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Back to the Basics:
Medicaid and CHIP's Foundational Role in Covering Kids and Families

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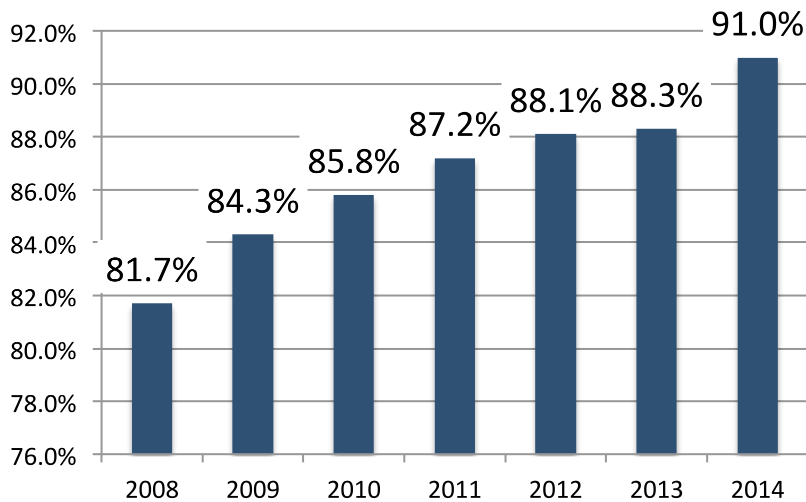
Medicaid → Critical Health Safety Net

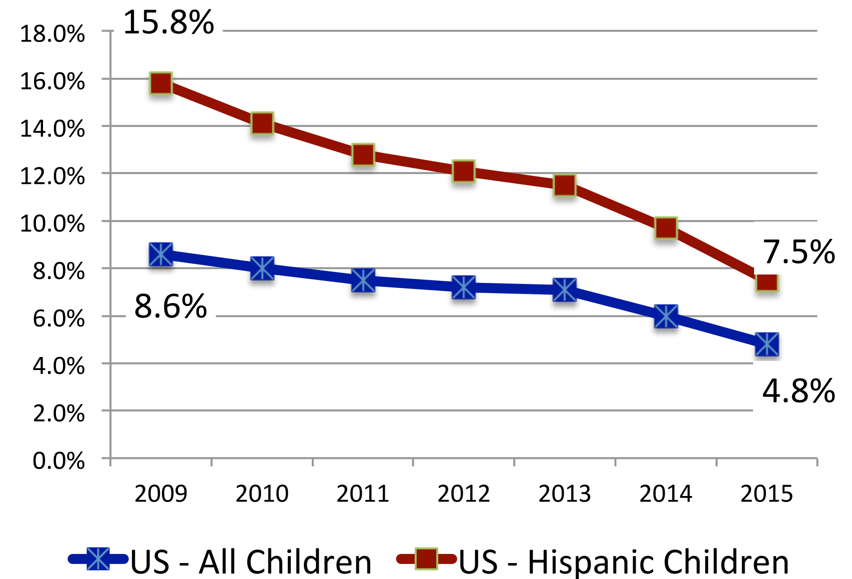
Focus of Today's Webinar: Kids and Families

Increased Participation in Medicaid and CHIP Have Driven Uninsured Rate to Historic Low

Participation Rates in Medicaid and CHIP



The Uninsured Rate for Children



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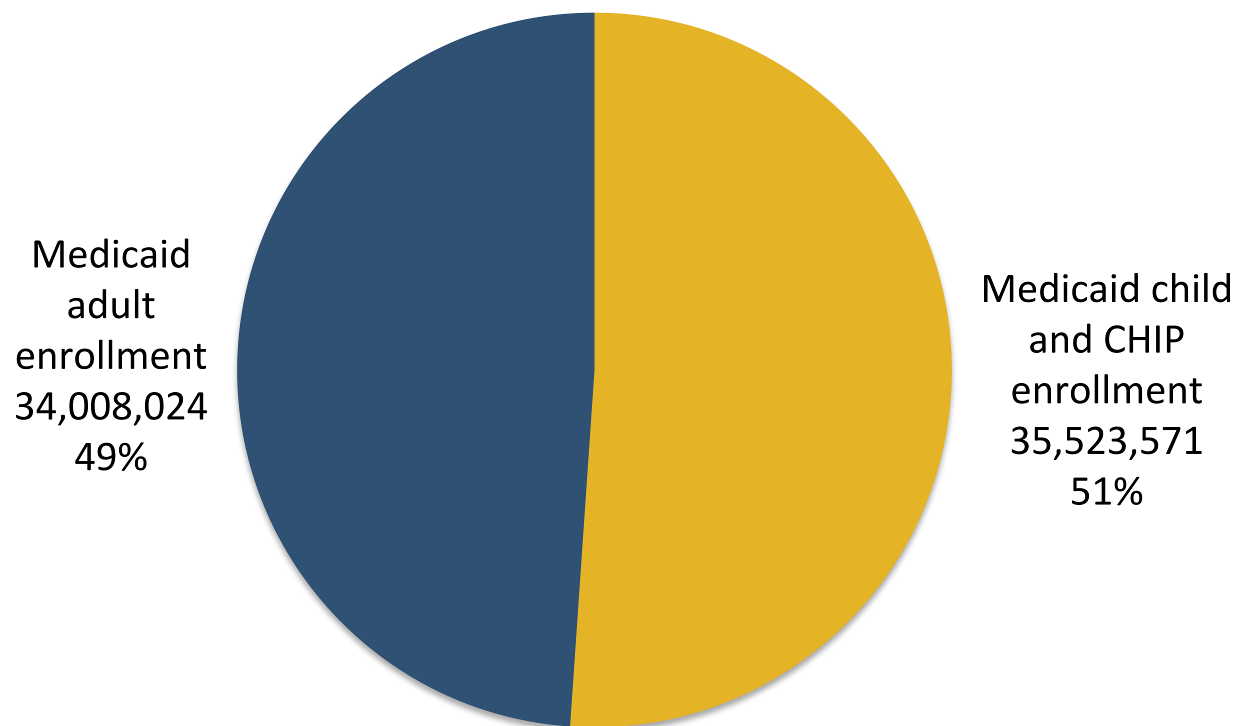
Slightly more than half of Medicaid enrollees are children



Includes data from 48 states that report both adult and child enrollment. Excludes enrollment data from AZ, CT, and TN.

Source: CMS Medicaid and CHIP Enrollment Report, September 2016

Medicaid Strengthens Families

- Children with Medicaid become healthier adults, have greater academic achievement, and attain greater economic success.
- Parents with Medicaid are healthier and better able to support their children's healthy development
- Families with Medicaid have greater economic security and are less likely to have medical debt or bankruptcy
- Coverage provides peace of mind that reduces family stress

The view from 30,000 feet

Medicaid: Background

- Enacted in 1965 as companion legislation to Medicare
- Initially focused on:
  - Single parents with dependent children
  - Aged, blind, disabled
  - Expansions of eligible groups over time
- Permanently authorized with guaranteed federal funding
- Guaranteed coverage for eligible individuals
- Minimum mandatory requirements with state options

Medicaid: Federal-State Partnership

<table>
<tr><th></th><th colspan="2">Federal Government</th><th>States</th></tr>
<tr><td>Administration</td><td colspan="2">Oversight</td><td>Direct administration</td></tr>
<tr><td>Financing</td><td colspan="2">Pays 50% to 83% of benefit costs, with no cap
50% of administrative costs</td><td>Pays non-federal share of cost</td></tr>
<tr><td rowspan="2">Program Rules</td><td colspan="2">Minimum standards:</td><td rowspan="2">• Delivery system
• Optional services
• Provider payment rates
• Cost-sharing</td></tr>
<tr><td>Children:
• Strong benefits (EPSDT)
• No cost-sharing <150% FPL</td><td>Adults:
• Mandatory and optional services
• No premiums under 100% FPL</td></tr>
<tr><td>Coverage Guarantee</td><td colspan="2">Guaranteed enrollment, if eligible</td><td>Cannot freeze or cap enrollment</td></tr>
</table>

CHIP: Background

- Enacted in 1997 to encourage states to expand coverage to *uninsured* children
  - Reauthorized in 2009 - 2013 (CHIPRA) with additional state options
  - Funding extension through 2015 (ACA) with additional federal match (23 percentage point bump) and requirement to maintain eligibility (MOE)
  - Funding extended through 2017 (MACRA) but reduced state ability to carry over more than 2/3's of unspent allotment
- Block grant with capped annual allotments
- No entitlement to coverage

CHIP: Federal-State Partnership

	Federal Government	States
Administration	Oversight	Direct administration
Financing	Pays 65% to 85% of costs; with a 23% point bump in 2016	Pays non-federal share of cost
Program Rules	Fewer minimum standards than Medicaid	• Set provider payment rates • Determine eligibility rules, benefits, and cost sharing within guidelines
Coverage Guarantee	None required	Can freeze or cap enrollment or require waiting periods

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State Options for CHIP Program Design

Medicaid Expansion

- All Medicaid rules apply except children must be uninsured
- States can use Medicaid funds to cover children with other coverage

Separate CHIP program

Choice of Benchmark Plan:

- State employee plan
- Federal employee plan
- Largest HMO in state
- Secretary approved

Combination Program

- Medicaid expansion for certain children based on age or income
- Separate CHIP program for other children

Who's Covered?

Income-Based Medicaid Coverage for Children and Families

Minimum Standards	Optional Coverage

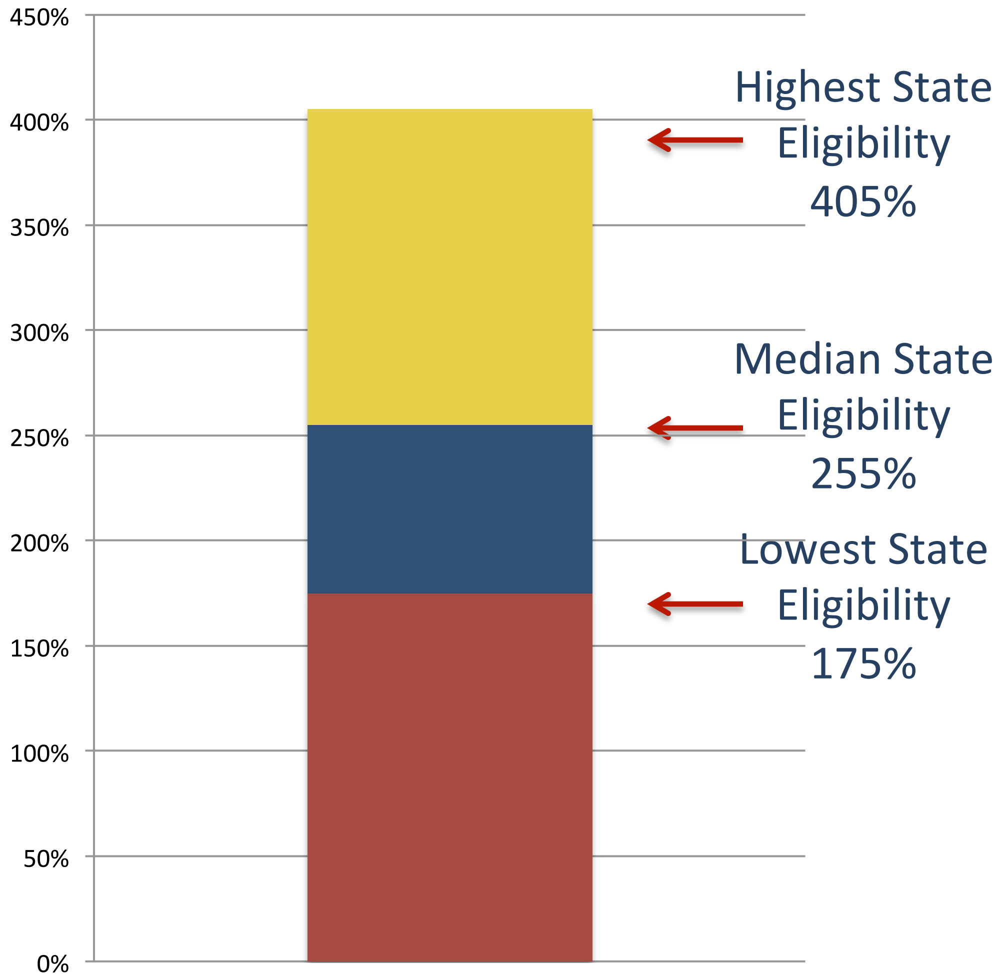
• Children 0-18 with income up to 133% FPL
• Infants born to women covered by Medicaid under pregnant women's coverage
  – Deemed newborns
• Parents/Caretakers at state eligibility level welfare reform in 1996
  – Known as 1931 parents
  – Median income ~ 41% FPL
	• Children ages 19 and 20
	• Children with income above 133% FPL
	• Parents and adults up to 133% FPL
	• Medical needy or spend down programs

CHIP Eligibility

- Children above Medicaid income levels at state option
  - 200% FPL upper limit, or
  - 50 percentage points > Medicaid limit in place in 1997
  - Pre-ACA, states used income disregards and deductions to achieve higher income eligibility thresholds; those levels are grandfathered as of enactment of the ACA
- Unborn children at state option

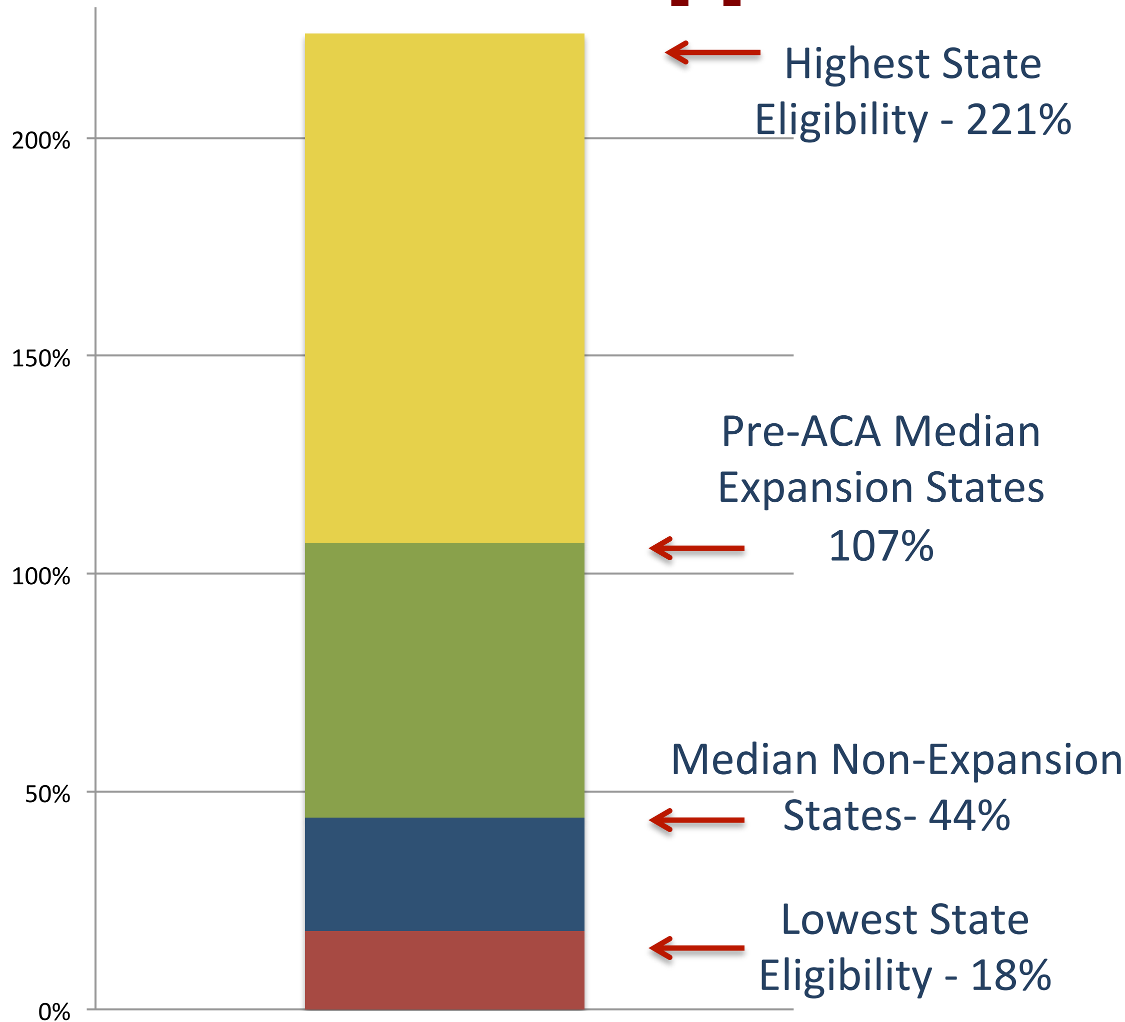
Where eligibility stands today

Children's Upper Income Eligibility



Breakdown of State Eligibility	
FPL	# of States
< 200%	2
200% – 250%	21
250% - 300%	9
> 300%	19

Parent's Upper Income Eligibility



Breakdown of State Eligibility	
FPL	# of States
< 50%	12
50% – 99%	4
100% - 138%	3
138%	28
> 138%	4

Benefits

Children

Medicaid	CHIP
• Comprehensive services through Early Periodic Screening Diagnostic and Treatment (EPSDT) • All services necessary to correct and ameliorate physical and mental health conditions	• Medicaid expansion: Medicaid benefit package • Separate program - based on Benchmark plan that is closer to private coverage • Secretary-approved coverage

Premiums and Cost-Sharing

Total premiums and cost-sharing limited to aggregate 5% of family income cap for all members enrolled. Applies to all groups in Medicaid and CHIP.

Premiums and Cost-Sharing in Medicaid

Premiums	Cost-Sharing
• Children – None below 150% FPL • Adults – None below 150% FPL (without waiver)	• Children – None below 133% FPL – None for preventive care • Adults – Nominal below 100% FPL – Twice nominal 100% – 150% FPL – None for family planning, emergency, pregnancy-related services

Maximum Allowable Medicaid Cost-Sharing Varies by Income

	< 100% FPL	> 100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of what state pays	20% of what state pays
Non-Emergency ER	$8	$8	No limit
Prescription Drugs	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: 20% of what state pays
Inpatient Services	$75 per stay	10% of total cost state pays*	20% of total cost state pays*

Up to 5% aggregate cap.

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Premiums and Cost-Sharing in CHIP

Premiums	Cost-Sharing
• State flexibility subject to 5% aggregate cap	• None for preventive care • Subject to same limitations as Medicaid: none below 133% FPL • State flexibility above 150% FPL, including using deductibles, subject to 5% aggregate cap,

How do states deliver care?

- **Fee-for-service (FFS)** – state contracts directly with providers and pays them for covered services
- **Managed care** – state contracts with managed care organizations (MCOs) to deliver services
- **Premium assistance** – Medicaid and CHIP funds used to purchase private insurance that is cost-effective and comparable
  - Provide benefit and cost-sharing wraps to achieve comparability
- **Combination of these approaches**

Financing

Medicaid Financing

- The federal government matches state spending on an open-ended basis.

Federal Medical Assistance Percentage (FMAP)
Formula based on per capita income, recalculated annually

1 – (0.45 X (state per capita income ÷ U.S. per capita income))

	Statutory Rates	2017 FMAP Rates
Minimum	50%	50%
Maximum	83%	74.6%

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CHIP Financing

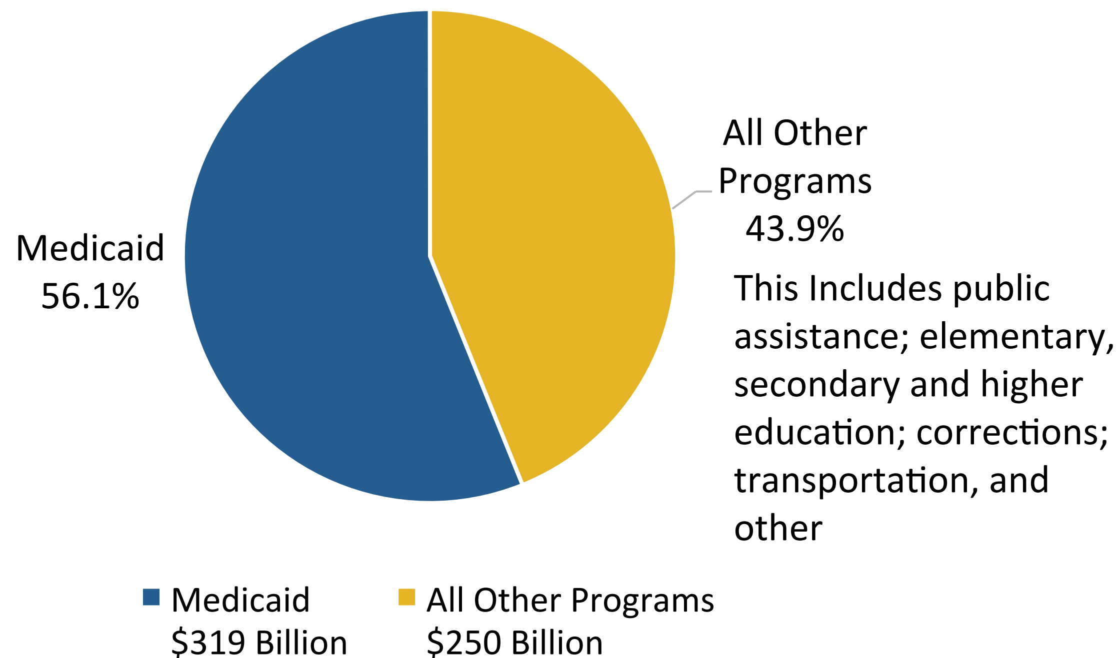
- Block grant with capped annual allotments
  - Unused allotment available for up to 2 years
  - Contingency fund covers shortfalls
- ACA bump = 23 percentage points up to 100% starting in FFY 2016

eFMAP Formula

FMAP + (0.3 x (1 – FMAP))

	Statutory Rates	2017 eFMAP Rates	2017 eFMAP with Bump
Minimum	65%	65%	88%
Maximum	83%	82.2%	100%

Medicaid is the Largest Source of Federal Funds for States



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Source: State Expenditure Report: Examining Fiscal 2014-2016 State Spending, National Association of State Budget Officers (NASBO).

A Closer Look at How Medicaid Could Be Restructured

Restructuring Medicaid

Waivers

- State Innovation Waivers (Section 1332) allow states to pursue new models of integrated coverage (only available if provision in the ACA is not repealed)
- Section 1115 Waivers allow states to change benefits, cost-sharing and other program rules

Block Grants

- Sets a specific amount for each state
- Fundamental change in entitlement and financing structure
- Would have major implications for beneficiaries, providers, managed care plans, states and localities
- To achieve federal savings, states would receive less funding

Per Capita Caps

- Would set amount states are reimbursed per enrollee
- Protects states if enrollment grows but does not protect against other risks (e.g. formula doesn't account for new treatments or epidemics)
- If costs exceed cap, states, providers and/or enrollees will make up the difference

State Flexibility May Sound Promising but Most Restructuring Proposals Involve Cuts to Medicaid Funding

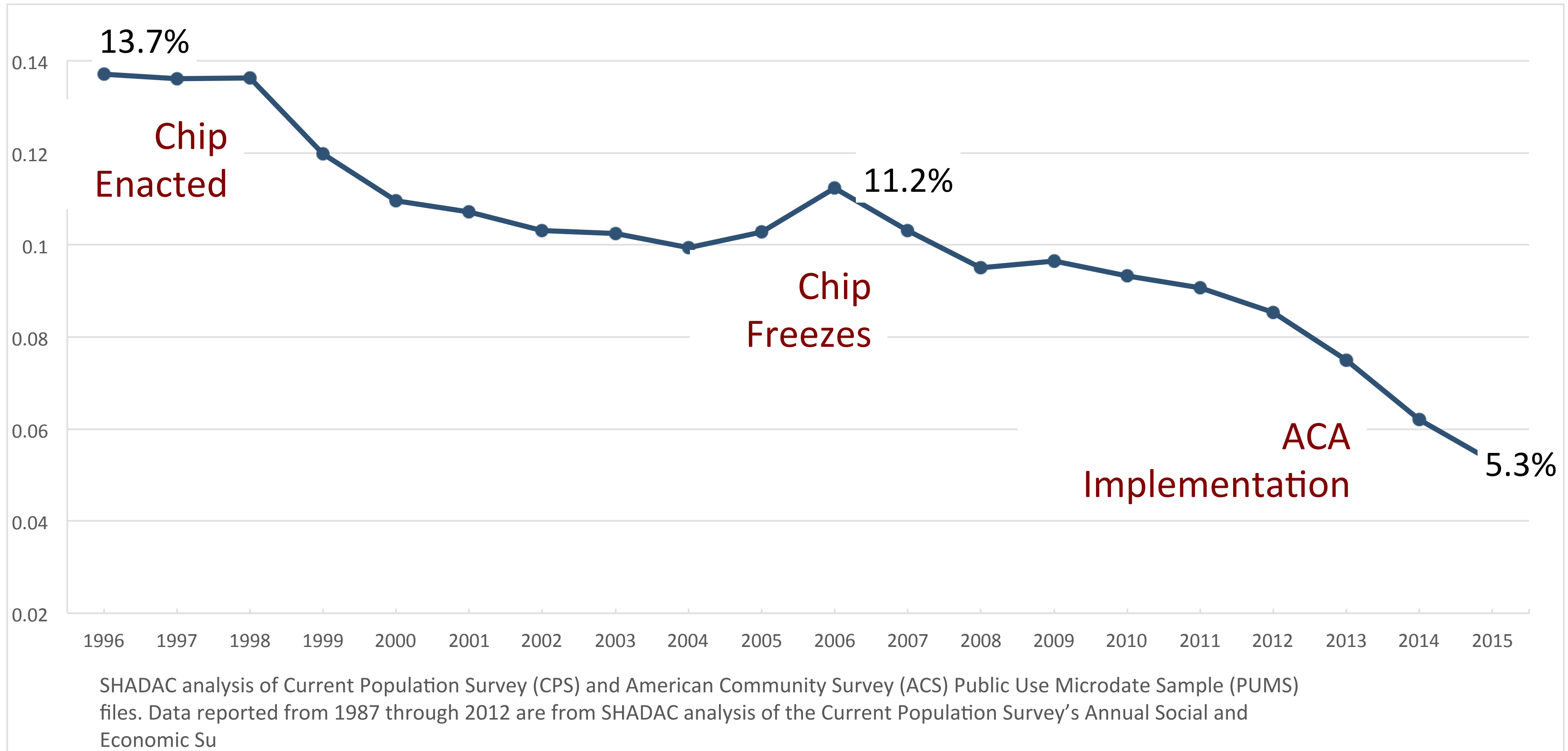
Enrollment caps or closed

More red tape and beneficiary requirements

Reduced Benefits

Increased Cost-Sharing

Uninsured Rate Rose with CHIP Freezes



What do we know about past restructuring proposals and the impact of ACA repeal?

Potential Risks to Children in Restructuring Proposals

- Cuts to Medicaid in exchange for state flexibility could eliminate core protections for children in federal standards:
  - Guarantee of coverage
  - Comprehensive benefits through EPSDT
  - Cost-sharing limitations

Repeal of the ACA Direct Impact on Children and Families

- Maintenance of Effort provision (MOE) requiring states to hold children's eligibility levels steady
- Coverage for former foster youth up to age 26
- Roll-back of stair-step kids (6-18, 100% - 133% FPL)
- Loss of parent expanded coverage and impact on:
  - Parent health
  - Family economic security
  - Welcome mat effect on child enrollment
- Loss of Marketplace coverage for 1 million kids

Diving into the weedy details of roll-back of ACA streamlining provisions

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Also Known as MAGI Provisions

- Asset/resource tests
- Longer than 90-day waiting periods in CHIP
- Elimination of no-wrong door access
- Multiple application channels
- Return to paper-driven eligibility verification
- Renewals more frequently than every 12 months

- No requirement for automated renewals
- Requirement for signature at renewal
- Potential to count non-taxable sources of income (e.g. child support, SSI, pre-tax deductions)
- Disruptions to state eligibility systems with change in basis of eligibility

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Other Policy Changes Proposed in the Past

- Substantial changes through waiver activity
- Elimination of 23% point e-FMAP increase for CHIP
- Mandated vs. optional 5-year waiting period for lawfully present immigrant children

Looking Forward to Future Back to the Basics Webinars

Next: A Deeper Dive into Medicaid and CHIP Financing

Questions?

For More Information

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Say Ahhh! Our child health policy blog

- http://ccf.georgetown.edu/blog/

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