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Medicaid and CHIP 101:

Medicaid and CHIP's Foundational Role in Covering Kids and Families

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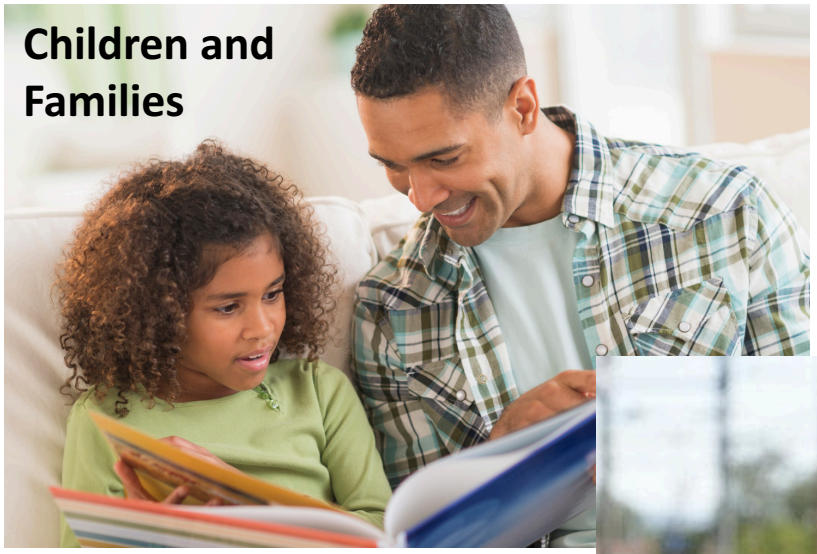
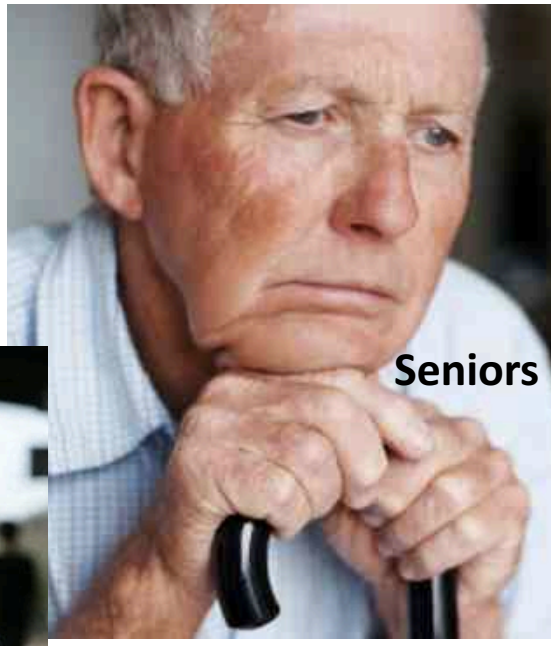
12-18-17

Medicaid → Critical Health Safety Net

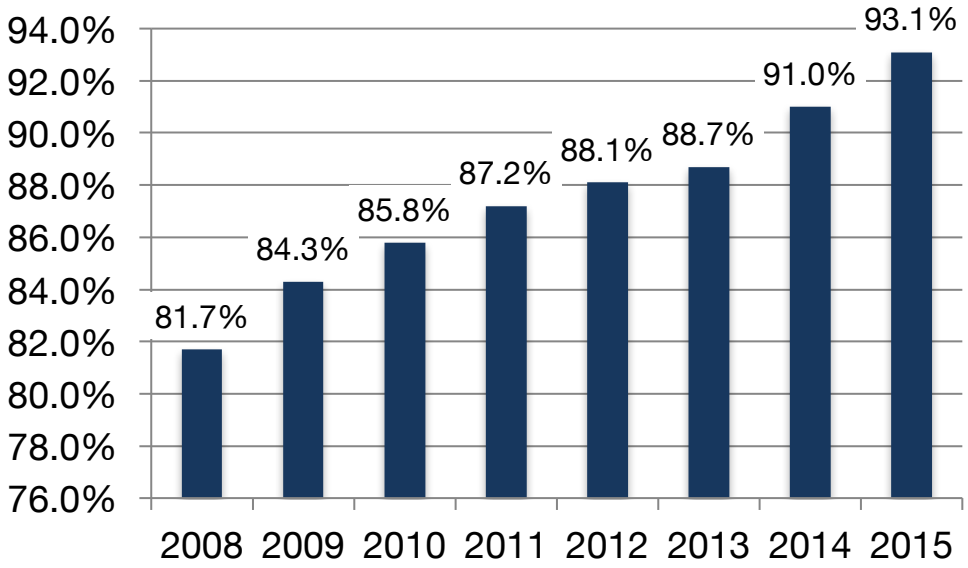




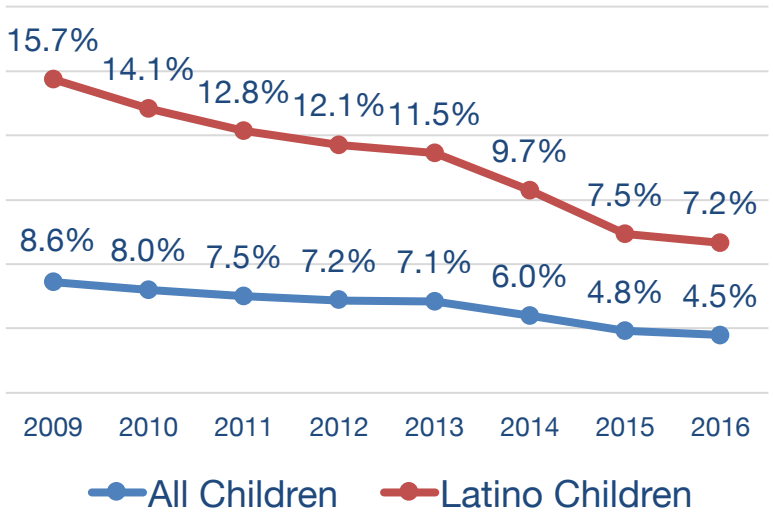
Focus of Today's Webinar: Kids and Families

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

Participation Rates in Medicaid/CHIP



U.S. Child Uninsured Rate



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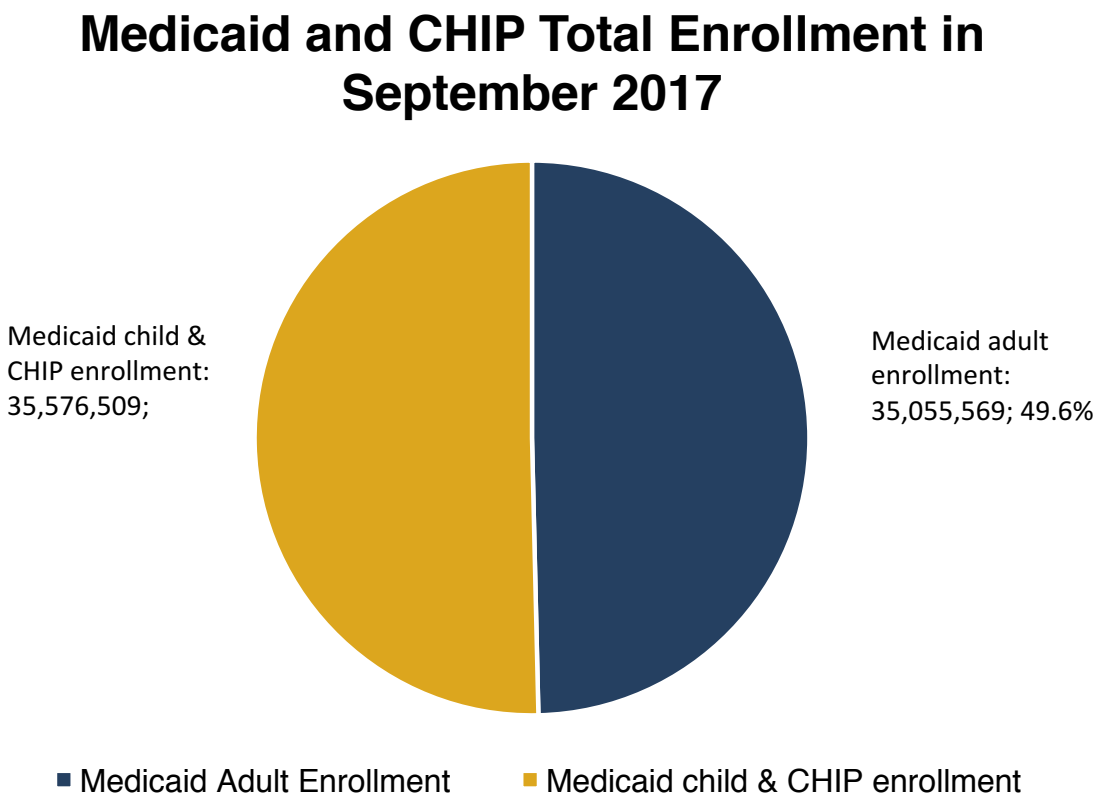
Sources: G. Kenney, J. Haley, C. Pan, V. Lynch, and M. Buettgens, "Medicaid/CHIP Participation Rates Rose among Children and Parents in 2015," Urban Institute, May 2017. S. Schwartz, S. Lopez, and S. Vargas Poppe. "Latino Children's Coverage Reaches Historic High, But too Many Remain Uninsured." Georgetown University Center for Children and Families and National Council of La Raza. December 2016.

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 2017

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

Sources: J. Alker and K. Wagnerman, "Medicaid: A Smart Investment in Children," April 2017, available at https://ccf.georgetown.edu/2017/04/10/medicaid-a-smart-investment-in-children/ and K. Wagnerman, "Medicaid: How Does it Provide Economic Security for Families?," March 2017, available at https://ccf.georgetown.edu/2017/03/09/medicaid-how-does-it-provide-economic-security-for-families/

The view from 30,000 feet

Medicaid: Background

- Enacted in 1965 as companion legislation to Medicare
- Initially limited to:
  - Children
  - 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

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

*Match varies by state and sometimes by eligibility group and service

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 2017 unspent allotment
  - Still waiting for Congressional action to fund 2018 and beyond
- Block grant with capped annual allotments
- No entitlement to coverage

CHIPRA

- Extended funding through 2013
- Dropped State in SCHIP
- Updated formula for state allotments
- Revised rules regarding carry-over funds
- Built in contingency funds for states that run out of allotment
- Enacted new tools and incentives to enroll Medicaid children
- Gave states options to expand eligibility
- Boosted benefit requirements
- Launched significant new emphasis on quality and access

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, 2017	Pays non-federal share of cost
Program Rules	Fewer minimum standards than Medicaid	• Delivery system • Provider payment rates • Eligibility rules, benefits, and cost sharing within guidelines
Coverage Guarantee	None required	Can freeze or cap enrollment or require waiting periods*

* Except under the Maintenance of Effort

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?

Medicaid Eligibility

Minimum Standards

- 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

Optional Coverage

- 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

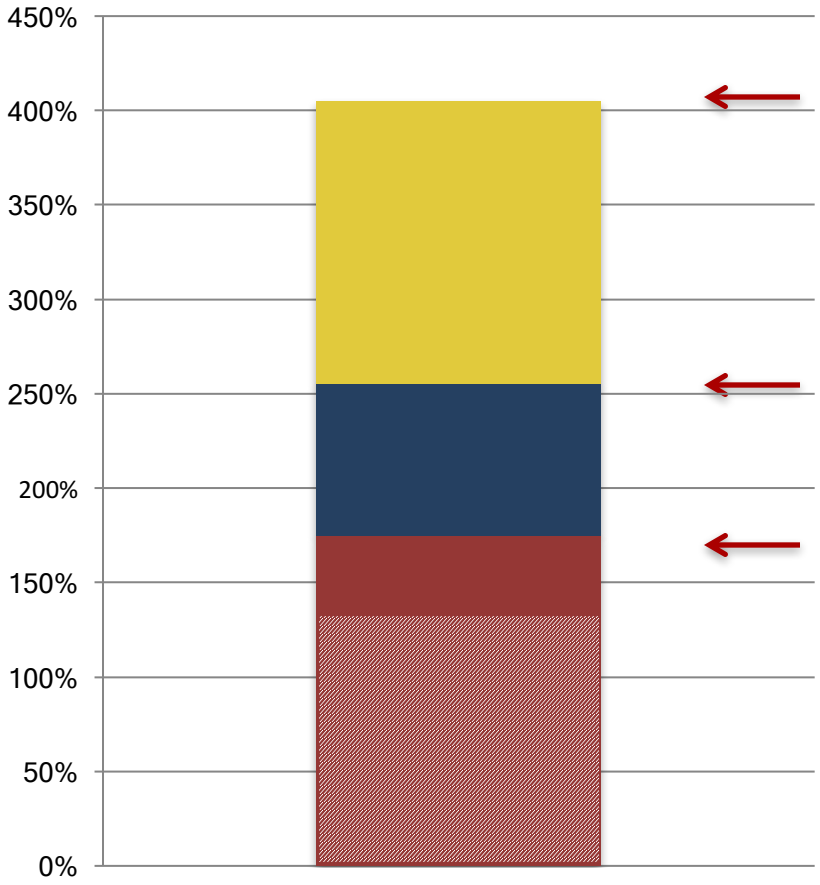
- Children above Medicaid income levels at state option
  - 200% FPL upper limit, or
  - 50 percentage points > Medicaid limit in place in 1997
  - Pre-ACA, states used income disregards and deductions to achieve higher income eligibility thresholds; those levels are grandfathered as of enactment of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

CHIP Outreach Requirement

- Must describe procedures to inform families of their eligibility for CHIP or other public/private health coverage programs, which may include:
  - Education and awareness campaigns
  - Enrollment simplification
  - Application assistance through community-based organizations and in combination with other benefits and services
- Receives CHIP match up to 10% cap on administration expenses
  - Including Medicaid outreach/assistance

Where eligibility stands today

Children's Income Eligibility: Medicaid & CHIP



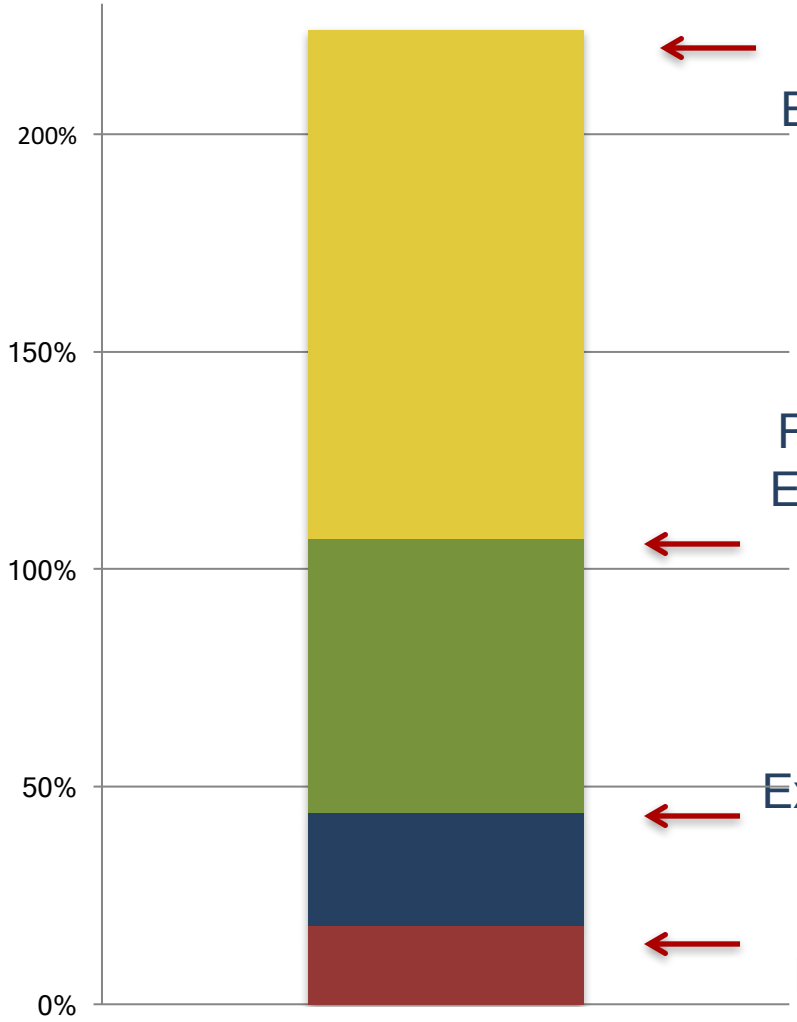
Highest State Eligibility 405%

Median State Eligibility 255%

Lowest State Eligibility 175%

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

Parent's Income Eligibility: Medicaid



Highest State Eligibility - 221%

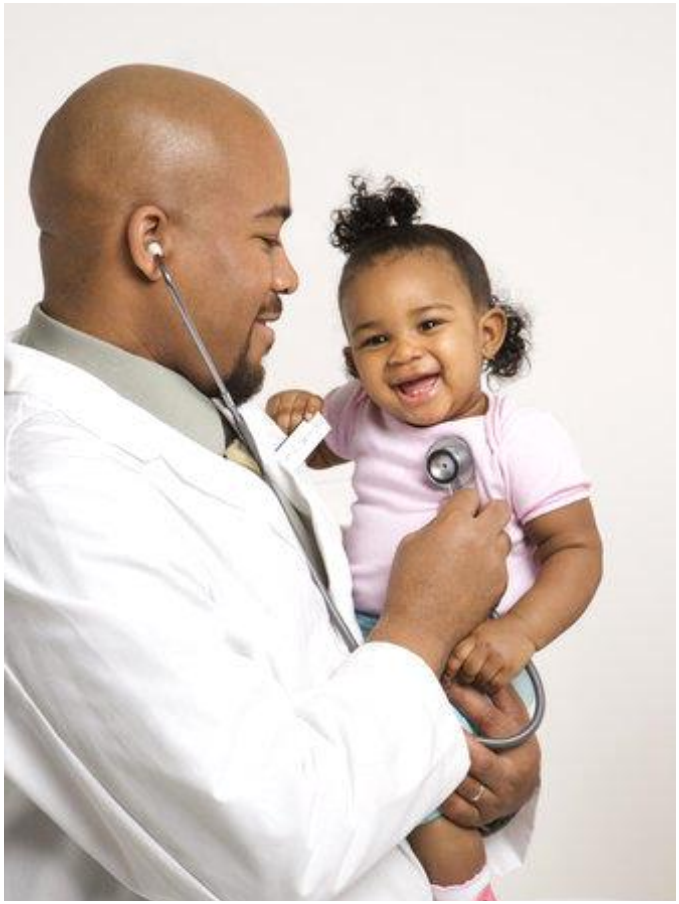
Pre-ACA Median Expansion States 107%

Median Non-Expansion States- 44%

Lowest State Eligibility - 18%

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

Benefits



Medicaid and CHIP-Funded Medicaid Expansions (M-CHIP)

- Comprehensive services through Early Periodic Screening Diagnostic and Treatment (EPSDT)
  - Screenings (developmental, hearing, vision, etc)
  - Diagnostic services
  - Treatment
- All services "medically necessary" to correct and ameliorate physical and mental health conditions
- Cannot impose limits; must provide wrap-around services if premium assistance or managed care limits benefits

Separate CHIP Benefits

Actuarially Equivalent to Benchmark Plan

1. HMO with state's largest enrollment
2. State Employee Plan
3. Federal Employee Plan, or
4. Secretary Approved

Services must include:

- Well child; preventive care
- Immunizations
- Emergency care
- Inpatient and outpatient hospital services
- Physician services
- Lab and x-ray
- Dental services
- Mental health parity

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.

Premiums and Cost-Sharing in CHIP

Premiums	Cost-Sharing
• State flexibility subject to 5% aggregate cap	• None for preventive care • Limited cost-sharing for children with income between 133% – 150% FPL* • State flexibility on all other services subject to 5% aggregate cap for children with income > 150% FPL.

* Cost-sharing limits in CHIP for children with income equal to or below 150% FPL vary based on type of service and the cost the state pays for the service as described in § 457.555.

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

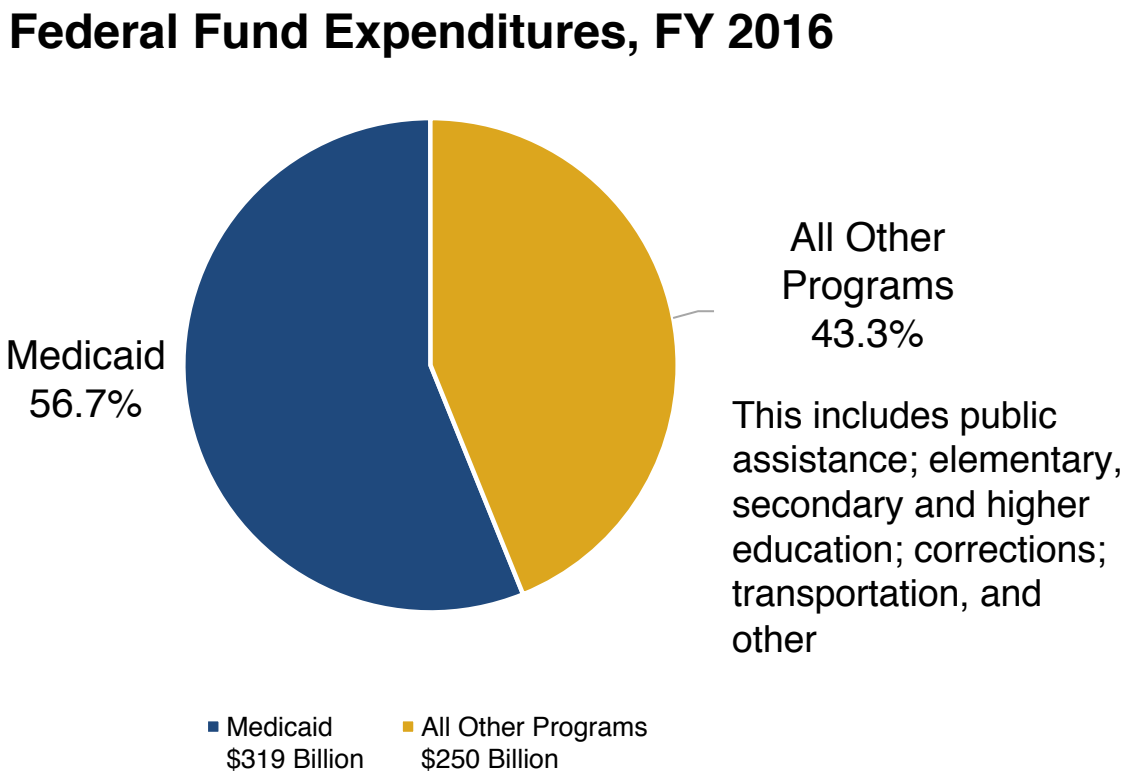
Medicaid Financing

- 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	2018 FMAP Rates
Minimum	50%	50%
Maximum	83%	75.7%

Medicaid is the Largest Source of Federal Funds for States



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Source: State Expenditure Report: Examining Fiscal 2015-2017 State Spending, National Association of State Budget Officers (NASBO).

CHIP Financing

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

eFMAP Formula

FMAP + (0.3 x (1 – FMAP))

	Statutory Rates	2018 eFMAP Rates	2018 eFMAP with Bump*
Minimum	65%	65%	88%
Maximum	85%	82.9%	100%

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*This assumes CHIP funding is renewed with the bump, as both House and Senate bills propose

Source: FY 2018: Federal Register, November 15, 2016 (Vol 81, No. 220), pp 80078-80080.

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
- 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

What do we know about past restructuring proposals and ACA repeal efforts?

State Choices to Offset Loss of Federal Funding

Boost State Spending

Impose more red tape to suppress enrollment and retention

Cut Benefits

Lower Reimbursement for Providers

Close or cap enrollment

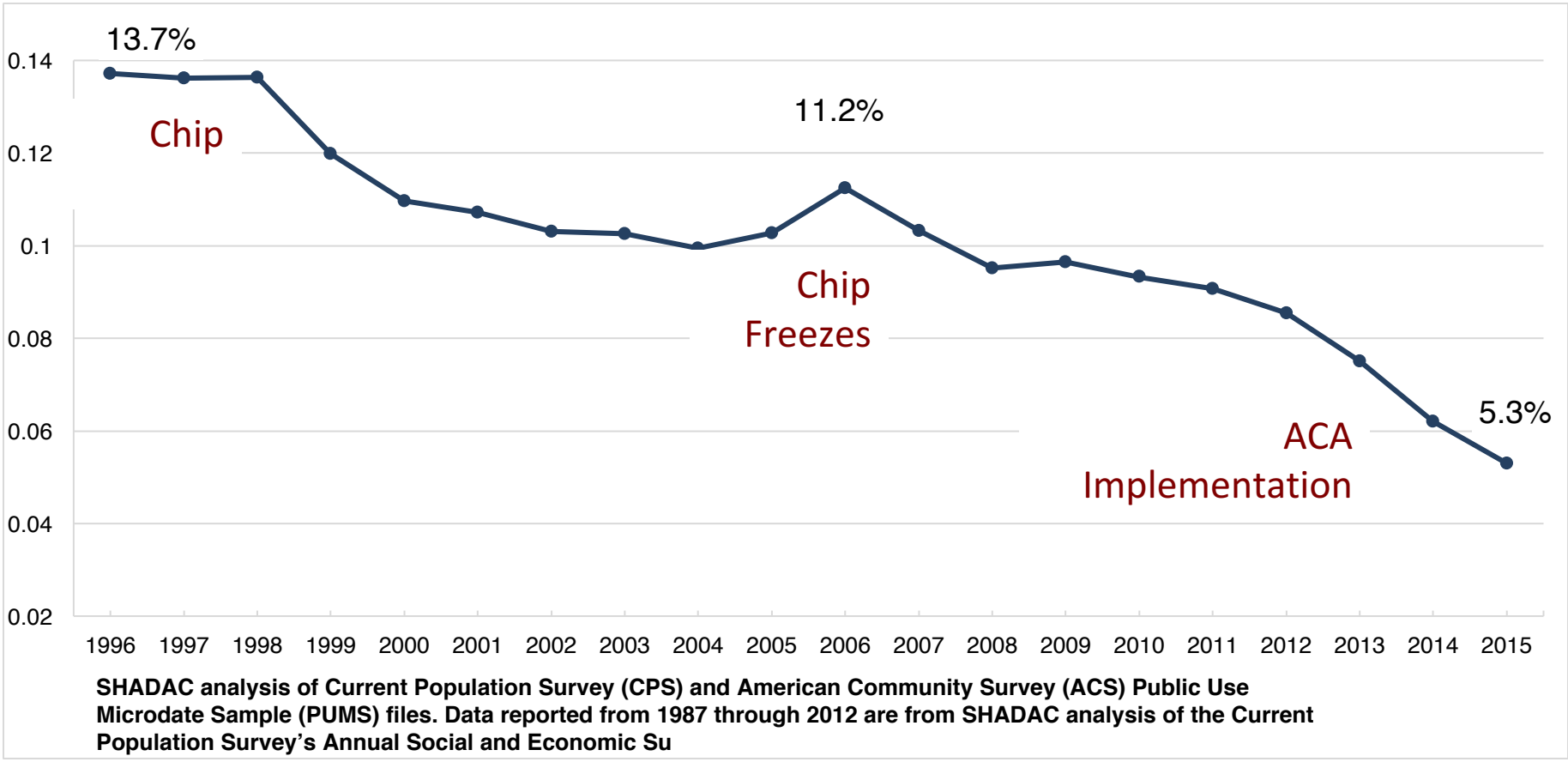
Reduce Eligibility

Increase Enrollee Costs

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
- Even without explicitly eliminating these protections, children's coverage would be at risk as federal funding declines

Uninsured Rate Rose with CHIP Freezes



SHADAC analysis of Current Population Survey (CPS) and American Community Survey (ACS) Public Use Microdate Sample (PUMS) files. Data reported from 1987 through 2012 are from SHADAC analysis of the Current Population Survey's Annual Social and Economic Su

Full 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

Also Known as MAGI Provisions

ACA Eliminated	ACA Requirements
• Asset/resource tests • Longer than 90-day waiting periods in CHIP • Paper-driven eligibility verification • Signatures at renewal • Renewals more frequently than every 12 months • Counting non-taxable sources of income	• Multiple application paths • No wrong door access; coordination with other programs • Must use electronic data before asking for paperwork • Option to apply reasonable compatible standard • 90% funding to upgrade eligibility systems

Questions?

For More Information

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