



MEMORANDUM

January 22, 2015

To: Subcommittee on Health, Committee on Energy and Commerce, House of Representatives
Attention: The Honorable Joseph R. Pitts
The Honorable Frank Pallone, Jr.

From: Evelyne P. Baumrucker, Analyst in Health Care Financing, 7-8913
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Subject: Responses to Questions for the Record from the December 3, 2014 Hearing, “The Future of the Children’s Health Insurance Program”

This memorandum was prepared in response to questions for the record from the December 3, 2014 Hearing, “The Future of the Children’s Health Insurance Program” before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives. Responses to questions from the Honorable Joseph R. Pitts begin on page 1, and responses to the Honorable Frank Pallone Jr. begin on page 19.

Questions from the Honorable Joseph R. Pitts:

1. To date, two bills have been introduced to extend CHIP – Senator Rockefeller’s CHIP Extension Act of 2014 (S. 2461) and Representative Pallone’s CHIP Extension and Improvement Act of 2014 (H.R. 5364). Does either of these bills currently include offsets? If they were enacted in their current form, what impact would these bills have on the federal deficit?

Two bills were introduced in the 113th Congress that would have extended the federal funding for CHIP, among other things. Senator John D. Rockefeller introduced the CHIP Extension Act of 2014 (S. 2461) on June 11, 2014, and the CHIP Extension and Improvement Act of 2014 (H.R. 5364) was introduced by Representative Frank Pallone Jr. on July 31, 2014.

Brief Comparison of Bill Provisions

The two bills have a number of comparable provisions that make changes to both Medicaid and CHIP, but each bill has at least a couple of provisions that are not included in the other bill. The following is a brief overview of the provisions in each of the two bills grouped by these topics: CHIP financing, coverage, cost sharing, benefits, pediatric quality measures, and miscellaneous.

CHIP Financing

Both bills would have funded CHIP through FY2019 with the same funding levels and allotment formulas. In addition, both bills would have extended the Child Enrollment Performance Bonus Payments through FY2019, and the bills would have similar but varying mechanisms for providing shortfall funding to states for FY2016 through FY2019.

Coverage

With regard to eligibility, the Senate bill would have extended CHIP eligibility to certain medically frail individuals under the age of 26. Among the coverage-related provisions, both bills addressed the Secretary's benefit comparability review of CHIP and the qualified health plans (QHPs) in the health insurance exchanges, as well as benefit coverage during transitions between Medicaid, CHIP, and QHPs. Both bills had identical provisions that would have modified the Internal Revenue Service rules regarding the ACA's individual mandate so CHIP pregnancy assistance would *not* be considered minimum essential coverage. Both bills would have broadened the Medicaid eligibility requirements for former foster care youth.

With regard to provisions that address outreach and enrollment facilitation, both bills would have eliminated the sunset date for the "Express Lane" eligibility state plan option under Medicaid and CHIP, however, each bill would have extended this state plan option to different populations. Both bills added federal appropriations to the CHIP outreach and enrollment grants for FY2016 and each fiscal year thereafter. Both bills would have added requirements around language and interpretation services in Medicaid and CHIP. While the Senate bill included an increased federal medical assistance percentage (FMAP) rate for language and interpretation services, the House bill did not. In addition, the House bill would have extended the populations for whom 12 months of continuous enrollment in Medicaid would apply and would have eliminated CHIP waiting lists and enrollment caps.

Cost Sharing

With regard to beneficiary cost sharing, both bills made changes to CHIP cost-sharing requirements and the aggregate cap on out-of-pocket costs for an individual or family. The Senate bill made additional changes to Medicaid cost-sharing requirements.

Benefits

Both bills would have added preventive services to the list of mandatory benefits under Medicaid and CHIP, but the details of the preventive services benefit coverage differed. Cost sharing for these preventive services would have been prohibited under both bills for Medicaid, but only the Senate bill prohibited cost sharing for these preventive services under CHIP. The bills made similar (but not identical) modifications to the Vaccines for Children program.

Pediatric Quality Measures

With respect to the pediatric quality measures, both the Senate and House bills would have: 1) extended funding for the pediatric quality measures program broadly; 2) awarded grants and contracts to enhance the pediatric measures program and publish recommended changes to the core set of measures; 3) required additional information in the existing state-specific annual reports; 4) required a report to Congress on child health quality priorities and the convening of an expert advisory panel on child health quality; and 5) extended funding for both the child health quality demonstration program and the childhood obesity demonstration program. The House bill would have made additional changes, including: 1) an enhanced FMAP for the development and modification of systems necessary to collect

and report the child health measures; 2) the provision of technical assistance to states for adopting and using the pediatric quality measures; and 3) a requirement that states report on the full set of pediatric quality measures within five years after enactment.

Miscellaneous

In the miscellaneous provisions, both bills would have extended the Maternal, Infant, and Early Childhood Home Visiting Program through FY2019. The Senate bill included a provision that would have directed the Government Accountability Office (GAO) to conduct an analysis of states that provide Medicaid or CHIP coverage through QHPs or employer-sponsored insurance. The House bill would have extended the increase to Medicaid primary care rates and the Pediatric Accountable Care Organization Demonstration Project. In addition, the House bill would have added therapeutic foster care as a Medicaid covered benefit and modified language around special needs trusts for non-elderly disabled individuals.

Offsets

Neither of the two bills introduced in the 113th Congress included revenue provisions or provisions that would have offset federal collections or receipts. When CHIP was last reauthorized in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), the law included a few revenue provisions. The following is a list of the revenue provisions in CHIPRA.¹

- Increased excise tax rate on tobacco products, such as cigarettes, cigars, tobacco, and cigarette papers and tubes;
- Expanded the scope of penalties for not paying the tobacco-related tax, clarified the statute of limitations, and mandated a study of tobacco smuggling;
- Adjusted the portion of corporate estimated taxes due from July through September 2013; and,
- Made changes to employer-sponsored health insurance coverage that were estimated to affect both on-budget (Medicare) and off-budget (Social Security) payroll taxes.

Impact on Federal Budget

The Congressional Research Service (CRS) is not able to provide a cost estimate of the two bills introduced in the 113th Congress that would extend federal CHIP funding because cost estimates are the purview of the Congressional Budget Office (CBO). There are not any current publicly available CBO cost estimates for the provisions in the two bills. A few of the provisions have previously received a cost estimate from CBO in other contexts, such as when the provision was established or previously extended of provisions. However, these cost estimates should be considered with care for a number of reasons, including the assumptions may have changed since the cost estimates were done; the estimates were conducted prior to the implementation of dynamic scoring, the provisions may not comparable, etc.

While CBO has not estimated the cost of these two bills that would have extended CHIP for four years with a number of programmatic changes to both Medicaid and CHIP, CBO did estimate the cost of a clean

¹ For more information about these provisions, see CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker, Elicia J. Herz, and Jane G. Gravelle and Congressional Budget Office, *Cost Estimate: H.R. 2 Children's Health Insurance Program Reauthorization Act of 2009*, February 11, 2009.

(i.e., no programmatic changes) two year extension of federal CHIP funding for the Medicaid and CHIP Payment and Access Commission (MACPAC). In the estimate for MACPAC, CBO calculated that providing federal CHIP funding for FY2016 and FY2017 would increase net federal spending by \$0 to \$5 billion above CBO's current law baseline as of June 2014. In CBO's estimation, the federal costs of providing federal CHIP funding for two more years would be largely offset by reductions in federal spending for Medicaid and subsidized coverage in the health insurance exchanges.²

CBO's estimate also reflects the rules that govern CBO's baseline projections for expiring programs. For expiring mandatory programs, baseline rules established by the Deficit Control Act call for extrapolating the program's funding for the last six months of its authorization for the remainder of the baseline projection period.³ Under current law, funding for CHIP in FY2015 (the last year CHIP is to receive federal funding) consists of two semiannual allotments of \$2.85 billion—amounts that are much smaller than the allotments made in the four preceding years. The first semiannual allotment in FY2015 will be supplemented by \$15.4 billion in one-time funding for the program. Following the rules prescribed by the Deficit Control Act, CBO extrapolates the \$2.85 billion provided for the second half of the year to arrive at projected annual funding of \$5.7 billion.⁴ Since the baseline projections assume \$5.7 billion in federal CHIP spending for FY2016 and subsequent years within the budget window, CBO's estimated cost of extending federal CHIP funding is lower than it would have been without this assumption.

2. How many CHIP enrollees—either as a percentage or a total number—are from families with income above 200 percent of the federal poverty level (FPL), which equates to about \$47, 700 in annual income for a family of four? As a point of reference, the national median income for 2012 was \$53,046, according to the U.S. Census Bureau.

FY2013 CMS administrative data show that approximately 89% of the 8.4 million CHIP child enrollees were in families with annual income at or below 200% FPL, and approximately 97% of child enrollees were in families with annual income at or below 250% FPL. (See **Table 1**.)

Table 1. Number of Children in CHIP by Income Level
FY2013

Income Range		
(% FPL)	Ever Enrolled	Percentage
0-200	7,243,295	88.5%
201 - 250	724,785	8.9%
251 - 300	165,120	2.0%
301 & Higher	51,791	0.6%
Total	8,184,991	100.0%

Source: Centers for Medicare and Medicaid Services, Child Health Insurance Program Budget Report, based on Form 21E and 64.21E Combined, as of April 2014.

Notes: The enrollment figures reported in this response represent “ever enrolled” counts which measure the number of children covered by CHIP for any period of time during a given year. These

² Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014

³ Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2014*, February 2014.

⁴ Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2014*, February 2014.

enrollment counts differ significantly from estimates based on “point-in-time” or average annual enrollment measures.

CMS administrative data are from FY2013 and represent the most recent CMS administrative data available to date.

In FY2013, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$ 23,550, in Alaska \$ 29,440 and in Hawaii \$ 27,090. In FY2014, 200% of the federal poverty level for a family of 4 in the 48 contiguous states was \$47,100, in Alaska \$58,880 and in Hawaii \$54,180. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), *2013 Poverty Guidelines*, available at <http://aspe.hhs.gov/poverty/14poverty.cfm>.

FPL: Federal poverty level.

Title XXI of the Social Security Act (SSA) defines a targeted low-income child as one who is under age 19 with no health insurance,⁵ and who would not have been eligible for Medicaid under the federal and state rules in effect when CHIP was first initiated in 1997.^{6,7} States have broad discretion in setting their income eligibility standards, and eligibility varies across states. In FY2014, statewide upper income eligibility thresholds for CHIP-funded child coverage range from a low of 175% FPL to a high of 405% FPL.^{8,9,10} These thresholds represent the eligibility ceiling for CHIP children. As of January 2014:

- 18 states and the District of Columbia provide coverage above 301% FPL; of these, two states extend coverage above 400% FPL, including New York (405% FPL) and California (416% FPL¹¹ in one county);
- 9 states provide coverage between 251% FPL and 300% FPL;
- 20 states provide coverage between 201% FPL and 250% FPL; and
- 3 states extend coverage at levels less than 200% FPL, including Idaho (190% FPL), North Dakota (175% FPL), and Arizona (100%).¹²

⁵ States are permitted to require a period of uninsurance (i.e., waiting period) of up to 90 days before a child who is otherwise eligible is permitted to enroll in CHIP. See 78 *Federal Register* 42160, July 15, 2013.

⁶ Section 2110(b) of the Social Security Act.

⁷ Children who meet the CHIP eligibility requirements do not always enroll in the CHIP program. The enrollment figures reported in this response represent “ever enrolled” counts which measure the number of children covered by CHIP for any period of time during a given year. These enrollment counts differ significantly from estimates based on “point-in-time” or average annual enrollment measures.

⁸ In FY2014, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$23,850, in Alaska \$29,820 and in Hawaii \$27,430. In FY2014, 200% of the federal poverty level for a family of 4 in the 48 contiguous states was \$47,700, in Alaska \$56,640 and in Hawaii \$54,860. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), *2014 Poverty Guidelines*, available at <http://aspe.hhs.gov/poverty/14poverty.cfm>.

⁹ Estimates of “real” median household income in 2013, the latest date for which these data are available, are \$51,939. Source: Carmen DeNavas-Walt and Bernadette D. Proctor; U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau; *Income and Poverty in the United States: 2013 Current Population Reports*; September 2014.

¹⁰ FY2014 CHIP upper income eligibility thresholds are from Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP, March 2014*, MACSTATS, Table 9.

¹¹ Most counties in California are in the state’s CHIP Medicaid expansion program which extends coverage up to 266% FPL. However, the state had a separate CHIP program that extended CHIP coverage up to 321% FPL in three counties, and up to 416% FPL in one county. During FY2013, children in the state’s separate CHIP program were transitioned to the state’s CHIP Medicaid expansion program.

¹² Federal authority for Arizona’s CHIP program to cover children in families with annual income above 100% FPL expired on January 31, 2014. As a result, children in families with income between 100-133% FPL transitioned to Medicaid effective (continued...)

Despite the fact that 27 states extend CHIP coverage to children in families with annual income greater than or equal to 251% FPL, CMS administrative data shows that CHIP enrollment is concentrated among families with annual income at lower levels.

3. The Affordable Care Act/Obamacare authorized CHIP through fiscal year 2019, but did not include funding for the program beyond 2015 even though the Act required a Maintenance of Effort for the program for these additional four years. Using CBO data, please provide an general sense of the possible increase of federal spending had the Act funded CHIP through fiscal year 2019.

As mentioned in Question #1, CRS is not able to provide a cost estimate of the impact on the federal budget if Congress had provided federal CHIP funding for FY2016 through FY2019 as part of the ACA because it is CBO's purview to provide cost estimates to Congress. Last year, CBO provided MACPAC with an estimate of the cost to provide federal CHIP funding for FY2016 and FY2017, and CBO estimated this clean two year extension would increase net federal spending by \$0–5 billion above CBO's current law baseline as of June 2014. See the response to question #1 for a more detailed explanation of this estimate.

4. Your report titled *State Children's Health Insurance Program: An Overview* indicates that, in fiscal year 2013, approximately 84 percent of separate CHIP program enrollees received coverage under some form of managed care. Please describe the types of managed care arrangements used in CHIP. To what extent are CHIP enrollees covered by managed care plans that also offer coverage in the private market versus plans that predominately cover Medicaid and CHIP population?

A vast majority of CHIP children receive coverage through managed care, and most of these children receive this coverage through comprehensive risk-based managed care as opposed to primary care case management. Of the children receiving coverage through comprehensive risk-based managed care, most of them have coverage through a plan that covers exclusively or primarily public programs such as Medicaid and CHIP.

Types of Managed Care

In general, benefits are made available to CHIP children via two service delivery systems: fee for service or managed care. Under the "fee for service" (FFS) delivery system, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under the "managed care" delivery system, Medicaid enrollees get most or all of their services from an organization under contract with the state. There are two main types of managed care used for CHIP:

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January 1, 2014. Children in families with income over 133% FPL were encouraged to apply for coverage through the health insurance exchange where premium subsidies are available for eligible households. While the state's CHIP program to extend coverage for CHIP-eligible children in families with annual income less than 100% FPL remains in effect, enrollment of new children has been frozen since January 1, 2010. As a result of the enrollment freeze, enrollment in Arizona's CHIP program has dropped from 45.8 thousand in January 2010 to approximately 2.3 thousand in February 2014. Source: Tricia Brooks, Martha Heberlein, and Joseph Fu, Georgetown University Health Policy Institute, Center for Children and Families, *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs*, May 2014.

- **Comprehensive risk-based managed care**—states contract with managed care plans to provide a comprehensive package of benefits to certain CHIP enrollees. States usually pay the managed care plans on a capitated basis, which means the states prospectively pay the managed care plans a fixed monthly rate per enrollee to provide or arrange for most health care services.
- **Primary care case management (PCCM)**—states contract with primary care providers to provide case management services to CHIP enrollees. Typically, under PCCM, the primary care provider receives a monthly case management fee per enrollee for coordination of care, but the provider continues to receive fee for service payments for the medical care services utilized by Medicaid enrollees.

A comparison of service delivery systems use in separate CHIP programs and CHIP Medicaid expansion programs from FY2010 showed that risk-based managed care was the predominant service delivery model for both separate CHIP and CHIP Medicaid expansion programs (**Table 2**). However, comprehensive risk-based managed care was more prevalent in separate CHIP programs than CHIP Medicaid expansion programs. In FY2010, separate CHIP programs used comprehensive risk-based managed care to cover 81% of the CHIP enrollees compared to 57% for CHIP Medicaid expansion programs.¹³ In the same year, PCCM was used to cover a larger percentage of children in CHIP Medicaid expansion programs than in separate CHIP programs with 22% of children in CHIP Medicaid expansion programs covered by PCCM and 5% of children in separate CHIP programs.¹⁴

Table 2. CHIP Enrollment, by Type of Program and Coverage
FY2010

	CHIP Medicaid Expansion Program		Separate CHIP Program		Total	
Comprehensive Risk-Based Managed Care	1,241,441	57%	4,503,711	81%	5,745,152	75%
Primary Care Case Management	450,253	21%	778,354	14%	1,228,607	16%
Fee for Service	474,256	22%	257,708	5%	731,964	9%
Total	2,165,950	100%	5,539,773	100%	7,705,723	100%

Source: Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2011, Table A-2.

An analysis by GAO about Medicaid managed care found a distinct difference between states that used the comprehensive risk-based managed care model as opposed to the PCCM model of managed care. GAO found that, in general, states with comprehensive risk-based managed care coverage had a higher concentration of low-income individuals living in urban areas, while states with greater PCCM coverage and no comprehensive risk-based managed care coverage generally had fewer individuals living in urban areas. GAO theorized that states with low concentration of low-income individuals living in urban areas

¹³ Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid*, June 2012.

¹⁴ Ibid.

may face challenges attracting comprehensive risk-based managed care plans due to concerns about establishing adequate provider networks or attracting sufficient enrollment. In addition, GAO found that states with a higher proportion of comprehensive risk-based managed care enrollment also typically had more managed care plans in the private market.¹⁵

Extent Managed Care Plans Offer Coverage in the Private Marketplace

States may design their CHIP programs in three ways: a CHIP Medicaid expansion program, a separate CHIP program, or a combination of both a CHIP Medicaid expansion program and a separate CHIP program. For CHIP Medicaid expansion programs, the CHIP children are covered in the same way as Medicaid children, while CHIP children in separate CHIP programs receive coverage different from children in Medicaid.

A survey of Medicaid programs found that 63% of Medicaid enrollees with comprehensive risk-based managed care coverage received that coverage through a plan that exclusively or primarily serves Medicaid enrollees (also known as a Medicaid-only plan) in FY2011.¹⁶ Of the 36 states that answered this question in the survey, 26 states had both Medicaid-only and mixed (i.e., a plan that serves both commercial and Medicaid populations) plans participating in their Medicaid managed care program. Five states had exclusively Medicaid-only plans and five states had exclusively mixed plans participating in their Medicaid managed care plans.¹⁷ Another study found that as of July 1, 2011, 43% of the comprehensive risk-based managed care plans participating in Medicaid were Medicaid-only plans.¹⁸

There is little information available on the managed care arrangements in separate CHIP programs, and few studies have researched how managed care operates in separate CHIP programs.¹⁹ However, one study researching Medicaid and CHIP managed care in 20 states focused on the types of managed care plans in the seven states in the study with CHIP comprehensive risk-based managed care programs that were part of separate CHIP programs. This study found that 57% of the plans participating in the separate CHIP programs for these seven states were comprehensive risk-based managed care plans that had public program enrollment only in 2010.²⁰

5. How does the current eligibility requirements of CHIP, Medicaid, and Exchange coverage affect whether or not parents and children have the same health coverage? Please provide illustrative examples of situations where a family may have members with different coverage, such as a child in CHIP and a parent with coverage in the Exchange.

¹⁵ Government Accountability Office, *Medicaid: States' use of managed care*, GAO-12-872R, August 17, 2012.

¹⁶ This figure includes total Medicaid enrollment not enrollment in CHIP Medicaid expansion programs. However, the same plans used for Medicaid are used for the CHIP Medicaid expansion programs.

¹⁷ Kathleen Gifford, Vernon K. Smith, and Dyke Snipes, et al., *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2011.

¹⁸ Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2013, Table 16.

¹⁹ Embry M. Howell, Ashley Palmer, and Fiona Adams, *Medicaid and CHIP Risk-Based Managed Care in 20 States*, Urban Institute, Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, July 2012; Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid*, June 2012.

²⁰ Ibid.

“Split-family” Coverage: Background

The ACA changed the health insurance coverage landscape through, among other things:

- the expansion of Medicaid up to 133% of the federal poverty level;²¹
- the creation of health insurance exchanges where certain individuals and businesses may purchase private health insurance;
- the creation of federal tax credits which eligible individuals may use towards paying premiums for insurance purchased through the exchanges;²²
- insurance market reforms; and
- the requirement that all individuals have minimum essential coverage whereby most individuals are required to maintain health insurance coverage or otherwise pay a penalty.²³

Within this new coverage landscape, there is the potential to provide a continuous source of subsidized coverage (of one sort or another) for lower-income individuals and families. However, in general, a person may be only eligible for one subsidized health coverage program (i.e., Medicaid, CHIP, or subsidized exchange coverage) at a time. As a result, it is possible for family members in the same household to be eligible for different health coverage programs (e.g., some in Medicaid, some in CHIP, and others in subsidized exchange coverage), and for their coverage to change over time. “Split-family” coverage, as it often called, is a result of different program eligibility requirements that take into account factors such as income, age, residency, disability status, immigration status, family composition, pregnancy status, duration of eligibility, other insurance coverage, and the availability of affordable employer-sponsored insurance for an individual and/or for his (or her) dependents. For example, children may be eligible for Medicaid or CHIP while their parents are not, because of different income eligibility thresholds for adults and children in a given state, or differences in citizenship status (e.g., all citizens, or a mix of citizens and noncitizens and citizens) among family members.

From the family’s perspective, “split family” coverage may mean that different family members will be subject to different plan coverage, provider networks, as well as benefit and cost structures.²⁴ Early work in this area (i.e., before the U. S. Supreme Court’s ruling in *National Federation of Independent Business v. Sebelius*) generated national estimates of the number of Medicaid or CHIP-eligible children with the potential for exchange-eligible parents.²⁵ Later estimates take into account state actions with regard to the

²¹ The ACA established 133% of the federal poverty level (FPL) (effectively 138% of FPL with an income disregard of 5% of FPL) as the new mandatory minimum Medicaid income eligibility level for most non-elderly individuals. On July 28, 2012, the U. S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for adults. For more information on the ACA Medicaid expansion, see CRS report R43564, *The ACA Medicaid Expansion*.

²² For a discussion about the premium credits and cost-sharing subsidies established under ACA, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

²³ For more information about the individual mandate, see CRS Report R41331, *Individual Mandate Under the ACA*.

²⁴ For example, families who are split between CHIP and exchange coverage would be subject to premiums and other cost-sharing associated with both programs. While each program has separate statutory limits on premiums based on family income and CHIP’s cost-sharing protections (i.e., aggregate cost-sharing under CHIP may not exceed 5% of annual family income) also take into consideration service-related cost-sharing, neither takes into account the effect of cost-sharing required by the other. This situation is often referred to as “premium stacking.”

²⁵ “In 2009, there were an estimated 15.7 million children living in this scenario. These children represent nearly 20 percent of all (continued...)”

take up of the ACA Medicaid expansion for non-elderly adults. According to GAO, “In 2012, we estimated that 21 percent of children eligible for Medicaid, CHIP, or the premium tax credit under PPACA would have different eligibility from their parents as of the beginning of the year, and an additional 9 percent would encounter that situation due to an income fluctuation during the course of the year.”²⁶

As per the Committee’s request, we are providing a description of key eligibility requirements across each of the ACA low-income subsidy programs (i.e., Medicaid, CHIP and subsidized exchange coverage), and examples of situations where a family is split across the ACA low-income subsidy programs. This response includes: (1) an example of what eligibility might look like for a family of four²⁷ with annual income at 150% of the federal poverty level based on the applicable eligibility rules across the low-income subsidy programs in 5 states (i.e., California, Louisiana, New Jersey, Pennsylvania, and Texas)²⁸ where *everyone* in the family is eligible for one of the ACA low-income subsidy programs in that state, and (2) two scenarios where given family members *do not* meet program eligibility requirements for one or more of the ACA low-income subsidy programs. In the later example, even though these individuals are in a family with annual income within the state’s income eligibility threshold for subsidized coverage—they cannot participate. These examples are not meant to be exhaustive, nor do they necessarily reflect the prevalence of these scenarios. They are intended to illustrate the impact that the program rules across the ACA low-income subsidy programs may have on a family in this income range.

Eligibility

Medicaid Eligibility

Eligibility for Medicaid is determined by both federal and state law, whereby states set individual eligibility criteria within federal standards. Individuals must meet both *categorical* (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain nonelderly childless adults) and *financial* (i.e., income and sometimes assets limits) criteria.²⁹ In addition, individuals need to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. States are permitted to apply to CMS for a waiver of federal law to expand health

(...continued)

U.S. children and more than one-third of Medicaid/CHIP eligible children.” Source: Stacey McMorrow, Genevive M. Kenny, and Christine Coyer; *Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas*; Urban Institute; May 2012.

²⁶ See U.S. Government Accountability Office (GAO); *Opportunities Exist for Improved Access to Affordable Insurance*; June 2012. See also, Carolyn L. Yocum, U.S. Government Accountability Office (GAO); *Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives; Children’s Health Insurance: Cost, Coverage and Access Considerations for Extended Federal Funding*, December 3, 2014.

²⁷ In this example, the family of four includes an infant, a non-disabled 8-year-old child, a pregnant mother and a father.

²⁸ These five states were chosen because their program eligibility policies represent a range of allowable policy options (e.g., decision to take up the ACA Medicaid expansion, diversity of upper income eligibility levels across programs and groups, differences in CHIP program design, differences in eligibility for pregnant women) that result in a diversity of outcomes in terms of the number of low-income subsidy programs that the family might be eligible for.

²⁹ Some groups, such as young people under the age of 26 who have aged out of foster care, are eligible for Medicaid coverage without regard to the youths’ income and assets.

coverage beyond the mandatory and optional groups listed in federal statute.³⁰ Medicaid eligibility must be redetermined at least annually.

If a state participates in Medicaid, the following are examples of groups that *must* be provided Medicaid coverage:

- low-income families that meet the financial requirements (based on family size) of the former Aid to Families with Dependent Children (AFDC) cash assistance program;
- pregnant women and children through age 18 with family income at or below 133% of the federal poverty level (FPL);³¹
- low-income individuals who are age 65 and older, or blind, or who are under age 65 and disabled who qualify for cash assistance under the Supplemental Security Income (SSI) program;
- recipients of adoption assistance and foster care (who are under age 18) under Title IV–E of the Social Security Act;
- certain individuals who age out of foster care, up to age 26, and do not qualify under other mandatory groups noted above; and
- certain groups of legal permanent resident immigrants (e.g., refugees for the first seven years after entry into the United States; asylees for the first seven years after asylum is granted; lawful permanent aliens with 40 quarters of creditable coverage under Social Security; immigrants who are honorably discharged U.S. military veterans) who meet all other financial and categorical Medicaid eligibility requirements.³²

Examples of groups that states *may* provide Medicaid to include:

- pregnant women and infants with family income between 133% and 185% of the FPL;

³⁰Under Section 1115 of the Social Security Act, the Secretary of HHS may waive Medicaid requirements contained in Section 1902 (including, but not limited to, what is known as “freedom of choice” of provider, “comparability” of services, and “statewideness”). States use this waiver authority to change eligibility criteria in order to offer coverage to new groups of people, to provide services that are not otherwise covered, to offer different service packages or a combination of services in different parts of the state, to cap program enrollment, and to implement innovative service delivery systems, among other purposes.

³¹ The poverty guidelines (also referred to as the federal poverty level) are a version of the federal poverty measure. They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes—for instance, determining financial eligibility for certain federal programs. In FY2014, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$23,850, in Alaska \$29,820 and in Hawaii \$27,430. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), *2014 Poverty Guidelines*, available at <http://aspe.hhs.gov/poverty/14poverty.cfm>.

³² Prior to the enactment of the Children’s Health Insurance Act of 2009, (CHIPRA, P.L. 111-3), legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years in the United States. With the enactment of CHIPRA, states are permitted to waive the five-year bar to Medicaid or CHIP coverage for pregnant women and children who arrived in the United States after August 22, 1996 and who are (1) lawfully residing in the United States and (2) are otherwise eligible for such coverage when certain requirements are met. Twenty-five states have opted to cover otherwise five-year barred children, and 20 states have opted to cover five-year barred pregnant women. Source: Hasstedt, K.; Guttmacher Policy Review; *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*; vol. 16, no. 1; pp 2–8; 2013. For more recent information on state take up of the five-year bar state plan option, see Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates and Robin Rudowitz and Laura Snyder, Kaiser Family Foundation, *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, October 2014.

- certain individuals who qualify for nursing facility or other institutional care and have incomes up to 300% of SSI benefit level, referred to as “the 300 percent rule”;
- “medically needy” individuals who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability, or are in families with children), but do not meet the applicable income requirements and, in some instances, assets requirements for those eligibility pathways;³³
- working people with disabilities, and
- nonelderly adults who otherwise are not eligible for Medicaid with income at or below 133% of FPL (i.e., the ACA Medicaid expansion).

CHIP Eligibility

In general, CHIP extends coverage to certain low-income children and pregnant women without health insurance in families with annual family income too high to qualify them for Medicaid. Specifically, Title XXI of the SSA defines a targeted low-income child as one who is under age 19 with no health insurance,³⁴ and who would not have been eligible for Medicaid under the federal and state rules in effect when CHIP was first initiated in 1997.³⁵ States have broad discretion in setting their income eligibility standards, and eligibility varies across states.

Child Eligibility in CHIP Medicaid Expansion Programs

Because CHIP eligibility builds on top of Medicaid eligibility, the Medicaid child eligibility rules that were in effect when CHIP was established in 1997 represent the Medicaid eligibility ceiling for children.³⁶ States with CHIP Medicaid expansion programs may cover CHIP children by expanding their Medicaid programs in the following ways: (1) by establishing a new optional eligibility group for such children as authorized in Title XXI of SSA, and/or (2) by liberalizing the financial rules for any of several existing Medicaid eligibility categories.³⁷ Regardless of the state’s approach, CHIP children are an optional eligibility group in Medicaid and enrollees must be covered statewide.

Child Eligibility in Separate CHIP Programs

States are permitted to determine the eligibility criteria for the group of CHIP children who may enroll in separate CHIP programs.³⁸ Title XXI of the SSA allows states to use the following factors in determining eligibility: geography (e.g., sub-state areas or statewide), age (e.g., subgroups under 19), income,

³³ For these groups, states are required to allow individuals to spend down to the medically needy income standard by incurring and paying medical expenses.

³⁴ States are permitted to require a period of uninsurance (i.e., waiting period) of up to 90 days before a child who is otherwise eligible is permitted to enroll in CHIP. See 78 *Federal Register* 42160, July 15, 2013.

³⁵ Section 2110(b) of the Social Security Act.

³⁶ Federal Medicaid statute establishes mandatory coverage floors (defined as a percentage of the federal poverty level) for its poverty-related pregnant women and children eligibility groups. States are permitted to extend coverage above these federal minimum thresholds which is why there is variability across states in terms of the income eligibility threshold at which CHIP begins.

³⁷ As of January 1, 2014, states are no longer permitted to expand eligibility standards to higher income levels through the adoption of income disregards. Section 1902(e)(14)(B) of the Social Security Act.

³⁸ Section 2102(b) of the Social Security Act.

residency, disability status (so long as any standard relating to disability status does not restrict eligibility),³⁹ access to or coverage under other health insurance (to establish whether such access/coverage precludes CHIP eligibility),⁴⁰ and duration of CHIP eligibility (states must re-determine eligibility at least annually).⁴¹

States can set the upper income level for CHIP children up to 200% of the federal poverty level (FPL), or 50 percentage points above the applicable pre-CHIP Medicaid income level. However, prior to January 1, 2014, states were able to use income disregards,⁴² which effectively permitted states to expand eligibility to children under age 19 at whatever level they chose. Two states, New Jersey, and New York, plus one California county used this income-counting methodology⁴³ to expand their CHIP programs to 355% FPL, 405% FPL, and 416% FPL, respectively.⁴⁴ The income-disregard option was eliminated under the ACA.⁴⁵ Under the ACA, states are permitted to use CHIP federal matching funds to cover children who lose Medicaid eligibility as a result of the elimination of income disregards,⁴⁶ and the ACA required states to transition CHIP children ages 6 through 18 in families with annual income less than 133% FPL to Medicaid, beginning January 1, 2014—these children are often referred to as “stair step children.”⁴⁷ As a

³⁹ States are permitted to offer different benefit packages for children with special needs, as long as the eligibility criteria for that coverage comply with the Americans with Disabilities Act (ADA) requirements for non-discrimination. Source: *The Administration's Responses to Questions About the State Children's Health Insurance Program*, July 29, 1998, Fifth Set.

⁴⁰ A CHIP child must not be found eligible for Medicaid, or other group health coverage, for example. See 42 C.F.R. §457.310.

⁴¹ States are permitted to continue coverage for CHIP-eligible children for a period of 12 months regardless of changes in family composition or income that may otherwise affect their eligibility status. While no explicit statutory authority for 12 months of continuous coverage currently exists in CHIP statute, HHS reports that 33 states provided 12 months of continuous coverage to CHIP children in FY2012. Source: Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2013.

⁴² Income disregards (including block of income disregards) and deductions effectively increase the amount of income a child's family can have and still be eligible for coverage, as they serve to eliminate from a family's countable income certain expenses, costs or amounts of income.

⁴³ Medicaid and CHIP financial eligibility requirements place limits on the maximum amount of income (and sometimes assets) individuals may possess to become eligible (often referred to as standards or thresholds). Additional guidelines specify how states should calculate these amounts (i.e., counting methodologies).

⁴⁴ Under the State Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), new states (in addition to California, New Jersey, and New York) were discouraged from expanding CHIP income eligibility through a policy that required a reduction in federal CHIP payments for coverage of children in families with income above 300% FPL. CHIPRA also included other provisions to provide financial incentives to states to find and enroll Medicaid eligible children at lower income levels through the use of CHIP Performance Bonus Payments. These payments were directed at states that adopted 5 out of 8 enrollment facilitation strategies and that successfully enrolled Medicaid-eligible children over target enrollment levels. These bonus payments expired at the end of FY2013.

⁴⁵ The ACA required states to transition to a new income counting rule based on the IRS' Modified Adjusted Gross Income (MAGI). Under the transition to MAGI, states were given a limited opportunity to expand CHIP eligibility above 200% of the FPL (not to exceed 300% FPL) using the old income counting rules by submitting a state plan amendment (SPA) before December 31, 2014.

⁴⁶ States must provide coverage through a separate CHIP program to children who lose Medicaid as a result of the elimination of income disregards permitted under Section 2101(f) of the ACA. Coverage for this population will be paid for out of the state's CHIP allotment at the CHIP enhanced match rate and will cease when the last child protected has been afforded 12 months of coverage (expected to be no later than April 1, 2016). While coverage of children protected by 2101(f) is mandated through a separate CHIP program, states may instead continue to provide coverage of these children in the state's Medicaid program. However, if a state chooses the option to maintain Medicaid eligibility for such children, funds through Title XIX of SSA and regular FMAP rates will apply. Sources: Centers for Medicare and Medicaid Services, *Medicaid/CHIP Affordable Care Act Implementation: Children's Health Insurance Program (CHIP) coverage for children who lose Medicaid eligibility due to the elimination of income disregards as a result of the conversion to MAGI. Section 2101(f) of the Affordable Care Act: Answers to Frequently Asked Questions*; April 25, 2013; and *CMS Answers to Frequently Asked Questions: Telephonic Applications, Medicaid and CHIP Eligibility Policy and 75/25 Federal Matching Rate*, August 9, 2013, December 31, 2013.

⁴⁷ Coverage for such children will continue to be paid for out of the state's CHIP annual allotment at the enhanced CHIP (continued...)

result of these CHIP program eligibility rules, statewide upper income eligibility thresholds for CHIP-funded child coverage vary substantially across states, ranging from a low of 175% FPL to a high of 405% FPL.

CHIP Eligibility for Pregnant Women and Unborn Children

In FY2014, nineteen states provided coverage to pregnant women under CHIP. The three main ways that states may extend CHIP coverage to pregnant women (regardless of their age) are through (1) the state plan option for pregnant women; (2) the Section 1115 waiver authority and/or (3) the unborn child pathway.⁴⁸ The latter is the predominant pathway used by states for this purpose. As of January 2014, four states (Colorado, New Jersey, Oregon, and Rhode Island) extended coverage to pregnant women under Section 1115 waiver authority or the CHIP pregnant women state plan option.⁴⁹ Under CHIPRA, states are permitted to cover pregnant women through a state plan amendment when certain conditions are met (e.g., the Medicaid income standard for pregnant women must be at least 185% FPL but in no case lower than the percentage level in effect on July 1, 2008; no preexisting conditions or waiting periods may be imposed; and CHIP cost-sharing protections apply). The period of coverage associated with the state plan option includes pregnancy through the postpartum period (roughly through 60 days postpartum). Infants born to such pregnant women are deemed eligible for Medicaid or CHIP, as appropriate, and are covered up to age one year.

Eligibility for Subsidized Exchange Coverage

Health insurance exchanges operate in every state and the District of Columbia (DC), per the ACA statute.⁵⁰ Exchanges are not insurance companies; rather, they are “marketplaces” that offer private health plans to qualified individuals⁵¹ and small businesses.⁵² Given that ACA specifically requires exchanges to

(...continued)
matching rate.

⁴⁸ Prior to the enactment of CHIPRA, legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years in the United States. With the enactment of CHIPRA, states are permitted to waive the five-year bar to Medicaid or CHIP coverage for pregnant women and children who arrived in the United States after August 22, 1996 and who are (1) lawfully residing in the United States and (2) are otherwise eligible for such coverage when certain requirements are met. Twenty-five states have opted to cover otherwise five-year barred children, and 20 states have opted to cover five-year barred pregnant women. Source: Hasstedt, K.; Guttmacher Policy Review; *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*; vol. 16, no. 1; pp 2–8; 2013. For more recent information on state take up of the five-year bar state plan option, see Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates and Robin Rudowitz and Laura Snyder, Kaiser Family Foundation, *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, October 2014.

⁴⁹ Medicaid and CHIP Payment and Access Commission, Report to Congress on Medicaid and CHIP, March 2014, Table 9, pp 80-82.

⁵⁰ See Kaiser Family Foundation, *State Health Insurance Marketplace Decisions*, January 27, 2014, at <http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/>. ACA §1323 allowed U.S. territories to choose to either establish an exchange or not; as of the date of this response, no territory opted to establish an exchange.

⁵¹ Enrollment in an exchange plan is voluntary; see §1312(d)(3) of ACA. The voluntary nature of exchange enrollment also applies to Members of Congress and their personal staff, who may be offered by the federal government only coverage created under the ACA or offered through an exchange, per ACA§1312(d)(3)(D). In other words, although the federal government may make only certain health coverage available to applicable Members and staff, such individuals retain their right to enroll in any coverage that may be available to them (e.g., a private employer’s health plan offered to the Member’s spouse). For a comprehensive discussion about these issues, see CRS Report R43194, *Health Benefits for Members of Congress and Certain Congressional Staff*.

offer insurance options to individuals and small businesses, exchanges are structured to assist these two different types of “customers.” Consequently, there is an exchange to serve individuals and families, and another to serve small businesses (“SHOP exchanges”), within each state.⁵³

Certain enrollees in the *individual* exchanges are eligible for premium assistance in the form of federal tax credits.⁵⁴ Such credits are not provided through the SHOP exchanges. The premium credit is an advanceable, refundable tax credit, meaning tax filers need not wait until the end of the tax year to benefit from the credit, and they may claim the full credit amount even if they have little or no federal income tax liability.

To be eligible for a premium credit through an individual exchange, a person (or family) must:

- have a household income (based on Modified Adjusted Gross Income (MAGI) between 100%⁵⁵ and 400% of the federal poverty level (FPL), with an exception,⁵⁶
- *not* be eligible for “minimum essential coverage”⁵⁷ (such as Medicaid,⁵⁸ Medicare, or an employer-sponsored plan that meets certain requirements),⁵⁹ other than through the individual health insurance market;
- be enrolled in an exchange plan; and
- be part of a tax-filing unit.⁶⁰

(...continued)

⁵² Before 2016, states will have the option to define “small employers” either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, large groups may participate in exchanges, at state option.

⁵³ ACA gives states the option to merge both exchanges and operate them under one structure.

⁵⁴ For additional information about ACA’s premium tax credits, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

⁵⁵ Given that the ACA Medicaid expansion is a state option, it leaves open the possibility that, as of 2014, certain individuals with incomes less than 100% FPL will not be eligible for either Medicaid or premium credits.

⁵⁶ An exception is made for lawfully present aliens with income below 100% FPL who are ineligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% FPL for purposes of the premium credit.

⁵⁷ The definition of minimum essential coverage is broad. It generally includes Medicare Part A; Medicaid; the State Children’s Health Insurance Program (CHIP); TRICARE; the TRICARE for Life program, a health care program administered by the Department of Veteran’s Affairs; the Peace Corps program; a government plan (local, state, federal), including the Federal Employees Health Benefits Program (FEHBP); any plan established by an Indian tribal government; any plan offered in the individual, small-group, or large-group market; a grandfathered health plan; and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.

⁵⁸ Certain individuals are eligible only for limited benefits under Medicaid. The IRS has promulgated regulations on whether or not it treats limited benefit Medicaid coverage as minimum essential coverage (MEC). (For a list of Medicaid limited benefits identified in relevant IRS rules, see the Appendix in CRS Report R41331, *Individual Mandate Under ACA*.) In the final regulation on non-compliance with ACA’s individual mandate, the IRS stated that certain limited benefit coverage under Medicaid would not be considered MEC in 2014 (78 *Federal Register* 53646, August 30, 2013). Individuals eligible for such coverage may still be able to access premium tax credits, assuming they meet all other eligibility requirements. Moreover, the IRS issued a proposed rule on MEC which identified other limited benefit Medicaid coverage as not meeting the definition of MEC (78 *Federal Register* 4302, January 27, 2014).

⁵⁹ Individuals who are offered health coverage through an employer may be eligible for the premium tax credit if the employer coverage does not meet affordability (employer-sponsored insurance is considered affordable if employees’ premiums contributions for self-only coverage comprise less than 9.5% of family income) and adequacy (standards). For a discussion of those standards, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*.

The Individual Mandate

Beginning in 2014, ACA requires most individuals to maintain health insurance coverage that meets a minimum set of standards or otherwise pay a penalty.⁶¹ Certain individuals are exempt from the individual mandate. For example, individuals with qualifying religious exemptions and those for whom health insurance coverage is “unaffordable” will not be subject to the mandate or its associated penalty. Individuals who do not maintain health insurance coverage and are not exempt from the mandate will have to pay a penalty for each month of noncompliance. The penalty is assessed through the federal tax filing process; any penalty that taxpayers are required to pay for themselves or their dependents must be included in their return for that taxable year.

Examples of “Split Family” Coverage

As per the Committee’s request, we were asked to provide illustrative examples of situations where a family may have members with different coverage. What follows are examples of what eligibility might look like for a family of four (i.e., an infant, a non-disabled 8-year-old child, a pregnant mother, and a father) with annual income at 150% of the federal poverty level in each of 5 states, including California, Louisiana, New Jersey, Pennsylvania, and Texas.⁶² In the first example, we assume that each family member meets the applicable eligibility requirements for the relevant ACA low-income subsidy program. This assumption allows us to examine how eligibility may change based on the applicable upper income eligibility levels across the low-income subsidy programs in these 5 states.

In a second example, we provide two scenarios where a given family member (or members) *does (do) not* meet program eligibility requirements for one (or more) of the low-income subsidy programs, and thus even though the family has annual income that is generally within the range of subsidized coverage—the individual cannot participate. Families at this income range are less likely to have access to employer-sponsored insurance, and thus this (these) individual(s) may be uninsured.⁶³ These examples are not meant to be exhaustive, nor do they necessarily reflect the prevalence of these scenarios. They are intended to illustrate the impact that the program rules across the ACA low-income subsidy programs may have on a family in this income range.

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⁶⁰Since the premium tax credits are administered through the individual income tax filing process, credit recipients are required to file federal tax returns, even if they do not have federal tax liability.

⁶¹ For more information about the individual mandate, see CRS Report R41331, *Individual Mandate Under the ACA*.

⁶² These five states were chosen because their program eligibility policies represent a range of allowable policy options (e.g., decision to take up the ACA Medicaid expansion, diversity of upper income eligibility levels across programs and groups, differences in CHIP program design, differences in eligibility for pregnant women) that result in a diversity of outcomes in terms of the number of low-income subsidy programs that the family might be eligible for. For example, California, New Jersey and Pennsylvania have taken up the ACA Medicaid expansion, and Louisiana and Texas have not.

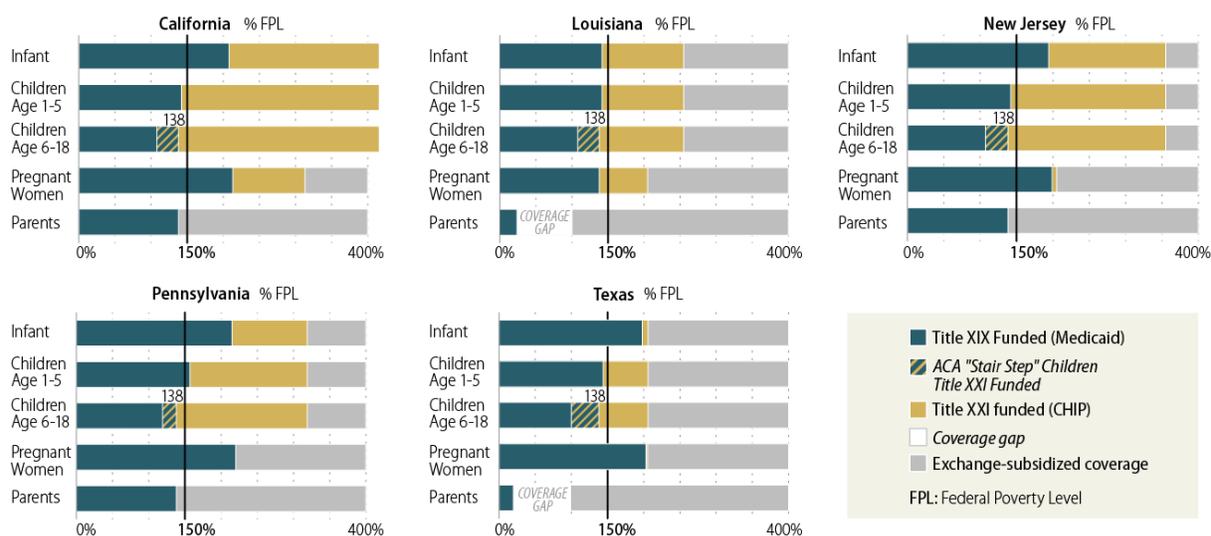
⁶³ For more information on the access to private insurance coverage among low-income children in CHIP, see Mathematica Policy Research, *CHIPRA Mandated Evaluation of the Children’s Health Insurance Program: Final Findings*, August 1, 2014.

Example 1: All Family Members are Eligible for at Least One Low-Income Subsidy Program

Figure 1 shows upper income eligibility levels for infants, children age 1 through 5, children age 6 through 18, pregnant women and parents in Medicaid, CHIP, and subsidized exchange coverage in 5 states (California, Louisiana, New Jersey, Pennsylvania, and Texas), as of January 1, 2014.⁶⁴

Figure 1. Selected Upper Income Eligibility Levels for Infants, Children Age 1 through 5, Children Age 6 through 18, Pregnant Women, and Parents as a Percentage of the Federal Poverty Level in Medicaid, CHIP and Subsidized Exchange Coverage

As of January 1, 2014



Source: CRS figure based on Medicaid and CHIP Payment and Access Commission; *Report to Congress on Medicaid and CHIP, March 2014*; MACStats; Tables 9 and 10.

Notes: Upper income levels (%FPL) represent the highest income eligibility threshold available in the state, and include the 5% disregard (which the law provides as a standard disregard).

It is important to note that CHIP coverage is limited to uninsured children, so children who have health insurance coverage and fall into the income eligibility range shown for CHIP are nonetheless not CHIP eligible due to their insurance status.

“Stair-step” children refer to children age 6 through 18 who were transitioned from separate CHIP programs to Medicaid under the ACA. Such children are considered Medicaid eligible, although their coverage is paid for out of the state’s CHIP annual allotment and matched at the CHIP enhanced FMAP (E-FMAP) rate.

In one county in California, CHIP coverage for children extends to a higher income eligibility threshold than subsidized exchange coverage (i.e., 416% of FPL).

Pennsylvania implemented the ACA Medicaid expansion for non-elderly adults up to 133% FPL (effectively 138% FPL with the 5% income disregard that the law allows). Medicaid eligibility rules for the parent coverage expansion have been added here to reflect this recent state action.

⁶⁴ Pennsylvania implemented its ACA Medicaid expansion for non-disabled adults as of January 1, 2015. The state’s ACA Medicaid expansion is shown in Figure 1.

In FY2014, the HHS poverty guidelines for a family of 4 in the 48 contiguous states was \$23,850, in Alaska \$29,820 and in Hawaii \$27,430. Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), 2014 Poverty Guidelines, available at: <http://aspe.hhs.gov/poverty/14poverty.cfm>.

FPL: Federal Poverty Level

In general, variability exists in the income eligibility ranges (i.e., income eligibility floors and ceilings) associated with each of the ACA low-income subsidy programs. The federal Medicaid statute establishes mandatory coverage floors (defined as a percentage of the federal poverty level) for its poverty-related pregnant women and children eligibility pathways. However, states are permitted to extend Medicaid coverage above these federal minimum levels; this is why there is variability across states in terms of the income eligibility levels at which CHIP begins. For example, the state of New Jersey extends Medicaid eligibility to infants in families with annual income less than or equal to 194% FPL, while the state of Pennsylvania extends Medicaid eligibility to infants in families with annual income less than or equal to 215% FPL. In another example, CHIP coverage for children extends to a higher income eligibility threshold than subsidized health insurance exchange coverage in one county in California (i.e., 416% FPL).

Figure 1 shows both the range of CHIP income eligibility relative to the other programs, and how the programs are envisioned to work together in extending coverage to low-income children and families. CHIP in Texas, for example, covers a relatively small segment of the income eligibility continuum while CHIP in California, New Jersey and Pennsylvania cover a larger segment of the continuum.⁶⁵ This is particularly true for infants and pregnant woman. In general, states have used the optional Medicaid eligibility pathways to set higher Medicaid income eligibility levels for infants and pregnant women relative to older children. As a result, CHIP has been used to provide health coverage to older uninsured children to a greater extent.

The vertical purple line in **Figure 1** represents 150% of the federal poverty level, and shows what eligibility across low-income subsidy programs might look like for a family of four with annual income at this level in each of the 5 states. In this example, the family of four includes an infant, a non-disabled 8-year-old child, a pregnant mother, and a father, all of whom otherwise meet the applicable eligibility requirements for the relevant ACA low-income subsidy program in that state.

Based on this example, in California, Pennsylvania and Texas family coverage would be similarly split across three low-income subsidy programs (i.e., Medicaid for the infant and pregnant mother, CHIP for the non-disabled 8-year-old child, and subsidized exchange coverage for the father). In Louisiana, family coverage would be split across two low-income subsidy programs (i.e., CHIP for the children and pregnant mother, and subsidized exchange coverage for the father). In New Jersey, family coverage would also be split across three low-income subsidy programs, however, CHIP would cover two of these individuals (i.e., Medicaid for the infant, CHIP for the non-disabled 8-year-old and pregnant mom, and subsidized exchange coverage for the father).

⁶⁵ This figure, however, is not weighted to reflect program enrollment by state. For example, it is possible that a state with a large uninsured child population but a CHIP program with a relatively narrow income eligibility range may result in a much larger number of CHIP program enrollees than a state with a relatively small uninsured child population and a CHIP program with a much broader income eligibility range. For example, in Texas, the CHIP eligibility range appears small by comparison to the CHIP eligibility range in Louisiana. However, in FY2013, CMS administrative data show CHIP child enrollment totaling approximately 1 million in Texas as compared to approximately 150,000 in Louisiana.

Example 2: At Least One Family Member is Ineligible for one of the Low-Income Subsidy Programs

It is important to note that not all individuals with family income within the ranges covered by the ACA low-income subsidy programs are eligible due to program rules that differ for each of these programs. For instance, CHIP is only available to uninsured children, subsidized exchange coverage is generally not available to individuals with access to minimum essential coverage, and insurance status is not considered when determining Medicaid eligibility. The following scenarios provide examples where a given family member (or members) in our family of four does (do) not meet program eligibility requirements for one (or more) of the low-income subsidy programs, and thus even though the family has annual income that is generally within the income eligibility thresholds for subsidized coverage—the individual cannot participate.

Scenario 1: Mix of Citizenship Status across Family Members

In this scenario, the infant in our family of four with annual income at 150% of the federal poverty level was born in the United States, the 8-year-old nondisabled child and pregnant mother are considered to be lawfully residing in the United States within the 5-year bar, and the father is undocumented. Based on the eligibility rules associated with citizenship status⁶⁶ in each of California, Louisiana, New Jersey, Pennsylvania, and Texas, the family would likely be split across two low-income subsidy programs, with one (or more) family members ineligible for at least one program depending on the state. In California and Pennsylvania, the infant and the pregnant mother would be eligible for Medicaid, the 8-year-old would be eligible for CHIP, and the father would be ineligible for coverage under any of the ACA low-income subsidy programs. In Louisiana, the infant and the pregnant mother (through the CHIP unborn child pathway) would be eligible for CHIP, but the 8-year old child and father would be ineligible for coverage under any ACA low-income subsidy programs. In New Jersey and Texas, the infant would be eligible for Medicaid, and the 8-year old child and pregnant mother would be eligible for CHIP (via the 5-year bar state plan option in New Jersey and the unborn child pathway in Texas), and the father would be ineligible for coverage under any ACA low-income subsidy programs.

Scenario 2:

In this scenario, our family of four has the same make up of an infant, an 8 year-old nondisabled, child, a pregnant mother, and a father, but the family's annual income is 95% of the federal poverty level. Under this scenario, the state's take up of the ACA Medicaid expansion becomes relevant because, in general, individuals are only eligible for subsidized exchange coverage if they have annual income between 100% and 400% of the federal poverty level (FPL).

Based on this scenario, in California, New Jersey and Pennsylvania the entire family would be eligible for the Medicaid program. In Louisiana and Texas, everyone but the father would be eligible for Medicaid. In these states, the father may be uninsured because he is not eligible for Medicaid and/or subsidized coverage under the exchanges, and purchase of private health insurance coverage through the exchange or otherwise would likely be very costly relative to family income.

⁶⁶ Hasstedt, K.; Guttmacher Policy Review; *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*; vol. 16, no. 1; pp 2–8; 2013.

Questions from the Honorable Frank Pallone, Jr.:

1. Sometimes we hear people criticize Medicaid and even CHIP, as being a “government run” program. While the federal government provides financial support and broad parameters, states have a lot of flexibility to design their programs. Do you agree?

States have a fair amount of flexibility to design their Medicaid and CHIP programs. First, participation in both programs is voluntary. However, all states, the District of Columbia, and the territories participate. Both programs are federal and state matching programs. States must follow broad federal rules in order to receive federal matching funds, but have flexibility to design their own version of Medicaid and CHIP within the federal statute’s basic framework. This flexibility results in variability across state Medicaid and CHIP programs.

Each state has a Medicaid and CHIP state plan that describes how the state will administer its programs. States submit these state plans to the federal Centers for Medicare & Medicaid Services (CMS) for approval. States that wish to go beyond what the law allows must seek approval from the Secretary of Health and Human Services under various waiver authorities.⁶⁷

While program flexibilities exist, some state health officials have the view that more flexibility is required. One common argument is that, under the current Medicaid financing structure it is difficult to control program costs especially during times of economic constraint when states typically see increases in program enrollment at the same time they see decreases in state revenues. Others suggest that states have less flexibility than it would appear since some of Medicaid’s optional services (e.g., prescription drug coverage) are not really optional in today’s world of medicine.

Table 3 summarizes some of the key program features that shape these programs, and highlights some of the flexibilities that states have in designing Medicaid and CHIP.

⁶⁷ The Social Security Act authorizes several waiver and demonstration authorities to provide states with the flexibility to operate their Medicaid programs. Each waiver authority has a distinct purpose and specific requirements. Under the various waiver authorities, states may try new or different approaches to the delivery of health care services or adapt their programs to the special needs of particular geographic areas or groups of Medicaid enrollees. The primary Medicaid waiver authorities include: Section 1115 Research and Demonstration Projects; Section 1915(b) Managed Care/Freedom of Choice Waivers; Section 1915(c) Home- and Community-Based Services Waivers (HCBS); and Section 1915(b) and (c) Waivers. The Section 1115 waiver authority also applies to CHIP.

Table 3. Flexibility Available to States Across Selected Program Features Between Medicaid, CHIP Medicaid Expansion Programs, and Separate CHIP Programs

Program Feature	Medicaid	CHIP	
		Medicaid Expansion	Separate Program
Program Design			
		States may cover eligible children under their Medicaid programs, create a separate CHIP program, or adopt a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. State choices for program design impact the coverage that enrollees receive.	
	Medicaid rules (Title XIX of SSA) typically apply.	Medicaid rules (Title XIX of SSA) typically apply.	Title XXI of SSA rules typically apply.
Eligibility			
Who is eligible?	Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain nonelderly childless adults) and financial (i.e., income and sometimes assets limits) criteria. In addition, individuals need to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. In general, Medicaid eligibility groups must be covered statewide.	CHIP extends coverage to certain low-income children and pregnant women without health insurance in families with annual family income too high to qualify them for Medicaid. CHIP children are an optional eligibility group in Medicaid and enrollees must be covered statewide.	Eligibility may vary based on geography, age, annual family income, residency, disability status, access to other health insurance, and duration of CHIP eligibility.
Entitlement nature	Individual entitlement.	Individual entitlement.	Not an individual entitlement.

Program Feature	CHIP		
	Medicaid	Medicaid Expansion	Separate Program
Implications of the ACA child maintenance of effort (MOE) requirement	States must maintain their child eligibility standards, methodologies, and procedures through September 30, 2019.	When federal CHIP funding is exhausted, CHIP Medicaid expansion children must continue to be enrolled in Medicaid through September 30, 2019, but the financing switches from CHIP to Medicaid.	States with separate CHIP programs are provided with exceptions to the MOE. When federal CHIP funding is exhausted, states must establish procedures to screen and enroll eligible children in Medicaid. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the Secretary of Health and Human Services to be “at least comparable” to CHIP in terms of benefits and cost sharing. If there are no certified plans, the MOE does not obligate states to provide coverage to these children.
Benefits	Benefits vary by population group and include a wide range of primary, preventive, and acute medical services as well as long-term services and supports (LTSS).	Regardless of program design, states must cover emergency services, well baby and well child care including age appropriate immunizations, and dental services. If offered, mental health services must meet federal mental health parity requirements.	

Program Feature	Medicaid	CHIP	
		Medicaid Expansion	Separate Program
Traditional Medicaid	<p>States define the specific features of each covered benefit within broad federal guidelines.</p> <p>Each service must be sufficient in “amount, duration, and scope” to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity.</p> <p>Within a state, services available to the various categorically needy groups must be equal in amount, duration, and scope (i.e., the “comparability” rule).</p> <p>With certain exceptions, the amount, duration, and scope of benefits must be the same statewide. (i.e., the “statewideness” rule).</p> <p>With certain exceptions, enrollees must have “freedom of choice” among health care providers or managed care entities participating in Medicaid.</p> <p>States are required to cover certain mandatory benefits (e.g., inpatient hospital services, physician services, EPSDT for children <21); others (e.g., prescribed drugs and clinic services) are available at state option.</p>	<p>Follows Medicaid program rules. CHIP children are entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage, which effectively eliminates any state-defined limits on the amount, duration, and scope of any benefit listed in Medicaid statute.</p> <p>Must provide the full range of mandatory Medicaid benefits, as well as all optional services that the state chooses to cover as specified in their state Medicaid plans.</p>	<p>States have more latitude in designing their benefit coverage. States are permitted to elect any of three benefit options: Benchmark benefit package, Benchmark-equivalent coverage; or Secretary-approved coverage.</p> <p>NA</p>

Program Feature	Medicaid	CHIP	
		Medicaid Expansion	Separate Program
Alternative Benefit Plans (ABPs)	ABPs must cover 10 essential health benefits that include preventive care, mental health services, prescribed drugs, rehabilitative services, FQHC services, EPSDT for children <21, family planning services and supplies, and non-emergency medical transportation .	ABP coverage available at state option and must follow the requirements specified under the Medicaid program.	NA
Cost-sharing			
	<p>In general, premiums and enrollment fees are often prohibited. However, premiums may be imposed on certain enrollees, such as individuals with incomes above 150% of FPL, certain working people with disabilities, and certain children with disabilities.</p> <p>States can impose service-related cost-sharing, such as copayments on most Medicaid-covered benefits up to federal limits that vary by income. Some subgroups of beneficiaries are exempt from cost sharing (e.g., children under 18 years of age and pregnant women).</p> <p>The aggregate cap on all out-of-pocket cost-sharing is generally up to 5% of monthly or quarterly income.</p>	Premiums and cost-sharing are generally prohibited for CHIP children under age 18.	In general, premiums and cost-sharing may be imposed. Allowable amounts are dependent on annual family income and are subject to an out-of-pocket aggregate limit of 5% of annual family income.
Financing			
Entitlement Nature	Open-ended entitlement.	Capped entitlement to states appropriated through FY2015.	Capped entitlement to states appropriated through FY2015.
Federal matching rate	Based on Federal Medical Assistance Percentage (FMAP) Rate.	Based on Enhanced-Federal Medical Assistance Percentage (E-FMAP) Rate.	Based on Enhanced-Federal Medical Assistance Percentage (E-FMAP) Rate.

Source: CRS analysis of Titles XIX and XXI of the Social Security Act.

2. Isn't it true that most of the coverage provided under both Medicaid and CHIP is provided through private insurance companies, either HMOs or some other arrangement?

Managed care is the predominant delivery model for both Medicaid and CHIP, especially for children. Most of this managed care covered is provided through comprehensive risk-based managed care, and under this model states contract with managed care plans (i.e., private health insurance companies) to provide a comprehensive package of benefits to Medicaid and CHIP enrollees. The primary reasons states provide for choosing managed care include promoting care management and care coordination, increasing cost-predictability, reducing costs, and improving access to care.⁶⁸

Managed Care in Medicaid

Traditionally, states provided Medicaid coverage on a fee for service basis, which means Medicaid enrollees independently identify health care providers that will accept Medicaid enrollees and the state pays the providers directly. Some states adopted Medicaid managed care during the early 1980s, but most states waited until the 1990s to use managed care for their Medicaid programs. Throughout the 1990s, managed care grew to become the dominant form of health care delivery for Medicaid.⁶⁹

The growth in Medicaid managed care enrollment has continued, and on July 1, 2011, almost 72% of Medicaid enrollees were covered by some type of managed care with 50% of Medicaid enrollees covered by comprehensive risk-based managed care.⁷⁰ As of FY2011, at least 36 states and the District of Columbia used comprehensive risk-based managed care in their Medicaid program.⁷¹ Twenty-six of these states and the District of Columbia had more than half of their Medicaid enrollees in comprehensive risk-based managed care in FY2011, and seven of these states had over 75% of their Medicaid population enrolled in comprehensive risk-based managed care.⁷²

Most states use managed care primarily for their non-disabled child and adult populations. In FY2011, just over 63% of all Medicaid children had coverage through comprehensive risk-based managed care, and 11 states and the District of Columbia had over 90% of their Medicaid children covered through comprehensive risk-based managed care.⁷³ While managed care has largely been used for Medicaid subgroups that do not have chronic health care needs, some states are turning to this type of service delivery system for the elderly and individuals with disabilities.

While over two-thirds of Medicaid enrollees are covered by managed care, Medicaid expenditures for managed care account for only 20% of total Medicaid expenditures. Managed care expenditures account

⁶⁸ Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid*, June 2012; Embry M. Howell, Ashley Palmer, and Fiona Adams, *Medicaid and CHIP Risk-Based Managed Care in 20 States*, Urban Institute, Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, July 2012.

⁶⁹ Embry M. Howell, Ashley Palmer, and Fiona Adams, *Medicaid and CHIP Risk-Based Managed Care in 20 States*, Urban Institute, Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, July 2012.

⁷⁰ Under comprehensive risk-based managed care, states contract with managed care plans to provide a comprehensive package of benefits to certain enrollees. States usually pay the managed care plans on a capitated basis, which means the states prospectively pay the managed care plans a fixed monthly rate per enrollee to provide or arrange for most health care services.

⁷¹ Data was not reported for Maine, Tennessee, and Vermont. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.)

⁷² *Ibid.*

⁷³ *Ibid.*

for such a small share of total Medicaid spending because Medicaid managed care enrollment is dominated by families and children who tend to have lower health care costs, while the highest-cost Medicaid enrollees (i.e., the elderly and disabled populations) generally receive FFS coverage.⁷⁴

Managed Care in CHIP

CHIP was established in the Balanced Budget Act of 1997 (P.L. 105-33) at a time when states' use of managed care for Medicaid was growing significantly. As a result, many states used comprehensive risk-based managed care as primary delivery model for their CHIP programs. States had the choice of establishing their CHIP program in one of three ways: CHIP Medicaid expansion, separate CHIP program, or adopt a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. In FY2013, the bulk of CHIP program enrollees received coverage through separate CHIP programs (approximately 70%). The remainder (approximately 30%) received coverage through a CHIP Medicaid expansion.

When states provide Medicaid coverage to CHIP children (i.e., CHIP Medicaid expansion), their states' Medicaid rules typically apply and CHIP children in CHIP Medicaid expansion programs are covered by managed care in the same manner as Medicaid children in their state. There isn't any current state-by-state information about managed care coverage for children in CHIP Medicaid expansion, but since the Medicaid structures and rules apply to CHIP Medicaid expansion programs, states' coverage of managed care in their Medicaid program can provide information about managed care coverage in CHIP Medicaid expansion programs.

Two of the CHIP Medicaid expansion states (Alaska and New Hampshire) did not use any comprehensive risk-based managed care in their Medicaid programs in FY2011, which means the CHIP children in these states would not receive comprehensive risk-based managed care coverage.⁷⁵ Three of the other six states (Hawaii, Maryland, and Ohio) and District of Columbia that operate their CHIP program as a full CHIP Medicaid expansion program use comprehensive risk-based managed care to cover over 90% of their Medicaid children, which means most of the CHIP children in these states would also have comprehensive risk-based managed care coverage.⁷⁶

Twenty-nine states operate their CHIP program as a combination of CHIP Medicaid expansion programs and separate CHIP programs.⁷⁷ Four of these states (Delaware, Florida, Indiana, and Wisconsin) covered more than 90% of their Medicaid children with comprehensive risk-based managed care in FY2011, which means most of the CHIP children in the CHIP Medicaid expansion portion of these states' CHIP programs would be covered by comprehensive risk-based managed care. However, eight⁷⁸ of these states did not cover any of their Medicaid children with comprehensive risk-based managed care in FY2011.⁷⁹

⁷⁴ Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: Key Data, Trends, and Issues*, Publication #8046, February 2010.

⁷⁵ Vermont operates their CHIP programs as a CHIP Medicaid expansion program, and there isn't managed care data in the Medicaid and CHIP Payment and Access Commission report for Vermont. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.)

⁷⁶ Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.

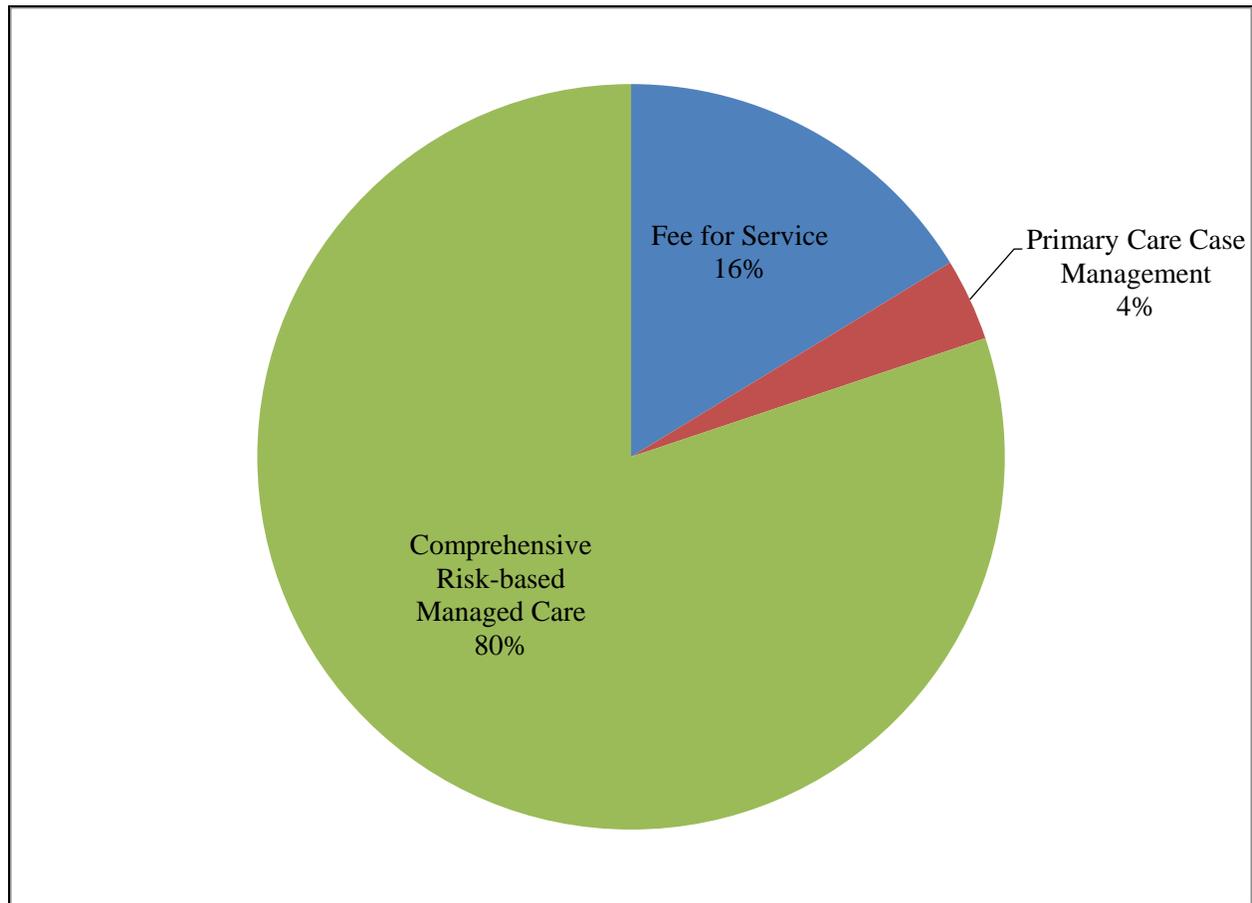
⁷⁷ Centers for Medicare and Medicaid Services (CMS), Children's Health Insurance Program Plan Activity, as of July 1, 2014.

⁷⁸ The eight states are Arkansas, Idaho, Iowa, Louisiana, Montana, North Carolina, Oklahoma, and South Dakota. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2014, Table 14.)

⁷⁹ Maine and Tennessee both operate their CHIP programs as a combination of a CHIP Medicaid expansion program and a separate CHIP program, and neither of these two states have managed care data in the Medicaid and CHIP Payment and Access Commission report. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June (continued...)

There is data from FY2013 for managed care coverage in separate CHIP programs, which includes states with full separate CHIP programs and combination programs. In FY2013, managed care was the predominant delivery system for separate CHIP programs. As shown in **Figure 2**, most (80%) of children in separate CHIP programs were covered by comprehensive risk-based managed care.⁸⁰ Of the 43 states with a separate CHIP programs, thirty-one used comprehensive risk-based managed care in their separate CHIP program. Of the states that used comprehensive risk-based managed care, 23 states covered more than 80% of the CHIP children in their separate CHIP program with comprehensive risk-based managed care, and eight of these states had all of the children in their separate CHIP program covered by comprehensive risk-based managed care.⁸¹

Figure 2. Children in Separate CHIP Programs, by Type of Delivery System
FY2013



Source: Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2014, Table 5, which is based on data from the CHIP Statistical Enrollment Data System (SEDS) as of March 4, 2014.

Notes: This figure does *not* include children in CHIP Medicaid expansion programs.

(...continued)
2014, Table 14.)

⁸⁰ Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2014, Table 5.

⁸¹ *Ibid.*

3. What Medicaid and CHIP do guarantee, however, is coverage that is child-appropriate. In Medicaid, and in CHIP programs provided through Medicaid, children are guaranteed the Early Periodic Screening Detection and Treatment (EPSDT) benefit. Could you discuss what EPSDT provides that is critical for children?

The EPSDT program is a required benefit for nearly all children (under age 21) who are enrolled in Medicaid (whether through traditional state plan coverage or otherwise), including CHIP Medicaid expansion programs.⁸² EPSDT covers health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services. The screenings and services must be provided at regular intervals that meet "reasonable" medical or dental practice standards.⁸³ States are required to provide all federally allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state's Medicaid plan. EPSDT sets Medicaid benefit coverage for children (including CHIP Medicaid expansion children) apart from other sources of health insurance in that it permits coverage of all services listed in Medicaid statute (regardless of whether a given benefit is covered in the state plan) and it effectively eliminates any state-defined limits on the amount, duration, and scope of this benefit.

While not required under separate CHIP programs, data from a 2013 study⁸⁴ that looked at benefit coverage in 42 separate CHIP programs (in 38 states) indicate that benefits offered under separate CHIP programs ranged from benefit coverage modeled after the state's Medicaid plan to more limited benefit coverage available through the commercial market. Of the 25 states with Secretary-approved coverage in 2013, 14 states modeled their coverage after the state's Medicaid program, and 11 of these 14 states offered EPSDT as a part of the state's separate CHIP program benefits.

Tracking receipt of EPSDT covered services is complicated by the diverse range of licensed providers (e.g., medical doctor, nurse practitioner, dentists, and others) that may offer the services, as well as the wide range of locations in which the screenings or other services may be provided (ranging from well-child clinics to Head Start programs and many other locations).⁸⁵ Further, the primary data source on use of EPSDT services is separate from the overall Medicaid claims data reported to CMS and does not include information received by specific eligibility groups.⁸⁶

At the same time, available information indicates receipt of EPSDT services by Medicaid children, is not always complete. In 2010, the Health and Human Services (HHS) Office of Inspector General (OIG)

⁸² EPSDT is not a mandatory benefit for the medically needy, although states that choose to extend EPSDT to their medically needy population must make the benefit available to all Medicaid-eligible individuals under age 21. Section 1905(r) of the Social Security Act and Section 1902(a)(43) of the Social Security Act.

⁸³ Section 1905(r) of the Social Security Act.

⁸⁴ Anita Cardwell, et al., National Academy for State Health Policy and Georgetown University Health Policy Institute, Center for Children and Families; *Benefits and Cost Sharing in Separate CHIP Programs*, May 2014.

⁸⁵ Eligible EPSDT providers and service locations are detailed in CMS, *State Medicaid Manual: Part 5: Early and Periodic Screening Diagnostic and Treatment Services*, Section 5124, pp. 5-19.

⁸⁶ States use CMS Form 416 to report annual aggregate data on the number of children (by age group) who are eligible for EPSDT services and have received certain services. See FY2013 data available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. Beginning, July 1, 2014 states must submit Medicaid program and financial data through the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS will replace CMS Form 416 data and will eventually allow for more detailed analysis of EPSDT service use.

reported that many Medicaid-eligible children did not receive all required EPSDT services.⁸⁷ In a follow up study conducted in 2013, the HHS OIG found that CMS had taken steps to encourage greater participation in EPSDT screenings and treatments. However, citing data that showed a national participation rate for EPSDT screenings of 63% in FY2013 (well below the HHS goal of 80% participation), it stated that the “underutilization of medical screenings is an ongoing concern.”⁸⁸

4. In the responses from governors that the Committee received to its July 2014 letter on the CHIP program, most governors expressed interest that Congress should act quickly to extend CHIP funding. I strongly agree that we need to act quickly. Please share some of the administrative and operational challenges that states would face if Congress were to delay acting on this issue.

Without Congressional action regarding the extension of federal CHIP funding, many states will be putting together their state fiscal year (SFY) 2016 budget with uncertainty about whether federal CHIP funding will be extended and at what level. In addition, for separate CHIP programs, if federal CHIP funding is *not* extended, these states need time to provide CHIP enrollees with “sufficient notice” of coverage termination.

State Budget Uncertainty

State governments do not know for certain whether federal CHIP funds will be extended past September 30, 2015, and if federal funding is extended, states do not know at what level the program will be funded. A vast majority of states will be developing their SFY2016 budgets between January and June 2015 with their SFY2016 beginning on July 1, 2015.⁸⁹ As a result, states will determine their SFY2016 budgets and putting together state legislation before knowing whether states will be receiving FY2016 CHIP allotments or the amount of those potential allotments.

In their responses to the committees request for information about CHIP, the governors from Alabama, Rhode Island, and Texas stated that their SFY2016 budget process would be complicated due to the uncertainty about the future of federal CHIP funding.⁹⁰ For instance, if federal CHIP funding is not extended, states with CHIP Medicaid expansion programs will need to continue covering the CHIP children in these programs at the lower Medicaid matching rate due to the ACA maintenance of effort (MOE) (see the following section for more information about the ACA MOE), and these states would need to budget for this increased expense.

⁸⁷ HHS, Office of the Inspector General (OIG), *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*, May 2010 (OEI-05-08-00520), <http://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf>. The report cited a need for improved documentation of certain screenings as well as better provider knowledge of what a screening entails (among other things) as ways to improve services. In December 2010, CMS convened a National EPSDT Improvement Workgroup to help identify areas to improve EPSDT and to work at the federal level and with states to improve children’s access to EPSDT services and the quality of the data reporting on receipt of those services.

⁸⁸ HHS, OIG, “Recommendation Follow-up Memorandum Report: *CMS Needs to Do More to Improve Medicaid Children’s Utilization of Preventive Screening Services* OEI-05-13-00690,” November 12, 2014. Available at <http://oig.hhs.gov/oei/reports/oei-05-13-00690.pdf>.

⁸⁹ National Conference of State Legislatures, *Budget Cycles*, December 2008.

⁹⁰ Responses to Bipartisan, Bicameral Letters to Governors Regarding CHIP, December 3, 2014, <http://energycommerce.house.gov/letter/responses-bipartisan-bicameral-letters-governors-regarding-chip>.

Starting in FY2016, under current law, the enhanced federal medical assistance percentage (E-FMAP or federal matching rate) for CHIP is to increase by 23 percentage points (not to exceed 100%) for most CHIP expenditures. This would increase the statutory range of the E-FMAP rate from 65% through 85% to 88% through 100%. With this 23 percentage point increase, the federal share of CHIP expenditures will be significantly higher. In formulating their SFY2016 budgets, states are uncertain whether to include this 23 percentage point increase or not.

Adequate Time to Notify Enrollees

If federal CHIP funding is not extended, states need sufficient lead time to make contingency plans and notify enrollees of coverage terminations. Due to the ACA maintenance of effort (MOE), only enrollees in separate CHIP programs might lose coverage if federal CHIP funding expired. The ACA MOE requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving payments under Medicaid.⁹¹

For states to continue to receive federal Medicaid funds, the ACA child MOE provisions require that CHIP-eligible children in CHIP Medicaid expansion programs must continue to be eligible for Medicaid through September 30, 2019.⁹² When a state's federal CHIP funding is exhausted, the state's financing for these children switches from CHIP to Medicaid. This switch would cause the state share of covering these children to increase because the federal matching rate for Medicaid is less than the E-FMAP rate. In the responses from governors, a few states mentioned the additional cost of the CHIP Medicaid expansion portion of their program if federal CHIP funding is not extended. The letter from New Hampshire said this increased cost "...would need to be offset by other Medicaid cuts at a time we are developing a new system of care."

For separate CHIP programs, only the CHIP-specific provisions of the ACA MOE requirements are applicable. These provisions contain a couple of exceptions:

- states may impose waiting lists or enrollment caps in order to limit CHIP expenditures or
- after September 1, 2015, states may enroll CHIP-eligible children into qualified health plans in the health insurance exchanges that have been certified by the Secretary to be "at least comparable" to CHIP in terms of benefits and cost sharing.

In addition, in the event that a state's CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen CHIP-eligible children for Medicaid eligibility,⁹³ and enroll those who are eligible in Medicaid.

For children not eligible for Medicaid, the state must establish procedures to enroll CHIP-eligible children in qualified health plans offered in the health insurance exchanges that have been certified by the Secretary of Health and Human Services (HHS) to be "at least comparable" to CHIP in terms of benefits

⁹¹ Section 2105(d)(3) of the Social Security Act.

⁹² Both the CHIP child MOE and the Medicaid child MOE concurrently apply to the CHIP Medicaid expansion programs. CHIP children covered under CHIP Medicaid expansion programs are an optional eligibility group under Medicaid. However, because the Medicaid MOE for children extends through FY2019, states are not permitted to roll back Medicaid eligibility for these children without the loss of all Medicaid federal matching funds.

⁹³ States must conduct eligibility redeterminations for Medicaid and CHIP at least annually. Due to fluctuations in income among the CHIP target population, it is possible that a former CHIP-eligible child may meet the state's Medicaid eligibility standard due to a change in annual income that may not have been taken into consideration until the enrollee's next regularly scheduled eligibility redetermination.

and cost sharing. Under these ACA MOE requirements, states are only required to establish procedures to enroll children in qualified health plans certified by the Secretary. If there are no certified plans, the MOE does not obligate states to provide coverage to these children. Even when there are certified plans, not all CHIP children may be eligible for subsidized exchange coverage due to the “family glitch”⁹⁴ among other reasons.

Without an extension of federal CHIP funding, children in separate CHIP programs would be expected to lose CHIP coverage unless the state decides to extend the program with state funding. There are laws and regulations pertaining to states’ termination of CHIP-financed coverage. None of the federal rules address terminating coverage as a result of the absence of federal funding, and HHS may issue guidance for states about the termination of coverage due to the absence of federal funding. Federal regulations require states to provide “sufficient notice” of CHIP eligibility suspension or termination “...to enable the child’s parent or caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.”⁹⁵ Neither federal statute nor regulations provides a specific length of time for “sufficient notice” to affected families. Aside from the federal requirements about notifying CHIP enrollees of eligibility termination, states may want to inform enrollees, and in the responses from governors, the letter from New York mentioned that “...states would need at least twelve months of lead time in order to plan for, notify, and efficiently transition children to other programs.”

Also, it is important to note that no federal statute or regulation prohibits states from continuing to operate their CHIP programs using state funding with the potential to receive future federal CHIP matching funds. A state may make claims for federal payment based on expenditures incurred by the state prior to or during the period of availability related to that fiscal year.⁹⁶

⁹⁴ Subsidized coverage in the health insurance exchanges is not available to individuals with access to affordable health insurance. The “family glitch” results from the definition of affordable coverage. Under the ACA, employer-sponsored insurance is considered affordable if an employee’s premium contributions for self-only coverage (not family coverage) comprise less than 9.5% of household income. However, there is no affordability limit on the employees’ share of premiums for family coverage. Due to the “family glitch,” some of the current CHIP enrollees would *not* be eligible for subsidized coverage in the health insurance exchanges based on a parent’s access to “affordable” employer-sponsored insurance. For more information about subsidized coverage in the health insurance exchanges, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

⁹⁵ 42 C.F.R. § 457.340(e)(2). It is unclear how this federal regulation may interact with the ACA MOE requirements.

⁹⁶ 42 C.F.R. § 457.614(a).
