FIRST FOCUS
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May 23, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
Washington, DC 20510

Dear Chairman Hatch:

Thank you for the opportunity to provide our comments and recommendations to address the range of health reform issues being considered by the House and Senate. Our comments are focused on the issues of importance to the health and well-being of our nation's children.

With your leadership, the Children's Health Insurance Program (CHIP) was enacted in 1997 and has, in tandem with Medicaid and private health insurance coverage, cut the uninsured rate for children from around 15 percent in 1997 to below 5 percent in 2015 – an astounding 68 percent reduction in the uninsured rate for children across this country in two decades.

First, "Do No Harm"

Our first request is that any legislation passed by the Congress should "do no harm" to this significant accomplishment. Now is not the time to reverse course and backtrack from what has been an enormous success story, which was sparked by your leadership with the passage of CHIP.

Over the course of the last two decades, the Senate has played an instrumental role in protecting the health of children. For example, despite the fact that both Medicaid and CHIP have been enormous success stories for children and the American public strongly supports both programs (for example, a recent Kaiser Family Foundation poll found that only 12 percent of Americans support cutting Medicaid), children's health coverage in both Medicaid and CHIP has been threatened on occasion, but the Senate has repeatedly acted to protect the health of children.

For example, in 2007, just months after enacting a nearly trillion-dollar health care package creating a prescription drug benefit in Medicare, President Bush tried to use CHIP's popularity and link his proposed changes to the tax code for health insurance to CHIP's extension. With your leadership, the Senate led the effort to pass a bipartisan bill that you argued was "the morally right thing to do" to reauthorize CHIP, but it was twice vetoed by the President. Fortunately, the Senate led the effort to save CHIP with a short-term extension of the program through 2009, when it was fully reauthorized.

Unfortunately, just a few months later when the Congress began work on health reform, the House of Representatives voted to phase-out CHIP and move millions of low-cost and low-income children into the new Obamacare exchange plans at the end of 2013. Child advocates asked Congress, just as we are once again asking, to be certain that "no child would be left worse off" by such a change and urged Congress to exhibit extreme caution before moving millions of children out of CHIP into a new and untested system. Once CHIP was gone, there would be nothing to turn back to if the new system had shortcomings.

Despite the request to "do no harm," the House ignored what was in the best interests of children and argued for the "greater good" that health reform would bring. Consequently, despite having voted to reauthorize CHIP just months earlier, the House voted to phase-out CHIP in its version of health reform.

Once again, after an independent actuarial study showed that children would be left worse off if CHIP were eliminated, you worked with Senator Rockefeller (D-WV) on an amendment that saved CHIP from repeal, and instead, extended funding for the program through 2015.

We raise this history because the House has, once again, ignored our plea to "do no harm," and instead, put children on the chopping block.

Oppose the Proposed AHCA Cuts to Children's Health Coverage in Medicaid

In legislation with the stated objective to "repeal and replace" the Affordable Care Act (ACA) or Obamacare, the House bill, called the American Health Care Act (AHCA), has taken steps to slash children's health coverage that has absolutely nothing to do with the ACA. In fact, even though children were not a part of the Medicaid expansion in the ACA, the House targeted children for severe Medicaid cuts in AHCA. A recent study by Avalere Health found that the AHCA would cut an astounding $43-78 billion from the health care of non-disabled children between 2020-2026 through the imposition of Medicaid per capita caps and a block grant option.

These numbers are even worse when you add in billions of dollars in cuts that would be imposed upon children with disabilities from the per capita cap proposal. The House's arbitrary limits on care and services to children with disabilities, who also have nothing to do with Obamacare's Medicaid expansion, would cause states to have to impose new limits or ration care to newborns, foster care kids, and children with asthma, autism, cancer, sickle cell anemia, cystic fibrosis, Rett Syndrome, spina bifida, hemophilia, or other chronic diseases and life-threatening illnesses.

The impact these cuts would have on children is compounded by the corresponding state cuts envisioned in the AHCA (for example, the AHCA's Medicaid block grant option calls for states to reduce their share of funding by 30 percent for children) and violates the repeated campaign promises by President Trump to not cut Medicaid.

Even worse, the proposal to impose a per capita cap and block grant in the Medicaid program will fall disproportionately on children. When House Speaker Newt Gingrich (R-GA) proposed to cap the Medicaid program in 1995, Senator John Chafee (R-RI) expressed grave concern that children would bear the brunt of a capped Medicaid program. He predicted:

> *As states are forced to ration finite resources under a block grant, governors and legislators would be forced to choose among three compelling groups of beneficiaries. Who are they? Children, the elderly, and the disabled. They are the groups that primarily they would have to choose amongst. Unfortunately, I suspect that children would be the ones that would lose out.*

With respect to the Medicaid per capita cap and block grant proposals in the AHCA, Senator Chafee was right about the disproportionate impact to children but the House of Representatives would impose greater harm even before the limitations are imposed on states.

It is important to understand the potential impact of the AHCA's per capita cap on children. Recent estimates from the Medicaid and CHIP Payment Advisory Commission (MACPAC) found that spending per enrollee for children will exceed that for the disabled and elderly populations by an average of 0.5 percentage points (4.8 percent for children compared to 4.2 percent for the disabled and 4.3 percent for seniors) annually between FY 2014 -2023. This is explained by the fact that children have been in Medicaid managed care for

decades now, and there are only limited additional savings that can be gained for children in Medicaid. Furthermore, technology advancements have led to an increase in the number of children that survive their first year of life, but many face challenging and life-threatening medical conditions into the future. These children, by definition, have more complicated and costly medical conditions than in the past.

Yet, the House legislation gives both the disabled and senior citizens an inflation adjustment that is a full percentage point higher than children under the per capita cap. According the House summary, "Recognizing the unique needs of the elderly and disabled, the amendment increases the annual inflation rate for the elderly and disabled Medicaid populations. This ensures that Medicaid spending on our most vulnerable more accurately reflects shifting demographics due to the aging of the Baby Boomers and the practical challenges of high-fixed costs for this vulnerable population."

Whether this policy is good for people with disabilities and senior citizens or not, under a capped funding mechanism children will be shortchanged and the billions of dollars in Medicaid cuts under the bill will be much tighter and fall disproportionately on children. This is confirmed by recent reports by the conservative American Action Forum (AAF) and Avalere Health.

As stated above, analysis of the AHCA by Avalere Health found that the House bill would reduce federal spending for non-disabled children in Medicaid by $43 billion between FY 2020-2026. That number would be even higher if the analysis were able to disaggregate the data to show the per capita cap's impact on children with disabilities. Meanwhile, the AAF study found that the arbitrarily imposed inflation rate established for children in the House bill would fall 27 percent below expected need.

The House proposal will forever lock in dramatic disparities in funding between states. In fact, according to estimates of per capita spending by population by the Urban Institute, the children in Vermont would receive 72 percent more per capita than the children in Utah from Medicaid. Moreover, Rhode Island would receive 149 percent more per child than New Hampshire. What could possibly justify locking in place such dramatic disparities for a decade or more into the future? Are children in Utah less worthy of comprehensive, high quality health coverage than the children in Vermont?

As for the block grant option, the House bill protects and exempts people with disabilities and senior citizens from the harm that would be caused by the block grant. In this case, children were not ignored by the House, they were specifically targeted for additional cuts. In addition to providing for an inflation adjustment that is half the rate that MACPAC estimates is needed for children, the AHCA also fails to adjust the block grant for population growth for children, which for children means babies. Members of the pro-life community have noted how this is the opposite of pro-life, and they have argued that this policy creates a financial incentive for states to limit births in order to stay under the block grant's arbitrary cap.

Furthermore, due to the lump sum nature and arbitrary cap created by the block grant, funding would not automatically adjust, as it does now, for changing needs, such as population growth, natural disasters, health care epidemics, or economic recessions. When states need the federal partnership the most and the needs of children would be greatest, the block grant leaves states solely responsible for addressing any increase in demand and the burden would hit children disproportionately. In fact, Avalere Health estimates that the AHCA's block grant would cut funding to non-disabled children by $78 billion.

In addition, according to the U.S. Census Bureau, Utah has the highest birth rate in the country and will soon be the fastest growing state in the country. Since the block grant does not adjust for births or population growth, Utah would be the most negatively impacted state in the country by the block grant option. In addition to Utah, other states that would be most harmed include Texas, Nevada, Arizona, Colorado, Idaho, Oklahoma, Arkansas, Georgia, North Carolina, South Carolina, Florida, Tennessee, Kentucky, Virginia, North Dakota, South Dakota, Montana, Nebraska Wyoming, Oregon, and Washington, as all of these states are all growing faster than the national average. Even worse, the populations of many of the states with the

lowest per-child spending levels in Medicaid are projected to grow much faster than the national average, while many states with high per-child spending have stagnant or even declining numbers of children. The block grant's failure to adjust for these demographic changes will serve to exacerbate the inequities between states and particularly harm states like Utah for decades into the future.

Any future health reform effort should meet a simple "do no harm" test and not leave people worse off, particularly children. It makes little sense to undo the enormous strides our nation has made over the last two decades in successfully expanding health insurance coverage to our nation's children since the passage of CHIP under your leadership.

Furthermore, if the goal is to "repeal and replace Obamacare," it makes absolutely no sense to cut the health coverage of children through Medicaid, as children's coverage through Medicaid was largely unaffected by the ACA.

As an example, children who are abused and neglected predominately receive their health coverage through Medicaid. By definition, foster youth have been sexually or physically abused or neglected and have been removed from their families. According to a study by the Center for Health Care Strategies (CHCS), "Children in foster care represented three percent of the Medicaid child population, but accounted for 15 percent of those using behavioral health services and 29 percent of total behavioral health spending for children." If we want these children to overcome the trauma and abuse that they have been subjected to, it does not make sense to impose an arbitrary cap and ration their care. Foster care children need care and services – not caps and cuts – to grow up to be healthy and productive adults.

It also flies in the face of the "21st Century Cures Act," which was touted as promoting new therapies, drugs, and treatments to improve the lives of the American people. Sadly, with the imposition of per capita caps or block grants in Medicaid, the federal government would be potentially rationing or denying access to the very life-saving care our nation's most vulnerable children need. According to a recent National Survey of Children's Health, 43.4 percent of children with special health care needs are enrolled in either Medicaid or CHIP.

Thus, we urge you to reject Medicaid per capita caps and block grants, as they impose arbitrary limits on coverage that will likely lead to disproportionate cuts to children's coverage and access to care.

Major Concerns with Undermining Important Patient Protections Included in the ACA

We strongly support leaving in place important patient protections from the ACA, including the ban on lifetime and annual limits; mandated coverage of essential health benefits important to children; coverage of dependents in family coverage up to age 26; the elimination of cost-sharing for preventive services, including well-child visits and vaccinations; and the catastrophic limits. We oppose the House bill's push to overturn those fundamental patient protections to the states.

Prior to the enactment of the ACA, the guarantee of coverage in the non-group market was dependent upon a wide array of state insurance laws and policies. In many states, children could be subjected to coverage denials for pre-existing conditions, even at birth if the parents were uninsured prior to the child's birth, just as happened to Houston Tracy (http://www.cbsnews.com/news/newborn-with-birth-defect-denied-coverage/) just months before the ACA took effect. Although Houston's parents had coverage for his two siblings, he was subjected to a pre-existing condition exclusion by his insurance carrier for a congenital heart defect at birth and denied coverage for his life-saving surgery at Cook Children's Medical Center in Fort Worth, Texas.

In Oklahoma, before the ACA was fully implemented, Governor Mary Fallin signed a rule that eliminated "'birth' as a qualifying experience for insurance" so that babies could be denied child-only individual coverage by insurance carriers through the first year of life.

Lifetime and annual caps were also an enormous threat, as children with special health care needs could reach lifetime limits within the first year or few years of life in both employer and individual market plans.

As a nation, we should not return to a period when coverage for our nation's most vulnerable children, including newborns, could be denied or excluded.

Concerns About the Structure and Adequacy of Tax Credits for Families

According to CBO's analysis of the AHCA, there are questions as to how changes in the tax credit structure under the AHCA would impact the affordability of health coverage to children in the nongroup market. CBO believes "the average subsidy under the legislation [to] be about 50 percent of the average subsidy under current law" by 2026 and that actuarial values of plans in the nongroup market will be lower. As a result, CBO and Joint Committee on Taxation (JCT) "expect that individuals' cost-sharing payments, including deductibles, in the nongroup market would tend to be higher than those anticipated under current law."

CBO asserts, "Because of plans' lower average actuarial values, CBO and JCT expect that individuals' cost-sharing payments, including deductibles, in the nongroup market would tend to be higher than those anticipated under current law. In addition, cost-sharing subsidies would be repealed in 2020, significantly increasing out-of-pocket costs for nongroup insurance for many lower-income enrollees."

One major problem in the ACA with covering dependents was created by the "family glitch," which denies access to the tax credits for *families* because of a determination of whether care is affordable for an *individual*. As advocates for children and families, we would hope that any future health reform effort would fix this problem that disproportionately impacts family coverage in terms of accessing the tax credits. Unfortunately, the AHCA makes the problem worse, as it denies tax credits to those who even have an offer of employer coverage, even if that coverage were to be unaffordable for both individuals and families.

A recent Kaiser Family Foundation and Health Research and Education Trust (HRET) report of firms that offer family coverage found, "45 percent of small firms and 18 percent of large firms provide the same dollar contribution for single and family coverage, which means that employees must pay the full additional premium cost to enroll family members in their plan. . . ."

According to Kaiser/HRET, the average annual employee share of health care premiums was $1,129 for single coverage and $5,277 for family coverage in 2016, or 367 percent more for family plans. In 15 percent of family plans, the employee has to pay more than half of the total premium compared to just 2 percent of those in single coverage plans.

Unfortunately, under the House bill, families would be unable to access to the credits even if an employer offers but does not subsidize family coverage at all or if such coverage is unaffordable. The House bill also inexplicably caps the cumulative credits that a family could receive at $14,000 in 2020. It is important to note that the same cap is not applied to the tax deductibility for those in employer coverage. Also, this arbitrary cap would discriminate against those in larger families. Again, Utah has the highest birth rate in the country and could be disproportionately harmed by such a cap. One might question whether it discriminates against families with certain religious affiliations, such as in the Mormon or Catholic faith.

Furthermore, experts believe that the average family plan premium will soon exceed $20,000 annually, and that doesn't take into account the costs of deductibles, coinsurance, and copayments that families incur to pay for their health care.

Unfortunately, the CBO score for the AHCA provides little insight on the possible impact of these provisions. The entire analysis of the tax credits is focused exclusively on the individual coverage. However,

the analysis estimates that "roughly 9 million fewer people, on net, would obtain coverage through the nongroup market in 2020 [and] that number would fall to 2 million in 2026" under the AHCA.

Concerns Related to Changes that Might Impact Children in Employer or Private Coverage

According to CBO, employer coverage would decline under the AHCA. As the score reads, "CBO and JCT estimate that, over time, fewer employers would offer health insurance because the legislation would change their incentives to do so. First, the mandate penalties would be eliminated. Second, the tax credits under the legislation, for which people would be ineligible if they had any offer of employment-based insurance, would be available to people with a broader range of incomes than the current tax credits are. That change could make nongroup coverage more attractive to a larger share of employers. Consequently, in CBO and JCT's estimation, some employers would choose not to offer coverage. . . ."

According to the score, CBO and JCT estimate that, by 2026, "roughly 7 million" fewer people would be enrolled in employer-based coverage under the AHCA.

Again, unfortunately the CBO estimate did not address the impact of the bill to children specifically. However, if employers were to drop coverage, it would be highly likely that the first to be cut would be dependents. Unfortunately, CBO and JCT did not mention dependent or family coverage in their analysis of the bill and this is another question on which we urge you to seek clarification from CBO.

Support for Changes Related to the Cadillac Tax

Finally, we support the provision in the AHCA that pushes implementation of the Cadillac tax back to 2025. As we wrote in our letter of support for the Kelly/Courtney "Middle Class Health Benefits Tax Repeal Act of 2007" (H.R. 173), "The threshold was set but is not adjusted for regional differences in health care costs or family health plan expenses. For example, the 'Cadillac Tax' sets the threshold for family plans at 2.69 times the expense of that for individuals. However, according to a recent report by the Kaiser Family Foundation and Health Research and Education Trust (HRET), the average premium cost for family coverage is 2.82 times greater than individual coverage. Thus, the excise tax will more heavily fall upon family plans, and thereby, children."

Hope for Real Health Reform for Children

The uninsured rate for children in this country now stands at a historic low – just 4.8 percent. This is largely due to the combination of employer coverage, Medicaid, and CHIP. We urge that Congress "do no harm" and reject any health reform package that would increase the uninsured rate for our nation's children or undermine the fundamental patient protections that were included in the ACA for children.

Instead, we urge Congress to focus on improving the tax credits and stability of the health insurance market. Congress should address the "family glitch" that was included in the ACA – and not make it worse, as the AHCA would – and eliminate tax provisions like the Cadillac tax that undermine employer coverage.

We also urge Congress to consider allowing families in small businesses to buy coverage through the Federal Employees Health Benefits Program (FEHBP). This would be popular with the American people, as they often complain, "Americans should have the same coverage that Members of Congress have." Rather than denying Congress and their staff access to FEHBP in order to meet this rallying cry, instead, why not allow families to buy into the FEHBP? There have been numerous health reform proposals over the years that Congress should consider, as they may improve coverage, access to care, and reduce costs for Americans who are struggling to buy health coverage for themselves and their families.

We also urge Congress to consider an expansion of the quality measures that were included for children's health coverage in Medicaid and CHIP to the private marketplace. Children are far too often an afterthought in private plans and incentives should be created to better address the quality of care, network adequacy, and benefits that children receive in these private plans.

Thank you for your consideration of these suggestions on behalf of our nation's children and families.

Sincerely,

Bruce Lesley
President