manatt
manatt | phelps | phillips

Testimony Submitted to the
Subcommittee on Health
Committee on Energy and Commerce

By Cindy Mann, JD[1]
Partner
Manatt, Phelps & Phillips

June 14, 2017

[1] Application for admission to the District of Columbia Bar pending. Practicing under the supervision of Jill DeGraff, a member of the District of Columbia Bar. Admitted to practice in New York and Massachusetts.

Good morning Chairman Walden, Congressman Barton, Congressman Pallone, Subcommittee Chairman Burgess, Congressman Guthrie, Congressman Green, and distinguished members of the Subcommittee. Thank you for the invitation to participate in this hearing on examining the extension of safety net health programs.

I am Cindy Mann, a partner at Manatt, Phelps & Phillips. At Manatt, I work with clients, including states, health care providers and provider organizations, foundations, and consumer organizations, on matters relating to health care coverage, delivery system reform, and financing, focusing primarily on publicly financed coverage and particularly, Medicaid and the Children's Health Insurance Program (CHIP). I also currently serve as an advisor to the Bipartisan Policy Center on the future of health care. Prior to joining Manatt, from June 2009 through January 2015, I served as Deputy Administrator for the Centers for Medicare & Medicaid Services (CMS) and as Director of the Center for Medicaid and CHIP Services. In that capacity, I was responsible for federal policy and oversight of Medicaid and CHIP and for supporting state implementation of those programs. Previously, I was a research professor at Georgetown University's Health Policy Institute and founded the Center for Children and Families, a research and policy organization focused on children's coverage. I also served as the Director of the Family and Children's Health Programs Group at the Health Care Financing Administration (now CMS), where I directed federal implementation of CHIP and Medicaid with respect to children, families and pregnant women from 1999 to 2001, the early years of CHIP implementation. I have over 30 years of experience in these matters both at the federal level and in states.

My testimony today will focus on the role of CHIP in providing affordable, comprehensive health coverage to low-income children and the key issues facing Congress given the expiration of federal funding for CHIP on September 30, 2017. I will highlight CHIP's success and bipartisan support, as well as its role in the children's coverage continuum, recognizing that CHIP's future and its ability to continue to perform well for children across the nation is closely tied to the future of Medicaid, which today covers more than 37 million low-income children nationwide.[2] The foundation of Medicaid makes it possible for CHIP to do its part.

Examining CHIP's 20-Year Success as a Safety Net Program

CHIP covers 8.9 million children nationwide, including children covered through the Medicaid program for whom states claim CHIP enhanced funding, as well as children enrolled in separate CHIP programs. As you know, states have a choice to use their CHIP funding to either expand Medicaid to children, serve children through a separate program or employ a combination of these two strategies. Of those enrolled under any of these options, 97% have household income at or below 250% of the federal poverty level (FPL).[3] Together—Medicaid and CHIP—have been primarily responsible for a historic decline in the children's uninsurance rate.

[2] https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf
[3] https://www.macpac.gov/wp-content/uploads/2017/03/The-Future-of-CHIP-and-Childrens-Coverage.pdf

Between 1997 and 2012, the uninsurance rate for children was cut in half[4] and has continued to decline, reaching 4.8% in Fiscal Year (FY) 2015, an all-time low.[5]

CHIP's success is the result of a number of factors:

- First, from the program's inception in 1997, there has been a strong, bipartisan commitment to children's coverage at the federal, state and community levels. While it was not initially clear how states would react to the new federal funding opportunity provided by CHIP, by 2000, this commitment to children's coverage—boosted by CHIP's enhanced federal funding—had translated to all 50 states and the District of Columbia implementing CHIP. The focus on children's coverage also prompted states and communities to promote enrollment of eligible children by simplifying the application process for both Medicaid and CHIP and undertaking targeted outreach efforts; as a result, participation rates—that is, the proportion of eligible children actually enrolled and covered by Medicaid and CHIP—have increased steadily over the years.

- Second, Congress' longstanding commitment to ensure an adequate federal financing stream for CHIP has been critical to the program's success. Established as a block grant administered through capped state allotments, federal CHIP funding proved too little to meet many states' needs during the program's first decade, resulting in states freezing enrollment and encountering other significant operational and budgetary challenges. However, beginning with the Children's Health Insurance Program Reauthorization Act (CHIPRA) in 2009 and continuing through CHIP's most recent reauthorization in 2015, Congress' commitment to the future of CHIP has been demonstrated by the authorization of sufficient financing and incorporation of financing features that have supported coverage in the years since. CHIP's past experience—first with shortfalls and enrollment freezes and then with adequate and timely funding—demonstrates why it is so important for Congress to act now to fully finance the program.

- Finally, CHIP's success also is based on its close connection to Medicaid; the majority of the 8.9 million children whose coverage is financed through CHIP are enrolled in Medicaid and others move between Medicaid and CHIP as family income or children's health needs change. In many ways, CHIP works well because of the foundation of coverage provided by and financed through the Medicaid program, which covers the nation's lowest-income children and plays a unique role for children with complex medical needs.

[4] https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8615-the-impact-of-the-children_s-health-insurance-program-chip-what-does-the-research-tell-us.pdf
[5] Georgetown Center for Children and Families analysis of the American Community Survey, https://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-02-1.pdf

Key Issues for CHIP

Ensuring Adequacy of Federal Funding for CHIP

Ample funding has propelled CHIP's success and ensured stability in coverage for children in recent years and is a critical factor to safeguard the program's continued ability to serve the nation's low- and moderate-income children. History shows a direct correlation between adequate financing and states' abilities to operate without shortfalls and to cover eligible children. From FY 1998-2001, as states ramped up their CHIP initiatives, the federal CHIP allotment was sufficient to meet federal CHIP expenditures, but between FY 2002-2008, those allotments proved inadequate. As a result, many states stopped enrolling eligible children by adopting enrollment caps or freezes.[6] For example, facing a $124 million shortfall, Georgia froze its CHIP program from March 11-July 1, 2007.[7] The impact on children was swift: when Florida instituted a freeze on July 1, 2003, more than 44,000 CHIP-eligible children were placed on a waiting list by mid-November 2003.[8] Research by the Kaiser Family Foundation shows that while most states' freezes lasted less than year, their impacts endured even after the freeze was lifted.[9] Moreover, shortfalls contributed to significant uncertainty for states, families, and health care providers, and on multiple occasions, prompted Congress to adopt short term, stop-gap measures to shore up funding to states facing shortfalls.[10]

These early experiences contributed to a strong resolve across party lines to ensure the adequacy of future CHIP allotments during subsequent CHIP reauthorizations. Under CHIPRA, Congress not only significantly increased federal CHIP allotments for an additional five years (FY 2009-13) but also revamped CHIP's financing structure to provide new cushioning under CHIP's capped funding model. Beginning in FY 2009, the federal CHIP allotment more than doubled from the average federal CHIP allotment during the program's first decade ($10.6 billion in FY 2009 compared to an average of $4.0 billion per year from FY 1998-2008).[11] By FY 2013, the annual federal CHIP allotment was $17.4 billion. Beyond authorizing federal CHIP allotments that the Congressional Budget Office (CBO) correctly projected would exceed federal CHIP outlays,[12] Congress included a number of additional measures to make the capped funding model more responsive and sustainable. CHIPRA revamped the state allotment formula (including allowing adjustments for population, health care inflation and changes in eligibility

[6] http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy_CHIP-not-a-model-for-block-grant.pdf
[7] http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/37/11/86098649PR-PeachCare_Enrollment_Freeze_Lift.pdf
[8] http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy_CHIP-not-a-model-for-block-grant.pdf
[9] https://kaiserfamilyfoundation.files.wordpress.com/2002/12/4081-north-carolina-health-choice.pdf
[10] http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy_CHIP-not-a-model-for-block-grant.pdf
[11] This does not account for the shortfall funding or CHIP bonus fund; https://www.gpo.gov/fdsys/pkg/GPO-MACPAC-MACBasics-CHIP-2011-09/pdf/GPO-MACPAC-MACBasics-CHIP-2011-09.pdf
[12] https://www.cbo.gov/sites/default/files/recurringdata/51296-2009-03-chip.pdf

and benefits), developed a contingency fund, and established a new redistribution plan for allocating unspent allotments to states facing shortfalls. Congress reaffirmed its commitment to robust federal funding for CHIP in the Affordable Care Act (ACA) and when it passed the Medicare Access & CHIP Reauthorization Act (MACRA) of 2015. In reflecting upon CHIP's success, it is clear that adequate funding—evidenced by appropriations that have exceeded expenditures for nearly the past decade—has enabled CHIP to provide coverage for a growing number of children and to maintain program stability.

The Future of the Enhanced FMAP and the Maintenance of Effort Provision

Beyond the overall level of funding, Congress also must consider whether and how it will address the 23 percentage point increase in the federal CHIP match rate and the maintenance of effort (MOE) provision adopted in the ACA. From CHIP's inception, states have received an enhanced federal medical assistance percentage (eFMAP) for CHIP (historically a 30% reduction in the state share under the regular FMAP rate), and since October 1, 2015, they have received an additional 23 percentage point increase to the match rate, boosting the federal share of CHIP funding to between 88 and 100%.

This enhanced federal funding has helped make it possible for states to maintain coverage for children (as required by the MOE provision), and in some instances, adopt discrete program improvements. A recent survey conducted by the National Academy for State Health Policy (NASHP) indicated that nine states used or planned to use the federal funding increase to enhance their CHIP benefits, invest in outreach and marketing to improve coverage rates, pursue health services initiatives or expand coverage to new populations.[13]

These enhanced federal funds are now fully integrated into states' budgets and a key source of funding for sustaining CHIP. Both the Medicaid and CHIP Payment and Access Commission (MACPAC)[14] and the National Governors Association (NGA)[15] recommend extending the enhanced CHIP match for five years through FY 2022.

In addition, the boost in the matching rate goes hand in hand with the requirement that states maintain children's coverage levels, a provision that extends, under current law, through FY 2019. Stability of the current CHIP and Medicaid eligibility levels is particularly critical given the uncertain future of the individual and small group markets and Marketplace subsidies—which many of the CHIP children would seek to use if CHIP coverage was curtailed. Even if these children were able to secure coverage in the individual market, relative to CHIP, they would face reduced benefits and their families would experience higher costs. Thus, it is important for Congress to retain and extend both the MOE and the enhanced financing provisions. Putting CHIP coverage at-risk in these uncertain times is both unnecessary and ill-advised. MACPAC

[13] http://www.nashp.org/wp-content/uploads/2017/02/2017-CHIP-Survey-Results.pdf
[14] https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf
[15] https://www.nga.org/cms/nga-letters/chip-reauthorization

proposes extending both the current match rate and the MOE for five years. At the very least, withdrawing the enhanced match ahead of the slated FY 2019 expiration date (and the expiration of the MOE provision) would be particularly problematic for states and disruptive to children's coverage.

Maintaining Medicaid as a Strong Foundation of Coverage for Low-Income Children

CHIP was established in 1997 to provide coverage for children in families with too much income to qualify for Medicaid but too little income to afford private insurance. At that time, 10 million children nationwide—nearly 15% of all children[16]—did not have health insurance.[17] The program emerged as way of enabling states to expand children's coverage beyond the Medicaid eligibility levels in effect at the time, while permitting considerable operational flexibility. As noted, states have flexibility in designing their program as either a Medicaid-expansion, separate CHIP or combination approach, and they also have flexibility in benefit design, though they must meet certain minimum standards. In partnership with Medicaid, CHIP has been able to have an outsized impact given its relative program size. Without the steady presence of Medicaid to cover the country's poorest, most vulnerable children, CHIP's impact would have been significantly more limited.

The record-low levels of uninsurance among children achieved in recent years is due to both CHIP and Medicaid. This is true not only because Medicaid is a far larger program, but also because the combined presence of Medicaid and CHIP offer families continuity of coverage as family incomes and circumstances fluctuate. The Congressionally-mandated CHIPRA evaluation found that one in four children enrolled in a separate CHIP program and half of all children enrolled in a CHIP-funded Medicaid expansion were covered at some point in the year in "regular" Medicaid. Over a three-year period, children moved between the two programs at even higher rates.[18] Without a stable Medicaid program to turn to, millions of CHIP children could lose coverage over a relatively short period of time.

CHIP's success is also due in part to the availability of more robust coverage through Medicaid. CHIP's benefit design, while pediatric-focused, is not as broad as Medicaid's, although some states have applied the Medicaid benefit standard in their separate CHIP programs. According to MACPAC, Medicaid finances 40 times as much care as CHIP overall, due both to the relative sizes of the programs and to Medicaid's role in the lives of children with significant health care needs.[19] Partly as a result of the lower incomes of the children served and partly as a result of eligibility design,[20] Medicaid is responsible for a greater share of children in poor health and

[16] http://www.urban.org/research/publication/uninsurance-among-children-1997-2015-long-term-trends-and-recent-patterns
[17] https://www.macpac.gov/subtopic/history-and-impact-of-chip/
[18] https://aspe.hhs.gov/system/files/pdf/77046/rpt_CHIPevaluation.pdf
[19] Manatt analysis of MACPAC spending data (FY 2015); Medicaid: $556 B; CHIP: $13.7 B
[20] Medicaid covers 100% of children in foster care nationwide, as well as children with higher income levels through states' disability pathway and medically-needy options.

those with the most complex medical needs such as cancer, cerebral palsy, and autism, among other special health care needs.[21,22] The Kaiser Family Foundation estimates that for more than 4 million children with special health care needs nationwide, public insurance, including Medicaid and CHIP, represent their sole source of health coverage.[23] Notably, more than one fifth (22%) of these children live in families with income below the FPL, while another 22% are in families with household income between 100-199% FPL.[24] Without Medicaid as the bedrock of public coverage for poor children and those with complex health care needs, either CHIP would face greater costs as states tried to fill the gap left behind by Medicaid or many children would face impediments accessing needed care. For CHIP's success to be assured in the future, Medicaid's future also must be secure.

Likewise, CHIP also has bolstered Medicaid's success. Most notably, CHIP offers coverage to children whose family income brings them over their state's Medicaid eligibility level and for whom affordable employer-based coverage is unavailable. But, the impact goes beyond coverage. The advent of CHIP prompted many states to examine their enrollment processes, not only for CHIP but also for Medicaid, leading to significant simplifications that helped boost participation in both programs. In addition, as states adopted CHIP outreach efforts, many families learned that their children were Medicaid-eligible, helping to drive down the overall uninsurance rate among low-income children (i.e., the "welcome mat" effect). CHIPRA also provided states with a new option to streamline the eligibility and renewal processes for both Medicaid- and CHIP-eligible children using Express Lane Eligibility (ELE).[25] A recent study conducted by the Office of the Inspector General found that all 14 states that initially adopted ELE reported benefits, including reduced costs and administrative burden.[26] Finally, through CHIP, federal and state policymakers have launched quality of care initiatives to improve children's coverage across public programs (influencing private insurance as well). These gains further highlight not only CHIP's contributions to children's coverage but also its critical partnership with Medicaid.

The Need for Timely Congressional Action

With federal funding for CHIP set to expire on September 30, 2017, Congressional action is needed as soon as possible to ensure program continuity, budget certainty for states, and, most importantly, stable coverage for children. According to MACPAC, unless federal CHIP funding is extended, four states and D.C. are projected to exhaust their federal funding allotments by

[21] https://www.macpac.gov/wp-content/uploads/2015/03/State-Children%E2%80%99s-Health-Insurance-Program_CHIP-Fact-Sheet.pdf
[22] http://khn.org/news/chip-offers-families-with-seriously-ill-kids-more-financial-protection-than-aca-plans/
[23] http://www.kff.org/medicaid/issue-brief/medicaid-and-children-with-special-health-care-needs/
[24] http://www.kff.org/medicaid/issue-brief/medicaid-and-children-with-special-health-care-needs/
[25] https://www.medicaid.gov/medicaid/outreach-and-enrollment/express-lane/index.html
[26] https://oig.hhs.gov/oei/reports/oei-06-15-00410.pdf

December 31, 2017, and all but one state are expected to exhaust their federal funding by June 30, 2018.[27]

Without an assurance from Congress on the extension of CHIP funding, many states will be left scrambling as early as this summer. Though the ACA's MOE provision requires states to maintain 2010 Medicaid and CHIP eligibility levels for children through FY 2019, separate CHIP states are not required to maintain coverage in the absence of federal funding. Thus, unless a state with a separate CHIP can replace federal funds with state dollars, these states will be forced to cap enrollment or terminate their CHIP programs. Doing so would require some states to begin making operational decisions this summer and then (or soon thereafter), noticing CHIP enrollees and terminating provider contracts.

This would have consequences for millions of children and families. Approximately 3.7 million children are enrolled in a separate CHIP program. While MACPAC estimates that approximately 2.6 million of these children would enroll either in subsidized Marketplace coverage or a parent's employer-sponsored insurance (ESI), the remaining 1.1 million of these children are projected to become uninsured if states terminate their CHIP programs.[28] Even for families that manage to secure an alternative source of coverage, they can expect to see their out-of-pockets costs rise substantially compared to out-of-pocket spending under CHIP. While the impact would vary by family, MACPAC projects that by adding a child to a parent's ESI, families could face an average of nearly $3,800 more in out-of-pocket costs annually; for some families, the additional out-of-pocket costs could reach almost $9,000 more than with CHIP, greater than 20% of a family's income.[29] Though not nearly as steep, MACPAC estimates that children moving from CHIP to subsidized Marketplace coverage also would face higher cost-sharing, mainly in the form of higher deductibles and copayments but also premium costs for some children.[30]

Children with special health care needs may be the most impacted during this transition. An analysis conducted by The Wakely Group in 2016 found that in some states, these children could go from having no cost-sharing in CHIP to over $10,000 in out-of-pocket costs annually in the Marketplace.[31] Compounding these substantial cost increases and concerns around benefit design is the uncertainty surrounding states' Marketplaces and the availability of sufficient subsidies in the American Health Care Act of 2017. These findings reinforce the need for Congress to act quickly to secure the future of CHIP.

---

[27] https://www.macpac.gov/wp-content/uploads/2017/03/Federal-CHIP-Funding-When-Will-States-Exhaust-Allotments.pdf
[28] https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf
[29] https://www.macpac.gov/wp-content/uploads/2015/03/Sources-of-Coverage-for-Children-If-CHIP-Funding-Is-Exhausted.pdf
[30] https://www.macpac.gov/wp-content/uploads/2015/03/Sources-of-Coverage-for-Children-If-CHIP-Funding-Is-Exhausted.pdf
[31] http://www.wakely.com/wp-content/uploads/2017/03/CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-Oct-2016.pdf

Recommendations

Several nonpartisan and bipartisan entities, including MACPAC,[32] NGA,[33] the National Association of Medicaid Directors (NAMD),[34] the Bipartisan Policy Center,[35] and the American Academy of Pediatrics (AAP),[36] among others, have issued recommendations on the future of CHIP. Their recommendations are based on ensuring that children continue to have access to affordable health coverage and that states have budget and program certainty in the years ahead.

Notably, these entities all support extending CHIP funding. MACPAC, NGA and the AAP recommend extending federal CHIP funding (including the enhanced matching rate) for five years (through FY 2022), and MACPAC and the AAP also recommends extending the MOE for the same time period. Similarly, the Bipartisan Policy Center recommends extending both federal CHIP funding and the MOE through FY 2021. In addition, during their respective confirmation hearings earlier this year, Health and Human Services Secretary Tom Price voiced his support for extending CHIP and suggested that an eight-year extension of CHIP would be better than a five-year extension;[37] similarly, CMS Administrator Seema Verma voiced her support for reauthorizing CHIP for "as long as possible."[38] Taken together, these actions would help ensure continuity of coverage for children, particularly given the current uncertainty surrounding other sources of health coverage in the U.S.

While the President's budget proposes to extend federal funding CHIP, the proposed two-year extension should be strengthened, in line with the five years proposed by MACPAC and NGA, along with an extension of the other key provisions discussed. A two-year extension, while valuable, provides little stability given state budgeting cycles and leaves states less able to plan, modify and improve their programs, a point confirmed by state CHIP directors in their communications with NASHP.[39] In its recommendation to Congress on the future of CHIP, NAMD echoed the importance of a timely extension of CHIP funding to assure states of budgetary and operational certainty.[40] There is little disagreement that CHIP has been a resounding success and little reason to put its future into question. Stability is even more important now given the questions associated with the future of states' Marketplaces and the critical importance of enabling states to continue providing affordable, pediatric-specific

[32] https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf
[33] https://www.nga.org/cms/nga-letters/chip-reauthorization
[34] http://medicaiddirectors.org/wp-content/uploads/2017/03/NAMD-Letter-CHIP-and-D-SNP-reauth-FINAL.pdf
[35] https://cdn.bipartisanpolicy.org/wp-content/uploads/2017/02/BPC-Health-CHIP.pdf
[36] American Academy of Pediatrics letter to Orrin Hatch (May 23, 2017).
[37] https://www.c-span.org/video/?422427-1/hhs-nominee-representative-tom-price-testifies-confirmation-hearing
[38] https://www.c-span.org/video/?423823-1/cms-administrator-nominee-seema-verma-testifies-confirmation-hearing
[39] http://www.nashp.org/wp-content/uploads/2017/02/2017-CHIP-Survey-Results.pdf
[40] http://medicaiddirectors.org/wp-content/uploads/2017/03/NAMD-Letter-CHIP-and-D-SNP-reauth-FINAL.pdf

coverage that serves as a much needed complement to Medicaid for millions of low-income children nationwide.

CHIP, in partnership with Medicaid, has been a remarkably successful program. Its bipartisan support over the past 20 years and its contribution to driving down the uninsured rate among children nationwide are just two of the many indications of its success. While Congress is in the midst of considering changes to the nation's health care system, it is imperative to heed the lessons from this program, whose inception and continuing success have their roots on both sides of the aisle. In the face of ongoing uncertainty in the health care system, there has never been a more important time to act with quick resolve to secure the future of children's health coverage.