



COMMONWEALTH OF PENNSYLVANIA  
OFFICE OF THE GOVERNOR  
HARRISBURG

THE GOVERNOR

October 31, 2014

Honorable Fred Upton  
Chairman  
Energy & Commerce Committee  
2183 Rayburn House Office Bldg.  
Washington, D.C. 20515

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

Honorable Henry Waxman  
Ranking Member  
Energy & Commerce Committee  
2204 Rayburn House Office Bldg.  
Washington, D.C. 20515

Honorable Orrin Hatch  
Ranking Member  
Committee on Finance  
104 Hart Office Bldg.  
Washington, D.C. 20510

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

Thank you for contacting Pennsylvania regarding the future of the Children's Health Insurance Program (CHIP) and how it should be extended. As the leader of a state with more than 157,200 children enrolled in CHIP, there is no question that funding for CHIP should be extended on a federal level. We must allow CHIP to continue to successfully provide quality, affordable health care coverage to children. Moreover, addressing this issue promptly is critical for providing certainty to CHIP families and making sure that children can stay with their health care providers.

CHIP works for kids. Pennsylvania's CHIP program (PA-CHIP) has provided vital health care coverage to hundreds of thousands of children in Pennsylvania for over 20 years and is an example of how states can develop innovative solutions to meet the needs of their residents. PA-CHIP was enacted in 1992, and five years later, when the federal CHIP was created, PA-CHIP was acknowledged as a national model for the federal health care coverage program for children. PA-CHIP continues to be one of the benchmark benefit packages recognized in the federal CHIP law.

Pennsylvania has worked tirelessly to continue providing PA-CHIP coverage as an option for children and their families. However, as you know, the passage of the Affordable Care Act (ACA) serves as a challenge for PA-CHIP because it forces an efficiently functioning program to

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conform to rigid federal standards. In addition to the ACA's overwhelming strain on the program's resources, the ACA has proved damaging to PA-CHIP's enrollment figures by requiring children in the 100%-133% Federal Poverty Level (FPL) range to be enrolled in Medicaid, rather than in CHIP.

Last year, Pennsylvania vehemently opposed a federal interpretation requiring an unnecessary transfer of children from PA-CHIP into Medicaid. I spoke personally with then-Secretary Kathleen Sebelius and said no child in Pennsylvania should be forced to change health care coverage and potentially lose access to his or her health care provider needlessly. Unfortunately, this is the scenario we now face because of the ACA. While the Obama Administration ultimately refused to grant Pennsylvania a permanent waiver from this ACA requirement in order to protect the child/health care provider relationship, we did successfully secure additional time to prepare for the transition and keep children with their providers for as long as possible.

When extending federal funding for CHIP, I also would suggest that the federal government use this extension as an opportunity to improve upon the federal program for the betterment of Pennsylvania's children and children nationwide. For example, Federal authorities should consider structuring flexibilities into the program for states, such as allowing states with separate CHIP programs the option to enroll children above 100% FPL in CHIP or Medicaid. Additionally, federal authorities should consider "at-cost" CHIP to be Minimum Essential Coverage (MEC), therefore avoiding unnecessary tax consequences for families.

With the health care needs of Pennsylvanian's children at stake, the extension of federal funding is critical to retain PA-CHIP as an option for families seeking health care coverage for their children. Thank you for the opportunity to share the importance of the extension of federal funding for CHIP and what it will mean for Pennsylvania's children and their families. With regard to your specific questions, please find the responses attached.

I urge you to extend CHIP's federal funding, and I look forward to working with you to improve this successful program.

Sincerely,



TOM CORBETT  
Governor

Enclosure

**Attachment A**

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)?

**Pennsylvania CHIP population characteristics. (September 2014)**

**Income Range**

Income Range	\$ 0	<\$10,000	<\$20,000	<\$30,000	<\$40,000	<\$50,000	<\$60,000	>\$60,000	Total
Enrollees	1,596	1,443	5,360	28,613	41,773	35,759	20,709	22,642	157,895

**Ethnicity**

Ethnicity	Unspecified	Hispanic	Non-Hispanic	Total
Enrollees	21,200	15,523	121,172	157,895

**Race**

Race	Unspecified	African American	Caucasian	Asian	Hawaiian /Islander	Alaskan /Indian	Asian (Indian)	Other Race	More Than One Race	Total
Enrollees	11,338	21,737	102,744	5,337	81	138	854	13,927	1,739	157,895

**Gender**

Gender	Female	Male	Total
Enrollees	78,493	79,402	157,895

**Cost Category**

<b>Cost Category</b>	<b>Free (133%-208%FPL)</b>	<b>Low Cost 1 (208%-262%)</b>	<b>Low Cost 2 (262%-288%FPL)</b>	<b>Low Cost 3 (288%-314%FPL)</b>	<b>At-Cost (314%FPL and above)</b>	<b>Total</b>
<b>Enrollees</b>	120,637	23,395	5,895	4,512	3,456	<b>157,895</b>

**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?**

As a result of the Affordable Care Act (ACA), Pennsylvania's CHIP (PA-CHIP) has faced tremendous operational and administrative challenges in order to comply with the requirements and expectations of the ACA, including but not limited to:

- Transitioned to the use of Modified Adjusted Gross Income (MAGI) to determine applicants' eligibility for PA-CHIP. The change to MAGI resulted in a complete reconfiguration of the methods by which PA-CHIP calculates applicants' income and determines applicants' household composition.
- Moved eligibility determinations out of the PA-CHIP Application Processing System and into a combined rules engine with the Medicaid program. PA-CHIP and the Medicaid program continue to work through discrepancies regarding eligibility, as the programs take different approaches to certain eligibility characteristics.
- Prepared for a transition of PA-CHIP enrollees ages 6-18 within 100%-133% FPL to the Medicaid program, consequently forcing enrollees to undergo an unnecessary transition of coverage and potential disruption in continuity of care.
- Implemented the "Single Streamlined Application" and renewal form. By changing the initial and renewal applications to remove requests for verifications prior to electronic verification sources being accessible, incomplete application and renewal forms accumulated to create a significant backlog. Each processing entity experienced significantly increased administrative workloads, and families experienced delays in processing and requests to produce paper verifications.
- Initiated coordination with the Federally Facilitated Marketplace (FFM) to transfer account information to and from the FFM. PA-CHIP faced significant challenges as the Federal Data Services Hub underwent inadequate testing and was not prepared to facilitate the transfer of the account information.
- Transitioned to Income Tax Rules, causing considerable confusion for a means tested program. Confusion as to the applicability of the rules to certain households'

composition continues, as federal regulators are still interpreting certain rules as to when or how income should be counted.

Currently, Pennsylvania administers a Title XXI CHIP through nine private insurance companies serving as contractors. (Title XXI of the Social Security Act allows states to operate a stand-alone CHIP program, separate and apart from a Title XIX Medicaid program.) The contractors provide healthcare benefits to the children, and are responsible for certain portions of the eligibility and enrollment process. Pennsylvania is the only state with this type of arrangement. In response to the ACA, along with the passage of the CHIP Reauthorization Act of 2009, PA-CHIP is performing a holistic assessment of the administration of the program to identify areas of possible administrative improvement. The review has thus far demonstrated the benefit of a Title XXI CHIP, and the corresponding use of contractors, as this administrative framework allows CHIP to operate very efficiently.

The ACA also impacted PA-CHIP's "Buy-In" program, which allows families with incomes greater than 300% FPL<sup>1</sup> to purchase the PA-CHIP benefit package at no cost to the state or federal government. Even though the Buy-In program maintains the same eligibility requirements and benefit package as the subsidized PA-CHIP, federal authorities have not yet concluded the Buy-In program constitutes Minimum Essential Coverage (MEC) for enrollees. Without this conclusion, enrollees in the Buy-In program may face penalties pursuant to the ACA's individual mandate if other coverage is not secured.

- 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.**

As a preliminary note, in a study performed by Deloitte Consulting, LLP (Deloitte) for Pennsylvania in August 2012, Deloitte analyzed the ten benchmark options for the exchange and concluded, among other things, that there was little variation in the benchmark options. Thus, for purposes of this response, the PA benchmark benefits and the majority of employer sponsored health plans in the state are assumed to be parallel, and our comments will focus on comparing PA-CHIP benefits and the PA benchmark benefits.

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<sup>1</sup> Factoring in the ACA MAGI rules, 300% FPL is effectively 314% FPL.

## Cost-Sharing

PA-CHIP has graduated levels of premiums and cost-sharing based on income level.<sup>2</sup> Under PA law, Free PA-CHIP covers children in families with an adjusted gross household income no greater than 200% of the FPL. There are no premiums and no co-payments collected for enrollees in this group. Low-cost PA-CHIP covers children in families with an adjusted gross household income greater than 200% but no greater than 300% of the FPL; these enrollees pay modest premiums.

Children in Low-cost PA-CHIP also are charged point-of-service co-payments for primary care visits (\$5), specialists (\$10), emergency room care (\$25, waived if admitted), and prescriptions (\$6 for generic and \$9 for brand names). There are no co-payments for well-baby visits, well-child visits, immunizations, or emergency room care that results in an admission. Co-payments apply to physical health services but are not applicable to routine preventive and diagnostic dental services or vision services. Cost sharing for PA-CHIP, the combination of premiums and point of service co-payments, is capped by federal CHIP regulation (42 C.F.R. 457.560) at 5% of household income.<sup>3</sup>

In summary, PA-CHIP enrollees pay modest premiums, depending on income level, and have limited cost-sharing:

Income Federal Poverty Level (FPL)	Premium as a % of the Per Member Per Month (PMPM) Cost	Approximate Average Premium Cost to Enrollee Per Month as of September 5, 2014	Total Premium Plus Cost-Sharing Per Year as % of Household Income
<201% FPL	0%	\$0	0%
201% FPL – 250% FPL	25%	\$50.25	5%
251% FPL – 275% FPL	35%	\$70.35	5%
276% FPL – 300% FPL	40%	\$80.40	5%

<sup>2</sup> As noted above, PA-CHIP also has a full-cost component for those above 300% FPL, which is not subsidized by either federal or state dollars. In keeping with the focus of the Congressional inquiry, this cost-sharing discussion addresses only the subsidized components.

<sup>3</sup> 42 C.F.R. §457.560(a): "A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State."

By comparison, premiums for the second lowest cost silver QHP in Pennsylvania for 2014 plans ranged from \$84.46 to \$149.13.<sup>4</sup> Moreover, with the addition of cost-sharing, premiums plus cost-sharing under the ACA may be substantially more than 5% of household income, even with premium tax credits and cost-sharing reductions.<sup>5</sup> Focusing on the cost-sharing differential only, a study by Wakely Consulting Group in July 2014<sup>6</sup> concluded that the cost sharing (deductible, copays, and/or coinsurance) for a child on a silver plan, with cost sharing reduction subsidies, would be considerably more than the cost sharing for PA CHIP coverage:

Income Level Coverage	160% FPL		210% FPL	
	PA-CHIP	QHP	PA-CHIP	QHP
Actuarial Value	100.0%	86%-88%	97.2%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	2.8%	26%-28%
Average Annual Cost Sharing	\$0	\$411-\$480	\$98	\$891-\$960
Maximum Out of Pocket	\$0	\$500-\$2,250	\$1,419	\$3,000-\$5,200

This cost-sharing structure of PA-CHIP compares very favorably to QHP coverage available through the exchange. In many instances, cost-sharing for PA-CHIP enrollees will be equal to or less than a family would experience with enrollment in a QHP.

### Benefits

PA-CHIP provides identical, comprehensive benefits to individuals enrolled in all levels of the program. Basic services include:

- Preventive care, including physician, nurse practitioner and physician assistant services;
- Specialist care, including physician, nurse practitioner and physician assistant services;
- Autism services, not to exceed \$36,000 annual benefit cap (specified by Act 62 of 2008);
- Diagnosis and treatment of illness or injury;
- Laboratory/pathology testing;
- X-rays;

<sup>4</sup> [http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet\\_home.cfm](http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm).

<sup>5</sup> See, e.g., [www.communitycatalyst.org/doc-store/.../affordability\\_in\\_aca.pdf](http://www.communitycatalyst.org/doc-store/.../affordability_in_aca.pdf); <http://www.kaiserhealthnews.org/features/insuring-your-health/2013/070913-michelle-andrews-on-cost-sharing-subsidies.aspx>.

<sup>6</sup> "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans", Wakely Consulting Group, July 2014 ("Wakely Study") available at <http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf>.

- Injections and medications;
- Emergency care, including emergency transportation;
- Prescription drugs;
- Emergency, preventive and routine dental care, and medically necessary orthodontia;<sup>7</sup>
- Emergency, preventive and routine vision care;
- Emergency, preventive and routine hearing care; and
- Inpatient hospital care (90 days including mental health).

Additional medically necessary and therapeutic services include mental health services, inpatient and outpatient treatment of substance abuse, rehabilitative therapies, medical therapies, home health care, hospice care, durable medical equipment, and maternity care.

Significantly, the Wakely Study distinguished child-specific benefits – those that are other than the core benefits typically included in a major medical insurance policy – and found that PA-CHIP covers 79% of those services, while QHPs cover only 50%. Child-specific benefits focus on dental, including orthodontics; vision; audiology; habilitation; and therapy coverages.<sup>8</sup>

PA-CHIP, like QHP coverage, includes some limitations on benefits. However, it is difficult to compare those limitations with the QHP coverage of those benefits for two reasons. First, QHPs may also impose limits, but data is not readily available to identify the frequency or level of those limitations, and the limits may vary by product and plan. Second, if a child is approaching those limits on PA-CHIP, it is likely that the child will be eligible for Medicaid coverage through a special PA Medical Assistance program for children with special health care needs or chronic conditions (for which income is not considered when determining eligibility).

- 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?**

Federal funding for CHIP should absolutely be extended promptly. PA-CHIP has provided health care coverage to hundreds of thousands of children in Pennsylvania for over 20 years and

<sup>7</sup> As a result of the CHIP Reauthorization Act of 2009 (CHIPRA), medically necessary orthodontia was added to the dental benefits package. The orthodontia benefit is capped at a lifetime maximum of \$5,200. The yearly dental benefit limit is \$1,500.

<sup>8</sup> See Wakely Study at Table 16, pages 26-27.

is an example of how states can develop innovative solutions to meet the needs of their residents. Pennsylvania has worked tirelessly to continue providing PA-CHIP coverage as an option for children and their families. With the health care needs of Pennsylvanian's children at stake, it is critical that federal funding be extended to allow PA-CHIP as an option for families seeking coverage for their children.

Pennsylvania strongly recommends that federal funding be extended to align with Congress's authorization of the program, i.e. through fiscal year 2019. As current federal funding of CHIP is set to expire on October 1, 2015, Congress should begin the reauthorization process immediately. States, as partners in the CHIP program, need the timely assurance of funding as they prepare their budgets. But perhaps more critically, Congress should urgently address the continued appropriation of federal funding for CHIP to provide certainty for families who rely on CHIP coverage for their children.

In the absence of CHIP, families would have fewer options for accessing health care and more than 157,200 Pennsylvania children would need to find replacement coverage, which could take time, be more expensive, and potentially jeopardize the children's access to health care services. This would be devastating to Pennsylvania families.

- 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 states' allotments are based on complex methodologies specified in Section 2104(m) of the Social Security Act. Each state's federal fiscal year (FFY) allotment is adjusted based on several factors, including per capita health care growth and the child population growth.

For FFY13, ACA mandated a "rebasings" process to determine the allotment. This methodology bases the allotment on the states' payments (i.e., based on enrollment) rather than the allotments for FFY12. For FFY14, the methodology reverted to using the prior year allotments as a base. For FFY15, there will be two allotments: one for each six months of the FFY.

Pennsylvania has been fortunate since the passage of CHIPRA to have adequate federal funds to meet the increased demand for the CHIP services. We saw our CHIP enrollment increase from 183,000 to nearly 198,000 between early 2009 and mid-2010 before enrollment again levelled off and began a slow decline through 2012. The decline has continued due to the ACA requirement that children in the 100%-133% FPL range be enrolled in Medicaid, rather than CHIP.

The federal matching rate is set to increase by 23 percentage points beginning in FFY15. This will lead to a quicker exhaustion of federal CHIP dollars. Simultaneously, as Pennsylvania has

experienced leaner enrollment figures – partially attributable to the unnecessary transfer of children to Medicaid – the formula works against Pennsylvania since the program's lower enrollment numbers will be used for calculating future allotments (rebasing). Thus, just as the matching rate is set to increase by 23 percentage points – resulting in a quicker exhaustion of federal CHIP funds – Pennsylvania will receive a smaller allotment of federal funds to support its CHIP program. Many states will be in a similar predicament.

In sum, it may be wise to take unspent funding from past years and make it available to states, such as Pennsylvania, that have decreased CHIP enrollment due to Medicaid expansion, so that their programs will not be doubly jeopardized when the significantly increased federal match funds are distributed in accord with the rebased allotments.

- 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?**

When contemplating federal policies to reduce the number of uninsured children, Pennsylvania suggests a shift of focus away from only looking at the number of enrollees and move towards structuring programs that empower families to get engaged in improving their health and becoming more well-informed consumers of their health care. Focusing solely on the fluctuations in enrollment numbers distracts advocates, legislators, auditors, and others away from the overall goal of improving the health of children by ensuring there are a range of coverage options to allow a child to be covered, regardless of changing life circumstances. Under Governor Corbett's leadership, the health care coverage rate for children in Pennsylvania is close to 95%. While this is extremely high, Governor Corbett believes we can still do more and has pushed to continuously work toward getting all kids covered while also seeking to strategically improve Pennsylvania's overall health insurance system. Any policy changes contemplated by the federal government should align with Governor Corbett's *Healthy Pennsylvania* priorities: providing affordability, improving access, and ensuring quality.

Access to health care coverage must be affordable for consumers. To accomplish this, more incentives should be built into government programs to allow states to help individuals transition from fully subsidized coverage to self-sufficiency, such as additional premium assistance for employer-sponsored insurance. Policymakers should shift away from eliminating premiums, and rather toward giving states the flexibility to develop premium structures that are affordable for consumers and begin to build into these programs various levels of health care consumer engagement and a stronger focus on healthy behaviors. CHIP premiums are designed on a sliding scale based upon a family's ability to pay. As income increases, the cost-sharing rises closer to what is experienced in commercial health insurance coverage. The flexibility to stagger

cost-sharing would allow the program time to engage consumers and begin educating enrollees on the benefits of having a personal stake in improving their health. Establishing greater flexibility could lead to the development of healthy behavior incentive programs that reward good health care choices and improved health, therefore, allowing CHIP enrollees to receive some of the newest innovations in health care coverage that are found in the commercial health insurance market.

Access to health care coverage must also be available for consumers. Policymakers should focus on how to attract and retain highly qualified medical professionals as providers to facilitate better access to the health care system. As enrollment numbers increase, so potentially do the wait times to see a practitioner. When individuals desire to be in the medical profession, we should provide incentives to fill the gaps as far as medical specialties – including general practitioners – and geographic locations. As part of *Healthy Pennsylvania*, Governor Corbett continues to support loan forgiveness programs to incentivize primary health care providers to practice in rural and underserved areas of the Commonwealth.

Policymakers should seize the opportunity presented by the federal extension of CHIP to improve upon the program's strengths, and to allow CHIP to serve as an integral bridge to independence for CHIP children and their families.