



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

NICK LYON  
DIRECTOR

November 25, 2014

Mr. Fred Upton, Chairman  
House Committee of Energy and Commerce

Mr. Ron Wyden, Chairman  
Senate Finance Committee

Mr. Henry A. Waxman, Ranking Member  
House Committee on Energy and Commerce

Mr. Orrin G. Hatch, Ranking Member  
Senate Finance Committee

Dear Representatives Upton and Waxman and Senators Wyden and Hatch:

This is in response to your letter of July 29, 2014, requesting information from Michigan regarding the Children's Health Insurance Program (CHIP) and its possible extension. After a brief introduction, this letter will respond to the specific questions laid out in your letter. You will find that our input leads to a strong recommendation that Congress reauthorize this successful program and maintain enhanced federal match rates that encourage this vital coverage for children.

Michigan's CHIP plan combines a standalone program named MICHild and a smaller CHIP funded Medicaid expansion that covers children above the traditional Medicaid income limits. With these combined strategies, Michigan currently covers close to 45,000 children and has provided services to well over 300,000 children since the inception of the program in 1998. Families with children on MICHild are required to contribute a premium of \$10 per month, a meaningful but very affordable form of participation in supporting the cost of care.

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

Michigan's CHIP program currently has about 45,000 children enrolled, 36,000 in the standalone MICHild program and 9,000 in a Medicaid expansion. This expansion provides coverage to 16 to 18 year olds with incomes between 110 and 160% for the federal poverty level. Monthly enrollment has seen a modest increase since the implementation of PPACA. Please see the attached chart for a detailed breakout of the MICHild demographics for three recent months.

**2. What changes has your state made to its CHIP program as a result of the Patient Protections and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?**

Michigan's program has not changed in design since the implementation of PPACA. The flexibilities afforded by CHIP prior to the enactment of the PPACA enabled Michigan to use the program's policy and administrative processes as a template in adapting to PPACA. For instance, Michigan was able to focus on coordination between programs by utilizing our existing CHIP online application as a model for a single application for all Medicaid and CHIP programs allowing us to better coordinate results and referrals among the various programs.

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

Michigan's MICHild is a standalone program based on employer coverage. By definition, it is comparable to large employer and Qualified Health Plan coverage on the Exchange. One key difference with the Exchange is that MICHild assures dental coverage while it has to be separately purchased on the Exchange, an option that may not be consistently exercised by families.

There also are important and substantial differences between MICHild and QHP cost sharing. Given the deductibles and copays that are built into the QHP cost sharing structure, we are very concerned about the impact on families of children with health conditions, especially those with special health care needs. Per a recently published Wakely Consulting Group analysis, cost sharing obligations for families can accumulate to more than \$1,000 per year and be a barrier to seeking services that are needed.

The most dramatic problem will be for children in families where the employed adult has access to affordable health insurance through their employer but where the policy is not affordable for the family and, hence, the children. This "family glitch" clearly creates a barrier for the affected cohort of children because of the great disparity in the cost of covering children in those families and the inability to access subsidies through the Marketplace.

- 4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

The CHIP program provides an affordable health care option for families and facilitates children's access to benefits designed with their specific needs in mind. Current information identifies factors that could significantly erode health coverage of children in various ways if CHIP is not extended. Therefore, we strongly recommend that Congress reauthorize CHIP. We believe that CHIP coverage has helped provide valuable coverage and contributed to the health of Michigan's children.

In terms of timeframes, we would prefer action in the next month or two as we are now in the process of formulating our fiscal year 2016 budget. The budget impact of CHIP ending, or making changes in the state's matching rate, would shift significant costs back to Michigan. If CHIP ended other existing programs would need to provide services to a range of vulnerable children.

We recommend a reauthorization of at least five years so that consistent coverage can be provided to our children. CHIP could be changed if there are other Congressional actions that would assure coverage of children beyond the provisions of PPACA. If that were to occur, changes to CHIP could be made concurrently as part of a larger legislative package.

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

The formula seems reasonable but should be able to respond more rapidly as conditions change in a state. Michigan currently is working with CMS to obtain needed allotment adjustments due to such changing conditions. We are anticipating a positive resolution.

- 6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe**

**there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?**

With CHIP and Medicaid, Michigan has built a system that has produced one of the lowest rates of uninsured children in the nation, about 5% for most of the recent years. We believe that the flexibilities afforded by CHIP have contributed to our success. While we have no specific recommendations for additional flexibility at this time, we are open to suggestions that contribute to improved health outcomes for children. We stand ready to help if you or your offices need any assistance or input on suggestions around this or other health programs.

Thank you for this opportunity to provide input on this important issue.

Sincerely,



Nick Lyon, Director  
Michigan Department of Community Health

Chart: Michigan's CHIP Demographics

	May-14		June-14		July-14	
	Count	Percent Enrolled	Count	Percent Enrolled	Count	Percent Enrolled
<b>Gender</b>						
Female	15,478	48.5%	16,559	48.6%	17,548	48.6%
Male	16,426	51.5%	17,478	51.4%	18,547	51.4%
Gender Total	31,904	100%	34,037	100%	36,095	100%

<b>Age (See note below)</b>						
Under age 1	163	0.5%	81	0.2%	58	0.2%
Age 1 through 4	6,455	20.2%	6,979	20.5%	7,708	21.4%
Age 5 through 14	18,246	57.2%	19,453	57.2%	20,438	56.6%
Age 15 through 18	7,040	22.1%	7,524	22.1%	7,891	21.9%
Age Total	31,904	100%	34,037	100%	36,095	100%

<b>Race</b>						
American Indian or Alaskan	300	0.9%	299	0.9%	299	0.8%
Asian Indian	49	0.2%	72	0.2%	101	0.3%
Black or African American	3,170	9.9%	3,522	10.3%	3,719	10.3%
Chinese	11	0.0%	15	0.0%	18	0.0%
Filipino	5	0.0%	6	0.0%	6	0.0%
Guamanian or Chamorro	0	0.0%	1	0.0%	1	0.0%
Hispanic	1,125	3.5%	1,073	3.2%	1,053	2.9%
Japanese	1	0.0%	2	0.0%	2	0.0%
Korean	6	0.0%	7	0.0%	7	0.0%
Native Hawaiian	7	0.0%	10	0.0%	12	0.0%
Other Race or Multiracial	1,972	6.2%	1,833	5.4%	1,682	4.7%
Pacific Islander	7	0.0%	15	0.0%	16	0.0%
Samoan	2	0.0%	1	0.0%	2	0.0%
Unknown	2,482	7.8%	2,703	7.9%	2,943	8.2%
Unspecified	70	0.2%	71	0.2%	87	0.2%
Vietnamese	3	0.0%	5	0.0%	6	0.0%
White/Caucasian	22,694	71.1%	24,402	71.7%	26,141	72.4%
Race Total	31,904	100%	34,037	100%	36,095	100%

<b>Ethnicity</b>						
Chicano	5	0.0%	5	0.0%	7	0.0%
Cuban	5	0.0%	10	0.0%	17	0.0%
Hispanic	322	1.0%	541	1.6%	811	2.2%
Mexican	53	0.2%	65	0.2%	107	0.3%
Mexican American	19	0.1%	26	0.1%	34	0.1%
Non-Hispanic	5,676	17.8%	9,017	26.5%	11,936	33.1%
Other	158	0.5%	193	0.6%	280	0.8%
Puerto Rican	6	0.0%	9	0.0%	12	0.0%
Unknown Ethnicity	25,660	80.4%	24,171	71.0%	22,891	63.4%
Ethnicity Total	31,899	100%	34,037	100%	36,095	100%

Note: The income guideline for children under age 1 is 195 to 212% of the Federal Poverty Level (FPL). The income guideline for other children is 160 to 212% of the FPL.



# STATE OF MINNESOTA

## Office of Governor Mark Dayton

116 Veterans Service Building ♦ 20 West 12th Street ♦ Saint Paul, MN 55155

October 8, 2014

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

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

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

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

Dear Senators and Congressmen:

Thank you for seeking input from governors regarding whether and how the Children's Health Insurance Program (CHIP) should be extended and whether any additional policy changes are needed.

Minnesota's circumstances differ from most states in the use of CHIP funding. To explain those differences, we offer this brief summary of the CHIP Program as it affected Minnesota. When CHIP was enacted in 1997, Minnesota had one of the lowest rates of uninsured children in the nation. In 1995, Minnesota expanded Medicaid coverage for children under age 21 with family income up to 275% of the federal poverty level through a federal waiver. The laws governing CHIP prevented Minnesota from using CHIP funds for children who were already covered under Medicaid at this high level. Because federal law prevents us from using the CHIP matching funds on behalf of children already covered, Minnesota covers relatively few people under the CHIP program.

Minnesota covers two groups with CHIP funds — a small group of infants under age two; and unborn children of mothers who are ineligible for Medicaid.

Over the years, Minnesota has also used other authority in the CHIP law to support special health initiatives; to cover parents via federal waivers; and more recently, the state has used its status as an expansion state to receive enhanced federal matching for a subset of Medicaid children. CHIP funds have helped support coverage for children and their families and I recommend that the program continue.

In response to your more specific questions, I offer the following:

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

Minnesota covers the following groups with CHIP funds:

- o Infants up to age two in the Medical Assistance (MA) Program with income between 275% and 283% of the federal poverty level; and
- o Unborn children of mothers ineligible for Medicaid who have income up to 278% of the federal poverty level.

Minnesota serves approximately 4,100 CHIP enrollees per year. In addition, the CHIP program provides enhanced funding for children enrolled in Medicaid.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

Minnesota has no changes other than the conversion of the income standards to the required modified adjusted gross income standards. The most significant impact to administration is the state-based Exchange that supports electronic application processing of Medicaid and CHIP eligibility.

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

Minnesota's CHIP benefits and services are modeled after those offered in the Medicaid program. No premiums or cost-sharing apply to children in either the Medicaid or CHIP programs.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

I recommend the extension of CHIP funding. This would help us continue to support our investment in health care coverage and continue to reduce the rate of uninsurance. As Governor of Minnesota, I do not plan to recommend reducing coverage for children. Extending the CHIP program would help avoid that result.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately?*

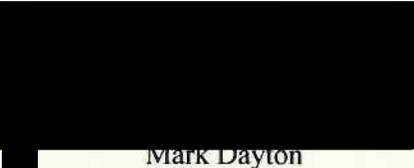
*Do you believe there is a need for Congress to further address the issue of unspent allotments?*

In my view, greater flexibility is needed in order for states to spend all available CHIP funding.

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

I recommend lifting or raising the cap on special health initiatives and other forms of child health assistance. Currently, we are limited to 10% of CHIP program expenditures.

In summary, the CHIP program has helped Minnesota maintain its high levels of coverage for children and maintain its high rate of insurance coverage among children, and I hope that support continues. Please do not hesitate to contact me if you have further questions or need additional information.



Mark Dayton  
Governor



BRIAN SANDOVAL  
Governor

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY  
1100 E. William Street, Suite 101  
Carson City, Nevada 89701  
(775) 684-3600

ROMAINE GILLILAND  
Director

LAURIE SQUARTSOFF  
Administrator

October 28, 2014

Representative Henry Waxman, Ranking Officer, House Committee on Energy and Commerce  
House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

Representative Fred Upton, Chairman, House Committee on Energy and Commerce  
House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Sirs:

The Nevada Division of Health Care Financing and Policy (DHCFP), the Nevada Medicaid and Children's Health Insurance Program administrative entity is supportive of Congress extending CHIP and CHIP funding after the end of Federal Fiscal Year 2015. In Nevada the CHIP is a combination program, both a Medicaid expansion program and a separate CHIP. In both CHIP models, Nevada provides the Medicaid benefit plan where coverage emphasizes children's unique needs. The DHCFP believes that the Nevada CHIP does provide medical coverage and care to children who otherwise may not get care due to the high cost of premiums, deductibles and co-payments that are part of commercial insurance plans, even those with subsidies available through the Health Care Exchange.

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

In State Fiscal Year 2014 (July 2013 – June 2014) Nevada's CHIP program covered 5,647 children through the Medicaid expansion program and a monthly average of 21,316 children through the Nevada's Separate CHIP program. The CHIP enrollees in the Medicaid expansion program, where the state receives the CHIP federal match percentage, have income levels up to 165% of the Federal Poverty Level for children below age 6 and have incomes up to 138% of the Federal Poverty Level for children age 6 through 18. Historically about 60% of the Nevada Check Up caseload has identified themselves as Hispanic and 87% of the caseload has resided in the urban areas of Nevada and has been served in our managed care delivery model.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

The state consolidated the CHIP and Medicaid eligibility process into a single state Division, the Division of Welfare and Supportive Services. Wherever possible we aligned Medicaid and CHIP policies, including the elimination of the six month crowd out (wait time between loss of private insurance) period for CHIP. The application process was consolidated and electronic applications can be entered through Nevada Health Link, the front face of the Nevada Health Insurance Exchange and Access Nevada the Division of Welfare and Supportive Services multi benefit application beginning November 2015.

3. *Please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.*

Nevada implements the Medicaid benefit plan which emphasizes child wellness services. It also includes behavioral health rehabilitative supports, dental and vision care and long term services and supports such as private duty nursing and attendant care.

The cost for the CHIP program is significantly less than the cost sharing on the exchange. The only cost is a quarterly premium. There are no co-payments, deductibles, or other charges for covered services. Premiums are determined by family size and income. Premiums are charged per family, not per child and are paid quarterly. The premium for a family with income up to 150% of FPL is \$25 per quarter with a total annual cost of \$100, for a family with income between 150% and 175% of FPL the premium is \$50 per quarter with a total annual cost of \$200 and for a family with income between 175% and 205% of FPL the premium is \$80 per quarter with a total annual cost of \$320.

For a child receiving coverage from a plan on the Health Care Exchange, the average premium cost at an income level of 168% of FPL would be \$326 a year for medical coverage. Dental coverage would run an additional \$18 - \$25 dollars a month. At this FPL the co-pays, though subsidized, would also be an additional cost. At 205% FPL, the yearly medical premium would be \$534 per year. These premiums are per child. Children are charged individually in a family unit up to the third child; at that point any additional children are not charged an additional premium.

If we utilize the exchange premium payment level of \$326 a year, an estimated dental monthly premium of \$20 and look at the Nevada CHIP population as a whole we would find that the per year per person cost of going from CHIP to the exchange would be \$480.50. This includes premiums only and does not include co-pays. The average CHIP household size is 2.5; therefore, the annual impact per CHIP family would be \$1,201.00 plus co-pays.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? How many children do you believe would become uninsured in the absence of CHIP?*

Nevada recommends that the Children's Health Insurance Program funding be extended. It is our belief that CHIP facilitates medical care to children in low income families. In comparing Nevada CHIP HEDIS, The National Committee for Quality Assurance

Healthcare Effectiveness Data and Information Set, rates to Nevada Medicaid percentiles, the CHIP program exhibits better rates, demonstrating this receipt of medical care. Because of this level of medical care and the success of CHIP programs we feel the CHIP program should become a permanent program for children, continuing to allow states to operate CHIP as a Medicaid expansion or a standalone CHIP. If Congress is concerned about making CHIP permanent, Nevada believes CHIP should remain funded at least until the end of the children's Maintenance of Eligibility period in 2019. This would give the state time to thoughtfully plan for the needs of these children.

Nevada, due to the ability to spend CHIP allotments in a future year, currently anticipates funds will be available through June of 2016. It is projected, if CHIP funding is eliminated that in State Fiscal Year 2017 (the first state fiscal year where lack of federal dollars to support CHIP will affect Nevada) the loss of the increased CHIP federal match percentage will cost Nevada up to an estimated (based on an estimated FMAP) additional \$10,000,000 to cover the cost of our Medicaid CHIP expansion children.

For those children in Nevada's Separate CHIP, it would cost Nevada approximately (based on an estimated FMAP) \$9.8 million in SGF if we expanded Medicaid children's eligibility and covered these children in Medicaid. To date, this possibility has not been part of Nevada's budget discussions.

For those children in Nevada's Separate CHIP program, if the program was eliminated without expanding Medicaid's coverage of children, with only the option to the families to access the more expensive coverage through the exchange, there is a potential these children will lose their medical coverage. Nevada has no method to determine the number of the children who would actually lose medical coverage, but, based on caseload projections, there are expected to be approximately 15,000 children in the Separate CHIP program that would be at risk.

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

The funding formula has been sufficient for Nevada. Nevada appreciates the ability to use unspent funds in a future year. This has allowed Nevada to address the cost swings that are present in smaller programs when a few high cost children can affect the overall program cost.

The availability to carryover unspent funds has also provided Nevada with the guarantee of some funding to cover ongoing costs, possibly needed for wind down or to transition operations when, through Congressional processes, ongoing CHIP funding has not been assured. Historically, states have continued to operate their CHIP programs, enrolling new children into the health care coverage, pending decisions on continued funding of CHIP from Congress. This remains true for the current situation. States are still operating and enrolling children into CHIP, pending information on the continued funding of the program.

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

Nevada has experienced a large increase in program enrollment (Medicaid and CHIP) including children this past year. Nevada believes this can be greatly attributed to the insurance mandate and the increased applications received through the Health Insurance Exchange entry point. Balance needs to be maintained between ease of application and policy for enrolling eligible individuals. Any changes that simplify application and enrollment processes must also be supported by the federally required audits of individual's eligibility. When these audits employ stricter processes than the actual enrollment process does, states are at risk of being cited for enrolling individuals who are not eligible.

Nevada believes program enrollment is only part of the process. Policies and processes need to focus on developing the health care workforce. A limited healthcare workforce will impact health care access and outcomes. There also needs to be federal support, systems and the companion funding, for states to implement expanded health care outcome data gathering and measurement that can be benchmarked across systems and states. States greatly appreciate the opportunities the federal government provides to receive grants or increased federal financial participation to support these activities.

Nevada appreciates the opportunity to provide our information and insights regarding the Children's Health Insurance Program. We believe the program has been successful in Nevada. We believe CHIP does provide medical coverage and care to children who otherwise may not get care due to the higher cost of commercial insurance plans, even those with subsidies available through the Health Care Exchange.

Thank you for your interest in the Children's Health Insurance Program. Should you require any additional information or have any other questions please feel free to contact Elizabeth Aiello, Deputy Administrator at [REDACTED]

Respectfully,

[REDACTED]

Laurie Squartsoff  
Administrator

Respectfully,

[REDACTED]

Romaine Gilliland  
Director, DHHS

Cc: Honorable Brian Sandoval, Governor Nevada  
Elizabeth Aiello, Deputy Administrator, DHCFF