



THE POTENTIAL IMPACT ON CHILDREN AND FAMILIES OF ENDING FEDERAL FUNDING FOR CHIP IN 2015

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FEBRUARY 2015

INTRODUCTION

Since the enactment of the Children's Health Insurance Program (CHIP) in 1997, the uninsured rate for children has declined from 13.9% to a record low of 6.5% in 2013.¹ This decline in uninsurance among children followed the enactment and expansion of CHIP, and growth in enrollment in CHIP and in Medicaid, a much larger program covering children in low-income families. The recently published congressionally mandated evaluation of CHIP found "CHIP to be successful in nearly every area examined. CHIP succeeded in expanding health insurance coverage to the population it is intended to serve, particularly children who would otherwise be uninsured, increasing their access to needed health care, and reducing the financial burdens and stress on families associated with meeting children's health care needs. These positive impacts were found for children and families in states with different CHIP program structures and features, across demographic and socioeconomic groups, and for children with different health needs. Medicaid and CHIP have worked as intended to provide an insurance safety net for low-income children during economic hard times."²

Yet, the federal block grant funding structure for CHIP has presented challenges over the years. Unlike Medicaid, which is an entitlement that requires both the federal government and states to fund program operations as needed without a cap or legislative action at the federal level, federal CHIP funding is in the form of an annual block grant, which sets federal CHIP funding at a specific amount per year and per state with mechanisms to redistribute unspent funds among the states and across years. When launched in 1997, CHIP was funded for ten years, but subsequent federal funding has been for shorter time periods. In 2009, after a two-year period of temporary funding, the Children's Health Insurance Program Reauthorization Act (CHIPRA) extended CHIP funding for 4.4 years (through Fiscal Year (FY) 2013) and in 2010, the Affordable Care Act (ACA) extended CHIP funding an additional year, through FY 2015.

The need to periodically renew CHIP funding has provided opportunities to consider the future of CHIP and how it fits into the mosaic of public and private health insurance alternatives for children and their families. Such considerations figured into the crafting of the ACA, which affirmed the success of public coverage programs for children by increasing and extending CHIP funding through FY 2015 and extending through FY 2019 the Maintenance of Effort (MOE) requirement that prohibits states from reducing CHIP and Medicaid eligibility levels for children over that time period.

Anticipation of the potential expiration of federal CHIP funding on September 30, 2015 provides yet another opportunity to focus on the future of CHIP and also on the nature of children's coverage under the ACA. But unlike in the past when CHIP provided the primary viable affordable coverage option for children in many low to moderate income families, the ACA provides a new coverage source for children in low to moderate income families: subsidized coverage in the state and federal Marketplaces. The ACA also requires most individuals to obtain coverage or face a penalty, including parents who do not cover their children.³

If federal CHIP funding is discontinued, it will have financial implications for federal, state, and family budgets and for the future of children's coverage. This brief focuses on the impact of the loss of federal CHIP funding on children's coverage and family finances in the three areas of CHIP's success identified in the recent federal evaluation: increased coverage, better access to needed health care, and reduced financial burden on families.

POTENTIAL IMPACT OF LOSS OF FEDERAL FUNDING ON THE CHIP PROGRAM

As noted in previous briefs in this series,⁴ the original CHIP legislation provided states with several structural options for their CHIP programs. For purposes of this brief, the options can be reduced to three: states could use their CHIP funds to expand Medicaid for children, develop new separate programs following federal guidelines, or combine a Medicaid expansion with a separate program. Regardless of their structure, all state programs are funded out of the CHIP block grant, receiving federal matching funds at an enhanced rate. This results in two sources of federal funds for children's coverage: Medicaid-Financed coverage, funded out of the federal Medicaid budget, and CHIP-Financed coverage for Medicaid and separate CHIP programs, funded out of the CHIP block grant.

While current law stipulates that no new federal funds will be available for CHIP beginning in FY 2016, states will be able to continue to use their unspent federal CHIP funds. Without renewed federal funding for CHIP in FY 2016, states will soon run out of federal CHIP funds.⁵

This loss of federal funds will affect CHIP-financed children's coverage under Medicaid and CHIP differently. With no change in current law, traditional Medicaid for children will not be affected and will continue as is under a Maintenance of Effort (MOE) requirement in the ACA until FY 2019. CHIP-financed Medicaid is subject to the same ACA MOE requirement, but with CHIP funds exhausted, federal funding for those programs will shift to the federal Medicaid budget, and the federal share of the cost of the program will decline to a state's lower Medicaid matching rate, leaving the state responsible for making up the difference with state funds. If a separate state CHIP program's federal CHIP funds are exhausted, the ACA provides that the state may end the program and that children in those programs (including those in the separate CHIP programs in states with combination programs) be screened for Medicaid or Marketplace coverage and enrolled in the appropriate program to the extent that the family elects to do so. The ACA says the Marketplace health plans (QHPs) must be certified by the Secretary of the Department of Health and Human Services as offering comparable benefits and cost sharing to the state's CHIP program in the event a state decides to end its CHIP program and transfer coverage to Marketplace QHPs. The law does not provide more specific criteria for determining the comparability of Marketplace QHPs to CHIP coverage and to date, Marketplace coverage offerings do not seem comparable to available CHIP programs.⁶ The ACA, however, does not address coverage options in states that do not have QHPs certified as comparable to separate-CHIP plans.

One impediment to Marketplace coverage for children who lose their CHIP coverage is the ACA's "affordability" criteria used to determine families' eligibility for subsidies to purchase Marketplace coverage. This affordability standard has come to be known as the "family" or "kid glitch" since it limits access to subsidies for those who have an offer of employer sponsored coverage.⁷ For full time employees, if the cost of employer sponsored insurance (ESI) does not exceed 9.5% of the employee's income that coverage is deemed "affordable" and neither the employee nor members of his/her family are eligible for subsidies to purchase Marketplace coverage. The affordability standard does not take account of the cost of dependent coverage, which can typically cost substantially more than coverage for the employee alone.

There is considerable uncertainty as to the number of children affected by the "family glitch". A recent MACPAC report projected that only 44% of children currently eligible for separate CHIP coverage would be eligible for exchange subsidies because they did not have access to "affordable" ESI. That estimate, however, may be too low because MACPAC assumed that all offers of employer coverage are "affordable" and include dependent coverage. The MACPAC estimate is also based on data from 2005 to 2010 and may not reflect the current situation.⁸ Data from a 2013-14 survey, found that among children in families with incomes of 138%-249% of the federal poverty level (FPL) enrolled in either Medicaid or separate CHIP programs, 57% had a parent with access to ESI though the "affordability" of that coverage was also not determined.⁹ This estimate is for a different population than the MACPAC estimate both because it is more recent and includes children in Medicaid who will not be affected if CHIP funding is not renewed. Nonetheless, since any access to affordable ESI could make a family ineligible for subsidized marketplace coverage, both estimates and several others based on different data sets suggest that as many as half of separate CHIP eligible children may not qualify for Marketplace subsidies if CHIP funding is not renewed.

IMPACT ON CHILDREN AND FAMILIES

According to enrollment data for FY 2013, 8.1 million children were enrolled in CHIP-funded coverage, approximately 2.5 million in CHIP-financed Medicaid and 5.6 million in separate CHIP programs.¹⁰ Subsequently, however, California closed its separate CHIP program, the largest such program in the country, transferring almost 1.1 million children to CHIP-funded Medicaid. New Hampshire also closed its small separate CHIP program and transferred enrollees to Medicaid. Arizona closed its small separate CHIP program altogether. Due to a provision of the ACA, in all other states with a separate-CHIP program, children 6-to-18 years old in families with incomes below 133% of the federal poverty level are being transferred to CHIP-funded Medicaid in 2014.¹¹ Though 2014 enrollment data is not yet available, it appears that as a result of all the transfers of CHIP-funded children from separate CHIP programs to Medicaid, the number of children in CHIP-funded Medicaid now likely exceeds the number in separate CHIP programs by a small margin.¹²

Loss of federal funding for separate-CHIP programs in 2015 will significantly affect the approximately 4 million children enrolled in separate-CHIP programs and the families of those children as well. Some of those children may remain uninsured, others may enroll in their parents' employer sponsored insurance (ESI) or get coverage in the private market, and it is also possible that some states will expand their children's Medicaid programs to include children formerly eligible for their separate-CHIP programs. It is likely, however, that except for those affected by the family glitch most children who lose CHIP coverage will seek coverage in the federal and state Marketplaces in large part because federal subsidies are available to purchase Marketplace coverage for families with incomes up to 400% of the federal poverty level (FPL) - an income range that encompasses all state separate-CHIP programs. In fact, as noted previously, the ACA requires states to screen

children for Medicaid eligibility and if they are ineligible, to enroll them in QHPs certified by the Secretary of Health and Human Services as being comparable to separate-CHIP programs with regard to both cost-sharing and benefits for children.^{13 14}

Several reports have been issued recently on aspects of this cost and benefit comparison in anticipation of the decision to be made by the Secretary by April 1, 2015.¹⁵ There are several different ways to measure costs and this brief attempt to synthesize the approaches and findings here. The brief also reviews briefly recent efforts to compare the benefits offered in separate CHIP programs and Marketplace QHPs.

Measuring Costs

Insured consumers' costs for health care services depend on a combination of up-front costs (premiums) and mechanisms for sharing the cost of care as it is consumed (deductibles, copayments, coinsurance, and out-of-pocket maximums). Insurance plans, including both separate-CHIP plans and Marketplace QHPs, may offer a variety of these features in different combinations. This variety may make it difficult for consumers to choose among different plans and make comparability judgments difficult for experts as well but allows insurers to market plans to consumers with different preferences. It is also difficult to know how families prioritize or value the various features of alternative coverage offerings when they need to choose among differences in affordability, access to providers, scope of benefits, family members being on the same plan, etc. These different features of plans may impact consumer's use of healthcare and may be worth consideration for that reason as well. In addition, for both separate-CHIP programs and subsidized Marketplace coverage, consumer costs tend to vary with family income (lower levels of cost sharing for lower income families) making across the board, apples-to-apples comparisons difficult.

Actuarial Values

One way to assess the value of an insurance product is to measure its actuarial value. The actuarial value of a health plan is the percent of allowed medical charges paid on average by a health plan. The actuarial value is determined by applying the different cost-sharing elements of a health plan (deductibles, coinsurance, copayments, and out-of-pocket maximum) to the experience of a reference population and is a measure of the average percent of allowed costs that the plan would have paid for that population. Things to keep in mind with regard to actuarial values:

- Actuarial values do not include premiums. The total cost of coverage is a combination of the premium cost and actuarial value.
- Actuarial values are an average for a specific population. Different individual members of that population may experience different levels of coverage depending on their actual use of services.
- The same insurance product may have different actuarial values for different populations depending on the patterns of use of services in the different populations.
- Health plans with different combinations of cost sharing features (deductibles, copays, etc.) can have the same actuarial value for a given population.
- Actuarial values are defined for a specified set of allowed services and do not reflect the cost of services that are not covered or are consumed above stated limits.
- A higher actuarial value means more of the costs of services are paid by the insurer and less by the consumer, but as a percentage the actuarial value does not measure how much is actually paid by either.

Actuarial values play an important function in offering consumers a form of standardized choice in the ACA Marketplaces. The ACA requires all plans offered in the Marketplace to offer a standardized set of essential health benefits. For some of these benefits (preventive services) no cost sharing is allowed, but for other services, health plans are allowed to apply a variety of cost sharing features. The actuarial values of the different plans are calculated and the plans assigned to different tiers (bronze, silver, gold, platinum) depending on their actuarial value. Insurers price the different offerings and consumers are offered a choice of the offered combinations of plans and premiums depending on actuarial values.

To make Marketplace coverage more affordable for low to moderate income families, the federal government subsidizes marketplace premiums for families with incomes up to 400% FPL and subsidizes cost sharing for families with incomes below 250% FPL. The amount of subsidy is based on family income and the premium for the second least expensive silver plan in a particular Marketplace (the benchmark plan). Although families can use the federal subsidy to purchase any plan offered through their local Marketplace, the subsidies offer a strong incentive for families to choose the benchmark plan. Separate CHIP programs are currently available to some children whose family incomes fall within the income range for the Marketplace subsidies, so a comparison of the costs of the benchmark plan to the costs of each CHIP program offers a reasonable measure of the costs to families of switching from CHIP to the benchmark plan in each state.¹⁶ Since the amount of subsidy for the benchmark plans and in some states CHIP coverage vary with income, this comparison is most appropriately made within income groups. Table 1 provides a comparison of the actuarial values of separate CHIP plans in 18 states with the actuarial values of Marketplace plans after federal subsidies have been applied to increase the actuarial value of the silver benchmark plan from 70% for families with incomes below 250% FPL.

Table 1: Comparison of Actuarial Values for 18 State CHIP Plans and Marketplace Plans

Family Income	CHIP Plans	Marketplace Plans
Less than 150% FPL Five states in 2013	98-100%	94%
150-200% FPL Five states in 2013 21 states in 2014	90-100% 89-100%	87%
200-250% FPL Four states in 2013 13 states in 2014	97-100% 87-99%	73%
251-400% FPL Two states in 2013	98-100%	70%

Sources: Wakely Consulting Group, *Comparison of Benefits and Cost Sharing In Children's Health Insurance Programs and Qualified Health Plans, July 2014*, Englewood, CO, and Medicaid and CHIP Payment and Access Commission, *Report to Congress On Medicaid and CHIP, June 2014*. Washington, D.C.

It appears that at all relevant income levels the actuarial values of all the CHIP plans are higher than the Marketplace plans. The difference may be as small as 2-3% in some states but can exceed 15% in many states for families with higher incomes. This means that on average families will face higher cost sharing expenses if they move from CHIP to Marketplace coverage.

Premiums

In addition to cost sharing for services, premiums are a cost of coverage and vary among CHIP programs and between CHIP and Marketplace coverage. On average, the total cost of coverage is the sum of the premium and mean out-of-pocket expense, which is closely related to a plan's actuarial value.

Thirty separate CHIP programs require families to pay premiums including nine programs requiring premiums from families with incomes below 150% FPL. The number of states charging premiums is larger at higher income levels and premiums frequently increase as income rises. Among CHIP programs that charge premiums, the median premium was recently found to vary from \$10 a month for children in families with incomes < 150% FPL to \$33 a month for children in families with incomes > 301% FPL.¹⁷ States that charge premiums frequently charge an additional premium for the second or third child in a family but premiums for families with more children are typically capped.

Unsubsidized premiums for Marketplace plans typically vary with actuarial value (a plan with a higher actuarial value will require a higher premium) and increase with family size as well. However, the federal government provides premium subsidies in the form of tax credits to families with incomes below 400% FPL to help offset the cost of buying Marketplace coverage. The premium subsidies vary by family income and are tethered to the cost of a benchmark plan. The premium subsidy varies so that a family's premium contribution for a particular plan is the same regardless of how many people enroll in that plan. The required premium contribution may increase however if a family enrolls in a plan that charges a higher premium than the benchmark plan.

For families with incomes below 400% FPL, Marketplace premiums taking into account the federal subsidy do not vary with family size, so the premium cost of adding one or more children to parents only coverage is zero. Consequently the average cost of moving a child from CHIP to Marketplace coverage is the difference in average cost sharing expense between CHIP and Marketplace plans less the CHIP premium. In situations where CHIP premiums are zero or nominal, CHIP coverage will cost a family less per child than Marketplace coverage. When CHIP premiums are higher (typically for higher income families), it is more difficult to generalize. However, the fact that the gap between the actuarial values of CHIP and Marketplace coverage widens as family incomes increase, suggests that in most situations CHIP coverage will be less expensive than Marketplace coverage even though CHIP premiums increase with income. A recent analysis of QHPs offered in the Marketplace in Arizona compared to Arizona's former CHIP program,¹⁸ considered 18 scenarios comparing the cost of the QHPs to CHIP for three children with minimal to extensive health services needs at varying income levels. In all but one case the cost of care under CHIP was less than the cost of care in the QHPs, and the study did not consider the added cost of premiums for families.¹⁹

Because CHIP premiums and actuarial values vary among states and by family income, the determination of whether Marketplace coverage is on average more or less expensive than CHIP coverage must be made based on actual state program characteristics and the health care services needed. But there are few situations in which Marketplace coverage will be more affordable than CHIP.

Average Costs and Premiums

The use of differences in actuarial values to measure cost differences, especially when premiums are added to the mix is challenging and may be confusing. Accordingly Table 2 presents estimates of the average annual enrollee cost sharing amount and premiums for a child in a family at two different incomes levels (160% FPL

and 210% FPL) in 22 states with separate CHIP programs. Also shown is the average annual cost-sharing amount for a child enrolled in Marketplace QHPs (based on a national reference population) at the two income levels. In two states (CT and LA), Medicaid is used to cover children in families with incomes at 160% FPL and ten states do not offer CHIP coverage for children in families with incomes above 200% FPL.

Table 2: Estimated Average Enrollee Annual Cost in CHIP and QHPs

State Programs	160% FPL			210% FPL		
	Premiums	Cost Sharing	Total Cost	Premiums	Cost Sharing	Total Cost
Marketplace QHP		\$446	\$446		\$926	\$926
Median CHIP	\$12	\$90	\$178	\$236	\$132	\$380
AL	\$108	\$97	\$205	\$108	\$281	\$389
CO	\$24	\$90	\$114	\$24	\$161	\$185
CT	Medicaid			\$0	\$77	\$77
FL	\$240	\$62	\$302	No CHIP		
GA	\$240	\$24	\$264	\$348	\$24	\$372
ID	\$180	\$135	\$315	No CHIP		
IL	\$180	\$38	\$218	\$480	\$203	\$683
IN	\$284	\$44	\$328	\$504	\$45	\$549
KY	\$0	\$48	\$48	No CHIP		
LA	Medicaid			\$600	\$448	\$1,048
MS	\$0	\$11	\$11	No CHIP		
MN	\$0	\$63	\$63	\$0	\$63	\$63
NJ	\$0	\$28	\$28	\$510	\$103	\$613
NC	\$48	\$145	\$193	No CHIP		
ND	\$0	\$133	\$133	No CHIP		
TN	\$0	\$173	\$173	\$0	\$185	\$185
TX	\$36	\$207	\$243	No CHIP		
UT	\$228	\$389	\$617	No CHIP		
VA	\$0	\$89	\$89	No CHIP		
WV	\$0	\$184	\$184	\$420	\$227	\$647
WI	\$0	\$23	\$23	\$120	\$23	\$143
WY	\$0	\$139	\$139	No CHIP		

Sources: Wakely Consulting Group, *Comparison of Benefits and Cost Sharing In Children's Health Insurance Programs and Qualified Health Plans*, July 2014, Englewood, CO, and A. Cardwell, J. Jee, C. Hess, J. Tuschner, M. Heberlein and J. Alker, *Benefits and Cost Sharing in Separate CHIP Programs*, National Academy for State Health Policy and Georgetown University Center for Children and Families, May 2014.

For children in families with incomes at 160% FPL enrolled in CHIP, average annual cost sharing per child ranges from \$11 in Mississippi to \$389 in Utah, with a national median of \$90. At this income level, CHIP average cost sharing in all the states listed is below the estimated average of \$446 in the benchmark QHP. When premiums are included in the annual cost of CHIP coverage, average annual total costs range from \$11

in Mississippi to \$617 in Utah with a median of \$178. And in all states listed except for Utah, average annual total costs including premiums are less than the average cost sharing burden alone in Marketplace coverage.

At the 210% FPL family income level, cost sharing, premiums, and total costs are higher in both CHIP plans and in the Marketplace. The average annual cost-sharing burden is at least twice as high in the Marketplace QHP as in any of the 10 state CHIP plans in the table. Even when premiums are added to estimated cost sharing in the CHIP plans, the cost-sharing burden in the Marketplace QHP substantially exceeds average total costs in all but one state (Louisiana). In both income groups, even with no premiums charged for Marketplace QHP coverage, Marketplace coverage was on average more than two times more expensive than the median cost of CHIP coverage including premiums.

Child-Only Plans

Although in some states adding a child to his/her parents’ QHP may occasionally be less costly than CHIP coverage, so-called child-only plans offered in the Marketplaces are always more expensive than CHIP coverage. “Child only” plans are not tailored specifically for children in terms of benefits or providers but are typical QHPs available for children who are not eligible for coverage with their families. Child-only plans are relevant for children living in complex coverage situations; these include citizen or legally resident immigrant children whose parents are undocumented or children not living with their parents. More children will likely be eligible for child-only coverage in the Marketplace if CHIP coverage ends. Coverage for these children may be very costly if the current subsidy structure for child-only plans is not modified. Not only will these children be subject to higher cost sharing in QHPs, they will also be subject to premiums in the Marketplace which would not be the case if they were added to their parents’ coverage. For example, a family of three with an income of \$41,000 a year (210% FPL) is expected to pay up to 6.65% of their income or \$2,535 per year toward the premium of the benchmark plan. In Maricopa County, AZ, (Arizona is the only state without a CHIP program) the annual premium for child-only coverage for a six-year-old would just under \$1,200 a year, well below the cap on premiums for a family of three with an income of \$41,000.²⁰ Even if a six-year-old’s family income were only \$31,500 (160% FPL), premium costs would still be around \$ 1,200 because that premium would be below the premium eligible for a subsidy. Table 3 shows the health care cost differences associated with moving a six-year-old from the average CHIP program to child-only marketplace coverage. These cost differences are large so some families may find switching from CHIP to child-only coverage unaffordable and choose to leave their children uninsured.

Table 3: Differences in Total Care Costs (Premiums and Cost Sharing) Between CHIP and Child-Only Marketplace Coverage

Costs at 160% FPL		Costs at 250% FPL	
Median CHIP	Benchmark QHP	Median CHIP	Benchmark QHP
	(94% AV)		(87% AV)
\$178	\$1,646	\$380	\$2,126

Sources: Wakely Consulting Group, *Comparison of Benefits and Cost Sharing In Children’s Health Insurance Programs and Qualified Health Plans*, July 2014, Englewood, CO, and A. Cardwell, J. Jee, C. Hess, J. Tauscher, M. Heberlein and J. Alker, *Benefits and Cost Sharing in Separate CHIP Programs*, National Academy for State Health Policy and Georgetown University Center for Children and Families, May 2014. Premium data is for the Benchmark child-only plan in Maricopa, AZ, retrieved from: <https://www.healthcare.gov/find-premium-estimates/#results/&aud=indv&type=med&state=AZ&county=Maricopa&age0=6&employerCoverage=no&householdSize=3&income=41400>.

IMPACT OF HIGHER COSTS ON CHILDREN AND FAMILIES

Impact on Children's Coverage

As highlighted in the recent CHIP evaluation, CHIP's great success was in expanding coverage to the children it was intended to serve, particularly those who would otherwise be uninsured. But the elimination of separate CHIP programs would require the almost four million children enrolled in those programs to find coverage elsewhere or become uninsured. However, as demonstrated above, the cost of coverage for these children in Marketplace QHPs will be substantially greater than in CHIP and the higher cost may present a barrier for families looking to purchase Marketplace coverage for their children. In addition, adult family members may have to purchase coverage for themselves in order to insure their children, and although adult coverage has value, the added cost of adult coverage may pose an additional barrier. Moreover, because of the "family glitch", many children may not be eligible for subsidized Marketplace coverage and their families would have to purchase expensive employer sponsored coverage in order to cover their children.²¹

Estimates published in 2011 projected that the number of children without health insurance coverage would increase by over 1.0 million if separate CHIP programs were to be eliminated, with the size of the change depending on the extent to which families choose to enroll their children in the costly ESI coverage that is available to them.²² These estimates are dated and do not account for children transferred from separate CHIP programs to Medicaid in California and New Hampshire since 2011 and the high cost of child-only plans in the Marketplace. The estimates also may not accurately reflect current conditions for children with respect to coverage, income, and ESI premiums for employees and dependents. Nonetheless, despite these uncertainties about the precise magnitude, of the impact of the elimination of separate CHIP coverage on children's uninsured rate, it appears likely that between one and two million more children will become uninsured.²³

Reduction in Use of Health Care Services

A second success of CHIP, increasing children's access to needed health care, will also be likely be adversely affected by the loss of federal CHIP funding. Because health insurance increases access to and utilization of health services by reducing the cost of those services at the time of service, the children who become uninsured when federal CHIP funding ends will experience reduced access to and utilization of needed health services. In a recent comparison of CHIP enrollees in 10 states with similar children who were uninsured, children with CHIP were found to experience better access to care and fewer unmet needs than children who were uninsured. For example, based on parent reports, 80% of CHIP enrollees had had a preventive or checkup visit in the past 12 months compared with only 55% of similar children who were uninsured, and only 5% of CHIP enrollees experienced an unmet need for care from a doctor or other health care professional compared with 12% of uninsured children.²⁴

In addition, the increase in cost sharing associated with moving from CHIP to either Marketplace or employer-sponsored coverage will likely also be associated with reductions in the utilization of health care services by children. A number of studies beginning with the landmark RAND Health Insurance Experiment have shown that like almost all goods, children's health care is subject to the economic law of downward sloping demand (as the price of a good falls more is purchased and as price increases less is purchased).²⁵ This decline in the purchase of health care services carries with it the risk of failure to get needed or timely treatment and a decline in children's health.

A puzzling and controversial finding of the RAND Experiment is the failure to find deterioration in children's health associated with the observed decline in the utilization of health services.²⁶ The RAND results are over 30 years old and reflect the effectiveness of children's health care at the time of the study. There have been many advances in children's health care since the time of the RAND study so reduced

access to needed health care today may be more deleterious to children’s health than in the past.²⁷ Subsequent studies in seniors have found that insurance-related increases in the cost of healthcare are associated with decreases in health status.²⁸ Two national studies that focused on child mortality, found a significant association between the expansion of Medicaid and CHIP and reductions in child mortality.²⁹ And, a 2012 study in families with children, found that children and other members of their families delay or forgo needed care including medical care, tests, treatments or prescription medications because of high cost.³⁰ The authors did not look at the effects on health status of this delayed or forgone care but suggest it could result in lower health status in both the short and long run.

Scope of Benefits

In addition to the level of cost sharing, the scope of benefits covered by a health plan is an important determinant of how well that plan facilitates access to needed health care services. A number of recent studies have compared state CHIP plans to Marketplace QHPs and found not only are QHPs more expensive than CHIP, as described above, but also that QHPs provide a much more limited set of benefits important to children and adolescents than CHIP plans.³¹ This makes intuitive sense when you consider that states designed CHIP benefits exclusively with children in mind, while private insurance and QHPs predominantly considered the broader population and the needs of adults.

Both CHIP plans and QHPs provide coverage for so-called “core” or “essential” benefits, physician services, outpatient services, laboratory tests and x-rays, inpatient services, prescription drugs and emergency medical transportation, with few limits on the amount of coverage. However, a study of 35 state CHIP programs found that CHIP plans covered an important set of child-specific services including dental and vision services, audiology, therapy for autism, physical, occupational and speech therapy, habitation and enabling services, non-emergency transportation and over-the-counter medications much more frequently than QHPs.³² In addition, CHIP programs tended to include fewer limits on the services they provided than QHPs.

While some of the child-specific benefits such as coverage for autism or habilitation therapies may only be relevant for a small percentage of children, they can be very costly and inadequate coverage can impose a substantial financial burden on families or cause them to cut back on or forgo those therapies altogether. Dental caries, however, is the most common chronic disease of childhood, and the routine and restorative dental services, covered in most CHIP plans, are important for children’s health. But dental coverage is not offered in more than half of Marketplace QHPs and in those situations must be purchased separately. When dental coverage is purchased separately, the cost of the coverage (premiums and cost-sharing) is not subsidized as it is for other Marketplace coverage, which would impose an additional cost on families moving from CHIP to Marketplace coverage.

Limitations on child-specific benefits may also be a feature of the employer-sponsored coverage available to children if their CHIP coverage ends. With regard to dental (oral health) care, the recent CHIP evaluation found that CHIP enrollees in a 10 state survey were 15% more likely to have dental coverage than similar children with private coverage. Children in CHIP were also more likely to have a usual source of dental care and had an easier time accessing preventive dental care than children with private insurance.³³

A recent study highlighted the financial impact of moving a child with special health care needs, Isabel, a young child with who has cerebral palsy and needs a range of acute and ongoing habilitation services to enable her to function and learn in school, from KidsCare (Arizona’s recently closed CHIP program) to a Marketplace QHP in Arizona.³⁴ Findings from the report using the cost sharing and coverage characteristics of Arizona’s benchmark QHP for two different levels of family income are summarized in Table 5.

Table 4: Differences in Health Care Costs Associated with Moving a Child with Special Health Care Needs from Arizona’s KidsCare (CHIP) to Marketplace Coverage

Child	Costs at 140% FPL		Costs at 190% FPL	
	KidsCare(CHIP)	Benchmark QHP (94% AV)	KidsCare(CHIP)	Benchmark QHP (87% AV)
Isabel - born prematurely, has cerebral palsy, needs extensive acute care and habilitation services	\$120	\$1,653 for covered services \$2,736 for uncovered habilitative services	\$600	\$2,595 for covered services \$2,736 for uncovered habilitative services

Source: T. Brooks, M. Heberlein, and J. Fu, *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child’s Health Care Costs*, Georgetown University Center for Children and Families, May 2014.

The results presented in Table 4 are illustrative but in their particulars reflect specific features of the KidsCare program and Marketplace coverage in Arizona. KidsCare charged families a premium based on income (\$10 per month for families with incomes below 150% FPL and \$50 per month for families with incomes 151%-200% FPL), but no cost sharing. However, as can be seen in Table 5, the annual health care costs in the benchmark QHP for a child like Isabel substantially exceed the costs in KidsCare even when taking the KidsCare premium into account. For Isabel, who has a chronic condition that requires on-going habilitation services, costs are even greater as the benchmark plan has a cap on the coverage for that service. Since her need exceeds the cap, her family might have to pay out-of-pocket approximately \$2700 for the service or cut back on use of that service if they cannot afford it. The costs shown in the table also include the additional nonsubsidized cost of dental care, which is not included in Arizona’s benchmark plan but was included at no additional cost in KidCare.

Increased Financial Burden and Stress

An important function of health insurance is to protect families from the burden of unusually high health care costs. It has been well documented that very high health care costs can lead to medical debt and even bankruptcy and that unexpectedly high out of pocket medical costs can subject a family already dealing with a sick child to added stress.³⁵ Under CHIP, health care expenses for enrollees are limited to 5% of family income, and observations of state CHIP program officials suggest that families rarely reach that cap.³⁶ In a recent 10 state survey, 92% of parents of CHIP enrollees reported that they had no problem paying their child’s medical bills as compared to only 64% of parents of uninsured children and 69% of parents of children with private coverage.³⁷ It is not surprising therefore that the recent CHIP evaluation cited CHIP’s reduction of the financial burdens and stress on families associated with meeting children’s health care needs as another success of the program.

Marketplace and employer-sponsored plans also have caps on out of pocket expenses but they tend to be higher than the CHIP caps even in plans where cost sharing is reduced by the federal government. The difference in the cap on out-of-pocket costs (Table 5) will not affect most families with children but for some it will be important. For example, only 1% of parents of CHIP enrollees reported having out-of-pocket costs greater than \$2,000 for their child while 7% of parents of privately insured children reported paying that much out-of-pocket.³⁸

In addition, for some children limitations on the scope of benefits in Marketplace plans, as illustrated in the example of Isabel above, can shift even more of the cost of care to families. Employer sponsored insurance also typically has more limited coverage for child-specific benefits than CHIP. And in the case of child-only coverage, the combination of premiums and out-of-pocket expenses in Marketplace coverage will exceed the 5% cap even for a child with only moderate health care needs.

Table 5: Maximum Out-of-Pocket Costs (Net of Premiums) in CHIP Compared to QHPs

	Costs at 140% FPL		Costs at 190% FPL	
	CHIP	QHP	CHIP	QHP
Overall Range	\$0-950	\$1,000-2,250	\$0-1,995	\$2,500-5,200

Note: Data for 31 state CHIP plans in 160% FPL category and 21 state CHIP plans in 210% FPL category. Source: Wakely Consulting Group, Comparison of Benefits and Cost Sharing in CHIP to Qualified Health Plans, July 2014.

Although eligibility for most public benefit programs including CHIP is tied to the official federal poverty guidelines, there is wide consensus that those guidelines considerably understate the cost of families' fundamental needs. The official poverty measure is a fairly arbitrary measure adopted over 40 years ago and has not been updated since except for annual adjustments for inflation. It applies to the 48 contiguous states³⁹ and does not reflect variation in the cost of living across the country or the actual costs to a family for an adequate though modest standard of living. The Economic Policy Institute's (EPI) Family Budget Calculator attempts to address some of the limitations in the official poverty measure by calculating the actual income families would need to attain a secure yet modest living standard by estimating community – specific costs of housing, food, child care, education, transportation, healthcare, other necessities and taxes.⁴⁰ Using the EPI measure, the 2013 basic family budget excluding the cost of health care for a two parent, two child family ranges from \$32,472 in Marshall County, Miss. to \$75,132 in New York City. These estimates are well above the 2014 poverty threshold, \$23,850, for a family of this type, and in fact for most families, the EPI basic family budget excluding health care exceeds 138%- 200% FPL, which characterizes the family income range of most enrollees in separate CHIP programs. Using the EPI Family Budget Calculator as a benchmark suggests that most families with children enrolled in or eligible for CHIP are already finding it difficult to maintain a modest but adequate standard of living. For these families, the additional costs of moving from CHIP coverage to either Marketplace or employer sponsored coverage will be an added burden and may require cutbacks in expenditures on basic needs such as food or housing.

Families living in high cost areas, such as New York City, where a modest standard of living may be over three times the poverty level, may experience the loss of CHIP coverage most acutely since they are so under-resourced relative to the costs they already face. Some states and localities have acknowledged the burdens most low and moderate-income families face by offering subsidized CHIP coverage to families at income levels well above the national average. For example, in New York families with incomes up to 4 times the federal poverty level are eligible for CHIP coverage⁴¹ and in California's Silicon Valley, county-based CHIP programs, called HeathyKids, are open to children in families with incomes 3 to 4 times the federal poverty level because of a decision that children's coverage available through the Marketplace may be too expensive for families with incomes below those levels.⁴²

Using the EPI's basic family budget can help highlight the economic impact of the unusually high healthcare expenses on family finances. Consider the example presented above (Table 6) of Isabel, the child with special health care needs living in Maricopa County (Phoenix), Arizona. The EPI estimated basic family budget excluding health care for a family of 2 parents and 1 child in Maricopa in 2013 was \$41,868, considerably below the cost in places like New York or Silicon Valley.⁴³ Nonetheless at 140% FPL and 190% FPL, Isabel's

family income \$27,706 and \$37,601 respectively would be below the basic budget for a family of three. Paying for the additional costs of Isabel's health care despite coverage in the benchmark Marketplace QHP, \$4,269 and \$4,731 respectively (including the uncovered habilitation services costs), would require the family to cut back on other basic needs. Alternatively, the family could cut back on Isabel's health care to have more money for their other needs.

Premium Stacking

With the roll out of Marketplace coverage for parents of CHIP-eligible children, attention has been called to the issue of premium stacking for some families.⁴⁴ Premium stacking occurs when parents or other family members pay premiums for Marketplace coverage and also pay premiums for their children's CHIP coverage. This appears to some to be an unwarranted financial burden on families because as was discussed previously for families with subsidized Marketplace coverage, there would be no additional premium associated with adding a child to a parent coverage plan. A more nuanced analysis suggests, however, that the CHIP premium may not be an added burden because CHIP coverage even in the presence of a premium is typically less costly than Marketplace coverage with no additional premium. Accordingly for most families, the combination of CHIP coverage for children and Marketplace coverage for their parents is less costly than Marketplace coverage for the entire family. To be sure, families facing above average premiums for CHIP may find premium stacking unduly burdensome and reducing CHIP premiums to zero or near zero especially for low income families might be good policy, but not because for many the combination of CHIP and Marketplace coverage is more costly than the cost of Marketplace coverage alone would be. Ironically, reducing CHIP premiums would increase the cost advantage CHIP enjoys over Marketplace coverage and make the transition to Marketplace coverage exclusively even less attractive.

CONCLUSION AND POSSIBLE POLICY RESPONSES

Failure to refund CHIP before current funding is exhausted by fall of 2015, risks a substantial reversal of the progress made over recent years in:

- Reducing the number of uninsured children. *Projections indicate that 1.0 to 2.0 million more children would become uninsured.*
- Increasing children's access to and use of needed health care. *Increases in cost sharing associated with Marketplace and employer sponsored plans as well as the increase in the number of uninsured children would reduce children's use of needed health care services and jeopardize their health.*
- Reducing the financial burden, stress and risk of high and unexpected health care costs faced by low and moderate-income families. *Limits on the scope of child-focused benefits, increased caps on out-of-pocket expenses and increases in the overall cost of coverage would be an added financial burden for families already trying to make do on incomes typically below the minimum estimated to be needed for a modest standard of living. Families with children who have chronic conditions and/or complex health care needs will be impacted especially hard.*

Pending legislation to extend CHIP funding until 2019 could go a long way to temporarily defer these risks with the added benefit of creating an opportunity to continue to make progress in these areas as CHIP enrollment grows in conjunction with further implementation of the ACA.

Efforts to address the family glitch by making it easier for families who face costly employer sponsored insurance to access subsidized Marketplace coverage may help reduce the risks associated with ending CHIP funding.⁴⁵ But, because Marketplace coverage is typically more expensive and offers less comprehensive benefits than CHIP, child and families could be worse off even if the glitch is closed.

Similarly, continuing CHIP funding for two years, as has been suggested as an interim measure by MACPAC⁴⁶ or for four years until the ACA MOE lapses in 2019, are only interim measures. It will require additional actions such as ensuring adequate, affordable coverage for children in the absence of CHIP or making funding for CHIP permanent to sustain the progress made on children's coverage and access to needed health care over the long run.

ABOUT THIS BRIEF

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Elizabeth Wright Burak, Carrie Fitzgerald, Joan Henneberry, Jenny Kenney, Ian Hill, and Sandra Shewry provided very helpful comments and helped the author avoid errors. Kym Teppo helped with the research. Any remaining errors are the sole responsibility of the author.

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provided under the State child health plan. However, the ACA does not specify the details of what constitutes comparability, and although certification is to take place in early 2015, the Secretary has not yet spelled out the specific criteria to be used.

¹⁴ It appears that in the absence of “certified” plans, families would only have the option of enrolling in plans which were not comparable to CHIP plans, and even if certified plans are available, families might choose to enroll in uncertified plans for reasons not related to the comparability of children’s coverage to no longer available CHIP coverage.

¹⁵ Ibid. 4. See also, A. Cardwell, J. Jee, C. Hess, J. Touschner, M. Heberlein and J. Alker, *Benefits and Cost Sharing in Separate CHIP Programs*, National Academy for State Health Policy and Georgetown University Center for Children and Families, (May 2014).

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