May 22, 2009

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

Senator Max Baucus
Chairman, Senate Finance Committee
U.S. Senate
Washington, D.C.

Senator Charles Grassley
Ranking Member, Senate Finance Committee
U.S. Senate
Washington, D.C.

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the Catholic Health Association of the United States, I am writing to you concerning the Senate Finance Committee's policy options paper, "Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans." Let me first thank you for your leadership in the effort to improve health care in the United States and to ensure that quality, affordable care is available for everyone. We are grateful for the opportunity to offer our comments regarding the committee's expansion of health care coverage proposals.

The Catholic Health Association of the United States (CHA) is the national leadership organization of the Catholic health ministry, representing the largest group of not-for-profit providers of health care services in the nation:

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- 1 in 6 patients in the United States is cared for in a Catholic hospital each year
- All 50 states and the District of Columbia are served by Catholic health care organizations.
- Over 600 hundred hospitals and more 800 post-acute care organizations provide the full continuum of health care.

By pursuing the priorities of the ministry, CHA and it members - more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations - are working to create health care that serves everyone. CHA's *Vision for U.S. Health Care* lays out the Catholic health ministry's principles for reforming the health care system. As a central component of our vision, we believe that health care should be patient centered, addressing health needs at all stages of life through services that are coordinated and integrated all along the continuum of care, with accountability for health outcomes. We also call for safe, effective health care delivered with the highest possible quality to achieve the best outcomes for patients.

We are pleased to see that these principles are reflected in many of the policy options included in the committee's paper. CHA would like to offer support for several aspects of these policies, as well to share our concerns relating to other aspects. Specifically, we would like to address the following sections of the committee's paper:

**Section I: Insurance Market Reforms**

CHA endorses the restructuring of the insurance market through the imposition of uniform federal requirements including rating restrictions to limit premium variations, requiring guaranteed issue and guaranteed renewal, and prohibiting preexisting health condition exclusions. We are concerned, however, that the allowable rating band for age is too large and would still allow for substantial variation in premiums, and recommend this rating band be further restricted.

We also believe that a federal medical loss ratio of 85 percent should be established for insurers, especially in light of inclusion of an individual mandate to purchase coverage, a risk-adjustment mechanism for insurers participating in the Exchange, and the federal tax subsidies that will be available to assist individuals and small employers to purchase health insurance coverage. Currently, a significant percentage of the cost of health insurance in the individual market goes toward administrative activities. An estimated 25 to 40 percent of premiums are consumed by claims administration, underwriting, marketing, profits, and other administrative costs, compared with 10 percent in employer group markets and 2 percent in Medicare. The costs of insurance administration are the fastest-growing component of U.S. national health expenditures. With federal limits on adverse selection coupled with risk-adjustment mechanisms, insurance companies should be held to at least an 85% medical loss ratio standard.

CHA supports the creation of the Health Insurance Exchange as described in the committee paper and believes the Exchange is critical for ensuring access to coverage for people with health problems; simplifying the decision-making process for consumers; and promoting competition between insures that is based on price and quality. We do not think it would be helpful to have multiple, competing exchanges in one geographic area. We believe this would increase administrative costs and cause added confusion for individuals and small business attempting to purchase insurance coverage.

**Section II: Making Coverage Affordable**

CHA supports the Committee's proposal to define a minimum coverage package as a "broad range of medical benefits" and supports using the actuarially equivalent value to define the benefit levels of the four benefit options. We support the explicit restriction on plans from establishing lifetime limits on coverage or annual limits on any benefits. Lifetime and annual benefit limits, however, usually set a dollar amount over which an insurer will not pay for a service. To protect consumers, plans should also be prohibited from including service limits (number of visits, number of hospitalizations, etc.) for medically necessary care. We believe these safeguards are critical to ensuring that plans offered in the proposed Exchange are comprehensive enough to meet consumers' health needs.

CHA also supports the committee's proposal to require that participating insurers charge the same prices and provide the same benefits outside of the Exchange as they do within the Exchange. We believe this is an essential provision that will protect both the integrity of market and the wellbeing of consumers by preventing adverse selection from occurring in the Exchange.

CHA supports the proposal to provide a refundable and advance-able tax credit for low income taxpayers who purchase health insurance though the Exchange. The tax credit would be available to individuals with modified adjusted gross income (MAGI) between 100 and 400 percent of FPL.

We strongly recommend, however, that the committee establish an out-of-pocket maximum for consumer spending, especially for individuals and families receiving low-income subsidies, in order to protect vulnerable individuals from financial distress as a result of cost-sharing for medical services. A good way to do this would be to impose an overall maximum out-of-pocket percent for families based on their MAGI, taking into account both premiums and other cost-sharing.

CHA supports the proposal to provide a tax credit to small employers for the purchase of employer provided health insurance.

**Provider Conscience Protections**

While not mentioned in the committee's proposals, we believe it is important for us to raise the need for continued provider conscience protections in any reformed health care system. Catholic health care has long operated under the protection of federal laws protecting the conscience rights of health care entities and providers. These protections are essential for both our own ministry and our nation's commitment to pluralism and to freedom of conscience and religion. While protecting the rights of patients, Catholics and others must not be forced to perform procedures that are contrary to their deeply held moral beliefs and principles. The application of federal conscience protection laws will continue to be of utmost importance in a reformed health care system.

**Section III: Public Health Insurance Option**

Whether or not to include a public insurance plan in competition with private insurance as part of health care reform has generated much debate. The committee's paper lays out four options: two proposals would be based more or less closely on Medicare but differ from each other on issues such as how the plan is administered, how payment rates are set, and how providers are selected for participation. Another proposal calls for a state-run public plan, while the final option would be to proceed without a public plan.

CHA is a strong supporter of health care reform because the injustice of millions of people without adequate access to health care insurance demands change. If creation of a public plan proves to be necessary to achieve that goal, then CHA would be willing to support it. Whether or not a public plan would be effective depends very much on the specific details. The

committee has identified many of the key questions: how providers are reimbursed, whether they would be required to participate, whether the public plan would play by the same rules as private plans, and whether a public plan would have to be self-sustaining.

If the committee decides to pursue a public plan option, we urge you to ensure that payment levels in a public plan would be set to reimburse hospitals and other providers adequately for the care they provide.

**Section IV: Role of Public Programs**

**Medicaid Eligibility Standards and Methodologies**
CHA applauds the committee's proposal to expand Medicaid coverage for pregnant women, children and parents up to 150 percent of FPL. However, we urge you to consider raising the level to 200 percent of FPL. Increasing the eligibility level to 200 percent of FPL is especially critical in light of the proposal to eliminate state income disregards under the Medicaid program. Eliminating income disregards will eliminate coverage for some low-income persons who currently are eligible because they are brought under the state Medicaid income thresholds through the use of the income disregards. If the committee wishes to eliminate income disregards to simplify the Medicaid eligibility determination and maintain consistency between Medicaid and the Exchange (goals supported by CHA), we urge you to increase the income eligibility threshold to account for persons who might have otherwise been eligible due to an income disregard (for example for work or child care expenses). Income disregards were developed to address the disincentives to work and pay for child care that are established when income eligibility for critical benefits are set too low. We recommend the income eligibility level be at least 200% FPL and be inclusive of low-income childless adults.

**Medicaid Program Payments**
We are pleased and strongly support the committee's proposal setting minimum provider reimbursement rates. Our experience and that of our clients and fellow advocates have shown that low rates significantly contribute to lack of access to providers in the Medicaid networks. However, we do not believe that 80% of Medicare may be adequate to provide a sufficient network. We recommend that payments for Medicaid providers be paid at the same rate as Medicare providers. Thus, by treating the Medicare and Medicaid populations equally with respect to provider rates, we will be increasing access to providers for Medicaid beneficiaries, taking steps to decrease disparities between the populations, and simplifying administration and payment processes for providers. Adequate reimbursement plays a key role in ensuring access to care for people in Medicaid. The proposal does not include detail about how such an increase would be accomplished. Absent full federal funding for new Medicaid coverage, it will be especially important to take into account how the funding for increased provider reimbursement rates affects funding for coverage and services in Medicaid. If states will be required to spend additional money on provider reimbursement, they may have even further incentive to scale back benefits and increase cost-sharing for Medicaid beneficiaries.

**Options for Medicaid Coverage -- Approach 1 –**We assume childless adults would be added as a Medicaid eligible group under this option. We support strengthening the current Medicaid structure so that current categories of beneficiaries and childless adults can continue to receive

their coverage/benefits through Medicaid. The Medicaid program has significant advantages as a mechanism for covering low-income people. It is already in place and operating; it is designed to meet the needs of people with low incomes and serious medical needs; it has strict limits on cost-sharing; and the benefits package includes coverage for services that are necessary for people with chronic health care conditions or disabilities that are usually not covered in private health insurance.

Caution with regard to premium assistance: The committee suggests that this option would come with a new requirement that states provide premium assistance to Medicaid beneficiaries with an offer of employer-sponsored health coverage. It is unclear whether this new requirement would carry the existing rules for premium assistance in Medicaid, or if it would operate under different rules. For example, states currently are permitted to provide premium assistance for employer-sponsored coverage where it is cost-effective to do so, and they must provide wrap-around coverage. These are rules that make sense to ensure that scarce federal and state funds are only spent on comprehensive health care coverage, and that individuals who qualify for Medicaid receive the same access to care, whether they are receiving primary coverage through Medicaid or through private health coverage. We strongly recommend that any new premium assistance requirement operate under those same rules. These individuals have such low incomes that they will not be able to afford any services not covered through their ESI or Medicaid.

**Approach 2 –** While we appreciate that this option describes a legal entitlement to coverage and services for Medicaid eligible populations including EPSDT and transportation, we have serious concerns about requiring children, pregnant women, parents and childless adults to obtain their coverage through insurance plans in the Exchange, especially through the "low-option plans." By their very nature, these plans have the least coverage of benefits of those in the Exchange. We know that people eligible for Medicaid, who have the very lowest incomes, also often have great medical needs. This sets up a system where many Medicaid beneficiaries being served in private plans through the Exchange either will not get many of their health needs met or will have to navigate a system not regularly accustomed to providing the benefits that they are entitled to receive, because most of the people in that system will not be afforded those benefits.

We are further concerned that the structure of providing benefits such as EPSDT as a wrap-around to a private plan with a less comprehensive benefits package will make it nearly impossible for Medicaid beneficiaries to obtain these benefits. We know that when faced with a denial and a requirement to find another doctor in another network, low-income people just end up turned away and denied necessary services altogether.

Furthermore, while it is valuable that the committee proposes that the entitlement to Medicaid would be preserved in this option, it is difficult to envision how that entitlement would be enforced. Before an option like this one is seriously considered, we suggest such issues must be fully resolved. Otherwise, the most vulnerable among us will end up with less health care and less ability to redress improper denials of care. Therefore, we do not recommend using this option, as it is likely to leave Medicaid recipients worse off than they currently are. If this option were to be seriously considered, however, then persons with Medicaid should at a

minimum be linked to the Highest Option plans, and much more work would need to be done to insure that the entitlement to Medicaid remains a reality in practice, not just in theory.

**Approach 3 –** We believe this is the best of the three approaches and could be workable for low-income persons. However, we do not believe that setting the eligibility limit for childless adults at 115% FPL is adequate. We urge you to provide coverage for childless adults up to 200% of FPL, as we have suggested for all other low-income persons, but at a minimum this group should be covered up to 150% FPL (as the committee has suggested elsewhere for other populations).

We appreciate the proposals within this option to further protect lowest income childless adults and the recognition that they are among the most vulnerable. If moving forward with a variant of this option covering childless adults through private plans in the Exchange, we recommend that additional protection be added to increase the benefit package, as has already been envisioned to include cost-sharing protections. One way to do that would be to require the lowest-income childless adults be fully subsidized to receive the Highest Option plan. Using the voucher system described to "buy-into" the Medicaid program might also meet their health needs, as long as additional necessary services that exceed the price of the voucher would be covered at no cost to the beneficiary and that sufficient cost-sharing protections were made available. Additionally, we recommend there be a mandatory pre-enrollment counseling requirement for childless adults between using the voucher to buy into Medicaid or choosing a private plan in the Exchange, to help them in the decision making process.

Finally, we seriously discourage the committee from utilizing the options outlined at the end of this approach allowing the states to "opt" whether to accept vouchers for their Medicaid programs and shifting currently mandatory Medicaid populations into private plans in the Exchange. Both these proposals could be very harmful to a low-income person's ability to access comprehensive health care.

**The Children's Health Insurance Program**

We are very supportive of the improvements to children's eligibility, benefits and cost-sharing protections in the CHIP section. Setting a national standard for CHIP eligibility at 275 percent of poverty coupled with the guarantee of EPSDT benefits and Medicaid's cost-sharing protections for children will help millions of uninsured children get the quality, affordable coverage they need.

**Medicaid Enrollment and Retention Simplification**

CHA has long been supportive of measures to improve outreach, enrollment and retention in public health insurance programs. We applaud the committee for recommending elimination of asset tests and face-to-face interview requirements for acute care coverage, and for recommending mandatory adoption of four required simplification measures. Since states are at varying degrees of implementing these strategies, many will need extensive technical assistance and additional funding to implement them, particularly to the larger Medicaid population (as opposed to only pregnant women and children, who have been the focus of many state simplification efforts to date).

**Mandatory Coverage for Prescription Drugs**

We applaud the committee for recognizing the importance of prescription drug coverage in any health care benefit package. Changing the status of prescription drug coverage from "optional" to "mandatory" in Medicaid will send a strong signal to states that they should provide an adequate benefit, and will protect prescription drug coverage from harmful reductions in the future.

**Automatic Countercyclical Stabilizer**

CHA fully supports an automatic countercyclical trigger to ensure that states receive the extra federal support they need for Medicaid during times of economic decline. During periods of economic decline, Medicaid enrollment grows while the state revenue available to finance this growth shrinks. Temporary increases in the FMAP have been enacted twice in the last six years, and have allowed states to avoid harmful cuts in Medicaid eligibility. The proposal to enact a permanent trigger will be especially important as health reform is implemented, if states will be called upon to take on a growing proportion of Medicaid costs after significant Medicaid eligibility expansions are enacted. Even in a system with a federal Medicaid eligibility floor, states could be forced to make drastic reductions in benefits, increases in cost-sharing, or increases in administrative burdens for enrollment and retention in order to reduce costs. A countercyclical stabilizer would guard against such cuts.

The proposed implementation date of January 1, 2012 presumably takes into account that the enhanced Medicaid match in the current economic recovery package expires at the end of calendar year 2010, and that if the economy has not recovered sufficiently by that date, Congress will consider an extension of the existing FMAP enhancement. Otherwise, we recommend the formula take effect January 1, 2011 instead.

**Medicaid DSH Program**

The Medicaid DSH program is our nation's primary source of support for safety-net hospitals that serve the most vulnerable populations – Medicaid beneficiaries, the uninsured and the underinsured. Many hospitals rely on Medicaid DSH payments to be able to keep their doors open. These funds go toward supporting a broad range of services for uninsured or underinsured children and adults such as chronic disease management, preventive care, dental care and child abuse screening. And Medicaid DSH funds help support essential community services such as trauma and burn care, pediatric intensive care, high-risk neonatal care and emergency psychiatric services. Such resources also help fund hospital readiness for natural and man-made disasters.

Even if universal coverage is achieved through health care reform, there will be populations that will remain uncovered, and hospitals will be asked to bear the burden of their health care and essential community services. We recommend that the committee delay reductions in federal support for DSH programs until coverage expansions are universal and fully implemented. It needs to be clearly demonstrated that significant improvements in the amount and volume of charity care and bad debt have occurred before DSH is reduced.

**Dual Eligibles**

CHA supports the proposals to expand and simplify Medicaid waivers to encourage states to use demonstration programs to help identify methods to improve care for the dual eligible population.

**Medicare Coverage**
CHA supports the elimination of the Medicare disability waiting period and the creation of a Medicare buy-in for people age 55 to 64.

**Section V: Shared Responsibility**

CHA has consistently supported the notion of shared responsibility in health care. The CHA *Vision For U.S. Health Care*, which names the Catholic health ministry's principles for reform, calls for a pluralistic system in which the public and private sectors are involved. Moreover, the *Vision* document states that financing of the health care system should be shared among all stakeholders including government, employers, individuals, charitable organizations and health care providers.

CHA supports coverage mandates if they lead to the outcome of insuring the greatest number of people and include protections for low-income individuals and families. Most important with regard to the individual mandate is each person's or family's ability to obtain affordable coverage. If a mandate is in place but affordable policies are not readily available to individuals and families, it would be impossible for them to comply with the requirement to carry insurance.

Therefore the individual mandate must be coupled with the insurance market reforms that are proposed in the Finance Committee paper (e.g., rating rules, no pre-existing condition exclusions), as well as adequate refundable and advancable tax credits or subsidies that ensure health insurance is affordable for low- and moderate-income families. These reforms will help minimize or eliminate obstacles to coverage in the current non-group market.

With regard to the proposed penalty for those found not to be complying with the mandate, CHA agrees with the circumstances under which individuals could apply for an exemption. However, we recommend that individuals who are below 200% of poverty (instead of the 100% suggested by the committee) be eligible for the penalty exemption. If an exemption is not available in a given situation, the penalty fee should be structured on a sliding scale to prevent undue hardship to low-income individuals.

CHA also supports the employer mandate and the pay-or-play requirement included in the proposal in order to prevent the deterioration of employer-sponsored coverage, and to preserve the financial contributions of the employer sector to the cost of coverage.

**Section VI: Options to Improve Access to Preventive Services and Encourage Health Lifestyles.**

The Catholic Health Association strongly supports the provisions for improving access to preventive services and encouraging healthy lifestyles. As noted in a recent report from the Robert Wood Johnson Foundation's Commission to Build a Healthier America, "although

medical care is essential for relieving suffering and curable illness, only an estimated 10 – 15 percent of preventable mortality has been attributed to medical care." (commissioinhealth.org)

Being proactive in preventing illness and promoting health by adopting healthy behaviors and early detection of health problems will lead to a healthier America, an improved quality of life and eventually will lower the cost of health care. Members of CHA, as well as many other non-profit tax-exempt organizations, already are engaged in the types of community health improvement services described in the paper through our community benefit programs. We look forward to partnering with others in our communities to ensure that programs and services described in the paper are fully accessed.

We support the options being proposed, including:

- Personalized prevention plans and routine wellness visits for Medicare beneficiaries: With the Medicare age population expected to go from about 40 to 80 million between 2010 and 2040 it will become increasingly important to promote health of Medicare patients and to prevent the need for costly treatments and services. The health risk assessment and follow- up will help to identify chronic disease and lead to modifying risk factors. We are especially pleased that review of medications currently prescribed by all providers will be part of the plan and health supervision.
- Incentives to use preventive services and engage in health behaviors: These provisions rely on scientifically-based recommendations for effective preventive services. With most seniors on fixed incomes, removing or limiting beneficiary cost-sharing will significantly increase the utilization of these important services.
- Adult access to preventive service under Medicaid: We support encouraging states to offer screening and preventive services for Medicaid eligible adults. In particular, providing Medicaid coverage for tobacco cessation services for pregnant women will lead to healthier babies and parents.
- Incentive for Medicaid enrollee to use preventive services and adopt healthy behaviors: Limiting cost-sharing for recommended clinical preventive services will sharply increase the use of these services among persons who have very low-incomes. We also support educating providers and making patients aware of covered preventive services.
- Preventing chronic disease and encouraging healthy lifestyles: We are pleased to see a variety of options presented for encouraging states to improve health outcomes, including local integrated delivery systems' team-based care, individualized plans for health care human service needs of low-income beneficiaries and other innovative approaches.

**Section VII: Long Term Care Services and Supports**

CHA is very pleased to see long term care services and supporting provisions included in the option paper on access to health care services. It will be important for a reformed health care delivery system to include attention to these services because the needs of older and disabled persons are linked to overall health care system.

Numerous demonstrations in recent years have shown well-designed long term health care and support services can reduce health care costs, promote the health and quality of life of older

and disabled person and help them remain in their homes and communities or in less intensive residential/institutional settings. These services include home care, day programs, community-based services, palliative care, chronic disease case management, health promotion and PACE.

We support the following options proposed by the Senate Finance Committee:

- Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Plan Option**:** CHA supports allowing states to offer additional services. This will help states to participate in the State Plan Option. We also support allowing individuals to simultaneously enroll in more than one Medicaid waiver.
- Eligibility for HCBS Services**:** We support eliminating the institutional level-of-care requirement for eligibility for section 1915(c) waivers and permitting states to replace it with less stringent criteria. We recommend, however, that this be an option for states rather than a requirement.
- Increasing Access to Medicaid HCBS: We support efforts to try to increase the number of persons under the cap in both of these authorities (Approach 1).
- Increasing Federal Match for Medicaid HCBS: We strongly support increasing the federal medical assistance percentage (FMAP) for HCBS under Medicaid and would support and even greater increase to change state behavior. As suggested by the National Council on the Aging and other organizations who advocate on behalf of older people, we would endorse phased in FMAP such as:

  2012– 1 percent increase
  2014– 2 percent increase
  2016– 3 percent increase
  2018– 4 percent increase
  2020 – 5 percent increase

- Medicaid Spousal Impoverishment Rules**:** CHA supports protecting against spousal impoverishment in all Medicaid Home and Community-Based Services programs by requiring states to apply the same spousal impoverishment rules currently provided to the spouses of nursing home residents on Medicaid. This provision is consistent with Section of S. 434, the *Empowered at Home Act*, introduced by Senators Kerry and Grassley.
- Medicaid Resources/Asset Test: We support increasing asset eligibility levels for Medicaid HCBS programs. However, we recommend the committee include the provision in last year's House version of the *Empowered at Home Act* (H.R. 7212) introduced by Reps. Pallone and DeGette.
- Long Term Care Grants Program**:** We support the creation of a separate funding vehicle, in addition to current appropriations accounts, for the priorities identified in this subsection. We also suggest that funding for evidence-based health promotion and disease prevention, and Aging and Disability Resource Centers (ADRCs), be made available through funding mechanisms as outlined in the Project 2020 proposal, soon to be introduced by Senators Cantwell and Grassley.
- Money Follows the Person Rebalancing Demonstration**:** We support extending the Demonstration through 2016.

**Section VIII: Options to Address Health Disparities**

Comprehensive health reform is essential to improving the health of populations and communities that have traditionally suffered health disparities and barriers to health care services. The coverage options paper includes several proposed options for addressing disparities by:

- Strengthening data collection requirements, methods, standardized categories, and public reporting;
- Improving language access and cultural competence;
- Permitting states to waive the five-year waiting period for Medicaid or CHIP coverage to non-pregnant legally-residing adults;
- Reducing infant mortality.

We strongly support inclusion of these elements and applaud the committee for addressing these important issues. However, key areas for improvement and clarification include:

- Initiating payments for language services in Medicare. For example, Medicare should provide payment adequate to cover the costs of language services for hospitals, community health centers and other Medicare health care providers. For clinicians receiving payment through the Physician Fee Schedule, Medicare should examine different alternatives and how payments would affect clinician payments, a clinician's practice, and beneficiary cost-sharing.
- Encouraging HHS to work with the Institutes of Medicine to evaluate, report, and make recommendations on language services and best practices for collecting language data and interpreter utilization across all health care and public health programs and insurers.
- Ensuring that legislative language for the proposal to "extend the 75% matching rate for translation services to all Medicaid beneficiaries for whom English is not the primary language" includes the same provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The increased matching rate under CHIPRA applies to "translation or interpreting services in connection with the enrollment of, retention of, and use of services by, individuals for whom English is not their primary language."
- Ensuring that grants for outreach and enrollment (included now under the Language Access subsection) extend beyond language access and include funding and support for community-based outreach activities, specifically for organizations working with hard to reach populations (including, but not limited to, language minorities).
- Developing a stable funding mechanism for community health workers and other members of the community to provide culturally and linguistically appropriate information to medically underserved communities.

**Immigrant Coverage**

In addition, CHA fully supports removing the five-year waiting period nationwide for all lawfully-residing immigrants in Medicaid and CHIP. Leaving it to the discretion of states as outlined in the options paper will create unequal coverage for this population across states and run contrary to the goals of national health reform. The committee also should explicitly eliminate the sponsor deeming requirements to ensure effective implementation. Previously,

the income and resources of an immigrant's sponsor were counted as part of their income when they applied for Medicaid and CHIP, but CHIPRA removed this sponsor deeming and liability for legal immigrant children and pregnant women.

CHA also fully supports eligibility for everyone residing in the U.S. to participate in our reformed health care system, including undocumented immigrants. As a matter of human dignity, we believe everyone is entitled to health care coverage. Like any basic element of life, health care sustains us and should always be accessible and affordable for everyone—where they need it, when they need it, with no exceptions and no interruptions.

Thank you again for the opportunity to provide comments on these proposed policy options and for all the efforts of the Senate Finance Committee to improve the health care system. If we at CHA can provide any clarifications of these comments or be of any further assistance, please do not hesitate to contact me or a member of our advocacy staff.

Sincerely,

Sr. Carol Keehan, DC
President and CEO