



January 21, 2015

The Honorable Joseph R. Pitts
Chairman, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
| Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2223A Rayburn House Office Building
| Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone:

Thank you for the opportunity to testify on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC) before the Energy and Commerce Committee's Subcommittee on Health on Wednesday, December 3, 2014 regarding the future of the State Children's Health Insurance Program.

I am pleased to have the opportunity to respond to the additional questions for the record you forwarded to me. Please do not hesitate to contact me if you or your staff have additional questions, or if MACPAC staff can be of further assistance.

Sincerely,

Anne L. Schwartz, PhD
Executive Director

Enclosure

Questions for the Record from the Honorable Joseph R. Pitts
Hearing on “The Future of the Children’s Health Insurance Program”
December 3, 2014
Anne L. Schwartz, PhD
Medicaid and CHIP Payment and Access Commission

Q1: What are the current estimates (CBO's and/or MACPAC's estimates) regarding the coverage effects on current CHIP enrollees if Federal CHIP funding is or is not extended? Specifically, what proportion of CHIP enrollees are expected to obtain coverage from Medicaid, the exchange, or employer-sponsored insurance, and what proportion are expected to become uninsured?

A1: Under current law, states and territories will exhaust their last remaining federal funding for the State Children’s Health Insurance Program (CHIP) during fiscal year (FY) 2016, which begins October 1, 2015. States will exhaust their remaining CHIP allotments at various points throughout FY 2016.

The maintenance of effort (MOE), which was included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), requires states to continue Medicaid and CHIP coverage at current eligibility levels for children at least through FY 2019. Because children enrolled in Medicaid-expansion CHIP are considered Medicaid-enrolled children who happen to be financed by CHIP (as long as such funds exist), the MOE applies regardless of the availability of federal CHIP funds. Thus, those children’s Medicaid coverage must continue (at least through FY 2019), although at a federal matching rate lower than CHIP’s. Without federal CHIP funding, states with children in CHIP programs separate from Medicaid may terminate that coverage.

For projections of the sources of coverage children would receive if separate CHIP coverage ended, MACPAC turned to the Urban Institute and its Health Insurance Policy Simulation Model-American Community Survey (HIPSIM-ACS). A preliminary analysis for MACPAC projects that if federal funding for CHIP is exhausted in 2016, 1.1 million children who would have been enrolled in separate CHIP programs would become uninsured. This is nearly one-third of the 3.7 million children (age 0–18) who would need to find other sources of coverage if their separate CHIP coverage ends. The remaining two-thirds are projected to enroll in subsidized exchange coverage (1.4 million) or job-based insurance (1.2 million).

The core data for this model are from the Census Bureau’s American Community Survey (ACS), which is an annual, state, and nationally representative survey of 3 million U.S. residents. National and state eligibility rules and out-of-pocket costs for Medicaid, CHIP, and exchange coverage were used to simulate eligibility and enrollment in these programs. The costs and eligibility for job-based coverage were also included. With this information, projections were produced as to who is eligible for coverage, how much would it cost, and who would enroll or be uninsured, based on various assumptions.

There are a number of caveats that need to be considered in any such modeling effort. First, there is uncertainty in the model’s assumptions about the rate of participation in employer-sponsored and subsidized exchange coverage. Sensitivity analyses are underway to test how much various assumptions would affect the projected number of uninsured. Second, in forecasting to 2016, the analysis assumes that the economic picture and the structure of employer-sponsored coverage remains constant, which may not be the case. Third, income, insurance coverage, premiums, health status, and other factors reported by or projected for CHIP-eligible children are subject to measurement and reporting errors.

Q2: Many of the members from both sides of the aisle at the December 3rd hearing, as well as health care providers and children's advocates, have praised CHIP as a program that is currently successful. Can you confirm that if Congress were to eliminate the 23 percent increase to the EFMAP in current law, CBO projects that extending CHIP for two years could save federal money/reduce the deficit?

A2: In the spring of 2014, CBO estimated that MACPAC's recommendation to extend CHIP by two additional years (to provide federal CHIP allotments for FY 2016 through 2017) would increase net federal spending by \$0–5 billion above the current law baseline. This recommendation assumed no changes in any other aspect of CHIP-funded coverage as it exists under current law, including the 23-percentage-point increase in the CHIP federal matching rate slated for FY 2016 through 2019.

At the same time, the Commission received from CBO an estimate of how much net federal spending would change if CHIP were extended by two years without the 23-percentage-point increase. In that case, CBO projected that net federal spending would decrease—from \$0–5 billion.

CBO's estimate reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2015 at \$5.7 billion each year.

Q3. As Congress moves to probably extend CHIP funding in some form, what offsets does the Commission recommend for our consideration? Will MACPAC commit to working to inform us on offsets for funding CHIP in a timely manner, similar to how MedPAC does for Medicare policies?

A3: MACPAC is committed to working with Congress to provide information on potential offsets and other financing considerations related to Medicaid and CHIP. With respect to the extension of CHIP funding, as noted in MACPAC's June 2014 Report to the Congress, the costs of extending CHIP would largely be offset by reductions in federal spending for Medicaid and subsidized exchange coverage - sources of federally subsidized coverage in which many children are assumed to enroll in if CHIP funding were to be exhausted under current law.

In addition, congressional budget rules require CBO to assume in its baseline that federal CHIP funding continues beyond FY 2015. Based on these assumptions, the CBO estimated that a two-year extension of CHIP would increase net federal spending by \$0-5 billion above the agency's current law baseline. This estimate assumes that the ACA's increase in the CHIP matching rate (23 percentage points) takes effect in FY 2016. Federal costs would be lower if CHIP matching rates remained at their current levels.

Q4. The bipartisan Rivlin-Domenici Debt Reduction Task Force - led by former Clinton White House OMB Director Alice Rivlin and Republican Senator Pete Domenici - warned that "the present debt trajectory of the United States federal government cannot be sustained and poses grave dangers to the American economy." They noted lawmakers "must make difficult decisions to get our fiscal house in order," acknowledging that "any realistic solution must include structural reforms to entitlements." Rivlin-Domenici noted that two of their operative principles were to (a) protect the truly disadvantaged to ensure a sustainable safety net while (b) making spending reductions and adopting policy reforms that focused benefits on those who need them most. When does MACPAC expect to recommend to Congress policies that will reduce Medicaid spending, while adhering to these sound principles?

A4: MACPAC strongly supports the principles of ensuring a sustainable safety net and adopting policy reforms that focus benefits on those who need them most. Throughout its tenure, the Commission has worked to develop analyses that shed light on patterns of spending within Medicaid (for example, by eligibility group, type of service). Such analyses are critical to identifying both which enrollees are most vulnerable and where improvements could be made to ensure that the program operates efficiently.

An area where Congress can expect to hear more from the Commission in the coming months are analyses of state efforts to promote value-based purchasing. In particular, we are interested in sharing what we have learned about the design and effectiveness of payment and delivery system changes that promote positive health outcomes while incentivizing more rational use of health services. In addition, we will be further developing our work focused on high-cost, high-need populations, such as users of long-term services and

supports and those with behavioral health needs. Our goal in this work is to identify how best to meet the needs of these vulnerable enrollees in a manner that is consistent with goals of economy and efficiency. We have also been monitoring efforts by the Centers for Medicare & Medicaid Services (CMS) as it tests new approaches to program integrity.

Across all of these programmatic areas, MACPAC has identified the lack of consistent, complete data as a barrier to promoting program accountability, value to the taxpayer, and access to appropriate health services for Medicaid enrollees. We will continue to highlight where data improvements will be critical to the goals of moderating program spending and serving those most in need.

Q5. With all the outreach that has occurred under the current CHIP program and given the amount of federal dollars spent on outreach encouraging consumers to get enrolled in health coverage related to the health care law, what, if any, policy rationale is there for continued federal funding of CHIP performance bonuses? Do states already receive federal matching funds for outreach conducted?

A5: As the Committee is aware, funding for performance bonuses for enrollment and outreach to eligible but uninsured children has expired. States may receive federal matching funds for most separate CHIP outreach expenses at the CHIP enhanced federal medical assistance percentage (FMAP) rate. Translation and interpretation services are eligible for a higher matching rate of 75 percent, or the 5 percentage points above the state's CHIP enhanced matching rate, whichever is higher (see §2105(a)(1) of the Social Security Act). In addition, a total of \$126 million in outreach grants were made available from FY 2009 through FY 2015 for outreach and enrollment grants for states, local governments, Indian tribes, and community organizations. These grants can fund outreach activities, but they cannot be used to provide coverage.

In MACPAC's November 17, 2014 comment letter on the U.S. Department of Health and Human Services reports on adult and children's health care quality reports to the Congress (available at www.macpac.gov/comment-letters), MACPAC noted that any decision to extend bonus payments would require significant design decisions. Specifically, many eligibility simplifications incentivized by the performance bonus program are now statutory requirements under the ACA and the current formula for calculating performance bonus payment amounts relies on pre-ACA eligibility standards (see 2103(a)(3)(F)(i) of the Social Security Act).

Q6: The Affordable Care Act/Obamacare required states to use modified-adjusted gross income (MAGI) for CHIP eligibility. What, if any, income sources are excluded from the MAGI calculation as part of CHIP eligibility determination and what is the rationale for these exclusions?

A6: Modified adjusted gross income (MAGI) is calculated on IRS Form 1040 plus any foreign earned income excluded from taxes, any tax-exempt interest, and any tax-exempt Social Security income. This measure was intended to align income-counting methodologies across Medicaid, CHIP, and subsidized exchange coverage. Thus, MAGI has required some changes in how income is counted in Medicaid for certain eligibility pathways. There are some income sources previously counted that may no longer be factored into income determinations. These include example, veteran's benefits, child support that a family receives, as well as any pre-tax contributions households may make toward expenses like childcare costs and flexible spending accounts. In addition, while self-employment income will still be counted, the tax code allows for various deductions, such as depreciation, that were not typically allowed in Medicaid prior to the ACA.

Similarly, the move to MAGI has required changes in calculation of family size. For example, under MAGI, stepparents are included as part of a child's household and their income counts toward income eligibility for a child. Prior to the ACA, most states would disregard such income, as the stepparent is not legally responsible for the child.

Q7: States have told us that, as a result of the modified-adjusted gross income (MAGI) calculation's treatment of lump sum payments, lottery winners are currently enrolled in Medicaid. In fact, in 2014, one state reported to us that roughly one in four of their lottery winners were enrolled in Medicaid or had a family member in Medicaid. This includes at least one individual who won more than \$25 million. Since CHIP uses MAGI calculations as well, is it possible that CHIP is providing coverage for lottery winners? Please explain how lump sum payments such as lottery winnings are treated under the MAGI calculation? Does MACPAC believe it is appropriate for multi-million dollar lottery winners who may have bank accounts greater than some CEOs to receive Medicaid?

A7: MAGI requires the use of the latest income information and prohibits the use of asset tests. For CHIP eligibility purposes, a large amount of income (e.g., from lottery winnings, cashing out a 401(k), sale of a home or vehicle, earnings) may count as income generally in the year in which it was realized and make a family ineligible that year. In years that follow, however, any remaining funds are treated as assets and generally do not count as income (unless they are bearing interest or other realized income).

It should be noted that asset tests were rarely used in separate CHIP programs prior to the implementation of MAGI. For example, in January 2013, only two states used asset tests in their separate CHIP programs—Missouri for \$250,000 and Texas for \$10,000.¹ States that voluntarily eliminated their asset tests in CHIP did so for reasons such as:

- the administrative burden and costs of asset tests on states;
- relatively few families being determined ineligible because of asset tests; and
- many eligible families being dissuaded from applying because of the administrative and application burden of asset tests.²

MAGI has made the elimination of asset tests in CHIP (and for some populations in Medicaid) a national standard and removes a potential barrier to enrollment.

To address this particular situation, Congress could amend MAGI to account for lottery winnings that no longer count as income. Congress previously amended MAGI to allow counting of tax-exempt Social Security income.³ The Commission expressed its support for congressional action in that case, noting that it was consistent with prior state practices and that it would avoid requiring states to calculate taxable versus tax-exempt Social Security income.⁴ However, the Commission has not recommended the reintroduction of CHIP asset tests, which the vast majority of states had voluntarily eliminated prior to the implementation of MAGI. The Commission will continue consideration of these issues as part of its ongoing monitoring of the implementation of MAGI and the ACA.

Q8: MACPAC has recommended creating a statutory option for states to implement 12-months continuous eligibility for children in CHIP. To what extent does a 12-month continuous eligibility option result in CHIP

¹ Table 6, M. Heberlein et al., *Getting into gear for 2014: Findings from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP, 2012-2013*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2013. <http://www.kff.org/medicaid/upload/8401.pdf>. In Missouri, this so-called net-worth test applied to children above 150 percent of the federal poverty level (FPL). Texas' asset test for separate CHIP children also applied only above 150 percent FPL.

² See, for example, V.K. Smith et al., *Eliminating the Medicaid asset test for families: A review of state experiences*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2001. <http://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf>.

³ §401 of P.L. 112-56, enacted November 21, 2011.

⁴ Medicaid and CHIP Payment and Access Commission (MACPAC), letter to HHS Secretary Kathleen Sebelius regarding CMS-2349-P "Eligibility Changes Under the Affordable Care Act of 2010," October 2011, http://www.macpac.gov/comment-letters/MACPAC_Comments-CMS_Eligibility_Rule_Oct2011.pdf.

coverage for individuals from families with incomes above the CHIP eligibility thresholds? How does a 12-month continuous eligibility policy affect the required premiums and cost sharing for an enrollee? Could it result in an enrollee paying more or less than required based on their current income?

A8: In its March 2013 report, MACPAC recommended that 12-month continuous eligibility be made statutorily available for children in CHIP, at state option, as is the case for children in Medicaid. At the time, 33 states were using 12-month continuous eligibility in their separate CHIP programs. However, because of the implementation of MAGI, it was unclear whether or not CMS would continue to permit 12-month continuous eligibility for children in CHIP. Since then, in May 2013, CMS clarified that states may continue offering 12-month continuous eligibility as a state plan option for children in CHIP.⁵

In considering the merits of continuous eligibility, it is important to note the frequent income fluctuations, potentially affecting Medicaid and CHIP eligibility, that are typical in the low-income population. Historical research has shown that, depending on the state and the size of its program, between 11 and 67 percent of children who were enrolled in a separate CHIP program at any point during the year were also enrolled in Medicaid-financed coverage at some time during the same year.⁶ With the addition of subsidized exchange coverage and the requirement that intra-year income changes be reported in Medicaid and CHIP, churning between programs may be more prevalent than churning off of coverage altogether.⁷

The amount that families pay depends upon the coverage source to which they churn. If they churn Medicaid, they may see a decline in out-of-pocket premiums and cost sharing relative to CHIP.⁸ If they move to subsidized exchange coverage, they may see an increase in out-of-pocket payments. In CHIP, total out-of-pocket payments for premiums and cost sharing are limited to 5 percent of family income, although most states have lower limits. For out-of-pocket premiums alone, subsidized exchange coverage generally requires 3 to 9.5 percent of family income in the typical CHIP income range. In no state are the cost-sharing protections for children in subsidized exchange coverage comparable to those of CHIP.⁹

MACPAC will be monitoring this issue as enrollment data become available for 2014.

Q9: How does the current eligibility requirements of CHIP, Medicaid, and the 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 member with different coverage, such as a child in CHIP and parent with coverage on the exchange.

A9: Medicaid, CHIP, and exchanges have different income eligibility rules for coverage or available subsidies, which can affect whether parents and children have the same coverage. The ACA set the minimum Medicaid income eligibility level for children at 138 percent of the federal poverty level (FPL), but many states provide Medicaid coverage to children in families with higher incomes. Under the ACA, states may also choose to

⁵ Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services, letter from Cindy Mann to State Health Officials and State Medicaid Directors regarding “Facilitating Medicaid and CHIP enrollment and renewal in 2014,” May 17, 2013, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>.

⁶ J.L. Czajka, *Movement of children between Medicaid and CHIP, 2005–2007*, MAX Medicaid policy brief no. 4. Princeton, NJ: Mathematica Policy Research, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/Medicaid_and_CHIP_Transitions.pdf.

⁷ 42 CFR 435.916(c).

⁸ Even in a state with 12-month continuous eligibility, children would be moved from CHIP to Medicaid if a decline in income is reported during the year that would make them eligible for a more generous program or cost-sharing protections. In a state with continuous eligibility, it is not clear the extent to which families would continue to report such declines in income.

⁹ A. Bly et al. *Comparison of benefits and cost sharing in Children’s Health Insurance Programs to qualified health plans*. Englewood, CO: Wakely Consulting Group, 2014, <http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf>.

cover eligible adults under age 65 in Medicaid with incomes at or below 138 percent FPL. As of January 16, 2015, 28 states are expanding coverage to this adult population (NASHP 2015).¹⁰

In addition, some parents are eligible for Medicaid through pathways other than the new adult group. Federal Medicaid rules in place prior to enactment of the ACA require states to cover parents with dependent children who would have been eligible for cash assistance under program rules in place prior to 1996 (when welfare reform was enacted), on average, 41 percent FPL (CMS 2015). States also may cover parents at higher income levels. Of the states not expanding Medicaid to the new adult group, 14 cover parents with income less than 50 percent FPL, 5 cover parents with income between 50 and 100 percent FPL, and 4 cover parents with income greater than 100 percent FPL (Brooks et al. 2015).

CHIP was designed to provide health insurance to low-income uninsured children above 1997 Medicaid eligibility levels and has also been used to fund coverage of pregnant women and other adults on a limited basis. While Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no mandatory income level up to which CHIP programs must extend coverage. Under the ACA, however, states must maintain their 2010 eligibility levels for children in both Medicaid and CHIP through FY 2019. States' upper limits for children's CHIP eligibility range from 175 percent to 405 percent FPL. It is worth noting, however, that 89 percent of the children enrolled in CHIP-financed coverage had incomes at or below 200 percent FPL in FY 2013 and 97 percent were at or below 250 percent FPL (MACPAC 2014a).

While there are no income limits on who can purchase coverage on exchanges, eligibility for subsidies is based on income. Premium tax credits may be available to those with incomes between 100 and 400 percent FPL and cost sharing reductions to those with incomes between 100 and 250 percent FPL, if they do not otherwise have access to affordable coverage.

Depending on the state, family income, and age of children, family members could be enrolled in different coverage sources. For example, consider two families both with two children aged 10 months and 8 years, at two income levels: 135 percent FPL and 200 percent FPL. The chart below provides examples of how members of a family could have different sources of coverage.

Sources of Coverage for Families at 135% of the Federal Poverty Level (FPL) and 200% FPL in Three States

State	135% FPL			200% FPL		
	Family member			Family member		
	10 month old	8 year old	Parents	10 month old	8 year old	Parents
California	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Exchange
Pennsylvania	Medicaid	Medicaid	Exchange	Medicaid	CHIP	Exchange
New Jersey	Medicaid	Medicaid	Medicaid	CHIP	CHIP	Exchange

Note: Based on state Medicaid and CHIP eligibility levels as of January 2014 and state Medicaid expansion decisions as of January 2015.

¹⁰ This includes five states (Arkansas, Iowa, Michigan, New Hampshire, and Pennsylvania) that are using an alternative to traditional expansion.

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Q1: 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?

A1: Yes, states have broad flexibility in many aspects of Medicaid and CHIP programs including benefit design, payment policy, delivery system design, and the extent to which they cover certain populations.

States have more flexibility within CHIP than Medicaid to design their benefit packages and can model their benefits based on specific private insurance benchmarks, a package equivalent to one of those benchmarks, or Secretary-approved coverage. The most flexible of these options is Secretary-approved coverage, which is the most common approach.

States also have the flexibility under CHIP to charge premiums and cost sharing at levels generally not permitted by Medicaid (although limited in total to 5 percent of family income). In addition, states’ separate CHIP programs can rely on administrative structures and payment policies and rates that are distinct from those in Medicaid.

States set eligibility levels for Medicaid and CHIP, subject to certain minimums and limitations. For example, Medicaid coverage must be available to children up to 138 percent FPL. There is no minimum eligibility level for CHIP. However, the MOE requires states to maintain their eligibility levels for children in Medicaid and CHIP through FY 2019.

States also have broad flexibility in establishing their payment policies and delivery systems. For example, some states rely almost entirely on managed care plans, while others use state-administered fee-for-service programs. For payments to plans and providers, states set their rates within broad federal parameters. As a result, payment levels and policies vary substantially across states.

Q2: 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?

A2: The majority of children enrolled in Medicaid and CHIP are enrolled in some form of managed care, including through HMOs or other arrangements (primary care case management).¹¹ In fiscal year 2013, 44 states enrolled at least some of the children with separate CHIP program coverage in some form of managed care. Among children enrolled in separate CHIP programs, 80.2 percent received care through a managed care plan, such as an HMO and 3.6 percent were enrolled in primary care case management (MACPAC 2014a). In fiscal year 2011, 46 states enrolled at least some of the children enrolled in Medicaid in some form of managed care. Of these children, 63.3 percent are enrolled in comprehensive, risk-based managed care and 18.7 percent were enrolled in primary care case management (MACPAC June 2014b).

Q3: 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,

¹¹ Under primary care case management, primary care providers receive a monthly fee to manage patients’ care.

Detection, and Treatment (EPSDT) benefit. Could you discuss what EPSDT provides that is critical for children?

A3: The Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services to all children under age 21 enrolled in Medicaid. States operating Medicaid-expansion CHIP programs must provide EPSDT to enrollees and although not required, 13 states operating separate CHIP programs also provide enrolled children EPSDT or EPSDT-like benefits (Cardwell et al. 2014).

Under EPSDT, states must screen children for and provide medically necessary services to treat physical, mental, vision, hearing, and dental problems or conditions. States must establish and adhere to a periodicity schedule based on professional guidelines that sets how often screenings for physical, mental, vision, hearing, and dental conditions occur. EPSDT requires that based on findings from the screening, states refer children in need of further evaluation and diagnosis to such services.

If a child requires medically necessary treatment or services to maintain or improve their health condition, any such services that could be covered under Medicaid regardless of whether the services are covered in the state's Medicaid state plan, must be covered. For example, services that children could receive through EPSDT include mental health and substance abuse services, personal care services (for example, assistance with performing activities of daily living, such as dressing, eating, and bathing), dental services, vision services (including eyeglasses) and hearing services (including hearing aids).

Q4: 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?

A4: Most states have fiscal years that begin on July 1 and most have begun their legislative sessions.¹² As such, they are already planning for the budget year that includes September 2015, when CHIP funding is set to expire, and will need to make assumptions about whether or not federal financing will continue. States that do not budget for ongoing CHIP funding may need to revisit their budget to allocate the state share of the program should federal financing be extended. States assuming ongoing federal spending may face a shortfall if funding is extended, but after their current allotment expires. If funding is ultimately not extended, states will face the administrative challenge of dissolving their separate CHIP programs or the fiscal challenge of maintaining their CHIP-financed Medicaid expansions at the lower Medicaid matching rate.

There are at least four primary administrative and operational areas that states will need to consider:

1. States will decide the level at which they will continue their existing separate CHIP coverage. States could maintain coverage for current enrollees and freeze any new enrollment, disenroll current CHIP children, or continue to operate an open program while possibly incurring the full cost of coverage. The extent to which they maintain their separate CHIP program will likely depend in part upon how much they have in carryover funding and how much they may be willing to spend in state-only funds.
2. States will also need to notify families of the upcoming programmatic changes, allowing them to report any updates in family circumstances or additional information that may make their children eligible for Medicaid or exchange coverage. Additionally, consumer assistance and education will also be needed so that families understand the changes occurring in CHIP. Should the program reopen

¹² National Conference of State Legislatures (NCSL). 2015. 2015 state legislative session calendar. <http://www.ncsl.org/research/about-state-legislatures/session-calendar-2015.aspx>. and NCSL. 2012. Quick reference fiscal table. <http://www.ncsl.org/research/fiscal-policy/basic-information-about-which-states-have-major-ta.aspx>.

after funding is extended, states will need to conduct further outreach and education, with the understanding that freezes in enrollment often affect future program participation.¹³

3. Eligibility and enrollment systems (including the exchanges) will need to be updated to reflect new income thresholds and whether or not CHIP is open for enrollment. If a waiting list is established, a system will also need to be developed to track and possibly enroll applicants. States have established procedures for coordinating between the various health insurance affordability programs and children found eligible will need to be enrolled in a qualified health plan that has been certified as comparable to CHIP by the Secretary, a certification that needs to be completed by April 1, 2015.
4. CHIP is primarily operated through managed care organizations and state contracts with plans may include provisions regarding operations in the case of a funding lapse. This may require certain notice requirements and ongoing coverage through a period of time, which may come at the expense of the state. If the CHIP program is ceasing operations, states will need to work with plans to terminate the contract.

CMS has not released any details on the certification of comparability nor any guidance for states (beyond what is in statute) on the transition from CHIP to Medicaid or exchange coverage should funding cease. Additionally, there is little precedent for what the agency might require as states end their CHIP programs or state experience to serve as a guide, since Arizona is the only state to effectively end its CHIP program and it operated under a waiver.

Q5: The Affordable Care Act took many steps to simplify how CHIP and Medicaid are administered, to ensure greater coverage of children—one of these steps was to create a uniform income eligibility standard for siblings within families. Prior to this, because of differences in income eligibility limits based on age, there were families with children who would no longer be eligible for Medicaid when they turned six, even as their younger siblings remained on Medicaid. The ACA effectively moved some children from CHIP to Medicaid coverage. Some of my colleagues across the aisle talk about this like it's a bad thing, and that "millions" of children have been affected.

- a. Can you give us an estimate of how many children have been affected by this "stairstep" provision?
- b. Can you also discuss the benefits of the stairstep provision for children and for States?

A5: Section 2001(a)(5)(B) of the ACA increased the minimum eligibility threshold for children ages 6-18 from 100 percent FPL to 133 percent FPL. As a result, states covering older children up to 133 percent FPL in separate CHIP programs needed to transfer these children to Medicaid as of January 1, 2014. CMS gave a number of states permission to implement an alternative approach, such as coordinating the transition with regularly scheduled renewals.

At the time of the ACA's enactment, 21 states were affected by this provision. Two states, New York and Colorado, implemented an early transition of children from CHIP to Medicaid, while New Hampshire and California decided to move all their children in their separate CHIP programs to Medicaid. Although CMS has not published any data on the number of children transitioning, available estimates suggest that more than 540,000 children enrolled in the 17 remaining separate CHIP programs would move to Medicaid.¹⁴

¹³ Cohen Ross, D. and L. Cox. 2003. Out in the cold: Enrollment freezes in six State Children's Health Insurance Programs withhold coverage from eligible children. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/out-in-the-cold-enrollment-freezes-in-six-state-children-s-health-insurance-programs-withhold-coverage-from-eligible-children.pdf>.

¹⁴ Prater, W. and J. Alker. 2013. Aligning eligibility for children: Moving the stairstep kids to Medicaid. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8470-aligning-eligibility-for-children.pdf>.

This shift in coverage allows children in families to remain enrolled in the same program regardless of their age. Additionally, as these children are now Medicaid enrollees, they are provided the same benefits, cost sharing, and other protections as other children covered through Medicaid. For example:

- Stairstep children will have access to the full Medicaid benefit packaged, including the EPSDT benefit.
- Because states may not charge premiums and cost sharing to children covered through the mandatory Medicaid eligibility pathways (which now includes the stair-step children), children transitioning will not be charged for their coverage or care.
- Waiting periods are not permitted in Medicaid without a waiver, so children with income between 100 and 133 percent FPL who are newly eligible for Medicaid coverage will no longer have to wait to enroll.
- Since Medicaid is an entitlement, states cannot cap or freeze enrollment and any child who is found eligible must be enrolled.

There may also be disadvantages to moving from separate CHIP into Medicaid. For example, there are anecdotal concerns that children fare better in CHIP in terms of access to care. For states, the transition clearly required additional administrative efforts such as identifying affected children, transitioning them to a new source of coverage, and providing families with timely notice of the change. However, once this transfer has occurred, states may see the administrative burden lessen, as they are no longer moving children from Medicaid to CHIP when a child turns six. Additionally, states will continue to receive the higher CHIP matching rate for coverage of children who moved from CHIP to Medicaid as a result of this provision.¹⁵

Q6: When Congress passed the Affordable Care Act, it included a provision called the Maintenance of Effort that required states to maintain coverage levels for children in Medicaid through 2019. The intent of this provision was to ensure that millions of low to moderate income children currently covered under Medicaid did not find themselves suddenly uninsured or underinsured as new coverage options were coming available. While I am sure a very small handful of states, if given the opportunity would simply drop coverage and hope children found their way to Marketplace coverage, most states appreciate the value of Medicaid and CHIP for children and would not take such a step. In the CHIP arena, however, I have heard some complaints that it is unfair that States that operate separate CHIP programs could simply drop children's coverage if CHIP funding is not continued, while for States that have chosen to administer CHIP via their Medicaid program, they will have to continue to cover these children. However, while some states may not like that maintenance of effort requirement, some states have deliberately chosen the Medicaid-CHIP expansion route because the state is guaranteed continued federal support for covering these children even if CHIP money runs out. Isn't that correct?

A6: Years ago, states faced several trade-offs when designing their CHIP programs. By using a separate CHIP program, states could implement waiting lists and enrollment caps, with flexibility to charge premiums and cost sharing and offer benefits less generous than required in Medicaid. However, if federal CHIP funding were exhausted, there would be no fallback for federal funding of separate CHIP programs.

On the other hand, states that chose Medicaid-expansion CHIP programs often found implementation easier. These states draw down enhanced federal CHIP matching funds for children enrolled through a simple Medicaid expansion. In addition, if federal CHIP funding were ever exhausted, these states would have federal Medicaid funds to fall back on, although requiring a 43 percent higher state share than CHIP.

¹⁵ Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. CMS answers to frequently asked questions: Telephonic applications, Medicaid and CHIP eligibility policy and 75/25 federal matching rate. August 9. <http://www.medicaid.gov/federal-policy-guidance/downloads/faq-08-09-2013.pdf>.

While states' ability to revert to Medicaid funding may have been a consideration when deciding how to implement their CHIP programs, they may have chosen differently if they had known that CHIP funding would end and that the MOE would require them to maintain their Medicaid-expansion coverage beyond the exhaustion of federal CHIP funding. As you note, however, it is not clear how these states would respond in the absence of both the MOE and federal CHIP funding.

Q7: Can you please provide more details on the purpose of the Maintenance of Effort and how it will help to keep low-income children insured, which I believe is a goal that we all have on both sides of the aisle?

A7: For children, the MOE requires state Medicaid and CHIP programs to have, until October 1, 2019, eligibility standards, methodologies, and procedures in place that are no more restrictive than those in place at the enactment of the ACA (March 23, 2010).¹⁶ In short, states must continue to cover children with no more restrictions than they did before. However, this MOE does not obligate states to continue funding separate CHIP programs if federal CHIP funding is exhausted; a state may limit separate CHIP enrollment based on available federal CHIP funding.

While the exhaustion of federal CHIP funds under current law will result in children now covered by separate CHIP programs having to find other coverage or become uninsured, the MOE will ensure that those covered under the Medicaid expansion approach remain covered through at least FY 2019.

Q8: In fact, if we are worried about states with M-CHIP programs having to maintain their coverage while states with separate state programs can cut if CHIP funding does not get extended, shouldn't we just extend CHIP funding to ensure states have adequate fiscal support and that children won't lose coverage?

A8: As long as MOE is in effect, the continuation of federal CHIP funding treats separate CHIP states and Medicaid-expansion states equitably and ensures that CHIP enrolled children do not become uninsured.

Q9: Please expand on MACPAC's underlying intentions of their CHIP recommendations. Does MACPAC still recommend that Congress act on these previously recommended program improvements, or does the Commission now recommend that Congress simply fund CHIP for two more years?

A9: In its March 2014 report, MACPAC made two recommendations to Congress that would have an immediate effect on children's coverage through CHIP: (1) eliminate CHIP waiting periods, and (2) exempt families below 150 percent FPL from CHIP premiums.

In its June 2014 report, MACPAC followed up with a recommendation regarding the future of CHIP, recommending that federal CHIP funding be extended by an additional two years. This recommendation did not eliminate the need to make the program improvements called for in MACPAC's March 2014 report. On the contrary, the continuation of CHIP makes it even more important for Congress to eliminate CHIP waiting periods and premiums for families below 150 percent FPL.

The Commission cited four primary reasons to eliminate CHIP waiting periods. First, eliminating CHIP waiting periods will reduce uninsurance and improve the stability of coverage. Waiting periods cause children to move between 90 days or less of enrollment in exchange coverage, or uninsurance, before being eligible for CHIP. Second, eliminating CHIP waiting periods will reduce administrative burden and complexity for families, states, health plans, and providers as children move from short-term exchange coverage to CHIP. Because most of the states with CHIP waiting periods rely on the federally facilitated exchange, which is generally not able to do CHIP determinations where waiting periods exist, CHIP waiting periods are a barrier to streamlined, coordinated eligibility determinations. Third, although CHIP waiting periods were instituted

¹⁶ §§1902(gg) and 2105(d)(3) of the Social Security Act.

to deter crowd-out of private coverage, the limited research on CHIP waiting periods has reached contradictory conclusions, primarily driven by the different sources of data used by the researchers. Fourth, eliminating CHIP waiting periods is consistent with the goal of having more simplified and coordinated policies across various programs. Since neither exchanges nor Medicaid require waiting periods, eliminating CHIP waiting periods would make CHIP consistent with exchanges and Medicaid in this regard. In the past few years, most states have eliminated their CHIP waiting periods.

MACPAC called for the elimination of CHIP premiums below 150 percent FPL to prevent uninsurance and to align premium policies of separate CHIP programs with Medicaid. Above 150 percent FPL, premiums can be effective at preventing crowd-out with little increase in uninsurance, depending on the amount of the premiums; below 150 percent FPL, however, even small premiums can lead to significant increases in uninsurance among children.¹⁷ Only a handful of states continue to charge CHIP premiums below 150 percent FPL. The CHIP premiums charged in this income range, generally less than \$10 per month, are so small that they would not represent a significant revenue loss to states if they were eliminated—especially as this also removes states’ burden in collecting and administering these premiums. This recommendation did not call for any change to CHIP’s premium policies for families above 150 percent FPL, the income range for the vast majority of CHIP enrollees subject to premiums.

Q10: What are the key elements we should consider to determine whether CHIP is no longer necessary and children can be moved to other forms of equally comprehensive and affordable coverage?

A10: MACPAC called for federal CHIP funding to be extended by two additional years to allow time to make changes in public policy needed to ensure adequate and affordable coverage for low-income children, equitable treatment of states, appropriate use of public dollars when private dollars may be available (for example, through employer-sponsored coverage), and smooth transitions across sources of coverage. The Commission is at work on developing and analyzing policy options to address concerns about adequacy and affordability of children’s coverage.

Q11: Can you discuss issues that still need to be resolved with regard to network adequacy and access to pediatric services in Qualified Health Plans?

A11: There is an often-stated assumption that CHIP networks are better for children than those in exchange plans because CHIP is designed for children. There is little available evidence, however, to support this assumption. As such MACPAC has been exploring what policies might be needed to ensure that children who might move from CHIP to the exchanges have access to appropriate care. This is a complex issue requiring consideration of the effects of market conditions on issuers’ ability to create networks, how to ensure appropriate access to specialty care, measures of network adequacy, network transparency, and how plans and payers balance access, quality, and cost in network design.

Market conditions can affect plans’ ability to create networks. It may be difficult to contract with providers that are members of a relatively rare subspecialty or are the only facility of their type for a region, such as children’s hospitals. These providers can sometimes demand higher rates than plans are willing or able to pay. It can be challenging to connect children to needed specialty care. There are gaps in the supply of certain specialists at a population level, as well as gaps in certain geographic areas. Even if sufficient specialists exist, some may not wish to contract with plans, regardless of payer. The network adequacy challenges in dental care mirror those in medical care, including provider participation, network transparency, and affordability.

¹⁷ S. Abdus et al., “Children’s Health Insurance Program premiums adversely affect enrollment, especially among lower-income children,” *Health Affairs* 33(8): 1353–1360, August 2014. J.B. Herndon et al., “The effect of premium changes on SCHIP enrollment duration,” *Health Services Research* 43(2): 458–477, 2008.

Measuring network adequacy can be challenging because networks change frequently. In addition, those that are adequate for the majority of patients may not be adequate for those with special needs. While plans can be required to negotiate special arrangements in such circumstances, if the burden of arranging this care falls on families, it could present a major barrier to access. Network transparency is also important to consumers. While directories are currently the only source of provider participation information for consumers, they are not always accurate nor sufficiently detailed. A beneficiary may need to see a subspecialist with experience treating a specific condition, and that expertise is not likely to be reflected in directories.

Network design must balance two key factors: which providers are needed to ensure access for the insured population, and which providers are available and willing to serve enrollees. These factors affect a health plan's ability to create a network at a cost that is acceptable to both the plan and the providers. A plan's leverage to negotiate lower payment rates can be limited by low provider density (for example, in rural areas), low supply (for example, of children's hospitals and many pediatric specialists), or extensive regionalization of specific services (for example, children's hospitals). Narrow network designs also give issuers the opportunity to offer plans that include providers who meet specific access and quality benchmarks, although this does not currently seem to be a widespread practice (Corlette et al. 2014a, 2014b, Howard 2014).

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