



Using CHIP and the ACA to Better Serve Children Now and in the Future

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Introduction

Over the past two decades, through Medicaid and the Children's Health Insurance Program (CHIP), states have made great strides in providing children in families with low-to-moderate income appropriate and affordable health coverage. Since CHIP was enacted in 1997, the national rate of uninsured children has been reduced from 14 percent to 6.2 percent (2014).¹ Over the past 20 years, states have not only increased enrollment in children's coverage programs, but also focused on children's unique care and developmental needs by ensuring habilitative, oral, and behavioral health services are available. The Affordable Care Act (ACA) created new coverage options for other populations, including parents who were previously uninsured. Research indicates that providing coverage for parents not only increases children's coverage rates, but also improves children's access to care and use of preventive health services.² However, with federal

CHIP funding only guaranteed through September 2017, there are concerns about the future of children's coverage, particularly regarding the availability of affordable, appropriate pediatric benefits in private coverage.

CHIP is a critical source of health coverage for children today and offers important lessons as children move in and out of public and private coverage due to family income changes. State officials are considering how to apply those lessons to improve private insurance coverage and use them to develop contingency plans if CHIP is not funded beyond 2017, when state officials would need to be ready to transition children enrolled in CHIP to other available sources of coverage.

The National Academy for State Health Policy (NASHP), with support from the David and Lucile Packard Foundation, convened a stakeholder group of health policy experts that included national advocates and state officials representing Medicaid, CHIP and health insurance exchanges to explore the policy options states may have to maintain children's coverage. The goal of the group's discussions was to raise potential options, not to plan how to implement these options. Future convenings of this stakeholder group and CHIP and Medicaid directors will address issues and policy considerations related to implementation of these approaches to coverage. This paper provides an overview of children's current coverage options and summarizes the themes from the stakeholder group's discussions that identified potential options for ensuring strong children's coverage into the future. A list of the policy experts participating in the NASHP discourse meeting is in appendix A.

Setting the Context: Children's Current Coverage Options

Currently families access health coverage for their children through several different sources that are publicly and privately funded. Medicaid and CHIP programs fill gaps that still remain in the private insurance market, particularly for families with low and moderate income that may have limited access to private, employer-sponsored coverage or face affordability challenges. There has been bipartisan support at the federal and state levels to gradually increase children's coverage, which has helped to make it a priority for policymakers.

Medicaid

Medicaid is a jointly funded federal-state entitlement program. The federal government contributes a specific percentage of Medicaid expenditures to states according to the Federal Medical Assistance Percentage (FMAP), which varies across states but ranges from 50 percent – 74 percent.

Medicaid was created to provide health coverage for vulnerable populations including those who are aged, blind and disabled, as well as families with dependent children receiving cash assistance, and expanded over time to include pregnant women, more low-income children, and some parents. Over time the federal government established mandatory coverage levels primarily for children and pregnant women and states could choose to expand Medicaid eligibility for these populations.³ Most recently, a provision in the ACA established a Medicaid eligibility floor of 138 percent of the federal poverty level (FPL) for most Medicaid eligibility groups, including children and adults. Though the Supreme Court issued a decision that the federal government could not compel states to expand Medicaid for adults up to that level, as of March 2016, [31 states and the District of Columbia](#) have chosen to do so, allowing children and parents with income up to 138 percent of the FPL to be covered. In addition to covering children in families with low income, states can opt to use Medicaid to cover children with complex medical conditions regardless of their family's income through waiver authority and most do so.⁴ During 2014, approximately, 30.6 million children were enrolled in Medicaid.⁵

Medicaid is required to provide a comprehensive benefit package to its enrollees, particularly for children. Those children enrolled in Medicaid are entitled to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and services, which include screening, diagnostic and treatment services. EPSDT is considered a model pediatric benefit package, which focuses on healthy development and maximizing function. These services, when medically necessary, are provided to children at little or no cost to their families. Overall, cost sharing requirements in Medicaid are very limited. Children and pregnant women in Medicaid with incomes up to 150 percent of the FPL are exempt from most premiums and cost sharing. Those enrolled with incomes above 150 percent of the FPL are responsible for nominal cost sharing that cannot exceed five percent of the families' income.⁶

The Children's Health Insurance Program (CHIP)

CHIP was created as part of the Balanced Budget Act of 1997, and is a jointly funded federal-state health coverage program. It is not an entitlement. CHIP is funded through a federal block grant that provides capped enhanced matching funds to states; the federal match for CHIP ranges between 88 and 100 percent. It provides coverage for low-income children in families whose income exceeds the threshold for Medicaid in their state and who generally do not have access to employer-sponsored health insurance.⁷ State income eligibility limits for CHIP vary greatly, from 150 percent of the FPL in North Dakota to 400 percent of the FPL in New York. Of the children enrolled in CHIP as of FY2013, almost 90 percent had family income at or below 200 percent of the FPL.⁸ Although states have some flexibility to charge premiums and cost-sharing in CHIP, federal law limits families' total annual cost-sharing for CHIP to no more than five percent of family income. Most state CHIP programs only require minimal cost sharing. During 2014, approximately 8 million children were enrolled in CHIP.⁹

States have the flexibility to create a separate CHIP program, use CHIP funds to expand Medicaid for children or a combination of both approaches.¹⁰ CHIP-funded Medicaid expansion programs offer CHIP-eligible children Medicaid benefits. Separate CHIP program benefits were originally defined using benchmark plans that states could choose, which included Medicaid or specific private insurance options. Over time, states have adopted new benefits and expanded upon others. As a result, state CHIP programs provide comprehensive benefit packages for their enrollees.¹¹

A provision in the ACA increased the states' CHIP enhanced FMAP beginning in Federal Fiscal Year (FFY) 2016. Prior to FFY 16, the CHIP FMAP range was 65-81percent

Originally CHIP was established for a ten-year period, but has been reauthorized and funding has been extended several times. The ACA reauthorized the program and the most recent extension of federal CHIP funds passed through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which extended federal funding through September 2017. It is unknown if Congress will extend CHIP federal funding beyond 2017.

Employer-Sponsored Insurance (ESI)

Nearly half of all children receive their health coverage through employer-sponsored insurance (ESI). It is estimated that 47 percent of children through age 18 (approximately 37 million) are insured through a parent's employer sponsored coverage.¹² While most children have a parent who works full time, their access to ESI differs significantly based on family income.¹³ For instance, 58.9 percent of children with family income between 139 percent and 200 percent of the FPL have access to ESI through a working parent, while 90.1 percent of children with family income at or above 400 percent of the FPL have access to ESI.¹⁴ Medicaid and CHIP fill gaps in the private coverage market for children with low to moderate family income.

Access to ESI for children of working parents depends on two factors: 1) whether or not an employer offers coverage to employees and their dependents and 2) the affordability of the premium for family coverage. An employer may give his/her employees the option to add their children to ESI, but substantial premiums, co-pays, or deductibles may prohibit families from doing so. As such, even if it is offered, not all families may be able to purchase ESI for their children.

Health insurance offered through employers is incredibly varied and cannot be easily summarized. Differences in ESI exist according to the size of the employer (small versus large), the type of insurance offered (Health Maintenance Organizations or HMOs; Preferred Provider Organizations or PPOs; Point of Service plans or POS; etc.), the provider networks included, the costs of the coverage, and more. Another major difference is whether or not the ESI is self-insured.¹⁵ If self-insured, the federal government sets the minimum standards for ESI through the Employee Retirement Income Security Act of 1974 (ERISA). As a result of this diversity, the costs and benefits within ESI cannot be uniformly summarized.

Health Insurance Exchanges (exchanges)

The ACA established health insurance exchanges or marketplaces, which are set up to facilitate the purchase of health coverage. Some states have opted to create and operate their own State-based Marketplace (SBM) and others use the exchange created by the federal government known as the federally facilitated marketplace (FFM). Through exchanges, consumers can purchase private health coverage and enroll in a qualified health plan (QHP), which is a certified health plan that meets benefit and cost sharing standards. At the end of the open enrollment period for plan year 2015, over 11.6 million individuals enrolled in QHPs; approximately six percent, or 790,000 enrollees were under age 18.¹⁶

The ACA uses actuarial value to measure how costs for QHPs and other non-grandfathered plans sold in the individual and small group markets are

split between the insurer and the consumer. Actuarial value is the percentage of total average costs that will be covered by a health plan. For example, a plan with 80 percent actuarial value would be expected to pay, on average, 80 percent of the standard population's medical expenses, which means an individual enrolled in that plan would be responsible for the remaining 20 percent in the form of deductibles, co-payments, and coinsurance.¹⁷

The ACA requires plans to meet distinct levels of coverage, called “metal levels” and each metal tier corresponds to an actuarial value based on its cost sharing. The metal level and corresponding actuarial value is below:

- Platinum plans = 90% actuarial value
- Gold plans = 80% actuarial value
- Silver plans = 70 % actuarial value
- Bronze plans = 60% actuarial value

The ACA also created sliding scale subsidies in the form of advanced premium tax credits (APTC) for individuals with incomes between 100 percent of the FPL and 400 percent of the FPL. Also cost sharing reductions (CSR) are available for consumers purchasing silver level QHPs with incomes up to 250 percent of the FPL. Exchanges are tasked with determining consumers' eligibility for these subsidies. When combined, the premium subsidies and cost sharing reductions can significantly reduce the out-of-pocket spending for those with family income between 100 percent of the FPL and 200 percent of the FPL.¹⁸

Families can face affordability challenges when purchasing coverage through exchanges. Eligibility for APTC, the premium subsidies for QHPs, is based on both income and access to affordable ESI. The definition of “affordable” ESI for this purpose is based on the cost to workers of self-only ESI coverage.¹⁹ If the premium for an individual policy offered through an employer is not greater than 9.66 percent of family income, then an adult with dependents is deemed to have access to

affordable coverage and is not eligible for the APTC – even though the additional premium cost to add dependents to the policy may be unaffordable for many low- to-moderate income households. This bind, in which a parent may be unable to afford family coverage through his or her employer but is also not eligible for premium subsidies to purchase exchange coverage, is known as the “family glitch.” Currently, CHIP provides an affordable pediatric coverage option for low-to-moderate income families caught in the “family glitch”. That is, parents enrolled in ESI can enroll their children in CHIP.

As required by the ACA, all non-grandfathered individual and small group market health plans, including QHPs, must cover the same set of 10 essential health benefits (EHBs). To implement the EHB requirements, the U.S. Department of Health and Human Services (HHS) chose to permit states to select a benchmark plan from among a set of plan options.²⁰ Each state’s EHB package is defined by a state’s benchmark plan selection. As many commercial benchmark plans did not include pediatric vision or oral health care services, HHS required states to choose a supplemental plan to cover these services if they were not part of the benchmark. Specifically, states could select the Federal Employees Dental and Vision Insurance Program (FEDVIP) or CHIP as the supplemental benchmark for pediatric vision or oral health care services.

Table 1. Essential Health Benefits

1.	Ambulatory patient services
2.	Emergency services
3.	Hospitalization
4.	Maternity and newborn care
5.	Mental health and substance use disorder services including behavioral health treatment
6.	Prescription drugs
7.	Rehabilitative and habilitative services and devices
8.	Laboratory services
9.	Preventive and wellness services and chronic disease management
10.	Pediatric services, including oral and vision care

* Source: “Information on the Essential Health Benefits (EHB) Benchmark Plans,” Centers for Medicare and Medicaid Services, accessed February 2016, <https://www.cms.gov/ccio/resources/data-resources/ehb.html>

Potential Future Shifts in Children’s Coverage

The ACA includes a Maintenance of Effort (MOE) provision that requires states continue the eligibility standards, including methodologies and procedures, for children that were in place on March 23, 2010 through September 30, 2019.²¹ Therefore, if federal CHIP funding expired at the end of FFY 2017, children enrolled in Medicaid-expansion CHIP programs would not lose their coverage. However, states would receive the federal Medicaid match rate for these children rather than the higher CHIP match rate. Given the increased Medicaid costs states would face in this scenario, it is expected that, once the MOE requirement expires at the end of FFY 2019, many states would decrease children’s eligibility for Medicaid, and that an additional 2.3 million children would lose Medicaid coverage after FFY 2019. Approximately 700,000 of these children would become uninsured.²²

There are more immediate concerns for children currently enrolled in separate CHIP programs. If federal funding is not extended beyond FFY 2017, estimates are that 3.7 million children currently enrolled in separate CHIP programs would lose that coverage.²³ Of these children, it is projected that approximately 1.4 million would enroll in subsidized exchange coverage, 1.2 million would enroll in employer-sponsored insurance, and 1.1 million would become uninsured.²⁴

While it is expected that approximately two-thirds of the children that may lose separate CHIP coverage will transition to either exchange or ESI coverage, their benefits will be less robust and their families' out-of-pocket costs will be greater. This is echoed in a recent Centers for Medicare and Medicaid Services (CMS) [white paper](#) highlighting results from a HHS state-by-state study that determined QHPs are not comparable to CHIP in either benefits or cost sharing.²⁵ Though the ACA requires plans sold both in and out of the exchanges to offer the EHB benefit package, additional studies have found CHIP benefits are more comprehensive, particularly for oral health, audiology exams and hearing aids, autism services, and habilitative services.^{26,27,28}



In addition to the comparability of benefits between CHIP and private coverage, there are concerns about the affordability of that coverage. The “family glitch”, which can keep some families from receiving APTC, is one challenge to ensuring children transitioning from CHIP to a QHP have affordable coverage. The estimated cost of child-only coverage through the exchange for parents who have ESI could exceed six times the cost of CHIP, depending on the family's income, which affects the amount of the premium subsidy.²⁹ However, even families that purchase silver level QHP coverage and are eligible to receive both APTC premium subsidies and cost-sharing reductions will be responsible for higher costs than if their children were enrolled in CHIP. On average, for parents enrolled in exchange coverage, the added cost of exchange coverage for two children is more than twice the cost of CHIP coverage.³⁰

A look at Arizona and the elimination of their CHIP program, KidsCare, offers a glimpse of how children coverage may change without CHIP. Arizona froze KidsCare enrollment due to state fiscal challenges in January 2010, prior to its effective date of the MOE requirement. The state created a short-term alternative CHIP program for children through December 2013 and provided families with information to enroll in exchange coverage beginning January 2014.³¹ According to data from the American Community Survey (ACS), Arizona's uninsured rate for children with family income between 138 percent and 199 percent of the FPL, which is within the CHIP eligibility income range, went from 10 percent in 2013 to 16.5 percent in 2014.³² This represented the highest uninsured rate for this income range in the country; the national uninsured rate for children within this income range in 2014 was nine percent.³³ These data affirm national projections that without CHIP, a portion of children will become uninsured. Additional ACS data from Arizona also affirms the expectation that a portion of children losing CHIP will transition to QHPs because children in the state enrolled in exchange coverage at a higher rate. In 2014, 19 percent of exchange enrollees in Arizona were children, compared to the national child enrollment rate of six percent.³⁴ This trend indicates that despite the higher cost sharing, families are committed to securing coverage for their children. Data on how many families may have fallen into the “family glitch” is unavailable. However, focus group discussions with families in Arizona suggest some were affected by the “family glitch” because they reported challenges in finding affordable coverage for their children.³⁵



Possible State Options for the Future of Children's Coverage

If federal funding for CHIP is not continued beyond FY2017, there is an array of options that could be considered to ensure continued coverage for children. It is expected that ESI will remain an important source of coverage for most children, with or without CHIP. As such, improvements in ESI coverage for children are an important consideration. However, given the variability of ESI coverage and lack of state control to set standards for ESI in the case of self-insured plans, the stakeholder group focused its discussions on Medicaid and ways to improve pediatric coverage in health insurance exchanges. The following are potential options identified from these discussions:

- Extend Medicaid eligibility at states' regular FMAP for children
- Maximize the potential in exchanges for families
 - o Offer CHIP through exchanges as the child-only plan
 - o Use CHIP as states' EHB benchmark plan for all QHPs
 - o Use CHIP to define pediatric benefits in EHB
 - o Provide additional financial assistance to families

Expand Medicaid Eligibility for Children

One option states have to provide affordable coverage for children who may lose coverage under separate CHIP plans would be to expand income eligibility for Medicaid, enabling these children to transition to the program. Since most children enrolled in CHIP come from families with incomes below 200 percent of the FPL, states could raise the Medicaid income eligibility threshold for children to 200 percent of the FPL (or a higher level) to reach children affected by the loss of CHIP. This option has been identified by the Medicaid and CHIP Payment and Access Commission (MACPAC) as a strategy should federal CHIP funding not be extended beyond FY 2017.³⁶

Expanding Medicaid eligibility for children would extend EPSDT's comprehensive benefits to children losing CHIP coverage at low or no cost to their families. Doing so would cost states more than they are currently spending on CHIP because, as noted earlier, the federal match rate for Medicaid is lower than the CHIP match rate. How much additional matching funds will be needed to extend Medicaid to more children? This will vary by state depending on the state's current Medicaid income eligibility levels, the increased income eligibility level the state chooses, and how many additional children will be seeking coverage in that state when CHIP ends. States choosing this option may be able to adjust the cost sharing structure for children in families with income higher than 138 percent of the FPL. For instance, the Medicaid cost sharing for these families could be established to align with CHIP cost sharing, which is up to five percent of family income.

Maximize the Potential in Exchanges

With nearly 20 years of success in addressing children's health care needs, CHIP could be used as a model to improve child coverage (and potentially family coverage), in the exchanges. Exchanges are a key component of the ACA's goal to provide additional coverage options for the uninsured through the private market. Although exchanges currently serve mostly adults enrolling in QHPs, options for improving this coverage for children exist because:

- 1) Premium subsidies and cost-sharing reductions are available for many individuals and families, particularly those within the current CHIP income eligibility range;
- 2) The ACA includes provisions to help serve children through exchanges in QHP coverage, such as the requirement of a "child-only plan" and the inclusion of "pediatric services" within the EHB; and
- 3) States have a fair amount of discretion in developing exchange coverage within federal guidelines.

Advantages for maximizing the potential within exchanges are both the added value for an entire family seeking coverage and the potential cost benefit to insurers. Health plans would likely welcome adding children to coverage sold through exchanges, as they are a relatively low-cost, low-risk population. It is expected that offering comprehensive, pediatric specific benefits could make exchange coverage more family-friendly. By doing so, the coverage may be viewed as a long-term solution for families rather than insurance to fill intermittent gaps in coverage, which could stabilize the exchange market from enrollment fluctuations.

The options for using CHIP to improve coverage for children offered through exchanges are outlined below.

Offer CHIP on Exchanges as the Child-only Plan

One option is to offer the state's CHIP plan through the exchange as a child-only plan.³⁷ All insurers offering QHPs through the exchanges are required to offer child-only QHPs for individuals up to age 21 at the same metal levels (bronze, silver, gold, platinum) as the other QHPs they offer. The ACA specifies that the coverage in these child-only plans must be equivalent to other QHP coverage offered under the corresponding metal levels. Currently, the child-only plans offered on the exchanges, which are available for children and youth regardless of whether their parents purchase coverage, are identical to the other QHPs sold on exchanges. Many stakeholders are interested in moving to child-only plans that cover comprehensive benefits specifically tailored to pediatric needs, like those covered by many CHIP programs.

Tailoring the child-only plan option to better meet children's health needs is appealing to stakeholders because families can purchase this coverage for children even if the parent(s) has employee-only ESI. Pricing a child-only plan would be critically important given the "family glitch". Since children are generally healthy and their health care costs are typically less than adults, it is worth exploring if there is some flexibility in setting the cost of a

child-only plan. Could exchanges offer child-only plans that share their own risk pool separate from that of adults purchasing QHPs? Would doing so help to lower premiums for child-only plans making them more affordable for families, especially those that can't receive APTC due to the "family glitch"?

There are considerations in adopting this option beyond addressing affordability issues. The ACA's standards concerning EHB-governed plans specify that benefits established through the EHBs cannot be limited based on age where there is no medical evidence for doing so.³⁸ Could a child-only plan that offers CHIP benefits conflict with this anti-discrimination language? Or does the provision establishing a child-only plan take precedence over the anti-discrimination language? Furthermore, since the EHB explicitly requires pediatric benefits, including oral and vision care, preventive and habilitative services, would a child-only plan need to include benefits beyond the EHB?

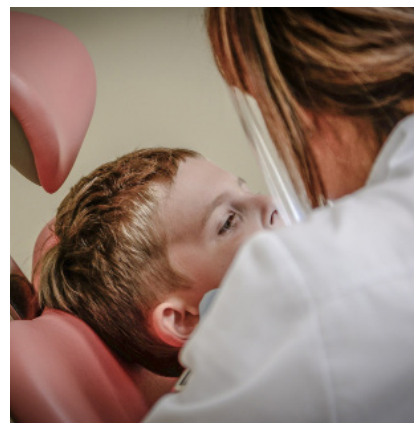
Use CHIP as the EHB Benchmark Plan

Another option that may improve health benefits not just for children but for entire families would be to permit states to select CHIP as a state's EHB benchmark plan. Establishing CHIP as an EHB benchmark option would comply with anti-discrimination provisions within the ACA because it would provide uniform benefits for both adults and children purchasing coverage within and outside of the exchange. CHIP's comprehensive benefits would meet adult health needs while providing improved pediatric benefits for children at the same time.

States could use their own CHIP benefit packages as the EHB benchmark. Alternatively, federal policymakers could define a national median CHIP benefit plan that would be the EHB benchmark option for states, or serve as a model EHB benchmark.³⁹ A 2014 analysis from Wakely Consulting Group comparing separate CHIP programs and QHPs outlined some of the key child-focused benefits that are more adequately covered by CHIP than by QHPs.⁴⁰ These benefits include physical,

Pediatric Dental Care

A notable advantage of providing states with the option to use CHIP as their EHB benchmark is that it would improve dental coverage in exchange plans, as CHIP is federally required to offer dental coverage. Many policymakers, experts, and advocates have noted concerns related to ensuring that children moving from CHIP to exchange coverage have access to adequate dental care. While pediatric oral care is required within the pediatric services category of the EHB, QHPs do not have to cover this benefit if there are stand-alone dental plans available on the exchange, and only a few states require families to purchase stand-alone dental coverage for children. In comparing separate CHIP program benefits to those offered through QHPs, dental services were not covered in 60 percent of the QHPs.⁴¹ Further, the cost of stand-alone dental coverage is not accounted for in the calculation of APTC and cost-sharing reductions cannot be applied to stand-alone dental coverage.



According to a recent analysis of QHPs which embed dental coverage in their health plans, in 23 of the 26 states with separate CHIP programs and federally-facilitated marketplaces, at least some -and in some states all-of the second-lowest-cost silver exchange plans did not include pediatric dental coverage.⁴² Additionally, data regarding the number of children enrolled in QHPs that embed dental coverage are not available.⁴³ Given these policy challenges related to ensuring that children with exchange coverage have access to dental coverage, a CHIP benchmark would be one policy option to address these concerns. Also, another advantage of this option is that it would also provide dental coverage to adults.

occupational and speech therapies, audiology and oral health care services. The findings from this study in particular could help inform the definition of a national median CHIP benefit package since states' CHIP benefits vary.

If a state were to choose the CHIP benchmark option, the national median CHIP benefit package would serve as the minimum. Some states with a more robust CHIP benefit package may be interested in using their own CHIP benefits as their EHB benchmark rather than the median national standard. In these instances, federal policymakers could permit states to select their own separate CHIP benefit package to serve as the EHB benchmark plan.

There are some changes that would need to happen to pursue this option. First, CHIP would need to be included on the list of federally-approved benchmark plans that states can choose to define EHB. States are permitted to use CHIP to define specific benefits (pediatric dental and vision) within the EHB and have opted to do so. Also, states have already chosen the benchmark plan they will use through plan year 2017, so the earliest this change could be implemented would be for plan year 2018. The HHS Secretary noted within the preamble of federal regulations that the approach to using benchmark plans for the EHB would be assessed prior to plan year 2018.⁴⁴ Perhaps during this assessment, the Secretary can consider additional plans that could be used for the EHB benchmark?

There are additional considerations in adopting CHIP as the EHB benchmark that would serve everyone, such as cost. To what extent will adding dental coverage, which is an embedded benefit in CHIP, to a state's EHB increase health care costs, particularly for adults? What other additional benefits would be made available to adults? And would those benefits affect costs?

Use CHIP to Define Pediatric Services in the EHB

A more limited alternative to permitting states to use CHIP as a benchmark for the entire EHB would be to permit states to use it as the benchmark for the pediatric services category of the EHB only. This option would allow states to continue to choose from the existing federally approved benchmark plans to define their overall EHB, but more clearly delineate the benefits and services provided to children by using CHIP's benefit package for the pediatric services category.

This option provides states with an opportunity to more clearly define the EHB's pediatric services category. The EHB benchmark plans that many states use to define all benefit categories are small group plans, which generally were not developed with specific consideration of children's unique needs. In contrast, CHIP offers a well established and ready-to-use model to help ensure that the scope of coverage offered through the pediatric services component of the EHB is clearly defined, comprehensive and tailored to meet children's unique developmental needs.

Although CHIP has already been used by states to supplement their EHB benchmark plans to meet the requirement for providing pediatric oral and vision care⁴⁵, the benchmark approach to specifically define the entire EHB's pediatric services category is a concept that has not yet been proposed by HHS. Some policy analysts have interpreted federal guidance to permit states to exercise flexibility in adjusting benefit design under the EHB pediatric services category.⁴⁶ Do states need explicit permission, either through statute or regulation, to use CHIP as a benchmark for the EHB's pediatric services category? Are there costs associated with altering the EHB's pediatric services category? Would there be administrative challenges for exchanges or QHPs in adding a benchmark plan for a specific benefit category within the EHB?

Additional Financial Assistance: Premium and Cost-Sharing Wraps

Allowing states to use CHIP to shape benefits in the QHPs offered through the exchanges in any of

the ways described would give them mechanisms to ensure that children, and perhaps parents and childless adults as well, have comprehensive benefits. However, policymakers would still need to confront the issue of affordability. As noted previously, families purchasing coverage for their children through the exchanges would face higher premiums and total out-of-pocket costs for that coverage compared to CHIP.

One option to make exchange coverage more affordable for families with children would be to provide a cost sharing 'wrap' to cover exchange plan premium costs and/or co-payments for families within certain income ranges. This wrap-around assistance would supplement any exchange premium subsidies and cost-sharing reductions that a family receives. This additional financial assistance would make exchange coverage more affordable for low- and moderate-income families, and would be especially beneficial for families facing significant out-of-pocket costs because of high health care needs. For families ineligible for APTC due to the "family glitch", the financial wrap assistance may help a child, who would have otherwise gone uninsured, be enrolled in a QHP.

To implement this option, particularly if federal support for CHIP is not extended, state and federal policymakers will need to identify available funding. Some states may opt to use the funding that would have gone towards their state CHIP match to instead pay for the financial assistance wrap. Federal funds are another possible source for financing a cost-sharing wrap. Even if federal funding for the overall CHIP program ends, could federal policymakers consider directing a dedicated amount of Title XXI funding solely for the purpose of providing cost-sharing wraps? To minimize the cost of this financial assistance, perhaps a cost-sharing wrap could be created specifically for those affected by the "family glitch"?

There are existing models in other health coverage programs—including CHIP—that could help guide policy development on the design and management of these cost-sharing wraps. For example, some states have premium assistance programs that use CHIP funding to subsidize the cost

of private coverage for children. Also state Medicaid programs in Massachusetts, New York, Rhode Island and Vermont are already testing a related model. These states are implementing premium wrap-around programs for adults enrolled in exchange coverage who would have been eligible for Medicaid prior to 2014 under state programs.⁴⁷ To date, these programs are limited in scope, and in the case of the Medicaid premium assistance programs, they are in the early stages of implementation. There are questions that will need to be considered prior to implementing a cost-sharing wrap for exchange coverage that is in addition to any federal subsidies. How administratively complex and costly will it be to execute? What kind of systems changes will be necessary? Despite these challenges, some states might choose to pursue the premium/cost-sharing wrap option in order to reduce the financial burden for low-income families with exchange coverage.

Conclusion

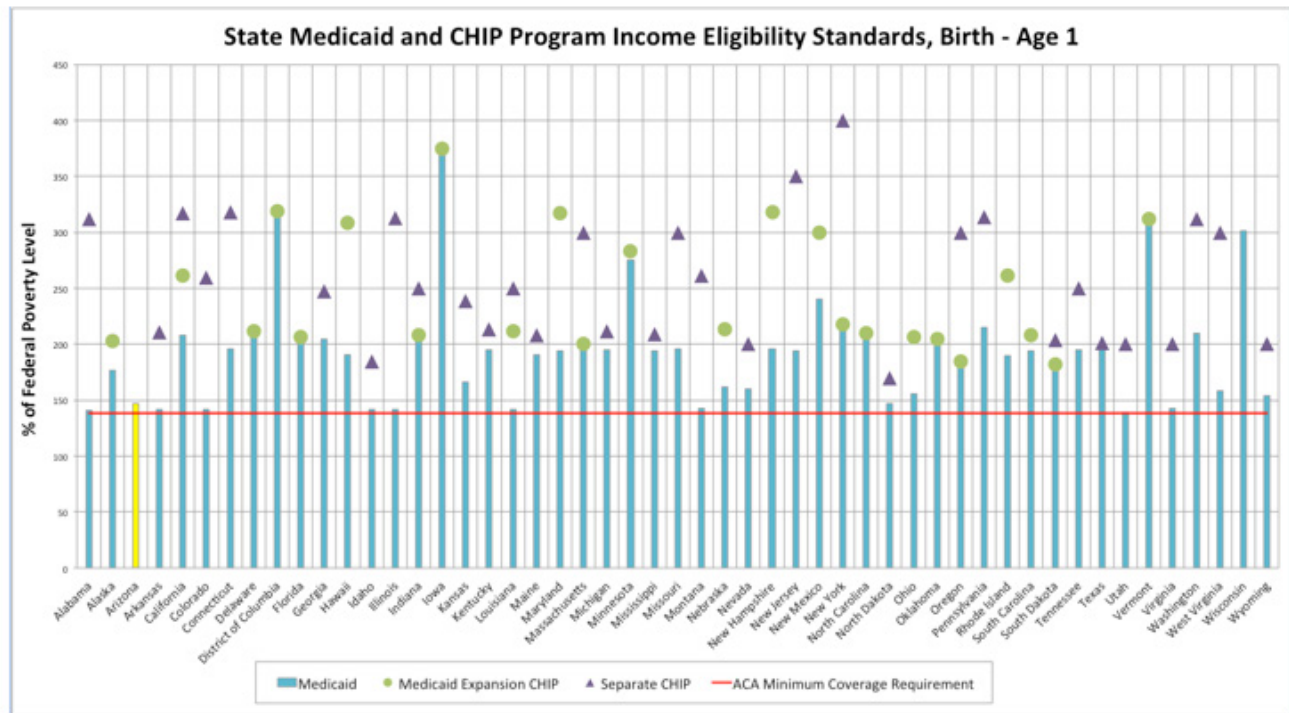
Medicaid and CHIP continue to be important coverage sources for children in families with low- to moderate-incomes. With the uncertainty of CHIP beyond 2017, stakeholders, especially state officials, must consider what alternative sources of coverage are available to maintain the over two decades of gains in covering uninsured children and providing comprehensive coverage made by all states since the passage of CHIP. The ACA provides some potential infrastructure through health insurance exchanges and the EHB for states to continue to provide comprehensive coverage for children. Using CHIP as either the child-only plan sold through exchanges or to better define the EHB could be possible options for ensuring strong children's coverage into the future. Policymakers likely also need to address affordability challenges for low-to-moderate income families. Perhaps this can be achieved by continuing to provide some additional financial assistance to subsidize children's coverage. But the pathways to implement these options require considerable analysis.

Appendix A

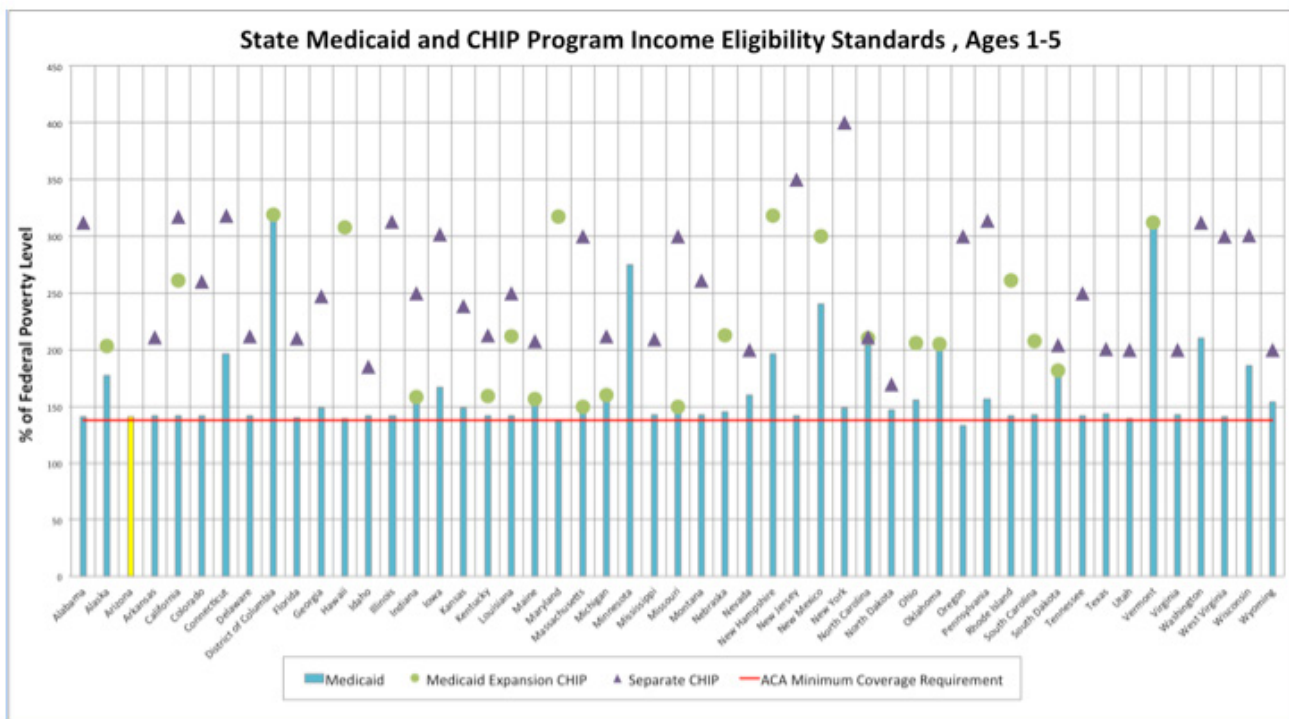
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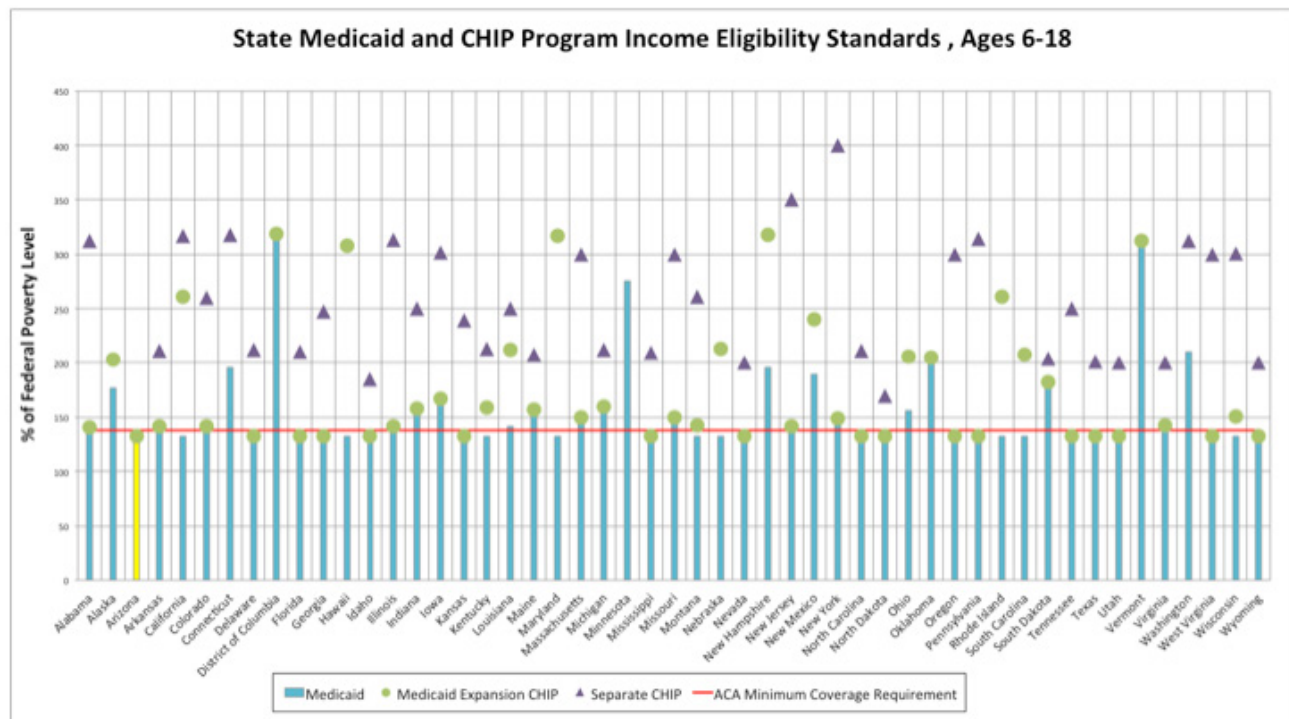
Appendix B



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 5: Design Considerations for the Future of Children's Coverage: Focus on Affordability," in March 2016 Report to Congress on Medicaid and CHIP, (Washington DC, 2016), 118-120.



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 5: Design Considerations for the Future of Children's Coverage: Focus on Affordability," in March 2016 Report to Congress on Medicaid and CHIP, (Washington DC, 2016), 118-120.



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 5: Design Considerations for the Future of Children's Coverage: Focus on Affordability," in March 2016 Report to Congress on Medicaid and CHIP, (Washington DC, 2016), 118-120.

Notes:

- The ACA established a minimum Medicaid income eligibility level of 138% of the FPL (this includes the required five percent income disregard) for those under age 65 that is noted in the chart using the red line.
- Medicaid and CHIP are financed through separate funding streams. CHIP dollars are used to fund both state's separate CHIP and Medicaid expansion CHIP programs at the enhanced federal match rate.
- As noted in the chart, there are states that operate Medicaid and CHIP programs with overlapping eligibility levels. In these cases, children with no other source of health coverage are enrolled in CHIP-funded programs, while those with another source of health coverage are enrolled in Medicaid. Children who have another other coverage are not eligible for CHIP.
- This chart does not include state CHIP programs that cover pregnant women through the unborn child coverage option.
- Arizona ended its CHIP program, but the state's income eligibility levels are noted in the chart for reference.

End Notes

1. Jessica C. Smith and Carla Medalia, U.S. Census Bureau, "Health Insurance Coverage in the United States: 2014," U.S. Government Printing Office, Washington, DC, 2015, <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>.
2. Leighton Ku and Matthew Broddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, Washington, DC, October 2006, <http://www.cbpp.org/sites/default/files/atoms/files/10-20-06health.pdf>.
3. Prior to ACA implementation, which created an eligibility floor of 138% of the FPL for most children and adults, the following was in place: states were required to cover children using Medicaid from birth through age 5 with family income up to 133% of the FPL and those 6 years old through 18 years old with family income up to 100% of the FPL. States had the option to cover pregnant women up to or over 185% of the FPL and most did so. "Children," Centers for Medicare and Medicaid, accessed February 2016, <https://www.medicaid.gov/medicaid-chip-program-information/by-population/children/children.html>.
4. Through both the Katie Beckett Waiver and the Tax Equity and Fiscal Responsibility Act (TEFRA) state plan option states are able to provide Medicaid coverage to children who have medically complex needs waiving their family income. They must meet the following criteria:
 - Be 18 years old or younger;
 - Meet the state's definition of institutional level of care;
 - Have medical care needs that can be safely provided outside of an institutional setting; and
 - The cost of care in the community must not exceed the cost of institutional care
5. "Health Insurance Coverage of Children 0-18," The Henry J. Kaiser Family Foundation, last modified March 2015, <http://kff.org/other/state-indicator/children-0-18/#>.
6. Robin Rudowitz and Laura Snyder, The Kaiser Commission on Medicaid and the Uninsured, "Premiums and Cost-Sharing in Medicaid," The Henry J. Kaiser Family Foundation, February 2013, available at <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid/>
7. In an effort to minimize or deter crowd-out, which is the substitution of publicly funded coverage for private health insurance, states can adopt a waiting period in which children must be uninsured for up to 90 days before being able to enroll in CHIP. However, there are federal exceptions to enforcing the waiting period. The following exceptions pertain to affordability of private coverage for families with incomes within CHIP eligibility ranges: (42 CFR 457.805(b)(3)) Children may be exempted from the waiting period if any of the following applies:
 - "The additional out-of-pocket premium to add the child to an employer plan exceeds 5 percent of income"
 - A parent is eligible for subsidized exchange coverage because the premium for the parent's self-only employer-sponsored coverage exceeds 9 percent of income"
 - "The total out-of-pocket premium for employer sponsored family coverage exceeds 9.5 percent of family income"
8. Anne Schwartz, "Children's Coverage Beyond CHIP: Policy Considerations for States," (presentation for NASHP's Future of Children's Coverage webinar, June 2015), available at http://www.nashp.org/wp-content/uploads/2015/06/June_2015_FOCC_Webinar_Slides.pdf.
9. "Total Number of Children Ever Enrolled in CHIP Annually," The Henry J. Kaiser Family Foundation, last modified May, 13, 2015, <http://kff.org/other/state-indicator/annual-chip-enrollment/>.
10. Currently, 8 states and the District of Columbia operate Medicaid expansion programs; 2 states operate separate CHIP programs; and 40 use a combination of both. "Children's Health Insurance Program," Centers for Medicare and Medicaid, map, last updated May 1, 2015, <https://www.medicaid.gov/chip/downloads/chip-map.pdf>.
11. Anita Cardwell, et al, "Benefits and Cost Sharing in Separate CHIP Programs," National Academy for State Health Policy and Georgetown University's Center for Children and Families, Washington, D.C., May 2014.
12. "Employer-Sponsored Coverage Rates for the Nonelderly by Age," The Henry J. Kaiser Family Foundation, accessed February 2016 <http://kff.org/other/state-indicator/rate-by-age-2/>.
13. Joanne Jee and Chris Peterson, "Approaches for Children's Coverage in a New Policy Context" (MACPAC meeting presentation, Washington, D.C., September, 2015). Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Approaches-for-Children%E2%80%99s-Coverage-in-a-New-Policy-Context.pdf>
14. Ibid.
15. If an employer opts to establish and offer a self-insured plan to its employees, the employer is responsible for paying all of the health care costs, including administrative costs for that coverage. Other employers purchase fully-insured health insurance plans and are responsible for premium costs (which can be a shared responsibility with the employees), but ultimately the health insurance company is responsible for paying the health care costs.
16. "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2015, https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf.

17. "Actuarial Value and Cost-Sharing Reductions Bulletin," Centers for Medicare and Medicaid, December 2011, <https://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf>
18. According to CMS's "Actuarial Value and Cost-Sharing Reductions Bulletin", after the premium subsidies and cost share reduction for those with family income between 100% of the FPL and 200% of the FPL the actuarial value of a silver level plan can be as much as 94%, which means on average the family is responsible for 6% of the costs of the coverage.
19. Tricia Brooks, "Health Policy Brief: The Family Glitch," Health Affairs, November 10, 2014, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129.
20. The plans available for states to select as benchmarks include: The largest plan in terms of enrollment in any of the three largest small group market insurance products in the state; the three largest state employee health plans; the three largest federal employee health plans; and the largest non-Medicaid HMO in the state.
21. Patient Protection and Affordable Care Act of 2010, U.S. Code § 2101(b)
22. Medicaid and CHIP Payment and Access Commission (MACPAC), "MACPAC's Work on Children's Coverage and Next Steps," (MACPAC meeting presentation, Washington, D.C., January, 28 2016).
23. Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 1: Sources of Coverage for Children if CHIP Funding is Exhausted," in March 2015 Report to Congress on Medicaid and CHIP, (Washington DC, 2015), 7-21. Analysis conducted by the Urban Institute; estimates are based on the number of children projected to be enrolled in separate CHIP programs in 2016.
24. Ibid.
25. U.S. Department of Health and Human Services, "Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans," November 25, 2015.
26. Peggy McManus, "A Comparative Review of Essential Health Benefits Pertinent to Children in Large Federal, State, and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans," Prepared for the American Academy of Pediatrics, July 2012
27. Wakely Consulting Group, "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans," July 2014.
28. Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 3: Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance," in March 2015 Report to Congress on Medicaid and CHIP, (Washington DC, 2015).
29. Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 2: Affordability of Exchange Coverage for Children Now Covered by CHIP," in March 2015 Report to Congress on Medicaid and CHIP, (Washington DC, 2015), 23-43. Based on 2015 exchange data.
30. Note that these estimates are for standard exchange coverage and not for the more robust CHIP benefit.
31. "KidsCare II Background Information," Arizona Health Care Cost Containment System, accessed February 2016, https://www.azahcccs.gov/Members/Downloads/KidsCareII/KCII_Background.pdf.
32. Elizabeth Wright Burak and Joseph Fu, "Children's Health Coverage in Arizona: How are Children Doing Without KidsCare?," Georgetown University Health Policy Institute Center for Children and Families, January 2016.
33. Ibid.
34. Ibid.
35. Ibid.
36. Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 2: Affordability of Exchange Coverage for Children Now Covered by CHIP," in March 2015 Report to Congress on Medicaid and CHIP, (Washington DC, 2015), 23-43.
37. The ACA requires the following in regards to child-only plans: Section 1201 (c) CHILD-ONLY PLANS. —If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) [related to actuarial value levels] of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.
38. Patient Protection and Affordable Care Act of 2010, U.S. Code § 1302(b)(4)
39. This national median CHIP benefit package would be based on separate CHIP plan benefit offerings.
40. Wakely Consulting Group, "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans," July 2014. (The information in the report about the QHPs is based on EHB summaries, and the report notes that because there may be variation by insurer, some QHPs may offer additional benefits or impose greater limits that are not reflected in their analysis.) Some of the child specific benefits highlighted in the report that are covered at different levels between CHIP and QHPs are: audiology, dental, vision, autism, habilitation, physical, occupational and speech therapies, enabling services and over the counter medications.
41. Ibid.
42. Medicaid and CHIP Payment and Access Commission (MACPAC), "Chapter 2: Affordability of Exchange Coverage for Children Now Covered by CHIP," in March 2015 Report to Congress on Medicaid and CHIP, (Washington DC, 2015), 23-43.

43. Christina Cousart, Andy Snyder, and Najeia Mention, “Dental Benefits in Health Insurance Marketplaces: An Update on Policy Considerations,” National Academy for State Health Policy, November 2015.
44. Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 45 CFR § 147,155, and 156 (2013).
45. In their original benchmark plan selections, 24 states used CHIP dental benefits and seven states used CHIP vision benefits as the supplemental benchmark for these services. In their 2017 benchmark plan selections, 12 states used CHIP dental benefits and three states used CHIP vision benefits as the supplemental benchmark for these services.
46. Wendy Lazarus, “Child-only plan provisions of the ACA in the context of essential health benefits,” memorandum to Sara Rosenbaum, August 12, 2012, Department of Health Policy, School of Public Health and Health Services, The George Washington University Medical Center.
47. Medicaid and CHIP Payment and Access Commission (MACPAC), “Chapter 2: Affordability of Exchange Coverage for Children Now Covered by CHIP,” in March 2015 Report to Congress on Medicaid and CHIP, (Washington DC, 2015), 23-43.

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