Columbia have a CHIP matching rate of 100 percent meaning that the Federal Government pays for 100 percent of the cost of providing CHIP coverage to children (Appendix B). An additional 22 States have CHIP matching rates ranging from 90 percent to 99 percent (MACPAC 2017a).

The Commission's recommendation reflects the view that an extension to the MOE, which it judged important to retaining gains in coverage, should be accompanied by an extension of enhanced funding. The increase to the CHIP matching rate is also thought to have influenced decisions in 2016 in some States to expand children's coverage, within permissible limits.¹ For example, Florida and Utah expanded Medicaid and CHIP coverage to lawfully residing immigrant children. In July 2016, Arizona reinstated CHIP, which it had previously closed.

The Commission has long held that coverage under separate CHIP authority should not be maintained indefinitely (MACPAC 2014a). The Commission also has stated that children's coverage should be affordable and comprehensive, and State flexibility in program design must be maintained. In the Commission's view, other current sources of coverage do not meet these standards. In addition, over the course of the Commission's deliberation, two additional facts became clear. First, more time is needed for assessing, planning, and implementing changes to address concerns of other coverage sources for children. Second, given the expectation that health insurance markets may face substantial changes over the next few years, Federal funding for CHIP would be exhausted before these changes would be fully realized.

IMPLICATIONS IF FEDERAL CHIP FUNDING IS NOT RENEWED

If CHIP funding ends and States exhaust available Federal funds, the implications for States depend on whether they operate CHIP as a Medicaid expansion or a separate program. As of January 1, 2016, 10 States (including the District of Columbia) ran CHIP as a Medicaid expansion, 2 States had separate CHIP, and 39 operated combination programs (MACPAC 2017a). In the absence of CHIP, children leaving separate CHIP and gaining other coverage likely would face higher cost sharing, different benefits, and enrollment in plans with different provider networks.

Increase in uninsurance. Although the MOE generally requires States to maintain their children's coverage eligibility levels in place when the ACA was enacted, States face different scenarios for separate CHIP and Medicaid-expansion if Federal CHIP funds run out. States with Medicaid-expansion CHIP must continue that coverage for children, but instead of receiving the enhanced CHIP match, States will receive the lower Medicaid matching rate. Of the 8.4 million children enrolled in

¹The definition of targeted low-income child at section 2110(b) created a CHIP upper income-eligibility limit of no greater than 50 points above the State pre-CHIP Medicaid income levels.

CHIP-funded coverage in 2015, 4.7 million were in Medicaid-expansion CHIP (MACPAC 2017a).

States with separate CHIP are permitted to terminate that coverage if Federal CHIP funds run out. In this case, the ACA requires States to develop procedures to automatically transition children from separate CHIP to exchange coverage that has been certified as “at least comparable to” CHIP programs with respect to benefits and cost sharing (§ 2105(d)(3)(B) of the Social Security Act (the Act)). If the Secretary finds that no exchange plans are comparable to CHIP, States are not required to facilitate the transition to exchange coverage, although families may obtain subsidized exchange coverage on their own. In November 2015, the Secretary of the U.S. Department of Health and Human Services (the Secretary) did not certify any exchange plan as comparable to CHIP coverage (CMS 2015).

We recently updated our analysis of how an end to separate CHIP would affect children’s coverage, finding that in the absence of CHIP, 1.2 million children enrolled in separate CHIP would become uninsured because the cost of other sources of coverage would be unaffordable.² We estimate that 1.1 million would enroll in employer-sponsored coverage, and almost 700,000 would enroll in subsidized exchange coverage.

This analysis also found that of the children losing separate CHIP and who would become uninsured:

- Forty-four percent will be eligible for exchange subsidies;
- Forty percent are eligible for exchange subsidies because their parents do not have an offer of employer coverage or the available employer-sponsored coverage excludes dependent coverage; and
- Fifty-six percent will have an offer of employer-sponsored coverage in the household.

However, the average additional premium to obtain family coverage would be 8 percent of income, making the total cost of family coverage equal to 11 percent of family income.

We also previously noted that the majority of separate CHIP-enrolled children who would become uninsured if CHIP funding is exhausted have family income below 200 percent FPL (61.3 percent) and are non-white (53.9 percent). In addition, 89.6 percent have a full-time worker in the family (MACPAC 2015).

Affordability of coverage. For children in the CHIP income-eligibility range, CHIP coverage is considerably less costly to families with respect to both premiums and out-of-pocket cost sharing than exchange or employer-sponsored coverage (MACPAC 2016, 2015).³ In 2015, the combined premiums and cost sharing of separate CHIP in 36 States averaged \$158 per year per child, \$127 for premium and \$31 for cost sharing. On average in these 36 States, the effective actuarial value of CHIP coverage was 98 percent. In other words, the plans covered 98 percent of the cost of covered medical benefits and enrollees 2 percent.

If these same children were enrolled in employer-sponsored insurance, they would have faced an estimated \$891 per year per child in average annual out-of-pocket spending (\$603 for premiums and \$288 in cost sharing), and if enrolled in the second lowest cost silver exchange plan, they would have faced an estimated \$1,073 per year per child (\$806 for premiums and \$266 in cost sharing). The effective actuarial value averaged 81 percent in employer sponsored insurance plans and 82 percent in second lowest cost silver exchange plans, with families responsible for the remaining 18 percent to 19 percent through cost sharing (MACPAC 2016).

Adequacy of benefits. MACPAC’s comparison of benefits in separate CHIP, Medicaid (including Medicaid-expansion CHIP), exchange plans, and employer-sponsored insurance found that covered benefits vary within each source—between States for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans (MACPAC 2015). Most separate CHIP, Medicaid, exchange, and employer-sponsored insurance plans cover major medical benefits, such as inpatient and outpatient care, physician services, and prescription drugs. Children enrolled in Medicaid-expansion CHIP are entitled to all Medicaid services, including early and

²Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSIM-ACS), August 2017.

³Premiums and cost sharing are permitted for children in separate CHIP (capped at 5 percent of family income), but they generally are prohibited for children in Medicaid.

periodic screening, diagnostic, and treatment (EPSDT) services that exchange and employer-sponsored plans often do not cover.

Differences are pronounced for dental care, an EPSDT service. Like Medicaid, separate CHIP covers pediatric dental services. However in most exchanges and employer-sponsored coverage, dental benefits are offered as a separate, stand-alone insurance product for which families pay separate premiums and cover cost sharing expenses. More than half of all employer-sponsored plans (54 percent) do not include pediatric dental coverage. Of the employers that offer separate dental coverage, many require an additional premium.

CHIP also covers many services important to children's healthy development that are not always available in exchange plans. For example, all separate CHIP and Medicaid programs cover audiology exams, and 95 percent of separate CHIP programs cover hearing aids. However, only 37 percent of exchange plan essential health benefit benchmarks cover audiology exams, and only 54 percent cover hearing aids (MACPAC 2015). Among employer-sponsored health plans, 34 percent cover pediatric audiology exams and 43 percent cover hearing aids (MACPAC 2015).

Provider networks. The Commission also looked at how CHIP provider networks compare to those of other sources of coverage. Under Federal law, CHIP managed care is subject to the same Federal provisions that establish standards for Medicaid managed care (§2103(f)(3) of the Act). These provisions require States to establish "standards for access to care so that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity" (§1932(c)(1)(A)(i) of the Act). CHIP regulations also specify that a State must ensure "access to out-of-network providers when the network is not adequate for the enrollee's medical condition" (42 CFR 457.495).

Advocates have suggested that separate CHIP networks are better than Medicaid or exchange plan networks because they are similar to private plan networks or because they are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, we found little empirical evidence to either support or refute this assertion.

IMPLICATIONS FOR STATES

MACPAC has also considered the financial and operational implications for States if CHIP funding were to end, which are described below. Unless funding for CHIP is renewed, States will begin running out of available Federal funds during the first quarter of FY 2018, which begins in just a few weeks. All States will exhaust their funds before the end of fiscal year 2018.

Exhaustion of Federal funds. Federal funding for CHIP is capped and allotted to States annually. States have 2 years to spend their allotments, and unspent allotments are available for redistribution to other States experiencing CHIP funding shortfalls.⁴ Under current law, new CHIP allotments are not available after FY 2017 and unspent FY 2017 CHIP allotments that remain available for expenditures in FY 2018 are reduced by one-third (§2104(m)(2)(B)(iv) of the Act).⁵

Under current law, in FY 2018, States may continue to spend unspent FY 2017 allotments and redistribution funds from prior years (an estimated \$4.2 billion in total), however these funds are expected to be insufficient to cover expected State CHIP expenses in FY 2018 (an estimated \$17.4 billion).⁶ Based on State spending estimates submitted to CMS, MACPAC projects that three States and the District of Columbia will exhaust available Federal CHIP funds sometime in the first quarter of the fiscal year, and 27 States will do so in the second quarter (Table 1 and Appendix C).

⁴MACPAC projects that the Federal CHIP funding that States have received through their FY 2017 allotments and the redistribution funding that is available from prior year allotments will be adequate to cover projected State spending in FY 2017 (MACPAC 2017b). Four States and the District of Columbia are projected to have CHIP spending that exceeds their FY 2017 allotment, but these States are expected to receive redistribution funds in FY 2017 sufficient to cover their projected CHIP funding shortfall. Approximately \$3 billion in redistribution funding is available in FY 2017 (MACPAC 2017b).

⁵States experiencing CHIP funding shortfalls can also receive contingency fund payments if their CHIP enrollment exceeds target levels specified in section 2105(n) of the Act. However, contingency fund payments are not available for FY 2018 and subsequent years.

⁶The projected FY 2018 Federal CHIP spending of \$17.4 billion includes States and territories.

Table 1. Projected Exhaustion of Federal CHIP Funds in Fiscal Year 2018

Quarter of fiscal year	Number of States	States
First quarter (October–December 2017)	4	Arizona, District of Columbia, Minnesota, and North Carolina
Second quarter (January–March 2018)	27	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nevada, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, and Washington
Third quarter (April–June 2018)	19	Alabama, Georgia, Illinois, Indiana, Iowa, Maine, Maryland, Michigan, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, West Virginia, and Wisconsin
Fourth quarter (July–September 2018)	1	Wyoming

Note: CHIP is the State Children’s Health Insurance Program.

Source: MACPAC 2017 analysis using June 2017 Medicaid and CHIP Budget and Expenditure System data from the Centers for Medicare and Medicaid Services, including quarterly projections provided by States in May 2017.

State policies may also affect when States exhaust their Federal CHIP funding. For example, while the ACA’s maintenance of effort (MOE) requirement generally prohibits reducing children’s eligibility for CHIP, States are permitted to impose enrollment limits “in order to limit expenditures . . . to those for which Federal financial participation is available” (§ 2105(d)(3)(A)(iii) of the Act). States may also take other actions to reduce CHIP spending such as allowing CHIP waivers to expire and cutting payments to plans and providers.

State budgets. Most States have fiscal years that begin July 1; thus they have already set their budgets for the State fiscal year 2018. Despite the uncertainty of Federal CHIP funding, 33 out of 40 States responding to a survey about the future of CHIP funding indicated that their State budget assumed that CHIP funding would continue; 21 States have assumed that the 23 percentage point increase in the CHIP match continues as well (NASHP 2017). Absent congressional action, these States will likely experience shortfalls and may have to close their separate CHIP programs or provide coverage to children enrolled in Medicaid-expansion CHIP with substantially fewer Federal funds than anticipated.

Operational considerations and timelines. Although States can continue to use FY 2017 funds into FY 2018, they cannot do so indefinitely. Moreover, they have legal obligations to notify families, plans, and providers about future plans, which may include freezing enrollment, transitioning children to other sources of coverage, and making eligibility and enrollment systems changes (NASHP 2017). In some States (*e.g.*, Arizona and West Virginia), State law requires termination of CHIP if Federal funding is not available.

Although we are hearing from State officials that they do not wish to unnecessarily alarm beneficiaries and other stakeholders, others are planning to send notices this month with freezes beginning in October and November.

Companion Recommendations to Promote Seamless Children’s Coverage

In addition to the recommendations pertaining to Federal CHIP funding, the Commission made a number of companion recommendations for moving toward a more seamless system of children’s coverage. These recommendations include:

- Creating and funding a children’s coverage demonstration grant program to support State efforts to develop, test, and implement approaches to providing CHIP-eligible children with seamless health coverage that is as comprehensive and affordable as CHIP;
- Eliminating waiting periods in CHIP, aligning separate CHIP premium policies with those of Medicaid, and permanently extending authority for States to use Express Lane Eligibility; and

- Extending funding to support outreach and enrollment of Medicaid- and CHIP-eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program.

Demonstration grants. State innovation will be a key driver in improving the system of coverage for low- and moderate-income children; Federal support of such efforts would ease financial barriers to States that aspire to transform their children's coverage systems.

To encourage and support child-focused efforts, the Commission recommends providing planning and implementation demonstration grants to develop and test models for transforming coverage systems for children. Such models could be developed using existing State plan and waiver authorities, such as those available under sections 1115 and 1332 of the Act. Developing options for a seamless system of affordable and comprehensive coverage for children across available coverage sources will require resources for research and analysis of markets, needs assessments, stakeholder and expert engagement, as well as legal, regulatory, policy, and cost analyses. These activities are typically not eligible for Federal match under State plan authority, and in past efforts to develop and implement health delivery system changes, States have used waiver authority or other grant funding such as the Real Choice Systems Change grant program to finance these planning activities. Historically, State demonstrations have been an effective way to gain experience from which learning and strategies can be gleaned for broader take up by States.

Eliminate CHIP waiting periods and premiums for children under 150 percent FPL. While CHIP has been enormously successful in reducing uninsurance, steps can be taken to promote greater continuity and seamlessness of coverage within the existing program. MACPAC initially recommended such steps relating to CHIP waiting periods and premiums in order to achieve these goals in March 2014, and continues to recommend them in 2017. There is little evidence showing that waiting periods have deterred crowd-out of private coverage; eliminating them would promote more stable coverage for children, simplify and make CHIP policy more consistent with Medicaid and other publicly finance coverage programs, and reduce administrative complexity and burden for families, States, health plans, and providers (MACPAC 2014b). Eliminating CHIP premiums for families with incomes under 150 percent FPL would reduce uninsurance and align CHIP premium policies with Medicaid policies for lower-income children. Compared to higher-income enrollees, families with incomes below 150 percent FPL are more price sensitive and less likely to take up CHIP coverage for their children when a premium is required (MACPAC 2017).

Express Lane Eligibility. The Commission recommends that Congress permanently extend Express Lane Eligibility (ELE) authority as an option States can adopt to simplify enrollment processes and promote continuity of coverage. ELE, currently authorized through September 30, 2017, permits States to rely on findings from another program designated as an Express Lane agency (*e.g.*, Supplemental Nutrition Assistance Program, the National School Lunch Program, and Head Start) when making Medicaid and CHIP eligibility determinations (including renewals of eligibility).

ELE processes are associated with positive enrollment gains (both new enrollment and renewals), and administrative savings in some States (OIG 2016, Hoag et al. 2013). A Federal evaluation indicated that, as of December 2013, nearly 1.4 million children enrolled in Medicaid or CHIP and retained coverage through ELE processes. Federal evaluations have found that some States reported that implementing ELE resulted in administrative savings. For example, one State reportedly saved \$7.3 million between 2011 and 2014, and another State reported that the Medicaid agency saved \$25.77 per initial enrollment and \$5.15 per renewal (OIG 2016).⁷ Without an extension, States that have implemented this option would be likely to incur additional costs in reverting to legacy eligibility processes. Should authority for the ELE option expire, the States that have implemented this option could only continue to do so under a section 1115 waiver.⁸

The Commission also recommends that the HHS Secretary, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of

⁷Savings were the result of reduced staff time to complete eligibility determinations due to simplified enrollment processes, according to State reports (OIG 2016).

⁸As of January 1, 2016, eight States use ELE for children at Medicaid enrollment, five States use ELE for CHIP enrollment, seven States use ELE for children at Medicaid renewal, and three States use ELE for CHIP renewal (KFF 2016).

Education, assess and report to Congress on the legislative and regulatory modifications needed to permit States to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families. Given the efficiencies and favorable enrollment gains associated with ELE as currently implemented, the Commission seeks information on changes necessary to modify ELE authority so that designated programs can use Medicaid or CHIP eligibility determination information, and the potential for reducing administrative burden for families and States.⁹

Renewal of other programs. The Commission recommends extending funding for three programs that focus on improving aspects of coverage or care for children enrolled in Medicaid or CHIP for 5 years through FY 2022: Medicaid and CHIP outreach and enrollment grants, the Childhood Obesity Research Demonstration (CORD) projects, and the Pediatric Quality Measures Program. In past years, funding for these programs has been renewed alongside CHIP funding.

- Outreach and enrollment grants created in 2009 have helped to support States, tribes, and community-based organizations in a variety of proactive outreach and enrollment activities. Funds have also supported a national outreach and enrollment campaign (CMS 2016). These grants are needed to maintain the historic successes in finding and enrolling eligible children and in helping them retain coverage at renewal. Absent such grants, State spending on outreach and enrollment would be limited by Federal law to the 10 percent cap on CHIP administrative spending. CHIPRA established this program, appropriating \$100 million for FYs 2009–2013. Funding was most recently renewed under the Medicare Access and CHIP Reauthorization Act (MACRA, Pub. L. 114–10) at \$40 million for FYs 2016–2017.
- CHIPRA also established the Childhood Obesity Research Demonstration (CORD) to identify and evaluate health care and community strategies to combat childhood obesity in children age 2–12 enrolled in or eligible for Medicaid or CHIP (Dooyema et al. 2013). CORD project grantees are evaluating whether multi-level, multi-setting approaches that integrate primary care with public health strategies can improve health behaviors and reduce childhood obesity. The second phase of CORD grants focuses on preventive services to individual children and families in Arizona and Massachusetts. Evaluation results which became available in July 2017 from some of the Phase I demonstrations, show a statistically significant reduction in child body mass index and increase in parent satisfaction with obesity related care. Providers who participated in one demonstration showed improved confidence in determining child overweight or obesity status, providing counseling, and setting behavioral goals with families. Most recently, MACRA extended funding for this effort, at \$10 million for FYs 2016–2017. Continued Federal funding is important to efforts to develop and test strategies to reduce childhood obesity, as well as disseminating results.
- In 2009, the Centers for Medicare and Medicaid Services (CMS) developed a core set of children’s health care quality measures for children in Medicaid and CHIP, the first focused effort to measure the quality of publicly funded children’s health care in a consistent way on a national level. Since 2010, State participation in reporting the voluntary core set of child health measures has increased; by FY 2014, all 50 States and the District of Columbia reported at least one measure (CMS 2016b, CMS 2011). In its initial phase, the Pediatric Quality Measures Program (PQMP) worked to improve and strengthen the initial child core set by bringing together experts, to develop and improve pediatric quality measures (AHRQ 2016, Sebelius 2014). Current PQMP grantees are assessing the feasibility and usability of the measures at the State, health plan, and provider levels (AHRQ 2016). MACRA extended funding of \$20 million over FYs 2016 and 2017.

An extension of PQMP funding will allow the Secretary to continue to develop, test, validate, and disseminate new child health quality measures, and to continue revising existing measures for children enrolled in Medicaid and CHIP. In a November 2014 letter to Congress, MACPAC stated that the needed investments in quality measurement are relatively small, but that they are important, not only for those whose care is financed by Medicaid and CHIP but also for taxpayers (MACPAC

⁹Specifically, the report should describe the legislative and regulatory changes necessary to allow designated programs to use publicly subsidized health program findings to determine eligibility for other programs. The report should also assess the operational challenges and technical feasibility of this policy, and evaluate the implications of broadening ELE authority.

2014b). In the letter, MACPAC noted several key areas in which ongoing work can build on progress to date, including strengthening CMS's capacity to calculate quality measures for States, improving quality measures for individuals with disabilities, and expanding the use of core quality measures in State quality improvement efforts. Continuation of the PQMP could also support efforts to measure and improve care provided to children with special health care needs enrolled in Medicaid and CHIP coverage.

FEDERAL BUDGET IMPLICATIONS

The Congressional Budget Office (CBO) estimates that these recommendations would increase net Federal spending by about \$18.7 billion above the agency's current law baseline over a 10-year period of FYs 2017–2026. CBO's estimate also reflects congressional budget rules that require the agency to assume in its current law spending baseline that Federal CHIP funding continues beyond FY 2015 at \$5.7 billion each year.¹⁰

CONCLUSION

CHIP has clearly played an important role in providing access to health-care coverage to low- to moderate-income children who otherwise would have been uninsured. In addition, CHIP has provided a platform for State innovations to improve take-up of public coverage among eligible but uninsured children, remove enrollment barriers, and focus on the quality of children's care. For example, outreach and enrollment techniques that often began as experiments in CHIP in individual States were subsequently identified as best practices and, in some cases, are now required in all States for both CHIP and Medicaid.

Congress now faces an important decision regarding the future of CHIP and its approach to providing a stable, affordable, and adequate source of coverage to millions of low- and moderate income children. MACPAC's recommendations provide advice on how to ensure a stable source of affordable and comprehensive coverage for low- and moderate-income children during a period of uncertainty affecting other health care markets.

When the Commission made its recommendations in January, it noted the urgent need for congressional action. With the end of the fiscal year in sight, the Commission must underscore the need for Congress to act as soon as possible to extend CHIP so that States do not respond to uncertainty around CHIP's future by implementing policies that reduce children's access to needed health-care services.

The Commission's longer-term vision looks to State innovations that would create a more seamless system of children's coverage, provide comprehensive and affordable coverage for low- and moderate-income children, and remove the potential for gaps in coverage and care as children transition between different sources of publicly and privately financed health insurance. Such a system would promote greater alignment between Medicaid, CHIP, and other insurance sources and would smooth out transitions between them. The recommendations of the Commission reflect these goals and take steps to provide States and their Federal partners the tools to transform children's coverage.

Thank you, members of the committee. I would be happy to answer any questions you may have.

References

Agency for Healthcare Research and Quality (AHRQ). 2016. *Pediatric Quality Measures Program*. Rockville, MD: AHRQ. <http://www.ahrq.gov/policymakers/chipra/pqmp.html>.

¹⁰The Congressional Budget Office (CBO) makes unique assumptions regarding the future of CHIP, which will affect the projected Federal cost of legislative proposals it examines. CBO is required to assume that CHIP and certain other expiring programs continue in perpetuity at the last appropriated level (2 U.S.C. 907(b)(2)(A)(i)). However, in order to reduce the long-term Federal spending projected by CBO under these assumptions, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was worded so that the last appropriated level for CBO's purposes was \$5.7 billion in FY 2013 rather than the \$17.4 billion actually appropriated for FY 2013. In extending Federal CHIP funding by 2 years, the ACA continued the use of this language so that the last appropriated level for CBO's purposes for CHIP past FY 2015 is \$5.7 billion rather than \$21.1 billion.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017a. *2016 number of children ever enrolled*. 2017. <https://www.medicare.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017b. *Key dates for calendar year 2017: Qualified health plan certification in the federally-facilitated exchanges; rate review; risk adjustment, reinsurance and risk corridors*, revised April 2017. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Revised-Key-Dates-for-Calendar-Year-2017-4-13-17.pdf>.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. *Connecting kids to coverage outreach and enrollment funding history*. Baltimore, MD: CMS. <https://www.insurekidsnow.gov/initiatives/connecting-kids/funding/history/index.html>.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. *2015 Annual Report on the quality of care for Children in Medicaid and CHIP*. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf>.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. *Certification of comparability of pediatric coverage offered by qualified health plans*. November 25, 2015. <https://www.medicare.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf>.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. *Children's Health Insurance Program Reauthorization Act 2011 annual report on the quality of care for children in Medicaid and CHIP*. Baltimore, MD: CMS. https://www.medicare.gov/medicaid/quality-of-care/downloads/2011_statereporttocongress.pdf.

Dooyema, C., B. Belay, J. Foltz, et al. 2013. "The Childhood Obesity Research Demonstration Project: A comprehensive community approach to reduce childhood obesity." *Childhood Obesity* 9, no. 5: 454–459.

Hensley-Quinn, M. and C. Hess. 2013. *How CHIP can help meet child specific requirements and needs in the exchange: Considerations for policymakers*. Washington, DC: National Academy for State Health Policy. https://nashp.org/?s=How+CHIP+can+help+meet+child+specific+requirements&category_name=.

Hoag, S., M. Harrington, C. Orfield, et al. 2011. *Children's Health Insurance Program: An evaluation (1997–2010). Interim report to Congress*. Ann Arbor, MI: Mathematica Policy Research. <http://aspe.hhs.gov/health/reports/2012/chip-irtc/index.pdf>.

Kaiser Family Foundation (KFF). 2016. *State adoption of Express Lane Eligibility for children's Medicaid and CHIP at enrollment and renewal*. <http://kff.org/health-reform/state-indicator/state-adoption-of-express-lane-eligibility-for-childrens-medicare-and-chip-at-enrollment-and-renewal/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Martinez, M.E, E.P Zammitti, and R.A. Cohen. 2017. *Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–September 2016*. Hyattsville, MD: National Center for Health Statistics. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017a. *Report to the Congress on Medicaid and CHIP*. March 2017. Washington, DC: MACPAC. <https://www.macpac.gov/publication/march-2017-report-to-congress-on-medicare-and-chip/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017b. *Federal CHIP Funding: When Will States Exhaust Allotments?* March 2017. Washington, DC: MACPAC. <https://www.macpac.gov/publication/federal-chip-funding-when-will-states-exhaust-allotments/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. "Chapter 5: Design considerations for the future of children's coverage: Focus on affordability." In *Report to Congress on Medicaid and CHIP*. March 2016. Washington, DC: MACPAC. <https://www.macpac.gov/publication/design-considerations-for-the-future-of-childrens-coverage-focus-on-affordability-2/>.

- Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. *Report to the Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicaid-and-chip/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2014a. *Report to the Congress on Medicaid and CHIP*. June 2014. Washington, DC: MACPAC. <https://www.macpac.gov/publication/ch-1-chip-and-the-new-coverage-landscape/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2014b. *Report to the Congress on Medicaid and CHIP*. March 2014. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-314/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2014c. Letter to Secretary of the U.S. Department of Health and Human Services and Congress regarding "Adult and Children's Health Care Quality Reports to the Congress," November 2014. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC-comments-on-HHS-quality-reports-to-Congress.pdf>.
- National Academy for State Health Policy (NASHP). 2017. *2017 CHIP directors survey results*. February 2017. Washington, DC: NASHP. <http://nashp.org/wp-content/uploads/2017/02/2017-CHIP-Survey-Results.pdf>.
- Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2016. *State use of Express Lane Eligibility for Medicaid and CHIP enrollment*. Washington, DC: OIG. <https://oig.hhs.gov/oei/reports/oei-06-15-00410.pdf>.
- Sebelius, K. 2014. *HHS Secretary's efforts to improve children's health care quality in Medicaid and CHIP*. Washington, DC: U.S. Department of Health and Human Services. <https://www.medicare.gov/medicaid/quality-of-care/downloads/2014-childrens-report-to-congress.pdf>.

APPENDIX A: ELIGIBILITY AND ENROLLMENT
Table A-1. CHIP Eligibility Levels (2016) and Enrollment (FY 2015) by State

State	Program type ¹ (as of July 1, 2016)	Children in Medicaid-Expansion CHIP ¹						Children in separate CHIP						Total CHIP-funded child enrollment ⁴
		Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Separate CHIP: Age 0-18 ²			Separate CHIP: Unborn		Total separate CHIP enrollment			
						Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Eligibility ³	Enrollment				
Total	-	-	-	-	4,702,185	-	-	3,362,642	-	327,175	3,689,817	8,397,651		
Alabama	Combination	-	-	107-141	45,697	142-312	87,346	-	-	87,346	-	133,043		
Alaska	Medicaid expansion	159-203	159-203	124-203	10,182	-	-	-	-	-	-	10,182		
Arizona ⁵	Combination	-	-	104-133	37,412	148-200	1,399	134-200	-	1,399	-	38,811		
Arkansas	Combination	-	-	107-142	108,706	143-211	- ⁶	143-211	209	3,365	3,365	112,071		
California ^{7, 8}	Combination	208-261	142-261	108-261	1,787,470	262-317	2,461	262-317	317	122,197	124,658	1,912,128		
Colorado	Combination	-	-	108-142	23,687	143-260	62,446	143-260	-	-	62,446	86,133		
Connecticut	Separate	-	-	-	-	197-318	24,884	197-318	-	-	24,884	24,884		
Delaware	Combination	194-212	-	110-133	238	- ⁹	16,141	134-212 ⁹	-	-	16,141	16,379		
District of Columbia	Medicaid expansion	206-319	146-319	112-319	10,676	-	-	-	-	-	-	10,676		
Florida	Combination	192-206	-	112-133	134,708	- ⁹	293,386	134-210 ⁹	-	-	293,386	428,094		
Georgia	Combination	-	-	113-133	53,906	206-247	176,909	134-247	-	-	176,909	230,815		
Hawaii	Medicaid expansion	191-308	139-308	105-308	27,239	-	-	-	-	-	-	27,239		
Idaho	Combination	-	-	107-133	8,937	143-185	25,576	134-185	-	-	25,576	34,513		
Illinois	Combination	-	-	108-142	113,105	143-313	191,328	143-313	208	26,138	217,466	330,571		

APPENDIX A: ELIGIBILITY AND ENROLLMENT—Continued
Table A-1. CHIP Eligibility Levels (2016) and Enrollment (FY 2015) by State

State	Program type ¹ (as of July 1, 2016)	Children in Medicaid-Expansion CHIP ¹						Children in separate CHIP						Total CHIP-funded child enrollment ⁴
		Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Separate CHIP: Age 0-18 ²			Separate CHIP: Unborn		Total separate CHIP enrollment			
						Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Eligibility ³	Enrollment				
Indiana	Combination	157-208	141-158	106-158	69,462	209-250	159-250	159-250	31,098	—	—	31,098	100,560	
Iowa	Combination	240-375	—	122-167	21,777	— ⁹	168-302 ⁹	168-302 ⁹	60,880	—	—	60,880	82,657	
Kansas	Combination	—	—	113-133	54	167-238	134-238	134-238	77,085	—	—	77,085	77,139	
Kentucky	Combination	—	142-159	109-159	50,926	196-213	160-213	160-213	36,050	—	—	36,050	86,976	
Louisiana	Combination	142-212	142-212	108-212	122,878	213-250	213-250	213-250	3,498	209	9,238	12,736	135,614	
Maine	Combination	—	140-157	132-157	13,440	192-208	158-208	158-208	8,870	—	—	8,870	22,310	
Maryland	Medicaid expansion	194-317	138-317	109-317	142,327	—	—	—	—	—	—	—	142,327	
Massachusetts ¹⁰	Combination	185-200	133-150	114-150	79,299	201-300	151-300	151-300	76,519	200	13,123	89,642	168,941	
Michigan ¹¹	Combination	195-212	143-212	109-212	29,226	—	—	—	85,302	195	5,171	90,473	119,699	
Minnesota	Combination	275-283 ¹²	—	—	474	—	—	—	—	278	3,361	3,361	3,835	
Mississippi	Combination	—	—	107-133	30,819	205-209	144-209	134-209	56,286	—	—	56,286	87,105	
Missouri	Combination	—	148-150	110-150	38,600	197-300	151-300	151-300	39,744	300	— ¹³	39,744	78,344	
Montana	Combination	—	—	109-143	16,008	144-261	144-261	144-261	29,253	—	—	29,253	45,261	
Nebraska	Combination	162-213	145-213	109-213	55,515	—	—	—	4,613 ¹⁴	197	2,090	6,703	62,218	
Nevada	Combination	—	—	122-133	17,763	161-200	161-200	134-200	44,145	—	—	44,145	61,908	

APPENDIX A: ELIGIBILITY AND ENROLLMENT—Continued
Table A-1. CHIP Eligibility Levels (2016) and Enrollment (FY 2015) by State

State	Program type ¹ (as of July 1, 2016)	Children in Medicaid-Expansion CHIP ¹						Children in separate CHIP			Total CHIP-funded child enrollment ⁴		
		Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Separate CHIP: Age 0-18 ²			Separate CHIP: Unborn Eligibility ³	Total separate CHIP enrollment			
						Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment					
												Age 0-18 (% FPL)	Enrollment
Wisconsin	Combination	—	—	101-151	96,973	— ⁹	187-301 ⁹	152-301 ⁹	67,845	301	3,758	71,603	168,576
Wyoming ²¹	Combination	—	—	119-133	— ²²	155-200	155-200	134-200	— ²²	—	—	— ²²	5,649

Notes: FY is fiscal year. FPL is Federal poverty level. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but separate CHIP for the second half), the individual would only be counted in the most recent category. Enrollment data shown in the table are as of July 2016; the most current enrollment data available; States may subsequently revise their current or historical data.

—99Dash indicates that State does not use this eligibility pathway.

¹Under CHIP, States have the option to use an expansion of Medicaid, separate CHIP, or a combination of both approaches. Ten States (including the District of Columbia) are Medicaid expansions and two States are separate CHIP only (Connecticut and Washington). There are combination programs in 39 States; among those, 11 consider themselves to have separate programs but are technically combinations due to the transition of children below 133 percent FPL from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, Wyoming). Medicaid-expansion CHIP eligibility ranges of 5 percentage points attributable to the mandatory 5 percent disregard are not shown. For States that have different CHIP-funded eligibility levels for children age 6-13 and age 14-18, this table shows only the levels for children age 6-13. For example, Oklahoma offers CHIP-funded Medicaid coverage to children age 6-14 with family income 115-205 percent FPL, and to 14- to 18-year-olds with family income 65-205 percent FPL. Tennessee offers CHIP-funded Medicaid coverage to children age 6-14 with family income from 109-133 percent FPL, and 14-19 year olds with family income 29-133 percent FPL.

²CHIP eligibility levels as of July 2016.

³Separate CHIP eligibility for children birth through age 18 generally begins where Medicaid coverage ends (as shown in the previous columns). For unborn children, there is no lower bound for income eligibility if the mother is not eligible for Medicaid.

⁴Total exceeds the sum of Medicaid expansion and separate CHIP columns due to only total CHIP enrollment being reported for Wyoming.

⁵Arizona closed separate CHIP (KidsCare) to new enrollment in January 2010; the State reinstated the program on September 1, 2016.

⁶Although Arkansas transitioned its Medicaid-expansion CHIP to separate CHIP effective January 1, 2015, the State continued to report enrollment for children age 0-18 years under Medicaid-expansion CHIP.

⁷California has separate CHIP in three counties only that covers children up to 317 percent FPL.

⁸Due to reporting system updates, California CHIP enrollment totals are estimates as a result of the exclusion of certain unborn CHIP enrollees in reporting.

⁹Separate CHIP in Delaware, Florida, Iowa, and Wisconsin covers children age 1-18.

¹⁰Certain enrollees who should have been assigned to CHIP were assigned to Medicaid beginning in the second quarter of 2014, making FY 2015 totals artificially low.

¹¹CHIP-funded Medicaid Michigan enrollees are included in Medicaid enrollment counts rather than in CHIP for FY 2015. Therefore, the CHIP enrollment totals are artificially low and the Medicaid enrollment totals are artificially high. Michigan transitioned its separate CHIP into Medicaid-expansion CHIP effective January 1, 2016.

¹²In Minnesota, only infants (defined by the State as being under age two) are eligible for Medicaid-expansion CHIP up to 283 percent FPL.

¹³Missouri began covering unborn children effective January 1, 2016; however the State has not reported enrollment for this coverage group.

¹⁴Separate CHIP enrollment figures in Nebraska, New Mexico, and Rhode Island are for the States' § 2101(f) coverage group under the Patient Protection and Affordable Care Act. Section 2101(f) required that States provide separate CHIP coverage to children who lost Medicaid eligibility (including through Medicaid-expansion CHIP) due to the elimination of income disregards under the modified adjusted gross income (MAGI) based methodologies. Children covered under § 2101(f) remained eligible for such coverage until their next scheduled renewal or their 19th birthday, or until they moved out of State, requested removal from the program, or were deceased. Coverage under § 2101(f) has now been phased out.

¹⁵North Carolina does not provide unborn children separate CHIP coverage. Errors in enrollment data reported are likely due to data quality issues.

¹⁶Separate CHIP enrollment in Oklahoma is for children enrolled in the State's premium assistance program.

¹⁷Certain Oregon enrollees who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FY 2014 and FY 2015.

¹⁸lack of enrollment for separate CHIP unborn coverage in Rhode Island is likely due to data quality issues.

¹⁹While Tennessee covers children with CHIP-funded Medicaid, enrollment is currently capped, except for children who roll over from traditional Medicaid.

²⁰West Virginia's enrollment totals are artificially high because children who transitioned between CHIP and Medicaid are reported in both programs, rather than the program they were last enrolled.

²¹OHSS FY 2015 children's enrollment report considers these values to be estimates.

²² Due to inconsistencies between the Statistical Enrollment Data System data and the Centers for Medicare and Medicaid Services' FY 2015 children's enrollment report, we do not report enrollment for Medicaid expansion and separate CHIP. We only report total CHIP enrollment as provided in CMS's FY 2015 children's enrollment report.

Sources: Personal communication with CMS staff on December 2, 2016 and December 9, 2016. For numbers of children: MACPAC, 2016, analysis of CHIP Statistical Enrollment Data System from Centers for Medicare and Medicaid Service as of July 1, 2016; MACPAC, 2016, *MACSaves: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, <https://www.macpac.gov/publication/child-enrollment-in-chip-and-medicare-by-state/>; For eligibility levels: MACPAC, 2016, *MACSaves: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, <https://www.macpac.gov/publication/medicaid-and-chip-income-eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-children-and-pregnant-women-by-state/>.

APPENDIX B: CHIP ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES
Table B-1. CHIP Enhanced Federal Medical Assistance Percentages by State, FYs 2013–2017

State	E-FMAPs for CHIP		
	FY 2015 ¹	FY 2016 ²	FY 2017 ²
All States (median)	70.8%	93.8%	94.0%
Alabama	78.3	100.0	100.0
Alaska	65.0	88.0	88.0
Arizona	77.9	100.0	100.0
Arkansas	79.6	100.0	100.0
California	65.0	88.0	88.0
Colorado	65.7	88.5	88.0
Connecticut	65.0	88.0	88.0
Delaware	67.5	91.4	90.9
District of Columbia	79.0	100.0	100.0
Florida	71.8	95.5	95.8
Georgia	76.9	100.0	100.0
Hawaii	66.6	90.8	91.5
Idaho	80.2	100.0	100.0
Illinois	65.5	88.6	88.9
Indiana	76.6	99.6	99.7
Iowa	68.9	91.4	92.7
Kansas	69.6	92.2	92.4
Kentucky	79.0	100.0	100.0
Louisiana	73.4	96.6	96.6
Maine	73.3	96.9	98.1
Maryland	65.0	88.0	88.0
Massachusetts	65.0	88.0	88.0
Michigan	75.9	98.9	98.6
Minnesota	65.0	88.0	88.0
Mississippi	81.5	100.0	100.0
Missouri	74.4	97.3	97.3
Montana	76.1	98.7	98.9
Nebraska	67.3	88.8	89.3
Nevada	75.1	98.5	98.3
New Hampshire	65.0	88.0	88.0

APPENDIX B: CHIP ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES—Continued
Table B–1. CHIP Enhanced Federal Medical Assistance Percentages by State, FYs 2013–2017

State	E–FMAs for CHIP		
	FY 2015 ¹	FY 2016 ²	FY 2017 ²
New Jersey	65.0	88.0	88.0
New Mexico	78.8	100.0	100.0
New York	65.0	88.0	88.0
North Carolina	76.1	99.4	99.8
North Dakota	65.0	88.0	88.0
Ohio	73.9	96.7	96.6
Oklahoma	73.6	95.7	95.0
Oregon	74.8	98.1	98.1
Pennsylvania	66.3	89.4	89.3
Rhode Island	65.0	88.3	88.7
South Carolina	79.5	100.0	100.0
South Dakota	66.2	89.1	91.5
Tennessee	75.5	98.5	98.5
Texas	70.6	93.0	92.3
Utah	79.4	100.0	100.0
Vermont	67.8	90.7	91.1
Virginia	65.0	88.0	88.0
Washington	65.0	88.0	88.0
West Virginia	80.0	100.0	100.0
Wisconsin	70.8	93.8	94.0
Wyoming	65.0	88.0	88.0

Notes: FY is fiscal year. FMAP is Federal medical assistance percentage. E–FMAP is enhanced FMAP. ACA is the Patient Protection and Affordable Care Act (ACA, Pub. L. 111–148, as amended). The E–FMAP determines the Federal share of both service and administrative costs for CHIP, subject to the availability of funds from a State’s Federal allotments for CHIP.

Enhanced FMAs for CHIP are calculated by reducing the State share under regular FMAs for Medicaid by 30 percent. In FYs 2016 through 2019, the E–FMAs are increased by 23 percentage points. For additional information on Medicaid FMAs, see <https://www.macpac.gov/subtopic/matching-rates/>.

E–FMAs for the territories are not included. In FY 2015, all territories had an E–FMAP of 68.5 percent, and in FY 2016 and 2017, 91.5 percent.

¹In FY 2015, States received the traditional CHIP E–FMAP.

²Under the ACA, beginning on October 1, 2015, and ending on September 30, 2019, the enhanced FMAs are increased by 23 percentage points, not to exceed 100 percent, for all States.

Sources: Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, ASPE FMAP reports for 2015, 2016, and 2017, <https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages> (for FY 2017), <http://aspe.hhs.gov/health/reports/2015/FMAP2016/fmap16.cfm> (for FY 2016), <http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.pdf> (for FY 2015).

Issue Brief

July 2017

Advising Congress on Medicaid and CHIP Policy

FEDERAL CHIP FUNDING: WHEN WILL STATES EXHAUST ALLOTMENTS?

Under current law, Federal funds for the State Children's Health Insurance Program (CHIP) are only provided through fiscal year (FY) 2017. Unless CHIP funding is extended, all States are expected to exhaust their Federal CHIP funds during FY 2018; this includes unspent CHIP funding from prior years. Three States and the District of Columbia are projected to exhaust their funds by December 2017. Most States (31 States and the District of Columbia) are projected to exhaust Federal CHIP funds by March 2018. These estimates are based on States' projections of their CHIP spending for FYs 2017 and 2018.¹ How quickly States deplete CHIP funds could change if actual CHIP spending is above or below projections.

This issue brief updates data on the exhaustion of CHIP funds presented in a March 2017 issue brief and with MACPAC's January 2017 *Recommendations for the Future of CHIP and Children's Coverage*. With the end of FY 2017 approaching, congressional action to renew CHIP funding is urgent to ensure the stability of children's coverage during a time in which health insurance markets are expected to face substantial changes, and to provide budgetary certainty for States. If CHIP funding is not renewed, States will need to make decisions including whether to end separate CHIP, how to finance Medicaid-expansion CHIP with reduced Federal spending, and how to provide information to families, providers, and plans (Hensley-Quinn and King 2016).

FEDERAL CHIP FUNDING AND ITS EXHAUSTION UNDER CURRENT LAW

Federal CHIP funds are allotted to States annually based on each State's recent CHIP spending, increased by a growth factor. States have 2 years to spend their allotments, and unspent allotments are available for redistribution to other States experiencing CHIP funding shortfalls. Under current law, new CHIP allotments are not available after FY 2017 and unspent FY 2017 CHIP allotments that remain available for expenditures in FY 2018 are reduced by one-third (§2104(m)(2)(B)(iv) of the Social Security Act (the Act)).

States experiencing CHIP funding shortfalls can also receive contingency fund payments if their CHIP enrollment exceeds target levels specified in section 2105(n) of the Act. However, contingency fund payments are not available for FY 2018 and subsequent years.

CHIP funding in FY 2017

The Federal CHIP funding that States have received for FY 2017 and the redistribution funding that is available from prior year allotments is projected to be adequate to cover projected spending in FY 2017. Two States (Arizona and Minnesota) are projected to have CHIP spending that exceeds their FY 2017 allotment, but these States are expected to receive redistribution funds in FY 2017 sufficient to cover their projected CHIP funding shortfall. Approximately \$3 billion in redistribution funding is available in FY 2017 (CMS 2017).

CHIP funding in FY 2018

Under current law, in FY 2018, States may continue to spend unspent FY 2017 allotments and redistribution funds from prior years. These funds will cover some but not all expected State CHIP expenses in FY 2018. By the second quarter of FY 2018, more than half of States are projected to exhaust all available Federal CHIP funding, including redistribution funds (Table 1).

¹States report their anticipated expenditures for both Medicaid and CHIP to the Centers for Medicare and Medicaid Services on a quarterly basis. The data used for this issue brief reflect quarterly projections provided by States in May 2017. MACPAC previously issued this data in March 2017 using States' budget projections submitted in February 2017.

Table 1. Projected Exhaustion of Federal CHIP Funds in Fiscal Year 2018

Quarter of fiscal year	Number of States	States
First quarter (October–December 2017)	4	Arizona, District of Columbia, Minnesota, and North Carolina
Second quarter (January–March 2018)	27	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nevada, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, and Washington
Third quarter (April–June 2018)	19	Alabama, Georgia, Illinois, Indiana, Iowa, Maine, Michigan, Maryland, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, West Virginia, and Wisconsin
Fourth quarter (July–September 2018)	1	Wyoming

Note: CHIP is the State Children's Health Insurance Program.

Source: MACPAC 2017 analysis using June 2017 Medicaid and CHIP Budget and Expenditure System data from the Centers for Medicare and Medicaid Services, including quarterly projections provided by States in May 2017.

An estimated \$4.2 billion in unspent FY 2017 allotments will be available for spending in FY 2018. Total projected FY 2018 Federal CHIP spending for States and territories is \$17.4 billion. States will exhaust their Federal CHIP funds at different points during FY 2018 depending on their rollover balances from prior year allotments and projected spending (Table 2).

Table 2. Projected Federal CHIP Funding and Spending in FY 2018, by State (millions)

State	Estimated unspent FY 2017 allotments A	Unspent FY 2017 allotments available in FY 2018 B = A × .67	FY 2018 projected redistribution funding from prior year allotments C	Total FY 2018 projected CHIP funding D = B + C	FY 2018 projected Federal CHIP spending E	Month projected to exhaust CHIP funding F
Total	\$6,346.2	\$4,230.8	\$2,949.4	\$7,180.2	\$17,372.4	N/A
Alabama	176.9	118.0	37.4	155.3	284.4	April 2018
Alaska	17.8	11.8	5.4	17.2	35.7	March 2018
Arizona	0.0	0.0	60.1	60.1	267.9	December 2017
Arkansas	96.3	64.2	28.7	92.9	191.9	March 2018
California	192.2	128.1	710.0	838.1	3,291.4	January 2018
Colorado	87.5	58.3	55.1	113.4	303.7	February 2018
Connecticut	24.3	16.2	14.3	30.5	79.9	February 2018
Delaware	10.6	7.1	6.3	13.4	35.2	February 2018
District of Columbia	1.6	1.1	10.9	11.9	49.4	December 2017
Florida	135.7	90.5	204.6	295.1	1,002.2	January 2018
Georgia	220.6	147.1	56.6	203.6	399.1	April 2018
Hawaii	17.4	11.6	8.2	19.8	48.1	February 2018

Table 2. Projected Federal CHIP Funding and Spending in FY 2018, by State (millions)—
Continued

State	Estimated unspent FY 2017 allotments A	Unspent FY 2017 allotments available in FY 2018 B = A × .67	FY 2018 projected redistribution funding from prior year allotments C	Total FY 2018 projected CHIP funding D = B + C	FY 2018 projected Federal CHIP spending E	Month projected to exhaust CHIP funding F
Idaho	22.2	14.8	15.4	30.2	83.4	February 2018
Illinois	349.1	232.7	36.6	269.3	395.7	June 2018
Indiana	144.8	96.5	19.9	116.4	185.2	May 2018
Iowa	75.8	50.6	19.4	70.0	137.2	April 2018
Kansas	47.7	31.8	15.9	47.7	102.8	March 2018
Kentucky	87.7	58.4	40.7	99.2	240.0	February 2018
Louisiana	134.1	89.4	58.5	147.9	350.0	March 2018
Maine	29.3	19.5	3.3	22.8	34.1	June 2018
Maryland	187.6	125.1	35.0	160.1	281.0	April 2018
Massachusetts	168.4	112.3	117.0	229.3	633.7	February 2018
Michigan	264.8	176.5	31.3	207.9	316.2	May 2018
Minnesota	0.0	0.0	38.8	38.8	172.9	December 2017
Mississippi	147.7	98.5	41.3	139.8	282.5	March 2018
Missouri	118.6	79.1	32.8	111.8	225.0	March 2018
Montana	31.8	21.2	18.4	39.6	103.2	February 2018
Nebraska	61.1	40.7	6.8	47.5	70.9	June 2018
Nevada	16.5	11.0	15.2	26.2	78.6	January 2018
New Hampshire	19.9	13.3	4.5	17.8	33.4	April 2018
New Jersey	337.1	224.7	59.7	284.4	490.7	April 2018
New Mexico	95.7	63.8	10.8	74.6	112.0	May 2018
New York	527.3	351.6	197.1	548.6	1,229.8	March 2018
North Carolina	12.2	8.2	182.9	191.1	823.2	December 2017
North Dakota	16.6	11.1	2.3	13.3	21.2	May 2018
Ohio	200.1	133.4	70.1	203.5	445.6	March 2018
Oklahoma	127.5	85.0	30.4	115.4	220.6	April 2018
Oregon	48.6	32.4	52.5	84.9	266.3	January 2018
Pennsylvania	193.6	129.1	114.1	243.2	637.6	February 2018
Rhode Island	11.1	7.4	15.4	22.8	76.1	January 2018
South Carolina	127.5	85.0	15.5	100.5	154.2	May 2018

Table 2. Projected Federal CHIP Funding and Spending in FY 2018, by State (millions)—
Continued

State	Estimated unspent FY 2017 allotments A	Unspent FY 2017 allotments available in FY 2018 B = A × .67	FY 2018 projected redistribution funding from prior year allotments C	Total FY 2018 projected CHIP funding D = B + C	FY 2018 projected Federal CHIP spending E	Month projected to exhaust CHIP funding F
South Dakota	16.2	10.8	4.5	15.3	30.9	March 2018
Tennessee	202.2	134.8	30.1	164.9	268.8	May 2018
Texas	1,074.5	716.4	204.6	921.0	1,628.0	April 2018
Utah	30.0	20.0	28.2	48.2	145.6	January 2018
Vermont	5.6	3.7	5.5	9.2	28.1	January 2018
Virginia	127.5	85.0	51.0	136.0	312.3	March 2018
Washington	42.1	28.0	49.0	77.1	246.6	January 2018
West Virginia	43.8	29.2	8.9	38.0	68.6	April 2018
Wisconsin	127.3	84.9	31.8	116.7	226.7	April 2018
Wyoming	12.2	8.1	0.8	8.9	11.5	July 2018

Notes: FY is fiscal year. CHIP is the State Children's Health Insurance Program. Total dollars include territories. Under current law, available unspent FY 2017 CHIP allotments are reduced by one-third in FY 2018. Projected redistribution funding is distributed proportionally among States based on their projected CHIP funding shortfalls for FY 2018 and the amount of unspent CHIP funding available from prior years.

Source: MACPAC 2017 analysis as of June 2017 of Medicaid and CHIP Budget Expenditure System data from the Centers for Medicare and Medicaid Services, including quarterly projections provided by States in May 2017.

IMPLICATIONS

The exhaustion of CHIP funding in FY 2018 will affect State budgets and will require States to make decisions about children's coverage depending on the type of CHIP program States had in place in March 2010.² Under the maintenance of effort requirement in the Patient Protection and Affordable Care Act (Pub. L. 111–148, as amended), States must maintain 2010 Medicaid and CHIP eligibility levels for children through FY 2019.

States with separate CHIP are permitted to terminate that coverage if Federal CHIP funding runs out; States with Medicaid-expansion CHIP must continue that coverage for children at the lower Federal Medicaid matching rate. As of January 2016, 10 States (including the District of Columbia) ran CHIP as a Medicaid expansion, 2 States had separate CHIP, and 39 States operated a combination of both approaches (Table 3, MACPAC 2017).

SEPARATE CHIP

Of the 8.4 million children enrolled in CHIP-funded coverage during FY 2015, 43.9 percent (3.7 million) were enrolled in separate CHIP. Once Federal CHIP funding is exhausted, States are not obligated to continue covering these children. In the absence of separate CHIP coverage, some of these children would be eligible for employer-sponsored insurance or subsidized exchange coverage. MACPAC's prior estimates indicated that 1.1 million children would become uninsured (MACPAC 2015).³ States that elect to shut down CHIP in the absence of Federal funding will bear little direct cost for children they formerly covered whether they move to employer-sponsored or subsidized exchange coverage, or become uninsured.

² States have the flexibility to structure CHIP as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches.

³ If CHIP funding were exhausted, unborn children enrolled through separate CHIP in 15 States could not be moved into Medicaid under current law and regulations.

MEDICAID-EXPANSION CHIP

In FY 2015, 4.7 million children were enrolled in Medicaid-expansion CHIP. If CHIP funding is exhausted, the Federal matching rate for these children falls back from the CHIP enhanced match to the regular Medicaid matching rate.⁴ Although States are generally prohibited from reducing eligibility levels in Medicaid-expansion CHIP through at least FY 2019, the budget consequences resulting from the higher State share of spending for those children could lead States to take other steps affecting access, such as lowering provider payment rates or increasing requirements for prior authorization.

Table 3. State CHIP Program Type and Enrollment

State	Program type ¹	CHIP-funded enrollment (FY 2015)					Month and year of projected CHIP funding exhaustion (as of June 2017)
		Medicaid-expansion CHIP	Separate CHIP			Total ²	
			Birth-18	Unborn	Total		
Total		4,702,185	3,362,642	327,175	3,689,817	8,397,651	
Alabama	Combination	45,697	87,346	–	87,346	133,043	April 2018
Alaska	Medicaid Expansion	10,182	–	–	–	10,182	March 2018
Arizona ³	Combination	37,412	1,399	–	1,399	38,811	December 2017
Arkansas	Combination	108,706	– ⁴	3,365	3,365	112,071	March 2018
California ^{5,6}	Combination	1,787,470	2,461	122,197	124,658	1,912,128	January 2018
Colorado	Combination	23,687	62,446	–	62,446	86,133	February 2018
Connecticut	Separate	–	24,884	–	24,884	24,884	January 2018
Delaware	Combination	238	16,141	–	16,141	16,379	February 2018
District of Columbia	Medicaid Expansion	10,676	–	–	–	10,676	December 2017
Florida	Combination	134,708	293,386	–	293,386	428,094	January 2018
Georgia	Combination	53,906	176,909	–	176,909	230,815	April 2018
Hawaii	Medicaid Expansion	27,239	–	–	–	27,239	March 2018
Idaho	Combination	8,937	25,576	–	25,576	34,513	February 2018
Illinois	Combination	113,105	191,328	26,138	217,466	330,571	May 2018
Indiana	Combination	69,462	31,098	–	31,098	100,560	May 2018
Iowa	Combination	21,777	60,880	–	60,880	82,657	April 2018
Kansas	Combination	54	77,085	–	77,085	77,139	March 2018
Kentucky	Combination	50,926	36,050	–	36,050	86,976	February 2018
Louisiana	Combination	122,878	3,498	9,238	12,736	135,614	March 2018
Maine	Combination	13,440	8,870	–	8,870	22,310	June 2018

⁴In FY 2017, the median CHIP matching rate is 94.0 percent and the median Medicaid matching rate is 58.5 percent (MACPAC 2016).

Table 3. State CHIP Program Type and Enrollment—Continued

State	Program type ¹	CHIP-funded enrollment (FY 2015)					Month and year of projected CHIP funding exhaustion (as of June 2017)
		Medicaid-expansion CHIP	Separate CHIP			Total ²	
			Birth-18	Unborn	Total		
Maryland	Medicaid Expansion	142,327	—	—	—	142,327	April 2018
Massachusetts ⁷	Combination	79,299	76,519	13,123	89,642	168,941	February 2018
Michigan ⁸	Combination	29,226	85,302	5,171	90,473	119,699	June 2018
Minnesota	Combination	474	—	3,361	3,361	3,835	December 2017
Mississippi	Combination	30,819	56,286	—	56,286	87,105	March 2018
Missouri	Combination	38,600	39,744	— ⁹	39,744	78,344	March 2018
Montana	Combination	16,008	29,253	—	29,253	45,261	February 2018
Nebraska	Combination	55,515	4,613 ¹⁰	2,090	6,703	62,218	May 2018
Nevada	Combination	17,763	44,145	—	44,145	61,908	January 2018
New Hampshire	Medicaid Expansion	16,651	—	—	—	16,651	April 2018
New Jersey	Combination	100,826	114,365	—	114,365	215,191	April 2018
New Mexico	Medicaid Expansion	17,155	40 ¹⁰	—	40	17,195	May 2018
New York	Combination	235,945	394,787	—	394,787	630,732	March 2018
North Carolina	Combination	134,413	100,237	4 ¹¹	100,241	234,654	December 2017
North Dakota	Combination	—	4,955	—	4,955	4,955	May 2018
Ohio	Medicaid Expansion	181,100	—	—	—	181,100	March 2018
Oklahoma	Combination	174,167	208 ¹²	16,483	16,691	190,858	April 2018
Oregon ¹³	Combination	—	115,726	6,143	121,869	121,869	February 2018
Pennsylvania	Combination	64,638	229,704	—	229,704	294,342	February 2018
Rhode Island	Combination	29,948	1,376 ¹⁰	— ¹⁴	1,376	31,324	February 2018
South Carolina	Medicaid Expansion	98,336	—	—	—	98,336	June 2018
South Dakota	Combination	12,441	3,775	—	3,775	16,216	March 2018
Tennessee ¹⁵	Combination	17,971	78,731	9,513	88,244	106,215	May 2018
Texas	Combination	336,769	614,417	98,437	712,854	1,049,623	April 2018
Utah	Combination	27,762	27,523	—	27,523	55,285	January 2018
Vermont	Medicaid Expansion	4,766	—	—	—	4,766	January 2018
Virginia	Combination	86,551	102,815	—	102,815	189,366	February 2018
Washington	Separate	—	37,883	8,154	46,037	46,037	January 2018

Table 3. State CHIP Program Type and Enrollment—Continued

State	Program type ¹	CHIP-funded enrollment (FY 2015)				Total ²	Month and year of projected CHIP funding exhaustion (as of June 2017)
		Medicaid-expansion CHIP	Separate CHIP				
			Birth–18	Unborn	Total		
West Virginia ¹⁶	Combination	15,242	33,036	–	33,036	48,278	April 2018
Wisconsin	Combination	96,973	67,845	3,758	71,603	168,576	April 2018
Wyoming ¹⁷	Combination	¹⁸	18	–	18	5,649	July 2018

Notes: FPL is Federal poverty level. FY is fiscal year. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but a separate CHIP program for the second half) the individual would only be counted in the most recent category. Enrollment data shown in the table are as of July 2016, the most current enrollment data available; States may subsequently revise their current or historical data.

– Dash indicates zero. State does not use eligibility pathway.

¹ Under CHIP, States have the option to use an expansion of Medicaid, separate CHIP, or a combination of both approaches. Eleven States consider their programs to be separate but technically have combination programs due to the transition of children below 133 percent FPL from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, and Wyoming).

² Total exceeds the sum of Medicaid expansion and separate CHIP columns due to Wyoming reporting total CHIP enrollment only.

³ Arizona closed its separate CHIP (KidsCare) to new enrollment in January 2010. The State reinstated the program on September 1, 2016.

⁴ Although Arkansas transitioned its Medicaid-expansion CHIP to separate CHIP effective January 1, 2015, the State continued to report enrollment for children age 0–18 years under Medicaid-expansion CHIP.

⁵ California has separate CHIP in three counties only that covers children up to 317 percent FPL.

⁶ Due to reporting system updates, California CHIP enrollment totals are estimates as a result of the exclusion of certain unborn CHIP enrollees in reporting.

⁷ Certain enrollees who should have been assigned to CHIP were assigned to Medicaid beginning in the second quarter of 2014, making FY 2015 totals artificially low.

⁸ In Michigan, CHIP-funded Medicaid enrollees are included in Medicaid enrollment counts, rather than in CHIP for FY 2015. Therefore, the CHIP enrollment totals are artificially low. Michigan transitioned from separate CHIP to Medicaid-expansion CHIP effective January 1, 2016.

⁹ Missouri began covering unborn children effective January 1, 2016. However, the State has not reported enrollment for this coverage group.

¹⁰ Separate CHIP enrollment in Nebraska, New Mexico, and Rhode Island are for the States' section 2101(f) coverage group under the Patient Protection and Affordable Care Act. Section 2101(f) required that States provide separate CHIP coverage to children to who lost Medicaid eligibility (including through Medicaid-expansion CHIP) due to the elimination of income disregards under the modified adjusted gross income-based methodologies. Children covered under section 2101(f) remained eligible for such coverage until their next scheduled renewal, their 19th birthday, they moved out of State, they requested removal from the program, or were deceased. Coverage under section 2101(f) has now been phased out.

¹¹ North Carolina does not provide unborn children with separate CHIP coverage. Errors in enrollment data reported are likely due to data quality issues.

¹² Separate CHIP enrollment in Oklahoma is for children enrolled in the State's premium assistance program.

¹³ Certain Oregon enrollees who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FYs 2014 and 2015.

¹⁴ Lack of enrollment for separate CHIP unborn children coverage in Rhode Island is likely due to data quality issues.

¹⁵ While Tennessee covers children with CHIP-funded Medicaid, enrollment is currently capped, except for children who roll over from traditional Medicaid.

¹⁶ West Virginia's enrollment totals are artificially high because children who transitioned between CHIP and Medicaid are reported in both programs, rather than the program they were last enrolled.

¹⁷ The Centers for Medicare and Medicaid Services (CMS) FY 2015 children's enrollment report considers these values to be estimates.

¹⁸ Due to inconsistencies between the Statistical Enrollment Data System (SEDS) data and CMS's FY 2015 children's enrollment report, we do not report enrollment for Medicaid expansion and separate CHIP. We only report total CHIP enrollment as provided in CMS's FY 2015 children's enrollment report.

Sources: For numbers of children: MACPAC analysis of CMS SEDS data from as of July 1, 2016; *MACStats: Medicaid and CHIP Data Book, December 2016*; personal communication with CMS staff on December 2, 2016; and December 9, 2016. For projected exhaustion of CHIP funds: MACPAC 2017 analysis using March June 2017 Medicaid and CHIP Budget and Expenditure System data from CMS, including quarterly projections provided by States in February–May 2017.

References

Financial Management Group, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Email to MACPAC staff, March 22.

Hensley-Quinn, M. and A. King. 2016. *Looking ahead: A timeline of State policy and operational considerations if Federal CHIP funding ends for States*. Portland, ME: National Academy for State Health Policy. <http://www.nashp.org/looking-ahead/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Recommendations for the future of CHIP and children's coverage*. January 2017. Washington, DC: MACPAC. <https://www.macpac.gov/publication/recommendations-for-the-future-of-chip-and-childrens-coverage/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Exhibit 6. "Federal medical assistance percentages (FMAPs) and enhanced FMAPs (E-FMAPs) by State, FYs 2013–2017." In *MACStats: Medicaid and CHIP Data Book*. December 2016. Washington, DC: MACPAC. <https://www.macpac.gov/publication/federal-medical-assistance-percentages-fmaps-and-enhanced-fmaps-e-fmaps-by-state-selected-periods/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. *Report to Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-314/>.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

During this busy month, it would be easy for casual watchers of political news to get lost in a jumble of Washington lingo and acronyms. The continuing resolution, the debt ceiling, CSR payments, the NDAA, and the Children's Health Insurance Program, or CHIP, whose funding authorization runs out in a matter of weeks.

It is vital that the Congress springs into action in the days ahead to reauthorize CHIP's funding. This program is a lifeline for nearly 9 million children. It's a source of profound relief for parents in Oregon and across the country, like the single mom who works multiple jobs, pays the bills, and handles life's many challenges on her own. The last thing she needs is a government letter stamped "NOTICE OF TERMINATION" explaining that her sick kids are on their own because CHIP's funding has run out.

She's already juggling a lot—she's not reading page A17 of the morning newspaper each day and decoding that Washington lingo to determine if and when Congress will act. She's sitting in her kitchen, that scary termination letter is all she has to go by, and she wants to know how she'll figure a way out of this mess.

That's the prospect families across the country are facing in a matter of weeks if Congress doesn't act. Kids who desperately need care might not get it. States will be required to start planning for the worst. That means enrollment freezes, belt-tightening and emergency steps to try to preserve care for the kids currently in the program. But a vulnerable child not yet enrolled in CHIP might have to wait until Congress gets its act together. At best that will leave families with a mountain of stress, anxiety, and heartache. At worst, it's a life and death proposition for some of the most vulnerable kids out there.

So today the Finance Committee will discuss the leading health-care issue Congress needs to address this fall. Congress created CHIP with one goal in mind: to make sure no American child falls through the cracks of a health-care system with far too many. In the coming weeks, the Finance Committee has an opportunity to lead the way by creating a strong, bipartisan agreement that upholds CHIP's promise to families and gives them security for years to come.

Personally, I'm optimistic about this committee's chances because of the leadership of our chairman. Chairman Hatch had a foundational role in the creation of CHIP, working in a bipartisan way with his late, great friend, Senator Ted Kennedy.

In the decades since they led the Congress to create CHIP, the percentage of kids in America living without health coverage has fallen from nearly 14 percent to less than 5 percent. Chairman Hatch and Senator Kennedy offered proof that leaders with fierce disagreements can find common ground when it comes to big health-care challenges. This month the Finance Committee will have an opportunity to show that's still possible 20 years later.

It's important for Congress to take action soon. There's no kicking this can down the road with a short-term bill. And this cannot wait until December. Because States run their programs differently, some will run out of funding earlier than others. And in that time, no family should face the panic of being unable to get the care their sick child needs.

As I wrap up, one point on how important it is to have CHIP and Medicaid working side-by-side. For American kids and families—particularly those families working hard every day to climb into the middle class—CHIP adds a level of security to their health care above and beyond Medicaid. CHIP can only work if Medicaid works.

So let's do the hard work now, colleagues, and uphold this body's promise to America's kids and their families. Today this committee is going to hear from a witness panel that knows CHIP from A to Z—a mother whose child counts on this program, an official who ensures CHIP runs smoothly in her State, and an independent expert who knows this program inside and out.

I hope that this hearing will be an opportunity for Senators on both sides to learn about and discuss this critical health-care program and to set the stage for the work to come. I'm confident that in short order Congress can pass a strong and bipartisan extension of CHIP that will last for many years—and that the Finance Committee can lead the way to get the job done.

COMMUNICATIONS

AASA ET AL.

September 5, 2017

Re: Extension of Children's Health Insurance Program

The Honorable Greg Walden Chairman House Energy and Commerce Committee U.S. House of Representatives Washington, DC 20515	The Honorable Frank Pallone Ranking Member House Energy and Commerce Committee U.S. House of Representatives Washington, DC 20515
The Honorable Orrin G. Hatch Chairman Senate Finance Committee U.S. Senate Washington, DC 20510	The Honorable Ron Wyden Ranking Member Senate Finance Committee U.S. Senate Washington, DC 20510

Dear Chairmen Hatch and Walden and Ranking Members Wyden and Pallone:

The undersigned 39 national organizations of the Save Medicaid in the Schools Coalition urge you to support a full, clean extension of funding for the Children's Health Insurance Program (CHIP) for 5 years at current funding levels. CHIP has benefited from strong bipartisan support since its creation in 1997. By providing medical assistance to children who are not eligible for Medicaid, CHIP provides essential funding to support states to cover uninsured children. Any delay or a failure to immediately extend funding for CHIP will jeopardize coverage for children who are eligible for school-based health-related services leading to immediate and lasting harmful effects for America's most vulnerable citizens. A lapse in coverage for children places more barriers on their ability to come to school ready to learn. During a time of great uncertainty in the health-care system, children need the consistent, reliable health coverage CHIP provides today.

A school's primary responsibility is to provide students with a high-quality education. However, children cannot learn to their fullest potential with unmet health needs. As such, school district personnel regularly provide critical health services to ensure that all children are ready to learn and able to thrive alongside their peers. Schools deliver health services effectively and efficiently since school is where children spend most of their days. The access to health care services that is supported through CHIP improves health care and educational outcomes for students. Providing health and wellness services for students ultimately enables more children to become employable and pursue higher education.

More than half of the nearly 9 million children served by CHIP are eligible to receive services in school through their state Medicaid programs. Fifteen states exclusively use CHIP funds to extend their Medicaid programs, meaning all children who qualify for CHIP receive identical services and benefits as their traditional Medicaid counterparts. In most states a substantial portion of children served by CHIP receive Medicaid services and benefits protections. If Congress does not act quickly to extend funding for these children's health care then school districts will lose funding for the critical health services these children receive that ensure they are healthy enough to learn. School districts depend on CHIP to finance many of these services and have already committed to the staff and contractors they require to provide mandated services for their upcoming 2017–2018 school year.

Without a CHIP extension, every child educated in school districts across the country will feel the pain. No school district's financial obligations and mandate to ad-

dress a child's health needs goes away simply because CHIP funds disappear. Children with unmet health needs miss more days of school and can fall behind. The failure to continue funding CHIP would merely shift the financial burden of providing services to the schools and the state and local taxpayers who fund them.

School districts use their Medicaid and CHIP reimbursement funds in a variety of ways to help support the learning and development of the children they serve. In a 2017 survey of school districts, district officials reported that two-thirds of Medicaid dollars are used to support the work of health professionals and other specialized instructional support personnel (*e.g.*, speech-language pathologists, audiologists, occupational therapists, school psychologists, school social workers, and school nurses) who provide comprehensive health and mental health services to students. Districts also use these funds to expand the availability of a wide range of health and mental-health services available to students in poverty, who are more likely to lack consistent access to health-care professionals. Further, some districts depend on Medicaid reimbursements to purchase and update specialized equipment (*e.g.*, walkers, wheelchairs, exercise equipment, special playground equipment, and equipment to assist with hearing and seeing) as well as assistive technology for students with disabilities to help them learn alongside their peers.

The loss of CHIP funds would also hinder many children's ability to access basic health screenings for vision, hearing, and mental-health challenges and access to early identification and treatment. Left unaddressed, these challenges or delays undermine children's ability to learn and make any problems more difficult and expensive to treat later. Loss of CHIP funding would also jeopardize schools' ability to conduct routine screenings on-site and help to enroll eligible students in Medicaid or other public coverage programs or connect them with needed community-based services.

Congress must act expediently to extend CHIP, so states and districts have the budget certainty necessary to continue to run CHIP programs and seek necessary reimbursements. We urge you to carefully consider the important benefits that CHIP provides to our nation's children. Schools are often the hub of the community, and failing to extend funding for CHIP could lead to meaningful reductions to comprehensive health and mental and behavioral health care for children.

If you have questions about the letter or wish to meet to discuss this issue further, please do not hesitate to reach out to the coalition co-chair Sasha Pudelski (spudelski@aasa.org).

Sincerely,

AASA, The School Superintendents Association
 Accelify
 AESA, Association of Education Service Agencies
 American Dance Therapy Association
 American Federation of School Administrators (AFSA)
 American Federation of Teachers
 American Psychological Association
 Association of School Business Officials International (ASBO)
 Association of University Centers on Disabilities (AUCD)
 Coalition for Community Schools
 Community Catalyst
 Council for Exceptional Children
 Council of Administrators of Special Education
 Council of Parent Attorneys and Advocates
 Division for Early Childhood of the Council for Exceptional Children (DEC)
 Family Voices
 First Focus
 Healthy Schools Campaign
 IDEA Infant Toddlers Coordinators Association (ITCA)
 Judge David L. Bazelon Center for Mental Health Law
 Learning Disabilities Association of America
 National Alliance for Medicaid in Education
 National Association of Elementary School Principals
 National Association of Pediatric Nurse Practitioners
 National Association of Secondary School Principals
 National Association of School Nurses
 National Association of School Psychologists
 National Association of Social Workers
 National Association of State Directors of Special Education (NASDSE)

National Black Justice Coalition
 National Disability Rights Network
 National Education Association
 National Health Law Program
 National Rural Education Association
 School Social Work Association of America
 The Arc of the United States
 The National Alliance on Mental Illness (NAMI)
 Union for Reform Judaism
 United Way Worldwide

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)

AAFP Headquarters
 11400 Tomahawk Creek Pkwy.
 Leawood, KS 66211-2680
 800-274-2237 • 913-906-6000
 fp@aafp.org

AAFP Washington Office
 1133 Connecticut Avenue, NW, Suite 1100
 Washington, DC 20036-1011
 202-232-9033 • Fax: 202-232-9044
 capitol@aafp.org

On behalf of the American Academy of Family Physicians (AAFP), which represents over 129,000 family physicians and medical students across the country, thank you for the opportunity to submit testimony for the record to the Committee on Finance regarding the continuation of the Children's Health Insurance Program (CHIP).

Congress Should Swiftly Approve a Long-Term Extension of CHIP Funding

The AAFP urges the Committee to swiftly approve a bipartisan long-term extension of CHIP, in order to promote stability and health security for 8.9 million low-income children¹ and their families. Time is of the essence in completing this work in order to ensure continuous access to primary and preventive services for this vulnerable population, protect progress in public health, and allow States to adequately plan.

The AAFP has supported CHIP since its inception in 1997, and during each subsequent reauthorization and extension of funding (2007, 2009, and 2015), as a way to extend health coverage to uninsured children whose families do not meet eligibility requirements for Medicaid. Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), in April 2015, the AAFP has reiterated support for CHIP funding beyond the current end-date of September 30, 2017—through letters to this Committee and to Congressional Leadership. As a medical specialty, family medicine is committed to the success of all of health insurance programs financed with public dollars, including CHIP. AAFP member data indicates that over two-thirds of AAFP members accept new Medicaid patients.² Although the AAFP does not collect member survey data on CHIP participation, we know (due to the close connection between Medicaid and CHIP—including the fact that some states operate combined Medicaid/CHIP programs—and the fact that family physicians perform so many pediatric services) that family physicians are helping to carry out Congress's intent behind CHIP: treating low-income children, many of whom would be uninsured without the program.

Family physicians play an important role in addressing American children's health needs. According to the AAFP's latest member census, published December 31, 2016, over 80 percent of AAFP members care for adolescents, and 73 percent care for infants and children.³ Other AAFP member survey data reflect that about 20 percent of AAFP's members deliver babies as part of their practice, with roughly 6 percent delivering more than 30 babies in a recent calendar year.⁴ Of AAFP active members with full hospital privileges, 70 percent provide newborn care in the hospital, and 64 percent provide pediatric care in the hospital.⁵ This is consistent with

¹ Centers for Medicare and Medicaid Services, 2016 Enrollment Report, available at <https://www.medicare.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>.

² AAFP, 2015 Practice Profile Survey (excerpt), available at <http://www.aafp.org/about/the-aafp/family-medicine-facts/table-12.html>.

³ AAFP Member Census (Dec. 31, 2016), available at <http://www.aafp.org/about/the-aafp/family-medicine-facts/table-13.html>.

⁴ AAFP, 2015 Practice Profile Survey (July 15, 2016).

⁵ *Id.*

family medicine's traditional role of practicing in the entire scope of the physician license, in order to meet the needs of the community in which the family physician practices. A family physician who serves a small rural community without a pediatrician, for example, will often perform most or all pediatric care for that community.

The AAFP also supports health care for all, consistent with the public-health mission of the specialty of family medicine. The AAFP promotes universal access to care in the form of "a primary care benefit design featuring the patient-centered medical home, and a payment system to support it," for everyone in the United States.⁶ AAFP believes that all Americans should have access to primary-care services (*e.g.*, in the case of infants and children, immunizations and other evidence-based preventive services, prenatal care, and well-child care), without patient cost sharing. The AAFP believes that universal health care also should include services outside the medical home (*e.g.*, hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting universal access to care is also consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care in the United States. Research supports the AAFP's view that having both health insurance and a usual source of care (*e.g.*, through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.⁷

The AAFP urges Congress to pass a "clean" extension of CHIP with a minimum of unnecessary policy changes. Accordingly, Congress should extend the current enhanced federal medical assistance percentage (FMAP), as well as the current maintenance of effort (MOE) provisions, which are both in effect through September 30, 2019, to align with an extension of CHIP funding. For example, if Congress extends CHIP funding for 5 years, then it should extend the enhanced FMAP and MOE provisions for 3 years. The AAFP also supports maintaining the enhanced FMAP on policy grounds: Maintaining the enhanced FMAP allows states to more easily devote scarce resources to their Medicaid programs, which collectively cover some 70 million low-income Americans. Destabilizing the enhanced FMAP in CHIP could also discourage the 19 "non-expansion" states from expanding their Medicaid programs and covering yet more uninsured children and adults.

Unlike Medicare and Medicaid, which provide stable and reliable federal funding under current law, CHIP funding is contingent upon congressional action at regular intervals. Given the importance of the program to almost 9 million children from low-income families, the AAFP urges the Committee to swiftly extend and stabilize the program on a long-term basis.

Congress Should Also Provide Long-Term Support for the Teaching Health Center Graduate Medical Education Program

As an additional note, the AAFP would like to emphasize to the Committee the importance of providing long-term support for the Teaching Health Center Graduate Medical Education (THCGME) program, which will also expire on September 30, 2017, absent Congressional intervention. THCGME is a successful primary-care training program, currently financing training for 742 medical and dental residents in community-based ambulatory settings. Residents in the THCGME program train exclusively in primary-care specialties.

Of relevance to the legislative process surrounding CHIP, two-thirds of the THCGME residents are training in family medicine and pediatrics.⁸ The THCGME program, administered by the Health Resources and Services Administration (HRSA), accounts for less than 1 percent of the annual federal spending devoted to graduate medical education, yet it is the only GME program that is devoted entirely to training primary-care physicians and dentists. Residents in the program train in community health centers (including federally qualified health centers), and tend to be concentrated in rural and underserved areas that need access to more providers, particularly primary-care physicians. American Medical Association Physician Mas-

⁶AAFP, *Health Care for All* (2014), available at <http://www.aafp.org/about/policies/all/health-care-for-all.html>.

⁷See, *e.g.*, The Robert Graham Center, "The Importance of Having Health Insurance and a Usual Source of Care," *Am. Fam. Physician* (Sept. 15, 2004), available at <http://www.aafp.org/afp/2004/0915/p1035.html>.

⁸Health Resources and Services Administration, *Teaching Health Center Graduate Medical Education Program, Academic Year 2014–2015*, available at <https://bhwh.hrsa.gov/sites/default/files/bhwh/nchwa/teaching-health-center-graduate-highlights.pdf>.

terfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.⁹ By comparison, fewer than 5 percent of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.¹⁰ Thus, the most effective way to get family and other primary-care physicians into rural and underserved areas is not to recruit them from remote academic medical centers but instead to train them in these underserved areas.

AMERICAN COLLEGE OF PHYSICIANS (ACP)

25 Massachusetts Avenue, NW, Suite 700
Washington, DC 20001-7401
202-261-4500, 800-338-2746

190 N. Independence Mall West
Philadelphia, PA 19106-1572
215-351-2400, 800-523-1546
www.acponline.org

The American College of Physicians (ACP) commends the Chairman of the Senate Finance Committee Senator Orrin Hatch and Ranking Member Ron Wyden for convening this hearing on the importance of extending the Children's Health Insurance Program (CHIP) which is set to expire at the end of the month. We applaud your working together to examine solutions that will ensure that this program will continue to provide funding for low income children who depend on it to ensure that they have health insurance coverage that meets their needs.

ACP is the largest medical specialty organization and the second largest physician group in the United States, representing 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP Urges Congress to Act Now to Continue CHIP

ACP has been a stalwart supporter of CHIP and we are pleased to know that an agreement on legislation to extend CHIP funding for 5 years has been reached between Chairman Hatch and Ranking Member Wyden. We urge Congress to support and pass this legislation, S. 1827, the Keep Kids Insurance Dependable and Secure Act of 2017, so that the nearly 9 million children who depend on it will not lose coverage. A 5 year extension of the program will provide states that administer the CHIP program with the certainty needed to plan a long-term budget that meets the needs of their children. It will alleviate the anxiety of many parents who are now wondering whether or not their children, who currently receive coverage under CHIP, will continue to have such coverage if Congress does not act by the end of September. State officials have warned the Congress that they may have to freeze CHIP enrollment or terminate coverage if funding is not extended by the end of the month.

Results of the CHIP Program

CHIP was created to provide health-care coverage for children who did not qualify for Medicaid but often found it difficult to obtain affordable health-care coverage in the private market. CHIP builds on the success of Medicaid and recent estimates determine that in 2016, CHIP covered 8.9 million children while 37.1 million children were enrolled in Medicaid coverage. CHIP has been an overwhelming success in reducing the uninsured rate among our nation's children and reducing the financial stress of families that must bear the cost of this coverage. As a result of the passage of CHIP, and Medicaid, new census data reflects that the uninsured rate among children has reached an all-time low of 4.5 percent. According to a recent study by the Urban Institute, "from 1997 when the CHIP program was enacted, to 2012, the uninsured rate among all children declined by 6 percentage points and by even more (12 percentage points) among children with incomes below 200 percent of the federal poverty level." The Urban institute also notes that CHIP and Medicaid have also improved access to care and reduced the financial burden for families with children enrolled in these programs. Not only do these programs result in improved

⁹ E. Blake Fagan, M.D., et al., "Family Medicine Graduate Proximity to Their Site of Training," *Family Medicine*, Vol. 47, No. 2, at 126 (Feb. 2015).

¹⁰ Candice Chen, M.D., MPH, et al., "Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions," *Academic Medicine*, Vol. 88, No. 9, p. 1269 (Sept. 2013).

access to health care for our children, but studies also show that Medicaid and CHIP coverage result in positive outcomes in health, educational advancement, and financial success.

Conclusion

As evidence has shown, CHIP has been a very successful program and it is critically important that Congress act now to extend the program for an additional 5 years. We thank Chairman Hatch and Ranking Member Wyden for working together, in a bipartisan fashion, on legislation to ensure the continuation of CHIP funding for the long term. ACP is pleased to lend its support to S. 1827, the Keep Kids Insurance Dependable and Secure Act, and help advance it through the legislative process. We urge Congress to act quickly to approve this legislation as only a few days remain before the program expires at the end of this month.

ASIAN AND PACIFIC ISLANDER AMERICAN HEALTH FORUM (APIAHF)

1629 K Street, NW, Suite 400
Washington, DC 20006

The Asian and Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the September 7, 2017 hearing before the Senate Committee on Finance entitled “The Children’s Health Insurance Program: The Path Forward.”

As the nation’s oldest and largest health policy and public health organization working with Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities, APIAHF provides a voice in the nation’s capital for AA and NHPI communities. APIAHF works toward health equity and health justice for all by influencing policy, mobilizing communities, and strengthening programs and organizations to improve the health of the over 20 million AAs and nearly 1 million NHPIs in the United States.

This hearing seeks to address continued funding for the Children’s Health Insurance Program (CHIP). APIAHF strongly urges the Committee to follow the Medicaid and CHIP Payment and Access Commission (MACPAC) guidance and extend funding for CHIP for 5 years, through fiscal year 2022.¹ Over 8.9 million children rely on CHIP, and states need the security of knowing CHIP funding will be set for the next 5 years.²

CHIP funding has dramatically reduced the coverage gap for children of color.

Over the course of 20 years, CHIP, together with Medicaid, has led to historic coverage rates for children of color. As of 2015, 95.9% of AA and NHPI children, for example, have coverage thanks to the combined efforts of CHIP, Medicaid, and the ACA.³ Importantly for this Committee, 28% of AA children and half of NHPI children rely on CHIP and Medicaid for their coverage.⁴ Similarly, 56% of Latino children, 58% of African American children, and 50% of American Indian Alaska Native children are covered by CHIP and Medicaid.⁵

Despite these coverage gains, communities of color remain more likely to be uninsured than whites.⁶ This coverage disparity is due to many factors, including pov-

¹*Recommendations for the Future of CHIP and Children’s Coverage*, MACPAC, March 2017, available at: <https://www.macpac.gov/publication/recommendations-for-the-future-of-chip-and-childrens-coverage-2/>.

²*Children’s Health Insurance Program (CHIP): FY 2016 Children’s Enrollment, Medicaid.gov*, February 15, 2017, available at: <https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>.

³Joan Alker and Alisa Chester, *Children’s Health Coverage Rate Now at Historic High of 95 Percent*, Georgetown University Health Policy Institute: Center for Children and Families, October 2016, available at: <https://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-02-1.pdf>.

⁴Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity*, Kaiser Family Foundation, June 7, 2016, available at: <http://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-4-health-coverage/>.

⁵Elizabeth Cornachione, et al., *Children’s Health Coverage: The Role of Medicaid and CHIP and Issues for the Future*, Kaiser Family Foundation, June 27, 2016, available at: <http://kff.org/health-reform/issue-brief/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future/>.

⁶Samantha Artiga, et al, *Health Coverage by Race and Ethnicity: Examining Changes Under the ACA and the Remaining Uninsured*, Kaiser Family Foundation, November 4, 2016, available

erty, health and English literacy and proficiency and immigration based restrictions. CHIP is vital for continuing to close this coverage gap because it specifically seeks to cover low-income working families. The program covers children and pregnant women that make too much to qualify for Medicaid, but not enough to afford private insurance. It also includes protections that are designed to directly serve low-income enrollees, including restrictions on cost-sharing. This coverage is critical for working families of color, who comprise 60% of all working families in this country.⁷

Children of color experience higher rates of chronic health conditions, and CHIP provides access to quality preventive care to prevent and treat those conditions.

Children of color face higher rates of health disparities due to a multitude of factors including poverty, living in less environmentally healthy areas, lack of access to fresh healthy food, and lack of health coverage. CHIP coverage is uniquely situated to address these disparities because it requires a broad scope of coverage and links children to continuous preventive care.⁸

Preventive care is important for AA and NHPI children who suffer from high rates of diabetes compared to other groups. AA children are 60% more likely to develop diabetes than white children, and NHPI children are three times more likely to develop diabetes than white children.⁹ CHIP coverage helps to reduce the burden of expensive and life-changing chronic conditions for AA and NHPI children by offering access to routine preventive care to screen early for conditions like diabetes, obesity, and cancer.

Similarly, African American children are four times more likely to die from asthma than white children, even though this condition is easily treated with regular care.¹⁰ By diagnosing conditions early and keeping children in treatment, CHIP helps to identify health challenges before they arise, and contributes to better health outcomes across the child's lifespan.

In conclusion, 8.9 million children are at risk of losing coverage if CHIP is not extended. If Congress does not act, children of color will be particularly impacted given that almost half are enrolled in CHIP or Medicaid.¹¹ States need to know that CHIP will remain as a major source of coverage with secure funding in order to effectively continue to plan enrollment and operate their programs. Therefore, APIAHF strongly urges the adoption of the MACPAC 5 year continued funding plan for CHIP.

For questions, contact Amina Ferati, Senior Director of Government Relations and Policy at [aferati@apiahf.org](mailto: aferati@apiahf.org) (202-466-3550).

CAMPAIGN TO END OBESITY ACTION FUND (CEO-AF)

1341 G Street, NW, 6th Floor
Washington, DC 20005
www.obesityactionfund.org

Who Is the Campaign to End Obesity Action Fund?

The Campaign to End Obesity Action Fund (CEO-AF) is a group of leaders from industry, academia, public health, and associations dedicated to reversing one of America's costliest diseases: obesity. Right now, more than one-third of adults and nearly one in six children have obesity. Taxpayers, governments and businesses

at: <http://www.kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-examining-changes-under-the-aca-and-the-remaining-uninsured/>.

⁷ Deborah Povich, et al., *Low-Income Working Families: The Racial/Ethnic Divide*, The Working Poor Families Project, 2015, available at: <http://www.workingpoorfamilies.org/wp-content/uploads/2015/03/WPFP-2015-Report-Racial-Ethnic-Divide.pdf>.

⁸ CHIP Benefits, *Medicaid.gov*, available at: <https://www.medicaid.gov/chip/benefits/index.html>.

⁹ Lenna L. Liu, MD, MPH, et al., "Type 1 and Type 2 Diabetes in Asian and Pacific Islander U.S. Youth," *Diabetes Care*, Vol. 32 (Suppl. 2), March 2009, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647693/>.

¹⁰ *Children's Environmental Health Disparities: Black and African American Children with Asthma*, Environmental Protection Agency, 2014, available at: https://www.epa.gov/sites/production/files/2014-05/documents/hd_aa_asthma.pdf.

¹¹ Elizabeth Cornachione, et al., *Children's Health Coverage: The Role of Medicaid and CHIP and Issues for the Future*, Kaiser Family Foundation, June 27, 2016, available at: <http://kff.org/health-reform/issue-brief/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future/>.

spend billions on obesity-related conditions each year, including over \$300 billion in medical costs.

Ending this epidemic requires change—in individuals, institutions and communities. CEO–AF advocates for federal policies to reverse the obesity epidemic and promote healthy weight in children and adults.

Timely Reauthorization of CHIP is Essential.

CHIP provides health-care services to approximately 8.9 million¹ Americans—many of whom have or are at risk for obesity. Nationwide, obesity rates continue to trend upward and some projections show that 50 percent of Americans will have obesity by 2030. Low-income children and families suffer from obesity rates that are 2.7 times higher than those living above federal poverty guidelines.² As such, it is imperative that Congress reauthorize CHIP as soon as possible so that services to these children are not interrupted.

CHIP reauthorization presents a unique opportunity to set these at-risk children up for a lifetime of healthy eating and exercise through early interventions within the health-care system. The continued availability of CHIP is crucial to improving children’s access to obesity prevention and treatment therapies, which can help them become healthy adults.

CEO–AF and 30 Other Groups Urge the Senate Finance Committee to Include CORD in CHIP Reauthorization.

CHIP, for the last two reauthorization cycles, has contained an important and ground-breaking pilot program: the Childhood Obesity Research Demonstration, or CORD.³

CORD 1.0 successfully identified childhood obesity intervention models, which were then tested further in CORD 2.0, with the intention of eventually expanding these evidence-based programs on a national level. Specifically through CORD, the Centers for Disease Control and Prevention (CDC), was able to fund multiple community grantees and evaluation centers to target children from low-income families at risk for or suffering from obesity.⁴ Through this funding, CDC was able to focus on prevention and management of childhood obesity by increasing obesity screenings and counseling services in the community and referring overweight and obese children to appropriate and evidence based lifestyle modification programs.⁵

A letter from CEO–AF and 30 other groups urging the reauthorization of CORD is attached as part of this statement.

CAMPAIGN TO END OBESITY ACTION FUND (CEO–AF)

September 7, 2017

The Honorable Orrin Hatch
Chair
Senate Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Greg Walden
Chair
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Hatch, Chairman Walden, Senator Wyden, and Representative Pallone:

The Campaign to End Obesity Action Fund (the CEO Action Fund) is a coalition of leaders from industry, academia, public health, and patient and disease commu-

¹ <http://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=O&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

² Robert Wood Johnson Foundation and Trust for America’s Health. *State of Obesity: Socioeconomics of Obesity*, <https://stateofobesity.org/socioeconomics-obesity/>.

³ <https://www.congress.gov/bill/111th-congress/house-bill/2>; <https://www.congress.gov/bill/114th-congress/house-bill/2>.

⁴ <https://www.cdc.gov/obesity/strategies/healthcare/index.html>.

⁵ <https://www.cdc.gov/obesity/strategies/healthcare/cord2.html>.

nities that advocates before Congress and federal agencies on needed policy solutions to reverse the U.S. obesity epidemic. As you may know, childhood obesity in the United States has reached epic proportions—one in five U.S. children already has obesity, a fact that also triggers long term health risks and related expenses to taxpayers—and we believe there are important opportunities to advance policies that can move the needle on this.

Specifically, as you work to put together the Children’s Health Insurance Program (CHIP) reauthorization package, we request that you include an extension of the Childhood Obesity Research Demonstration (CORD). This program—now in its second iteration—has been pivotal in beginning to identify scalable approaches to addressing childhood obesity in America.

CORD 1.0 was first authorized in 2009 through the Children’s Health Insurance Program Reauthorization Act (CHIPRA)¹ and ran from 2011–2015. The project, as CORD 2.0, was reauthorized in the Medicare Access and CHIP Reauthorization Act of 2015 for an additional 2 years, and is set to expire in Fiscal Year 2017.² CORD 1.0 successfully identified childhood obesity intervention models, which were then tested further in CORD 2.0, with the intention of eventually expanding these evidence-based programs on a national level. CORD 2.0 is an ongoing project—it is essential that CORD continues to receive funding so that the project can continue to expand incrementally with the goal of continuing to identify scalable, cost-effective solutions to combat childhood obesity.

Through CORD, the Centers for Disease Control and Prevention (CDC), has funded multiple community grantees and evaluation centers to target children from low-income families at risk for or suffering from obesity.³ Without this program, CDC would be without needed, dedicated resources to focus on the prevention and effective management of childhood obesity. Of particular importance, CORD funding empowered CDC to increase obesity screenings and counseling services in the community and refer obese children to appropriate and evidence based lifestyle modification programs.⁴

Today, some 30 states have childhood obesity rates of 30 percent or more.⁵ Childhood obesity is a major contributor to other costly health conditions, such as cancer, cardiovascular disease, dyslipidemia, Type 2 Diabetes, fatty liver disease, asthma, and psychological conditions. Because it can negatively impact school performance and social development,⁶ the toll on families, communities, the health care system, and the budget of this very troubling trend is enormous and growing. Congress must continue to fund the tools, such as CORD, that are making a difference in communities that are hit hardest by this epidemic.

Indeed, U.S. taxpayers, businesses, communities, and individuals spend over \$300 billion per year in medical costs due to obesity.⁷ Accordingly, we must continue to invest—as we have with CORD—in programs that can reduce obesity and, in the long-run, saves lives and taxpayer money. According to a recent Gallup study, if the 10 cities in the U.S. with the highest rates of obesity were able to cut their obesity rates down to the 2009 national average of 26.5%, each city would save nearly \$500 million every year.⁸

Today, CORD remains an essential tool in combatting childhood obesity, and we urge the Committee to reauthorize the program in September.

Thank you again for your leadership, and for your consideration of our request. For any questions you may have, please contact Michelle Seger at michelle@obesityactionfund.org or 202-466-8100.

Sincerely,

The Campaign to End Obesity Action Fund
Afterschool Alliance
American College of Sports Medicine
American Council on Exercise
American Heart Association

¹ <https://www.congress.gov/bill/111th-congress/house-bill/2>.

² <https://www.congress.gov/bill/114th-congress/house-bill/2>.

³ <https://www.cdc.gov/obesity/strategies/healthcare/index.html>.

⁴ <https://www.cdc.gov/obesity/strategies/healthcare/cord2.html>.

⁵ <http://obesityactionfund.org/page.asp?id=28>.

⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4322789/>.

⁷ <https://www.ncbi.nlm.nih.gov/pubmed/25381647>.

⁸ <http://www.gallup.com/businessjournal/145778/cost-obesity-cities.aspx>.

American Medical Women's Association
 American Psychological Association
 American Society for Metabolic and Bariatric Surgery
 Arkansas Center for Health Improvement
 Center for Science in the Public Interest
 Consortium to Lower Obesity in Chicago Children
 Healthcare Leadership Council
 Healthy Schools Campaign
 National Association for Health and Fitness
 National Association of County and City Health Officials
 National Association of School Nurses
 National Coalition for Promoting Physical Activity
 National Hispanic Medical Association
 Nemours Children's Health System
 Obesity Action Coalition
 Obesity Medicine Association
 School Based Health Alliance
 The American Cancer Society Cancer Action Network
 The Endocrine Society
 The Hope Heart Institute
 The Obesity Society
 Trust for America's Health
 United States Bone and Joint Initiative
 University of Wisconsin American Family Children's Hospital
 Weight Watchers
 YMCA of the USA

CHILDREN'S HOSPITAL ASSOCIATION

600 13th St., NW, Suite 500
 Washington, DC 20005
 202-753-5500

16011 College Blvd., Suite 250
 Lenexa, KS 66219
 913-262-1436

www.childrenshospitals.org

Contact us: public.policy@childrenshospitals.org

The Children's Hospital Association represents 220 hospitals nationwide dedicated to the health and well being of our nation's children. On behalf of our nation's children's hospitals and the patients and families they serve, we thank the Senate Finance Committee (the Committee) for its steadfast commitment to the Children's Health Insurance Program (CHIP). The Committee's support and dedication over CHIP's long bipartisan history has resulted in improved access to health care for millions of vulnerable children improving their lives and the overall health of our nation. We greatly appreciate the joint statement by Chairman Hatch and Ranking Member Wyden, released on the 20th anniversary of the program, reaffirming their strong support for a swift and bipartisan CHIP renewal. We share these goals and it is our hope that, following the Committee's consideration of the program during its hearing, Congress will take prompt steps to renew funding for CHIP. We urge Congress to pass a long-term extension of current policy and funding of CHIP before the end of the fiscal year in order to give children and families the certainty and stability they need.

CHIP is an important health coverage program for over 6 million low-income children. Congress created CHIP in 1997, with strong bipartisan support, to fill a gap in the coverage landscape. CHIP builds off of a strong Medicaid program by providing coverage for children who fall above Medicaid eligibility levels, but lack access to other health coverage options. Congress designed CHIP with children in mind and included child appropriate benefits, access to pediatric providers, and cost-sharing limits to protect vulnerable children and families. CHIP, together with Medicaid, has brought the rate of uninsured U.S. children to an all-time low, with 95 percent of all children insured. If this program is not extended beyond 2017, many CHIP-enrolled children will likely become underinsured or uninsured altogether, threatening our nation's historic gains in insuring children over the past two decades. Healthy children grow up to become healthy adults, and CHIP helps ensure that the children covered by the program are able to reach their full potential.

Congress must act now to enact a long-term CHIP extension to give states and families the certainty they need. State budget cycles and regulations make it difficult

for states to maintain their CHIP programs in the absence of federal funding certainty, and many states have already planned for the funding to continue. If CHIP funding were to lapse, states may be forced to make tough choices at the expense of vulnerable children, including steps to disenroll children, impose lock-outs and waiting periods, or wind down their CHIP programs altogether. A clean 5-year extension of CHIP is supported by the National Governors Association, the Medicaid and CHIP Payment and Access Commission, and child health advocates because it provides predictability in the program and encourages states to make programmatic improvements.

Efforts to extend CHIP should maintain current policy, which includes the underlying CHIP program along with items like the Pediatric Quality Measures Program (PQMP), express lane eligibility, and outreach and enrollment grants—all of which are important components of CHIP. The PQMP is the only significant federal investment in pediatric health-care quality. An extension of this program with CHIP is particularly important in order to continue to improve care and lower costs for families and purchasers of care, such as state and federal governments. To ensure maximum stability for children, families and states, we ask Congress to enact a 5-year extension of current policy.

We thank the Chairman, Ranking Member, and Committee members for their leadership and resolute support for CHIP. We are thankful for champions for children like these leaders, and we look forward to working with the Committee this month to maintain a strong CHIP program and strengthen health care for children into the future.

THE FED IS BEST FOUNDATION

Based on June 2017 Medicaid data, there are more than 35 million Medicaid child and Children’s Health Insurance Program (CHIP) enrollees nationwide whose health needs depend on coverage by these important health insurance programs. The Fed Is Best Foundation is a non-profit, public health education organization led by health-care professionals who believe that (1) babies should never go hungry, and (2) mothers should be informed of the signs and consequences of preventable hunger and should be supported in choosing clinically safe feeding options for their babies. The most recent peer-reviewed clinical data shows alarming trends in infant feeding, namely a rise in rehospitalizations for feeding complications in exclusively breastfed newborns who do not receive enough milk in the first days of life, including increasing rates of jaundice, hypoglycemia, and dehydration, which threaten a newborn’s brain and can lead to life-long and costly medical needs.

Programs like Medicaid and CHIP are the most significant payors of infant medical care and are well-positioned to establish infant nutritional criteria that will protect infants against accidental starvation and the medical complications that follow while reducing costs for both one-time and, in many cases, life-long care needs that infants who suffer from jaundice, hypoglycemia, and dehydration face. These are costly and avoidable outcomes and could save the health-care system millions of dollars each year. Clinical data show that insufficient breast milk production affects at least 1 in 5 women in the first days of an infant’s life. Without enough milk, infants can starve, and accidental starvation can cause brain injury leading to preventable cognitive and developmental delays and an increased risk of seizure disorders.

As reported by the Centers for Medicare and Medicaid Services’ (CMS) Maternal and Infant Health Initiative, Medicaid currently funds about 45% of all births in the U.S. In 2014, an expert panel was convened by CMS to examine program policies “that could result in better care, improve birth outcomes, and reduce the costs of care for mothers and infants in Medicaid and CHIP.” There is more work to be done, including closing the critical gap in public-health education and protocols for infant nutrition monitoring and support. Such policy changes can prevent accidental starvation-related care and hospitalization costs which give rise, in many cases, to life-long cognitive and developmental medical care needs for both CHIP and Medicaid beneficiaries.

Contact

Christie del Castillo-Hegy, M.D., Board Certified Emergency Physician, Co-Founder, Fed Is Best Foundation at christie@fedisbest.org/(505) 803-5304

HEALTHCARE LEADERSHIP COUNCIL (HLC)

September 7, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

As the Committee prepares to hold a hearing on the Children's Health Insurance Program (CHIP), the Healthcare Leadership Council (HLC) welcomes the opportunity to share our thoughts on this important program with you.

HLC is a coalition of chief executives from all disciplines within American health care. It is the exclusive forum for the nation's health-care leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high quality care accessible for all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies—advocate for measures to increase the quality and efficiency of health care through a patient-centered approach.

CHIP is a critical part of our country's health-care infrastructure. HLC urges Congress to support some of our most vulnerable citizens—children from families with low and moderate incomes—by continuing to fund this program. CHIP has provided coverage and encouraged participation by simplifying the enrollment and renewal process. Along with other factors, this has led to a steep decline in the number of uninsured children, from around 10 million in 1997 (when the program was enacted) to around 3 million in 2015. Coverage has especially increased among racial and ethnic minorities. CHIP and Medicaid cover more than half of Hispanic and African-American children, compared to about one-quarter of White and Asian children.

HLC strongly believes that keeping children healthy by giving them access to care is essential to the well-being of our society. Diagnosing and treating problems at an early age increases the likelihood that children will grow into healthy adults. This care will also save costs, as these children will be more able to work and contribute to our nation's economy in the future.

Without congressional action to extend CHIP beyond September 30th, states will soon exhaust their CHIP funds. In this time of limited state resources and tight budgets, a lack of federal assistance means that states will have to remove children from CHIP. Many of these children will not be eligible for Medicaid nor will their parents be able to afford a private insurance plan. They will then become uninsured and will have to go without necessary doctor visits, prescriptions, and other health-care services. They will not be able to access preventive care and will instead likely be treated in emergency rooms and other high-cost settings.

HLC urges Congress to extend CHIP funding for 5 years. In addition, we ask the Committee to consider giving states flexibility in administering this program. For example, states could reduce their costs by making CHIP a wraparound option for children who are eligible for the program but who have access to private insurance through their parents. This option would fill in the gaps in what the private plan covers and would also cover the cost-sharing expenses of the private plan. States could also be given incentives for managing CHIP efficiently and streamlining the enrollment process.

Thank you for your work on this important issue. HLC looks forward to continuing to collaborate with you. If you have any questions, please do not hesitate to contact Debbie Witchev at (202) 449-3435.

Sincerely,

Mary R. Grealy
President

NATIONAL CHILD HEALTH ORGANIZATIONS

**Statement for the Record Urging Quick Bipartisan
Action on a Strong, Five-Year Extension of Funding for the
Children's Health Insurance Program**

As advocates for children and pregnant women, we call on Congress to take immediate action to enact a 5-year extension of CHIP funding. Since its inception in 1997, CHIP, together with Medicaid, has helped to reduce the numbers of uninsured children by a remarkable 68 percent. With CHIP funding set to expire on September 30, 2017, now is the time for Congress to stabilize the CHIP funding stream and protect the gains in children's health coverage that have resulted in more than 95 percent of all children in America being enrolled in some form of insurance coverage.

CHIP has a proven track record of providing high-quality, cost-effective coverage for low-income children and pregnant women in working families. CHIP was a smart, bipartisan solution to a real problem facing American children and families when it was adopted in 1997 and its importance and impact in securing a healthy future for children in low-income families has only increased. Senators, representatives, and governors all recognize the importance of CHIP in providing affordable, pediatric-specific coverage to almost 9 million children who cannot afford private coverage or lack access to employer-based coverage. CHIP also delivers quality, affordable care to pregnant women in 19 states, allowing them to obtain the care they need to have healthy pregnancies and give birth to healthy infants.

With federal CHIP funding set to end on September 30, 2017, states are facing critical decisions about the future of their CHIP programs. Many states are just weeks away from setting in motion processes to establish waiting lists and send out disenrollment notices to families. Once undertaken, these actions will have an immediate effect, creating chaos in program administration and confusion for families.

Extending CHIP is particularly important in light of the ongoing debate on and uncertainty regarding the future of the Affordable Care Act (ACA), Medicaid, and the stability of the individual insurance markets. With state budgets already set for the coming year, states are counting on CHIP to continue in its current form. Changes to CHIP's structure—including changes to the Maintenance of Effort or the enhanced CHIP matching rate—would cause significant disruption in children's coverage and leave states with critical shortfalls in their budgets. Given CHIP's track record of success, changes to CHIP that would cause harm to children must not be made.

Today, we stand united in urging Congress to honor CHIP's 20 years of success by securing this critical source of coverage for children and pregnant women into the future. As Congress continues to work on larger health system reforms, a primary goal should be to improve health coverage for children, but at a minimum, no child should be left worse off. We urge our nation's leaders to work together to enact a 5-year extension of CHIP funding as an important opportunity for meaningful, bipartisan action.

Contact: Ari Goldberg, VP Communications, First Focus, 240-678-9102; agoldberg@firstfocus.org.

#KeepKidsCovered
#CHIPworks

Endorsing Organizations

1,000 Days
Academic Pediatric Association
ADAP Advocacy Association (aaa+)
AFSCME
AIDS Alliance for Women, Infants, Children, Youth, and Families
Alliance for Strong Families and Communities
America's Essential Hospitals
American Academy of Family Physicians
American Academy of Nursing
American Academy of Ophthalmology
American Academy of Pediatrics
American Association for Pediatric Ophthalmology and Strabismus
American Association of Child and Adolescent Psychiatry
American Congress of Obstetricians and Gynecologists

American Dental Education Association
 American Heart Association
 American Lung Association
 American Muslim Health Professionals
 American Network of Oral Health Coalitions
 American Pediatric Society
 American Public Health Association
 American Society for Radiation Oncology
 American Society of Pediatric Hematology/Oncology
 Asian and Pacific Islander American Health Forum
 Association for Community Affiliated Plans
 Association of Asian Pacific Community Health Organizations (AAPCHO)
 Association of Maternal and Child Health Programs
 Association of Medical School Pediatric Department Chairs
 Association of Pediatric Hematology/Oncology Nurses
 Association of School Business Officials International (ASBO)
 Association of University Centers on Disabilities (AUCD)
 Autism Speaks
 Cancer Support Community
 Center for Law and Social Policy (CLASP)
 Center for Popular Democracy
 Child Care Aware of America
 Child Welfare League of America
 Children and Family Futures
 Children's Brain Tumor Foundation
 Children's Cause for Cancer Advocacy
 Children's Defense Fund
 Children's Dental Health Project
 Children's Health Fund
 Children's Hospital Association
 Children's Leadership Council
 Children's Mental Health Network
 Clearinghouse on Women's Issues
 Coalition on Human Needs
 Community Access National Network (CANN)
 Community Catalyst
 Cystic Fibrosis Foundation
 Division for Early Childhood of the Council for Exceptional Children (DEC)
 Doctors for America
 Easterseals
 Every Child Matters
 Families USA
 Family Focused Treatment Association
 Family Voices
 First Focus
 First Star Institute
 Forum for Youth Investment
 Generations United
 Health Care for America Now
 Healthy Schools Campaign
 Healthy Teen Network
 Heart Rhythm Society
 HIV Medicine Association
 IDEA Infant Toddler Coordinators Association (ITCA)
 Judge David L. Bazelon Center for Mental Health Law
 Justice in Aging
 League of Women Voters of the United States
 Leukemia and Lymphoma Society
 Make Some Noise: Cure Kids Cancer Foundation, Inc.
 March of Dimes
 Mental Health America
 NAACP
 National Alliance on Mental Illness (NAMI)
 National Alliance of State and Territorial AIDS Directors (NASTAD)
 National Alliance of Children's Trust and Prevention Funds
 National Association for Children's Behavioral Health
 National Association of Community Health Centers
 National Association of Councils on Developmental Disabilities

National Association of County Human Services Administrators
 National Association of Pediatric Nurse Practitioners
 National Association of Perinatal Social Workers
 National Association of Social Workers
 National Black Women's HIV/AIDS Network
 National Center for Transgender Equality
 National Consumers League
 National Council of Jewish Women
 National Crittenton Foundation
 National Health Law Program
 National Immigration Law Center
 National Partnership for Women and Families
 National Patient Advocate Foundation
 National Respite Coalition
 National Women's Health Network
 Nemours Children's Health System
 NETWORK Lobby for Catholic Social Justice
 National Minority AIDS Council (NMAC)
 Nurse-Family Partnership
 Oral Health America
 Out2Enroll
 Partnership for America's Children
 Pediatric Infectious Diseases Society
 Pediatric Policy Council
 Physicians for Reproductive Health
 Raising Women's Voices for the Health Care We Need
 Religious Institute
 RESULTS
 School-Based Health Alliance
 Society for Pediatric Research
 Solving Kids' Cancer
 The Children's Partnership
 The Jewish Federations of North America
 The United Methodist Church—General Board of Church and Society
 Trust for America's Health
 United Way Worldwide
 Universal Health Care Action Network
 Voices for Progress
 Young Invincibles
 ZERO TO THREE

For more information, please contact:

Lisa Shapiro
 Vice President, Health Policy
 First Focus
 1400 Eye Street, NW, Suite 650
 Washington, DC 20005
 Office: (202) 657-0675
 Email: lisas@firstfocus.org

Kathleen King
 Deputy Director, Child Health
 Children's Defense Fund
 25 E Street, NW
 Washington, DC 20001
 Office: (202) 662-3576
 Email: kking@childrensdefense.org

NEMOURS CHILDREN'S HEALTH SYSTEM
 1201 15th Street, NW, Suite 520
 Washington, DC 20005
www.nemours.org
 Contact: Daniella Gratale
 Email: daniella.gratale@nemours.org

Nemours Children's Health System owns and operates freestanding children's hospitals in Wilmington, DE and Orlando, FL, as well as primary and specialty practices and urgent care clinics throughout the Delaware Valley and Florida. As one of the nation's largest pediatric-focused health systems specializing in serving the needs of children, including medically complex children, our 7,000 associates provide direct care and services to more than 350,000 children, with over 1.3 million unique patient encounters annually.

We join with our nation's children's hospitals and the patients and families they serve, in thanking the Senate Finance Committee (the Committee) for its steadfast commitment to the Children's Health Insurance Program (CHIP). The Committee's

bipartisan support over CHIP's long history has resulted in improved access to health care for millions of vulnerable children—improving their lives and the overall health of our nation. We greatly appreciate the joint statement by Chairman Hatch and Ranking Member Wyden, released on the 20th anniversary of the program, reaffirming their strong support for a swift and bipartisan CHIP renewal. Particularly, Nemours would be remiss not to recognize and thank Chairman Hatch for working hand in hand with former Senators Kennedy, Rockefeller and Chafee to pass the original CHIP program. It is our hope that, following the Committee's consideration of the program during its hearing, Congress will take prompt steps to renew funding for CHIP before the current authorization expires on September 30, 2017.

CHIP is an important health coverage program for over 6 million low-income children. Congress created CHIP in 1997, with strong bipartisan support, to fill a gap in the coverage landscape. CHIP builds off a strong Medicaid program by providing coverage for children who fall above Medicaid eligibility levels but lack access to other health coverage options. Congress designed CHIP with children in mind and included child appropriate benefits, access to pediatric providers, and cost-sharing limits to protect vulnerable children and families. CHIP, together with Medicaid, has brought the rate of uninsured U.S. children to an all-time low, with 95 percent of all children insured.

At Nemours, in 2016 nearly 15,000 CHIP-enrolled children sought care within our system across the Delaware Valley and Florida (a total of 35,000 visits and discharges). Healthy children are more likely to grow up to become healthy adults with a greater chance of success in life, and CHIP helps ensure that the children covered by it have greater opportunity to reach their full potential. If this program is not reauthorized, many CHIP-enrolled children will likely become underinsured or uninsured, threatening our nation's historic gains in insuring children over the past two decades.

Nemours joins the National Governors Association, the Children's Hospital Association, the Medicaid and CHIP Payment and Access Commission (MACPAC), and many other child health advocates in supporting a clean, 5-year reauthorization of CHIP in order to provide certainty, stability and predictability in the program for states and families and enable states to make programmatic improvements.

Time is of the essence for Congress to act. State budget cycles and regulations make it difficult for states to maintain their CHIP programs in the absence of federal funding certainty, and many states have already planned for the funding to continue. If CHIP funding were to lapse, states may be forced to make tough choices at the expense of vulnerable children, including steps to disenroll children, impose lock-outs and waiting periods, or wind down their CHIP programs altogether.

Efforts to reauthorize CHIP should maintain current policy, which includes the underlying CHIP program along with items like the Pediatric Quality Measures Program (PQMP), express lane eligibility, Childhood Obesity Research Demonstration Projects (CORD) and outreach and enrollment grants—all of which are important components of CHIP. The PQMP is the only significant federal investment in pediatric health-care quality. An extension of this program with CHIP is particularly important in order to continue to improve care and lower costs for families and purchasers of care, such as state and federal governments. Similarly, CORD supports promising health care and community strategies to combat childhood obesity in children age 2–12, who are enrolled in or eligible for Medicaid or CHIP. An extension of CORD (as well as PQMP) is recommended by MACPAC and dovetails with Nemours' longstanding priority to focus on preventive services to reduce childhood obesity across the nation.

We thank the Chairman, Ranking Member, and Committee members for their leadership and resolute support for CHIP. We are thankful for these champions for children, and we look forward to working with the Committee this month to maintain a strong CHIP program and strengthen health care for children into the future.

ORAL HEALTH AMERICA (OHA)
 180 N. Michigan Ave., Ste. 1150
 Chicago, IL 60601
 phone (312) 836-9900
 fax (312) 836-9986
www.oralhealthamerica.org

September 5, 2017

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

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

Re: CHIP Reauthorization is Essential to Children's Oral Health and Well-being

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of Oral Health America (OHA), a leading nationwide organization dedicated to changing the lives by connecting communities with resources to increase access to care, education, and advocacy for all, especially those most vulnerable, I write to submit a statement for the record following the Senate Committee on Finance's September 7, 2017 hearing on "The Children's Health Insurance Program: The Path Forward." OHA requests the importance of extending funding for the Children's Health Insurance Program (CHIP) be taken into strong consideration by the Committee as the September 30th deadline approaches. Specifically, OHA urges Congress to support a 5-year extension through to fiscal year 2022 as has been widely-recommended. OHA is deeply concerned the President's FY 2018 budget cuts CHIP by an estimated \$6 billion, or a 20% cut, despite the program being extended through to 2019.

Since 1997, CHIP has helped children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance. CHIP has reduced the number of uninsured children by more than 50% while improving health outcomes and access to care for children and pregnant women across the nation. **Of direct interest to the oral health community is the fact CHIP is the only insurance that guarantees 8 million children a dental health benefit that includes coverage for screenings and exams, cleanings, fluoride, and sealants.** Untreated tooth decay can cause pain that may lead to difficulty eating, sleeping, and concentrating in school, leading to poor school attendance, and academic performance. Without CHIP, these children would lose much needed medical and dental coverage. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), without CHIP some families would be susceptible to additional premiums and cost sharing to access dental services in marketplace plans and/or employer-sponsored insurance. This is particularly concerning for low-income families and children. Furthermore, CHIP contributes to overall cost-savings to the system by decreasing the number of emergency room visits that are 10-times more expensive than routine, preventative care.¹

Historically, CHIP has had bipartisan support. It gives states flexibility in designing their programs, allowing them to implement the program by expanding Medicaid, creating a separate program, or a combination of both approaches.² With that flexibility, states can design a program that works best for their state and its children. Simply stated, CHIP provides states needed "certainty" in planning their budgets. MACPAC estimates all states would exhaust federal CHIP funding at some point in FY18, with four states and the District of Columbia running out of federal funds as early as December 2017.³ Therefore, time is of the essence. OHA urges Congress to act soon with a 5-year CHIP funding extension.

Respectfully submitted,

Beth Truett
 CEO and President

¹ Health Policy Institute, American Dental Association. Thomas Wall, Marko Vujicic. "Emergency Department Use for Dental Conditions Continues to Increase." April 2015.

² <https://www.hhs.gov/about/budget/fy2017/budget-in-brief/cms/chip/index.html>.

³ <https://www.macpac.gov/topics/chip/>.

UNIDOSUS
1126 16th Street, NW, Suite 600
Washington, DC 20036-4845

Submitted by Eric Rodriguez, Vice President
Office of Research, Advocacy, and Legislation

Introduction

UnidosUS, formerly the National Council of La Raza, is the largest national Hispanic civil rights and advocacy organization in the United States. We have a long history of advancing opportunities for middle- and working-class Latino children and families, including immigrant and mixed-status households, to achieve the highest level of health possible.

In this capacity, UnidosUS and its Affiliate network of over 260 local, community based organizations in 41 states, the District of Columbia, and Puerto Rico, work diligently to ensure that the needs of our community are met. Through our work with these affiliates we help ensure that all individuals—regardless of who they are or where they are from—have access to affordable, quality health coverage and care. Advancing health equity is crucial for all Americans, including Latino children who are more likely to be uninsured than their peers. Our children are the future of this nation, and it is important that every child has the opportunity and ability to grow up healthy.

As evidence of our commitment to improving access to health coverage and care, UnidosUS has published several reports on policies and programs, like the Children’s Health Insurance Program (CHIP), demonstrated to have had a positive impact on the health and well-being of Latino children, including:

- *Latino Children’s Coverage Reaches Historic High, But Too Many Remain Uninsured*, published by UnidosUS and the Georgetown Center for Children and Families (December 2016)
- *Toward a More Equitable Future: The Trends and Challenges Facing America’s Latino Children*, published by UnidosUS and the Population Reference Bureau (September 2016)
- *Historic Gains in Health Coverage for Hispanic Children in the Affordable Care Act’s First Year*, published by UnidosUS and the Georgetown Center for Children and Families (January 2016)

The Children’s Health Insurance Program (CHIP), has proven to be essential to keeping millions of children and families, including Latinos, healthy and financially secure. Since 1997, CHIP has provided no-cost and low-cost health insurance for children of working families who earn too much to qualify for Medicaid, but not enough to afford private insurance. This program has enjoyed bipartisan support throughout its 20-year history. Chief among these champions has been Chairman Hatch, along with Democratic counterparts, including the late Senator Edward Kennedy and Senator Jay Rockefeller.

CHIP’s impact on our children has only grown during this time. In 2016, there were nearly 9 million children enrolled in the CHIP program. Most of these children (89 percent) are in working families earning between \$24,600 and \$49,200 for a family of four, or between 100 percent and 200 percent of the Federal Poverty Level (FPL).¹ The increase in coverage for children in working families has precipitated a dramatic decline in the number of all uninsured children. Since 1997, the overall child uninsured rate has declined by two-thirds, from 14.9 percent in 1997 to 4.8 percent in 2015, the lowest rate ever recorded.²

UnidosUS recognizes the power of this program and, along with our Affiliates, has worked over the past 20 years to expand access to CHIP coverage for Latino children. Most recently, we have engaged with partners at the state level to ensure that

¹ Medicaid and CHIP Payment and Access Commission, *Child Enrollment in CHIP and Medicaid by State, FY 2016* (Washington, DC: MACPAC, 2017), Exhibit 31, <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-31-Child-Enrollment-in-CHIP-and-Medicaid-by-State-FY-2016.pdf> (accessed August 15, 2017).

² Jason Gates et al., *Uninsurance Among Children, 1997–2015: Long-Term Trends and Recent Patterns* (Washington, DC: Urban Institute, 2016), <http://www.urban.org/research/publication/uninsurance-among-children-1997-2015-long-term-trends-and-recent-patterns> (accessed August 2017), and Sonya Schwartz et al., “Latino Children’s Coverage Reaches Historic High, But Too Many Remain Uninsured” (DC: Georgetown University Health Policy Institute Center for Children and Families and National Council of La Raza, December 2016), <http://publications.nclr.org/handle/123456789/1672> (accessed August 2017).

children have access to coverage through the CHIP program in their states. For example, in 2016, we worked with child advocacy groups in Arizona to reinstate their CHIP program, expanding access to quality, affordable health coverage for an estimated 30,000–40,000 children.³

Despite this success, funding for this vital program ends on September 30, 2017. If CHIP funding is delayed or allowed to expire, the health and well-being of nearly 9 million children currently enrolled in CHIP will suddenly be at risk, along with the tremendous progress made in narrowing health inequities experienced by all children of color, including Latinos. With the uncertainty surrounding other important health programs like the Affordable Care Act and Medicaid, it becomes even more important for Congress to meet this deadline.

This written testimony will focus on the importance of the CHIP program to the Latino community, narrowing inequities in health coverage for Latino children, and the steps Congress must take to safeguard the well-being of millions of children.

CHIP Narrows Coverage Gaps for Latino Children

While CHIP plays an important role in health coverage for nearly 9 million children, it has been especially influential in providing access to health coverage and care for Latino children, who have historically been more likely to be uninsured than their peers. Every child deserves to grow up healthy and thrive, and many Latino children and families depend on CHIP coverage for this opportunity:

- Along with the Affordable Care Act, CHIP is responsible for reducing the rate of uninsured Latino children from 28.6 percent in 1997, to 7.5 percent in 2015.⁴
- Most Latino children (61 percent) live in families earning below 200 percent FPL, which makes them income-qualified for Medicaid/CHIP coverage in nearly every state. 56 percent of Latino children are enrolled in Medicaid or CHIP coverage.⁵
- Latino children account for the largest share of Medicaid and CHIP enrollees (37 percent) of any ethnic group, despite accounting for only 25 percent of the child population.⁶

CHIP not only has allowed more children to have health coverage, it has dramatically reduced health-care inequities affecting children of color from working families. From 1997 to 2015, the coverage disparity between White children and Latino children narrowed from 13 percentage points to 3.7 percentage points, with CHIP accounting for much of this decline.⁷ Further, a recent federally mandated evaluation of CHIP enrollment across 10 states found that over half of CHIP enrollees (54 percent) were Latino.

Finally, the coverage provided by CHIP is unique in our health-care system because its benefits are specifically tailored for children in working families and may be more effective in detecting or preventing certain conditions. Children with Medicaid or CHIP coverage are more likely than children with private insurance to have had a routine checkup, and are just as likely to have a primary, consistent source of

³Vera Gruessner, “Arizona’s Children’s Health Insurance Program Back in Action,” *Health Payer Intelligence*, July 26, 2016.

⁴Jason Gates et al., *Uninsurance Among Children, 1997–2015: Long-Term Trends and Recent Patterns* (Washington, DC: Urban Institute, 2016), <http://www.urban.org/research/publication/uninsurance-among-children-1997-2015-long-term-trends-and-recent-patterns> (accessed August 2017), and Sonya Schwartz et al., “Latino Children’s Coverage Reaches Historic High, But Too Many Remain Uninsured” (DC: Georgetown University Health Policy Institute Center for Children and Families and National Council of La Raza, December 2016), <http://publications.nclr.org/handle/123456789/1672> (accessed August 2017).

⁵The Annie E. Casey Foundation, *Children Below 200 Percent of Poverty by Race* (Baltimore, MD: Annie E. Casey, 2016), <http://datacenter.kidscount.org/data/tables/6726-children-below-200-percent-poverty-by-race?loc=1&loct=1#detailed/1/any/false/573/12,1/13819,13820> (accessed August 2017), and Georgetown Center for Children and Families, *Snapshot of Children’s Coverage by Race and Ethnicity* (Washington, DC: CCF, 2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/04/Snapshot-of-Children%E2%80%99s-Coverage-by-Race-and-Ethnicity.pdf> (accessed August 2017).

⁶Georgetown Center for Children and Families, *Snapshot of Children’s Coverage by Race and Ethnicity* (Washington, DC: CCF, 2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/04/Snapshot-of-Children%E2%80%99s-Coverage-by-Race-and-Ethnicity.pdf> (accessed August 2017).

⁷Genevieve M. Kenney et al., *CHIPRA Mandated Evaluation of the Children’s Health Insurance Program: Final Findings* (Washington, DC: Urban Institute, 2014), https://www.medicare.gov/chip/downloads/chip_report_congress-2014.pdf (accessed August 2017).

care.⁸ Most children enrolled in CHIP have access to the Early and Periodic Screening, Diagnostic, and Treatment Benefit (EPSDT), which enables these children to receive medically necessary services—like treatment for vision, dental, and hearing problems—ensuring that children of all ages in this income bracket have access to the specific services appropriate at their current stage of development.⁹

Moving Forward with CHIP Funding Reauthorization

Since its inception, CHIP has enjoyed bipartisan support, including the last time the program was reauthorized in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This bipartisan support has helped make CHIP an especially effective program, capable of reducing child uninsured rates regardless of the political or economic climate.

While most states do not officially exhaust their CHIP funding until later this year or next year, the state budget cycle requires many to begin winding down their programs and sending out cancellation letters several months in advance. If Congress does not authorize funding past September 30th, children across the nation will face coverage disruptions, causing them to fall behind on their well-child visits or delay medically necessary treatment. Any delay in reauthorizing this funding could reverse course on the tremendous progress that has been made in reducing the number of uninsured children.

We believe that CHIP funding should be reauthorized in a way that enables the program to continue to meet the unique health-care needs of children in working families, including Latinos. As Congress considers ways to continue to fund the CHIP program, we urge you to put children first, and build on the foundation laid under previous reauthorizations of this program including MACRA and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). UnidosUS strongly believes that Congress should consider the following priorities as they work to reauthorize funding for CHIP:

1. ***Extend federal CHIP funding on time.*** It is essential for the health and well-being of our children that Congress reauthorize CHIP funding by the September 30th deadline. This will allow states the budgetary certainty they need to continue providing coverage for children eligible for CHIP. Given the tremendous uncertainty surrounding other parts of our health-care system, congress must ensure that CHIP funding is not allowed to lapse for any period of time or children will lose their health coverage.
2. ***Extend current funding levels established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Affordable Care Act (ACA).*** The enhanced Federal Medical Assistance Percentage (E-FMAP) authorized under MACRA, along with the current CHIP Maintenance of Effort provision established under the ACA, has given states the ability to provide coverage, without gaps, for children in families earning under a specific income threshold. The increase of funding authorized by MACRA provides states the ability to continue expanding access to coverage to more children, and opened the doors for Arizona to reinstate its program. If CHIP is not funded at current levels, some states will once again impose waiting lists and enrollment caps on their programs and currently eligible children may suddenly find themselves without access to CHIP coverage.
3. ***Authorize a five-year extension of federal CHIP funding through FY 2022.*** Renewing federal funding for an additional 5 years, as opposed to a more short-term extension, will provide states with long-term budgetary certainty necessary to develop and test approaches for a more coordinated delivery system of comprehensive, affordable coverage for children. A 5-year extension, at current funding levels, would also better synchronize the program's funding with the current CHIP authorization timeline.¹⁰
4. ***Ensure the eligibility of at least as many children as allowed under current law.*** When it comes to children's coverage, we should always be look-

⁸Medicaid and CHIP Payment and Access Commission, *The Future of CHIP and Children's Coverage, Chapter 1* (Washington, DC: MACPAC, 2017).

⁹Anita Cardwell et al., *Benefits and Cost Sharing in Separate CHIP Programs* (Washington, DC: Georgetown CCF and National Academy for State Health Policy, 2014), <http://ccf.georgetown.edu/wp-content/uploads/2014/05/Benefits-and-Cost-Sharing-in-Separate-CHIP-Programs.pdf> (accessed August 2017).

¹⁰*Ibid.*

ing forward, not back. It is critical to the success of this program, and to the health and well-being of America's children, that current eligibility standards are maintained or expanded. All children, no matter who they are or where they are from, deserve the opportunity to live healthy lives and thrive. Congress must ensure that CHIP continues to play this role within our health-care system.

Conclusion

Despite undeniable success, long-standing bipartisan support, and program reauthorization through 2019, funding for this vital program is at risk. UnidosUS believes that the stakes—the health and well-being of nearly 9 million children, a significant share of whom are Latino—are too high for any delay or lapse in funding. CHIP is a foundational part of our nation's health-care system, and helps ensure a stronger and brighter future for our children. The millions of children enrolled in CHIP cannot afford to go without coverage; children with health coverage are more likely than those who go without to graduate high school, attend college, and attain economic success in adulthood. By investing in our children today we help ensure not only their individual success but that of our nation. CHIP is a truly effective program that helps give our children the healthiest start they need in life. It is paramount that funding for this program remains strong for years to come.

