



FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

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April 24, 2014

Diane Rowland, SC. D.

Chair

Medicaid and CHIP Payment and Access Commission

1800 M Street, NW, Suite 650 South

Washington, DC 20036

David Sundwall, M.D.

Vice Chair

Medicaid and CHIP Payment and Access Commission

1800 M Street, NW, Suite 650 South

Washington, DC 20036

Dear Dr. Rowland and Dr. Sundwall:

As a bipartisan children's advocacy organization, we are dedicated to making children and families the priority in federal policy and budget decisions. We work on all issues related to children's health and well-being. To that end, I want to express my gratitude for the work that the Medicaid and CHIP Payment and Access Commission does for children who receive health coverage through Medicaid and CHIP. The reports, research, and data provided by the commission are incredibly useful to the work of advocates and others in the child health arena. We greatly appreciate your efforts.

Today, I am writing on behalf of First Focus to express our deep concern about the recent vote taken by MACPAC approving a recommendation for just a two-year extension of the Children's Health Insurance Program (CHIP). First Focus has long supported all federal policy efforts to protect and improve health coverage for low-income children, with a focus on Medicaid and CHIP, and we are certainly heartened by the coverage trends for children. Today the numbers of uninsured children stand at a record low with 93 percent of children in America enrolled in coverage. They can count on and CHIP is a major part of this positive coverage trend for children. In its 17-year history, CHIP has successfully evolved to serve as a catalyst for cutting the uninsured rate for children in half.

While we understand and fully support MACPAC'S efforts to ensure that coverage provided through the Affordable Care Act (ACA) is appropriate to meet the needs of children, we believe it is critical to adopt a policy that we "do no harm" and not gamble with health coverage for children. As such, we fundamentally disagree that setting an arbitrary sunset date for CHIP is an effective way to achieve these important goals. We should only consider moving children to the federal exchange plans only at the time when child health coverage is fully comparable and equivalent to what is offered to children through CHIP.

First of all, since the ACA's passage, the children's community has been united in providing comments to proposed rules and regulations and meeting with the Administration to make sure that children's coverage in the exchanges includes benefits to meet children's unique health and developmental needs; access to pediatric providers, including children's hospitals and pediatric specialists; and coverage affordability that is comparable to CHIP. Unfortunately, as MACPAC has recognized, these issues have not been addressed.

In addition, there are a number of legislative changes that would have to be passed into law and fully implemented before there could possibly be comparability in coverage. MACPAC has identified a number of them, such as the significant cost sharing differences that currently exist between CHIP and the exchange plans and the fact that nearly 2 million children currently eligible for CHIP would be at risk of not receiving subsidized coverage in the exchanges because of the “kid glitch.”

Although we will continue to work with federal policymakers to make the ACA work well for children, we strongly believe that it is premature to assign an end date for CHIP until it is clear that the marketplace will provide coverage that is fully comparable to CHIP. We should all agree that we cannot afford to gamble with children’s health coverage and risk that they will be left worse off by allowing CHIP to end.

Recognizing that the vote on a two-year extension has already been approved, we urge the Commission to ensure that any MACPAC recommendation regarding CHIP reauthorization include specific language outlining the specific policy issues that must be addressed before children who rely on CHIP could be transitioned into exchange coverage.

Specifically, we urge the Commission’s recommendations to specify that these issues be adequately addressed before CHIP is terminated:

Pediatric benefits: CHIP benefits are designed with children’s needs in mind. In Medicaid-expansion CHIP programs, children receive Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is particularly important for children with special health care needs who often require an array of services on an ongoing basis. Some states with separate CHIP programs have also developed comprehensive benefit packages with children in mind so they have access to a range of necessary health services to meet their needs.

But the Essential Health Benefits (EHB) under the ACA have not been implemented in a way that takes into account the needs of children. The federal EHB standards fall short in ensuring that children have access to a comprehensive package of services, particularly coverage for rehabilitative therapies and other ancillary services that are critical for children with chronic or complex conditions. Children need comprehensive benefits that address their continuous growth and development. Gaps in benefits can result in life-long health consequences that generate extensive and avoidable costs and suffering. Children should not have to wait for exchange plans to be designed to meet their needs.

Exchange plans must cover EHBs that have been largely set through state and federal choices for 2014 and 2015. To prepare for the entrance of millions of children into those plans, if CHIP goes away, states should establish a definition of habilitation that ensures children access to all necessary services and devices to attain and maintain function. States should adopt a definition of rehabilitative services no more restrictive than the one put forth by the National Association of Insurance Commissioners. Next, to ensure children have access to all necessary benefits in the EHB, states should create a definition of medical necessity that applies across health plans in the state, modeled on Medicaid’s EPSDT standard, which is based on children’s unique health care needs. It is also critical that states develop methods for measuring children’s access to needed care under the state’s chosen EHB benchmark plan. States must monitor the EHBs for any gaps, with particular attention to children who may go without needed services because they are uncovered and to families who must pay out-of-pocket for uncovered but medically-necessary care.

Network adequacy: Because CHIP is a program dedicated to children, CHIP has pediatric provider networks designed to meet their needs. For example, under CHIP, children have access to a full range of primary, specialty and ancillary pediatric providers to ensure that they receive comprehensive and medically and developmentally appropriate care. In addition, CHIP requires states to ensure that children with special health care needs have access to specialists and out-of-network providers when the CHIP provider network does not meet a child’s health needs. This is a critical component of an accessible health care system for the

children covered by CHIP.

Pediatric provider networks in the Exchanges should include a full range of primary, specialty, and ancillary pediatric providers. The networks should also include contracts with all essential community providers as defined in the statute. Pediatric-specific network adequacy standards (related to timeliness, quantity and types of providers, and monitoring); developed with input from pediatric health researchers, providers, and families; will ensure children have access to needed services without unreasonable delay. Required contracts with all essential community providers will ensure access to especially qualified providers with expertise in the care of low-income and critically or chronically ill and disabled children. In addition, network standards that require or encourage shared or overlapped networks with Medicaid/CHIP will allow for continuity of care for children who move between public and private coverage.

Cost-sharing: For many families, CHIP is the only affordable insurance option for their children even though the ACA was intended to expand access to affordable coverage. During consideration of the ACA, First Focus commissioned an actuarial value (AV) study that showed CHIP has a 98% AV compared with 65-95% AV in the exchanges (depending on the level of exchange plan, bronze, silver, gold, or platinum.) In short, as has been confirmed by staff with the Centers for Medicare and Medicaid Services (CMS), there is not one state in the country where the out-of-pocket costs for health services to children would be comparable in the exchange to that offered in CHIP. For children with special health care needs, this disparity would result in thousands of dollars in increased out-of-pocket costs for children moved from CHIP to exchange coverage.

CHIP also contains important cost-sharing protections that limit aggregate cost sharing to five percent of a family's income. In addition, 18 states do not impose CHIP premiums on families. CHIP's cost-sharing protections are critical to ensuring families seek needed care for their children rather than forgoing care because of cost constraints. Families do not find these same protections in the private coverage options under the ACA.

Affordability: If CHIP ends, 1.9 million kids will lose coverage due to the “**kid glitch**” because families won't be able to afford ESI-offered family coverage but will be ineligible for subsidized marketplace coverage. First Focus has asked the Administration, Congress, and the Treasury Department to address this serious issue several times to no avail. Without a fix, either administratively or legislatively, without CHIP, children will be left uninsured. It will take us back to the pre-CHIP days, even though we have the ACA in place.

Since its inception in 1997, CHIP has been a vital program for low-income children in working families whose parents earn too much to qualify for Medicaid but too little to purchase private health insurance. It has helped to cut the numbers of uninsured children by an astounding 50 percent while improving health outcomes and access to care for children and pregnant women across the nation. In FY 2012, more than 8 million children relied on CHIP for their health coverage.

With all of the success we have won for children's health coverage over the last two decades now is not the time to gamble with children's health care. Children certainly should not be used as leverage to elicit action from Congress. Setting a short CHIP timeframe is simply not in the best interest of children. We fought hard to ensure that affordable, high quality pediatric care was part of the ACA and we continue to hope that there will be a day when the exchanges are functioning in a way that addresses children's unique health needs but those improvements must come first before setting a timeline for moving kids into marketplace plans. MACPAC should not recommend an arbitrary date to move kids into the exchanges. Children must be able to keep the coverage they have until it is clear that exchange plans provide similar cost sharing, benefits, etc. Kids should not end up worse off.

To the extent that it is too late to alter the MACPAC recommendation for a two-year CHIP extension, we urge MACPAC in the strongest possible terms to memorialize the policy concerns that were raised during the meeting regarding what children would need if CHIP is terminated and establish specific conditions that need to be met before children would be moved into marketplace coverage. Again, we simply cannot gamble with strong coverage that over 8 million low-income children are currently receiving in CHIP until we can be fully assured that any alternative is both comparable and equitable on a range of factors. Children simply must not be left worse off.

We appreciate your consideration of these issues and would be happy to provide any additional information that might be helpful.

Sincerely,

A handwritten signature in blue ink that reads "Bruce Lesley". The signature is written in a cursive style with a prominent underline under the word "Lesley".

Bruce Lesley
President