



FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

Testimony

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Washington, D.C.

**Senate Finance Committee
Subcommittee on Health Care**

Hearing on

**“The Children’s Health Insurance Program:
Protecting America’s Children and Families”**

September 16, 2014

Thank you Chairman Rockefeller, Ranking Member Roberts, and members of the Finance Committee's Health Subcommittee for inviting me to speak to you today about the Children's Health Insurance Program (CHIP) and the positive impact it has had on the lives of millions of children across this country.

I would like to start by recognizing Chairman Rockefeller for his lifetime achievements in championing an array of issues, including child health, foster care, Supplemental Security Income (SSI), and child poverty, that have been critically important to the children of West Virginia and this entire country. As a former Senate staffer who worked for Senators Graham, Breaux, and Bingaman for over a decade, I witnessed Senator Rockefeller's passion and commitment to these issues up close and would like to personally thank him for his leadership on behalf of children, including his bipartisan work in this Committee with Senators Hatch, Kennedy, Chafee, and Grassley in helping create the Children's Health Insurance Program.

Mr. Chairman, CHIP has been an undeniable, bipartisan success story. As those of us that worked on the issue back in 1997 can attest, the lack of health insurance coverage among children was a national tragedy.

In fact, one in seven of our nation's children had no health insurance coverage and, in places like El Paso, Texas, where I grew up, the Public Health Department reported that nearly 40 percent of the children were living without health coverage and that families were just an illness away from tragedy or bankruptcy. I grew up with kids whose parents would not let them play sports out of fear that they would become injured and had a childhood classmate and friend who died tragically because his parents could not afford the expensive cancer treatment he needed to survive.

These were not isolated incidents. An Institute of Medicine (IOM) committee, which began analyzing the problems with children's health in 1996, found that "insurance coverage is the major determinant of whether children have access to health care" and that uninsured children are "most likely to be sick as newborns, less likely to be immunized as preschoolers, less likely to receive medical treatment when they are injured, and less likely to receive treatment for illnesses such as acute or recurrent ear infections, asthma, and tooth decay."

The report concluded:

Access to health care can influence children's physical and emotional growth, development, and overall health and well-being. Untreated illnesses and injuries can have long-term – even lifelong – consequences.

And, according to a 1991 landmark report entitled *Beyond Rhetoric: A New American Agenda for Children and Families* by the bipartisan National Commission on Children, which was chaired by Senator Rockefeller:

Perhaps no set of issues moved members of the National Commission on Children more than the wrenching consequences of poor health and limited access to medical care. In urban centers and rural counties, we saw young children with avoidable illnesses and injuries, pregnant women without access to prenatal care, families whose emotional and financial resources were exhausted from providing special care for children with chronic illnesses and disabilities, and burned-out health care providers asked to do more than is humanly possible.

If this nation is to succeed in protecting children's health, there must be a major commitment from families, communities, health care providers, employers, and government to meet children's basic health needs and to ensure that all pregnant women and children have access to health care.

CHIP Is a National Success Story

Mr. Chairman, that commitment to protecting the health of our nation's children was answered by Congress in a bipartisan manner, with the passage of CHIP in 1997.

Through the leadership of Chairman Rockefeller and Senators Hatch, Kennedy, Chafee, Roth, and Moynihan in the Senate, the creation of CHIP was the result of a year-long debate and series of compromises that led to the commitment of \$24 billion over seven years toward the goal of dramatically cutting the number of uninsured children in America.

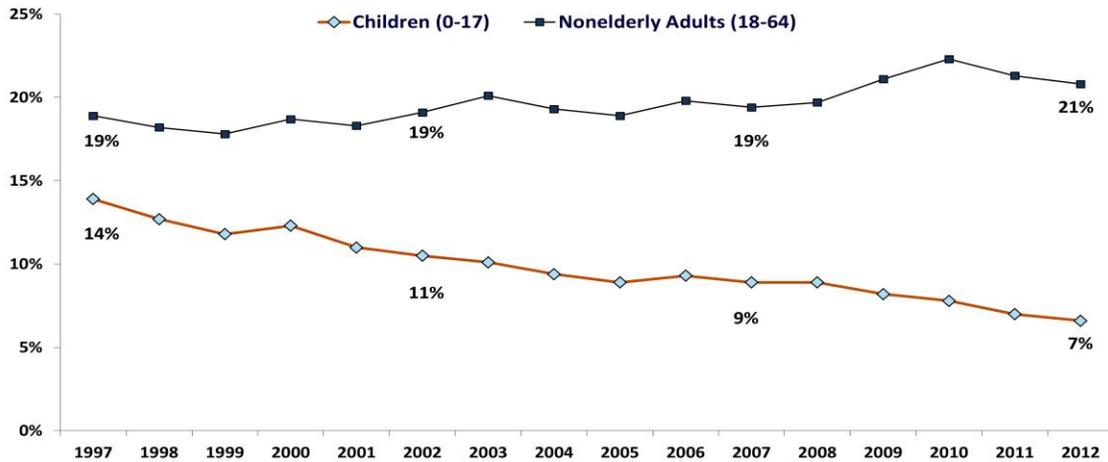
The bipartisan discussions that senators had over the course of that year were inspiring. Although there were some disagreements about how the program should operate and compromises had to be found, the fact is that all of the members of the Finance Committee believed that we should no longer tolerate a situation where children should be sick, live in pain, or go without preventive care like vaccinations and annual check-ups just because their parents have lost their job or simply can't afford health insurance.

Democrats and Republicans agreed that investing in the health of our children is investing in America and its future. They recognized that when our children develop and thrive, we are paving the way for our country's next generation of workers and leaders. And when our kids aren't healthy, they do not learn and our nation will fail to stay the world's leader in innovation. That is why CHIP has proven to be so important.

Toward these goals, CHIP has been a rousing success story, as the uninsured rate for our nation's children has been cut in half – from 14 percent in 1997 to just 7 percent in 2012 (see Figure 1 from Kaiser Family Foundation) while the uninsured rate for adults (ages 18-64) has increased.

Figure 1

Uninsured Rates Among Nonelderly Adults and Children, 1997-2012



NOTE: Children includes all individuals under age 18.

SOURCE: KCMU analysis of the National Health Interview Survey data.



This past year, according to the Kaiser Family Foundation and the Congressional Budget Office (CBO), CHIP covered an average of 5.7 million children during a given month and over 8 million children for the year.

These success points exceed the expectations of many at the time CHIP was passed. For example, days before CHIP was passed by the U.S. Senate in 1997, Bobby Jindal, Louisiana's Director of Health and Hospitals (DHH) told Senator Breaux, whom I worked for at the time, that he thought it was highly unlikely that Louisiana would take up an expansion of coverage for children via CHIP.

However, although Louisiana was slow to act, the State did enact a program that was named LaCHIP. Louisiana's proposal to expand coverage to children was the 43rd plan approved by the federal government and, after a gradual phase-in of coverage over a couple of years, the State's program has proven to be incredibly successful. In fact, the uninsured rate for children in the Pelican State has, according to the U.S. Census Bureau, dropped from 23.2 percent in 1999 when LaCHIP was truly getting off the ground under Republican Governor Mike Foster and Democratic Governor Kathleen Blanco to 8.3 percent today under now Republican Governor Jindal.

Louisiana's positive experience is similar to that of most states across the country, as both Democratic and Republican governors and legislators have embraced and improved CHIP over the years so that today we are closing in on the bipartisan

National Commission on Children’s goal and your vision, Senator Rockefeller, of ensuring that our nation’s children and pregnant women have access to health care.

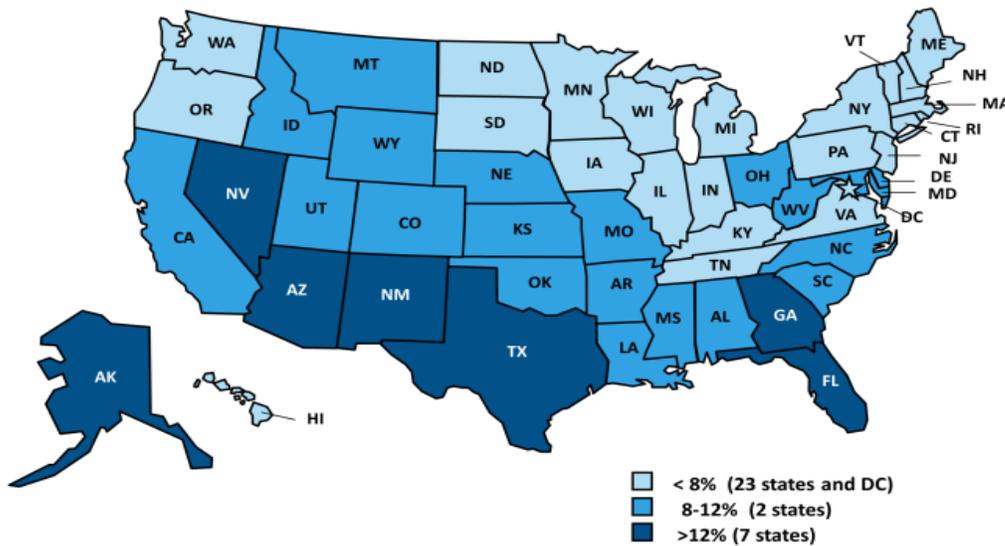
CHIP is also a program that has been tailored to the specific needs of children and pregnant women in the individual states. Recognizing that wages and health care costs are far different across the states, CHIP gives states discretion in working with their providers and insurance plans to set premiums, cost sharing, benefits, income eligibility levels, and provider networks for children and pregnant women rather than having a one-size-fits-all federal standard.

The downside to state flexibility has been that progress has been somewhat uneven. In 43 states and the District of Columbia, the uninsured rates for children are now below 12 percent and the rate is below 5 percent in the states of Massachusetts, Connecticut, Hawaii, Michigan, and Vermont.

In contrast, the rates of uninsured children, although much improved, tend to remain highest in the Southwest, where I grew up, and the South. Only seven states still have uninsured rates for children that exceed 12 percent and they are: Nevada, Texas, Alaska, Arizona (which is the only state in the country that has frozen CHIP), Florida, New Mexico, and Georgia (see Figure 2 from the Kaiser Family Foundation).

Figure 2

Uninsured Rates for Children by State, 2011-2012



SOURCE: KCMU/Urban Institute analysis of the 2013 ASEC Supplement to the CPS.



Fortunately, we continue to make progress in closing in on the “finish line” of covering all kids. According to a report by Eugene Lewit at the Stanford University Center for Health Policy and Primary Care and Outcomes Research:

Approximately 88 percent of Medicaid or CHIP eligible children were enrolled in the programs in 2012. That was the highest rate of program participation for children among a number of other means-tested programs. It also represented an impressive increase in children’s participation since the early years of CHIP and an increase of over six percentage points since just before the enactment of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) in February 2009.

Nonetheless, an estimated 5 million of the remaining 7 million uninsured children in the country are eligible for but not enrolled in Medicaid and CHIP. Lewit found that groups with participation rates below the national average include teenagers, children not living with their parents, Hispanic children, American Indian/Alaskan Native children, citizen children with noncitizen parent(s), eligible noncitizen children, and children with at least one parent eligible for Medicaid but unenrolled.

One of the hallmarks of CHIP has been the willingness of leaders on both sides of the aisle to work together to improve the enrollment of these children. For example, President George W. Bush championed a proposal to target eligible but unenrolled kids through outreach and enrollment grants. This initiative was incorporated into bipartisan legislation by Republican Majority Leader Frist and Senator Bingaman and was eventually included in CHIPRA. These grants have supported a number of community efforts to enroll into coverage some of our nation’s most vulnerable children and have successfully helped drive down the uninsured rate of children.

Furthermore, Express Lane Enrollment is a streamlined process that facilitates Medicaid or CHIP enrollment for children based on verified eligibility criteria from other public assistance programs. This state option has been successfully adopted in a number of states, including Alabama, Colorado, Georgia, Iowa, Louisiana, Maryland, Maine, New Jersey, New York, Oklahoma, Pennsylvania, South Carolina, and Utah.

According to an evaluation of the program by Mathematica that was published this past December, the Express Lane Eligibility state option has been proven to reduce bureaucratic red tape and administrative costs while improving coverage rates in a number of states. Unfortunately, Express Lane Eligibility is currently slated to expire in March 2015. Instead, the state option should be extended permanently.

CHIP Is, by Definition, Child-Focused

CHIP is, as you know and by definition, child-focused and that has been a critical factor in its success for children. If you have talked to pediatricians or been inside a children’s hospital, within the first five minutes, you have likely heard the mantra

that “children are not little adults.” As the IOM committee that issued the report entitled *America’s Children: Health Insurance and Access to Care* in 1998 understood, children are better off if they are seen within a network of providers that have pediatric expertise and experience. The report recommended, “Public and private insurance should be encouraged to develop affordable products that address the specific needs of children, including children with chronic conditions and special health care needs.”

Mr. Chairman and members of the Finance Committee, that is exactly what CHIP is. CHIP provider networks have been built and improved over the years in every single state and they must meet specific pediatric quality standards that address the unique developmental and health care needs of children.

According to the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services (HHS), “A survey of parents of CHIP enrollees in 10 states found that most CHIP enrollees (88 percent) had a usual source of care in the last 12 months and that 83 percent of CHIP parents found it usually or always easy to get appointments. The same survey also found that four-fifths of children received a preventive visit and 86 percent had a doctor or other health professional visit in 2012.”

Similarly, a 2012 CHIP evaluation report by Mathematica Policy Research found, 92 percent of parents of CHIP enrollees never or rarely had problems paying their child’s medical care. In sharp contrast, nearly half of the uninsured are not confident they can afford to pay for the health care services they need.

Therefore, CHIP has successfully expanded health coverage to kids, tailored services and benefits to address the special health care needs of children, improved access to health care, and reduced financial burdens for low-income families. In the face of a raft of bad news for children, including the fact that 22 percent of our America’s kids are living in poverty, CHIP stands out as a shining success story.

In contrast, while the health of children and pregnant women are the first and only thought in CHIP, they can be an afterthought in the adult health care system, including private employer plans, the Federal Employees Health Benefits Program (FEHBP), and Marketplace exchange plans.

When I worked on Capitol Hill for Senator Bingaman, staff were shocked to hear at a briefing by FEHBP that program administrators did not even know how many children were served in the program and how some of the plans had very limited pediatric networks. One plan only listed a few pediatricians in all of Prince George’s County, Maryland in its network and calls by staff found that even these few pediatricians were not accepting new patients. If you enrolled in that plan, lived in Prince George’s County, and had kids, you would have been hard-pressed to find a primary care doctor for your child.

Worse, during one enrollment cycle, D.C.'s Children's Hospital was excluded from FEHBP's most popular Blue Cross plan option and it sent shock waves throughout the federal government as parents lined up at Office of Personnel Management (OPM) enrollment booths to get information on how to change their insurance option to protect their children's access to care. Unfortunately, when parents changed their plans, it was often at the expense of losing their own provider networks, and I can personally attest that this was a disaster for many of us.

Subsequently, with the advent of the insurance exchanges in the Affordable Care Act (ACA), although we strongly support important provisions related to bans on pre-existing condition exclusions or lifetime caps that were so harmful to a number of children, there remains a number of issues that need to be worked out for kids. For example, just this past week, Seattle Children's Hospital resolved a lawsuit and lengthy negotiation with insurers, including Premera Blue Cross and Regence in Washington State, to ensure that the Children's Hospital can be included as an available provider option to children in the State's exchange plans.

CHIP Plays a Key Role in Reducing Health Disparities

CHIP, in partnership with Medicaid, serves as an important source of coverage for children of all races and ethnicities. According to the Kaiser Family Foundation, about a quarter of white (26 percent) and Asian-American (25 percent) children, and over half of African-American (54 percent) and Hispanic (52 percent) children are served by Medicaid and CHIP.

According to the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, one of the foremost action strategies of the Secretary is to "increase the proportion of people with health insurance and provide patient protections in Medicaid, CHIP, Medicare, health insurance exchanges, and other forms of health insurance."

As noted earlier, strategies that include outreach and enrollment grants and the use of Express Lane Eligibility are important mechanisms to reduce the number of uninsured and disparities in health coverage.

One example of this is to better utilize community health workers or "promotoras" to help uninsured but eligible children get enrolled into coverage but to also assist families in navigating the health care system to ensure their children receive the insurance benefits and public health services that their kids need.

"Such activities will have a focus on reducing disparities in coverage for racial and ethnic minorities and those experiencing language barriers," according to the Action Plan. "Linking enrollment of children and families in CHIP and Medicaid to enrollment in human service programs will improve the access and availability of both health care and human services for underserved populations."

Therefore, in addition to extending CHIP's funding, it is important that Congress also extend the authorization and funding for both outreach and enrollment efforts that include the use of community health workers or "promotoras" and Express Lane Eligibility.

And, beyond coverage improvements, a study published by the National Institutes of Health (NIH) found that CHIP coverage has been critically important and successful in reducing disparities in access to care measures, including usual source of care (USC), preventive care use, unmet needs, patterns of USC use, and parent-rated quality of care between white children and black or Hispanic children. However, more work needs to be done in terms of addressing language barriers, improving provider workforce diversity, and expanding quality initiatives to drive further reductions in health disparities.

Rural Children Would Stand to Lose the Most if CHIP Expires

As a former Senate staffer to the Senate Rural Health Caucus, I know that many of you are deeply concerned about the impact that health policy has in rural communities. Consequently, First Focus commissioned a study of the uninsured rate and coverage rates of Medicaid and CHIP in both rural and urban communities and found what may be a surprising result to some.

In this study by William O'Hare entitled *Rural Children Increasingly Rely on Medicaid and State Child Health Insurance Programs for Health Insurance*, he analyzed Census Bureau data for child health coverage and his key findings include:

- *The percent of children who lack health insurance is the same in both urban and rural areas but the source of insurance coverage differs.*
- *Of the fifty counties with the highest rate of uninsured children, 45 are rural counties.*
- *In 2012, 52 percent of rural children lived in low-income families (those with income less than 200 percent of the poverty line) compared to 42 percent of urban children.*
- *Children in rural areas are more reliant on health insurance from public sources. In 2012, 47 percent of rural children are covered by public insurance compared to 38 percent of urban children.*

Due to the higher levels of child poverty in rural America, where over half the children live in families with income below 200 percent of the poverty line, the uninsured rate for children would be much higher if it were not for the health coverage offered by Medicaid and CHIP.

In fact, if CHIP were to be allowed to expire, it is clear the result would be negative to both rural and urban children, but that the children in rural America would stand the most to lose and would be disproportionately harmed.

Even worse, for those rural communities that already have some of the highest uninsured rates for children in the country, the loss of CHIP would compound what is already an enormous problem.

CHIP is Overwhelmingly Popular with the American People

In light of the importance that CHIP plays in the lives of millions of children and the many successes that CHIP has had since its inception 17 years ago, it is not surprising that the American people know a good thing when they see it.

In November 2008, a Lake Research Partners survey found that American voters supported renewing CHIP, which was facing expiration in March 2009, by a resounding 82-10 percent margin.

Four years later, another Election Eve poll by Lake Research Partners found that, despite the partisanship and acrimony that had developed around the Affordable Care Act (ACA), voters in both political parties overwhelmingly supported extending CHIP by a wide 83-13 percent margin.

And in May of this year, a poll by American Viewpoint found that voters continue to support extending CHIP by a margin of 74-14 percent.

At a time when one-quarter of the American people seem to be so disenchanted and cynical that they oppose just about everything, it is a testament to CHIP that it has maintained such strong bipartisan support over the years. The same is true when the pool breaks down support by age, gender, and racial groups.

In the American Viewpoint poll, for example, the level of support versus opposition to extending CHIP is:

- 80-10 percent among Democrats
- 66-19 percent among Republicans
- 75-15 percent among Independents
- 66-18 percent among self-identified “Tea Party supporters”
- 77-12 percent among women
- 71-16 percent among men
- 80-9 percent among adults 18-29 years of age
- 72-15 percent among adults over the age of 65
- 72-14 percent among whites
- 79-14 percent among African-Americans
- 79-12 percent among Hispanics
- 79-13 percent among parents
- 73-16 percent among grandparents
- 71-15 percent among adults without children

- 76-14 percent among urban voters
- 74-15 percent among suburban voters
- 72-13 percent among rural voters
- 75-15 percent in states where both senators are Republicans
- 71-13 percent in states where the senators are split
- 76-14 percent in states where both senators are Democrats

No matter how you break it down, American voters support CHIP by wide margins.

Unfortunately, CHIP's 8 Million Children Are at Risk

Although CHIP celebrated its 17th birthday this year and has achieved a remarkable record of success, funding for the program expires on September 30, 2015, and there is some urgency to addressing the issue as soon as possible because states are beginning their budget preparation now and are facing uncertainty about how to handle CHIP beginning in October 2015. In addition to the state's budget planning needs, states also need to resign contracts with private health plans and those private health plans need to resign contracts with their health care providers for the upcoming year.

Unfortunately, with the establishment of the ACA Marketplace plans, there are some that are questioning whether CHIP should be extended after September 2015. The problem is that, if CHIP funding were allowed to expire – either purposely or due to congressional inaction – it is estimated that up to 2 million children who currently rely on CHIP's coverage for their asthma, vision, dental, or cancer treatment would become uninsured unless they are able to obtain alternative coverage through some alternative source, such as Medicaid, the exchange plans, employer coverage, or the individual market.

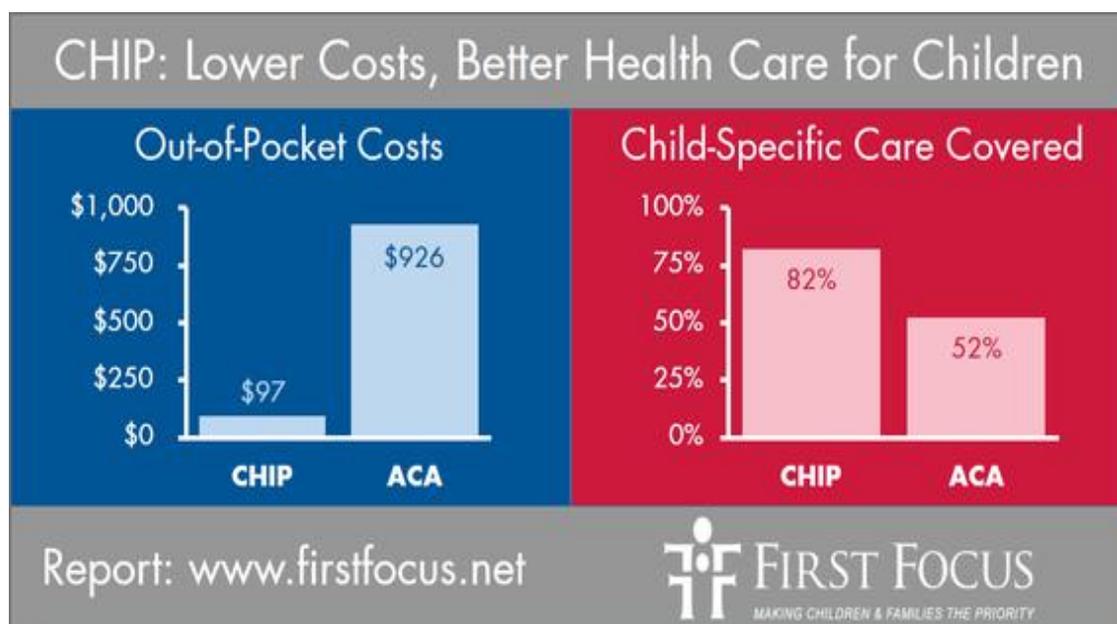
In analyzing the question of what would happen to the health coverage of 8 million children if CHIP were allowed to expire, the Medicaid and CHIP Payment and Access Commission (MACPAC) issued a report in June which "found that many children now served by the program would not have a smooth transition to another source of coverage" and that the "number of uninsured children would likely rise...."

One of the major factors, according to researchers at the Urban Institute, is that "as many as half of the children with Medicaid or CHIP coverage and family incomes above 138 percent of poverty might not qualify for Marketplace subsidies if CHIP were not reauthorized." This is because the ACA precludes families from receiving exchange subsidies to purchase coverage if they are made an offer of "affordable" employer-sponsored coverage to an individual employee, even if the cost of health coverage for the entire family is "unaffordable." This problem is referred to as either the "family glitch" or "kid glitch" in the ACA.

But, even for those that would be able to make the leap from CHIP to the qualified health plans (QHPs) in the Marketplaces, the Wakely Consulting Group, on behalf of the Robert Wood Johnson Foundation, compared the actuarial value and benefits offered by CHIP plans to QHPs in 35 states.

In their report entitled *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans*, the Wakely Group found that children are currently offered excellent and superior pediatric-focused coverage through CHIP than they could obtain through the Marketplaces (see Figure 3).

Figure 3: Wakely Group Comparison of Cost Sharing and Benefits in CHIP versus Exchange Plans



The report's findings include:

- **Average Cost Sharing:** In every state, children covered by CHIP would have significantly lower levels of cost sharing than through plans offered on the exchanges. For example, the Wakely Group found that the average cost sharing for a child in CHIP is estimated at \$97 for households with incomes at 210 percent of the federal poverty level (FPL) compared to \$926, which is 955 percent higher, for a child in the exchanges. In every single one of the 35 states studied, CHIP cost sharing is much lower than the level of cost sharing required in QHPs through the exchanges. **CHIP is superior**
- **Total Out-Of-Pocket Costs:** Children with special health care needs that are currently served by CHIP would be hardest hit by a transition to QHPs. In some states, children with special health care needs could go from paying \$0 in cost

sharing in CHIP to over \$5,000 in annual out-of-pocket expenditures in the exchange plans. **CHIP is superior**

- **Coverage of Benefits and Services:** CHIP covers more child-specific services and benefits with fewer limits than QHPs. For example, CHIP covers more child-specific services and benefits, such as pediatric dental, vision, hearing, autism services, habilitation, etc., than QHPs in the exchanges.

As an example, on the issue of pediatric dental coverage, QHPs can exclude dental benefits if a stand-alone dental plan is available in that state. As a result, only 40 percent of QHPs that were reviewed offer pediatric dental as an embedded benefit in the QHP. In more than half of the states studied, children moving from CHIP plans into QHPs would likely need to purchase separate stand-alone dental plans in order to have comparable coverage, which means that families would face additional costs for the separate premium required in a stand-alone dental plan. **CHIP is superior**

- **Benefit Limits or Caps:** Even with respect to benefits that are provided through both CHIP and QHPs, the Wakely Group found that CHIP plans have fewer limits or caps that are imposed on that coverage.

For instance, with respect to physical, occupational, and speech therapy, the Wakely study found that both CHIP and QHPs cover all of these services. However, four-fifths, or 80 percent, of QHPs impose utilization limits and caps for these services, which is in sharp contrast to 42 percent of CHIP plans. **CHIP is superior**

In all 35 states studied and analyzed by the Wakely Group, if children were transitioned from CHIP to exchange QHPs, they would face significantly higher out-of-pocket costs and have fewer child-specific benefits covered. In short, millions of children would be left worse off if Congress fails to extend CHIP.

- **Child-Centered Networks:** But, even beyond the lower cost-sharing and stronger benefits, CHIP is important to protect because the health provider networks in CHIP are made up largely with doctors, nurses, and hospitals that have pediatric and maternal child health expertise. They are educated and trained to recognize and treat the unique array of physical, mental, social, and emotional developmental needs of children as they grow from infancy through adolescence. This focused attention and expertise in addressing children's special needs stands in sharp contrast to the situation in other types of adult-centered coverage.

For example, while a CHIP quality review panel's time is spent almost entirely reviewing and discussing ways to improve child health, child advocates have found it difficult to even get even one pediatric expert to be named to such a panel in adult-centered networks or to get time focused on the needs of children.

According to analysis by the Urban Institute, just 1-2 percent of all spending in the health reform Marketplaces is projected to be attributable to children's coverage, so

attention to the cost and quality of care for kids will simply not be a top priority.
CHIP is superior

Conclusion and Recommendations

Toward the end of World War I, the United States Children's Bureau and Woman's Committee of the Council of National Defense issued a decree in April 1918 that declared: "The health of the child is the power of the nation." They recognized that the health of children is a cornerstone to ensuring both their and the nation's long-term well-being and success.

Over the years, our nation's leaders have chosen to make some key strategic investments toward these goals of improving the lives of children and securing our nation's long-term success. In 1997, even amidst a discussion to pass a major deficit reduction package, the Congress – beginning with leadership in this Committee – chose to make such an investment to improve the health of our nation's children.

This has proven to be a wise investment, as CHIP has – in partnership with Medicaid – cut the uninsured rate for our nation's children in half over its 17 years. Since its beginning, CHIP has been a bipartisan, state-administered, public-private partnership that has always understood that "children are not little adults" and have unique developmental needs that often require pediatric expertise.

CHIP has also made important strides in reducing health disparities. And, despite two recessions and the resulting increase in child poverty, CHIP and Medicaid have managed to keep reducing the uninsured rate of children while the uninsured rates for adults were heading in the other direction. Consequently, the American public recognizes its value and, by overwhelming margins, strongly support its continuation.

In short, CHIP works and works well.

Nevertheless, with the passage of the ACA, there are some that have questioned whether we or not we should fold CHIP into the Marketplace exchanges. However, when you look at all the evidence, research from the Wakely Consulting Group, the Urban Institute, MACPAC, the American Academy of Pediatrics, the National Academy for State Health Policy, the Georgetown Center for Children and Families, the Children's Dental Health Project, the March of Dimes, the National Alliance to Advance Adolescent Health, and First Focus all point to the fact that, although the ACA holds great promise for millions of uninsured adults who otherwise lack affordable coverage options, allowing CHIP to expire would leave millions of children without health coverage and millions of others worse off unless significant legislative and regulatory improvements are made to the ACA.

Much would need to be improved in the exchanges and the law before Congress should consider moving children from CHIP to the Marketplace plans or else millions of children would be left worse off.

Consequently, over 400 organizations representing all 50 states have signed a joint letter urging Congress to, as soon as possible, protect and fully extend CHIP into the future.

Recommendations

Specifically, we urge Congress to adopt a **four-year extension of CHIP funding** through 2019. This would rightfully align the funding with the program's reauthorization date and we urge the Congress to pass such an extension during the lame duck session, as there is some urgency to this.

In fact, although CHIP funding does not expire until September 30, 2015, states are beginning to put together their budgets for FY 2016 now and state agencies are working with managed care organizations and providers across the country on CHIP network contracts. They are looking to the Congress for some assurances that the program will continue as they do their work.

We would also urge the **extension of outreach and enrollment grants, the pediatric quality standards, and Express Lane Eligibility** (which expires in March 2015) so that we continue to make progress toward the goal of covering all children.

And, although it is a Medicaid issue, we would also like to express our support for legislation by Senators Murray and Brown entitled the "Ensuring Access to Primary Care for Women and Children Act," as it would provide a 2-year extension to a provision in the ACA that raised Medicaid payments for certain primary care services up to Medicare levels. This **extension of the pay parity provision** would help improve access to care for children and pregnant women in the Medicaid program but it is currently set to expire on Dec. 31, 2014.

In closing, I would like to once again thank Chairman Rockefeller and Ranking Member Roberts for holding this important hearing about children's health. This Committee has always provided the leadership on CHIP and we look forward to working with you all toward its extension.

I would also like to personally recognize and thank Chairman Rockefeller for his outstanding career as a champion for our nation's most vulnerable citizens: its children. We appreciate all that you have done over the years for kids. Thank you!