Statement of

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Medicaid and CHIP Payment and Access Commission

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Medicaid and CHIP Payment and Access Commission
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Summary

Since its enactment with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health care for tens of millions of low- and moderate-income children with incomes just above Medicaid eligibility levels. Lessons learned from CHIP should continue to inform public policy even as changes in coverage options dictate a re-examination of its role and purpose.

In its June 2014 report to the Congress, MACPAC recommended that the Congress extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed. In coming to this consensus recommendation, the Commission considered what would happen if no CHIP allotments were made to states after fiscal year 2015. It found that many children now served by the program would not have a smooth transition to another source of coverage. The number of uninsured children would likely rise, cost sharing would often be significantly higher, and exchange plans appear unready to serve as an adequate alternative in terms of benefits and provider networks.

When the Commission made this recommendation, it noted that there was insufficient time between then and the end of FY 2015 to address all these issues, either in law or regulation. Under current law, states will run out of CHIP funding at various points during FY 2016 with more than half of states exhausting funds in the first two quarters. In the absence of federal CHIP funding, states with Medicaid-expansion CHIP programs must maintain their 2010 eligibility levels for children through FY 2019 at their regular Medicaid matching rate, meaning at increased state costs. States operating separate CHIP programs are not obligated to continue funding their programs if federal CHIP funding is exhausted and will most likely terminate such coverage.

A time-limited extension of CHIP funding is needed to minimize coverage disruptions and provide for a thorough examination of options addressing affordability, adequacy, and transitions to other sources of coverage. An abrupt end to CHIP would be a step backward from the progress that has been made under CHIP. In addition, congressional action is required so that states do not respond to uncertainty around CHIP's future by implementing policies that reduce children's access to services that support their healthy growth and development. Finally, MACPAC has stated that this transition period could be extended if the problems it has identified have not been addressed within that two-year period.

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Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee on Health. I am Anne Schwartz, executive director of the Medicaid and CHIP Payment and Access Commission (MACPAC). As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on issues affecting these programs. Its 17 members, led by Chair Diane Rowland and Vice Chair David Sundwall, are appointed by the U.S. Government Accountability Office (GAO). While the insights and expertise I will share this morning build on the analyses conducted by MACPAC's staff, they are in fact the consensus views of the Commission itself. We appreciate the opportunity to share MACPAC's recommendations and work as this Committee considers the future of the State Children's Health Insurance Program (CHIP).

Since its enactment with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health care for tens of millions of low-income children with incomes just above Medicaid eligibility levels. Over this period, the share of uninsured children in the typical CHIP income range (those with family income above 100 percent but below 200 percent of the federal poverty level (FPL)) has fallen by more than half—from 22.8 percent in 1997 to 10.0 percent in 2013 (MACPAC 2014a). Over that time period, which included two recessions, private coverage for children in this income range also declined substantially—from 55 percent in 1997 to 27.1 percent in 2013 (Martinez and Cohen 2013, 2012).[1]

Given that the last federal CHIP allotments under current law are now being distributed to states, the Commission has focused considerable attention on CHIP over the past year in order to provide the Congress with expert advice about the program's future. This inquiry, which is ongoing, has considered the program in its new context, given the significant change in insurance options since 1997. Subsidized exchange plans now potentially offer an alternative source of coverage to some children now covered by CHIP. Other policy changes included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) may also lead to additional enrollment of parents of those covered by CHIP in employer-sponsored coverage.

In addition to considering CHIP's future from the perspective of low-income children and families, the Commission has also examined issues in CHIP financing—in particular, how states will be affected if federal CHIP funding ends. MACPAC's most recent analyses focus on when, absent congressional action, states will run out of CHIP funds and how the requirement that states maintain coverage for children through FY 2019 will differentially affect states based on their decisions to run CHIP as a Medicaid expansion or a separate program.

In my testimony today, I will first present the rationale behind the recommendation, reached unanimously by Commission members, that CHIP funding be extended two years, as well as the evidence they considered in making that recommendation. I will then turn to financing issues.

Rationale for the Recommendation to Continue CHIP Funding for Two Years

In its June 2014 report to the Congress, MACPAC recommended that the Congress extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

The Congressional Budget Office (CBO) estimates that MACPAC's recommendation would increase net federal spending by $0–5 billion above the agency's current law baseline. The federal costs of providing CHIP allotments for two more years would be largely 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 if CHIP funding were to be exhausted under current law. CBO's estimate also 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.[2]

In coming to this consensus recommendation, the Commission considered several options as it examined the role of CHIP given new coverage options for low-income families. The Commission considered what would happen under the current-law scenario, under which states would exhaust CHIP funding as FY 2016 begins. It found that many children now served by the program would not have a smooth transition to another source of coverage offering comparable benefits and cost sharing. The number of uninsured children would likely rise, and the cost sharing for children obtaining other coverage would often be significantly higher. Moreover, in the Commission's view, it is not clear that exchange plans are ready to serve as an adequate alternative for children now insured by CHIP in terms of covered benefits and provider networks.

The Commission also considered extending CHIP funding through FY 2019, consistent with the current law requirement that states maintain eligibility for children under Medicaid and CHIP through FY 2019. In addition to aligning coverage and financing policies, this approach would allow for completion and consideration of the Secretary's assessment of the comparability of CHIP and exchange coverage in terms of benefits and cost sharing, which I will discuss more in a moment.

Without question, CHIP has reduced the number of uninsured children, and lessons learned from that experience should continue to inform public policy. But the ACA transformed the policy context for CHIP such that CHIP-funded coverage now represents a small wedge among coverage options, potentially adding complexity for families and administrative costs for the states and the federal government. Thus, in the Commission's view, coverage for children under a separate CHIP authority should not be maintained indefinitely. The optimal outcome for children and families is to address affordability and adequacy so that low- and moderate-income children have affordable coverage that offers access to high-quality care, services that are critical to children's healthy development. They should also have smooth transitions to other sources of coverage, including Medicaid, exchange, and employer-sponsored coverage, as their family circumstances change.

When the Commission made this recommendation this past June, it noted that there was insufficient time between then and the end of FY 2015 to address all these issues, either in law or regulation. A time-limited extension of CHIP funding is needed to minimize coverage disruptions and provide for a thorough examination of the coverage options for children. The members of the Commission believe that these limitations must be addressed so as not to step backward from the relatively high level of good coverage children now have through CHIP.

MACPAC has stated that this transition period could be extended if the problems it has identified have not been addressed within the two-year period. However, the Commission also stated in the June report its view that the changes necessary to ensure that children have access to high-quality coverage can be accomplished during these two years.

Below, I describe in greater detail the Commission's three major concerns about an abrupt end to CHIP.

- The number of uninsured children would increase significantly. Not all children currently covered by CHIP would be eligible for subsidized exchange coverage. Among those whose

parents are enrolled in or who are eligible for employer-sponsored insurance, premiums for family coverage could be too high relative to families' ability to pay.

- Cost sharing for services would increase substantially for many families.
- It is unclear whether exchange plans are ready to serve as an adequate source of coverage (in terms of benefits and adequacy of provider networks) relative to CHIP.

Future Sources of Coverage for Children Now Enrolled in CHIP

If CHIP funding ends, the children now covered by the program will face different scenarios based on family circumstances (for example, whether a parent has access to employer-sponsored coverage) and the historical choices made by states to run their CHIP program as a Medicaid expansion or separate CHIP program.

Children in Medicaid-expansion CHIP programs. Of the 8.1 million children enrolled in CHIP in FY 2013, 30 percent were in Medicaid-expansion CHIP. Medicaid-expansion CHIP enrollment is expected to increase in part due to the transition in 19 states of children between 100 percent and 133 percent FPL from separate CHIP to Medicaid, so-called stairstep children. States' spending projections indicate that half of CHIP spending in FY 2015 will be for children in Medicaid-expansion CHIP.[3] If CHIP funding runs out shortly after FY 2015, consistent with current law, these children would continue in Medicaid coverage but with federal funding from Medicaid at Medicaid's lower matching rate.[4]

Children age 0–18 in separate CHIP programs. Approximately two-thirds of children age 0–18 with CHIP coverage in FY 2013 were in separate CHIP programs. (Appendix Table 1-A-3 in MACPAC's June 2014 report details CHIP enrollment by state.) Separate CHIP programs generally operate under a set of federal rules that allow states to design benefit packages that look more like commercial insurance than Medicaid. States may also charge premiums, institute enrollment caps, create waiting periods, and brand and market their CHIP programs separately from Medicaid.

Although children in separate CHIP programs are generally in the income range to qualify for subsidized exchange coverage, in fact, such coverage is likely to be available to less than half of these children. One analysis estimated that the end of CHIP could lead to as many as 2 million more children becoming uninsured (Kenney et al. 2011).[5]

There are several reasons for this gap. First, children are generally only eligible for subsidized exchange coverage if a parent is not offered affordable employer-sponsored insurance. More than half (56 percent) of children have parents who report having access to employer-sponsored insurance—the vast majority of which would be considered affordable under the ACA definition, therefore disqualifying them from exchange subsidies. The ACA defines employer-sponsored coverage as affordable if an employee's out-of-pocket premiums for self-only coverage would account for no more than 9.5 percent of a family's income. This affordability test is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered.

For families not eligible for Medicaid, nearly all employer-sponsored coverage would be considered affordable based on the ACA's self-only coverage definition. Even at the 90th percentile of premiums for job-based coverage, the self-only premium paid by employees for a family of three at 138 percent FPL would comprise only 8.2 percent of income—still short of the 9.5 percent threshold to qualify for exchange subsidies (MACPAC 2013).[6]

Second, even among those children whose parents are not offered employer-sponsored insurance, and thus could qualify for subsidized exchange coverage, it is not clear how many would enroll due to higher cost sharing and premium payments associated with exchange coverage (MACPAC 2014a).

And finally, while the ACA requires states to develop procedures to automatically transition children from separate CHIP to exchange coverage as CHIP allotments run out (§2105(d)(3)(B) of the Social Security Act (the Act)), it also requires a special certification that sets a high bar for such transitions. By April 1, 2015, the Secretary of the U.S. Department of Health and Human Services (the Secretary) must certify plans that are "at least comparable to" CHIP programs with respect to benefits and cost sharing (§2105(d)(3)(C) of the Act). As I will discuss, while categories of covered benefits in separate CHIP and exchange coverage may be fairly comparable, cost sharing in exchange plans at current subsidy levels does not appear comparable to CHIP. If the Secretary finds that no exchange plans are comparable to CHIP, states are not required to seamlessly transition children from separate CHIP to exchange coverage, although families may obtain subsidized exchange coverage on their own.

MACPAC is currently working to develop projections using more recent data to determine how many children would become uninsured and how many children would enroll in employer-sponsored coverage if CHIP funding were exhausted. The analyses will also assess how changes in

the affordability test would affect the ability of families to obtain exchange subsidies. We look forward to sharing this information with the Congress in our 2015 report.

The Consequences for Children of Moving from CHIP to Exchange Coverage

If CHIP funding ends, those children shifting to exchange coverage are likely to face higher cost sharing, different benefits, and enrollment in plans with different provider networks. MACPAC's June 2014 report highlighted these concerns. Staff are now updating these analyses with more recent information that we anticipate including in the Commission's March 2015 report.

Higher cost sharing. Children moving from separate CHIP programs to exchange coverage would experience higher cost sharing in the form of deductibles, copays, and coinsurance. MACPAC compared the actuarial values of cost sharing in five separate CHIP programs to the actuarial values of exchange plans with cost-sharing reductions. Actuarial values measure the percentage of covered health care expenses that an insurer would pay, on average, for a typical enrollee population. The metal tiers for unsubsidized exchange plans are as follows:

- bronze: actuarial value of 60 percent,
- silver: actuarial value of 70 percent,
- gold: actuarial value of 80 percent, and
- platinum: actuarial value of 90 percent.

Exchange plans in the silver tier are required to provide cost-sharing reductions to qualifying enrollees with incomes below 250 percent FPL. Cost-sharing reductions must increase actuarial values as follows:

- for those with incomes up to 150 percent FPL: actuarial value of 94 percent,
- for those with incomes between 151 and 200 percent FPL: actuarial value of 87 percent, and
- for those with incomes between 201 and 250 percent FPL: actuarial value of 73 percent.

Because the medical benefits in separate CHIP and exchange coverage are largely consistent, the differences in actuarial values between exchange plans and separate CHIP programs in this analysis can largely be attributed to cost sharing.

To estimate actuarial values of separate CHIP programs, MACPAC used detailed cost-sharing information provided in a GAO study on the separate CHIP programs in five states—Colorado,

Illinois, Kansas, New York, and Utah (GAO 2013). To obtain actuarial values for the CHIP cost-sharing structure in these five states, MACPAC used the actuarial value calculator from the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS).[7]

With one exception, all of the states in the study at all income levels have actuarial values in their separate CHIP programs ranging from 97 to 100 percent (MACPAC 2014a). The one exception is for Utah's highest income range in its CHIP program (151 to 200 percent FPL), which has an actuarial value of 90 percent (MACPAC 2014a). Across income eligibility levels, the actuarial values of the five states' CHIP programs are consistently higher than the actuarial values prescribed for exchange plans with cost-sharing reductions. As a result, children moving from separate CHIP programs to exchange coverage would experience greater cost sharing.

Above 250 percent FPL, no cost-sharing reductions are available for exchange plans. Thus, above 250 percent FPL, individuals enrolled in a silver plan would have a 70 percent actuarial value. Above 250 percent FPL, the CHIP actuarial value is 97 percent in Illinois and 100 percent in New York; the other three states do not offer CHIP benefits at this income level (MACPAC 2014a).

Recent reports by the Wakely Consulting Group (Wakely) and the National Alliance to Advance Adolescent Health had similar findings regarding affordability. Wakely found that actuarial values for health plans in all 35 states with separate CHIP programs at both 160 and 210 percent FPL are higher than the actuarial values for the qualified health plans (QHPs) at the same income levels even after accounting for cost-sharing reductions available to lower-income enrollees in the exchanges (Bly et al. 2014).[8] Researchers at the National Alliance to Advance Adolescent Health reported findings similar to those of the Wakely study, based on their analysis of cost sharing in separate CHIP programs and child-only exchange plans in five states. In general, CHIP programs do not require deductibles or coinsurance, while the child-only exchange plans do (McManus and Fox 2014).

In addition to cost sharing for services, premiums also affect CHIP's affordability. Based on policies in place in January 2013, MACPAC estimates that approximately 44 percent of children covered with CHIP funds (3.4 million) faced premiums in 33 states, including in some Medicaid-expansion states (MACPAC 2014b).

While CHIP and exchange coverage each have a statutory limit on premiums (combined with cost sharing in the case of CHIP) based on family income, neither takes into account the effect of premiums required by the other. In states charging premiums of CHIP enrollees, the combination, or stacking, of both CHIP and exchange premiums could be substantial for families. MACPAC recommended in March 2014 that, 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 (MACPAC 2014b).

Differences in covered benefits. Exchange plans offer covered benefits that are largely consistent with separate CHIP coverage, but with a few differences. A GAO study comparing separate CHIP programs and essential health benefits (EHB) benchmarks in five states found that most benefit categories were covered in both programs. For example, benefits like inpatient and outpatient mental health services and chronic disease management services were covered in both separate CHIP programs and EHB benchmark plans in all five states. However, outpatient habilitative therapies and pediatric hearing services were covered inconsistently in separate CHIP programs and EHB benchmark plans (GAO 2013).[9] The Wakely report's examination of covered benefits also found that many benefits such as physician services, inpatient services, radiology, and laboratory services are largely consistent between separate CHIP programs and QHPs. Other services—for example, eyeglasses, audiology, and applied behavioral analysis (ABA) services important to children with autism disorders—tend to be offered more often by CHIP programs than by QHPs and with fewer benefit limits. Moreover, coverage of these services is highly variable even among CHIP programs.

CHIP and QHPs also differ in their approach to providing pediatric dental coverage. Separate CHIP programs are required to provide coverage for dental services. Although pediatric oral health is an essential health benefit, exchange plans are not required to cover pediatric oral health benefits if stand-alone dental plans are available in an exchange (§1302(b)(4)(F) of the ACA).[10] Thus some plans cover all 10 EHBs, including pediatric dental services, while others offer a stand-alone dental plan in addition to medical policies that exclude dental benefits.

When dental coverage is only available in an exchange as a stand-alone plan, families would need to purchase separate plans and pay two premiums.[11] Moreover, individuals and families are not required to purchase pediatric dental coverage when offered separately (unless required by state law).[12] Stand-alone dental plans may also establish separate cost sharing; in addition, there are no additional

subsidies for this coverage. Questions have been raised about the affordability of pediatric dental coverage and whether people will take up pediatric dental coverage in the absence of the requirement to do so (AAPD et al. 2013).

Network adequacy. The adequacy of provider networks is another key consideration in considering a shift for low- to moderate-income children from CHIP to exchange coverage. It is frequently assumed that CHIP networks are better than Medicaid and QHP networks because many CHIP networks mirror private plan networks or that CHIP networks are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, limited empirical information exists to support or refute this assertion. MACPAC recently held a roundtable discussion with diverse stakeholders including state officials, health plan executives, physicians, and beneficiary advocates to shed light on the extent to which such networks differ and to learn about how exchange plan networks are designed. Other organizations are also studying the composition of networks in different geographic areas and we look forward to examining more empirical information about network design to inform the Commission's deliberations. MACPAC is also exploring whether additional consumer protections might be needed to promote continuity of care and ease a transition from CHIP to other sources of coverage, when such transitions ultimately take place.

State Financing Issues

In addition to examining the future of CHIP from the perspective of children and families, MACPAC has also considered how different policy scenarios will affect states. Federal funding for CHIP is capped and is allotted to states annually based on a methodology that relies on each state's recent CHIP spending. States have two years to spend each allotment. If CHIP funding is allowed to end, the Congress will also have to consider the differential financial impact across states.

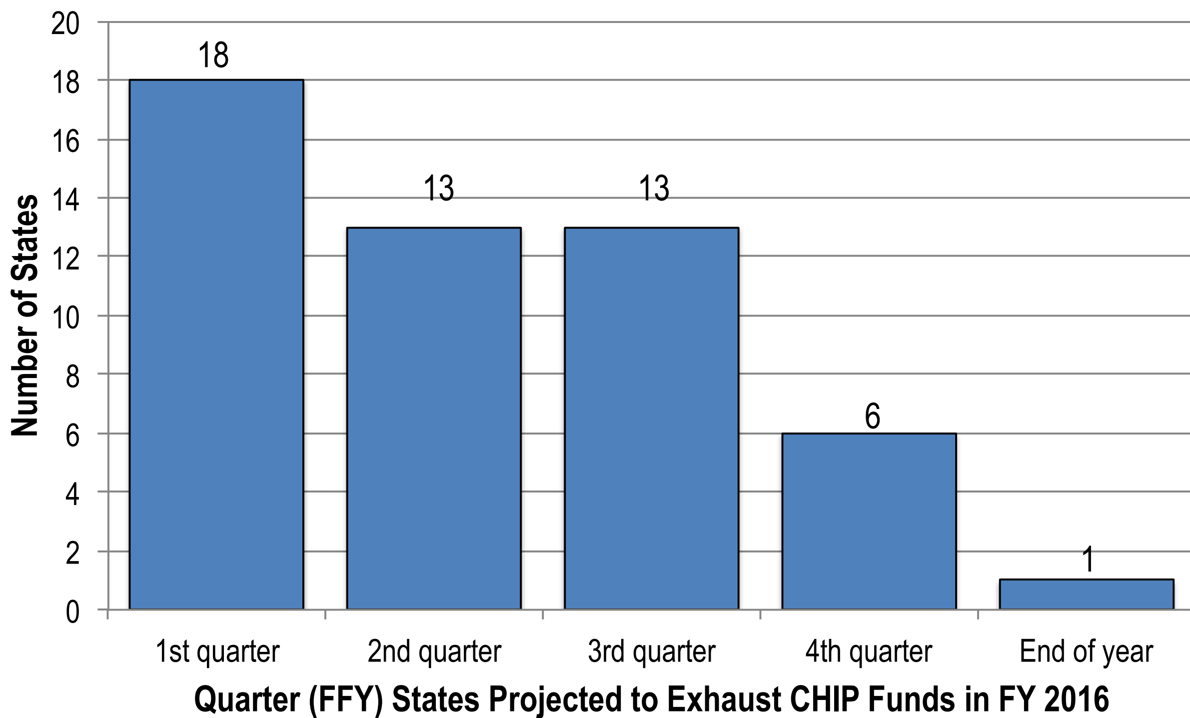
There are no new federal CHIP allotments after FY 2015. Under current law, states will run out of CHIP funding at various points during FY 2016, depending on a number of factors, with more than half of states exhausting funds in the first two quarters of the year (Figure 1).

The primary determinant of when states will exhaust their federal CHIP funds is how much of their FY 2015 allotment remains unspent at the beginning of FY 2016. Various federal policies would also affect when states run out of federal CHIP funds. For example, the ACA increases the federal matching rate for CHIP by 23 percentage points for FY 2016 through FY 2019. This will accelerate

the pace at which states will use any remaining federal CHIP funds in FY 2016. From the state perspective, states' current share of CHIP expenditures ranges by state from 17 to 35 percent; a 23-point increase in the federal share would reduce the state share to a range of 0 to 12 percent—as long as funds are available (MACPAC 2014a).

State policies may also affect when states exhaust their federal CHIP funding. For example, while the ACA's maintenance of effort (MOE) requirement generally prohibits reducing children's eligibility for CHIP, states are permitted to impose enrollment limits "in order to limit expenditures…to those for which Federal financial participation is available" (§2105(d)(3)(A)(iii) of the Act). States may also take other actions to reduce CHIP spending such as allowing CHIP waivers to expire and cutting payments to plans and providers.

Figure 1. States Will Exhaust CHIP Funds at Different Points in FY 2016



Note: FY 2016 spending is FY 2015's plus 5% and reflects 23-point increase in federal matching rate.

Source: Preliminary MACPAC analysis based on state FY 2014–2015 projections as of August 2014 on Form CMS-37.

It is important to note that the exhaustion of CHIP funds has different implications for states depending upon whether children are enrolled in a Medicaid-expansion or separate CHIP program. If no new CHIP funds were made available, through FY 2019, states would be required to continue Medicaid-expansion CHIP coverage at their regular federal Medicaid matching rates, which are

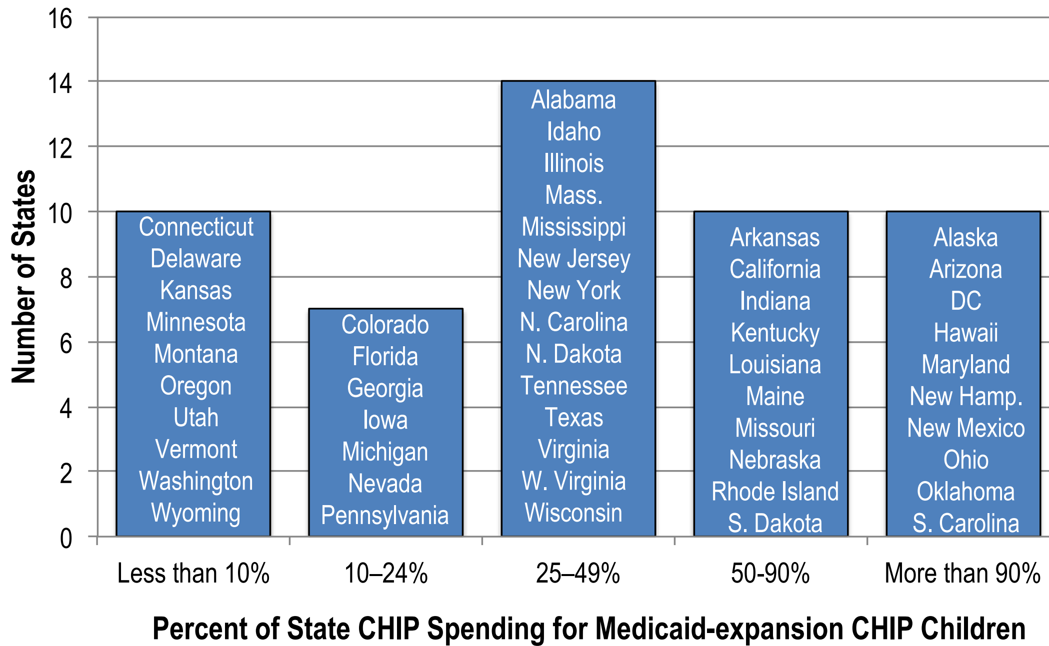
significantly lower than those provided under CHIP. Approximately 3 million children enrolled in Medicaid-expansion CHIP would be protected with continued coverage.

Recall, however, that Medicaid's federal funding is open ended. Thus, for states relying on Medicaid expansions, there is no prospect of federal Medicaid funds running out, as with CHIP, but the state contribution would increase. A reduction from the CHIP matching rate—not including the 23-point increase for FY 2016—to Medicaid's traditional matching rate would generally increase state expenditures for those children by 43 percent (MACPAC 2014a).

While Medicaid-expansion CHIP accounts for half of projected CHIP spending nationally, that national number obscures the state variation and thus the differential effects on state budgets once CHIP funding is exhausted. In 10 states, Medicaid-expansion CHIP accounts for more than 90 percent of projected CHIP spending. Thus, once CHIP funding is exhausted, these 10 states must continue coverage at increased state cost for nearly all of their current CHIP population. At the other end of the spectrum, another 10 states have less than 10 percent of CHIP spending attributable to Medicaid expansions and thus would face little increased state spending if services are financed under the regular Medicaid match once CHIP funding is exhausted (Figure 2).

By contrast, states operating separate CHIP programs (now serving over 5 million children) are not subject to the maintenance of effort if CHIP funding is exhausted, and thus would have no legal obligation to continue financing coverage for these children. These states' only federal requirement would be to have procedures to enroll children in exchange plans that are certified as being comparable to CHIP, if available. Thus, states with a separate CHIP program could be released from any state spending and separate CHIP coverage would effectively end. Many of those affected children would become uninsured or face significantly higher cost sharing and potentially different benefits and provider networks in the exchange. For children who would qualify for subsidized exchange coverage if their CHIP coverage were to end, the cost of the subsidy would be entirely federal.

Figure 2. Percentage of States' CHIP Spending for Medicaid Expansions, FY 2015



Source: Preliminary MACPAC analysis based on state FY 2015 projections as of May 2014 on Form CMS-37.

MACPAC's analysis of state financing issues is ongoing. We expect to get new numbers on the final federal allotments later this month. Combined with relatively recent projections from states, we will soon have a clearer picture of how different states will be affected and we intend to share those analyses when complete.

Conclusion

CHIP has clearly played an important role in providing access to health care coverage to millions of low- to moderate-income children who would have otherwise been uninsured. In addition, some of CHIP's design features provided a platform for state innovations to improve take-up of public coverage among eligible but uninsured children. Many states branded their CHIP programs separately from Medicaid and launched targeted outreach and marketing efforts. These strategies increased enrollment of children in both CHIP and Medicaid, further reducing uninsurance rates among children. Outreach and enrollment techniques that often began as experiments in CHIP in individual states were subsequently identified as best practices and, in some cases, are now required in all states for both CHIP and Medicaid.

Even so, changes in the policy environment dictate a re-examination of CHIP's role and purpose. MACPAC has recommended a two-year extension of CHIP to provide the impetus to make the

legislative and regulatory changes necessary to smooth the transition and to make other coverage options work well for children now covered by CHIP. A short-term extension is also more fiscally prudent.

MACPAC's Commissioners urge the Congress act soon to extend CHIP so that states do not respond to uncertainty around CHIP's future by implementing policies that reduce children's access to needed health care services.

Thank you, members of the Subcommittee. I would be happy to answer any questions you may have.

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[1] This decline in private coverage could be the result of multiple factors. It could, for example, reflect a broader decline in the availability of employer-sponsored health insurance for adults and children. It could also reflect a degree of substitution of public coverage for available private coverage, which is frequently referred to as crowd-out. Researchers have struggled to answer the question of whether CHIP eligibility expansions caused crowd-out of private coverage or whether private coverage would have declined anyway, with CHIP preventing children from becoming uninsured.

[2] The Congressional Budget Office (CBO) makes unique assumptions regarding the future of CHIP, which will affect the projected federal cost of legislative proposals it examines. CBO is required to assume that CHIP and certain other expiring programs continue in perpetuity at the last appropriated level (2 USC 907(b)(2)(A)(i)). However, in order to reduce the long-term federal spending projected by CBO under these assumptions, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was worded so that the last appropriated level for CBO's purposes was $5.7 billion in FY 2013 rather than the $17.4 billion actually appropriated for FY 2013. In extending federal CHIP funding by two years, the ACA continued the use of this language so that the last appropriated level for CBO's purposes for CHIP past FY 2015 is $5.7 billion rather than $21.1 billion.

[3] In FY 2013, at least 19 states reported enrollment of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs: Alabama, Arizona, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming.

[4] Because the MOE is tied to eligibility policies in place on March 23, 2010, it is not clear whether states that elected to convert much of their population from separate CHIP to Medicaid-expansion coverage, such as California and New Hampshire, would be able to remove those children from Medicaid as CHIP funding is exhausted.

[5] While ending CHIP would lead to some children being uninsured, the magnitude of the effect depends on a number of factors, many of which are difficult to model with precision. In addition, this estimate was modeled using data from several years ago and does not take into account that some states, most notably California, have transitioned the vast majority of their enrollees from separate CHIP to Medicaid-expansion CHIP coverage.

[6] While 98 percent of employees who are eligible for their employers' coverage also have access to dependent coverage, that coverage may not be practically affordable.

[7] MACPAC used the proposed 2015 Actuarial Value Calculator publicly available in February 2014. The calculator draws upon 2010 claims data from Health Intelligence Company, LLC, which is licensed by the Blue Cross and Blue Shield Association. The claims data are from 54 million adults and children in commercial insurance plans, representing group and individual health plans. The calculator determines actuarial values based on enrollees' cost-sharing information and a standard population representing "those likely to be covered in the individual and small group markets in 2014" (Knuth 2013).

[8] Wakely estimated the AV of CHIP plans with cost sharing requirements using the Federal Actuarial Value Calculator for 2015.

[9] In the study, the GAO compared the benefit categories offered by separate CHIP programs and the EHB benchmark definition in five states. The list of services available within each category may vary among separate CHIP and EHB benchmark definitions, and therefore coverage of a specific service may vary. EHB benchmark definitions establish a minimum standard that all exchange plans must meet in order to be certified. Issuers can provide additional services or establish higher benefit limits than those established in EHB definitions. When the GAO conducted its analysis, exchange plan details were not available. As a result, actual coverage may vary from the EHB benchmark used for comparison.

[10] Stand-alone dental plans cover dental services only and must meet the state-defined pediatric oral services EHB standard (§1311(b)(2)(B)(ii) of the ACA).

[11] Individuals who purchase both separate medical and stand-alone dental plans face premium payments for each policy.

[12] Three states (Kentucky, Nevada, and Washington) require families and individuals to purchase dental coverage for children when it is not embedded within a QHP (Snyder et al. 2014).