CHAPTER 5

Children's Coverage under CHIP and Exchange Plans

Recommendations

Children's Coverage under CHIP and Exchange Plans

5.1 To reduce complexity and to promote continuity of coverage for children, the Congress should eliminate waiting periods for the State Children's Health Insurance Program (CHIP).

5.2 In order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums.

Key Points

- The establishment of health insurance exchanges and subsidized coverage for individuals between 100 percent and 400 percent of the federal poverty level (FPL)—a population that substantially overlaps with the income levels of many children covered by CHIP—creates a new context for considering CHIP's role within the broader health care system. In this chapter, we begin to sketch out a vision for what CHIP coverage might look like beyond fiscal year 2015, but also offer recommendations to improve CHIP as it currently exists.
- Eliminating CHIP waiting periods reduces uninsurance and improves stability of coverage while reducing administrative burden on states, plans, and enrollees. Moreover, waiting periods have not been shown to be particularly effective in reducing crowd-out over the years. The Commission's recommendation on eliminating CHIP waiting periods enhances program simplification and promotes coordinated policies across public programs.
- The Commission also recommends that the Congress eliminate CHIP premiums for families with incomes below 150 percent FPL. Such a policy would reduce uninsurance for a particularly price-sensitive group of enrollees and align CHIP and Medicaid policy on premiums. The recommendation would also eliminate premium stacking—the combined burden of both CHIP and exchange coverage premiums—for the lowest-income families.

CHAPTER 5

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Since its creation in 1997, the State Children's Health Insurance Program (CHIP) has focused the attention of state and federal policymakers on children's coverage, and in particular on expanding eligibility and enrollment of children in CHIP and Medicaid. The number and share of children who are uninsured have declined substantially over the past 16 years, as children have gained CHIP and Medicaid coverage.[1] CHIP and Medicaid have promoted access to care for many more children who would otherwise face significant challenges obtaining needed care.

The Congress has revisited CHIP several times over the years. In 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) made significant changes to strengthen CHIP and extended federal CHIP allotments through fiscal year (FY) 2013. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) made additional changes to CHIP the following year, including a shift to the use of modified adjusted gross income (MAGI) for eligibility determinations and the movement of certain children from separate CHIP programs into CHIP-funded Medicaid. While policymakers raised questions as to whether CHIP should continue, or whether CHIP-eligible children should be enrolled in the health insurance exchanges, the ACA ultimately contained provisions to extend federal CHIP allotments by two years, through FY 2015. The ACA also requires states to maintain children's eligibility levels through FY 2019, as long as federal CHIP allotments to states are sufficient, leaving open the question of CHIP's long-term future in the new health insurance landscape.

The establishment of health insurance exchanges and subsidized coverage for individuals between 100 percent and 400 percent of the federal poverty level (FPL)—a population that substantially overlaps with the income levels of many children covered by CHIP—creates a new context for considering CHIP's role within the broader health care system. The ACA required states to move children in separate CHIP coverage with family incomes below 138 percent FPL into Medicaid (with CHIP funding), leaving up for discussion the disposition

long-term future of those with higher incomes remaining in separate CHIP programs.[2]

This moment presents an opportunity for policymakers to consider a long-term vision, not just for CHIP, but for coverage of lower-income children more broadly. In this chapter, we begin to sketch out a vision for what such coverage might look like beyond FY 2015. While the Commission plans to develop this vision further in its June 2014 report, this report focuses on some short-term changes to align the program with long-term goals. The chapter begins with background information on the program to help orient the reader to the discussion of near-term policy changes and long-term goals. The chapter concludes with two Commission recommendations pertaining to CHIP—that the Congress should provide that children in CHIP not be subject to waiting periods, and that children with family incomes below 150 percent FPL ($29,685 in annual income for a family of three) not be subject to CHIP premiums. The Commission approved these recommendations to promote simplicity, program coordination, and affordability and continuity of coverage for children.

Key Features of CHIP Today

CHIP is a joint federal-state program that provides coverage primarily to uninsured children in families whose incomes are too high to qualify for Medicaid (MACPAC 2013a). CHIP is smaller than Medicaid both in terms of covered individuals (8.4 million versus an estimated 71.7 million in FY 2013) and total spending ($13.2 billion versus $460.3 billion in FY 2013, including both federal and state dollars).[3] As with Medicaid, CHIP is administered by states within federal rules, and states receive federal matching funds for program spending. CHIP, however, differs from Medicaid in a variety of ways.

Program design. CHIP gives states flexibility to create their programs as an expansion of Medicaid, as a program entirely separate from Medicaid with its own branding, or as a combination of both approaches. For example, some states use a Medicaid-expansion CHIP program to cover younger or lower-income children and a separate CHIP program for others. When states use a Medicaid-expansion CHIP program, federal Medicaid rules generally apply. Separate CHIP programs generally operate under a separate set of federal rules that allow states to design benefit packages that look more like commercial insurance than Medicaid. In 2014, 8 states and 5 territories ran CHIP as a Medicaid expansion, 14 states operated separate CHIP programs, and 29 states operated a combination program (MACStats Table 9). Although all states are eligible to receive CHIP funding for at least some Medicaid enrolled children as of 2014 due to the implementation of two ACA requirements, 14 states are still categorized as separate programs in this report because they did not have approved state plan amendments on the CMS website indicating whether they will characterize themselves as combination states. The two ACA requirements are: a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs to Medicaid coverage, and a mandatory income disregard equal to 5 percent FPL that effectively raises Medicaid (and CHIP) eligibility levels by 5 percentage points.

Entitlement. While individuals who meet eligibility criteria for Medicaid (including Medicaid-expansion CHIP programs) are entitled to Medicaid coverage, there is no individual entitlement to coverage in separate CHIP programs. Under a maintenance of effort (MOE) provision in the ACA that applies to children through FY 2019, states may generally not reduce eligibility levels or institute new CHIP enrollment caps as long as federal CHIP funding is available. As discussed later in this chapter, states may continue to impose existing waiting periods in separate CHIP programs. Neither waiting periods nor enrollment caps are permitted in Medicaid without a waiver.

Eligibility levels. 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 (MACStats Table 9). Although many states offer CHIP coverage at higher income levels (generally with higher premiums and cost sharing), 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 (MACStats Table 4).

Benefit packages. States with separate CHIP programs have greater flexibility around the design of their benefit packages than is permitted in Medicaid. Separate CHIP program benefits may be more similar to those offered in the commercial health insurance market and are not required to include the full array of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services mandated for children in Medicaid. However, 13 separate CHIP programs cover EPSDT benefits (Touschner 2014). CHIP programs may charge premiums for coverage and may also require enrollees to pay higher cost sharing than is allowed in Medicaid.

Federal funding. Regardless of whether states implement CHIP through a Medicaid expansion, a separate CHIP program, or a combination of both, states' CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's. CHIP's enhanced federal medical assistance percentage (E-FMAP) varies by state, ranging from 65 percent to 81 percent, compared to 50 percent to 73 percent for children in Medicaid (MACStats Table 14). Unlike Medicaid, federal CHIP funding is capped (MACStats Table 21).

Weighing the Future of CHIP

At its core, the debate on the future of CHIP weighs the benefits of continuing a uniquely child-focused effort versus integrating children into Medicaid, exchange, or other existing coverage. At the time CHIP was enacted in 1997, it was designed to reach children above Medicaid eligibility levels for whom other coverage options might be unavailable or unaffordable. Today, many CHIP children have parents who are eligible for subsidized exchange coverage.

Because exchange coverage is new, and because CHIP and Medicaid programs are also implementing multiple provisions of the ACA, children's experiences in these various sources of coverage may evolve through 2014 and beyond. The Commission recognizes the importance of maintaining CHIP while exchanges get off the ground and children's experience with exchange coverage is assessed. It also views the impending exhaustion of federal CHIP funding as an opportunity to think broadly about how best to meet the needs of lower-income children in the new landscape of coverage.

The Commission's vision for the future of children's coverage is one that reflects lessons learned from CHIP. Regardless of the form such coverage takes, it should follow CHIP's lead in limiting premiums and cost sharing to affordable levels. In assessing affordability, the interactions between families' costs for CHIP and subsidized exchange coverage should be taken into account. Coverage should also include certain pediatric benefits that are appropriate to the specific needs of children, with networks that ensure access to the

health care providers who can meet those needs. In addition, to the extent that there is an ongoing role in the future for states in serving children currently covered by CHIP, it may be desirable to maintain some degree of state flexibility in program design.

While the recommendations in this chapter focus on areas for improvement in the near term, here we provide a brief preview of issues under consideration for MACPAC's June 2014 report that will address the future of CHIP beyond FY 2015.

Flexibility in program design. Separate CHIP programs are able to operate with benefit packages, cost sharing, and administrative structures that are distinct from and offer more state flexibility than Medicaid. Over time, however, certain flexibilities afforded to separate CHIP programs have narrowed for a variety of reasons. Some outreach and enrollment techniques that began as experiments in individual states were subsequently identified as best practices and are now required in all states in both CHIP and Medicaid.[4] Other policies have been limited at the federal level as well. For example, beginning with the enactment of the ACA, separate CHIP programs cannot cap enrollment unless they will otherwise exhaust all available federal CHIP funds.

While CHIP was initially implemented with no minimum or maximum levels of eligibility, the ACA has limited states' ability to alter their CHIP income-eligibility levels. The ACA's MOE requirement has limited states' flexibility to reduce children's eligibility levels through FY 2019.[5] The ACA's MAGI requirement has eliminated the ability of all but a few states to expand CHIP income-eligibility levels.[6]

Availability and take-up of coverage. Even with the availability of subsidized exchange coverage, the absence of CHIP would cause some children to become uninsured. For example, due to higher premiums and cost sharing for exchange coverage relative to CHIP, some parents could be deterred from enrolling their formerly CHIP-eligible children (and themselves) in such coverage.

Moreover, many children in the income range now covered by CHIP would be ineligible for subsidized exchange coverage because a parent is offered employer-sponsored insurance that is considered affordable. Under the ACA, employer-sponsored insurance is considered affordable if employees' out-of-pocket premiums for self-only coverage comprise less than 9.5 percent of family income. This policy is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered. In the absence of CHIP, this affordability test could contribute to many formerly CHIP-eligible children moving to uninsurance if families find that employer-sponsored insurance and unsubsidized exchange coverage are too expensive. Approximately 1.9 million children, one-third of CHIP-financed children, would be ineligible for subsidized exchange coverage because a parent is offered and enrolled in employer-sponsored insurance that is considered affordable (GAO 2012).

However, the impact of CHIP is not limited to such direct effects. CHIP has also played additional roles by encouraging coverage through outreach, enrollment, and marketing efforts aimed at increasing awareness of and reducing stigma associated with public insurance more generally. The ongoing need for these efforts may be reduced, however, as millions of additional people are enrolled in publicly subsidized coverage beginning in 2014, making such coverage more mainstream.

Affordability. CHIP programs generally require higher out-of-pocket premiums and cost sharing than Medicaid but lower amounts than subsidized exchange plans, an issue that must be addressed in any consideration of future coverage for the children currently served by CHIP. The core issue with regard to affordability is the reasonable level

of contribution that may be expected on the part of a child's family toward the cost of care without becoming a financial obstacle that impedes access to and use of appropriate care. For children in CHIP programs that impose premiums or cost sharing, the aggregate amount is limited to 5 percent of a family's income—although states' cost-sharing levels are typically well below those levels.[7]

However, because the calculation of family premiums is not coordinated across CHIP and exchanges, certain families may pay combined CHIP and exchange premiums in 2014 that exceed the amount they would have paid if CHIP did not exist and children were instead enrolled in their parents' exchange coverage.

Premiums are not the only factor in determining affordability; cost sharing for services can also be a source of significant cost differences between programs. In exchange plans, individuals with incomes at or below 250 percent FPL are eligible for cost-sharing subsidies. Even with these subsidies, exchange coverage requires far more service-related cost sharing than CHIP, particularly for enrollees above 150 percent FPL (Watson Wyatt Worldwide 2009).[8]

Covered benefits. The breadth and depth of CHIP's benefit package relative to Medicaid and the exchanges is an important issue that raises larger questions of access to appropriate care for all children in the future, regardless of their coverage source. In the case of Medicaid-expansion CHIP programs, CHIP-funded children receive the same benefit package as Medicaid-funded children, including comprehensive EPSDT services that were designed to emphasize pediatric care and to ensure coverage of dental and other optional services that are not always offered to adults in Medicaid. Separate CHIP programs must cover certain benefits, including dental, but are not required to include EPSDT services. At least a quarter of separate CHIP programs have elected coverage that is similar to Medicaid, while others have benefits that more closely mirror commercial coverage (Touschner 2014). In an analysis of five states, separate CHIP programs offered benefit packages that were generally comparable to the benchmarks chosen for exchange plans (GAO 2013). However, additional analyses are needed to assess other states and to compare CHIP benefit packages to actual exchange plans, rather than to just the state's benchmark benefit package.

Provider networks. One argument for retaining the current structure of CHIP is the notion that the program offers provider networks that are designed to meet the specific needs of children. Some directors of separate CHIP programs also point out that their networks include more providers than Medicaid (Caldwell 2013a). However, there is little systematic information available that would allow comparisons among Medicaid, CHIP, and exchange networks, either in terms of their composition or capacity. With regard to exchange coverage, current federal standards provide substantial flexibility to states with little specific guidance on pediatric provider networks.

Continuity of coverage. While separate CHIP coverage may have certain advantages over Medicaid and exchange coverage, some of these programs cover a relatively small wedge of children in between the larger population of lower-income children served by Medicaid and the potentially larger population of higher-income children covered in the exchanges. This creates challenges for the continuity of coverage.

Large variation exists by state in the number of transitions between Medicaid and CHIP programs—often referred to as churning (Czajka 2012). Research has found that the primary predictor of a state's churning was the size of its CHIP program—that is, if its CHIP program covered a relatively narrow income band, children in that CHIP program were more likely to

transition between sources of coverage (Czajka 2013). Although there are strategies available under CHIP to mitigate such churning (see, for example, the discussion of continuous eligibility and eliminating waiting periods in this chapter), the very existence of an additional program like CHIP means that there are more boundaries for churning between programs that may lead to periods of uninsurance or discontinuity of care.[9]

Financing. If CHIP funding is exhausted, the financial impact on states will differ based on the type of program they operate. Should CHIP funding run out in FY 2016, the federal financing for children in Medicaid-expansion CHIP programs will revert to Medicaid funding at the regular federal medical assistance percentage (FMAP), which will increase states' financial burden for covering these children. On the other hand, states with separate CHIP programs will see many of these children go to exchange coverage, where subsidies are 100 percent federally financed. Although an MOE requirement exists for children's Medicaid and CHIP eligibility through FY 2019, separate CHIP programs may limit their enrollment based on the availability of federal CHIP funds.

While the federal cost of CHIP's continuation was a major legislative issue for reauthorization in 2009, it may be less of an issue in the future because of the assumptions used by the Congressional Budget Office (CBO). In 2009, CBO assumed that extending CHIP would increase federal spending because many children who would otherwise be uninsured would enroll in CHIP coverage. However, if CHIP allotments are not extended past FY 2015, CBO assumes that the bulk of enrollees would receive federally funded coverage from other sources—primarily through exchanges and Medicaid. Since an extension of CHIP would replace other forms of federally subsidized coverage, federal cost estimates of extending CHIP may not be as large as one might expect.

Timing of federal and state action. The absence of new federal CHIP allotments beyond FY 2015 (which runs through September 2015) will be a major concern for state fiscal year (SFY) 2016 budgets, which run from July 2015 through June 2016 in all but Alabama, Michigan, New York, and Texas (NCSL 2012). Although states will continue to spend from their leftover CHIP allotments in FY 2016, a scheduled E-FMAP increase of 23 percentage points will cause them to exhaust those funds more quickly. Most states will begin their SFY 2016 budget planning processes in earnest during the fall of 2014 and will continue into the first half of 2015. To provide some degree of certainty during this period, the Congress would need to enact legislation that, at a minimum, addresses CHIP funding through June 2016.

Issues for CHIP in the Near Term

The Commission's vision for children's coverage and the future of CHIP beyond FY 2015 will be further developed in MACPAC's June 2014 report. This report makes specific policy recommendations intended to better align the program with Medicaid and exchange coverage in the near term. The two recommendations are that the Congress should provide that children in CHIP not be subject to waiting periods, and that children with family incomes below 150 percent FPL not be subject to CHIP premiums. These changes are consistent with longer-term goals for children's coverage that include both continuity and affordability.

Promoting continuity of children's coverage in CHIP

Changes in insurance coverage can result in lapses in care, discontinuity in providers, and administrative burden for individuals, health plans, and public

programs (MACPAC 2013b). Implementation of the ACA affects how these changes might occur and how widespread they might be.[10]

Exchange coverage introduces an additional source of coverage to the mix when considering how children are likely to transition in and out of CHIP and other coverage. At the same time, ACA policies to simplify renewals may reduce administrative churning at the time of CHIP enrollees' regular redeterminations.

The Commission's March 2013 report described the ability of 12-month continuous eligibility policies to reduce churning, particularly among children (MACPAC 2013b). By waiving the requirement that families report changes in income between their annual redeterminations, 12-month continuous eligibility can increase continuity of coverage, lower use of more expensive care, and reduce states' administrative burden in processing this information outside of their regular eligibility cycle. No explicit statutory authority exists to provide 12-month continuous eligibility for children in CHIP, although such authority exists for children in Medicaid. Nevertheless, 28 of the 38 separate CHIP programs used 12-month continuous eligibility in January 2013 (Heberlein et al. 2013). While the Centers for Medicare & Medicaid Services (CMS) proposed regulations in January 2013 to permit 12-month continuous eligibility in CHIP, the final regulation in July 2013 did not include that provision. CMS informed state health officials that 12-month continuous eligibility continues to be available as a CHIP state plan option (CMS 2013a).

To assure states that this option would continue, the Commission recommended in March 2013 that the Congress authorize 12-month continuous eligibility statutorily in CHIP, parallel to the current option for children in Medicaid. In this report, the Commission reiterates its support for the recommendation in the March 2013 report. Adoption of this recommendation would formalize states' ability to provide 12-month continuous eligibility for children in CHIP, as is currently in use by most states. The CBO projects no cost for making 12-month continuous eligibility a statutory option in CHIP, because it merely formalizes a state plan option that is currently in place.

The remainder of this section discusses CHIP waiting periods and their effect on the stability of coverage in CHIP, and includes the Commission's recommendation that the Congress end the use of CHIP waiting periods. CHIP waiting periods—the length of time that some states require children be without employer-sponsored insurance before enrolling in CHIP—reflect the initial design of the CHIP program and concerns that public coverage would crowd out private coverage. During the CHIP waiting period, many children are now eligible for exchange coverage (although not all children will be eligible for subsidies or be enrolled). After the CHIP waiting period has been satisfied, they will be eligible for CHIP, not exchange coverage. Thus, CHIP waiting periods will require children to churn between exchange coverage (or uninsurance) and CHIP, which leads to administrative burden and expenses for families, states, providers, and plans, with the potential for delays in children's coverage and care.

Use of waiting periods. State CHIP programs are required to have methods in place to prevent the substitution of public coverage for private coverage, often referred to as crowd-out. One strategy to reduce crowd-out is built into CHIP eligibility—that to qualify for CHIP, children cannot be enrolled in employer-based coverage. States have flexibility to adopt additional measures to limit crowd-out, including CHIP waiting periods.

Under new regulations effective January 1, 2014, CHIP waiting periods cannot exceed 90 days (42 CFR 457.805(b)(1)). Previously, CHIP waiting periods could be as long as 12 months. In reducing the CHIP waiting period to 90 days, CMS pointed out that CHIP should not permit waiting periods longer than

those that apply in private plans, which the ACA limited to 90 days beginning in 2014 (HHS 2013).

The new regulations also instituted multiple federal exemptions to CHIP waiting periods, some of which were already in use by many state CHIP programs (42 CFR 457.805(b)(3)). Children may be exempted from the waiting period if any of the following applies:

- the additional out-of-pocket premium to add the child to an employer plan exceeds 5 percent of income;
- a parent is eligible for subsidized exchange coverage because the premium for the parent's self-only employer-sponsored coverage exceeds 9.5 percent of income;
- the total out-of-pocket premium for employer-sponsored family coverage exceeds 9.5 percent of income;
- the employer stopped offering coverage of dependents (or any coverage);
- a change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (regardless of potential eligibility for COBRA coverage);
- the child has special health care needs; or
- the child lost coverage due to the death or divorce of a parent.

Twenty-one states currently have CHIP waiting periods, a reduction from 37 states with waiting periods in 2013 (Table 5-1). Another seven have reduced their waiting periods to 90 days or less to comply with the new CHIP regulations. In 2013, eight states reported waiting periods as their only crowd-out policy (Arizona, Arkansas, Georgia, Kentucky, Maryland, South Dakota, Virginia, and Wyoming); Kentucky and Maryland have since eliminated waiting periods.[11]

While CHIP waiting periods have been long-standing practice, waiting periods are not permitted in Medicaid or in exchange coverage.[12] In fact, individuals may be enrolled in both Medicaid and employer-sponsored insurance, in which case employer-sponsored insurance serves as first payer. In exchange coverage, the key mechanism to prevent crowd-out is to make individuals ineligible for subsidies if they are offered employer-sponsored insurance that is considered affordable.

Children affected by CHIP waiting periods. Relatively few children eligible for CHIP are subject to states' CHIP waiting periods, because only a small proportion of uninsured children had employer-sponsored insurance in the prior three months. To be eligible for CHIP, children must be uninsured, and only 4.6 percent of uninsured children with family incomes between 125 percent and 199 percent FPL had employer-sponsored coverage three months beforehand (Figure 5-1).[13]

Even fewer children will be subject to CHIP waiting periods because of the new federal exemptions. Existing data do not permit analyses of the share of children who might qualify for the numerous exemptions to CHIP waiting periods. However, at least half of children potentially subject to a CHIP waiting period are likely to be exempt due to the high out-of-pocket costs associated with employer-sponsored insurance. The median out-of-pocket premium for employer-sponsored family coverage in 2012 was $3,700, which would be 9.7 percent of the income of a family of three at 200 percent FPL (AHRQ 2013). Since family contributions exceeding 9.5 percent of income are an exception to CHIP waiting periods, this one exemption alone could apply to over half of the potentially affected families. Some of the remaining families may face little or no premium for their employer-based coverage; for families with lower required contributions, many face no employee contribution for family coverage

TABLE 5-1. CHIP Waiting Periods by State (Months)

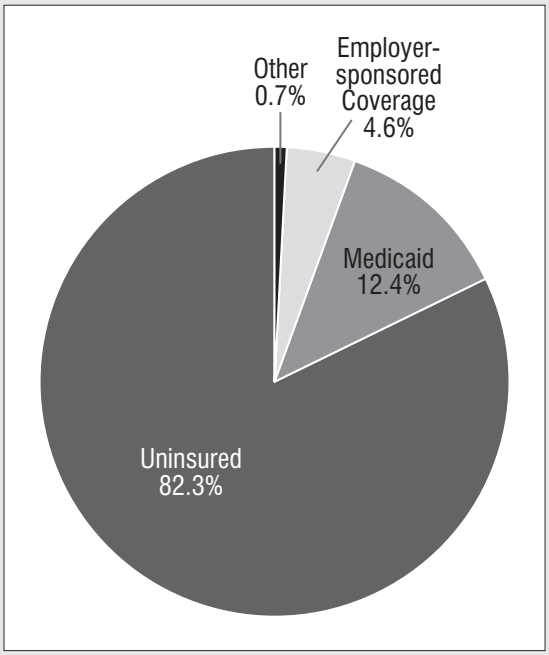
State	January 2013	January 2014	Exempt Groups Based on Income
Alabama	3	–	–
Arizona	3	3	–
Arkansas	6	3	–
California	3	–	–
Colorado	3	–	–
Connecticut	2	–	–
Delaware	6	–	–
Florida	2	2	–
Georgia	6	2	–
Idaho	6	–	–
Indiana	3	3	–
Iowa	1	1	Individuals below 200% FPL
Kansas	8	3	Individuals below 200% FPL
Kentucky	6	–	–
Louisiana	12	3	Individuals below 200% FPL
Maine	3	3	–
Maryland	6	–	–
Massachusetts	6	–	Individuals below 200% FPL
Michigan	6	3	–
Missouri	6	6[1]	Individuals below 150% FPL
Montana	3	3	–
Nevada	6	–	–
New Jersey	3	3	–
New Mexico	6	–	Individuals below 185% FPL
New York	6	3	Individuals below 250% FPL
North Dakota	6	3	–
Oregon	2	–	–
Pennsylvania	6	–	Individuals below 200% FPL
South Dakota	3	3	–
Tennessee	3	–	–
Texas	3	3	–
Utah	3	3	–
Virginia	4	4[1]	–
Washington	4	–	–
West Virginia	3	–	–
Wisconsin	3	3	Individuals below 150% FPL
Wyoming	1	1	–

Notes: FPL is federal poverty level. This table includes only states that had a waiting period in January 2013; all other states had no waiting periods at that time. Dashes in the January 2014 column indicate there was no waiting period. Dashes in the Exempt Groups column indicate that no individuals are exempt from the waiting period based solely on income. For states that provided exemptions from the waiting periods in 2013 that will maintain waiting periods in 2014 (IA, KS, LA, MO, NY, WI), the exemptions will apply to the same individuals in 2014.

[1] As of January 2014, the state legislature had not yet reduced its CHIP waiting period to three months.

Sources: For January 2013: Heberlein et al. 2013. For January 2014: personal communication by MACPAC staff and Center for Children and Families at Georgetown University with state CHIP officials, October–November 2013.

FIGURE 5-1. Source of Health Insurance in September for Children between 125 Percent and 199 Percent Federal Poverty Level (FPL) Who Were Uninsured in December



Source: Analysis for MACPAC by Social & Scientific Systems of 2009–2011 data from the Medical Expenditure Panel Survey (MEPS).

(generally in small firms) and are less likely to seek CHIP coverage for their children.[14]

Churning due to CHIP waiting periods. In the 21 states continuing to use CHIP waiting periods in 2014, many affected children will churn back and forth between exchanges and CHIP for their coverage, or remain uninsured during this period. For those children who enroll in an exchange plan during the waiting period, the child must be moved to CHIP once the waiting period has been satisfied. Other children—for example, those in families who do not enroll in exchange coverage, with its required premiums—would likely be uninsured for the duration of the CHIP waiting period.

This churning risks disruptions in children's coverage and in their continuity of care, particularly in the 20 waiting-period states using the federally facilitated exchange (CMS 2013b).[15] Because of the complexity and state variation around CHIP waiting periods, the federally facilitated exchange does not determine children's eligibility for CHIP in most of these states (HHS 2013). Instead, the federally facilitated exchange assesses whether a child is eligible for CHIP and, if potentially subject to a waiting period, transfers the case to the state CHIP program to determine whether or not an exemption applies. The CHIP agency must inform the exchange if a child is subject to a waiting period so the child can receive subsidized exchange coverage, if eligible, for the duration of the waiting period.[16]

Health plans have also noted the negative effects of churning associated with CHIP waiting periods. Regarding the now-eliminated waiting period for West Virginia CHIP (WVCHIP), the president of the state's largest insurer, Highmark West Virginia, wrote that:

> continuation of a waiting period requirement could be cumbersome to our potential customers seeking to enroll, and administratively burdensome to both the Marketplace and WVCHIP's application and eligibility systems. Delayed access to services for children as well as disruptions of coverage that could result in some cases could also be a potential outcome. The waiting period may have served a meaningful purpose in the earlier days of WVCHIP's existence. But given the changes to occur as of January 2014, if the WVCHIP Board were to act to eliminate the waiting period at this juncture, this would not pose a significant issue for us (Highmark West Virginia 2013).

Commission Recommendation

Recommendation 5.1

To reduce complexity and to promote continuity of coverage for children, the Congress should eliminate waiting periods for CHIP.

Rationale

The Commission focused on 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 (HHS 2013).

Third, although CHIP waiting periods were instituted to deter crowd-out, it is not clear that they have been effective in doing so. The limited research on CHIP waiting periods has reached contradictory conclusions, primarily driven by the different sources of data used by the researchers.[17] In addition, the potential pool of children who might be targeted by this strategy is small. As described earlier, estimates suggest that only a small percentage of uninsured children in the CHIP income range had employer-sponsored coverage in the prior 90 days.

Fourth, eliminating CHIP waiting periods is consistent with the Commission's desire to have 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.[18]

Congressional action to end CHIP waiting periods would be consistent with the trend in state actions on this policy. Of the 37 states that began 2013 with CHIP waiting periods, 16 eliminated those waiting periods by 2014. States have eliminated their CHIP waiting periods because of the resulting short-term transitions between exchange coverage and CHIP, the additional administrative burden on states, and the new federal regulations that exempt most children who would otherwise face a CHIP waiting period (Caldwell 2013a).

Implications

Federal spending. This recommendation would increase federal spending in 2015 by $50 million to $250 million, based on ranges provided by CBO. Over the five-year period of 2015 to 2019, this recommendation would increase federal spending by less than $1 billion. These represent net federal costs, reflecting not only increased federal CHIP spending, but also reduced federal spending for exchange subsidies.

States. Ending the use of CHIP waiting periods would simplify eligibility and reduce the administrative burden associated with determining which children may be subject to CHIP waiting periods (as well as the federal and state exemptions). This would enable states to use the federally facilitated exchange for CHIP determinations, if they so choose. In states currently using CHIP waiting periods, eliminating the waiting periods could increase state CHIP spending resulting from the additional months of CHIP coverage. However, at least one state predicted little additional cost from

eliminating the CHIP waiting period, considering the administrative cost and burden of administering the policy and the relatively low number of children who would gain additional coverage (Caldwell 2013b).

Enrollees. Because the majority of the children seemingly subject to a CHIP waiting period are likely exempt, the primary impact of eliminating the waiting period would be relieving families of the administrative burden of verifying their exemption and avoiding any associated delays in coverage. For children who are not currently exempt, eliminating CHIP waiting periods would reduce the risk that children subject to a waiting period may go uninsured if families do not enroll their children in exchange coverage or if the transition from exchange to CHIP coverage is not implemented correctly.

Plans and providers. Eliminating CHIP waiting periods would reduce administrative burden associated with processing individuals' moves on and off of plans, and can ensure that efforts to improve management of enrollees' care and to measure quality are not compromised because of churning.

CHIP premiums

Separate CHIP programs may charge premiums and cost sharing, while Medicaid—including Medicaid-expansion CHIP programs—generally may not. Although some limited authority exists to charge small premiums in Medicaid, federal law generally prohibits premiums in Medicaid for children and for individuals with income below 150 percent FPL ($29,685 for a family of three).

When CHIP was originally enacted, the ability to charge premiums and cost sharing was a key component of the flexibility states were provided as they expanded eligibility to children above Medicaid levels. CHIP premiums were originally authorized to ensure that relatively higher-income families contributed their fair share toward their children's coverage and to prevent crowd-out of employer-sponsored insurance. Some reconsideration of the role of CHIP premiums, particularly for the lowest-income families, may be merited due to their effect on increasing uninsurance and their interaction with exchange premiums and other ACA policies. On the other hand, the Commission recognizes that efforts to reduce uninsurance are undermined if substantial crowd-out occurs.

The use of CHIP premiums is fairly widespread. Based on policies in place in January 2013 (Heberlein et al. 2013), MACPAC estimates that approximately 44 percent of CHIP-funded children (3.4 million) faced premiums in 33 states. In states charging CHIP premiums, the combination, or stacking, of both CHIP and exchange premiums could be substantial for families. While CHIP and exchange coverage each has separate statutory limits on premiums based on family income, neither takes into account the effect of premiums required by the other. With more than 3 million children facing CHIP premiums, many families will be subject to premium stacking if they purchase coverage on the exchange in addition to enrolling their children in CHIP.

This section begins with a review of states' current use of CHIP premiums, followed by a description of premium levels for subsidized exchange coverage. We then illustrate how premium stacking could affect families, depending on their income and state. The final part of this chapter describes the Commission's recommendation to eliminate CHIP premiums for families below 150 percent FPL, to align with Medicaid's premium policy.

Current use of CHIP premiums. In January 2013, 33 states charged premiums for children enrolled in CHIP-financed coverage; no premiums were charged in the other 17 states and the District of Columbia (Table 5-2). Those monthly premiums for children up to 251 percent FPL varied from $4 to more than $50, depending on the state and

TABLE 5-2. Premium and Enrollment Fee Requirements for Children in CHIP-Funded Coverage as of January 2013

State	Income at Which CHIP Funding Begins (% FPL)	Income at Which CHIP Premiums Begin (% FPL)	Upper Income Eligibility Level for Children's CHIP-Funded Coverage (% FPL)
Alabama	101%	101%	300%
Arizona	101	101	200
California	101	101	250/300[1]
Colorado	101	151	250
Connecticut	186	235	300
Delaware	101	101	200
Florida[2]	101	101	200
Georgia[3]	101	101	235
Idaho	101	133	185
Illinois	101	151	200
Indiana	101	150	250
Iowa	101	150	300
Kansas	101	151	232
Louisiana	101	201	250
Maine	126	151	200
Maryland	186	200	300
Massachusetts	115	150	300
Michigan	101	151	200
Missouri	101	150	300
Nevada[4]	101	36	200
New Jersey	101	201	350
New York	101	160	400
North Carolina	101	151	200
Oregon	101	201	300
Pennsylvania	101	201	300
Rhode Island	101	150	250
Texas	101	151	200
Utah	101	101	200
Vermont	226	226	300
Washington	201	201	300
West Virginia	101	201	300
Wisconsin[5]	101	200	300

Notes: Some states have changed policies with regard to premiums in CHIP since January 2013. For example, 6- to 18-year-olds between 100 and 138 percent of the federal poverty level (FPL) must be enrolled in Medicaid-expansion CHIP rather than separate CHIP programs, as of January 1, 2014, and therefore are not subject to premiums. Table excludes premiums for Medicaid-funded children in Minnesota and Vermont.

[1] California's county program expanded eligibility to 300 percent FPL under its separate CHIP program in four counties (three of the four counties have implemented this provision), with all other counties at 250 percent FPL.

[2] Florida operates two CHIP-funded separate programs. Healthy Kids covers children age 5 through 19, as well as younger siblings in some locations. MediKids covers children age 1 through 4. Children in MediKids pay premiums, while children in Healthy Kids pay premiums and copayments.

[3] Children under age six in Georgia are exempt from CHIP premiums.

[4] In Nevada, although Medicaid covers children in families with income up to 100 percent or 133 percent FPL, some children with lower incomes may qualify for CHIP depending on the source of income and family composition. Such families with incomes at or above 36 percent of the FPL are required to pay premiums.

[5] In Wisconsin, infants covered in Medicaid between 200 percent and 300 percent of the FPL would be subject to premiums.

Source: MACPAC analysis of Heberlein et al. 2013.

TABLE 5-3. Premiums for CHIP-Financed Children at Selected Income Levels for States Charging CHIP Premiums as of January 2013

State	Effective Amount Per Child[1] at: 101% FPL	151% FPL	201% FPL	251% FPL	301% FPL	351% FPL
Monthly Payments						
Arizona	$10	$40	$50	N/A	N/A	N/A
California[2]	4/7	13/16	21/24	$21/24	N/A	N/A
Connecticut	–	–	–	30	$30	N/A
Delaware[3]	10	15	25	N/A	N/A	N/A
Florida	15	20	20	N/A	N/A	N/A
Georgia	10	20	29	N/A	N/A	N/A
Idaho	–	15	N/A	N/A	N/A	N/A
Illinois	–	15	15	N/A	N/A	N/A
Indiana	–	22	42	53	N/A	N/A
Iowa	–	10	20	20	20	N/A
Kansas	–	20	50	N/A	N/A	N/A
Louisiana[4]	–	–	50	50	N/A	N/A
Maine	–	8	32	N/A	N/A	N/A
Maryland[4]	–	–	50	63	63	N/A
Massachusetts	–	12	20	28	28	N/A
Michigan[4]	–	10	10	N/A	N/A	N/A
Missouri	–	13	43	105	N/A	N/A
New Jersey	–	–	41.50	83	134.50	$134.50
New York	–	–	9	30	45	60
Oregon[5]	–	–	28.50	43	43	N/A
Pennsylvania[5]	–	–	48	67	N/A	N/A
Rhode Island[4]	–	61	92	92	N/A	N/A
Vermont[6]	–	–	–	20/60	20/60	N/A
Washington	–	–	20	30	30	N/A
West Virginia	–	–	35	35	N/A	N/A
Wisconsin	–	–	10	34	97	N/A
Quarterly Payments						
Nevada[4]	$25	$50	$80	N/A	N/A	N/A
Utah[4]	30	75	75	N/A	N/A	N/A
Annual Payments						
Alabama[7]	$52	$104	$104	$104	$104	N/A
Colorado	–	25	25	75	N/A	N/A
North Carolina	–	50	50	N/A	N/A	N/A
Texas	–	35	50	N/A	N/A	N/A

Notes: For states with eligibility levels ending at 200 percent of the federal poverty level (FPL), the highest premiums are shown in the column for 201 percent FPL; this approach also applies to the columns for 251 percent FPL, 301 percent FPL, and 351 percent FPL. Dashes represent states with no premium and/or where children are enrolled in Medicaid. N/A represents states that do not extend CHIP eligibility to children at that income level. Some states have changed policies with regard to premiums in CHIP since January 2013. For example, 6- to 18-year-olds between 100 and 138 percent FPL must be enrolled in Medicaid-expansion CHIP rather than separate CHIP programs, as of January 1, 2014, and therefore are not subject to premiums. Table excludes premiums for Medicaid-funded children in Minnesota and Vermont. The following states had no premiums or enrollment fees: AK, AR, DC, HI, KY, MN, MS, MT, NE, NH, NM, ND, OH, OK, SC, SD, TN, VA, and WY.

[1] Family caps may apply.

[2] Premiums in California depend on whether the child is enrolled in a community provider plan. The first figure applies to children enrolled in a community provider plan; the second applies to those who are not.

[3] In Delaware, premiums are per family per month regardless of the number of eligible children. Delaware has an incentive system for premiums where families can pay three months and get one premium-free month, pay six months and get two premium-free months, and pay nine months and get three premium-free months.

[4] In Louisiana, Maryland, Michigan, Rhode Island, Nevada, and Utah, premiums are family-based, not costs per child.

[5] In Oregon and Pennsylvania, premiums vary by plan. The average amount is shown.

[6] In Vermont, premiums are for all children in the family, not costs per child. For those above 225 percent FPL, the monthly charge is $20 if the family has other health insurance and $60 if there is no other health insurance.

[7] Alabama's premium is an annual fee and is not required before a child enrolls in coverage.

Source: MACPAC analysis of Heberlein et al. 2013.

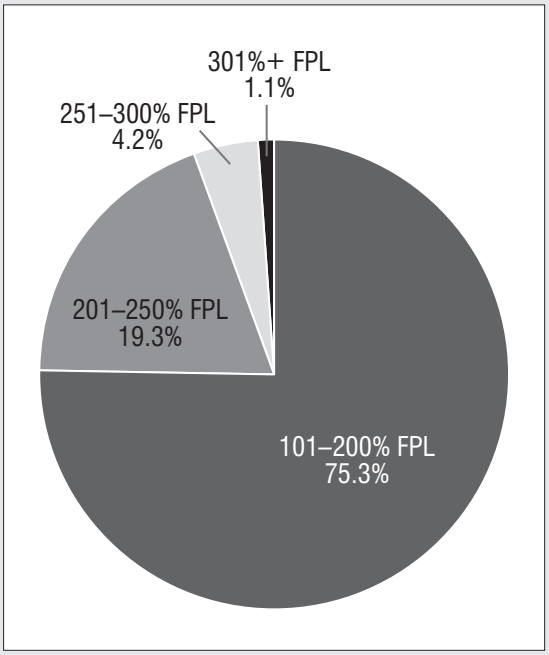
income level (Table 5-3). For a family of three at 251 percent FPL ($49,673 per year) with two children, CHIP premiums of $50 per month per child ($1,200 per year) would amount to 2.4 percent of family income.[19] A family's total out-of-pocket costs in CHIP—premiums as well as cost sharing—may not exceed 5 percent of family income.

Although states may not charge premiums to Medicaid enrollees below 150 FPL, separate CHIP programs may do so. As of January 2013, several states reported charging CHIP premiums below 150 percent FPL—Alabama, Arizona, California, Delaware, Florida, Georgia, Idaho, Nevada, and Utah (Table 5-2). Since then, California has changed most of its CHIP program to a Medicaid-expansion program and has eliminated premiums below 150 percent FPL, which could reduce the number of children in that state subject to CHIP premiums by nearly 500,000 children (CMS 2012).[20]

Based on the state policies reported as of January 2013 (Heberlein et al. 2013), a MACPAC analysis of FY 2012 CHIP Statistical Enrollment Data System (SEDS) estimated that approximately 44 percent of CHIP-financed children—3.4 million—were subject to CHIP premiums. The vast majority of these children were in families whose incomes fell between 101 percent and 200 percent FPL (Figure 5-2).[21] Excluding California, an estimated 371,000 children were estimated to be subject to CHIP premiums below 150 percent FPL, according to MACPAC analyses of FY 2012 CHIP enrollment data in eight states: Alabama, Arizona, Delaware, Florida, Georgia, Idaho, Nevada, and Utah.[22]

The ACA is reducing the number of children below 150 percent FPL subject to CHIP premiums from 371,000 to approximately 110,000. This is occurring because of two ACA policies. First, 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs will transition to Medicaid-expansion CHIP programs. These children will no longer be charged premiums, because Medicaid does not permit premiums below 150 percent FPL. This will decrease the number of children below 150 percent FPL who may be charged CHIP premiums in eight states by approximately 216,000.

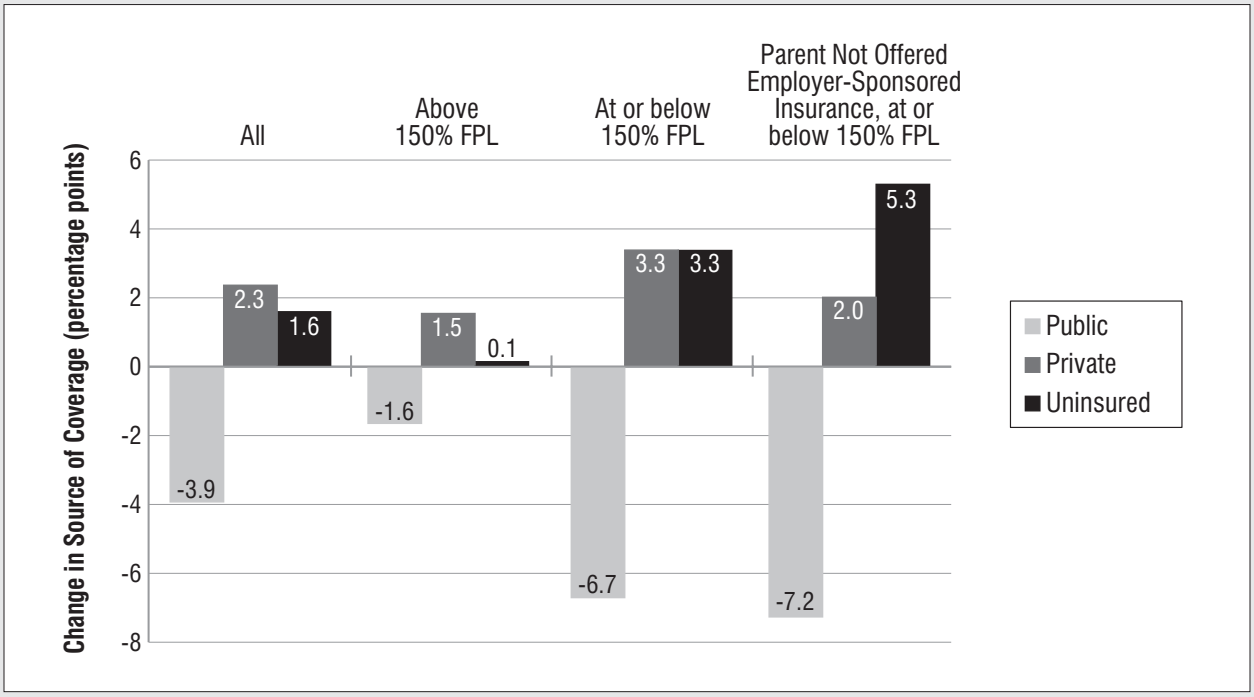
FIGURE 5-2. Estimated Distribution of CHIP-Enrolled Children Charged CHIP Premiums, by Federal Poverty Level (FPL)



Sources: MACPAC analysis of FY 2012 CHIP Statistical Enrollment Data System (SEDS) and state policies reported in Heberlein et al. 2013.

Second, the number of children subject to CHIP premiums below 150 percent FPL will also be reduced by the move to counting family income according to MAGI. Because MAGI requires disregarding an additional 5 percentage points of the FPL when determining if children are eligible for Medicaid and CHIP, in most states, Medicaid will effectively extend eligibility for children to 138 percent FPL rather than 133 percent FPL. This will reduce the number of children potentially subject to CHIP premiums in these eight states by another 46,000.

FIGURE 5-3. Simulated Effect of $120 Increase in Annual Premiums on Medicaid and CHIP Children above 100 Percent Federal Poverty Level (FPL)



Note: Components may not add to total due to rounding.

Source: Abdus et al. 2013.

TABLE 5-4. Examples of the Impact of Combined CHIP and Exchange Premiums for a Family of Three with Two CHIP-Enrolled Children

Federal Poverty Level	Annual income	Annual Exchange Out-of-Pocket Premiums		Monthly CHIP Out-of-Pocket Premiums Per Child	Annual CHIP Out-of-Pocket Premiums		Combined Annual Exchange and CHIP Out-of Pocket Premiums	
		Dollars	Percent of income		Dollars	Percent of income	Dollars	Percent of income
151%	$29,490	$1,193	4.05%	$20	$480	1.6%	$1,673	5.7%
201%	39,255	2,487	6.34	30	720	1.8	3,207	8.2
251%	49,020	3,960	8.08	30	720	1.5	4,680	9.5
301%	58,785	5,585	9.50	100	2,400	4.1	7,985	13.6

Note: Components may not add to total due to rounding. The CHIP premiums illustrated here are designed to represent typical premiums between the lowest and highest amounts in use by states. The exchange premiums are based on the maximum allowable premiums for the second lowest-cost silver plans for individuals eligible for subsidies based on 2013 FPLs, which apply for determining eligibility for subsidized exchange coverage in 2014. The exchange out-of-pocket premium shows the maximum permitted for subsidy-eligible individuals. However, if the total premium for the second lowest-cost exchange plan is less than the amount shown, then the family would pay that lower amount and receive no premium tax credit.

Source: MACPAC analysis of Heberlein et al. 2013.

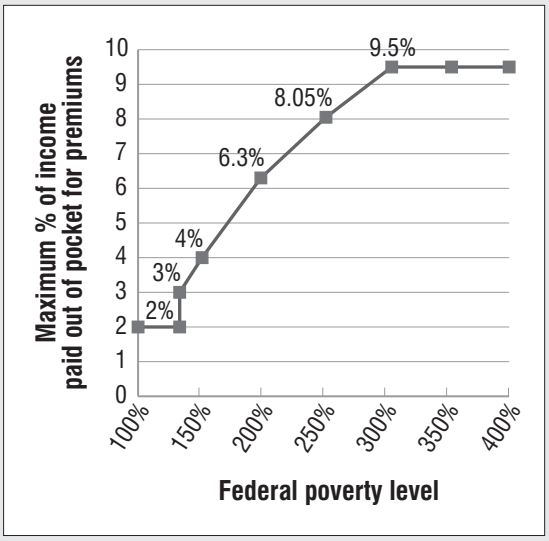
While CHIP premiums below 150 percent FPL may prevent crowd-out of employer-sponsored insurance, they also increase children's uninsurance (Abdus et al. 2013, Herndon et al. 2008). For example, increasing CHIP premiums by $120 annually—including going from no CHIP premium to $120 per year—for children at or below 150 percent FPL would decrease public coverage by 6.7 percentage points, increase private coverage by 3.3 percentage points, and increase uninsurance by 3.3 percentage points (Figure 5-3). For families in this income range who are not offered job-based coverage, the impact of premiums increasing uninsurance is even larger, and the reduction in private coverage is smaller (Abdus et al. 2013). For children above 150 percent FPL, the effect of premiums in increasing uninsurance is much smaller (Figure 5-3).[23]

CHIP–exchange premium stacking. Parents of some CHIP-enrolled children will be eligible for subsidized exchange coverage, for which they will generally pay some out-of-pocket premiums. The amount they pay will vary by income, family size, the plan in which they enroll, and the area in which they live. Exchange plans vary by actuarial value (i.e., the percentage of health care costs paid by the plan), with plans generally classified into four categories—bronze, silver, gold, and platinum.[24] The amount of the premium tax credit is tied to the silver plan with the second-lowest premium in every area, for which families' contribution ranges from 2 percent of income (for those below 133 percent FPL) to 9.5 percent of income (for those between 300 percent and 400 percent FPL) (Figure 5-4).[25] (See Appendix Table 5-A-1 for additional examples of premiums in different geographic areas.)

The combination of premiums for both CHIP and exchange coverage could be substantial for some families (Table 5-4). For example, a single mother with two children who earns $29,490 per year (151 percent FPL) would be eligible for an exchange subsidy, limiting her premium contribution for the benchmark plan to 4 percent of her income, or $1,193. Her children would be required to enroll in CHIP, not the exchange. In a state charging $20 per child per month for CHIP coverage, the additional cost for this coverage would be an additional 1.6 percent of her income. In total, she would be paying 5.6 percent of her income for insurance coverage, more than contemplated by the limits established in the ACA.

The Commission discussed CHIP-exchange premium stacking and the financial hardship that could result for families. The Commission considered ways to mitigate premium stacking, with consideration of how costs associated with addressing the issue could be split between states and the federal government. No clear consensus was reached for the best approach. The Commission will continue to monitor this issue and assess possible policy options.

FIGURE 5-4. Percent of Income for Out-of-Pocket Premiums for Subsidized Exchange Coverage in the Second Lowest-Cost Silver Plan, by Federal Poverty Level (FPL)



Source: MACPAC analysis.

Commission Recommendation

Recommendation 5.2

In order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums.

Rationale

Eliminating CHIP premiums for families with incomes under 150 percent FPL will reduce uninsurance and align CHIP premium policies with Medicaid policies for lower-income children. Compared to higher-income enrollees, children in families below 150 percent FPL are much more price sensitive and less likely to take up CHIP coverage when a premium is required (Abdus et al. 2013, Herndon et al. 2008). The CHIP premiums charged in this income range, generally less than $10 per month (Table 5-3), 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 (Kenney et al. 2007). Ending these CHIP premiums would also address some CHIP-exchange premium stacking for the lowest-income CHIP enrollees, limiting family insurance costs to the amounts set out in the ACA. This recommendation does 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.

As described in this chapter, while CHIP premiums are widely used, only eight states continue to charge CHIP premiums below 150 percent FPL.[26] Because of ACA changes effective in 2014, the income band for premiums under 150 percent FPL in separate CHIP programs is narrowed down to the income range of 139 to 150 percent FPL, with the number of children potentially facing CHIP premiums below 150 percent FPL reduced to approximately 110,000.

Implications

Federal spending. CHIP matching funds would be available for any increase in state CHIP spending due to loss of premiums or increased enrollment, up to the point at which states have expended their allotments. This recommendation would increase federal spending by less than $50 million in 2015 and by less than $1 billion over the five-year period of 2015 to 2019. These are the smallest non-zero ranges provided by CBO.

States. Eight states charge premiums below 150 percent FPL in their separate CHIP programs. Because of the ACA, the number of children subject to CHIP premiums below 150 percent FPL is shrinking considerably in 2014—to a narrow window between 139 and 150 percent FPL. Ending the use of CHIP premiums would affect state spending in three ways. First, states would lose a small amount of revenue from premiums currently paid by families under 150 percent FPL. Second, states would likely see administrative savings associated with no longer collecting these CHIP premiums. The amount of revenue from CHIP premiums obtained from families below 150 percent FPL is relatively small compared to the administrative costs they create (Kenney et al. 2007). Third, some increased CHIP spending would result from increased enrollment, from children otherwise prevented from enrolling by the premiums.

Enrollees. If states no longer charged CHIP premiums below 150 percent FPL, an estimated 110,000 children would be exempted from CHIP premiums, based on FY 2012 data. As a result of ending these premiums, additional children might also enroll in CHIP, reducing uninsurance but also

private coverage (Abdus et al. 2013, Herndon et al. 2008).

Plans. Plans would no longer have to obtain premiums from newly exempted families, which would reduce administrative burden and increase enrollee retention. Ending CHIP premiums for families below 150 percent FPL might also increase CHIP enrollment in the eight affected states.

Providers. Ending CHIP premiums for families below 150 percent FPL would not have significant direct effects on providers.

Endnotes

[1] For a more in-depth discussion on the impact of CHIP on children's uninsurance, see "Impact of CHIP" in Chapter 3 of MACPAC's January 2013 publication entitled *Overview of Medicaid and CHIP*. See also Martinez and Cohen 2013.

[2] Because of the ACA requirement to count income according to MAGI, states will be required to disregard income equal to 5 percent FPL. For this reason, Medicaid eligibility for children (and other groups) is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[3] Medicaid figure excludes about 1 million individuals in U.S. territories. See MACStats Tables 3 and 8 for state-by-state information on CHIP enrollment and spending.

[4] Through FY 2013, states could receive CHIPRA bonus payments for implementing five of eight particular outreach activities. Four of those eight are now required for children's eligibility in Medicaid and CHIP: no asset test, no requirement for an in-person interview, use of the same application and renewal forms in both Medicaid and CHIP, and administrative renewal based on information available to the state.

[5] In addition, CMS issued guidance that states would also be in violation of the MOE if they increased premiums considerably or if they imposed premiums for the first time on existing eligibility groups (CMS 2011).

[6] While the federal CHIP statute limits states' upper-income eligibility levels to 200 percent FPL, or, if higher, 50 percentage points above states' pre-CHIP Medicaid levels, states were permitted to count applicants' income so they could effectively expand eligibility to any income level (HCFA 2001). MAGI eliminated that income-counting flexibility. Unless states obtain federally approved waivers, the original statutory limitation at 200 percent FPL, or 50 percentage points above their 1997 Medicaid levels for children, holds for 2014 forward. (States that expanded prior to 2014 and the implementation of MAGI are grandfathered.)

[7] Cost sharing is also limited by other federal CHIP policies. For example, federal law prohibits states from charging cost sharing for preventive or pregnancy-related services.

[8] Cost-sharing subsidies are given in terms of a plan's actuarial value. Actuarial values estimate the percentage of covered expenses that are paid for by the plan, with the remaining percentage paid for by the enrollee as cost sharing. Actuarial values are calculated as averages for an entire population. In exchange plans, qualifying individuals up to 150 percent FPL are eligible for plans with an actuarial value of 94 percent (i.e., cost sharing equal to 6 percent on average across all enrollees and services). The subsidy decreases as family income rises. Actuarial values are 87 percent for those above 150 percent FPL but at or below 200 percent FPL, and 73 percent for those above 200 percent FPL but at or below 250 percent FPL (§1402(c)(2) of the ACA). An analysis of 16 separate CHIP programs estimated their actuarial values as all above 95 percent FPL—at 175 percent FPL and 225 percent FPL (Watson Wyatt Worldwide 2009). West Virginia was included in the original analysis, but its results are not included here because it has since reduced its CHIP cost sharing, which would increase its actuarial value (MACPAC 2013c).

[9] To minimize burden on individuals and ensure that eligibility is determined promptly, state CHIP agencies must have agreements with Medicaid and exchanges to share application information and maintain proper oversight of determinations made by the other program (42 CFR 457.348).

[10] Research on churning has historically focused on transitions from Medicaid or CHIP to uninsurance, particularly at children's regular eligibility redetermination. The main emphasis of that prior research was on what is called administrative churning, where children's coverage terminates because families do not or cannot provide the necessary application or documentation. However, the ACA required states to streamline eligibility determinations and to use existing data wherever possible, in order to minimize the likelihood of administrative churning at redeterminations. Assessing the impact of the ACA on administrative churning and children's coverage will not be possible until actual enrollment data are available, and this will be an area of interest to the Commission when those data are available.

[11] In addition, 8 reported cost sharing, 28 monitoring, and 8 with some other activity. These data are from the federal CHIP Annual Reporting Template System (CARTS). All states are asked to complete Section IIIB, which pertains to "substitution of coverage (crowd-out)." After noting whether or not there are "substitution prevention policies in place," states answering in the affirmative must check one or more of the following: imposing waiting periods between terminating private coverage and enrolling in CHIP, imposing cost sharing in approximation to the cost of private coverage, monitoring health insurance status at the time of application, and "Other, please explain."

[12] States may be able to implement waiting periods in Medicaid with a federally approved waiver. However, waiting periods under these Medicaid waivers are generally limited to populations not otherwise entitled to Medicaid.

[13] Among uninsured children with incomes between 200 and 399 percent FPL, 9.2 percent had employer-sponsored insurance three months beforehand, 83.9 percent were uninsured, 5.3 percent had Medicaid, and 1.6 percent had other coverage. These estimates are derived from analysis of the Medicaid Expenditure Panel Survey for uninsured children based on pooled data from December of 2009, 2010, and 2011, along with information on these children's health insurance three months prior. MACPAC explored using administrative data for this analysis. The best candidate for information on CHIP waiting periods among administrative data sources was the CARTS. However, MACPAC staff assessed the information reported by states through CARTS on CHIP waiting periods and on applicants' prior employer-sponsored insurance, and the data do not appear usable. For example, states are required to report the percentage of children subject to a CHIP waiting period and exempt from a CHIP waiting period. By state, the percentages ranged from 0 percent to 100 percent.

[14] While survey estimates indicate that relatively few uninsured children had employer-sponsored insurance three months beforehand, they do not shed light on the effectiveness of CHIP waiting periods in deterring crowd-out. The primary purpose of CHIP waiting periods is not to force uninsured children to go without coverage, but to deter parents from dropping their children's employer-sponsored insurance in favor of CHIP coverage that is less expensive to the family and more costly to the federal and state governments. However, no available sources of data ask parents whether they continued their children's enrollment in employer-sponsored insurance because of the waiting periods required in CHIP.

[15] New York is the only state continuing to use CHIP waiting periods that is not using the federally facilitated exchange; New York's exchange is a state-based model. The other 20 states shown in Table 5-1 as having CHIP waiting periods in 2014 use the federally facilitated exchange—either exclusively or in partnership with the state.

[16] Five of the states shown in Table 5-1 as having CHIP waiting periods in 2014 are both using the federally facilitated exchange and permitting the exchange to perform eligibility determinations for Medicaid and, in some cases, CHIP. In three of those states (Louisiana, Texas, and Wisconsin), the federally facilitated exchange is performing Medicaid and CHIP determinations "temporarily as a mitigation strategy" (CMS 2013b). In Wyoming, the federally facilitated exchange is performing Medicaid determinations, but not CHIP determinations. The fifth state, Montana, appears to have a permanent arrangement for the federally facilitated exchange to perform both Medicaid and CHIP determinations (CMS 2013b).

[17] CMS called the evidence base on crowd-out generally "robust but inconclusive" (HHS 2013). On CHIP waiting periods in particular, there are two studies that analyzed the effects of CHIP waiting periods on crowd-out. One found that CHIP waiting periods reduced crowd-out (LoSasso and Buchmueller 2004). The second found "there is certainly no reason to conclude that waiting periods are lowering the crowd-out rate" (Gruber and Simon 2007). In a follow-up analysis, LoSasso and Buchmueller used the data used in their research but applied the approach by Gruber and Simon and continued to find evidence that waiting periods reduce crowd-out; thus, the main difference between the results appears to be the dataset used (Gruber and Simon 2007). LoSasso and Buchmueller used the Current Population Survey, while Gruber and Simon used the Survey of Income and Program Participation—both surveys administered by the U.S. Census Bureau.

[18] Waiting periods are not unprecedented in federal health insurance programs. For most individuals, there is a 24-month waiting period for Medicare after an individual qualifies for Social Security Disability Insurance.

[19] While most states charge CHIP premiums on a monthly basis, some apply premiums (or enrollment fees) on a quarterly or annual basis (Table 5-3). Some also cap the family amount of CHIP premiums.

[20] According to California's approved waiver documentation, for children who have family income between 151 percent and 250 percent FPL, monthly CHIP premiums will be $13 for one child, $26 for two children, and $39 for three or more children. This waiver allowed California to transition its CHIP-enrolled children from a separate CHIP program to a Medicaid-expansion CHIP program while permitting premiums for those children above 150 percent FPL. In addition, families who pay three months of premiums in advance will receive the fourth consecutive month with no premium required. Families paying by means of electronic funds transfer, including credit card payment, will receive a 25 percent discount (CMS 2012).

[21] The SEDS income categories do not allow breaking down the 101 percent to 200 percent FPL range into smaller groups. The large percentage of CHIP-enrolled children charged premiums who are between 101 and 200 percent FPL is reflective of CHIP enrollment overall. Approximately 89 percent of CHIP-enrolled children are below 200 percent FPL.

[22] California was not included because the state has stopped charging CHIP premiums below 150 percent FPL.

[23] For children above 150 percent FPL, a $120 annual CHIP premium increase would decrease public coverage by 1.6 percentage points, increase private coverage by 1.5 percentage points, and increase uninsurance by 0.1 percentage points (Abdus et al. 2013).

[24] The actuarial values are 60 percent for bronze plans, 70 percent for silver plans, 80 percent for gold plans, and 90 percent for platinum plans. For certain individuals under age 30, catastrophic plans are also available through exchanges.

[25] No credit is available if the premium for the second lowest-cost silver plan is less than the amount individuals are required to pay out of pocket. If a credit is available, the family's choice of plan will affect the out-of-pocket costs they pay. For families who choose lower-cost plans (e.g., bronze plans or the lowest-cost silver plan), the premium tax credit may cover a greater portion of the premium. If families choose more expensive plans (e.g., gold or platinum plans), they will be responsible for the difference. However, cost-sharing reductions for families below 250 percent FPL are only available if the family chooses a silver plan. Families will also have to pay separate premiums and cost sharing for exchange-based stand-alone dental plans, in states where offered.

[26] Alabama, Arizona, Delaware, Florida, Georgia, Idaho, Nevada, and Utah.

References

Abdus, S., J. Hudson, S.C. Hill, and T. Selden. 2013. Children's insurance coverage: Evidence from the Medical Expenditure Panel Survey (MEPS). Presentation before the Association for Public Policy Analysis & Management, November 9, 2013, Washington, DC; follow-up with slightly revised numbers from authors, December 13, 2013.

Agency for Healthcare Research and Quality (AHRQ). 2013. Table I.G.2(2012). Employee contribution distributions (in dollars) for employees enrolled in single, employee-plus-one, and family coverage at the 10th, 25th, 50th (median), 75th, and 90th percentiles at private-sector establishments that offer health insurance by firm size: United States, 2012. Rockville, MD: AHRQ. http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tig2.pdf.

Caldwell, C. 2013a. Presentation before the Medicaid and CHIP Payment and Access Commission, November 14, 2013, Washington, DC. http://www.macpac.gov/home/transcripts/MACPAC_2013-11_Transcript.pdf.

Caldwell, C., Alabama Department of Public Health. 2013b. E-mail to MACPAC staff, December 4.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. 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.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. Medicaid and CHIP marketplace interactions. Baltimore, MD: CMS. http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-and-the-Marketplace/medicaid-chip-marketplace-interactions.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. *Centers for Medicare & Medicaid Services special terms and conditions: California bridge to reform demonstration.* Baltimore, MD: CMS. http://www.dhcs.ca.gov/provgovpart/Documents/1115amendapprovallet12312012.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Letter from Cindy Mann to State Health Officials regarding "Maintenance of effort." February 25, 2011. http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf.

Czajka, J.L., Mathematica Policy Research. 2013. E-mail to MACPAC staff, February 15.

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

Gruber, J., and K. Simon. 2007. *Crowd-out ten years later: Have recent public insurance expansions crowded out private health insurance?* NBER Working Paper, no. 12858. Cambridge, MA: National Bureau of Economic Research. http://www.nber.org/papers/w12858.pdf.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 2001. Medicaid program; Change in application of federal financial participation limits. Final rule. *Federal Register* 66, no. 8 (January 11): 2316–2322.

Heberlein, M., T. Brooks, J. Alker, et al. 2013. *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 Family Foundation. http://www.kff.org/medicaid/upload/8401.pdf.

Herndon, J.B., W.B. Vogel, R.L. Bucciarelli, and E.A. Shenkman. 2008. The effect of premium changes on SCHIP enrollment duration. *Health Services Research* 43(2): 458–477.

Highmark West Virginia. 2013. Letter from J. Fred Earley, II, president, to Sharon L. Carte, executive director of West Virginia Children's Health Insurance Program. August 6, 2013.

Kaiser Family Foundation (KFF). 2013. Subsidy calculator: Premium assistance for coverage in exchanges. Washington, DC: KFF. http://kff.org/interactive/subsidy-calculator/.

Kenney, G., J. Marton, J. McFeeters, and J. Costich. 2007. Assessing potential enrollment and budgetary effects of SCHIP premiums: Findings from Arizona and Kentucky. *Health Services Research* 42 (6 Pt 2): 2354–2372.

LoSasso, A., and T. Buchmueller. 2004. The effect of the State Children's Health Insurance Program on health insurance coverage. *Journal of Health Economics* 23(5): 1059–1082.

Martinez, M.E., and R.A. Cohen. 2013. *Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2013*. Hyattsville, MD: National Center for Health Statistics. http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201312.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013a. *Overview of Medicaid and CHIP*. January 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013b. *Report to the Congress on Medicaid and CHIP*. March 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013c. Public meeting, November 2013. Washington, DC: MACPAC. http://www.macpac.gov/home/transcripts/MACPAC_2013-11_Transcript.pdf.

National Conference of State Legislatures (NCSL). 2012. Quick reference fiscal table. Washington, DC: NCSL. http://www.ncsl.org/research/fiscal-policy/basic-information-about-which-states-have-major-ta.aspx#fyrs.

Touschner, J. 2014. Separate CHIP benefits and cost sharing. Presentation before the Medicaid and CHIP Payment and Access Commission, January 23, 2014, Washington, DC. http://www.macpac.gov/home/2014-01/2014JanuarySession3aTouschner.pdf.

U.S. Department of Health and Human Services (HHS). 2013. Medicaid and Children's Health Insurance Programs: Essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; exchanges: eligibility and enrollment. Final rule. *Federal Register* 78, no. 135 (July 15): 42180.

U.S. Government Accountability Office (GAO). 2013. *Children's health insurance: Information on coverage of services, costs to consumers, and access to care in CHIP and other sources of insurance.* Report no. GAO-14-40. Washington, DC: GAO. http://www.gao.gov/assets/660/659180.pdf.

U.S. Government Accountability Office (GAO). 2012. *Children's health insurance: Opportunities exist for improved access to affordable insurance.* Report no. GAO-12-648. Washington, DC: GAO. http://www.gao.gov/assets/600/591797.pdf.

Watson Wyatt Worldwide. 2009. *Implications of health care reform for children currently enrolled in CHIP programs*. Washington, DC: First Focus. http://www.firstfocus.net/library/reports/implications-health-care-reform-children-currently-inrolled-chip-programs.

Chapter 5 Appendix

APPENDIX TABLE 5-A-1. Examples of Premiums and Cost Sharing (Out-of-Pocket Maximum) for a Family of Three with Two Adults (Age 40) and One Child in the Silver Plan with the Second-Lowest Premium

	150 Percent FPL	200 Percent FPL	300 Percent FPL	350 Percent FPL
Household income	$29,295	$39,060	$58,590	$68,355
Maximum premium as a percent of income	4%	6.3%	9.5%	9.5%
Enrollee premium responsibility	$1,172	$2,461	$5,566	$6,494
Out-of-pocket maximum for services	4,500	10,400	12,700	12,700
Tax Credits in Selected Locations				
Little Rock, Arkansas ($9,174 total premium)	$8,002	$6,713	$3,607	$2,680
Sacramento, California ($8,090 total premium)	6,918	5,629	2,524	1,596
Tallahassee, Florida ($8,791 total premium)	7,620	6,331	3,225	2,298
Atlanta, Georgia ($7,506 total premium)	6,334	5,045	1,940	1,012
Indianapolis, Indiana ($10,202 total premium)	9,030	7,741	4,636	3,708
Augusta, Maine ($9,583 total premium)	8,411	7,122	4,017	3,089
Albany, New York ($11,699 total premium)	10,527	9,238	6,133	5,206
Bismarck, North Dakota ($8,602 total premium)	7,430	6,141	3,036	2,108
Columbus, Ohio ($7,578 total premium)	6,406	5,117	2,012	1,084
Austin, Texas ($7,478 total premium)	6,306	5,017	1,912	984
Charleston, West Virginia ($8,642 total premium)	7,470	6,181	3,076	2,148

Note: FPL is federal poverty level. Because exchange coverage uses the prior year's FPL, this table reflects the 2013 FPLs.
Source: KFF 2013.