CHAPTER 1

CHIP and the New Coverage Landscape

Recommendation

CHIP and the New Coverage Landscape

- The Congress should extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

Key Points

- CHIP is widely acknowledged to have played an important role in increasing the number and share of children with health insurance coverage, and providing access to affordable and high-quality care. Since the enactment of CHIP, the percentage of uninsured children has been cut in half.
- Under current law, the final federal CHIP allotments will be distributed to states on October 1, 2014. These allotments are expected to last through fiscal year (FY) 2015 but begin running out shortly afterward.
- The Commission recommends an extension of CHIP funding for two years due to its concerns that when CHIP funding runs out shortly after FY 2015, as under current law:
    - The number of uninsured children would increase significantly. Not all children currently covered by CHIP would be eligible for subsidized exchange coverage. For some, premiums for other sources of coverage would be too high relative to families' ability to pay.
    - Cost sharing for services would increase substantially for many families.
    - It is unclear whether or not exchange plans are ready to serve as an appropriate alternative.
- The Commission recommends an additional two years of CHIP funding, through FY 2017, to enable policymakers to address these concerns so that children currently enrolled in CHIP can be integrated into other sources of coverage that are of high quality and affordable to families. To aid the Congress in this endeavor, the Commission's future analyses will explore such policy options and the associated trade-offs.
- If it becomes evident during this two-year transition period that more time is necessary to ensure that needed reforms are in place and that children's transitions into other coverage options are appropriate, further extending this transition period should be considered. The Commission remains confident that the changes necessary to ensure that children have access to high-quality coverage can be made during this transition period.

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Over the past two years, MACPAC has discussed a range of issues associated with implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and its relationship to Medicaid and the State Children's Health Insurance Program (CHIP). These include changes in eligibility and enrollment, such as the transition to new income determination rules and eligibility processes, and the expansions in many states to cover childless adults and additional low-income parents. We have also examined how the coverage offered by subsidized exchange plans to many individuals between 100 and 400 percent of the federal poverty level (FPL) interacts with Medicaid, CHIP, and employer-sponsored coverage.

While Medicaid provides coverage to 39 million children, CHIP is an important source of coverage for 8 million children with low to moderate incomes (MACPAC 2014a). With implementation of the ACA, the coverage options for these children and their families could change. Subsidized exchange plans potentially offer an alternative source of coverage to some children in this income range. The individual mandate to obtain coverage may also lead to additional enrollment in employer-sponsored coverage by some parents and children now enrolled in CHIP.

With CHIP funding currently scheduled to run out shortly after fiscal year (FY) 2015, the question naturally arises as to how to address the program's future. One approach would be to allow funding to run out and leave many children now served by CHIP to find coverage elsewhere—through Medicaid, the exchanges, or employers, if available. As the analyses presented in this chapter suggest, however, such transitions would not be smooth, and a significant number of children could become uninsured. An alternative approach at the other end of the spectrum would be to provide funding for CHIP indefinitely, maintaining a separate source of coverage not integrated with other coverage options. MACPAC's recommendation looks for a middle ground. As described in this chapter, the Commission recommends extending federal funding for CHIP

for a transition period of two additional years, during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

CHIP is a joint federal-state program that offers coverage that complements Medicaid (with $13 billion versus $460 billion in spending in FY 2013). And it is an important source of affordable coverage for enrolled children, 97 percent of whom were at or below 250 percent FPL in FY 2013 (MACPAC 2014a).

While the program's statutory authorization continues indefinitely, the final federal CHIP funding allotment under current law will be for FY 2015. These funds will be distributed to states on October 1, 2014, and will begin to run out a year later. States are required to maintain their 2010 eligibility levels for children in both Medicaid and CHIP through FY 2019, a requirement referred to as maintenance of effort (MOE). If CHIP funding runs out between FY 2015 and FY 2019, states with Medicaid-expansion CHIP programs subject to the MOE must continue that coverage with Medicaid funds, but at Medicaid's lower federal matching rate. However, separate CHIP programs may limit their enrollment based on the availability of federal CHIP funds, which effectively provides an exception to the MOE requirement in the absence of such funds.

Under current law, the children currently covered under separate CHIP programs could face one of a number of scenarios if their CHIP coverage comes to an end. Some could enroll in a parent's employer-sponsored insurance. Those not eligible for employer-sponsored coverage may seek subsidized coverage through exchanges. Either way, however, some affected families may not enroll their children in exchange or employer-sponsored coverage that is available to them—because the premiums for such coverage are too high relative to their ability to pay, for example. One analysis estimated that the end of CHIP could lead to as many as 2 million more children becoming uninsured (Kenney et al. 2011).[1]

Those shifting to exchange coverage may face higher cost sharing, different benefits, and enrollment in plans with different provider networks. Much remains to be learned about how well exchange plans meet the needs of lower-income children and whether they are a viable alternative to CHIP coverage.

Because so much is unknown about the post-CHIP landscape under current law and the adequacy of new exchange coverage for children, the Commission recommends a two-year extension of CHIP financing through FY 2017. During this time, MACPAC will continue to examine a range of issues about the design and adequacy of coverage for the population now covered by CHIP and will offer options to provide a more seamless continuum of children's coverage that better accommodates transitions in coverage among Medicaid, the exchanges, and employer-sponsored insurance. This timing should permit the Congress and the U.S. Department of Health and Human Services (HHS) to consider the analyses and options, consult with states and stakeholders, and make desired changes with sufficient lead time for states and the federal government to manage any transitions effectively.

This chapter presents the analyses that led the Commission to its recommendation to extend CHIP funding through FY 2017. We begin by reviewing the impact that CHIP has had on children's coverage. We then examine how children currently covered by CHIP could be affected if funding is exhausted as under current law. The chapter concludes by outlining the options considered by the Commission and our recommendation for extending CHIP funding for two additional years as a transition plan is developed.

History and Impact of CHIP

This section describes CHIP's creation, how it has evolved over the past 17 years, and the impact it has had on children's coverage.

Creation of CHIP

In 1997, the Congress focused attention on expanding coverage to low-income children not eligible for Medicaid. The congressional proposals that emerged ranged from the provision of tax credits to the expansion of Medicaid with uncapped federal financing at an enhanced federal matching rate (Smith and Moore 2010).

The legislation that became CHIP (the Balanced Budget Act of 1997, P.L. 105-33, referred to as BBA 97) gave states flexibility either to use an expansion of Medicaid or to create CHIP programs separate from Medicaid. States could also use both approaches, in which they generally covered lower-income children with a Medicaid expansion.

Separate CHIP programs could be structured to differ from Medicaid in several ways. First, while Medicaid-eligible individuals are entitled to Medicaid coverage (including through Medicaid-expansion CHIP programs), there is no individual entitlement to coverage in separate CHIP programs. For example, states were permitted to institute enrollment caps and waiting periods in separate CHIP programs, policies not permitted in Medicaid without a waiver. In addition, while states with Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no minimum mandatory income level up to which CHIP programs must extend coverage. Moreover, states with separate CHIP programs have greater flexibility around the design of their benefit packages and enrollee cost sharing than is available for children in Medicaid.[2]

In addition to providing flexibility in program design, the Congress also made enhanced federal matching available through CHIP in order to encourage state participation. Since its enactment, CHIP spending has been reimbursed by the federal government at a matching rate higher than Medicaid's. In both separate CHIP and Medicaid-expansion programs, the enhanced Federal Medical Assistance Percentage (E-FMAP) varies by state but, on average, pays for 70 percent of CHIP spending, compared to 57 percent historically for Medicaid. Unlike Medicaid, however, federal CHIP funding is capped, and states could exhaust their federal CHIP allotments.

At the time of CHIP's creation, it was not clear how many states would respond to the new federal funding opportunity by extending eligibility to more children. By FY 2000, however, every state, territory, and the District of Columbia had enrolled children in CHIP-financed coverage.

Impact of CHIP

One of the hallmarks of CHIP was the aggressive effort it spurred to identify and enroll uninsured children who were eligible for coverage in CHIP and Medicaid. These efforts ultimately proved extremely successful, and CHIP is now widely acknowledged to have played an important role in increasing the number and share of children with health insurance coverage.

Since the enactment of CHIP in 1997, the share of children who are uninsured has fallen by half—from 13.9 to 7.1 percent (Martinez and Cohen 2013). The effects were even larger for children in the typical CHIP income range. Among children with family income above 100 percent FPL but below 200 percent FPL, uninsurance dropped by more than half—from 22.8 percent in 1997 to 10.0 percent in 2013. Over that time period, which included two recessions, private coverage for children between 100 and 200 percent FPL also declined substantially—from 55 percent in 1997 to 27.1 percent in 2013 (Martinez and Cohen 2013, 2012). Gains in Medicaid and CHIP enrollment more than offset the loss.[3]

Despite generally high rates of coverage for children relative to other groups, some children remain uninsured, with the rate varying significantly by state. In 2012, children's uninsurance rates ranged from 1.4 percent in Massachusetts to 17.0 percent in Nevada (Appendix Table 1-A-1). Thirty percent of the nation's uninsured children (1.8 million) live in Texas and California.

Some of CHIP's design features also provided a platform for state innovations to improve take-up of public coverage among eligible but uninsured children. Many states branded their CHIP programs separately from Medicaid and launched targeted outreach and marketing efforts. These strategies increased enrollment of children in both CHIP and Medicaid, further reducing uninsurance rates among children. Over time, these efforts and other policy changes contributed to changing the perception of Medicaid from a welfare program to a more mainstream source of health insurance coverage for children. Outreach and enrollment techniques that often began as experiments in CHIP in individual states were subsequently identified as best practices and, in some cases, are now required in all states for both CHIP and Medicaid—including through requirements in the ACA.[4]

As a result of these efforts, 88.1 percent of eligible children were enrolled in Medicaid or CHIP in 2012 (Kenney and Anderson 2014).[5] This is 6.4 percentage points higher than in 2008, potentially reflecting additional outreach and enrollment simplification efforts encouraged by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). However, these rates vary significantly by state—from 70.6 percent in Nevada to 97.4 percent in Massachusetts (Appendix Table 1-A-2). Of the shrinking number of uninsured children, an estimated 68.4 percent are eligible for Medicaid or CHIP (Kenney and Anderson 2014).

In addition to its role in boosting rates of coverage, CHIP is more affordable for low-income working families than private coverage, although most states charge CHIP premiums to at least some CHIP enrollees. Categories of covered benefits are often similar between separate CHIP and private plans, but CHIP is more comprehensive with regard to dental coverage. In addition, Medicaid-expansion CHIP programs are required under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) rules to provide children under age 21 with any medically necessary service named in the Medicaid statute, even if the service is otherwise not covered by the state.

Key legislative actions affecting CHIP financing

Although CHIP was enacted with federal appropriations through FY 2007, the Congress intervened to provide additional funding for FY 2006 and FY 2007, when several states were poised to exhaust all their available federal CHIP funding. While the first several years of the program saw CHIP allotments much larger than states' spending, the situation reversed as CHIP programs matured and expanded to other groups, including childless adults (Allen 2007). To avoid shortfalls, the Congress appropriated additional funding for FY 2006 ($283 million) and again for FY 2007 ($650 million).

CHIPRA extended the program by providing CHIP appropriations through FY 2013, at much higher levels than under the original 1997 legislation. The formula for allotting these funds to states was also overhauled to better target states' actual CHIP spending. Since CHIPRA's enactment, no congressional action has been necessary to eliminate state shortfalls. CHIPRA made several other changes to CHIP, such as requiring separate CHIP programs to cover dental benefits and ensuring that any covered mental health benefits had parity with medical benefits.

In 2010, as the ACA was being debated, policymakers raised questions as to whether CHIP should continue, or whether CHIP-eligible children should

be enrolled in the health insurance exchanges created by the ACA. Ultimately, the Congress decided to extend federal CHIP allotments by two years, through FY 2015, leaving open the question of CHIP's long-term future. If CHIP allotments are extended again, the ACA requires the federal matching rate for CHIP to increase by 23 percentage points (up to 100 percent) for FY 2016 through FY 2019, the last four years of the ACA's MOE for children. Additional changes made by the ACA to CHIP include a shift to modified adjusted gross income for eligibility determinations and the movement of certain children from separate CHIP programs into CHIP-funded Medicaid.

Eligibility for CHIP and Other Insurance

As noted above, CHIP currently finances coverage for approximately 8 million children nationwide. This section explores the sources of health insurance coverage that would be available to current CHIP-eligible children in the absence of CHIP funding after FY 2015.

CHIP eligibility today

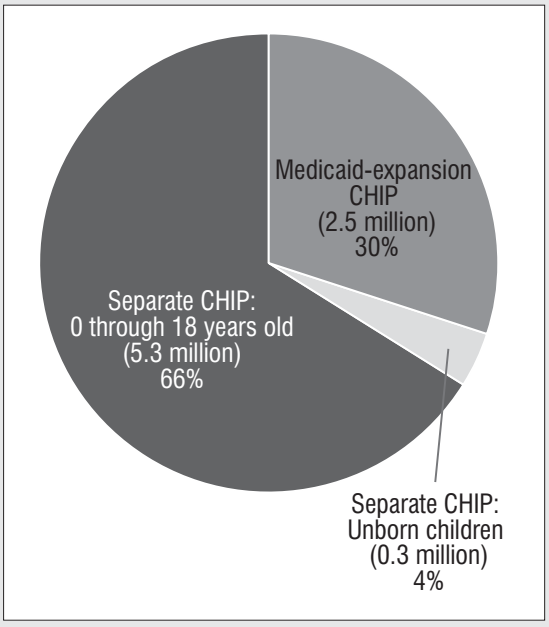
CHIP was designed to provide health insurance to low-income uninsured children above 1997 Medicaid eligibility levels.[6] Unlike Medicaid, CHIP has no requirement to cover children up to a specific income level. States' upper income limits for CHIP range from 175 to 405 percent FPL (Appendix Table 1-A-3). Although 19 states and the District of Columbia offer CHIP coverage to at least 300 percent FPL (with higher-income families generally subject to higher premiums and cost sharing), 89 percent of the children enrolled in CHIP-financed coverage had incomes at or below 200 percent FPL in FY 2013, and 97 percent were at or below 250 percent FPL (MACPAC 2014a).

As of January 2014, 7 states, 5 territories, and the District of Columbia ran CHIP entirely as a Medicaid expansion, 14 states operated separate CHIP programs, and 29 states elected to operate a combination program (Appendix Table 1-A-3).[7] As noted previously, under the ACA, states must maintain their 2010 eligibility levels for children in both Medicaid and CHIP through FY 2019. However, this MOE does not obligate states to continue funding separate CHIP programs if federal CHIP funding is exhausted. A state may limit enrollment if it projects that it will exhaust its federal CHIP funding.

Sources of coverage if CHIP funding is exhausted

The type of coverage children will be eligible for if CHIP funding is exhausted will reflect state choices as to whether they use a Medicaid-expansion, separate CHIP program, or a combination of the two (Figure 1-1).

FIGURE 1-1. Children's CHIP Enrollment by Program Type and Unborn Status, Fiscal Year 2013



Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from the Centers for Medicare & Medicaid Services (CMS) as of March 4, 2014.

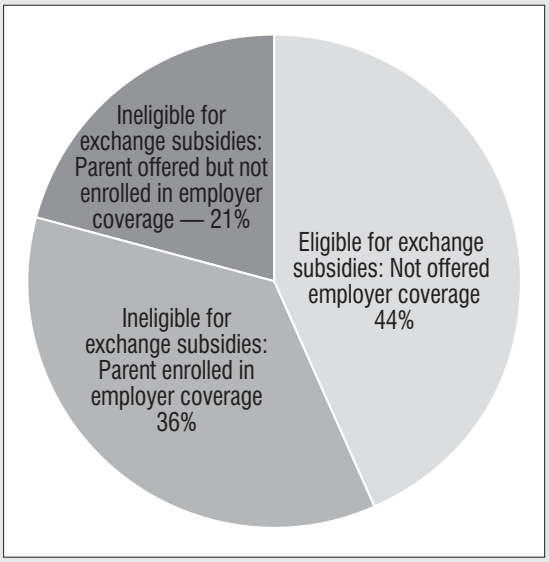
Children in Medicaid-expansion CHIP programs. Of the 8.1 million children enrolled in CHIP in FY 2013, 30 percent (2.5 million in 32 states and the District of Columbia) were in Medicaid-expansion CHIP (Figure 1-1). If CHIP funding runs out shortly after FY 2015, consistent with current law, these children would continue in Medicaid coverage but with federal funding from Medicaid at Medicaid's lower matching rate.[8]

Children age 0 through 18 in separate CHIP programs. Approximately two-thirds (5.3 million) of CHIP-funded children in FY 2013 were 0- to 18-year-olds in separate CHIP programs in 39 states (Figure 1-1, Appendix Table 1-A-3).[9] While one might assume that children in separate CHIP programs (who are generally in the income range for subsidized exchange coverage) would move to subsidized exchange coverage in the absence of CHIP funding, such coverage is likely to be available to less than half of these children.

There are several reasons why this would occur. First, while the ACA requires states to develop procedures to automatically transition children from separate CHIP to exchange coverage as CHIP allotments run out (§2105(d)(3)(B) of the Social Security Act (the Act)), it also requires a special certification that sets a high bar for such transitions. By April 1, 2015, the Secretary of the U.S. Department of Health and Human Services (the Secretary) must certify plans that are "at least comparable to" CHIP programs with respect to benefits and cost sharing (§2105(d)(3)(C) of the Act). As described below, while categories of covered benefits in separate CHIP and exchange coverage may be fairly comparable, cost sharing in exchange plans at current subsidy levels does not appear comparable to CHIP. If the Secretary finds that no exchange plans are comparable to CHIP, states are not required to seamlessly transition children from separate CHIP to exchange coverage, although families may obtain subsidized exchange coverage on their own.

Children are generally only eligible for subsidized exchange coverage if a parent is not offered affordable employer-sponsored insurance. According to an analysis of survey data for MACPAC by the Agency for Healthcare Research and Quality, among children in separate CHIP coverage (5.3 million in FY 2013), 44 percent are estimated to have parents who are not offered employer-sponsored insurance and therefore could qualify for subsidized exchange coverage (Figure 1-2). If CHIP funding were exhausted, however, it is not clear how many of

FIGURE 1-2. Eligibility for Subsidized Exchange Coverage If Separate CHIP Programs Did Not Exist, among Children Age 0 through 18 Currently Eligible for Separate CHIP Coverage



Notes: Assumes all employer-sponsored insurance is available to dependents and is affordable based on the definition in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Analysis is among non-disabled children not enrolled in employer-sponsored insurance or Medicare who are eligible for their state's separate CHIP program. Numbers do not sum to 100 percent due to rounding. In fiscal year 2013, 5.3 million children age 0 through 18 were enrolled in a separate CHIP program at some point during the year.

Source: Estimates for MACPAC from the Agency for Healthcare Research and Quality (AHRQ) from 2005 to 2010 Medical Expenditure Panel Survey (MEPS) with PUBSIM simulated 2014 eligibility.

these children would be enrolled in the subsidized exchange coverage for which they are eligible—particularly if it would require additional cost sharing and premium payments by families.

The parents of the remaining 56 percent of children in separate CHIP coverage report having access to employer-sponsored insurance—the vast majority of which would be considered affordable under the ACA, therefore disqualifying them from exchange subsidies. It is not clear, without CHIP, what share of these children would be enrolled in the employer-sponsored coverage their parents are offered or would become uninsured.

The ACA defines employer-sponsored coverage as affordable if an employee's out-of-pocket premiums for self-only coverage would account for no more than 9.5 percent of a family's income. This affordability test is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered. In 2013, the average annual worker contribution toward self-only coverage was $999, compared to $4,565 for family coverage (KFF and HRET 2013).[10]

For families not eligible for Medicaid, nearly all employer-sponsored coverage would be considered affordable based on the ACA's self-only coverage definition. Even at the 90th percentile of premiums for job-based coverage, the self-only premium paid by employees for a family of three at 138 percent FPL would comprise only 8.2 percent of income—still short of the 9.5 percent threshold to qualify for exchange subsidies (MACPAC 2013a).[11] There are no published estimates, however, specifically on how many CHIP parents' coverage would meet this definition of affordability and how many would not. There are also no published estimates of how many more parents would meet the definition if it were amended to be based on family rather than self-only coverage.

Unborn children in separate CHIP programs. About 4 percent of CHIP-funded enrollees (approximately 300,000) in FY 2013 were unborn children (Figure 1-1). The option to cover unborn children, in use by 16 states, was created through federal CHIP regulations in 2002 that revised the definition of the term child to include the period from conception to birth (Appendix Table 1-A-3, CMS 2002). States that elect this option are technically providing coverage to the unborn child, not the pregnant woman herself. As a result, the citizenship or immigration status of the mother is immaterial. However, unborn children are not eligible in their own right to be enrolled in Medicaid or exchange coverage. As a result, if the mother's immigration status, for example, makes her ineligible for Medicaid or exchange coverage, then the unborn children in those 16 states would lose access to federally subsidized coverage of prenatal care if CHIP ends.

Key policy issues: Eligibility

The potential for a significant number of children currently covered by CHIP to become uninsured if CHIP financing is not extended was one factor leading the Commission to recommend that the Congress extend federal CHIP funding for another two years to allow time to design a structure for children's coverage after FY 2017 without undoing the gains in improving the rate of coverage made since 1997. Issues meriting further exploration include the extent to which employer-sponsored coverage is available and affordable for affected children and whether they might enroll in that coverage or become uninsured.

MACPAC also plans to learn more about state actions affecting children covered under separate CHIP programs. For example, California recently moved most of its CHIP-enrolled children from a separate program into a Medicaid expansion. Arizona recently terminated its separate CHIP

program, an action permissible because these enrollees were in an expansion that occurred after the ACA's enactment and thus was not subject to the MOE. The Commission hopes to learn more about how these children are now being covered and how their access to care has been affected.

Cost Sharing and Premiums in CHIP Compared to Subsidized Exchange Coverage

In assessing the future of the program, the out-of-pocket cost sharing and premiums in CHIP relative to other forms of coverage are key considerations. While the Secretary must publish (by April 1, 2015) an assessment of whether the cost sharing in CHIP and exchange plans is comparable, the findings of our analysis, outlined in this section, suggest that children moving from separate CHIP programs to exchange coverage would experience higher cost sharing in the form of deductibles, copays, and coinsurance.

For both cost sharing and premiums, this section provides an overview of current CHIP policy and practice before turning to how cost sharing and premiums are affected by the ACA. This is followed by a discussion of the affordability implications for a post-CHIP landscape.

Overview of CHIP cost sharing

Twenty-eight separate CHIP programs require cost sharing for at least some types of services. For example, 21 states impose cost sharing for non-preventive physician visits, and 21 states have service charges for non-emergency use of the emergency department. Other common service categories associated with enrollee cost sharing include inpatient hospital visits, emergency room visits, and prescription drugs (Cardwell et al. 2014).

As with Medicaid (including Medicaid-expansion CHIP), combined expenses for separate CHIP premiums and cost-sharing expenses may not exceed 5 percent of a family's income (§2103(e)(3)(B) of the Act). Among the 42 separate CHIP programs analyzed, 22 utilize the 5 percent limitation, while 20 states have a lower cap (Cardwell et al. 2014).

Overview of cost sharing in exchange plans

The ACA established four metal tiers that denote average levels of cost sharing in exchange plans, described in terms of actuarial values. Actuarial values measure the percentage of covered health care expenses that an insurer would pay, on average, for a typical enrollee population. The metal tiers for unsubsidized exchange plans are as follows:

- Bronze: Actuarial value of 60 percent
- Silver: Actuarial value of 70 percent
- Gold: Actuarial value of 80 percent
- Platinum: Actuarial value of 90 percent

Additionally, exchange plans in the silver tier are required to provide cost-sharing reductions to qualifying enrollees with incomes below 250 percent FPL.[12] Cost-sharing reductions must increase actuarial values as follows (Figure 1-3):

- Up to 150 percent FPL: Actuarial value of 94 percent
- 151–200 percent FPL: Actuarial value of 87 percent
- 201–250 percent FPL: Actuarial value of 73 percent

Individuals above 250 percent FPL do not qualify for cost-sharing reductions. For them, the default silver plan actuarial value of 70 percent would

apply; however, individuals above 250 percent FPL may choose to enroll in a non-silver plan. For example, some individuals could choose a gold or platinum plan and pay higher premiums but lower deductibles, while others could choose a lower-premium bronze plan with higher deductibles.

States have the flexibility to allow insurers offering exchange plans to design differing cost-sharing structures as long as they meet the actuarial value requirements and are in accordance with other federal guidelines regarding benefits and out-of-pocket maximums. As a result, two exchange plans may have the same actuarial value, even though one may have a higher deductible and lower copayments relative to the other.

Assessing cost sharing using actuarial values

To provide insight into the comparability of plan affordability, MACPAC compared the actuarial values of cost sharing in five separate CHIP programs to the actuarial values of exchange plans with cost-sharing reductions. Because the medical benefits in separate CHIP and exchange coverage are largely consistent—with some exceptions, as described in the next section of this chapter—the differences in actuarial values between exchange plans and separate CHIP programs in this analysis can largely be attributed to cost sharing.

Actuarial values of selected separate CHIP programs. To estimate actuarial values of separate CHIP programs, MACPAC used a recent study by the U.S. Government Accountability Office (GAO) that provided detailed cost-sharing information for programs in five states—Colorado, Illinois, Kansas, New York, and Utah (GAO 2013). To obtain actuarial values for the CHIP cost-sharing structure in these five states, MACPAC utilized the actuarial value calculator from the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS).[13]

Two of the five states in the GAO analysis—Kansas and New York—charged no cost sharing for any children in the separate CHIP programs and therefore had actuarial values of 100 percent (Figure 1-3). Both states charged premiums to their higher-income CHIP enrollees, which are not reflected in actuarial values. For the lowest-income CHIP enrollees in Colorado (101 to 150 percent FPL), cost sharing is so small (e.g., $2 copayments for doctor's visits and inpatient hospitalization) that the actuarial value (99.5 percent) rounds to 100 percent.

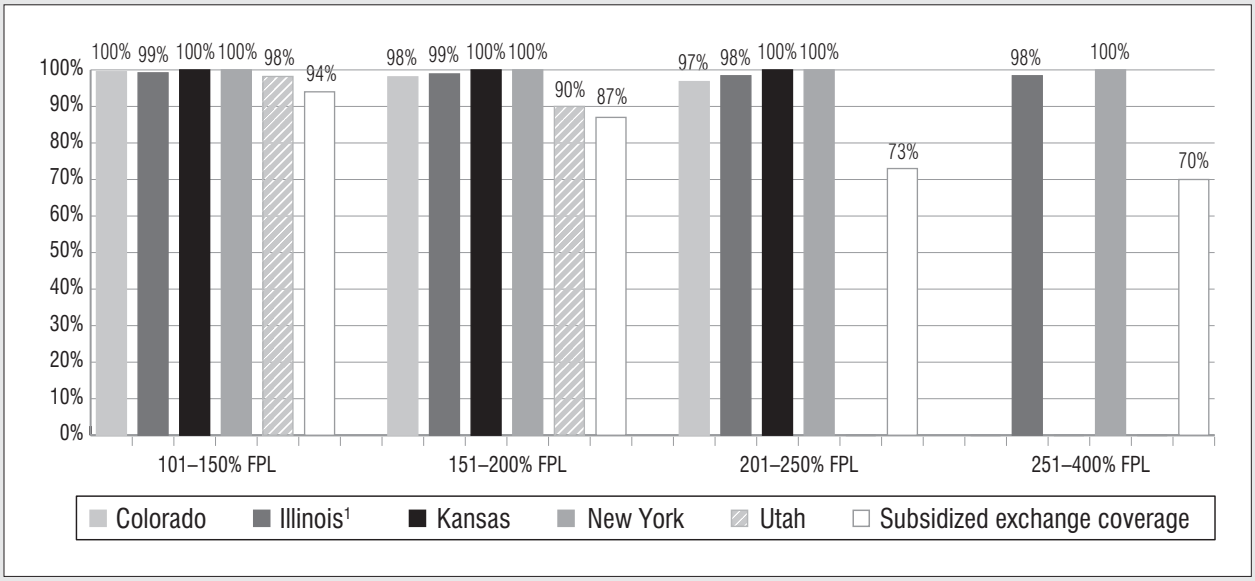
With one exception, all of the other states and income levels have actuarial values in their separate CHIP programs ranging from 97 to 99 percent (Figure 1-3). The exception is for Utah's highest income range in its CHIP program (151 to 200 percent FPL), which has an actuarial value of 90 percent. For these children, Utah has a deductible of $500, with $25 copays for a visit to a primary care physician and 20 percent coinsurance for inpatient hospital care (GAO 2013).

These actuarial values are comparable to those calculated in a 2009 analysis of separate CHIP programs. In that analysis, the actuarial values of 16 separate CHIP programs were all estimated to be above 95 percent—with separate estimates of the actuarial values based on the cost sharing charged to children at 175 and 225 percent FPL (Watson Wyatt Worldwide 2009).[14]

Comparison of CHIP and exchange plan cost-sharing amounts. Across income eligibility levels, the actuarial values of the five states' CHIP programs are consistently higher than the actuarial values prescribed for exchange plans with cost-sharing reductions. As a result, children moving from separate CHIP programs to exchange coverage would experience greater cost sharing.

Up to 150 percent FPL, all five states' CHIP programs had actuarial values in the range of 98 to 100 percent—levels significantly higher than

FIGURE 1-3. Actuarial Values of Five States' Separate CHIP Programs and of Subsidized Exchange Coverage, by Family Income



Notes: In 2014, 200 percent of the federal poverty level (FPL) is $23,340 for an individual and $8,120 for each additional family member in the lower 48 states and the District of Columbia. Bars are not shown where a state's CHIP program does not extend eligibility at that level.

[1] For the lowest income range in the figure, Illinois' separate CHIP program eligibility was between 134 and 150 percent FPL. For the highest income range in the figure, Illinois' eligibility extends up to 300 percent FPL.

Source: MACPAC analysis of GAO 2013 and CMS 2014a.

exchange plans' actuarial value of 94 percent at that income level (Figure 1-3).

Between 151 and 200 percent FPL, all five states' CHIP programs except Utah had actuarial values in the range of 98 to 100 percent—levels significantly higher than exchange plans' actuarial value of 87 percent at that income level. Even in Utah, the CHIP program's actuarial value of 90 percent exceeded the actuarial value of subsidized exchange coverage (87 percent) by more than a percentage point and therefore would not be considered comparable under federal regulations.[15]

Between 201 and 250 percent FPL, subsidized exchange plans' actuarial value of 73 percent is eclipsed by the actuarial values of the four states analyzed with eligibility levels above 200 percent FPL (Colorado, Illinois, Kansas, and New York). In that income range, the CHIP actuarial values in those four states ranged from 97 to 100 percent.

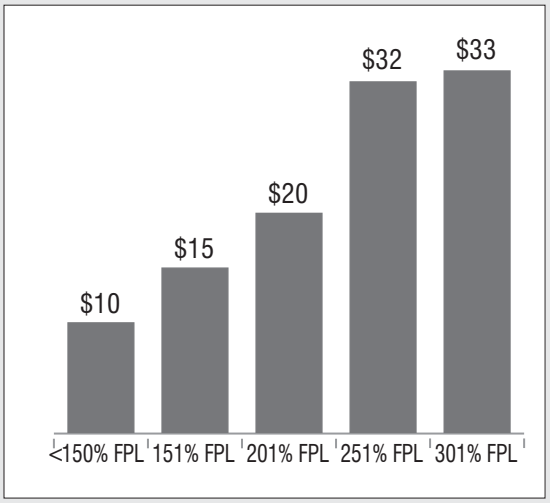
Above 250 percent FPL, no cost-sharing reductions are available for exchange plans. Thus, above 250 percent FPL, the 70 percent actuarial value would apply to individuals enrolled in a silver plan. Above 250 percent FPL, the CHIP actuarial value is 97 percent in Illinois and 100 percent in New York; the other three states do not offer CHIP benefits at this income level (Figure 1-3).

Overview of CHIP premiums

In addition to cost sharing for services, premiums also affect CHIP's affordability. As the Commission has previously noted, the use of premiums in CHIP programs is fairly widespread. Based on policies in place in January 2013, MACPAC estimates that approximately 44 percent of CHIP-funded children (3.4 million) faced premiums in 33 states, including in some Medicaid-expansion states (MACPAC 2014a). In states that charge premiums,

all require them when eligibility is extended beyond 200 percent FPL. The amount of those premiums also increases with family income (Figure 1-4).

FIGURE 1-4. Median Monthly CHIP Premium per Child Enrolled in CHIP, by Federal Poverty Level (FPL), 2013



Notes: Medians are calculated among states charging premiums at that income level. Premiums listed at 201, 251, and 301 percent include states whose upper income levels are 200, 250, and 300 percent FPL. Oregon and Pennsylvania were excluded because premiums vary by contractor.
Source: Cardwell et al. 2014.

In some states, lower-income CHIP enrollees also face premiums. As of January 2013, several states reported charging CHIP premiums below 150 percent FPL—Alabama, Arizona, California, Delaware, Florida, Georgia, Idaho, Nevada, and Utah. Since then, California has changed most of its CHIP program to a Medicaid-expansion program and has eliminated premiums below 150 percent FPL. In the remaining eight states, approximately 110,000 children below 150 percent FPL are estimated to be subject to CHIP premiums (MACPAC 2014a).

In order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Commission recommended—in MACPAC's March 2014 *Report to the Congress on Medicaid and CHIP*—that the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums (MACPAC 2014a). Based on evidence from research, the Commission concluded that eliminating CHIP premiums for families with incomes under 150 percent FPL would reduce uninsurance and would cause less crowd-out relative to higher-income enrollees (MACPAC 2014a, Abdus et al. 2013, Herndon et al. 2008). Moreover, the CHIP premiums charged in this income range, generally around $10 per month (Figure 1-4), are small enough that the revenue loss to states if they were eliminated would potentially be offset by reduced costs for collecting and administering the premiums (Kenney et al. 2007).

Interactions between CHIP and exchange premiums

While CHIP and exchange coverage each have a statutory limit on premiums (combined with cost sharing in the case of CHIP) based on family income, neither takes into account the effect of premiums required by the other. In states charging premiums of CHIP enrollees, the combination, or stacking, of both CHIP and exchange premiums could be substantial for families. With more than 3 million children facing CHIP premiums, many families will be subject to premium stacking if they purchase exchange coverage in addition to enrolling their children in CHIP.

As noted in the Commission's March 2014 report, a single mother with two children who earns $29,490 per year (151 percent FPL) would be eligible for an exchange subsidy limiting her premium contribution to approximately 4 percent of her income, or $1,193.[16] If eligible, her children would enroll in CHIP, not her exchange plan. In a state charging $20 per child per month for CHIP coverage ($480 annually), the additional cost for this coverage would be an additional 1.6 percent

of her income. In total, she would pay 5.7 percent of her income for insurance coverage ($1,673), more than the limits established for subsidized exchange premiums in the ACA. If the children in this example were not eligible for CHIP, then they could enroll in the mother's exchange plan for the same out-of-pocket premium of $1,193—for a savings to the family of $480 in premiums. Similarly, if CHIP ends, children currently subject to CHIP premiums whose parents are enrolled in subsidized exchange coverage could see a reduction in total family premiums.

Key policy issues: Affordability

The affordability of children's health care coverage needs to be assessed as coverage options are developed for children enrolled in separate CHIP programs. At issue is the appropriate level of financial contribution to be expected of families toward their health coverage—whether for enrollment in CHIP, employer-sponsored coverage, the exchanges, or other sources of coverage.

In extending CHIP funding beyond FY 2015, the issue of premium stacking would remain, as families split between CHIP and exchanges face premiums from both sources and perhaps from stand-alone dental plans offered through exchanges as well. As noted in MACPAC's March 2014 report, the phenomenon of premium stacking is of concern to the Commission. The Commission has not come to a conclusion about how the associated costs of addressing the issue might be split between states and the federal government. The Commission also seeks data regarding the prevalence of split family coverage and premium stacking and is working with CMS to identify how many families are affected.

Covered Benefits in CHIP and Exchange Coverage

State flexibility in benefit design leads to differences in the benefits offered by separate CHIP programs, Medicaid (including Medicaid-expansion CHIP programs), and exchange plans. Separate CHIP programs can model their benefits based on specific private insurance benchmarks, a package equivalent to one of those benchmarks, or Secretary-approved coverage. The most flexible of these options is Secretary-approved coverage, which is the most common approach. As a result of this flexibility, covered benefits in CHIP have the potential to differ substantially from state to state. On the other hand, 14 programs use a benefit package similar to Medicaid for Secretary-approved separate CHIP programs (Cardwell et al. 2014).[17]

States also have flexibility to define the array of benefits that qualified health plans (QHPs) must cover in order to be certified, consistent with federal minimum requirements for exchange coverage. One of those requirements is that exchange plans must provide coverage of the 10 essential health benefits (EHBs) required by the ACA (§1302(b)).

Benefit design affects access to care. As a result, the differences in the benefits offered by Medicaid, separate CHIP programs, and exchange plans raise questions about which benefit design is appropriate for children's coverage. Exchange coverage is new relative to the CHIP program, so comparisons between the programs are just now emerging and are likely to evolve as the exchange market matures. Existing research points to three areas where some differences between separate CHIP and exchange coverage exist: certain covered benefits, benefit limits, and the approach to offering dental coverage. Medicaid-expansion CHIP benefits differ from both separate CHIP and private coverage due to Medicaid's EPSDT requirements.

Coverage of benefit categories

Exchange plans offer covered benefits that are largely consistent with separate CHIP coverage, but with a few differences. A GAO study comparing separate CHIP programs and EHB benchmarks in five states found that most benefit categories were covered in both programs. For example, benefits like inpatient and outpatient mental health services and chronic disease management services were covered in both separate CHIP programs and EHB benchmark plans in all five states. However, outpatient habilitative therapies and pediatric hearing services were covered inconsistently in separate CHIP programs and EHB benchmark plans (GAO 2013).[18] For example, separate CHIP programs in three of five states (Colorado, Illinois, and New York) covered outpatient habilitative therapies, while benchmark plans in two states (Illinois and Utah) covered the benefit.

Benefit limits

In the five states GAO examined, separate CHIP programs generally include fewer benefit limits relative to EHB benchmark plans. Comparisons of benefit limits between separate CHIP programs and EHB benchmark plans can be difficult to make because benefit limits can be applied differently. For example, the CHIP program in New York allows 6 weeks of physical therapy services, while the EHB benchmark plan allows up to 60 visits per condition. With this difficulty in mind, the GAO first compared whether limits were applied to the same benefit categories. They found that separate CHIP programs and EHB benchmark plans tend to apply limits to the same benefit categories, typically home and community-based services, outpatient therapies, and services that are mandated for children but not adults, such as dental, vision, and hearing services. And where benefit limit comparisons were clearer, the GAO found that CHIP programs tend to have higher benefit limits than benchmark plans. For example, Utah's benchmark plan limits home and community-based services to 30 visits per year, whereas the CHIP program does not impose any limits on this service.

Pediatric dental coverage

Another key difference is the approach to providing pediatric dental coverage. Separate CHIP programs are required to provide coverage for dental services. Although pediatric oral health is an essential health benefit, exchange plans are not required to cover pediatric oral health benefits if stand-alone dental plans are available in an exchange (§1302(b)(4)(F) of the ACA).[19] Thus some plans cover all 10 EHBs, including pediatric dental services, while others offer a stand-alone dental plan in addition to medical policies that exclude dental benefits.

When dental coverage is only available in an exchange as a stand-alone plan, families would need to purchase separate plans and pay two premiums.[20] Moreover, individuals and families are not required to purchase pediatric dental coverage when offered separately (unless required by state law).[21] Stand-alone dental plans may also establish separate cost sharing (45 CFR 156.150). Questions have been raised about the affordability of pediatric dental coverage and whether people will take up pediatric dental coverage in the absence of the requirement to do so (AAPD et al. 2013).

The approach to providing pediatric dental coverage in exchange plans varies by state; for example, in nine states with a federally facilitated or partnership exchange, two-thirds or more of the QHPs have pediatric dental benefits embedded within coverage. On the other hand, in 14 states with a federally facilitated or partnership exchange, 15 percent or fewer QHPs offer plans with embedded pediatric dental coverage (Reusch 2014). The Commission recognizes the importance of dental benefits to children's health and development and that there

is more to be learned about how and the extent to which children in exchange plans get pediatric dental coverage.

Key policy issues: Covered benefits

While benefit design will be an important element of a long-term vision for children's coverage, systematic information comparing benefits between exchange plans and CHIP has only recently begun to emerge. Comparing covered benefits may be easier in the future. For example, more details are emerging on how insurers have designed exchange plans in light of the EHB requirements. In addition, QHP benefit design could change as health insurance issuers gain market experience in the coming years.

MACPAC will assess, for example, whether plans are adopting the limits set forth in EHB benchmark plans or are providing coverage beyond the benchmark. MACPAC will review how coverage of habilitative benefits in exchange plans compares to separate CHIP plans in terms of what services are covered and what limits are applied to coverage. And MACPAC will monitor the extent to which dental coverage is offered separately and what effect, if any, this has on access to pediatric dental services. This new information can be used to better compare the type of benefits and the amount of coverage available in CHIP and exchange plans, a critical element in understanding how CHIP and exchange plans address the health care needs of children.

In addition to developing a better understanding of what services are covered, MACPAC also seeks to strengthen its understanding about the quality of those services. CHIPRA provided $45 million per year for FY 2009 through FY 2013 ($225 million total) for the Secretary to identify, publish, and periodically update a core set of child health quality measures for states' voluntary use in Medicaid and CHIP.[22] Of the 22 child health quality measures currently in use as a result of this initiative, all states reported on 2 of the measures in FY 2012.[23] The median number of measures reported by states was 14 (HHS 2013). MACPAC strongly supports efforts to measure and improve the quality of health care for children in Medicaid and CHIP and will continue to monitor HHS efforts to improve quality in Medicaid and CHIP and the effectiveness of the efforts funded by CHIPRA.

Network Adequacy in CHIP, Medicaid, and QHPs

The adequacy of provider networks to provide access to necessary services for plan enrollees is another key consideration when evaluating the potential impact of moving children now covered by CHIP to subsidized exchange coverage. There is an often-stated assumption that CHIP networks are better than Medicaid and QHP networks, supported by the arguments that many CHIP networks mirror private plan networks or that CHIP networks are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, limited empirical information exists to support or refute this assertion.

While there are no data comparing networks in Medicaid, CHIP, and the exchanges, a comparison of federal requirements for Medicaid, CHIP, and QHP network adequacy shows that the provisions under each program are similar. There are exceptions, however. Medicaid and CHIP offer access to out-of-network providers when the network is not sufficient for an enrollee's medical needs. QHP network adequacy provisions do not require an out-of-network option except in cases of emergency, although some QHPs may be preferred provider organizations or point-of-service plans that may provide such an option with higher cost sharing. These federal requirements are broad standards, however, and in many cases substantially

more detailed network adequacy requirements are established at the state level. QHP networks are still relatively new, so little information is available on their adequacy for children.

Medicaid and CHIP network adequacy requirements

Managed care plans in Medicaid and CHIP are subject to the same federal network adequacy requirements (§2103(f)(3) of the Act, CMS 2009). These requirements provide that states must establish "standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity" (§1932(c)(1)(A)(i) of the Act). In addition, each managed care organization (MCO) must demonstrate that it has "the capacity to serve the expected enrollment" in its service area and must also offer "an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled" and "[maintain] a sufficient number, mix, and geographic distribution of providers and services" (§1932(b)(5)(A) and (B) of the Act).

Medicaid also requires states to cover services at federally qualified health centers (FQHCs), which effectively ensures access to health center providers. No such federal rules exist for CHIP, but at the state level, more than 80 percent of fee-for-service separate CHIP programs and nearly 60 percent of managed care separate CHIP programs require FQHCs to be included (Hess et al. 2011). CHIP programs also frequently place other requirements on coverage of certain providers: more than 80 percent of fee-for-service separate CHIP programs and over 50 percent of managed care separate CHIP programs require contracting with rural health clinics. In addition, 62 percent of fee-for-service separate CHIP programs and 28 percent of managed care separate CHIP programs cover services at school-based health centers (Hess et al. 2011).[24]

Adding to these requirements, CHIP regulations specify that a state must assure "access to out-of-network providers when the network is not adequate for the enrollee's medical condition" (42 CFR 457.495). Medicaid MCOs also must cover out-of-network services if the network is unable to provide them (42 CFR 438.206, 42 CFR 438.52). In addition, children covered by Medicaid are entitled to EPSDT services regardless of network.

QHP network adequacy requirements

Federal rules govern minimum network adequacy standards for exchange plans. QHP provider networks must be sufficient "to permit access to care without unreasonable delay" (45 CFR 156.230). The QHP issuer must make its provider directory available to the exchange and identify those providers not accepting new patients (45 CFR 156.230(b)). CMS has clarified that within the initial open enrollment period, enrollees can move to another plan of the same issuer in the same metal tier to access a more inclusive provider network (CMS 2014b).

Oversight of network adequacy dependent on exchange type. In federally facilitated exchanges for 2014, HHS used a state's network adequacy review if it was at least as stringent as the federal requirements (CMS 2013a). However, CMS has issued new network adequacy standards for 2015 (CMS 2014c). In 2015, CMS will require issuers to submit a provider list detailing all in-network providers and facilities for all plans for which it seeks QHP certification. CMS will no longer use issuer accreditation status, network access plans, or state review to determine network adequacy. CMS will instead use a "reasonable access" review standard to assess whether a network will provide access without unreasonable delay. CMS will also

use information gathered about provider networks to develop time and distance standards for federally facilitated exchange QHP standards in the future (CMS 2014c). HHS is also soliciting comments on its interpretation of the ACA's provider non-discrimination requirements (HHS 2014).

States running a state-based exchange can issue their own regulations that comply with federal network adequacy requirements. Similarly, states running a plan management partnership exchange recommend QHP certification to HHS. This allows states to use their regulatory authority to approve network adequacy, but HHS retains the ultimate responsibility for ensuring that federal requirements are met (CMS 2013b).

Essential community providers. QHP provider networks must include a sufficient number and geographic distribution of essential community providers (ECPs), defined as providers who serve low-income, medically underserved individuals (45 CFR 156.235). An alternate standard applies to QHP issuers that provide a majority of covered services through physicians they employ or through a single contracted medical group. These issuers must have a sufficient number and geographic distribution of such providers "to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the exchange's network adequacy standards" (45 CFR 156.235(b)). To monitor inclusion of ECPs in 2014, HHS verified that the issuer: (1) contracted with at least 20 percent of the ECPs in its service area, (2) contracted with at least one ECP of each available type—FQHC, Ryan White provider, family planning provider, Indian Health provider, certain hospitals, and other providers such as tuberculosis clinics—in each county, and (3) offered a contract to all available Indian Health providers. If an issuer could not meet this standard, it was required to provide a satisfactory justification (CMS 2013a, 2013b). In 2014, issuers under the alternate standard were also required to meet the 20 percent ECP guideline or provide a satisfactory justification (CMS 2013a, 2013b).

To evaluate ECP network adequacy in 2015, CMS will verify that an issuer contracts with at least 30 percent of available ECPs in the service area or that it provides a satisfactory justification if it cannot meet this standard. In addition, issuers must offer contracts in good faith to all available Indian Health providers and to at least one ECP in each ECP category. In 2015, issuers under the alternate standard must also meet the 30 percent ECP guideline or submit a narrative justification (CMS 2014c).

Key policy issues: Network adequacy

Unlike CHIP, QHP network adequacy provisions do not require access to out-of-network care if the network is not sufficient for the enrollee's condition, though some QHPs may offer such access with higher cost sharing. Narrow provider networks in QHPs could violate the ACA's prohibition of discrimination on the basis of disability and could therefore require access to out-of-network care if in-network care is not sufficient to address the enrollee's medical needs (§1557 of the ACA, 45 CFR 156.200, Keith et al. 2013).

In contrast with QHPs, CHIP programs are not federally required to contract with ECPs. Even so, many CHIP programs have requirements that plans include FQHCs and rural health clinics (Hess et al. 2011).

Many such network adequacy requirements are established at the state level, and how they are monitored and enforced via state law, state regulations, and contracts between state agencies and health plans varies by state. In future reports, MACPAC will examine network adequacy monitoring and enforcement to provide further context to these comparisons.

A fuller picture of QHP network adequacy for children will emerge as enrollees access care throughout the first year of the program. Complaint tracking and network adequacy reports from consumer advocates may be the first signals of access issues.

While some reports suggest that narrower networks are a trend in both employer-sponsored coverage and QHPs, it will be important to monitor the effect of such networks on children's access to necessary care (Kliff 2014, McKinsey 2013).[25] For future reports, MACPAC will continue to monitor differences in network adequacy between CHIP and QHPs.

Federal Financing Issues

If CHIP funding is extended, the Congress will have to make decisions about the program's federal financing. Before describing these issues, this section provides an overview of federal CHIP financing.

Overview of CHIP financing

Federal funding for CHIP is capped and is allotted to states annually based on a methodology that relies on each state's recent CHIP spending. States have two years to spend each allotment. Thus, in FY 2014, states have their new FY 2014 allotment available to them, as well as any leftover FY 2013 funds.[26] The current CHIP allotment formula has been in place since the enactment of CHIPRA in 2009.

If a state uses all of its available FY 2013 and FY 2014 CHIP allotments in FY 2014, two other sources of additional federal CHIP funds could be made available to qualifying states: (1) the CHIPRA contingency fund and (2) FY 2012 redistribution funds from states that did not exhaust their FY 2012 allotment after two years of availability.[27] Since the contingency fund was created by CHIPRA, it has only been used for one state, in 2009.

Under the ACA, appropriations for FY 2014 and FY 2015 are higher than previous levels, but at slightly lower levels of growth (10 percent) compared to those set in CHIPRA for FY 2010 to FY 2014 (13 percent, on average).[28] Within these total appropriations, states' FY 2014 CHIP allotments were based on their FY 2012 spending, and states' FY 2015 CHIP allotments will be based on their FY 2014 spending.

Based on state estimates of their projected spending made in February 2014, federal CHIP spending in FY 2014 is projected to be $9.6 billion, 6 percent higher nationally than in FY 2013 (Appendix Table 1-A-4). This average masks variation at the state level. For example, five states are projecting increases in federal CHIP spending of at least 40 percent—South Carolina (63 percent), Alaska (42 percent), North Carolina (41 percent), Alabama (40 percent), and Kansas (40 percent).[29] On the other hand, as a result of the termination of CHIP-funded coverage of parents required by CHIPRA, New Jersey and New Mexico are projecting large declines in federal CHIP spending in FY 2014 compared to FY 2013 (47 and 43 percent, respectively).[30]

Federal financing of former CHIP children in a post-CHIP landscape

This section describes, under current law, the timing of states' exhaustion of federal CHIP funds in FY 2016 and the financing implications of children's coverage in a post-CHIP landscape.

Timing of states' exhaustion of federal CHIP funds. While no new CHIP allotments are slated for FY 2016 or after, CHIP's authorization does not expire. In FY 2016, states may continue to use any unspent FY 2015 CHIP allotments. Under current law, however, contingency fund payments are not authorized past FY 2015, so this source of funding would not be available as states run out of CHIP funds (§2104(n)(3)(A) of the Act). Any

redistribution amounts available in FY 2016 would likely be small.

Under current law, states will run out of CHIP funding at various points during FY 2016, depending on a number of factors. The primary determinant of when states will exhaust their federal CHIP funds would be how much of their FY 2015 allotment remains unspent at the beginning of FY 2016. Various federal policies would also affect when states run out of federal CHIP funds. For example, the ACA included a policy that increases the federal matching rate for CHIP by 23 percentage points for FY 2016 through FY 2019 (although it cannot exceed 100 percent). Thus, beginning in FY 2016, the federal CHIP matching rates will range from 88 to 100 percent, rather than the current range of 65 to 83 percent (Appendix Table 1-A-4). This will accelerate the pace at which states will use any remaining federal CHIP funds in FY 2016. From the state perspective, states' current share of CHIP expenditures ranges by state from 17 to 35 percent; a 23-point increase in the federal share would reduce the state share to a range of 0 to 12 percent—as long as funds are available.

State policies may also affect when states exhaust their federal CHIP funding. For example, while the ACA generally prohibits reducing children's eligibility for CHIP, states are permitted to impose enrollment limits "in order to limit expenditures… to those for which Federal financial participation is available" (§2105(d)(3)(A)(iii) of the Act). Other actions states may take to reduce CHIP spending that are not prohibited under the ACA's MOE include allowing CHIP waivers to expire and cutting payments to plans and providers.

Federal funding for children if CHIP funding is exhausted. As discussed earlier, states with a Medicaid-expansion CHIP program will generally be required to continue their Medicaid coverage if CHIP funding is exhausted shortly after FY 2015 as under current law. While Medicaid's matching rate is lower than CHIP's, Medicaid's federal funding is open ended. Thus, for states relying on Medicaid expansions, there is no prospect of federal Medicaid funds running out, as with CHIP, but the state contribution would increase. A reduction from the CHIP matching rate—not including the 23-point increase for FY 2016—to Medicaid's traditional matching rate would generally increase state expenditures for those children by 43 percent. The District of Columbia and seven states operating their CHIP programs entirely as an expansion of Medicaid (Alaska, Hawaii, Maryland, New Hampshire, New Mexico, Ohio, and South Carolina) could face the largest increases in state expenditures for continuing coverage through Medicaid if federal CHIP funding and its enhanced matching rate were not available.

States with separate CHIP programs would no longer be required to provide coverage after federal CHIP funding is exhausted. Forty-three states operate some portion of their CHIP programs separate from Medicaid, including 14 states with CHIP programs wholly separate from Medicaid (Appendix Table 1-A-3). These states' only federal requirement would be to have procedures to enroll children in exchange plans that are certified as being comparable to CHIP, if available. Thus, states with a separate CHIP program could be released from any state spending, while many of those affected children would become uninsured or face significantly higher cost sharing. For children who would qualify for subsidized exchange coverage if their CHIP coverage were to end, the cost of the subsidy would be entirely federal.

The federal cost of CHIP's continuation was a major legislative issue for reauthorization in 2009, but coverage changes made by the ACA have led the Congressional Budget Office (CBO) to assume that much of the cost of a CHIP extension would be offset by reductions in other federal spending.

Under current law, if CHIP allotments are not extended past FY 2015, CBO assumes that many enrollees would receive federally subsidized coverage from other sources, including through exchanges, Medicaid, and employer-sponsored insurance. Since an extension of CHIP would replace other forms of federally subsidized coverage, federal cost estimates of extending CHIP are partially offset by reductions in other programs. On the other hand, the 23-percentage point increase in the CHIP matching rate slated under current law for FY 2016–2019 has increased the federal cost of an extension of CHIP relative to prior law.

Key policy issues: Federal financing

The prospect of CHIP funding ending shortly after FY 2015 under current law and the extension of CHIP funding through FY 2017 under the Commission's recommendation raise questions regarding the appropriate level of federal versus state financing of public coverage. How much federal financing is necessary to ensure appropriate levels of program participation—not only by individuals but also by states? The federal government also subsidizes exchange coverage and employer-sponsored insurance. Considering all of the sources of coverage subsidized by the federal government, do the levels of federal spending toward each represent the optimal use of taxpayer dollars for ensuring access to appropriate care?

If the Commission's recommendation to extend CHIP funding through FY 2017 is adopted, a new set of issues will emerge around financing children's coverage in FY 2018 as policymakers consider the future of CHIP once more.

Options for the Future of CHIP

The Commission considered several options as it examined the role of CHIP given new coverage options for low-income individuals. These included what might happen if current law were allowed to stand or if CHIP funding were extended for four years or more. It concluded, for reasons discussed below, that neither option is desirable and thus recommended two additional years of funding. This transition period, which would last through the end of FY 2017, will, in the Commission's view, provide time to address the limitations that have become evident in the availability and adequacy of pediatric coverage, particularly through exchanges. The Commission believes that these limitations must be addressed so as not to step backward from the relatively high level of good coverage children now have through CHIP.

Maintain current law

The Commission considered what would happen under the current-law scenario, under which states would exhaust CHIP funding shortly after FY 2015. It found that many children now served by the program would not have a smooth transition to another source of coverage offering comparable benefits and cost sharing. The number of uninsured children would likely rise, and the cost sharing for children obtaining other coverage would often be significantly higher. In the Commission's view, it is not clear that exchange plans are ready to serve as an adequate alternative for CHIP children in terms of covered benefits and provider networks.

Under current law, the exhaustion of CHIP funding would also have an inequitable financial impact on states. Through FY 2019, Medicaid-expansion CHIP states would be required to continue Medicaid coverage at reduced federal matching rates. Approximately 3 million children enrolled in Medicaid-expansion CHIP would be protected

with continued coverage. However, states operating separate CHIP programs (now serving over 5 million children) would have no legal obligation to continue financing coverage for these children.

From the Commission's perspective, there is insufficient time between now and the end of FY 2015 to address all these issues, either in law or regulation. A time-limited extension of CHIP funding appears warranted to minimize coverage disruptions and provide for a thorough examination of the coverage options for children.

Transition funding of CHIP through FY 2019

The Commission also considered extending CHIP funding through FY 2019, consistent with the ACA's MOE. In addition to aligning coverage and financing policies, this approach would also allow for completion and consideration of the Secretary's assessment of the comparability of CHIP and exchange coverage in terms of benefits and cost sharing.

The Commission believes that coverage for children under a separate CHIP authority should not be maintained indefinitely. The optimal outcome for children and families is to address affordability and adequacy so that low- and moderate-income children can be fully integrated into other sources of coverage, including Medicaid, exchange, and employer-sponsored coverage. In order for exchange coverage to meet the affordability and care standard of CHIP, it must become more responsive to the health needs of all children, including those whose families need financial assistance in order to make coverage affordable. In the view of the Commission, health coverage for children should be high quality, affordable to families, and be integrated with the full array of coverage options.

CHIP has clearly played a historic role in reducing the number of uninsured children, and lessons learned from that experience should continue to inform public policy. But the ACA transformed the policy context for CHIP such that CHIP-funded coverage represents a small wedge among coverage options, potentially adding complexity for families and administrative costs for the states and the federal government.

We have recommended the short-term extension of CHIP to provide the impetus to make the legislative and regulatory changes necessary to smooth the transition and to make coverage options work well for CHIP children. A shorter-term extension is also more fiscally prudent.

Commission Recommendation

Recommendation 1.1

The Congress should extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

Rationale

This recommendation calls for extending federal CHIP allotments through FY 2017, thereby enabling two additional years of transition. The Congress should act soon to extend CHIP allotments through FY 2017 so that states do not respond to the uncertainty around CHIP's future by implementing policies that reduce children's access to appropriate care. This recommendation assumes no changes in any other aspect of CHIP-funded coverage as it exists under current law, including the 23-percentage-point increase in the CHIP federal

matching rate slated for FY 2016 through 2019, which states have built into their budget estimates.

This short-term extension would provide an opportunity for policymakers to develop sound policies for coverage of children now served by CHIP. During this time, a thoughtful, comprehensive assessment is needed to develop and implement specific changes in public policy that will ensure adequate and affordable coverage for low-income children, equitable treatment of states, appropriate use of public dollars when private dollars may be available (for example, through employer-sponsored coverage), and smooth transitions across sources of coverage.

There are three primary reasons for this extension. First, extending CHIP would prevent increased uninsurance among children. This projected increase could be mitigated substantially if the ACA's affordability test for employer-sponsored coverage accounted for the cost of family coverage, not just self-only coverage, or to allow more low-income working families to access exchange subsidies if employer-sponsored coverage is still too costly; however, such changes would result in increased federal costs for subsidies in the exchange.

Second, in the absence of CHIP, many families would see significant increases in cost sharing for health care services. The higher cost-sharing levels for exchange coverage would increase financial burden and may raise barriers to low-income children's access to care. This could be addressed in several ways—for example, by increasing cost-sharing assistance associated with exchange coverage, offering such assistance for those with employer-sponsored insurance, or by providing wraparound cost-sharing assistance through other means. These options raise additional design questions such as which children should be eligible for these additional cost-sharing protections and how such enhancements would be financed.

Third, there is little evidence on children's experience in exchange plans to determine whether or not the plans, benefits, and networks are adequate and appropriate for children currently enrolled in CHIP. For example, while children's dental care must be covered in CHIP and made available in exchange plans, parents may find that stand-alone dental plans in exchanges are too expensive, even with the subsidies, and forgo such coverage. In addition, little is known about how exchange plans' networks compare to those in CHIP and how low-income children are faring in these plans. Evidence needs to be further developed on the adequacy of coverage for children in exchange plans.

The Commission stresses that it considers this additional funding transitional. This means that during this time period, specific steps will need to be taken to ensure that exchange coverage adequately responds to the needs of children and that other options to improve employer-sponsored and Medicaid coverage are explored. If it becomes evident during this extended transition period that more time is necessary to ensure that needed reforms are in place and that children's transition into new coverage options is appropriate, further extending this transition period should be considered. However, the Commission remains confident that the changes necessary to ensure that children have access to high-quality coverage that addresses their needs can be made during this transition period.

Implications

Federal spending. Providing federal CHIP funding for an additional two years beyond FY 2015 is projected to increase federal spending, in part because of the ACA's increase in the CHIP matching rate (23 percentage points). As a result of this increase in the matching rate, the federal government will pay for approximately 93 percent

of states' CHIP expenditures during this period, up from the historical average of 70 percent of CHIP expenditures.

CBO estimates that this recommendation, to provide federal CHIP allotments for FY 2016 through 2017, would increase net federal spending by $0–5 billion above the agency's current law baseline. The federal costs of providing CHIP allotments for two more years would be largely offset by reductions in federal spending for Medicaid and subsidized exchange coverage—sources of federally subsidized coverage in which many children are assumed to enroll if CHIP funding were to be exhausted under current law. CBO's estimate also reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2015 at $5.7 billion each year.

States. This recommendation would enable states to continue providing CHIP-funded coverage for another two years to 8 million children without the risk of increased uninsurance and increased state Medicaid spending if CHIP were to end.

The effect of this recommendation would not only extend the life of CHIP but also lower state CHIP matching payments relative to what states currently pay, as the 23-point increase in the CHIP matching rate under current law goes into effect.[31]

Enrollees. The effect on CHIP enrollees of a two-year extension of CHIP will differ depending on the type of CHIP program in their state and on enrollees' circumstances. Children in Medicaid-expansion programs would experience no change, since the MOE obligates states to continue that coverage even after federal CHIP funding is exhausted. Extending CHIP through FY 2017 would ensure that children currently covered in separate CHIP programs do not become uninsured or moved to coverage that requires higher cost sharing.

Plans and providers. Extending CHIP funding would ensure that the plans and providers currently participating in CHIP could continue that coverage without disruption.

Next Steps

In future analyses and reports, the Commission will explore in greater depth the issues raised in this chapter that must be addressed before children currently enrolled in CHIP can be integrated into other sources of coverage, including coverage through Medicaid, exchanges, and employers. The Commission will explore policy options that can address these known shortcomings in children's coverage that would exist without CHIP and what the trade-offs would be for each of them. We will also examine any emerging evidence regarding children's experiences in exchange plans to determine whether other issues need to be addressed to ensure coverage is adequate and appropriate for children currently enrolled in CHIP.

Endnotes

[1] While ending CHIP would lead to some children being uninsured, the magnitude of the effect depends on a number of factors, many of which are difficult to model with precision. In addition, this estimate was modeled using data from several years ago and does not take into account that some states, most notably California, have transitioned the vast majority of their enrollees from separate CHIP to Medicaid-expansion CHIP coverage.

[2] The most commonly chosen option for benefit design among separate CHIP programs is coverage approved by the Secretary (25 programs). Among the 25 Secretary-approved separate CHIP programs, 14 of the programs are based on the Medicaid benefits package offered in the same state (Cardwell et al. 2014).

[3] This decline in private coverage could be the result of multiple factors. It could, for example, reflect a broader decline in the availability of employer-sponsored health insurance for adults and children. It could also reflect a degree of substitution of public coverage for available private coverage, which is frequently referred to as crowd-out. Researchers have struggled to answer the question of whether CHIP eligibility expansions caused crowd-out of private coverage or whether private coverage declines would have occurred regardless and CHIP prevented uninsurance. Based on a review of the most reliable studies available in 2007, CBO determined that 25 to 50 percent of the increase in public coverage resulting from CHIP was from a decline in private coverage. In other words, for every 100 children who enroll in public coverage as a result of CHIP, private coverage falls by between 25 and 50 children (CBO 2007).

[4] Under the ACA, individuals whose Medicaid or CHIP eligibility is determined based on modified adjusted gross income must face no asset test or requirement for an in-person interview (§§1413(b)(1)(A) and 2002 of the ACA). In addition, ACA regulations require states to attempt to renew eligibility on the basis of data already available to the state before requiring information from enrollees (42 CFR 435.916(a)(2) and 457.343). Prior to these requirements, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) provided bonus payments to states implementing these (and other) strategies and that increased child Medicaid enrollment by certain amounts (§104 of CHIPRA). States often used CHIP as a forerunner to test the use of these strategies before applying them to populations in Medicaid.

[5] The analysis excludes children enrolled in employer-sponsored coverage.

[6] CHIP also funds coverage of pregnant women on a limited basis. In FY 2013, 10,149 adult pregnant women received CHIP-funded coverage, excluding unborn children (MACPAC 2014a).

[7] Although all states will be eligible to receive CHIP funding for at least some children in Medicaid as of 2014 due to the implementation of two ACA requirements, 14 states are still categorized as separate programs in this report because they did not have approved state plan amendments on the Centers for Medicare & Medicaid Services (CMS) website indicating whether they will characterize themselves as combination states. The two ACA requirements are: a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs to Medicaid coverage, and a mandatory 5 percent of income disregard that effectively requires Medicaid coverage for all children at or below 138 percent FPL.

[8] Because the MOE is tied to eligibility policies in place on March 23, 2010, it is not clear whether states that elected to convert much of their population from separate CHIP to Medicaid-expansion coverage, such as California, would be able to remove those children from Medicaid as CHIP funding is exhausted.

[9] FY 2013 CHIP-funded enrollment reflected states' coverage of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs. The ACA requires these children to be transitioned to Medicaid-expansion CHIP coverage, which will shift an estimated 700,000 children from separate CHIP to Medicaid-expansion CHIP. In FY 2013, at least 19 states reported enrollment of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs: Alabama, Arizona, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming.

[10] For a family of three, 200 percent FPL is $39,580. For such a family, the average worker contribution for self-only coverage would comprise 2.5 percent of income, while family coverage would consume nearly 12 percent of income.

[11] While 98 percent of employees who are eligible for their employers' coverage also have access to dependent coverage, that coverage may not be practically affordable.

[12] Excludes American Indians, for whom different cost-sharing levels apply in exchange plans.

[13] MACPAC used the proposed 2015 Actuarial Value Calculator publicly available in February 2014. The calculator draws upon 2010 claims data from Health Intelligence Company, LLC, which is licensed by the Blue Cross and Blue Shield Association. The claims data are from 54 million adults and children in commercial insurance plans, representing group and individual health plans. The calculator determines actuarial values based on enrollees' cost-sharing information and a standard population representing "those likely to be covered in the individual and small group markets in 2014" (Knuth 2013).

[14] A 17th state, West Virginia, was included in the original analysis. It has since reduced its CHIP cost sharing, which would increase its actuarial value. At the time of the 2009 analysis, the actuarial value for its coverage was estimated at 92 percent.

[15] See 45 CFR 156.400 regarding the definition of de minimis variation for a silver plan variation.

[16] This assumes the mother chooses the second-lowest cost silver plan, on which the premium credits are based. If she chooses a more expensive plan, she is also responsible for the difference.

[17] MACPAC has previously discussed the states' role in benefit design in CHIP programs and defining benefit standards for exchange plans (MACPAC 2014b). For example, states can implement a Medicaid-expansion CHIP program in which federal Medicaid rules apply, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service requirements. Essential health benefits do not apply to CHIP programs. For more information on benefit design, see MACPAC 2014b and MACPAC 2013b.

[18] In the study, the GAO compared the benefit categories offered by separate CHIP programs and the EHB benchmark definition in five states. The list of services available within each category may vary among separate CHIP and EHB benchmark definitions, and therefore coverage of a specific service may vary. EHB benchmark definitions establish a minimum standard that all exchange plans must meet in order to be certified. Issuers can provide additional services or establish higher benefit limits than those established in EHB definitions. When the GAO conducted their analysis, exchange plan details were not available. As a result, actual coverage may vary from the EHB benchmark used for comparison.

[19] Stand-alone dental plans cover dental services only and must meet the state-defined pediatric oral services EHB standard (§1311(b)(2)(B)(ii) of the ACA).

[20] Individuals who purchase both separate medical and stand-alone dental plans face premium payments for each policy.

[21] Three states (Kentucky, Nevada, and Washington) require families and individuals to purchase dental coverage for children when it is not embedded within a QHP (Snyder et al. 2014).

[22] The child quality measures are not funded by CHIP and are not part of the CHIP statute, but pertain to both Medicaid and CHIP.

[23] Nationally, 43 percent of children in Medicaid and CHIP received preventive dental services in FY 2012, and 24 percent received a dental treatment service.

[24] Forty-six states, including the District of Columbia, responded to this National Academy for State Health Policy survey (Hess et al. 2011).

[25] A recent study by McKinsey & Company found that 70 percent of silver plan networks studied were narrow or ultra-narrow (McKinsey 2013).

[26] The current CHIP allotment formula has been in place since CHIPRA's enactment in 2009. For even-numbered years (FY 2010, FY 2012, and FY 2014), allotments are calculated as last year's allotment and any shortfall payments (e.g., contingency funds), increased by a state-specific growth factor. For these years, a state can also have its allotment increased to reflect a CHIP eligibility or benefits expansion. For odd-numbered years (FY 2011, FY 2013, and FY 2015), the allotments are rebased, based on last year's federal CHIP spending in each state or territory, including from contingency funds, plus its growth factor.

[27] By the beginning of FY 2014, all but five states had exhausted their FY 2012 allotments. These states' unspent amounts (Arizona for $8.5 million, Michigan for $13.8 million, New Mexico for $148.7 million, Utah for $13.8 million, and Wisconsin for $1.0 million) total $185.8 million and are available for redistribution to any state facing a shortfall of federal CHIP funds in FY 2014.

[28] Under CHIPRA, appropriations for federal CHIP allotments were as follows: $10.6 billion for FY 2009, $12.5 billion for FY 2010, $13.5 billion for FY 2011, $15.0 billion for FY 2012, and $17.4 billion for FY 2013. Under the ACA, the federal CHIP appropriations for CHIP allotments are $19.1 billion for FY 2014 and $21.1 billion for FY 2015.

[29] Even with these projected increases, these states are not expected to exhaust their available federal CHIP funding in FY 2014.

[30] CHIPRA required states to eliminate CHIP-funded coverage of parents by September 30, 2013. In FY 2013, CHIP-funded enrollment of parents existed in New Jersey (183,717), New Mexico (14,790), and Arkansas (10,425).

[31] Based on the FY 2014 and FY 2015 federal CHIP matching rates, a 23-point increase would result in no state share for CHIP expenditures in the District of Columbia and 10 states (Alabama, Arizona, Arkansas, Idaho, Kentucky, Mississippi, New Mexico, South Carolina, Utah, and West Virginia). For other states, their share of CHIP expenditures would not exceed 12 percent, compared to the current maximum of 35 percent.

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Chapter 1 Appendix

APPENDIX TABLE 1-A-1. Percentage and Number of Uninsured Children under Age 19 by State, 2012

State	Percent of Children Who Are Uninsured	Number of Uninsured Children	Share of Total Uninsured Children
United States	**7.5%**	**5,866,000**	**100.0%**
Alabama	4.4	52,000	0.9
Alaska	13.4	26,000	0.4
Arizona	13.3	227,000	3.9
Arkansas	5.9	44,000	0.7
California	8.5	829,000	14.1
Colorado	8.9	117,000	2.0
Connecticut	3.9	33,000	0.6
Delaware	3.7	<10,000	–
District of Columbia	2.7	<10,000	–
Florida	11.4	484,000	8.3
Georgia	9.5	251,000	4.3
Hawaii	3.3	11,000	0.2
Idaho	8.0	36,000	0.6
Illinois	3.7	119,000	2.0
Indiana	8.2	138,000	2.4
Iowa	4.6	35,000	0.6
Kansas	7.4	56,000	1.0
Kentucky	6.4	69,000	1.2
Louisiana	5.8	69,000	1.2
Maine	4.9	14,000	0.2
Maryland	4.2	60,000	1.0
Massachusetts	1.4	21,000	0.4
Michigan	4.5	109,000	1.9
Minnesota	5.8	79,000	1.3
Mississippi	7.8	62,000	1.1
Missouri	7.7	114,000	1.9
Montana	11.6	27,000	0.5
Nebraska	5.9	29,000	0.5
Nevada	17.0	118,000	2.0
New Hampshire	4.4	13,000	0.2
New Jersey	5.4	116,000	2.0
New Mexico	8.6	47,000	0.8
New York	4.3	196,000	3.3
North Carolina	7.6	183,000	3.1
North Dakota	7.4	12,000	0.2
Ohio	5.7	161,000	2.8
Oklahoma	10.7	106,000	1.8
Oregon	6.0	54,000	0.9
Pennsylvania	5.2	152,000	2.6
Rhode Island	5.8	14,000	0.2
South Carolina	8.4	97,000	1.7
South Dakota	4.2	<10,000	–
Tennessee	5.9	94,000	1.6
Texas	13.0	958,000	16.3
Utah	9.8	91,000	1.6
Vermont	3.0	<10,000	–
Virginia	5.9	117,000	2.0
Washington	5.9	99,000	1.7
West Virginia	4.6	19,000	0.3
Wisconsin	4.9	69,000	1.2
Wyoming	10.2	15,000	0.3

Notes: Because three states and the District of Columbia are estimated to have less than 10,000 uninsured children, specific estimates are not provided due to concerns about the lack of precision. All other estimates are rounded to the nearest thousand. Dashes indicate the share of the national total is not included because the estimated number of children is below 10,000.

Source: Analysis for MACPAC by Social & Scientific Systems of 2012 data from the American Community Survey (ACS).

APPENDIX TABLE 1-A-2. Children's Medicaid/CHIP Participation Rates and Number and Share of Children under Age 19 Eligible for Medicaid or CHIP but Uninsured, by State, 2012

State	Children's Medicaid/CHIP Participation Rate	Estimated Number of Children Eligible but Uninsured	Share of National Total of Children Eligible but Uninsured
United States	**88.1%**	**3,722,000**	**100.0%**
Massachusetts	97.4	12,000	0.3
District of Columbia	97.1	< 10,000	–
Vermont	95.2	< 10,000	–
Maine	94.0	< 10,000	–
Delaware	93.9	< 10,000	–
Arkansas	93.9	22,000	0.6
Illinois	93.8	81,000	2.2
Connecticut	93.0	19,000	0.5
Alabama	92.6	40,000	1.1
Hawaii	92.6	< 10,000	–
Louisiana	92.5	44,000	1.2
New York	92.4	147,000	3.9
Michigan	92.2	71,000	1.9
South Dakota	92.1	< 10,000	–
Maryland	91.9	37,000	1.0
West Virginia	91.1	15,000	0.4
Rhode Island	90.4	< 10,000	–
Tennessee	90.3	64,000	1.7
Mississippi	90.3	41,000	1.1
Oregon	90.2	38,000	1.0
Kentucky	90.2	43,000	1.1
Iowa	89.8	27,000	0.7
New Hampshire	89.7	< 10,000	–
North Carolina	89.6	107,000	2.9
Ohio	89.5	108,000	2.9
Pennsylvania	89.4	115,000	3.1
Washington	89.4	67,000	1.8
New Mexico	89.3	30,000	0.8
Wisconsin	88.7	53,000	1.4
New Jersey	88.7	78,000	2.1
Nebraska	88.5	17,000	0.5
Virginia	87.5	67,000	1.8
South Carolina	87.5	63,000	1.7
California	87.0	570,000	15.3
Kansas	86.4	37,000	1.0
Idaho	86.3	22,000	0.6
Georgia	85.8	167,000	4.5
Oklahoma	85.8	62,000	1.7
Missouri	85.5	88,000	2.4
Florida	85.5	270,000	7.3
Minnesota	85.3	58,000	1.6
Wyoming	85.2	< 10,000	–
Colorado	85.0	69,000	1.8
North Dakota	84.5	< 10,000	–
Indiana	84.4	102,000	2.7
Texas	84.3	516,000	13.9
Arizona	81.8	136,000	3.6
Alaska	81.7	11,000	0.3
Montana	81.0	20,000	0.5
Utah	75.8	58,000	1.6
Nevada	70.6	75,000	2.0

Notes: Estimates reflect adjustments for possible misreporting of coverage on the American Community Survey (ACS). For the nine smallest states and the District of Columbia, all of which have estimated totals that are below 10,000, specific estimates are not provided because of concerns about the lack of precision. All other estimates are rounded to the nearest thousand. Dashes indicate the share of the national total is not included because the estimated number of children is below 10,000.

Source: Kenney and Anderson 2014.

APPENDIX TABLE 1-A-3. CHIP Enrollment (FY 2013) and Income Eligibility Levels (January 2014) by Program Type and State

State	Program Type[1] (as of January 1, 2014)	Children in Medicaid-Expansion CHIP[1]				Children in Separate CHIP							
						Separate CHIP: Age 0–18				Separate CHIP: Unborn		Total Separate CHIP Enrollment	Total CHIP-Funded Child Enrollment
		Infants <1	Age 1–5	Age 6–18	Enrollment	Infants <1	Age 1–5	Age 6–18	Enrollment	Eligibility	Enrollment		
Total	–	–	–	–	**2,481,333**	–	–	–	**5,338,939**	–	**310,521**	**5,649,460**	**8,130,793**
Alabama	Separate	–[2]	–[2]	108–146% FPL	–	147–317% FPL	147–317% FPL	147–317% FPL	113,490	–	–	113,490	113,490
Alaska	Medicaid expansion	160–208% FPL	160–208% FPL	125–208	16,566	–	–	–	–	–	–	–	16,566
Arizona	Separate	–[2]	–[2]	105–138	–	153–205	147–205	139–205	80,238	–	–	80,238	80,238
Arkansas	Combination	143–216	143–216	108–216	106,413	–	–	–	–	0–216% FPL	2,888	2,888	109,301
California[3]	Combination	209–266	143–266	109–266	510,424	267–321/416	267–321/416	267–321/416	975,699	0–313	117,160	1,092,859	1,603,283
Colorado[4, 5]	Combination	–[2]	–[2]	109–147	–	148–265	148–265	148–265	126,169	–	–	126,169	126,169
Connecticut	Separate	–[2]	–[2]	–[2]	–	202–323	202–323	202–323	18,999	–	–	18,999	18,999
Delaware	Combination	195–217	–[2]	111–138	79	–	148–217	139–217	8,535	–	4,566	13,101	13,180
District of Columbia	Medicaid expansion	207–324	147–324	113–324	9,057	–	–	–	–	–	–	–	9,057
Florida	Combination	193–211	–[2]	113–138	1,072	–	146–215	139–215	472,343	–	–	472,343	473,415
Georgia	Separate	–[2]	–[2]	114–138	–	211–252	155–252	139–252	269,906	–	–	269,906	269,906
Hawaii	Medicaid expansion	192–313	140–313	106–313	30,979	–	–	–	–	–	–	–	30,979
Idaho	Combination	–[2]	–[2]	108–138	19,881	148–190	148–190	139–190	25,518	–	–	25,518	45,399
Illinois	Combination	–[2]	–[2]	109–147	162,134	148–318	148–318	148–318	149,685	0–205	25,278	174,963	337,097
Indiana	Combination	158–213	142–163	107–163	105,655	214–255	164–255	164–255	46,760	–	–	46,760	152,415
Iowa	Combination	241–380	–[2]	123–172	22,159	–	173–307	173–307	61,511	–	–	61,511	83,670
Kansas	Separate	–[2]	–[2]	114–138	–	172–250	155–250	139–250	76,164	–	–	76,164	76,164
Kentucky	Combination	–[2]	143–164	110–164	51,391	201–218	165–218	165–218	32,678	–	–	32,678	84,069
Louisiana	Combination	143–217	143–217	109–217	140,876	218–255	218–255	218–255	4,956	0–205	4,136	9,092	149,968
Maine	Combination	–[2]	141–162	133–162	19,071	197–213	163–213	163–213	10,641	–	–	10,641	29,712
Maryland	Medicaid expansion	195–322	139–322	110–322	135,454	–	–	–	–	–	–	–	135,454
Massachusetts	Combination	186–205	134–155	115–155	69,113	206–305	156–305	156–305	70,735	0–205	8,871	79,606	148,719
Michigan	Combination	–[2]	144–165	110–165	19,229	201–217	166–217	166–217	62,985	0–190	7,456	70,441	89,670
Minnesota	Combination	276–288	–[2]	–[2]	91	–	–	–	–	0–283	3,744	3,744	3,835
Mississippi	Separate	–[2]	–[2]	108–138	–	200–214	149–214	139–214	93,120	–	–	93,120	93,120
Missouri	Combination	–[2]	–[2]	111–153	55,017	202–305	154–305	154–305	37,901	–	–	37,901	92,918
Montana[5]	Combination	–[2]	–[2]	110–148	–	149–266	149–266	149–266	31,496	–	–	31,496	31,496
Nebraska	Combination	163–218	148–218	112–218	53,790	–	–	–	–	0–202	1,993	1,993	**55,783**
Nevada[5]	Combination	–[2]	–[2]	123–138	–	165–205	165–205	139–205	20,277	–	–	20,277	**20,277**
New Hampshire	Medicaid expansion	197–323	197–323	197–323	19,450	–	–	–	–	–	–	–	**19,450**
New Jersey	Combination	–[2]	–[2]	108–147	90,512	200–355	148–355	148–355	116,249	–	–	116,249	**206,761**

APPENDIX TABLE 1-A-3, Continued

State	Program Type[1] (as of January 1, 2014)	Children in Medicaid-Expansion CHIP[1]				Children in Separate CHIP							
						Separate CHIP: Age 0–18				Separate CHIP: Unborn		Total Separate CHIP Enrollment	Total CHIP-Funded Child Enrollment
		Infants <1	Age 1–5	Age 6–18	Enrollment	Infants <1	Age 1–5	Age 6–18	Enrollment	Eligibility	Enrollment		
New Mexico	Medicaid expansion	201–305	201–305	139–245	9,368	–	–	–	–	–	–	–	**9,368**
New York[5]	Combination	197–223	–[2]	111–154	–	224–405	155–405	155–405	490,114	–	–	490,114	**490,114**
North Carolina	Combination	195–215	142–215	108–138	81,656	–	–	139–216	201,916	–	–	201,916	**283,572**
North Dakota	Combination	–[2]	–[2]	112–138	2,331	153–175	153–175	139–175	8,950	–	–	8,950	**11,281**
Ohio	Medicaid expansion	142–211	142–211	108–211	286,817	–	–	–	–	–	–	–	**286,817**
Oklahoma	Combination	170–210	152–210	116–210	140,373	–	–	–	456	0–190	7,082	7,538	**147,911**
Oregon	Separate	–[2]	–[2]	–[2]	–	191–305	139–305	139–305	124,731	0–190	3,330	128,061	**128,061**
Pennsylvania	Separate	–[2]	–[2]	120–138	–	221–319	163–319	139–319	267,073	–	–	267,073	**267,073**
Rhode Island	Combination	–[2]	–[2]	110–266	24,508	–	–	–	–	0–258	2,069	2,069	**26,577**
South Carolina	Medicaid expansion	195–213	144–213	108–213	76,191	–	–	–	–	–	–	–	**76,191**
South Dakota	Combination	178–187	178–187	125–187	13,357	188–209	188–209	188–209	4,275	–	–	4,275	**17,632**
Tennessee	Combination	–[2]	–[2]	110–138	22,906	201–255	148–255	139–255	72,695	0–255	10,872	83,567	**106,473**
Texas	Separate	–[2]	–[2]	101–138	–	204–206	150–206	139–206	939,469	0–205	95,144	1,034,613	**1,034,613**
Utah	Separate	–[2]	–[2]	106–138	–	145–205	145–205	139–205	63,001	–	–	63,001	**63,001**
Vermont	Separate	–[2]	–[2]	–[2]	–	238–317	237–317	237–317	7,393	–	–	7,393	**7,393**
Virginia	Combination	–[2]	–[2]	110–148	92,690	149–205	149–205	149–205	104,221	–	–	104,221	**196,911**
Washington	Separate	–[2]	–[2]	–[2]	–	213–305	213–305	213–305	32,139	0–198	11,934	44,073	**44,073**
West Virginia	Separate	–[2]	–[2]	109–138	–	164–305	147–305	139–305	37,065	–	–	37,065	**37,065**
Wisconsin	Combination	189–306	–[2]	102–156	92,723	–	192–306	157–306	70,571	0–305	3,998	74,569	**167,292**
Wyoming	Separate	–[2]	–[2]	120–138	–	160–205	160–205	139–205	8,815	–	–	8,815	**8,815**

Notes: FPL is federal poverty level. FY is fiscal year. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but a separate CHIP program for the second half), the individual would only be counted in the most recent category. Enrollment data shown in table are as of March 4, 2014; states may subsequently revise their current or historical data.

1 Under CHIP, states have the option to use an expansion of Medicaid, a separate CHIP program, or a combination of both approaches. However, due to a mandatory income disregard equal to 5 percent FPL that effectively raises Medicaid eligibility levels by 5 percentage points, all states in 2014 are eligible to receive CHIP funding for at least some Medicaid-enrolled children. In addition, beginning in 2014, several states (including those previously considered separate CHIP programs) will have Medicaid-expansion CHIP enrollment due to a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL from separate CHIP programs to Medicaid; the 16 states with an upper-income level of 138 percent FPL are those that waited until after 2013 to transition these children. For five states (Nevada, North Dakota, South Carolina, Texas, and Utah), the income ranges for children in Medicaid-expansion CHIP do not reflect eligibility for CHIP-financed coverage solely due to the elimination of an asset test in Medicaid after 1997; in these states, affected children at Medicaid income-eligibility levels may qualify for CHIP-financed coverage.

2 Medicaid-expansion CHIP eligibility ranges of 5 percentage points attributable to the mandatory 5 percent disregard are not shown.

3 During 2013, California transitioned most of its separate CHIP children into a Medicaid-expansion CHIP program. California has a separate CHIP program in three counties that covers children up to 321 percent FPL and in one county up to 416 percent FPL.

4 Colorado data are from FY 2012.

5 Montana, Nevada, and New York were combination programs in FY 2013 but did not report any Medicaid-expansion enrollees in the CHIP Statistical Enrollment Data System (SEDS). Colorado became a combination program in FY 2013 but had not yet reported any SEDS data for that year as of March 4, 2014; as a result, FY 2012 data shown here do not include Medicaid-expansion enrollees.

Sources: For numbers of children: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) from Centers for Medicare & Medicaid Services (CMS) as of March 4, 2014; MACPAC 2014a.

APPENDIX TABLE 1-A-4. Projected Federal CHIP Spending, by State and Program Type, and Federal Matching Rates, FY 2014

State	States' Projections of FY 2014 CHIP Spending (dollars in thousands)						FY 2014 CHIP Matching Rate	FY 2014 Medicaid Matching Rate	CHIP Matching Rate Plus 23 Percentage Points
	Medicaid-expansion CHIP		Separate CHIP and administration		Total CHIP				
	Total	Federal	Total	Federal	Total	Federal			
Total	**$5,808,957**	**$4,082,044**	**$7,885,509**	**$5,556,158**	**$13,694,466**	**$9,638,202**	–	–	–
Alabama	48,105	37,368	224,368	174,292	272,473	211,660	77.68%	68.12%	100.00%
Alaska	42,915	28,005	3,276	2,130	46,191	30,135	65.00	50.00	88.00
Arizona	68,853	52,013	32,543	25,064	101,396	77,077	77.06	67.23	100.00
Arkansas	48,332	38,216	26,350	19,336	74,682	57,552	79.07	70.10	100.00
California	1,870,825	1,216,036	522,699	339,783	2,393,524	1,555,819	65.00	50.00	88.00
Colorado	51,509	33,481	182,430	118,580	233,939	152,061	65.00	50.00	88.00
Connecticut[1]	0	21,646	30,618	19,901	30,618	41,547	65.00	50.00	88.00
Delaware	775	535	24,026	16,514	24,801	17,049	68.72	55.31	91.72
District of Columbia	18,545	14,650	265	210	18,810	14,860	79.00	70.00	100.00
Florida	73,444	52,256	551,831	391,518	625,275	443,774	71.15	58.79	94.15
Georgia	45,688	34,792	432,396	329,270	478,084	364,062	76.15	65.93	99.15
Hawaii	46,169	30,418	2,639	1,748	48,808	32,166	66.30	51.85	89.30
Idaho	20,878	16,730	31,936	25,861	52,814	42,591	80.15	71.64	100.00
Illinois	146,682	96,515	359,223	233,569	505,905	330,084	65.00	50.00	88.00
Indiana	121,400	93,490	52,641	40,449	174,041	133,939	76.84	66.92	99.84
Iowa	30,559	21,558	114,517	80,792	145,076	102,350	70.55	57.93	93.55
Kansas[2]	0	0	105,334	73,566	105,334	73,566	69.84	56.91	92.84
Kentucky	120,183	94,800	70,207	55,379	190,390	150,179	78.88	69.83	100.00
Louisiana	175,925	127,880	32,202	23,408	208,127	151,288	72.69	62.11	95.69
Maine	22,757	16,633	16,279	11,898	39,036	28,531	73.09	61.55	96.09
Maryland	268,439	174,485	22,532	14,645	290,971	189,130	65.00	50.00	88.00
Massachusetts	241,330	156,865	287,497	186,874	528,827	343,739	65.00	50.00	88.00
Michigan	20,373	15,569	129,027	98,603	149,400	114,172	76.42	66.32	99.42
Minnesota[1]	125	21,853	25,620	16,737	25,745	38,590	65.00	50.00	88.00
Mississippi[2]	0	0	215,133	174,558	215,133	174,558	81.14	73.05	100.00
Missouri	122,619	90,033	68,408	50,232	191,027	140,265	73.42	62.03	96.42
Montana	2,508	1,917	79,306	68,990	81,814	70,907	76.43	66.33	99.43
Nebraska	63,426	43,333	10,680	7,295	74,106	50,628	68.32	54.74	91.32
Nevada	3,305	2,451	38,222	28,350	41,527	30,801	74.17	63.10	97.17
New Hampshire[1]	20,763	16,331	557	362	21,320	16,693	65.00	50.00	88.00

APPENDIX TABLE 1-A-4, Continued

State	States' Projections of FY 2014 CHIP Spending (dollars in thousands)						FY 2014 CHIP Matching Rate	FY 2014 Medicaid Matching Rate	CHIP Matching Rate Plus 23 Percentage Points
	Medicaid-expansion CHIP		Separate CHIP and administration		Total CHIP				
	Total	Federal	Total	Federal	Total	Federal			
New Jersey	$211,456	$137,446	$263,807	$171,475	$475,263	$308,921	65.00%	50.00%	88.00%
New Mexico	78,405	61,457	1,101	868	79,506	62,325	78.44	69.20	100.00
New York	276,714	179,864	761,735	495,193	1,038,449	675,057	65.00	50.00	88.00
North Carolina	139,444	106,047	418,555	318,311	557,999	424,358	76.05	65.78	99.05
North Dakota	12,244	7,953	17,659	11,478	29,903	19,431	65.00	50.00	88.00
Ohio	416,731	308,840	10,145	7,519	426,876	316,359	74.11	63.02	97.11
Oklahoma	168,541	126,086	12,717	9,513	181,258	135,599	74.81	64.02	97.81
Oregon[2]	0	0	223,333	165,713	223,333	165,713	74.20	63.14	97.20
Pennsylvania[2]	0	0	433,426	292,413	433,426	292,413	67.46	53.52	90.46
Rhode Island	52,164	33,948	19,402	12,633	71,566	46,581	65.08	50.11	88.08
South Carolina	203,949	161,902	12,274	9,746	216,223	171,648	79.40	70.57	100.00
South Dakota	18,027	12,157	7,083	4,778	25,110	16,935	67.48	53.54	90.48
Tennessee	72,656	55,000	225,900	170,894	298,556	225,894	75.70	65.29	98.70
Texas	235,362	167,296	1,204,118	855,861	1,439,480	1,023,157	71.08	58.69	94.08
Utah[2]	0	0	49,685	39,400	49,685	39,400	79.24	70.34	100.00
Vermont[1]	0	6,774	9,634	6,607	9,634	13,381	68.58	55.11	91.58
Virginia	127,467	82,853	209,401	136,111	336,868	218,964	65.00	50.00	88.00
Washington[1]	0	12,000	137,793	89,565	137,793	101,565	65.00	50.00	88.00
West Virginia	19,900	15,872	52,699	42,034	72,599	57,906	79.76	71.09	100.00
Wisconsin[1]	79,465	56,690	104,908	74,841	184,373	131,531	71.34	59.06	94.34
Wyoming[2]	0	0	17,372	11,291	17,372	11,291	65.00	50.00	88.00

Notes: FY is fiscal year.

1 These are states with some projected Medicaid-expansion CHIP spending that is entirely federal, per Section 2105(g) of the Social Security Act, which permits qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level.

2 Although every state should have some Medicaid-expansion CHIP spending in FY 2014 because of the new mandatory 5 percentage point disregard that applies in both Medicaid and CHIP, these states are projecting no Medicaid-expansion CHIP spending.

Source: MACPAC analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) data from the Centers for Medicare & Medicaid Services (CMS) as of February 2014.