

Report to Congress on Medicaid and CHIP

MARCH 2015



MACPAC

Medicaid and CHIP Payment
and Access Commission

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, 42 U.S.C. 1396, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

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Commissioners

Diane Rowland, ScD, *Chair*
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Gustavo Cruz, DMD, MPH
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Yvette Long
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PhD, RN, FAAN
Charles Milligan, JD, MPH
Sheldon Retchin, MD, MSPH
Patricia Riley, MS
Sara Rosenbaum, JD
Peter Szilagyi, MD, MPH
Steven Waldren, MD, MS

Anne L. Schwartz, PhD
Executive Director

March 13, 2015

The Honorable Joseph R. Biden, Jr.
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit MACPAC's March 2015 Report to Congress on Medicaid and CHIP. MACPAC is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). This document fulfills our statutory mandate to report each year by March 15.

Given the urgent need for action on CHIP, we have focused the first half of the March 2015 report on the future of children's coverage. Following up on the Commission's recommendation last June to extend the CHIP program for two years while issues of affordability and adequacy of other sources of coverage are addressed, this report looks at those issues in depth, examining scenarios for children if fiscal year 2015 is the last year for federal CHIP allotments, as under current law. The Commission is especially concerned that an abrupt end to CHIP could increase the number of uninsured children. A new analysis by the Urban Institute for MACPAC, presented in Chapter 1, estimates that the share of uninsured children nationwide could rise as much as 40 percent if CHIP funding expires.

Families transitioning their children to other sources of coverage could experience substantially higher cost sharing and many would also face significantly higher premiums without changes to policy. We estimate that the average additional costs for exchange coverage are more than twice that of CHIP if the children's parents are already enrolled in exchange coverage and more than six times higher than CHIP if the children's parents are not enrolled. High out-of-pocket maximums for cost sharing combined with premiums in the exchanges could consume 12 to 19 percent of family income for families in the CHIP income range.



Moreover, it is not clear that exchange plans, as they stand now, offer adequate coverage in terms of covered benefits and provider networks for children now insured by CHIP. Of particular concern is access to dental care, a required service under CHIP, but frequently only offered as a stand-alone product in the exchanges and without any premium subsidy.

These analyses underscore the Commission's view about the need for congressional action to extend CHIP before funding runs out. In the months ahead, MACPAC will continue its work to develop policy solutions, weighing their impact on families, states, and the federal government carefully.

The second half of the March report offers detailed perspectives on Medicaid payment. It includes an analysis of premium assistance waivers, an approach currently approved in Arkansas and Iowa to purchase exchange coverage for adults newly eligible for Medicaid. Such waivers are reducing the number of uninsured adults and will require careful monitoring to ensure that they are structured to provide appropriate services to enrollees and value to the taxpayer.

The report takes a closer look at how Medicaid coverage of Medicare cost sharing affects access to care. Today, almost 20 percent of Medicare beneficiaries receive Medicaid assistance with Medicare premiums or cost sharing. The Commission is concerned that current cost-sharing policies, as well as the complexity involved in processing claims across these two programs, may reduce access to care for beneficiaries. Given current policy interest in Medicare benefit redesign, it is the Commission's view that Congress should focus on how best to provide assistance to low-income Medicare beneficiaries and the associated roles of both Medicare and Medicaid.

The March report also outlines a new payment framework for analyzing how payment and delivery systems meet statutory principles of economy, quality, access, and efficiency. The final chapter provides an update on the primary care payment increase that expired in December, concluding it is still unclear if paying providers at Medicare rates in fact improved Medicaid beneficiaries' access to primary care.

MACPAC is committed to providing in-depth, nonpartisan analyses of Medicaid and CHIP and these programs' impact on beneficiaries, states, providers, and the broader health care sector. We hope our work will prove useful to Congress as it considers legislative changes to Medicaid and CHIP.

Sincerely,



Diane Rowland, ScD
Chair

Enclosure



Commission Members and Terms

Diane Rowland, ScD, Chair
Washington, DC

Marsha Gold, ScD, Vice Chair
Washington, DC

Term Expires December 2015

Donna Checkett, MPA, MSW
Phoenix, AZ

Patricia Gabow, MD
Denver, CO

Mark Hoyt, FSA, MAAA
Phoenix, AZ

Patricia Riley, MS
Portland, ME

Diane Rowland, ScD
Washington, DC

Steven Waldren, MD, MS
Leawood, KS

Term Expires December 2016

Sharon Carte, MHS
South Charleston, WV

Andrea Cohen, JD
New York, NY

Herman Gray, MD, MBA
Detroit, MI

Norma Martínez Rogers, PhD, RN, FAAN
San Antonio, TX

Sara Rosenbaum, JD
Washington, DC

Term Expires December 2017

Gustavo Cruz, DMD, MPH
New York, NY

Marsha Gold, ScD
Washington, DC

Yvette Long
Philadelphia, PA

Charles Milligan, JD, MPH
Albuquerque, NM

Sheldon Retchin, MD, MSPH
Columbus, OH

Peter Szilagyi, MD, MPH
Los Angeles, CA

Commission Staff

Anne L. Schwartz, PhD, *Executive Director*

Office of the Executive Director

Annie Andrianasolo, MBA, *Executive Assistant*

Kathryn Ceja, *Director of Communications*

Policy Directors

Amy Bernstein, ScD, MHSA
Policy Director and Contracting Officer

Moira Forbes, MBA, *Policy Director*

April Grady, MPAff, *Policy Director*

Mary Ellen Stahlman, MHSA, *Policy and
Congressional Affairs Director*

Principal Analysts

Martha Heberlein, MA

Joanne Jee, MPH

Chris Peterson, MPP

Anna Sommers, PhD, MS, MPAff

James Teisl, MPH

Kristal Vardaman, MSPH

Senior Analysts

Veronica Daher, JD

Benjamin Finder, MPH

Robert Nelb, MPH

Chris Park, MS

Katie Weider, MPH

Analyst

Sarah Melecki, MPAff

Research Assistant

Nicholas Elan

Operations and Management

Ricardo Villeta, MBA, *Deputy Director
of Operations, Finance, and Management*

James Boissonnault, MA, *Chief Information Officer*

Vincent Calvo, *Administrative Assistant*

Benjamin Granata, *Finance/Budget Specialist*

Saamil Parikh, MBA, *IT Specialist*

Ken Pezzella, *Chief Financial Officer*

Eileen Wilkie, *Administrative Officer*

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Executive Summary: March 2015 Report to Congress on Medicaid and CHIP

The Medicaid and CHIP Payment and Access Commission (MACPAC) releases its March 2015 *Report to Congress on Medicaid and CHIP* at a time of critical change for both of these programs.

The State Children's Health Insurance Program (CHIP) confronts exhaustion of federal funds, with the last allotments to states being made under current law in fiscal year (FY) 2015. MACPAC began analyzing the implications of this scenario in its March and June 2014 reports to Congress, documenting problems with affordability and adequacy of both exchange plans and employer-sponsored insurance for children who would lose CHIP coverage. In those reports, the Commission recommended extending CHIP for two years while these issues could be addressed. The first four chapters of the March 2015 report to Congress follow up on that recommendation in depth.

Meanwhile, Medicaid, which this year marks a half-century of providing access to health care for the most disadvantaged Americans, is expanding. As a result of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), in over half of states, a new group of low-income adults became eligible for Medicaid in 2014, alongside the populations Medicaid has traditionally covered: low-income families with children, pregnant women, people age 65 and older, and people with disabilities. The March report offers perspective on two approaches being tested in Iowa and Arkansas to use Medicaid funds to purchase exchange coverage for the new adult group.

The Commission also looks closely at whether current policies for Medicaid payment of Medicare cost sharing affect access to care for the 20 percent of beneficiaries who are dually eligible for

these programs. The report also outlines a new payment framework to examine how payment and delivery systems meet statutory principles of economy, quality, access, and efficiency. It concludes with an update on the primary care payment increase that expired in December 2014.

CHAPTER 1: Sources of Coverage for Children If CHIP Funding Is Exhausted

In considering the future of children's coverage, the Commission has noted that the long-term goal should be to ensure that low- and moderate-income children have affordable coverage and access to the high-quality services critical to their healthy development. Chapter 1 looks specifically at the sources of health insurance coverage that would be available to families whose children are enrolled in CHIP, considering who would enroll and premium costs to families if federal funding for CHIP runs out in FY 2016.

A new analysis for MACPAC conducted by the Urban Institute finds that, while the number of uninsured children has been halved since CHIP's creation 18 years ago, exhaustion of federal CHIP funds under current law would substantially erode those gains. Specifically, if federal CHIP funding is not renewed and states exhaust their federal balances, a third of the children currently enrolled in separate CHIP would become uninsured—approximately 1.1 million children. The remaining two-thirds of the children covered in separate CHIP would move to exchange coverage or their parents' job-based insurance. The costs to families for such coverage would be significant. For families with job-based coverage, projected premiums could average \$3,751 per year, or 9.1 percent of family income. Families with subsidized coverage on the exchange might see smaller or no premium costs, but they would face much higher cost-sharing amounts (in the form of deductibles and service level cost sharing) than under CHIP.

These findings reinforce the Commission's recommendation that CHIP funding should be extended for two years while options are developed to address concerns about affordability and adequacy, with the ultimate goal being integration into Medicaid, employer-sponsored, or exchange coverage, depending upon a family's circumstances. The Commission will weigh such alternatives carefully, based on their costs and impact on families, states, and the federal government.

CHAPTER 2: Affordability of Exchange Coverage for Children Now Covered by CHIP

In Chapter 2, the Commission compares the cost of covering children in exchange plans to CHIP. Average additional costs for exchange coverage are estimated to be more than twice that of CHIP if the children's parents are already enrolled in exchange coverage and more than six times higher than CHIP if the children's parents are not enrolled, depending on income. In an exchange plan, a family's total potential exposure (premiums plus maximum service-level cost sharing) to cover children with exceptionally high health needs could exceed 11.7 percent of family income at 160 percent of the federal poverty level (FPL) and 18.8 percent at 210 percent FPL.

The differences between CHIP and exchange plan premiums and cost-sharing requirements or responsibilities occur because the programs' rules reflect fundamentally different policy goals. CHIP was designed to provide coverage to low-income children who do not qualify for Medicaid. Premiums tend to be nominal and there is a 5 percent of family income limit on what families pay in combined premiums and cost sharing. Exchanges were designed primarily to assist uninsured working adults and their families in purchasing insurance coverage. Exchange premiums and cost-sharing levels reflect product designs in the private market, with federal subsidies providing some assistance in paying for premiums and cost sharing. Premiums for

exchange coverage vary depending on an enrollee's age, rating area, and metal tier of an exchange plan selected (bronze, silver, gold, or platinum).

The Commission noted previously and remains concerned that the higher costs for exchange coverage would increase the financial burden and may raise barriers to care. Both the absolute cost of coverage and those costs relative to families' other household expenses affect consumer decisions to enroll in coverage or seek care. Research has consistently shown that premiums influence a family's decision to enroll low-income children in coverage and that low-income consumers are particularly sensitive to the price of point-of-service cost sharing—and in exchange plans that price is high.

Future analyses will evaluate options to address affordability concerns for children's coverage, including how possible approaches might be designed, their benefits and drawbacks, and their cost implications from the perspectives of families, state and federal governments, and other stakeholders.

CHAPTER 3: Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance

A key question for the Commission as it explores the future of children's coverage is whether exchange plans or other sources of coverage provide sufficient benefits to meet the health needs of children now enrolled in CHIP. Survey data indicate that children at CHIP income levels are more likely than privately insured children to have a higher prevalence of chronic conditions and use more health services.

Chapter 3 reviews benefits generally available in CHIP, Medicaid, exchange plans, and employer-sponsored insurance plans. The analysis finds that CHIP, Medicaid, and private coverage all include major medical benefits, such as inpatient care,

physician services, and prescription drugs, but for other benefits, coverage varies. For example, although Medicaid and CHIP cover dental benefits, most exchange plans offer dental benefits as a separate, stand-alone insurance product.

CHIP and Medicaid programs cover many services that are not always available in exchange plans. All CHIP and Medicaid programs cover audiology exams, and 95 percent of state CHIP programs cover hearing aids. However, only 37 percent of exchange plan benchmarks cover audiology exams and 54 percent cover hearing aids. Coverage for other benefits, such as applied behavioral analysis therapy and autism services, varies.

Covered benefits also vary within each source—at the state level for Medicaid and CHIP, and at the plan level for employer-sponsored insurance and exchange plans. It is important to note that benefit comparisons are inherently complex and must be considered in the context of payer and plan policies on the amount, duration, and scope of covered benefits, the definition of services within benefit categories, and definitions of medical necessity. It also is worth noting that coverage of a benefit does not guarantee access to services. As a result, it can be quite difficult to assess the effect of differences in benefit categories on individuals.

The Commission is now examining the feasibility, complexity, and costs of a range of policy options to address concerns about the adequacy of exchange benefits for children.

CHAPTER 4: Provider Networks and Access: Issues for Children's Coverage

Chapter 4 continues the discussion of the future of children's coverage with an analysis of how well exchange networks can serve children now covered by CHIP. While concerns have been raised about the adequacy of these networks, experience with exchange plans is too new to make definitive conclusions about whether differences between

Medicaid, CHIP, and exchange plan networks would affect children's access to care.

Although Chapter 4 focuses on the children who stand to lose CHIP coverage when federal funding is exhausted, it is important to keep in mind that the availability of providers who can meet children's unique needs is important for all children, whether they are enrolled in Medicaid, CHIP, or exchange plans. A provider network that is adequate for adults is not necessarily adequate for children. Children need access to care not just because they are sick or injured, but also to promote their growth and development. A given population of children also can require access to a wide variety of pediatric medical and surgical specialists over time. Children in low- and moderate-income families—those expected to churn between Medicaid, CHIP, and exchange plans—have additional needs. For example, children at CHIP and Medicaid income levels are more likely to have special health care needs than privately insured children.

Network design must balance two key factors: which providers are needed to ensure access for the insured population, and which providers are available and willing to contract with the health plan at price that is acceptable to the plan, providers, and those paying premiums. However, plans may have less control over the number, type, and distribution of providers in a given network than network adequacy regulations may presume. For example, a plan may have limited negotiating power when a provider is the only facility of its type in the area.

Ensuring network adequacy also requires monitoring and enforcement of standards, particularly because plans across all payer types are relying increasingly on narrow networks to control costs. Consumers depend on states, plans, and the federal government to enforce minimum standards so they can understand the insurance products they purchase and the trade-offs they may make between the cost and scope of networks. MACPAC will continue to monitor network adequacy issues with a particular emphasis on children's

ability to access specialty care; development of meaningful and accurate measures of network adequacy; network transparency; and how plans and payers will balance access, quality, and cost.

CHAPTER 5: Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market

Premium assistance—the use of Medicaid funds to purchase private market plans—is one way that states may expand coverage to previously ineligible, low-income adults. Arkansas and Iowa have been using premium assistance to purchase plans on the exchange through Section 1115 research and demonstration waivers since January 2014, and other states have expressed interest in this approach.

States cite various rationales for considering premium assistance, including easing the transition from Medicaid to exchange plan eligibility and improving access to care by enrolling individuals in private market plans. Relying on the private market could enable states with limited managed care or provider capacity to serve the influx of new enrollees. States also point to the potential for Medicaid enrollees to substantially increase enrollment in the exchange, which in turn could improve the risk pool and encourage issuer participation.

While approved premium assistance waivers retain certain protections for exchange plan enrollees—including retroactive coverage, benefit appeals rights, and exemptions for medically frail enrollees—they have notable differences from traditional Medicaid. For example, there are some instances where Medicaid continues to provide benefits not covered by exchange plans and other instances where benefits have been waived and are no longer available to enrollees. In terms of cost sharing, Medicaid's limit to 5 percent of income remains, but both Arkansas and Iowa are instituting

new approaches to cost sharing that could affect enrollment and utilization.

The expanded use of the recent premium assistance models raises important policy considerations that include:

- whether these approaches result in more covered individuals and improvements in access to care;
- whether restricting non-emergency medical transportation also restricts access to care;
- whether enrollees are able to access necessary benefits through wrap-around coverage;
- whether premiums, cost sharing, and incentives for healthy behaviors have an impact on enrollment and service utilization;
- whether exchange plan enrollment improves continuity of coverage as enrollee income changes;
- whether screening can accurately identify the medically frail for exemption;
- whether purchasing exchange plans for the Medicaid population increases competition and reduces costs in the exchange market; and
- the costs to the state and federal Medicaid program and federal spending generally.

While it will be several years before the data are available that can provide a full assessment of premium assistance, raising questions now can help guide future analysis and evaluation, including whether its use should be broadened in Medicaid and CHIP.

CHAPTER 6: Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care

Since its enactment in 1965, Medicaid has played a role in paying for some Medicare premiums and cost sharing for certain beneficiaries who are dually eligible for Medicare and Medicaid. Medicare's out-of-pocket costs can be a financial burden for low-income beneficiaries. More than three-quarters of people who are dually eligible have incomes below \$15,000, while Medicare Part B's yearly deductible and monthly premiums together exceeded \$1,400 for most beneficiaries in 2014. Today, almost 20 percent of Medicare beneficiaries receive assistance with Medicare premiums or cost sharing through one of the four separate Medicare Savings Programs or through full Medicaid benefits.

For the more than 10 million dually eligible beneficiaries, Medicaid is an important supplement to Medicare coverage. But despite successfully reducing beneficiaries' out-of-pocket health care costs, Medicaid's coverage of Medicare premiums and cost sharing warrants further examination. Since 1997, the Medicaid statute has explicitly allowed states to pay less than the full Medicare cost-sharing amount if it would result in a provider receiving more than the state's Medicaid rate for the same service. In 2012, Medicaid fee-for-service physician fees averaged 66 percent of Medicare physician fees for selected services. This means that Medicaid payment for cost sharing associated with Medicare services provided to dually eligible beneficiaries was almost always less than what would have been paid for Medicare beneficiaries without Medicaid coverage.

The Commission is concerned that this "lesser of" policy, combined with the administrative complexity of processing claims across these two programs, may create disincentives for providers to treat dually eligible patients, thus limiting their access to care. New research presented in this chapter supports this concern and finds that, relative to non-dually eligible Medicare beneficiaries, paying

a higher percentage of Medicare cost sharing increases dually eligible beneficiaries' likelihood of using selected Medicare outpatient services and decreases the use of safety net provider services.

Current interest in redesigning Medicare's cost-sharing policies provides an opportunity to reexamine the roles of both Medicare and Medicaid in providing assistance for low-income Medicare beneficiaries. But given Medicare and Medicaid's interconnected designs and these programs' wide-ranging impacts, changes to Medicaid's coverage of Medicare's out-of-pocket costs must be considered in conjunction with changes to Medicare policy in order to understand fully how they would affect beneficiaries, providers, and federal and state budgets. Future Commission work will focus on eligibility and enrollment issues related to the Medicare Savings Programs and areas where Medicaid policy changes can improve access for low-income Medicare beneficiaries.

CHAPTER 7: A Framework for Evaluating Medicaid Provider Payment Policy

Payment policy can be a powerful lever to contain costs and improve access to and quality of care. So, after years of focusing primarily on prices, state Medicaid programs increasingly are adopting more sophisticated purchasing strategies emphasizing value. Although Medicaid statute designates efficiency, quality, economy, and the same access to care as the general population—all measures of value—as fundamental goals of payment policy, these principals are largely unaddressed in federal regulation.

In the absence of administrative rules, legal challenges have determined how efficiency, quality, economy, and access and appropriate levels of utilization should be applied. These court rulings generally address payment levels, but not the methodologies used to set the payment levels. In addition, they do not offer guidance to policymakers

in developing payment or delivery systems that set an appropriate balance among statutory aims, or among providers, beneficiaries, and taxpayers.

MACPAC has developed a payment policy framework to assist policymakers in gauging how well various approaches to payment and delivery follow statutory principles of economy, quality, access, and efficiency. MACPAC is collecting the following information to support this analysis:

- states' payment methodologies for various provider types;
- comparative information on payment rates and methodologies across states and payers, provider costs, and the share of provider revenue that the payments represent; and
- payment's effects on outcomes, including recommendations for appropriate measures and comparisons to other states and payers.

The Commission's goal is to get past the work of describing payment methods to pinpointing specific payment approaches that best address efficiency and economy while promoting access to quality services and appropriate utilization.

CHAPTER 8: An Update on the Medicaid Primary Care Payment Increase

The final chapter in the March 2015 report provides an update on the ACA's Medicaid primary care payment increase. The increase, which was funded at the federal level and expired at the end of 2014, required all state Medicaid programs to pay for primary care services at Medicare payment levels during calendar years 2013 and 2014. The payment increase was intended to address the need to maintain provider networks for those currently enrolled in Medicaid in light of the ACA-mandated expansion of Medicaid eligibility (later made optional by the U.S. Supreme Court).

Although the provision seemed like a straightforward rate increase, it proved complicated to implement. States had to identify eligible providers and maintain separate fee schedules to pay those providers the enhanced rate while paying ineligible providers a lower rate, and they had to work with their Medicaid managed care organizations to do the same.

MACPAC interviewed state Medicaid agencies, Medicaid managed care organizations, and provider organizations in eight states between June and September 2014 and learned that although early operational issues had largely been resolved, uneven implementation led to payment delays. These delays, combined with the short time frame in which the provision was in effect, made it difficult to evaluate the program's impact before it expired.

In the Commission's view, there is not enough evidence to definitively determine whether the payment increase had an effect on provider participation or enrollee access to primary care in Medicaid. Most states have not evaluated the effect of the payment increase on provider participation, and data required for federal evaluations are not yet available. Despite this lack of data, some states are continuing to pay Medicaid primary care providers at higher rates even without the enhanced federal matching funds.

The Future of Children's Coverage

The Future of Children's Coverage

Since its enactment 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 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) has fallen by more than half—from 22.8 percent in 1997 to 8.9 percent in 2014 (Martinez and Cohen 2014, 2012). In fiscal year (FY) 2013, 8.1 million children were enrolled in CHIP for at least part of the year. Preliminary FY 2014 data show about half of CHIP enrollees in Medicaid-expansion programs and about half in separate CHIP programs.

The Commission has focused considerable attention on CHIP over the past year in order to help inform congressional deliberations about the program's funding and future (MACPAC 2014a, 2014b). We have assessed CHIP's current role for children and how CHIP coverage compares to other sources, including that offered by the exchanges and employers. Most immediately, the Commission has considered what would happen under the current-law scenario under which federal CHIP funding is exhausted in FY 2016. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) put in place a maintenance of effort (MOE) requirement to ensure that states continue coverage at current eligibility levels for children in Medicaid-expansion CHIP programs at least through FY 2019. This means that these children will continue to have coverage, although it will be financed at the lower Medicaid matching rate. But the MOE requirement only applies to separate CHIP programs as long as federal CHIP funding is available. Therefore, if CHIP funds run out, then states may close down separate CHIP programs because the MOE does not apply to them.

Further, the Commission's analysis has found that an abrupt end to CHIP would result in an increase in the number of uninsured children. Those transitioning to other sources of coverage would experience substantially higher cost sharing, and many would also face significantly higher premiums. Moreover, it is not clear that exchange plans, as they stand now, offer adequate coverage for children now insured by CHIP in terms of covered benefits and provider networks.

In light of the problems associated with the exhaustion of federal CHIP funding, the Commission, in our June 2014 report to Congress, recommended that 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 should be addressed. At that time, the Commission noted that this transition period could be extended if the problems identified were not fully addressed within the two-year period. However, we also stated that we believed the changes necessary to ensure that children have access to high-quality coverage that addresses their needs could be made during this transition period.

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, creating new sources of coverage for many families in the CHIP income range. In considering the future, the goal should be to ensure that low- and moderate-income children have affordable coverage that offers access to high-quality care that is critical to children's healthy development. These children should also have smooth transitions to other sources of coverage, including Medicaid, exchange, and employer-sponsored coverage. For this reason, the Commission continues to recommend that CHIP be extended while safeguards are developed to address concerns about affordability and adequacy, with the ultimate goal being integration into Medicaid, employer-

sponsored, or exchange coverage depending upon their family circumstances.

When we made our recommendation last June, we noted that there was insufficient time between then and the end of FY 2015 to address concerns about coverage, affordability, and adequacy, either in law or regulation. We explained then, and continue to believe now, that 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. These limitations must be addressed so as not to step backward from the relatively high level of good coverage that children now have through CHIP.

The four chapters that follow present the Commission's analyses to date on coverage, affordability, benefits, and network adequacy, providing additional detail and nuance to the problems identified in our previous reports. Our analyses confirm our fundamental conclusions about the need for additional policy changes that will ensure that children continue to have access to high-quality coverage.

The Commission will continue to explore ways to address the concerns about the potential rise in uninsurance, changes in benefits and cost sharing, access to care, and financial implications for states that will arise if CHIP funding ends. We will be carefully weighing the impact of alternative policies on families, states, and the federal government and will report further in our June report. In the meantime, we thought it was important to share our analyses with Congress and others engaged in the discussion about the future of CHIP.

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CHAPTER 1

Sources of Coverage for Children If CHIP Funding Is Exhausted

Sources of Coverage for Children If CHIP Funding Is Exhausted

Key Points

- MACPAC projects that if federal funding for the State Children's Health Insurance Program (CHIP) is not extended this year, then 3.7 million children would lose separate CHIP coverage in fiscal year (FY) 2016. Approximately half of these children would be eligible for subsidized exchange coverage and the other half for employer-sponsored insurance, according to an analysis by the Urban Institute for MACPAC.
- Of the children projected to lose separate CHIP coverage, 1.1 million children would become uninsured, bringing the number of uninsured children in the United States to 4 million. This would be a nearly 40 percent increase in the projected number of uninsured children nationally.
- Children covered in Medicaid-expansion CHIP programs are not at risk of becoming uninsured. This is because a maintenance of effort provision enacted in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires states to continue such coverage at least through FY 2019. Federal funding in Medicaid-expansion CHIP would revert from the CHIP enhanced matching rate to the lower Medicaid matching rate, making states liable for additional spending.
- More than two-thirds of children covered under separate CHIP programs are projected to obtain coverage from other payers—1.4 million (36.5 percent) through subsidized exchange coverage and 1.2 million (32.6 percent) through a parent's job-based coverage.
- The out-of-pocket premiums for adding children to employer-sponsored coverage could be substantial. On average, these projected premiums would average \$3,751 per year, or 9.1 percent of family income. The impact on individual families will depend upon various factors, including whether other family members are already enrolled. The increase ranges from \$125 per year on average among the 25 percent of families facing the lowest additional premiums to \$8,814 for the 25 percent of families facing the highest premiums.
- These findings reinforce the Commission's recommendation that CHIP be extended for two years while safeguards are developed to address concerns about affordability and adequacy, with the ultimate goal being the integration of CHIP-enrolled children into other sources of coverage, including Medicaid, exchange plans, or employer-sponsored insurance. The Commission will weigh such alternatives carefully, based on their costs and impact on families, states, and the federal government.

CHAPTER 1:

Sources of Coverage for Children If CHIP Funding Is Exhausted

Under current law, federal funding for the State Children's Health Insurance Program (CHIP) will be exhausted in fiscal year (FY) 2016. A new analysis for MACPAC by the Urban Institute projects that this will result in 3.7 million children needing to find another source of health insurance coverage.¹ More than two-thirds would enroll in subsidized exchange coverage or employer-sponsored insurance, but nearly one-third, 1.1 million children, would become uninsured.² This number would rise further if the U.S. Supreme Court were to rule in *King v. Burwell* that subsidies are not permitted in the federally facilitated exchanges.

In this chapter we describe the sources of health insurance coverage available to children who would lose access to CHIP if no additional federal CHIP funding is provided and states exhaust their remaining balances in FY 2016. Projections are then provided of how many of these children would be eligible for other sources of coverage in the absence of CHIP, how much it would cost them, and whether or not families would enroll. These projections are based on the Urban Institute's Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS).

In considering the future of children's coverage, the Commission has noted that the long-term goal should be to ensure that low- and moderate-income children have affordable coverage that offers access to high-quality care and services critical to children's healthy development. These children should also have a smooth transition to other sources of coverage, including Medicaid, exchange plans, and employer-sponsored insurance. For this reason, the Commission has

recommended that CHIP be extended in the short term while safeguards are developed to address concerns about affordability and adequacy and until enrollees can be integrated into other coverage. The Commission will carefully weigh such alternatives based on their cost and impact on families, states, and the federal government.

Overview of Coverage Alternatives If CHIP Funding Is Exhausted

The type of coverage children will be eligible for if CHIP funding is exhausted depends on several factors, the first being whether they are enrolled in a Medicaid-expansion CHIP program or a separate CHIP program. States with Medicaid-expansion CHIP programs must maintain those eligibility levels through at least FY 2019, while separate CHIP programs can be shut down, with those enrollees left to find other coverage or become uninsured. Forty-one states would face both of these effects because, as combination states, they have some children in Medicaid-expansion CHIP and others in separate CHIP programs (HHS 2015). For example, in 2014 the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required many states that had previously run separate CHIP programs exclusively to move 6- to 18-year-olds between 100 and 138 percent of the federal poverty level (FPL) from separate CHIP coverage into new Medicaid-expansion CHIP coverage. (For a family of three in the contiguous 48 states and the District of Columbia, 100 percent FPL is approximately \$20,000 per year.)

In the absence of CHIP funding, states' budget obligations will increase for children enrolled in Medicaid-expansion CHIP due to the maintenance of effort requirement included in the ACA. This maintenance of effort requires states to continue Medicaid coverage at current eligibility levels for children in Medicaid and Medicaid-expansion CHIP

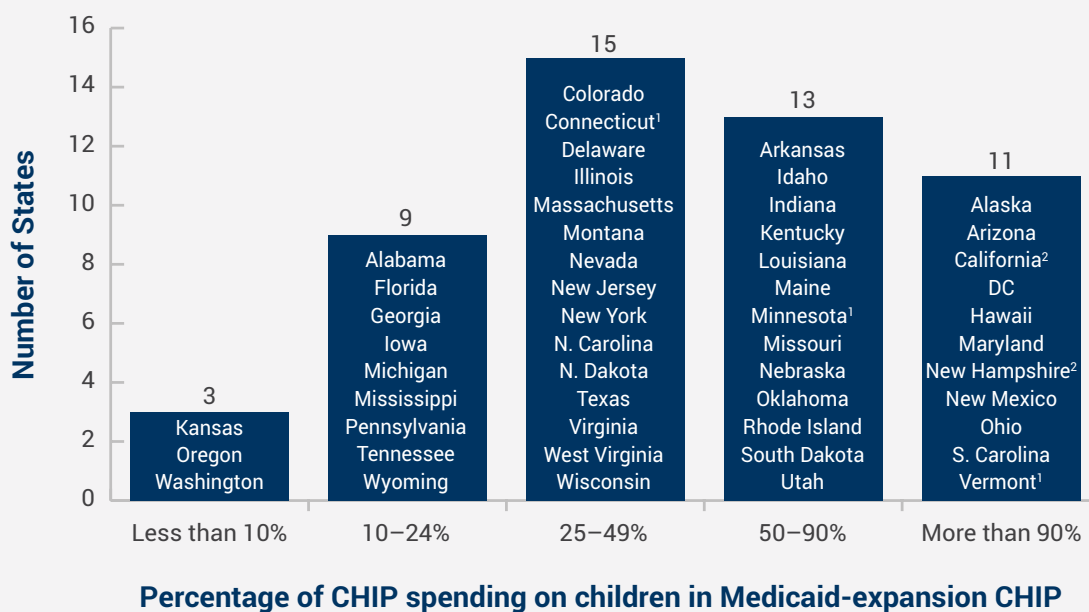
at least through FY 2019 even if CHIP funding runs out (HHS 2015).³

However, when CHIP funding is exhausted, federal matching will decrease from CHIP rates to Medicaid rates, and states will have to make up the difference, resulting in a 43 percent larger state contribution than currently required under CHIP.⁴

The extent to which states will be affected by the maintenance of effort requirement as CHIP funding

is exhausted varies substantially.⁵ Overall, states project that half of their CHIP spending in FY 2016 will be for children in Medicaid-expansion CHIP; but in 11 states, Medicaid-enrolled children account for more than 90 percent of projected federal CHIP spending (Figure 1-1). So these 11 states must continue coverage at increased state cost for nearly all of their current CHIP-financed population, with relatively few of their children projected to become uninsured. In contrast, three states are projected to have less than 10 percent of CHIP

FIGURE 1-1. Projected Share of Federal CHIP Funds to Be Spent on Children in Medicaid-Expansion CHIP, Fiscal Year 2016



Notes:

¹ In this figure, spending under §2105(g) of the Social Security Act is treated as spending for children in Medicaid-expansion CHIP. Section 2105(g) permits 11 qualifying states to use federal CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level. State projections for fiscal year (FY) 2016 indicate that §2105(g) spending would account for 44 percent of federal CHIP spending in Connecticut, 55 percent in Minnesota, 15 percent in New Hampshire, and 57 percent in Vermont. Section 2105(g) spending in these four states places them in a higher category.

² Maintenance of effort is tied to eligibility policies in place on March 23, 2010, the date the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) was enacted. California and New Hampshire converted much of their separate CHIP population to Medicaid-expansion coverage after that date, and it is not clear whether these states will be permitted to remove these children from Medicaid as CHIP funding is exhausted.

Source: MACPAC analysis of projections of FY 2016 federal CHIP spending provided by states in the Medicaid and CHIP Budget and Expenditure System as of January 2015.

spending attributable to Medicaid-enrolled children and thus would face little increased state Medicaid spending for enrollees whose coverage must continue under the regular Medicaid match.

The experience of two states illustrates how the exhaustion of federal CHIP funds affects states differently depending on their share of enrollees with either Medicaid-expansion or separate CHIP coverage. Maryland is one of eight states considered to run a Medicaid-expansion CHIP program exclusively. In Maryland, CHIP pays for children's Medicaid coverage that is above the pre-CHIP Medicaid eligibility levels, up to 322 percent FPL. Maryland must maintain these eligibility levels up to 322 percent FPL through FY 2019. The state would face increased state spending as the federal matching rate falls from that of CHIP to Medicaid. In 2015, the federal CHIP matching rate for Maryland is 65 percent, compared to 50 percent for Medicaid.⁶ On the other hand, all of these children would remain insured, at least through FY 2019, even if CHIP funding were exhausted.

In contrast, Iowa has both Medicaid-expansion CHIP and separate CHIP. Its Medicaid-expansion CHIP covers 1- to 18-year-olds above pre-CHIP Medicaid eligibility levels, up to 172 percent FPL.⁷ Its separate CHIP covers 1- to 18-year-olds between 173 and 307 percent FPL. If CHIP funding ends, Iowa must maintain its Medicaid-expansion CHIP eligibility levels through FY 2019 but can end its separate CHIP coverage.

When the maintenance of effort requirement expires after FY 2019, some states will likely roll back their eligibility levels for children's Medicaid and Medicaid-expansion CHIP to the federal Medicaid minimums—nationally at 138 percent FPL.⁸ The additional number of children becoming uninsured without CHIP as the maintenance of effort expires after FY 2019 will depend not only on whether states decide to reduce eligibility levels, but also on what alternatives are available to children then.⁹

Projected Coverage among Children Losing Separate CHIP in 2016

As indicated above, approximately 3.7 million children age 0–18 are projected to be enrolled in separate CHIP in 2016. Because the maintenance of effort requirement does not apply to these separate CHIP programs in the absence of federal funding, states may close them down after their CHIP funds are exhausted. The remainder of this chapter provides projections of the coverage in which separate-CHIP-enrolled children would enroll in 2016 in the absence of CHIP, based on an Urban Institute analysis (Box 1-1). To produce these projections, the Urban Institute considered a number of factors, including the following:

- out-of-pocket premium costs, accounting for the extent to which the whole family must be enrolled in coverage in order to cover children, whether for employer-sponsored insurance or subsidized exchange coverage;
- family members' expected health care costs;
- historical data on individual coverage decisions that weigh costs and health risks;
- the impact of the individual mandate penalty being fully in effect;¹⁰ and
- other demographic, socioeconomic, and health characteristics.¹¹

Projected eligibility versus projected enrollment

Eligibility. If all separate CHIP programs are discontinued in 2016, then an estimated 1.9 million of the projected 3.7 million separate-CHIP-enrolled children will be eligible for subsidized exchange coverage.¹² This group comprises 1.6 million children whose parents do not have an offer of employer-sponsored insurance, 0.1 million children whose

BOX 1-1. Modeling Approach Used to Project Coverage among Children Losing Separate CHIP Coverage in 2016

In this chapter, projections of children's eligibility, enrollment, and premiums were provided by Urban Institute researchers using their Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS). The core data in the model are from the Census Bureau's American Community Survey, which is an annual survey of 3 million U.S. residents, representative at the state and national level. To follow the data trends forward to 2013, Census Bureau estimates of individual state population growth from 2010 to 2013 are used. Census Bureau population projections are used to produce estimates through 2016. Additional information, such as detailed firm size and unemployment compensation, is incorporated into the model from the Census Bureau's Current Population Survey (CPS). Health care use and spending are estimated for each individual for all of the possible insurance types based on data from the Household Component of the Medical Expenditure Panel Survey (MEPS) and benchmarked to relevant standards for each type of insurance.

To support analyses of children's coverage absent CHIP, HIPSM-ACS was enhanced with data provided by the Agency for Healthcare Research and Quality (AHRQ) from the Insurance Component (IC) of MEPS. The MEPS-IC obtains detailed information about employers, the extent to which they offer health insurance, the cost of that coverage, and the firms' and employees' characteristics associated with those offers. In particular, HIPSM-ACS was enhanced to allow for the modeling of offers and costs of employee-plus-one coverage and of the joint distribution of the employee and employer costs of self-only, employee-plus-one, and family coverage. This enhancement allowed for more precise modeling of the cost of self-only coverage and circumstances in which the cost of such coverage for the employee would be low but the cost for family coverage would be high. These data were critical in projecting the offers and family out-of-pocket costs for job-based coverage if an employee's child's separate CHIP coverage were to end.

National and state rules and costs for Medicaid, CHIP, and exchange coverage were used to simulate eligibility for these programs. The costs and eligibility for employer-sponsored coverage were also included. With this information, each individual in the model can be assessed in order to project the following as of 2016:

- Who is eligible for coverage?
- How much would it cost?
- Who would enroll or be uninsured?
- How would coverage change under different scenarios?

There are a number of caveats that need to be considered in any simulation model regarding assumptions, forecasting, and measurement error. First, there is uncertainty in the model's assumptions about the rate of participation in subsidized exchange coverage at different income levels and in participation among those who were previously eligible for Medicaid and CHIP. These assumptions affect the coverage projected in 2016 as well as the effects for the scenario in which separate CHIP coverage ends. To address this uncertainty, estimates were also produced that

BOX 1-1 (continued)

assumed lower take-up rates than the standard model. Even with rates that led to a difference of several million in the overall number of uninsured people, the number of newly uninsured children as a result of the discontinuation of CHIP increased only modestly, from 1.1 to 1.2 million. Second, in forecasting to 2016, the analysis assumes that the economic picture and the structure of employer-sponsored coverage remains constant. However, improvements in the economy could result in fewer children being eligible and enrolled in separate CHIP coverage, potentially leading to an overestimation of the number of children who would become uninsured if separate CHIP programs were discontinued. On the other hand, trends in employer-sponsored insurance, such as increasing family premiums and deductibles, may encourage more families to enroll their children in separate CHIP coverage, potentially leading to an underestimation of the number of children who would become uninsured if separate CHIP programs were discontinued. Third, income, insurance coverage, and premiums faced by CHIP-eligible families are subject to measurement and reporting errors.

Detailed documentation for the analyses in this chapter and of the HIPSM-ACS as enhanced with the MEPS-IC can be found in Dubay et al. 2015.

parents have an offer of employer-sponsored coverage that is not available to dependents, and 0.2 million children whose parents have an offer of employer-sponsored insurance that is not considered affordable according to the ACA (Figure 1-2).

The remaining 1.8 million children projected to lose separate CHIP coverage in 2016 would be ineligible for exchange subsidies because they have a parent or parents with an offer of employer-sponsored insurance that is available to dependents and that is defined by the ACA as affordable. In the majority of these families, a parent is already enrolled in job-based coverage (Figure 1-2).

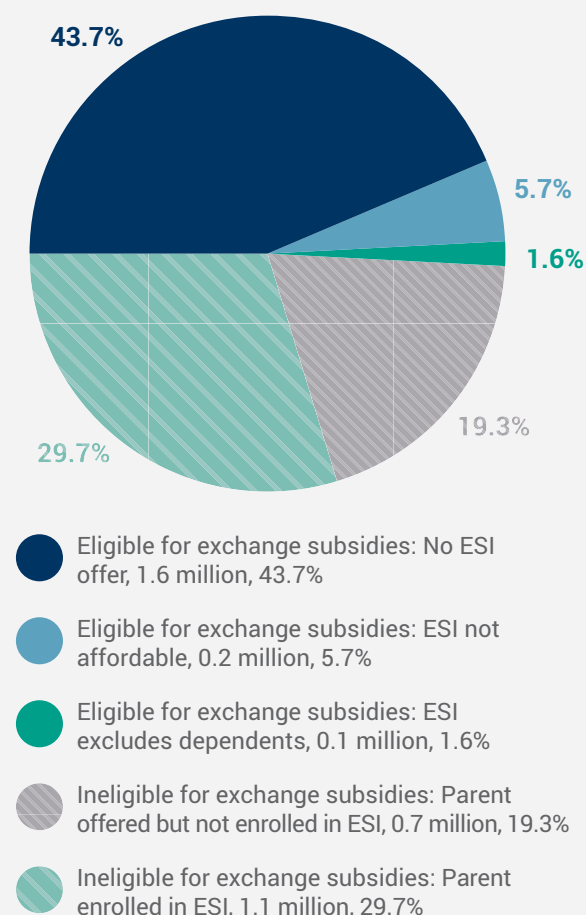
Affordable coverage. The ACA defines employer-sponsored coverage as affordable if an employee's out-of-pocket premiums for self-only coverage would account for no more than 9.5 percent of family income. This affordability test is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered. In 2013, employee contributions for employer-sponsored, self-only coverage averaged \$1,170, which amounts to 3.7 percent of income for a family of three at

160 percent FPL and 2.9 percent of income at 210 percent FPL (AHRQ 2013a). For family coverage, the out-of-pocket premiums averaged \$4,421, which amounts to 14.1 percent of income for a family of three at 160 percent FPL and 10.8 percent of income at 210 percent FPL (AHRQ 2013b).

Using the current affordability test, 5.7 percent of children projected to lose separate CHIP would be eligible for exchange subsidies because the self-only premium for employer-sponsored coverage exceeds 9.5 percent of income (Figure 1-2). Note, however, that even families made eligible for exchange subsidies under the current affordability test may choose not to enroll for a variety of reasons, including costs, as discussed in greater detail below.

Enrollment. The Urban Institute projects that of the 3.7 million children who will lose separate CHIP coverage in 2016, an estimated 1.4 million will enroll in subsidized exchange coverage, 1.2 million will enroll in employer-sponsored coverage, and 1.1 million will become uninsured (Figure 1-3).¹³

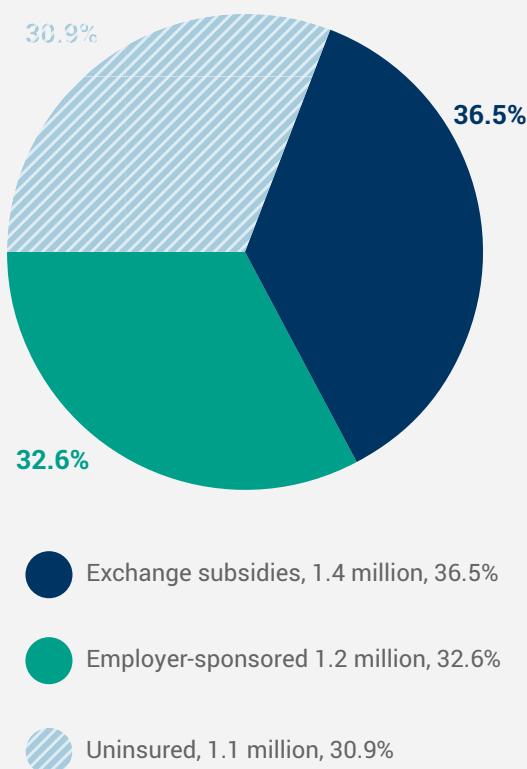
FIGURE 1-2. Eligibility among the Projected 3.7 Million Separate-CHIP-Enrolled Children Who Will Lose That Coverage in 2016



Notes: ESI is employer-sponsored insurance. The number 3.7 million is the number of children projected to be enrolled in separate CHIP at a point in time in 2016 assuming the continuation of CHIP into that year. Excludes unborn children and children enrolled in Medicaid-expansion CHIP. Affordable is defined as ESI with self-only premium less than 9.5 percent of family income per the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

FIGURE 1-3. Projected Subsequent Enrollment in Health Insurance Coverage and Uninsurance among the Projected 3.7 Million Separate-CHIP-Enrolled Children Who Will Lose That Coverage in 2016



Notes: The number 3.7 million is the number of children projected to be enrolled in separate CHIP at a point in time in 2016 assuming the continuation of CHIP into that year. Excludes unborn children and children enrolled in Medicaid-expansion CHIP.

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

Children losing CHIP who are eligible for employer-sponsored coverage

Approximately 1.8 million children projected to lose separate CHIP coverage will be eligible for employer-sponsored coverage (Figure 1-2), in which an estimated 1.2 million will enroll (Figure 1-3). If CHIP ends, nearly all children who have a parent in employer-sponsored coverage are projected to join that coverage. This is based on historical experience that parents rarely let their children go uninsured if they have employer-sponsored coverage for themselves.

On the other hand, among the 0.7 million children in separate CHIP coverage whose parents are not enrolled in the employer-sponsored coverage for which they are eligible, 87 percent are projected to become uninsured if CHIP ends. For the parents

of these children to obtain employer-sponsored coverage for their children, they must also obtain coverage for themselves, and the total out-of-pocket premiums may be substantial.

For example, for families whose children lose separate CHIP and are eligible for employer-sponsored coverage, the average additional premiums to obtain family coverage would be approximately \$3,751, or 9.1 percent of family income (Table 1-1).¹⁴ In comparison, the average annual premium for an individual child enrolled in CHIP is \$92 at 160 percent FPL (0.3 percent of family income) and \$319 at 210 percent FPL (0.8 percent of family income) (Bly et al. 2014, Cardwell et al. 2014). Chapter 2 discusses out-of-pocket costs in more detail.

TABLE 1-1. Estimates of Out-of-Pocket Premiums for the 1.8 Million Separate-CHIP-Enrolled Children Who Will Lose That Coverage and Be Eligible for Employer-Sponsored Insurance in 2016

	Additional premium contribution to add child to employer-sponsored insurance ¹		Total premium contribution for family coverage in employer-sponsored insurance	
	Increase in out-of-pocket premium ¹	Percent of income	Total out-of-pocket premium	Percent of income
Average	\$3,751	9.1%	\$5,163	12.2%
Median (50 th percentile)	2,969	6.9	4,169	9.7
First quartile average	125	0.3	4,413	9.1
Second quartile average	2,067	5.3	2,691	6.9
Third quartile average	3,999	9.7	4,389	10.6
Fourth quartile average	8,814	21.1	9,163	22.0

Notes: The number 1.8 million is the number of children projected to lose separate CHIP and be eligible for employer-sponsored insurance at a point in time in 2016. Excludes unborn children, children enrolled in Medicaid-expansion CHIP, and children losing separate CHIP coverage who qualify for exchange subsidies.

¹ This captures the range of possibilities for families to enroll their children, taking into account family structure and the availability and enrollment in employer-sponsored coverage by other family members. For example, in families where one parent is already enrolled, the cost to add a child will be the additional premium for employee-plus-one coverage (if available) or family coverage. On the other hand, if no one is enrolled, then the additional cost to enroll the child is, in fact, the out-of-pocket premium to enroll the entire family.

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSIM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

The additional contributions for employer-sponsored coverage will vary by a number of factors, including whether or not the employee and other dependents are already enrolled. For example, if the employee is already enrolled, then the additional premium to move from self-only to family coverage will be less than if the employee is not enrolled and is moving from no coverage to family coverage. As a result of this and other family and employer characteristics, the average out-of-pocket premiums incurred for adding dependent coverage range widely, from 0.3 percent of income (\$125) in the lowest quartile to 21.1 percent of income (\$8,814) in the highest quartile (Table 1-1).

The total out-of-pocket premiums—that is, employee premium contributions for the entire family—for families with children losing separate CHIP but qualifying for employer-sponsored coverage would average \$5,163, or 12.2 percent of family income (Table 1-1). In light of these substantial costs, many families will decide not to enroll, leading to the projection that approximately 37 percent of children eligible for employer-sponsored insurance will become uninsured without CHIP.

Cost-sharing expenses, such as deductibles and copayments, may also be quite high and influence family decisions about insurance coverage. In 2013, the deductible for those enrolled in employer-sponsored family coverage averaged \$2,491, which amounts to 7.9 percent of income for a family of three at 160 percent FPL and 6.0 percent of income at 210 percent FPL (AHRQ 2013c). As described in Chapter 2 of this report, separate CHIP programs generally do not have deductibles and have substantially less cost sharing (or none at all) compared to employer-sponsored or subsidized exchange coverage.

Children losing separate CHIP who are eligible for subsidized exchange coverage

Among the 1.9 million children losing separate CHIP coverage who would be eligible for exchange

subsidies, 67 percent are projected to enroll in exchange plans and 8 percent in available employer-sponsored coverage, while 25 percent would become uninsured.

Of this group of subsidy-eligible children, 63 percent are expected to face no additional premium to obtain exchange coverage. This is because one or more family members will have already obtained premium tax credits for an exchange plan and, in doing so, will already have paid the maximum family contribution.¹⁵ Thus, the cost of adding the child would be borne not by the family but by the federal government in the form of an increase in the family's tax credit. Nearly all of these children are expected to enroll in subsidized exchange coverage. Despite the fact that the additional premium costs would be fully covered, these children will likely face higher cost-sharing amounts in the form of deductibles and copayments than they would under CHIP.

The remaining 37 percent of subsidy-eligible children will face some premiums, varying according to family income. The required contribution for a family's subsidized exchange coverage in the CHIP income range varies from 3 percent to 9.5 percent of family income, excluding any additional premiums for a standalone dental plan, as described in Chapter 2. While these premiums are generally lower than for employer-sponsored coverage, they would typically be higher than for CHIP. CHIP premiums across all incomes are relatively modest, and they are lower than those in private coverage, particularly for lower-income families.

Children losing CHIP who become uninsured

Of the 1.1 million children projected to become uninsured if CHIP funding is exhausted, 59.1 percent will be eligible for a parent's employer-sponsored coverage and therefore ineligible for exchange subsidies (Figure 1-4). In nearly all of these cases, the parent is not enrolled in that

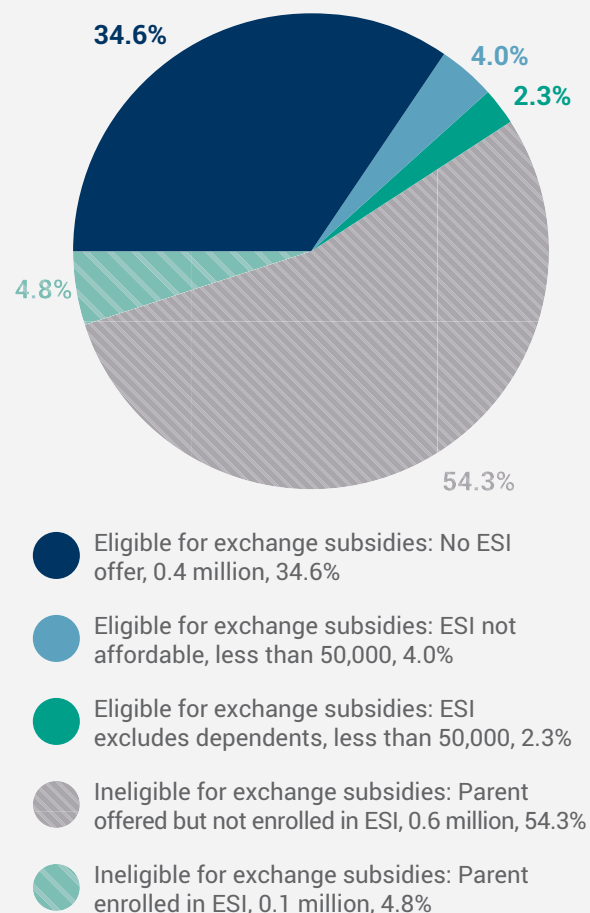
employer-sponsored coverage. The remaining 40.9 percent of children becoming uninsured after CHIP funding runs out would be eligible for subsidized exchange coverage, including 34.6 percent with parents with no offer of employer-sponsored insurance, as well as 2.3 percent whose parents have an offer of employer-sponsored coverage that is not available to dependents, and 4.0 percent whose parents have an offer of employer-sponsored insurance that is not considered affordable according to the ACA (Figure 1-4).

The 1.1 million separate-CHIP-enrolled children who will become uninsured if CHIP funding is exhausted have varying characteristics. The majority are below 200 percent FPL (61.3 percent) and are non-white (53.9 percent). Close to 90 percent have a full-time worker in the family (Table 1-2).

Policy Implications

While the number of uninsured children has been halved since CHIP's creation 18 years ago, the exhaustion of federal CHIP funds under current law is projected to erode some of those coverage gains. Under current law, states will exhaust their federal CHIP funds in FY 2016, and this is projected to increase the number of uninsured children in 2016 by nearly 40 percent, from 2.9 to 4 million.¹⁶ To prevent this in the short term, the Commission recommended in 2014 that CHIP be extended by two years. For the long term, the Commission is exploring policy options that could reduce the number of children projected to become uninsured without CHIP. These potential options include expanding access to and subsidies for exchange-based coverage, employer-sponsored coverage, and Medicaid. For each option, the Commission is considering the impact on government spending and the effects on families, states, the federal government, plans, and providers, as well as enrollment in privately funded versus publicly funded sources of coverage.

FIGURE 1-4. Eligibility among 1.1 Million Children Projected to Become Uninsured If Their Separate CHIP Coverage Ends in 2016



Notes: ESI is employer-sponsored insurance. The number 1.1 million is the number of separate-CHIP-enrolled children projected to become uninsured at a point in time in 2016 if CHIP funding is not extended. Excludes unborn children and children enrolled in Medicaid-expansion CHIP. Affordable is defined as ESI with self-only premium less than 9.5% of family income per the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

TABLE 1-2. Characteristics of Children Age 0–18 Projected to Have Separate CHIP Coverage and Those Projected to Become Uninsured if CHIP Ends in 2016

Characteristics	Separate CHIP enrollees		Percent projected to become uninsured	Separate CHIP enrollees projected to become uninsured	
Total	3,715,000	100.0%	30.9%	1,148,000	100.0%
Income					
139–150% FPL	277,000	7.5	31.5	87,000	7.6
151–200% FPL	1,926,000	51.8	32.0	616,000	53.7
201–300% FPL	1,360,000	36.6	29.3	399,000	34.8
301–405% FPL	152,000	4.1	29.9	45,000	4.0
Race/Ethnicity					
White, non-Hispanic	1,940,000	52.2	27.3	529,000	46.1
Black, non-Hispanic	574,000	15.5	32.2	185,000	16.1
Hispanic	902,000	24.3	37.8	341,000	29.7
Other	299,000	8.0	30.9	92,000	8.0
Census Division					
New England ¹	157,000	4.2	41.4	65,000	5.6
Middle Atlantic ²	889,000	23.9	30.1	267,000	23.3
East North Central ³	565,000	15.2	40.8	231,000	20.1
West North Central ⁴	223,000	6.0	25.5	57,000	4.9
South Atlantic ⁵	702,000	18.9	28.0	197,000	17.1
East South Central ⁶	331,000	8.9	28.4	94,000	8.2
West South Central ⁷	453,000	12.2	28.2	128,000	11.1
Mountain ⁸	218,000	5.9	29.8	65,000	5.7
Pacific ⁹	177,000	4.8	25.4	45,000	3.9
Age					
0	91,000	2.5	35.7	33,000	2.8
1–5	977,000	26.3	33.1	324,000	28.2
6–12	1,481,000	39.9	31.2	461,000	40.2
13–18	1,166,000	31.4	28.3	330,000	28.8
Parent employment					
Full-time worker in family	3,387,000	91.2	30.4	1,028,000	89.6
Only part-time workers in family	263,000	7.1	32.5	86,000	7.5
No workers in family	64,000	1.7	53.1	34,000	3.0
Any small firm worker in family	1,254,000	33.8	35.7	447,000	39.0
Any self-employed worker in family	741,000	19.9	22.0	163,000	14.2
Child's health status					
Fair or Poor	266,000	7.2	29.6	79,000	6.8
Excellent, Very Good, or Good	3,449,000	92.8	31.0	1,069,000	93.2

Notes: FPL is federal poverty level. Numbers projected at a point in time in 2016.

¹ New England is Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

² Middle Atlantic is New Jersey, New York, and Pennsylvania.

³ East North Central is Illinois, Indiana, Michigan, Ohio, and Wisconsin.

⁴ West North Central is Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota.

⁵ South Atlantic is Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, Washington D.C., and West Virginia.

⁶ East South Central is Alabama, Kentucky, Mississippi, and Tennessee.

⁷ West South Central is Arkansas, Louisiana, Oklahoma, and Texas.

⁸ Mountain is Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming.

⁹ Pacific is Alaska, California, Hawaii, Oregon, and Washington.

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

Endnotes

¹ This projection of children enrolled in separate CHIP programs in 2016 (3.7 million) is lower than MACPAC's previously published historical numbers. This is primarily because the projections in this chapter are of the number of children enrolled in separate CHIP at a point in time, while MACPAC's CHIP enrollment is generally of children ever enrolled during the year, even if for one month. The number ever enrolled during the year will be higher than the number at a point in time. For example, in its June 2014 report to Congress, MACPAC reported that there were 5.3 million children age 0–18 ever enrolled in separate CHIP during fiscal year (FY) 2013, while average monthly enrollment (which is generally comparable to a point-in-time estimate) among these children was 3.4 million. Beginning in 2014, the implementation of modified adjusted gross income as well as the required transition of 6- to 18-year-olds between 100 and 138 percent of the federal poverty level (FPL) from separate CHIP into Medicaid-expansion CHIP have decreased the number of separate CHIP enrollees projected in the model. On the other hand, projected enrollment in separate CHIP is increased because of other factors, such as the effect of the individual mandate penalty being fully in effect.

² An analysis by the Urban Institute from 2011 found that as many as 2 million children could become uninsured if CHIP funding were exhausted (Kenney et al. 2011). That estimate differs from the current one for several reasons. For example, it 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.

³ Because the maintenance of effort requirement 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 after that date, such as California and New Hampshire, will be permitted to remove those children from Medicaid as CHIP funding is exhausted. In addition, if a state covers children enrolled in Medicaid-expansion CHIP under a §1115 waiver that expires prior to FY 2020, the maintenance of effort does not require a state to request an extension (CMS 2011).

⁴ Historically, the federal matching rate has averaged 70 percent for CHIP spending, versus 57 percent for Medicaid. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) increases the federal CHIP matching rate for FYs 2016–2019 by 23 percentage points. As a result, moving from CHIP to Medicaid funding will result in an even larger increase in state spending than the 43 percent difference that has been in place since the creation of CHIP.

⁵ Additional budget effects will be unique to five states with projected CHIP spending under §2105(g) of the Social Security Act. Section 2105(g) spending is projected to total 1 percent of federal CHIP spending nationally in FY 2016. Under §2105(g), 11 qualifying states that expanded Medicaid to higher-income children prior to CHIP's enactment may use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent FPL. Thus, when considering the post-CHIP implications on state budgets, CHIP funding under §2105(g) is similar to funding for children enrolled in Medicaid-expansion CHIP—that is, in both cases, these are children who are enrolled in Medicaid with additional funding provided from CHIP and for whom, in the absence of CHIP funding, states must continue providing coverage through at least FY 2019 with Medicaid funds at Medicaid's federal matching rate. In FY 2016, §2105(g) spending is projected to account for 44 percent of the federal CHIP spending in Connecticut, 55 percent in Minnesota, 15 percent in New Hampshire, 57 percent in Vermont, and 8 percent in Washington.

⁶ Under the ACA, the FY 2016 CHIP matching rate in Maryland will increase by 23 percentage points, to 88 percent.

⁷ Iowa's Medicaid-expansion CHIP also covers infants (under age 1) at 241–380 percent FPL.

⁸ When the maintenance of effort requirement for children expires after FY 2019, states with Medicaid eligibility levels above 138 percent FPL could roll back to the minimum levels. The following 19 states must also maintain Medicaid eligibility levels for infants above 133 percent FPL to at least the levels that were in place on December 19, 1989 (§1902(l)(2)(A)(iv) of the Social Security Act): California, Connecticut, Florida, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, New York, North Carolina, Rhode Island, South Carolina, Vermont, Washington, and West Virginia. The highest level permitted at that time was 185 percent FPL, which was used by all of these states except Florida, Kansas, North Carolina, and West Virginia, which used 150 percent FPL (NGA 1990).

⁹ Even after the maintenance of effort requirement expires, 43 states and the District of Columbia will continue covering at least some children below 138 percent FPL who are mandatory under Medicaid but were previously funded by CHIP. The other seven states (Connecticut, Minnesota, New Hampshire, New Mexico, Oregon, Vermont, and Washington) expanded children's Medicaid eligibility to some level at or above 138 percent FPL prior to the enactment of CHIP and therefore do not qualify for any CHIP-funded coverage of Medicaid-enrolled children below 138 percent FPL.

¹⁰ In the typical CHIP income range in 2016, this penalty will be \$695 for each adult who is uninsured for the entire year and \$347.50 per child, up to a family maximum of \$2,085—or 2.5 percent of countable income, if higher (subject to other limitations). There are several statutory and regulatory exemptions to this penalty (§5000A(d)-(e) of the Internal Revenue Code, 26 CFR 1.5000A-3). While these exemptions would not necessarily apply to all children who lose CHIP, the Secretary of the U.S. Department of Health and Human Services (the Secretary) has the flexibility to exempt any individual found to have suffered a hardship (§5000A(e)(5) of the Internal Revenue Code, 26 CFR 1.5000A-3(h)(3)(iii)). Thus, the Secretary could waive these penalties for all families losing CHIP. However, doing so would further increase the number of children projected to become uninsured without CHIP.

¹¹ The HIPSM-ACS relies on a microsimulation approach based on the relative desirability of health insurance options. This approach, known as a utility-based framework, allows new coverage options to be assessed beyond simply extrapolating from historical data. As mentioned, the decisions of individuals and families in the model take into account factors including premiums and out-of-pocket health care costs for available insurance products, health care risk,

whether or not the individual mandate would apply to them, and family disposable income. Affordability of coverage is built into the model and decisions can be greatly affected by the individual mandate for those who do not qualify for an exemption. The utility model takes into account an individual's choices as reported in the survey data. For example, if a child is currently eligible for Medicaid or CHIP but not enrolled, then the child's parents have shown a preference against such coverage. Such preferences are used to customize individual utility functions so that an individual's current choices score the highest, and this affects that individual's behavior if separate CHIP coverage ends. The resulting health insurance decisions made by individuals, families, and employers are calibrated to findings in the empirical economics literature, such as price elasticities for employer-sponsored and non-group coverage (Dubay et al. 2015).

¹² These projections are of separate-CHIP-enrolled children age 0–18. They exclude children enrolled in Medicaid-expansion CHIP, adult pregnant women covered by CHIP, and unborn children. In the absence of CHIP funding, unborn children would not be eligible in their own right for Medicaid or exchange coverage.

¹³ These projections do not take into account the possibility that in the absence of CHIP, states could take other actions to cover children in the income range for separate CHIP, such as expanding Medicaid or funding affected children's coverage at 100 percent state expense.

¹⁴ This estimate includes the cost of enrolling the parents who are offered that coverage but are not already enrolled. The estimate is higher among the subset of children projected to become uninsured if CHIP funding ends: It is approximately \$5,500 per year on average, or 13.2 percent of family income, for children projected to become uninsured who are eligible for job-based coverage rather than subsidized exchange coverage.

¹⁵ This assumes families enroll in the second-lowest-cost silver exchange plan, on which premium tax credits are based. If families choose a plan with a different premium, their out-of-pocket payments will vary accordingly.

¹⁶ The projected 2.9 million is the number of uninsured children at a point in time in 2016 assuming the continuation of CHIP in that year.

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CHAPTER 2

Affordability of Exchange Coverage for Children Now Covered by CHIP

Affordability of Exchange Coverage for Children Now Covered by CHIP

Key Points

- MACPAC's analysis of premiums and cost sharing for children's exchange coverage compared with CHIP estimates that average additional costs for exchange coverage for two children are more than twice the cost of CHIP if the children's parents are already enrolled in exchange coverage and more than six times the cost of CHIP if the children's parents are not enrolled.
 - Parents' enrollment affects premium contributions required for children's exchange coverage, even after tax credits are applied.
 - Premiums for stand-alone dental plans and higher cost sharing for exchange plans also increase family costs relative to CHIP.
- For children with exceptionally high health needs who would reach their out-of-pocket cost-sharing maximum in an exchange plan, a family's total potential exposure for children's coverage could exceed 11.7 percent of family income at 160 percent of the federal poverty level (FPL) and 18.8 percent at 210 percent FPL.
- Differences in the costs to families of CHIP versus exchange coverage reflect the different policy goals and program rules for these sources of coverage.
 - CHIP was designed to provide coverage to low-income children who do not qualify for Medicaid. Premiums tend to be nominal and the cost of premiums and cost sharing combined is limited to 5 percent of a family's annual income.
 - Exchanges were designed primarily to assist uninsured working adults and their families in securing insurance coverage. Premiums and cost-sharing levels reflect product designs in the private market, with federal subsidies providing some assistance in paying for exchange premiums and cost sharing.
- Consumer decisions to enroll in coverage or seek care are affected not only by the absolute costs of coverage, but also by those costs relative to other family and household expenses.
 - Research has consistently shown that premium prices influence decisions to enroll low-income children in coverage and that low-income consumers are sensitive to the price of point-of-service cost sharing.
 - The relationship between cost sharing and access to care is of particular concern for children who need frequent and ongoing services.
 - Low- and moderate-income families spend a substantial portion of their incomes on basic living expenses and have few remaining resources to cover health care costs.
- The Commission is assessing options to address affordability concerns for children's coverage, including how possible approaches might be designed, their benefits and drawbacks, and their cost implications from the perspectives of families, state and federal governments, and other stakeholders.

CHAPTER 2: Affordability of Exchange Coverage for Children Now Covered by CHIP

In examining what the experience of children now covered by the State Children's Health Insurance Program (CHIP) would be if federal funding for the program came to an end, MACPAC's June 2014 report to Congress noted that families would face substantially higher costs for exchange and employer-sponsored coverage than they do now for CHIP. Since then, the Commission has been conducting additional analyses of the costs of premiums and cost sharing associated with such coverage in order to more fully describe how moving to these sources of coverage would affect families with children now covered by CHIP. Our analyses have focused on estimating enrollment in other coverage sources based in part on family decisions about the cost of care (as described in Chapter 1), comparing the costs of exchange and employer-sponsored coverage to those of CHIP, and understanding such costs within the context of the household expenses of low- to moderate-income families.

MACPAC estimates that the average additional cost of exchange coverage for two children is more than twice that of CHIP coverage if the children's parents are already enrolled in exchange coverage and more than six times higher than CHIP if the children's parents are not enrolled in such coverage, depending on income. (Parents' enrollment affects the additional premium contributions required for children's exchange coverage, even after tax credits are applied.) This finding is based on our analysis of premiums and cost sharing under several scenarios of family size, income, and current parent coverage. These scenarios were designed to reflect the

realities that families with children now covered by CHIP would experience if program funding were to come to an end.

Premiums for pediatric dental coverage and the consistently higher service-level cost sharing in exchange plans also contribute to the higher overall costs for children in an exchange relative to what families have experienced under CHIP. For children with exceptionally high health needs who reach their out-of-pocket cost-sharing maximum in an exchange plan, a family's total potential financial exposure for children's coverage (reflecting premiums and the maximum amount of out-of-pocket cost sharing) could exceed 11.7 percent of family income at 160 percent of the federal poverty level (FPL) and 18.8 percent of family income at 210 percent FPL.

The fact that premium and cost-sharing amounts differ so dramatically between the exchanges and CHIP is not surprising. The rules affecting the level of premiums and other out-of-pocket costs reflect fundamentally different policy goals. CHIP was designed to provide coverage to low-income children who do not qualify for Medicaid, in some cases with a design that looks more like private coverage than Medicaid, but with greater affordability protections than are typically found in private coverage. Although states can require enrollees to make much greater financial contributions to the cost of their coverage than is typically allowed in Medicaid, CHIP explicitly limits the amount families pay—in premiums and cost sharing combined—to 5 percent of family income. CHIP cost sharing is relatively modest compared to cost sharing in the private market. CHIP premiums are also modest and are not designed to cover a significant share of program spending.

By contrast, the exchanges were designed primarily to assist uninsured working adults and their family members secure health insurance coverage, often because their employers do not offer such coverage or the available coverage (either through an employer or the individual market) is not

affordable. Premiums and cost-sharing levels are set by issuers and thus reflect product designs in the private market. Federal subsidies provide some assistance in paying for exchange premiums and cost sharing, but even the subsidized cost of coverage represents a significant expense for some families. Those with high levels of health care use and those receiving lower subsidies will face significant out-of-pocket costs.

Although the costs to cover children in employer-sponsored coverage are important to consider in discussions about the future of CHIP, in this chapter, we focus here on comparing CHIP and exchange coverage, primarily because comprehensive data are not available to make direct comparisons between CHIP and employer-sponsored coverage. As described in Chapter 1, we know that average premiums for children in employer-sponsored coverage are higher than for exchange coverage. But that analysis also found wide variation in premiums among employer-sponsored health plans, making it more difficult to accurately compare costs with those families now face in CHIP. Moreover, there is no readily available source of data on cost sharing for children in employer-sponsored coverage that can be used to estimate the overall costs for families.

The chapter begins by providing context for understanding how out-of-pocket costs affect enrollment in coverage and use of health services. It then provides an overview of CHIP and exchange premiums and cost-sharing rules, concepts, and terminology. Next, the chapter presents the analysis of the relative costs of CHIP and exchange coverage. It ends by describing some possible policy options for addressing concerns about how the higher costs of care in the exchange would affect family decisions about signing up for coverage and seeking care when needed. The Commission will develop and analyze policy options more thoroughly in future reports.

Affordability in Context

The absolute cost of coverage and services, as well as those costs relative to families' other household expenses, can affect whether low-income consumers enroll in coverage or seek care. In fact, the use of premiums and cost sharing in CHIP reflects a philosophy that everyone should pay something for their care and that families should make careful and considered decisions when both purchasing coverage and when going to the doctor or the emergency room. On the other hand, there is concern that if costs are too high, they could deter families from enrolling their children in coverage or getting the care they need. Policymakers must consider the impact of not only premiums but also cost sharing at the point of service. While plans with lower premiums may be attractive to families because of the lower monthly payment required, point-of-service cost sharing tends to be higher in lower-premium plans than in plans with higher premiums.

Premiums. Research has consistently found that premium prices influence decisions about whether to enroll low-income children in coverage. Use of premiums in public coverage programs such as CHIP have been associated with lower enrollment in coverage and greater rates of uninsurance, particularly among children in families with incomes below 150 percent FPL who do not have access to employer-sponsored coverage (Abdus et al. 2014, Hadley et al. 2006, Liu and Chollet 2006). This price sensitivity, even at the relatively nominal levels of CHIP premiums (which averaged \$18 per child per month at 151 percent FPL in January 2015), gives weight to concerns about the effects of higher premiums charged for exchange coverage (Brooks et al. 2015). Parents of children with chronic health conditions, however, are less sensitive to the cost of premiums and are less likely to disenroll their children from coverage when premiums are increased (Marton et al. 2014, Marton and Talbert 2010), which might leave health plans exposed to adverse selection.

Cost sharing. Low-income consumers are also sensitive to the price of cost sharing—copayments, coinsurance, or deductibles—that may be required of enrollees at the point of service. In some CHIP programs where cost sharing is required, there have been reductions in service use (Liu and Chollet 2006). More generally, a study by the RAND Corporation (2006) found reduced use of a range of services such as physician visits, hospitalizations, dental care, and mental health care by low-income consumers, including children, as enrollee cost sharing increased. In addition, cost sharing does not lead only to the reduction of services that might be considered unnecessary. In fact, cost sharing can reduce the use of health care services for children even when care seeking is appropriate and services are needed (Lohr et al. 1986).

The relationship between cost sharing and access to care is of particular concern for children who need frequent and ongoing services and are therefore more likely to incur greater out-of-pocket costs than those with routine health care needs (Selden et al. 2009). Although little information is available about utilization patterns among children now covered by separate CHIP, an estimated 24 percent of these children have special health care needs and may require ongoing use of medications, services, or therapies. Relatively common conditions among this population include asthma and behavioral health conditions (MACPAC 2015a). Regular use of medications and visits to clinicians could thus present a particular burden for these children's families or result in lapses in care.

Health care costs in relation to other household expenses. A family's use of health care services does not happen without regard to other expenses. Data from the 2013 Consumer Expenditure Survey indicate that families with children and income between 140 and 180 percent FPL had average before-tax incomes of \$39,088 per year and annual expenses of \$41,137—that is, expenses actually exceeded income by 5 percent. Families with children and income between 180 and 240 percent

FPL had average before-tax incomes of \$50,928 and annual expenses of \$47,764 (KFF 2015).¹

Families at these income levels spend a substantial portion of their incomes on basic living expenses, such as housing, transportation, food, clothing, and education, and have less income remaining to cover the costs of health care. In the 140–180 percent FPL range, the average family with children spent 82 percent of their income on basic living expenses. Those in the 180–240 percent FPL range spent 71 percent of their income on basic living expenses. By contrast, across all families with children, the average income is \$77,928 (332 percent FPL) and just 55 percent of income is spent on basic living expenses (KFF 2015).²

Low-income families have few resources to spend on health care and little cushion to pay for expenses such as a costly car or home repair, or to sustain a short-term loss of income resulting from time taken off from work to care for an ill family member or other circumstance.

In 2013, total out-of-pocket health expenses for families with children averaged about 6 percent of family income for those between 140 and 240 percent FPL, compared to 4 percent on average for all families with children. In both cases, health insurance premiums account for about two-thirds of these expenses, and cost sharing (for medical services, prescription drugs, and medical supplies) accounts for the remaining one-third of all out-of-pocket health expenses, on average (KFF 2015).³

CHIP and Exchange Premiums and Cost-Sharing Rules

To help understand MACPAC's analysis of how the costs for the typical family are likely to change if children currently enrolled in CHIP move to coverage in the exchange, we provide a review of the general premium and cost-sharing rules that apply to CHIP and exchange plans. Premium and cost-sharing

requirements vary somewhat at the state and plan level; those details are not described here.

Because premiums and cost-sharing rules vary by family income and other family characteristics, it is important to keep in mind the demographic characteristics of children currently covered by separate CHIP. First, despite the fact that some states allow enrollment in CHIP at higher income levels, 96.2 percent of children enrolled in separate CHIP lived in families with incomes below 250 percent FPL in 2013 (MACPAC 2015b).⁴ Second, these children tend to live in two-parent families. MACPAC's analysis of the National Survey of Children's Health for 2010–2012 found that 64 percent of children projected to be eligible for separate CHIP lived in two-parent families (MACPAC 2015a). Third, families with incomes between 150 and 250 percent FPL have on average 1.9 children per family, with state averages across the country ranging from 1.4 to 2.5 children per family (MACPAC 2015c).

CHIP premiums

States set CHIP premiums within federal guidelines. The premiums are described in the CHIP state plan and are subject to approval by the Centers for Medicare & Medicaid Services (CMS). The cost of premiums and cost sharing is limited to 5 percent of a family's annual income.

While CHIP premiums can help to offset state and federal costs of coverage and signal the importance of enrollees contributing to the costs of care, in practice they are relatively modest and, particularly for lower-income families, lower than private coverage premiums. For example, at 151 percent FPL, more than half of states do not charge premiums for separate CHIP coverage. In the 11 states that charge premiums for separate CHIP coverage at this income level, the average monthly premium is about \$18 per child per month (ranging from \$3 to \$40 per child per month).⁵ For families at 201 percent FPL, half of states with separate CHIP charge premiums of less than \$10 per child

per month. In the 22 states charging premiums at this income level, the average monthly premium is about \$24 per child per month (ranging from \$2 to \$76 per child per month). Missouri has the highest separate CHIP premiums of any state (\$186 per child per month at 251 percent FPL). Six separate CHIP states offer CHIP buy-in programs, which provide access to CHIP benefits at even higher premiums to higher income families that do not qualify for separate CHIP assistance (Brooks et al. 2015, Kenney et al. 2008).

Exchange premiums

Premiums for exchange coverage vary depending on an enrollee's age, rating area, and metal tier of the exchange plan selected (bronze, silver, gold, or platinum). Exchange plan issuers set the unsubsidized premium rates (that is, the cost of enrolling in an exchange plan before premium tax credits are applied). The unsubsidized premium rates are subject to approval by the state insurance commissioner or CMS, depending on the state's exchange model.⁶

Premium tax credits and premium contributions.

To help pay for exchange premiums, individuals and families with incomes between 100 and 400 percent FPL can receive a premium tax credit if they are not eligible for Medicaid or other minimum essential coverage and if they do not have access to employer-sponsored coverage that is deemed affordable.⁷ The tax credit can be applied to the purchase of an exchange plan at any metal tier.⁸ The amount of the premium tax credit is calculated as the difference between the cost of the second-lowest-cost silver plan and a set maximum-expected premium contribution based on family income (Table 2-1).

A family's maximum-expected premium contribution for exchange coverage does not vary based on the number of family members enrolled. Therefore, if the children's parents are already paying the maximum-expected premium contribution for parent-only exchange coverage,

TABLE 2-1. Income and Maximum-Expected Premium Contribution for the Second-Lowest-Cost Silver Plan, Family of Four, 2015

Income as a percent of FPL	Annual income	Maximum-expected premium contribution (annual)	
		Percent of income	Amount
100%	\$23,850	2.00%	\$477
133	31,721	3.00	952
150	35,775	4.00	1,431
200	47,700	6.30	3,005
250	59,625	8.05	4,800
300	71,550	9.50	6,797
350	83,475	9.50	7,930
400	95,400	9.50	9,063

Note: FPL is federal poverty level.

Source: MACPAC calculation based on the U.S. Department of Health and Human Services 2014 poverty guidelines (used to calculate 2015 premium tax credits) for the 48 contiguous states and the District of Columbia and the maximum-expected premium contribution percentages specified in Internal Revenue Service regulations (26 CFR 1.36B-3(g)(2)).

then there is no additional premium contribution required for adding children to the second-lowest-cost silver exchange plan. Most low-income parents of children eligible for exchange subsidies will likely fall into this scenario. In some cases, parents enrolled in exchange coverage would not be paying their maximum-premium contribution for parent-only coverage and thus would face additional costs for adding children. These include higher income families, whose maximum-expected premium contribution is greater than the maximum-expected premium contribution for families at lower incomes, and families with lower parent-only premiums, such as single-parent families.⁹

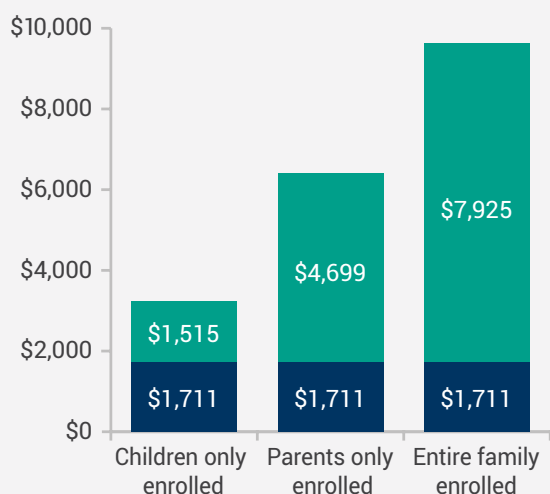
Most parents of children eligible for exchange subsidies will also be eligible for the subsidies for their own coverage. The exceptions would be parents who receive an affordable offer of employee-only coverage (estimated to affect 3.1 percent of children who are now covered by separate CHIP and projected to be eligible for exchange coverage) and parents who are undocumented immigrants (Dubay et al. 2015).

Adding children affects what families pay in premiums. The cost of adding children to exchange coverage depends on income, parents' enrollment in exchange plans, and what exchange plan is purchased. To illustrate how these factors and exchange premium rules affect what families pay for exchange coverage, consider a family of four, two parents and two children, with annual income at 160 percent FPL (\$38,160 in 2014) (Figure 2-1).

The unsubsidized premium for the second-lowest-cost silver plan changes according to how many family members are enrolled and their ages. In this illustrative example, the average annual unsubsidized second-lowest-cost silver plan premium is \$3,226 for two children. Covering the two parents without children would be \$6,410, and covering the entire family would be \$9,636.

The maximum-expected premium contribution for the second-lowest-cost silver plan is the same, regardless of how many family members are enrolled in the plan. For a family of four at 160 percent FPL, the maximum-expected premium contribution for the second-lowest-cost silver

FIGURE 2-1. Average Annual Premium Tax Credits and Maximum-Expected Premium Contributions for the Second-Lowest-Cost Silver Plan under Different Enrollment Scenarios, 2015



Credits and contributions for a family of four (two parents, two children), 160% FPL



Notes: FPL is federal poverty level. Our calculations of the average premium tax credits shown are based on 2015 exchange data from all 35 states with federally facilitated exchanges; in calculating the example tax credits, we assumed two non-smoking parents age 38 and 40. Actual family premiums may vary depending on rating area, age, smoking status, and the particular exchange metal tier and plan selected. Amounts shown do not include the cost of stand-alone dental plans. The 2014 federal poverty guidelines are used to determine eligibility for 2015 premium tax credits.

Source: MACPAC analysis of ASPE 2015.

plan is \$1,711 per year. This family is eligible for a premium tax credit to cover the difference between the maximum-expected premium contribution (which in all scenarios is \$1,711) and the remaining cost of the unsubsidized premium for the applicable second-lowest-cost silver plan.

If the family is already paying its maximum-expected premium contribution for parent-only coverage prior to enrolling the children in an exchange plan, there would be no additional premium cost to the family associated with adding the children. However, if parents are not already enrolled in an exchange plan, the family will face additional costs for enrolling their children in exchange coverage.

Premiums for dental coverage. Families will incur additional premium costs if they choose to purchase a stand-alone dental plan. Exchange plans are not required to provide pediatric dental benefits if stand-alone dental plans are offered on the exchange. (See Chapter 3 for additional discussion of this issue.) In 23 of the 26 states with separate CHIP and federally facilitated exchanges, at least some (and in some states, all) of the second-lowest-cost silver exchange plans exclude pediatric dental coverage (MACPAC 2015d).¹⁰

Moreover, the cost of stand-alone dental plan premiums is not included in the calculation of a family's premium tax credit and there is no additional premium subsidy for purchasing stand-alone dental coverage. Therefore, a family purchasing a second-lowest-cost silver exchange plan without pediatric dental coverage would need to pay an additional premium to obtain this coverage. Using 2015 exchange data, the estimated average annual cost of such coverage is at least \$238 per child (MACPAC 2015d).¹¹ If a family purchases an exchange plan with a premium that is less than the second-lowest-cost silver plan, any remaining tax credit (after it is first applied to the cost of the exchange plan) can be used toward the cost of the stand-alone dental plan (45 CFR 155.340(e)). In comparison, CHIP enrollees pay one premium for all covered services, including dental care.

Overview of CHIP and Exchange Cost Sharing

Cost sharing is the amount enrollees pay for health care services in the form of copayments, coinsurance, or deductibles. Cost-sharing amounts vary according to many factors, including health plan design, type or site of service, and whether or not the service is provided by an in-network provider. However, the generosity of a plan's cost-sharing requirements can be broadly assessed using actuarial values and out-of-pocket cost-sharing maximums.

Actuarial value measures the percentage of covered health care expenses an insurer would pay, on average, for a standard enrollee population. For example, a plan with an actuarial value of 87 percent would pay for 87 percent of covered medical spending and enrollees in that plan would pay the remaining 13 percent, on average. Individual enrollee spending will vary based on actual health care services used. Those who use more services than average (which might include those with chronic conditions) will pay more.

The out-of-pocket cost-sharing maximum is the maximum total cost sharing that enrollees will pay for covered benefits in a plan year. After an individual or family reaches the out-of-pocket cost-sharing maximum, the health plan is typically responsible for cost sharing for covered services for the remainder of the plan year.

CHIP cost sharing

Twenty-eight separate CHIP programs require cost sharing for at least some types of services, typically in the form of copayments (Bly et al. 2014, Cardwell et al. 2014).¹² Cost sharing is not permitted for preventive services, and cost sharing for other services is limited to nominal levels for children below 150 percent FPL (42 CFR 457 Subpart E). For example, some state CHIP programs charge enrollees copayments between

\$1 and \$5 for prescription drugs. For children above 150 percent FPL, cost sharing is permitted in CHIP with no specific limits, although total family spending on cost sharing combined with premiums may not exceed 5 percent of income (§2103(e)(3)(B) of the Social Security Act). Twenty-two separate CHIP programs use the 5 percent cap, and 20 programs use a lower cap (Cardwell et al. 2014). Out-of-pocket maximums in separate CHIP range from \$0 to \$950 (excluding premiums) for families with income at 160 percent FPL and \$0 to \$1,995 (excluding premiums) for families with income at 210 percent FPL (Bly et al. 2014).

Exchange plan cost sharing

Exchange plans have flexibility within federal rules to implement cost-sharing requirements, including the type and amount of cost sharing, as long as the required actuarial values are met.¹³ Like CHIP, exchange plans are not permitted to charge cost sharing for preventive services, including well-child visits. However, exchange plans are more likely than CHIP to charge cost sharing for routine services (e.g., routine vision services, eyeglasses, and pediatric dental services).

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) established four metal tiers and corresponding actuarial values for unsubsidized exchange plans: 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.¹⁴ Generally, plans with higher actuarial value have lower cost sharing, but enrollees pay a higher premium for that coverage.

The ACA also established out-of-pocket cost-sharing maximums for exchange plans, which in 2015 are \$6,600 for individuals and \$13,200 for families in unsubsidized exchange plans.¹⁵ However, in practice, exchange plans with higher actuarial values typically have lower out-of-pocket maximums. For example, in 2015, the average bronze plan on the federally facilitated exchange

had a family out-of-pocket cost-sharing maximum of \$12,746, and the average platinum plan had a family out-of-pocket cost-sharing maximum of \$3,867 (MACPAC 2015d). In-network cost-sharing expenses for essential health benefits for all family members enrolled in an exchange plan are counted toward a family's out-of-pocket cost-sharing maximum. Unlike CHIP, the out-of-pocket cost-sharing maximums in exchange plans do not include premium expenses.

To lower out-of-pocket cost sharing for individuals and families with household incomes between 100 and 250 percent FPL buying silver-level exchange plans, the ACA provides cost-sharing reductions. Individuals eligible for such reductions can enroll in a silver plan and receive a version of that plan with higher actuarial value and lower out-of-pocket maximums at no additional cost (Table 2-2). Even so, the highest actuarial value for an exchange plan once federal cost-sharing reductions are considered is 94 percent, which is still below that of most CHIP plans.¹⁶

Cost-sharing reductions are only available to those purchasing silver plans. Gold and platinum plans, with actuarial values of 80 and 90 percent respectively, generally pay for a greater proportion of the cost of covered services than some silver plans with cost-sharing reductions, depending on enrollee income. However, a gold or platinum plan is likely to have a higher premium than a silver plan.

Cost-sharing reductions are not available for stand-alone dental plans. Those plans are only offered at two tiers, a high option (90 percent actuarial value) and a low option (70 percent actuarial value), and enrollees are responsible for cost sharing commensurate with those actuarial values. Stand-alone dental plans have out-of-pocket cost-sharing maximum limits that are separate from those of exchange health plans. In 2015, the out-of-pocket cost-sharing maximums for stand-alone dental plans are \$350 for one covered child and \$700 for two or more covered children (45 CFR 156.150(a)).

TABLE 2-2. Actuarial Value and Maximum Out-of-Pocket Cost for Silver Exchange Plans with Federal Cost-Sharing Reduction by Income, 2014

Income as a percent of FPL	Actuarial value for silver plan with federal cost-sharing reduction	Out-of-pocket maximum for individual coverage	Out-of-pocket maximum for family coverage
100–150%	94%	\$2,250	\$4,500
150–200	87	2,250	4,500
200–250	73	5,200	10,400
>250	70	6,350	12,700

Note: FPL is federal poverty level. Generally, there are no cost-sharing reductions above 250 percent FPL. American Indians receive higher cost-sharing reductions, which eliminate cost sharing for silver exchange plans. Massachusetts provides cost-sharing subsidies in addition to federal cost-sharing reductions.

Source: CMS 2013.

Comparing the Costs of CHIP to Exchange Coverage

The Commission analyzed several family scenarios that are illustrative of what might happen to children who are now covered by CHIP if they were to move to exchange coverage. The Commission estimates that the total average additional cost for covering two children in the exchange is more than twice the cost of CHIP coverage if the children's parents are already enrolled in exchange coverage, and that the average additional costs for exchange coverage is more than six times the cost of CHIP coverage if the children's parents are not already enrolled in exchange coverage, depending on income. (Parents' enrollment affects the additional premium contributions required for children's exchange coverage, even after tax credits are applied.) For children with exceptionally high health care utilization who reach their out-of-pocket cost-sharing maximum, a family's total potential financial exposure associated with covering those children through an exchange could exceed 11.7 percent of family income at 160 percent FPL and 18.8 percent of family income at 210 percent FPL.

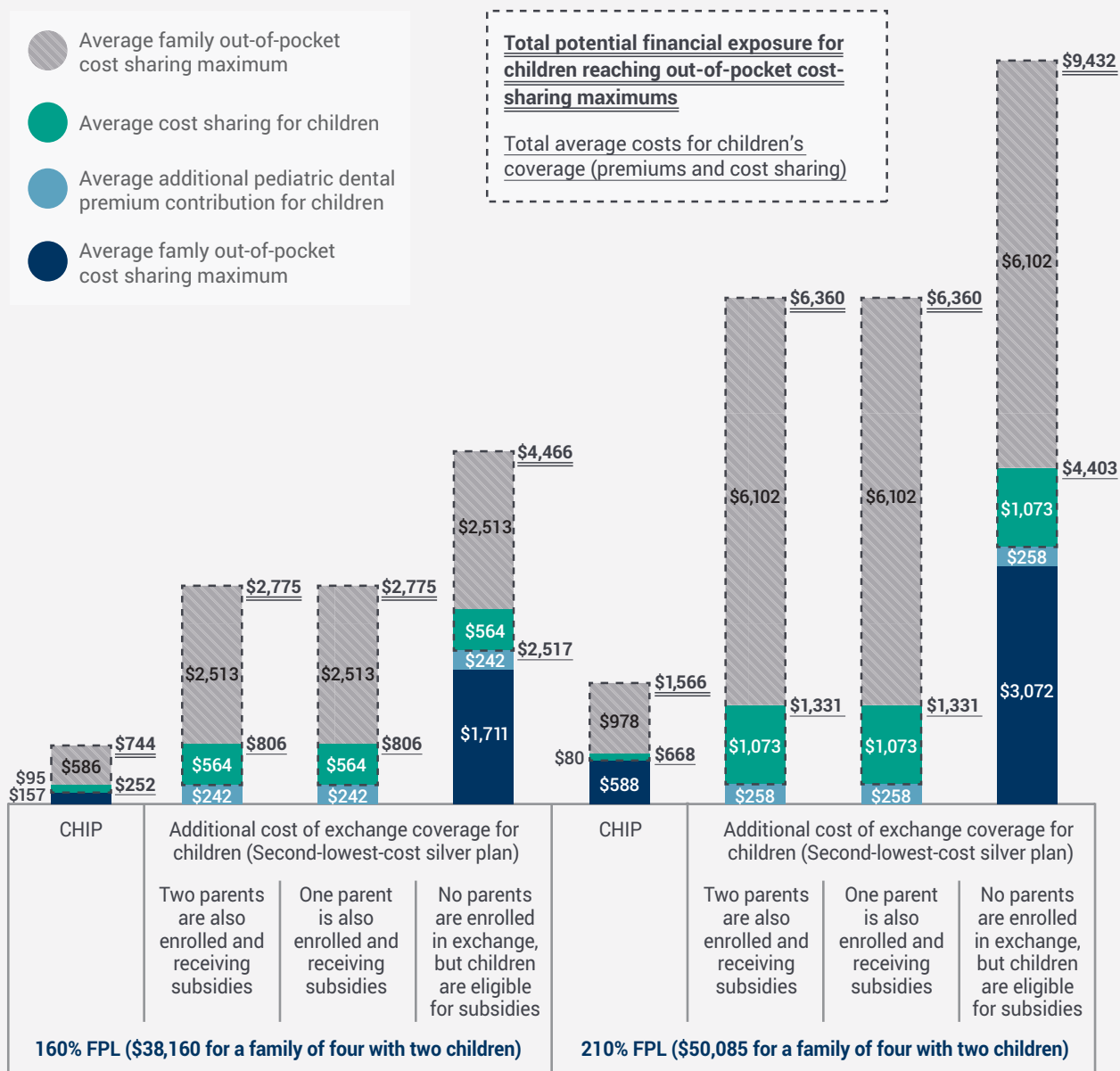
To compare the costs of enrolling in exchange coverage with costs under existing CHIP coverage, we examined two illustrative families, each with two children—one family at 160 FPL and one family at 210 FPL (Figure 2-2).¹⁷ We estimated average premiums, cost sharing, and out-of-pocket cost-sharing maximums that families would experience under CHIP and under subsidized exchange plans (including stand-alone dental plans, if needed, for children to access pediatric dental coverage). We compare CHIP to the additional cost of covering the children in the exchange under three scenarios: (1) one parent already enrolled in exchange coverage, (2) both parents already enrolled, and (3) neither parent enrolled in the exchange. Below we present costs for premiums and cost sharing combined, as well as total financial exposure, which includes premiums and out-of-pocket cost-sharing maximums. We then discuss each element separately.

These findings are based on data on CHIP in 31 states with separate CHIP coverage as of 2014, and exchange data from 23 states with separate CHIP and a federally facilitated exchange.¹⁸ We note that the experience of specific children and their families will differ based on where they live, the metal tier of the plan they select, the age of enrollees, and their health care use. More information about the methods used is provided in Appendix 2A.

For two children at 160 percent FPL, the total average costs for premiums and cost sharing in CHIP are \$252 a year. The average additional costs for covering two children in an exchange are three times higher (\$806) if one or both parents are already enrolled in an exchange plan and 10 times higher (\$2,517) if neither parent is enrolled (Figure 2-2). At 210 percent FPL, the average cost of CHIP is \$668. The cost of covering two children in the exchange is also higher at 210 percent FPL than it is at 160 percent FPL, but the relative increase in costs for the average family is lower. The average additional costs for children's exchange coverage are two times higher than CHIP (\$1,311) if one or both parents are already enrolled in an exchange plan and more than six times higher than CHIP (\$4,403) if neither parent is enrolled.¹⁹

We also looked at the combined impact of premiums and out-of-pocket cost-sharing maximums to assess total financial exposure for the family. The total potential financial exposure for families at 160 percent FPL with children with exceptionally high health care use is \$744 in CHIP, which is 1.9 percent of family income. This amount increases to 7.2 percent of family income in an exchange plan with one or two parents enrolled and 11.7 percent of family income in an exchange plan with no parents enrolled. At 210 percent FPL, the total potential financial exposure for families with children with exceptionally high health care use is 3.1 percent of family income in CHIP, 12.7 percent in an exchange with one or two parents enrolled, and 18.8 percent in an exchange with no parents enrolled.²⁰

FIGURE 2-2. Average Additional Annual Cost of Covering Two Children with CHIP Versus Subsidized Exchange Coverage, Family of Four, 2015



Notes: FPL is federal poverty level. This figure illustrates the average additional annual cost to families of covering two children beyond any coverage costs for their parents. This means that the total cost to a family for covering two children and both parents is higher than what is shown here. Numbers may not add due to rounding.

The average annual costs for CHIP coverage are calculated using data from 31 states with separate CHIP coverage as of 2014, and the average annual costs of exchange coverage are calculated using data from 23 of these states that participate in the federally facilitated exchange. More information about the methods used and the components of MACPAC's calculations is provided in Appendix 2A.

Source: MACPAC analysis of Brooks et al. 2015, Bly et al. 2014, Cardwell et al. 2014, CMS 2014, and BLS 2014b.

Premiums. The differences in cost between CHIP and exchange premiums are highly dependent on family circumstances. This is because the costs of covering children in the exchange cannot be entirely separated from the coverage status of their parents. In the examples above, if the children's parents are not enrolled in exchange coverage, a family's average additional expected premium contribution for covering children in the exchange is about 11 times higher than CHIP at 160 percent FPL and 5 times higher than CHIP at 210 percent FPL.²¹ But if the children's parents are already enrolled in exchange coverage, there is no additional expected premium contribution for enrolling children in the exchange because the family would already be paying its maximum-expected premium contribution for parent-only coverage.

If families also enroll their children in a stand-alone dental plan, they would face additional premiums for those plans, which may by themselves exceed the cost of CHIP premiums. For example, at 160 percent FPL for the illustrative family in Figure 2-2, the average CHIP premiums are \$157 and the average additional premiums for pediatric dental coverage alone are \$242.

Cost sharing. Average annual cost sharing for children's coverage in an exchange in this example is estimated to be about six times higher than CHIP at 160 percent FPL and about 13 times higher than CHIP at 210 percent FPL.²² Unlike premiums, this difference does not vary by the number of family members enrolled in exchange coverage. It would, however, vary depending upon service utilization. In particular, children with high health care use, whether due to ongoing care or an acute illness or injury, would have higher than average cost-sharing expenses.

Even in the states with the highest levels of cost sharing under CHIP, exchange coverage is more expensive. Utah has the highest annual CHIP cost sharing at 160 percent FPL (88.7 percent actuarial value) and Louisiana has the highest annual CHIP cost sharing at 210 percent FPL (86.9 percent

actuarial value). Even so, these actuarial values are still greater than the actuarial value for a silver exchange plan with cost-sharing reductions at those income levels (87 percent actuarial value at 160 percent FPL and 73 percent actuarial value at 210 percent FPL) (Bly et al. 2014).

Out-of-pocket maximums. For children who reach their out-of-pocket cost-sharing maximum, exchange coverage offers less financial protection than CHIP. Out-of-pocket cost-sharing maximums for exchange coverage are about four times higher than CHIP at 160 percent FPL and about six times higher than CHIP at 210 percent FPL. The out-of-pocket maximums for family exchange coverage are 6.6 percent of family income at 160 percent FPL and 12.2 percent of family income at 210 percent FPL.²³

In this example, the out-of-pocket cost-sharing maximums for children's exchange coverage are the same regardless of whether the children's parents are enrolled because the maximums are set at the family level. However, if parents are not enrolled in exchange coverage, any out-of-pocket costs they incur for their own health care would not count toward the exchange out-of-pocket maximum.

Comparison to employer-sponsored coverage

Although our ability to compare the costs of CHIP and employer-sponsored coverage is limited, the available data indicate that employer-sponsored coverage is even more expensive than exchange coverage for families in the CHIP income range. Considering the coverage available to children currently enrolled in CHIP, the average additional family premium for covering a child under employer-sponsored coverage is \$3,751 per year, higher than the cost of exchange premiums for two children at either 160 or 210 percent FPL, even in the scenario where the children's parents are not enrolled in exchange coverage. However, the costs of adding children to employer-sponsored coverage

varies widely: it is estimated to be less than \$125 for one quarter of families and more than \$8,814 for one quarter of families (Dubay et al. 2015). (See Chapter 1, Table 1-1, for additional discussion of this issue.)

The majority of employer-sponsored insurance plans are estimated to have actuarial values below 88 percent, which is lower than CHIP and generally higher than exchange plans with cost-sharing reductions (ASPE 2011). But the wide variation between plans makes direct comparisons based on actuarial value difficult as well. Compared to other employer-sponsored coverage, health maintenance organizations have been estimated to have the highest actuarial values (93 percent on average), and high-deductible health plans have been estimated to have much lower actuarial values (76 percent on average) if employers do not make any contribution to a health savings account (Peterson 2009). However, because the benefits offered in employer-sponsored coverage vary so widely, it is difficult to interpret these data or estimate the average annual cost sharing that a family would face.²⁴

Possible Approaches for Addressing Affordability

In making its recommendation to extend federal CHIP funding for a transition period of two years, the Commission stressed that during this period, issues related to affordability of coverage should be addressed. Since making this recommendation, MACPAC has assessed newly available data. The Commission remains concerned that the higher costs for exchange coverage would increase the financial burden on low-income families and may raise barriers to low-income children's access to care.

The design of policy options to lessen this burden is not straightforward. A policy that narrowly targets children eligible for or currently enrolled in CHIP would be complex to administer (especially

over time) and would make permanent an eligibility structure that is now both variable and dynamic. On the other hand, broader policy changes, for example, those focused on a specific income threshold, would affect many more individuals than those now covered by CHIP.

The Commission is considering several key questions for designing an approach to make children's coverage more affordable for families with children who may move from CHIP to exchange coverage:

- To what extent should approaches to improve affordability of children's coverage address affordability of premiums, cost sharing, or both? What would have the greatest impact? What approach would be the most feasible and efficient to implement and administer?
- Which children should an affordability option target? Would it be available to all children in the CHIP income range or a subset?
- How much of the enrollees' share of premiums and cost sharing should be subsidized? What is the appropriate balance between cost sharing that encourages more careful use of health care services and the risk that cost sharing could cause some families to forgo coverage and care altogether?
- Should additional subsidies be available only after families have reached out-of-pocket expenses of 5 percent of income, the current CHIP maximum on out-of-pocket spending?
- What are the costs (for both benefits and administration) to state and federal governments, and how would they be paid for?

The Commission has not yet come to a conclusion about how to address affordability concerns for children enrolled in CHIP who might transition to exchange coverage if CHIP funding is exhausted. In its deliberations, the Commission will consider which approaches would be most effective in

addressing these concerns, looking at the question from the perspective of families, states, and the federal government. Below, we preview some possible approaches.

Augmenting existing exchange subsidies

Existing exchange subsidies—the premium tax credit and cost-sharing reductions—could be augmented to give families more help. An enhanced premium tax credit could pay for a greater share of families’ exchange premiums and may allow some families to purchase gold or platinum exchange plans. These exchange plans have higher premiums than silver plans, but also have lower baseline cost sharing, which some families may prefer. (However, cost-sharing reductions are available only for silver plans and enrollees would need to compare which metal tier would offer the greatest cost-sharing protection.) The premium tax credit could also be enhanced by taking into account the premium costs of stand-alone dental plans and could assist families in purchasing such plans. This approach may encourage some families who would have forgone stand-alone dental coverage due to premium cost to purchase such coverage. However, families of different income and composition are likely to experience differing magnitudes of premium changes by moving children to exchange coverage, which could create challenges in developing a targeted enhanced premium tax credit.

Increasing cost-sharing reductions in exchanges could help to lower expected cost sharing for families after they enroll in an exchange plan. Existing exchange cost-sharing reductions could be expanded either by increasing the amount of assistance provided to families that already receive a cost-sharing reduction or by providing the reductions to families with incomes greater than 250 percent FPL. The out-of-pocket maximum levels for families of children moving from CHIP to exchanges could also be reduced (or

possibly capped at the current CHIP out-of-pocket spending limit) but such a change would need to be accompanied by an increase in the allowable actuarial value for the silver-level plans. Additional cost-sharing assistance would help families with children who only need routine services as well as those with special health care needs.

Augmenting premium and cost-sharing subsidies could build on existing mechanisms for the subsidies, so no new ones would need to be developed. Premium and cost-sharing subsidies in the exchange are available to all those who meet eligibility requirements, without any targeting to subpopulations. Thus augmented subsidies could reach a broader population than just children who had been enrolled in CHIP.

Providing wrap-around coverage for premiums or cost sharing

Premium and cost-sharing wrap-around coverage could be developed to improve affordability of exchange coverage for families in the CHIP income range. Models for wrap-around coverage exist within Medicaid and CHIP already via premium assistance for the purchase of private health insurance. Although little has been reported publicly about how effective these programs are in ensuring that consumers obtain health insurance coverage, states generally view them as successful even while acknowledging some operational challenges. Challenges include high administrative costs associated with providing premium assistance, communicating with health plans to obtain needed information, and educating consumers and providers about the coverage (KFF 2013, GAO 2010).

Recently, some state Medicaid programs (Massachusetts, New York, Rhode Island, and Vermont) have started subsidizing premiums for adults enrolled in exchange coverage through Section 1115 demonstrations. These Medicaid-financed premium wrap-around programs are

limited to adults that would have been eligible for Medicaid coverage under state programs that were phased out in 2014, and the amount of the premium wrap-around subsidies are tied to pre-2014 Medicaid premium levels. These state premium wrap-around programs are relatively new and there are few details so far on how they have been operationalized.

A cost-sharing wrap-around benefit would help families of children currently enrolled in CHIP that will purchase exchange coverage with out-of-pocket cost sharing, which will be higher in exchanges than CHIP. Cost-sharing wrap-around benefits would be particularly helpful to families of children with special health care needs who require frequent and ongoing services and who may thus incur greater out-of-pocket cost-sharing expenses.

Some Medicaid and CHIP programs provide cost-sharing wrap-around benefits to those receiving premium assistance for the purchase of employer-sponsored coverage. However, such programs have historically faced operational challenges in tracking how much cost sharing an enrollee has paid, providing and reconciling the subsidy paid, and educating enrollees and providers (GAO 2010).²⁵ Some states are testing cost-sharing wrap-arounds as part of demonstrations in which they purchase exchange coverage for the newly eligible Medicaid adult population.²⁶ In these programs, states purchase an exchange plan with a high actuarial value and cover certain cost-sharing expenses, such as deductibles and costs that exceed 5 percent of a family's income.

Providing premium or cost-sharing wrap-around benefits could be administratively complex; could create confusion for families, providers, and plans; and in most states would require development and implementation of a mechanism for providing the benefit. The existing models for premium assistance provide some insights into possible challenges, which could be accounted for if an option to provide premium wrap-around benefits were developed.

Alternatives to exchange coverage

Providing Medicaid to children within the CHIP income range rather than enrolling them into exchange plans is another way to improve affordability of coverage for this population. States could raise the minimum Medicaid eligibility level for children from 138 percent FPL to another set level, such as 200 percent FPL. This approach would address both affordability of premiums and cost sharing and would provide greater uniformity of program eligibility for children across states. Children also would receive the Medicaid benefit package, including Early and Periodic Screening, Diagnostic, and Treatment services, which would help ensure adequacy of covered benefits. However, this would expand the number of children entitled to public coverage and states would experience greater costs in covering this population at the regular Medicaid matching rate. Finally, there are concerns about the capacity of Medicaid providers and provider networks to care for an expanded Medicaid population.

Next Steps

The Commission will continue evaluating options to address concerns about the affordability of children's health coverage if CHIP funding is not renewed. The assessment will include a more detailed look into the possible approaches described above and how they might be designed to improve affordability of coverage. The Commission also will assess the benefits, drawbacks, and cost implications of the approaches from the perspective of families, health plans, providers, states, and the federal government.

Endnotes

¹ Consumer expenditure data reflect consumer units with at least one child under age 18. The analysis did not include after-tax income because adjusted-gross-income and tax-credit calculations underwent substantial changes in 2013 (BLS 2015). For families at lower income levels, after-tax income may be somewhat higher than before-tax income as a result of refundable tax credits. For those at higher income levels, after-tax income may be lower than before-tax income. Based on published 2013 data for all consumer units (with and without children), the 40 percent of consumer units with incomes in the two lowest quintiles had after-tax incomes amounts that exceeded before-tax incomes amounts. Consumer units in the third-lowest income quintile had average before-tax income of \$45,826 and after-tax income of \$43,592, meaning that they paid 4.9 percent of their gross income in taxes (BLS 2014a).

² As noted earlier, incomes provided here are before taxes, and tax payments are an additional liability that can reduce a family's available income. Based on MACPAC calculations using published 2013 data noted earlier, families between 140 and 180 percent FPL are likely to have similar before-tax and after-tax incomes, while those between 180 and 240 percent FPL may have tax payments that lower their after-tax incomes.

³ Over-the-counter drug costs are not included in the Consumer Expenditure Survey measure of health spending.

⁴ In 2014, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required all states to expand Medicaid to all children below 138 percent FPL and to convert separate CHIP eligibility levels to modified adjusted gross income. These changes will affect the income distribution of children enrolled in separate CHIP.

⁵ Some separate CHIP programs charge premiums on a quarterly or annual basis instead of on a monthly basis. In addition, some states charge a per-family premium rather than per-child premium and other states cap premiums once a certain number of children are enrolled. For the purpose of comparison, these premiums were converted to their monthly equivalent for one child.

⁶ In states with federally facilitated exchanges where CMS is conducting plan management functions, CMS reviews and approves rate requests.

⁷ Based on federal rules, employer-sponsored coverage is considered affordable if the cost of that coverage for just the employee, rather than the family, is less than 9.5 percent of family income.

⁸ Families receive the same premium tax credit amount regardless of the exchange plan that they enroll in. However, the premium tax credit cannot exceed the cost of the exchange plan premium.

⁹ For example, in 2015, two-parent (ages 38 and 40), two-child families with incomes above 290 percent FPL would pay additional premiums for adding their children to an exchange plan. Single parent (age 40), two-child families would face additional premium costs for children's exchange coverage at a lower income threshold, 226 percent FPL (MACPAC 2015e). The examples in Figures 2-1 and 2-2 are based on the average second-lowest-cost silver exchange plans offered in the federally facilitated exchange for two non-smoking parents. Actual family premiums will vary depending on their rating area, age, smoking status, and the particular exchange metal tier and plan they select.

¹⁰ MACPAC analyzed 2015 federal exchange data and found that of states with separate CHIP and federally facilitated exchanges, eight do not have any second-lowest-cost silver plans with embedded dental coverage, 15 have a mix of second-lowest-cost silver plans with or without embedded dental coverage, and three have embedded dental in all second-lowest-cost silver plans (MACPAC 2015d).

¹¹ Estimate for the average annual cost of stand-alone dental plans is based on the average premium costs for the lowest-cost stand-alone dental plans available in states with separate CHIP offering stand-alone dental plans in the federally facilitated exchange.

¹² Only a few separate CHIP programs require coinsurance or a deductible (Cardwell et al. 2014).

¹³ Federally recognized American Indians and Alaska Natives with incomes between 100 and 300 percent FPL are exempt from cost sharing for essential health services covered by an exchange plan.

¹⁴ The metal tier actuarial value requirements do not apply to catastrophic plans.

¹⁵ The out-of-pocket maximum levels apply to all plans required to conform to essential health benefit requirements under the ACA as well as large and self-insured plans.

¹⁶ Separate CHIP has an average actuarial value of 98 percent for families with incomes of 160 percent FPL and an average actuarial value of 97 percent for families with incomes of 210 percent FPL (Bly et al. 2014).

¹⁷ MACPAC analyzed the cost of coverage for two children at 160 percent FPL and 210 percent FPL, using illustrative examples that are intended to represent the typical CHIP family: In 2013, 96.2 percent of separate CHIP children lived in families with incomes below 250 percent FPL, and in 2014, families with incomes between 150 and 250 percent FPL had an average of 1.9 children per family, with state averages across the country ranging from 1.4 to 2.5 children per family (MACPAC 2015a, 2015b). MACPAC's analysis relied on CHIP cost-sharing data from the Wakely Consulting Group, which was only available at 160 and 210 percent FPL (Bly et al. 2014).

¹⁸ Data for 2015 exchange plans were not readily available in the nine states with separate CHIP operating state-based exchanges (CO, CT, ID, KY, MA, NV, NY, OR, and WA). CHIP cost-sharing information at 210 percent FPL was not available for seven states with separate CHIP at this income level (DE, FL, KY, ME, MI, MS, and NC) (Bly et al. 2014). In addition, six states included in the Wakely Consulting Group study at 160 percent FPL were excluded from MACPAC's analysis because these states currently cover children at this income level through Medicaid instead of separate CHIP (IA, IN, KY, ME, MI, and SD) (Bly et al. 2014).

¹⁹ See Appendix 2A for source data used for comparison.

²⁰ In 2014, 160 percent of the FPL for a family of four was \$38,160, and 210 percent of the FPL for a family of four was \$50,085. The 2014 federal poverty guidelines are used to calculate 2015 exchange subsidies.

²¹ See Appendix 2A for source data used for comparison.

²² See Appendix 2A for source data used for comparison.

²³ See Appendix 2A for source data used for comparison.

²⁴ Because actuarial value measures the percentage of covered health benefits an insurer would pay, on average, for a typical enrollee population, variation in covered health benefits affects the comparability of actuarial values.

²⁵ A 2010 GAO study found that 34 Medicaid or CHIP premium assistance programs paid for some or all cost sharing for some or all of the covered population, and that five programs limited enrollees' annual out-of-pocket expenditures. CMS regulations on monitoring of cost sharing for Medicaid managed care plans strongly discouraged the practice of enrollee tracking of cost-sharing expenses for retrospective reimbursement (42 CFR 447.50-56).

²⁶ The Arkansas and Iowa Section 1115 premium assistance programs also include cost-sharing subsidies that are entirely paid for by the state Medicaid program.

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APPENDIX 2A: Methodology and Data Used to Estimate Average Premiums and Cost Sharing for Illustrative Families in CHIP and Exchange Coverage

In this chapter, MACPAC used a variety of data sources to estimate average premiums, cost sharing, and out-of-pocket cost-sharing maximums for two children at 160 percent of the federal poverty level (FPL) and 210 percent FPL (Figure 2-2). We compare CHIP costs to the additional cost of exchange coverage for children for an illustrative family of four under three scenarios: one parent already enrolled in exchange coverage, both parents already enrolled, and neither parent enrolled in the exchange.

These family scenarios use data from 31 states that have separate CHIP at 160 percent FPL or 210 percent FPL. Exchange plan cost estimates rely on data from 23 of these states that participate in the federally facilitated exchange. Exchange plan data from 2015 were not readily available in the nine states with separate CHIP programs that are operating state-based exchanges (CO, CT, ID, KY, MA, NV, NY, OR, and WA). CHIP cost-sharing information at 210 percent FPL was not available for seven states with separate CHIP at this income level (DE, FL, KY, ME, MI, MS, and NC) (Bly et al. 2014). In addition, six states included in the Wakely Consulting Group study at 160 percent FPL were excluded from MACPAC's analysis because these states currently cover children at this income level through Medicaid instead of separate CHIP (IA, IN, KY, ME, MI, and SD) (Bly et al. 2014).

CHIP premiums were based on premiums in effect on January 1, 2015 (Brooks et al. 2015). State policies that adjust CHIP premiums based on the number of children enrolled were also taken into account to calculate each state's annual premium for two children (Cardwell et al. 2014).

MACPAC calculated exchange plan premiums for the second-lowest-cost silver plan using its own analysis of 2015 exchange premiums (CMS 2014). In the states studied, the unsubsidized average exchange premium for two children is \$3,270 per year. This figure is similar to other published estimates for children's coverage among all states with federally facilitated exchanges, which averages \$3,226 per year for two children in 2015 (MACPAC 2015e).

Family premium contributions after tax credits were based on 2014 federal poverty guidelines, which were used to calculate 2015 exchange tax credits. The maximum-expected premium contribution for a family of four is \$1,711 at 160 percent FPL and \$3,352 at 210 percent FPL.

MACPAC also used federal exchange data to calculate average premiums for additional pediatric dental coverage based on the lowest-cost stand-alone dental plan in rating areas where the second-lowest-cost silver plan did not include pediatric dental coverage. In 20 of the 23 states with federally facilitated exchanges used in this analysis, at least some (and in some states, all), of the second-lowest-cost silver plans exclude pediatric dental coverage. In 2015, the average annual premium of stand-alone dental plans in these states is \$432 for two children. If pediatric dental coverage was included in the second-lowest-cost silver plan, the additional cost for pediatric dental coverage was assumed to be \$0 for the averages presented in Figure 2-2. After adjusting for exchange plans with pediatric dental coverage, the average premiums for pediatric dental coverage vary slightly between 160 and 210 percent FPL (\$242 versus \$258) because of the different states that offer separate CHIP coverage at each income level.

Cost sharing estimates for both CHIP and exchange coverage reflect the average annual costs that a family is expected to pay based on each health plan's actuarial value and an estimate of the average allowed claims cost for children's coverage in each state. The average allowed claims cost is estimated by dividing the second-lowest-cost silver plan premium by an actuarial value of 70 percent, after accounting for health plan administrative

costs (assuming a medical loss ratio of 20 percent). Average cost sharing for pediatric dental services was estimated using a similar method. This method does not take into account benefit variation between CHIP and exchange plans (except for dental coverage) and assumes that exchange plan premiums for children's coverage reflect the actual cost of coverage. In practice, there are other benefit variations between CHIP and exchange coverage (as described in Chapter 3), and exchange plan rating rules also impose limits on the extent to which health plans can set special rates for children.

MACPAC relied on CHIP actuarial values calculated by the Wakely Consulting Group (Bly et al. 2014).

These actuarial values were determined using the 2015 Federal Actuarial Value Calculator (available at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html#ApplicationResources>). By April 1, 2015, the U.S. Department of Health and Human Services is required to publish an assessment of whether cost sharing in CHIP and exchange plans is comparable, and at that time may provide updated estimates of CHIP actuarial values.

National averages for coverage costs under CHIP and exchange plans are calculated using a weighted average based on the number of families at the specified income level in each state (BLS 2014b).

TABLE 2A-1. Average Additional Annual Cost of Covering Two Children with CHIP Versus Subsidized Exchange Coverage, Family of Four, 2015

Average cost	160% FPL (\$38,160 for a family of four)			210% FPL (\$50,085 for a family of four)		
	CHIP	Additional cost of exchange coverage for children (Second-lowest cost silver plan)		CHIP	Additional cost of exchange coverage for children (Second-lowest cost silver plan)	
		With parent(s) also enrolled in exchange and receiving subsidies	Parent(s) are not enrolled in exchange, but children are still eligible for subsidies		With parent(s) also enrolled in exchange and receiving subsidies	Parent(s) are not enrolled in exchange, but children are still eligible for subsidies
Premiums for children's medical coverage	\$157	\$0	\$1,711	\$588	\$0	\$3,072
Additional premiums for children's dental coverage	n/a	242	242	n/a	258	258
Cost sharing for children's coverage	95	564	564	80	1,073	1,073
Total additional cost to families for children's coverage	252	806	2,517	668	1,331	4,403
Premiums paid for children's medical coverage	157	0	1,711	588	0	3,072
Additional premiums for children's dental coverage	n/a	242	242	n/a	258	258
Out-of-pocket cost-sharing maximum	586	2,513	2,513	978	6,102	6,102
Total potential financial exposure	744	2,755	4,466	1,566	6,360	9,432

Notes: FPL is federal poverty level. This table summarizes the average additional annual cost to families of covering two children in addition to any coverage costs for their parents. This means that the total cost to a family for covering two children and both parents is higher than what is shown here. Numbers may not add due to rounding.

The average annual costs for CHIP coverage are calculated using data from 31 states with separate CHIP coverage as of 2014, and the average annual costs of exchange coverage are calculated using data from 23 of these states that participate in the federally facilitated exchange.

Source: MACPAC analysis of Brooks et al. 2015, Bly et al. 2014, Cardwell et al. 2014, CMS 2014, and BLS 2014b.

CHAPTER 3

Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer- Sponsored Insurance

Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance

Key Points

- States are expected to exhaust existing funding for their CHIP programs during fiscal year 2016 under current law. Under that scenario, most children now served by the program would likely transition to Medicaid, exchange plans, and employer-sponsored insurance. A key question in considering the future of CHIP is whether other sources of coverage will provide sufficient benefits for the health care needs of these children.
- Children at CHIP-eligible income levels tend to have a higher prevalence of chronic conditions and use more health services than those with private insurance, so the adequacy of benefits is a key consideration for this population.
- MACPAC's analysis of benefits offered by separate CHIP, Medicaid, exchange plans, and employer-sponsored insurance found the following:
 - Covered benefits vary within each source—between states for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans.
 - Most CHIP, Medicaid, exchange plans, and employer-sponsored insurance plans cover major medical benefits, such as inpatient and outpatient care, physician services, and prescription drugs.
 - Although Medicaid and CHIP cover pediatric dental services, dental benefits are offered as a separate, stand-alone insurance product in most exchanges.
 - CHIP and Medicaid cover many services that are not always available in exchange plans. For example, all state CHIP and Medicaid programs cover audiology exams, and 95 percent of state CHIP programs cover hearing aids. However, only 37 percent of exchange plan essential health benefit benchmarks cover audiology exams, and only 54 percent cover hearing aids.
 - For other benefits, such as applied behavioral analysis therapy and autism services, coverage varies.
- Benefit comparisons are inherently complex and must be considered in the context of payer and plan policies on the amount, duration, and scope of covered benefits as well as the definition of services within benefit categories and definitions of medical necessity.
- The Commission is examining the feasibility, complexity, and costs of a range of policy options that address concerns about the comparability of CHIP coverage to other sources, and the implications that such options might have for children and families, and federal and state governments.

CHAPTER 3: Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance

A key question in considering the future of children's coverage is whether other sources of coverage, to which children now enrolled in CHIP may transition, will provide children with coverage that meets their health care needs. Survey data indicate that children likely to have CHIP coverage are more likely to have special health needs than those who are privately insured (24 percent vs. 19 percent). They have a prevalence of chronic conditions that is similar to children likely to be enrolled in Medicaid, but higher than that of children with private coverage (MACPAC 2015). And they use more services, including dental care, than children likely to be enrolled in Medicaid, but use fewer services than privately insured children. Moreover, children likely to be enrolled in CHIP reported unmet need for medical care (5 percent) and dental care (3 percent) at levels comparable to those likely to be enrolled in Medicaid, but higher than privately insured children (2 percent for both medical and dental care). Whether other sources of coverage will provide children with benefits that meet their health care needs remains a key consideration for the Commission.

The Commission's June 2014 report highlighted concerns about whether other sources of coverage can serve as an appropriate alternative to CHIP. It is expected that states will exhaust existing funding for their CHIP programs during fiscal year 2016 under current law. Most children now served by the program would likely transition to other sources of coverage, including Medicaid (for children enrolled

in Medicaid-expansion CHIP), exchange plans, and employer-sponsored insurance as dependents. Covered benefits vary within each source—between states for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans. Most major medical benefits, such as inpatient care, physician services, and prescription drugs, are offered by all of these sources. For other benefits, coverage varies. For example, dental services are a covered benefit in Medicaid and CHIP, but they are often offered as a separate stand-alone insurance product in exchange plans and employer-sponsored insurance.

Benefit comparisons are inherently complex because the extent to which different types of services are offered must be considered in the context of payer and plan policies on the scope of coverage, description of benefit categories, and definitions of medical necessity. It is also worth noting that coverage of a benefit does not guarantee access to services. Utilization management practices and cost-sharing requirements (the latter of which is discussed in greater detail in Chapter 2) can limit access to services for some families. As a result, it can be quite difficult to assess the effect of differences in benefits on individuals.

This chapter begins with a description of the benefits generally available in CHIP, Medicaid, exchange plans, and employer-sponsored insurance plans, including a discussion of health benefit mandates. We then compare CHIP coverage—what is typically available to current CHIP enrollees—to the coverage generally available in Medicaid, exchange plans, and employer-sponsored insurance. These comparisons are intended to be instructive of the experience of CHIP-enrolled children if they were to transition to other sources of coverage. The chapter concludes by discussing some possible policy options for addressing concerns about the comparability of coverage between CHIP and other sources. Policy options identified to address these concerns include changing the essential health benefit definition of pediatric services, allowing states the option of establishing a separate

pediatric coverage benchmark, and requiring that all exchange plans embed pediatric dental coverage. However, all of these options have not only cost implications, but also implications for individuals, families, states, and the federal government. The Commission will continue to consider these and other potential options for smoothing the transition to other sources of coverage.

Health Benefit Coverage

CHIP benefits. Benefits offered by state CHIP programs vary because states have flexibility in designing their programs. States can operate CHIP as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches (MACPAC 2013). States can model their separate CHIP benefits on specific private insurance benchmarks, create a package that is equivalent to one of those benchmarks, or provide coverage approved by the Secretary of the U.S. Department of Health and Human Services (Secretary-approved coverage). The most flexible of these options is Secretary-approved coverage, which is used by 25 of the 42 separate CHIP programs (Cardwell et al. 2014). Fourteen of these 25 programs use a benefit package similar to Medicaid.¹

Some services are universally covered by separate CHIP programs. Federal rules require that all separate CHIP programs cover dental services, well-baby and well-child care (including age-appropriate immunizations), and emergency services (42 CFR 457.10(b)). All separate CHIP programs also covered inpatient and outpatient services, physician and surgical services, clinic services, durable medical equipment, and prescription drug coverage in 2013, although some states limited the scope or coverage, applied a monetary cap on benefits, or both (Cardwell et al. 2014). Although they rarely do, states can reduce benefits in separate CHIP as there are few mandatory benefits.

Some benefits are available in many, but not all, states. For example, all separate CHIP programs except Arkansas cover inpatient substance abuse services (Cardwell et al. 2014). Other such benefits include autism services (available in 35 of 42 states with separate CHIP programs), nursing care services (38), disposable medical supplies (39), hearing aids (39), podiatry services (39), outpatient substance abuse services (41) and hospice services (41).²

Some benefits are covered by a smaller number of states. For example, non-emergency medical transportation services are covered in 23 of 42 separate CHIP programs. Over-the-counter medications (covered in 28 of 42 programs) and enabling services (14) are two other examples.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is available in separate CHIP in 13 states. EPSDT is a Medicaid benefit under which states must cover medically necessary services for children, even if a particular service is not available as a covered benefit in the Medicaid state plan. EPSDT benefit coverage is not required in separate CHIP, but several states have opted to include EPSDT coverage in their Secretary-approved coverage.³

Medicaid benefits. Medicaid benefits are categorized as either mandatory or optional. The coverage available to an individual will depend on the state in which the individual is enrolled. Mandatory benefits include inpatient and outpatient services, physician and surgical services, federally qualified health center and rural health clinic services, laboratory and X-ray services, home health services, family planning services, and non-emergency medical transportation.

Medicaid is required to cover the EPSDT benefit for children under age 21 who are enrolled in Medicaid. Medicaid coverage for children is generally viewed as comprehensive because the EPSDT benefit can expand coverage to include optional Medicaid services not listed in the Medicaid state plan. For example, under EPSDT requirements, states must

cover autism screenings and services if medically necessary (CMS 2014).

Some optional services are covered widely, and others less so.⁴ All states provide prescription drug coverage through their Medicaid programs, 42 states cover eyeglasses, and 41 cover hospice care (KCMU 2014). Physical and speech therapies are covered in 36 states, and occupational therapy is covered in 34. While states have the option of providing dental services to adults, they must provide dental services to children as a required Medicaid EPSDT benefit.

Children enrolled in Medicaid-expansion CHIP receive the Medicaid benefit package available in their state, including coverage of the EPSDT benefit.

Exchange plan benefits. Exchange plans must cover specific benefits in order to be certified. One of the federal minimum requirements is that health insurers, if they offer any coverage in an exchange, must also offer child-only plans. Child-only plans, which are restricted to individuals under the age of 21, are similar to other exchange plans in that they must be offered at the same actuarial value categories, and they must cover the essential health benefits.

All exchange plans must provide coverage of the 10 essential health benefits, as required by Section 1302(b) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).⁵ Each state defines its essential health benefit package by choosing a benchmark plan from among four options; the benchmark plan then serves as a model and minimum standard of coverage (including scope of coverage) that must be met for exchange plans to be certified.⁶ If a benchmark plan is missing any of the 10 essential health benefits, federal regulations require states to supplement the benefit category using an alternative benchmark option.

Habilitative benefits and pediatric services are exceptions to the benefit supplement framework, and regulations establish specific rules for

these two benefit categories. In the preamble to the final rule on exchange plan benefits, the Centers for Medicare & Medicaid Services (CMS) explained that employer-sponsored plans do not often include habilitative services, and that small group plans do not typically cover pediatric oral and vision services (CMS 2013).⁷ CMS adopted a more uniform definition of what is considered a habilitative benefit in 2015, and states continue to have some flexibility to determine what services are included under the habilitative services benefit category (CMS 2015).⁸

State flexibility in defining their essential health benefit benchmarks leads to some differences in the benefits offered by exchange plans across states. For example, in 2014, general autism services were not covered in exchange plans in 23 percent of states (Bly et al. 2014). Audiology exams were not covered in essential health benefit benchmarks in 63 percent of states, and hearing aids were not covered in 46 percent of states (Bly et al. 2014).

Pediatric dental services are required as part of the pediatric services essential health benefit, but not all exchange plans cover this benefit because federal law does not require exchange plans to provide pediatric dental coverage if a stand-alone dental plan is also available in an exchange.⁹ Moreover, families are not required to purchase a stand-alone dental plan for their children, except in four states.¹⁰ The cost of stand-alone dental plan premiums is rarely included in the calculation of a family's premium tax credit, and there is no additional premium subsidy specifically for purchasing stand-alone dental coverage. This raises concerns about the affordability of pediatric dental coverage, which we address in more detail in Chapter 2 of this report.¹¹

Employer-sponsored insurance benefits. Employer-sponsored insurance (ESI) plans vary in terms of benefits covered because such plans are designed by employers and insurers with employee health needs and costs in mind, and there are few federally mandated benefits.¹² Plans must cover preventive

services, including contraceptives and breast pumps for women. Plans are not required to cover mental health and substance use disorder services, but if they do, they must cover these services at parity with their other medical and surgical benefits. Plans are not required to cover inpatient hospital care or physician services, although a 2008 survey found that nearly all plans did (Mercer 2008). Most benefit mandates are issued at the state level. For example, even without federal mandates, 37 states and the District of Columbia required plans to cover certain autism services (NCSL 2012). Some states require employer-sponsored insurance to provide other benefits, including certain screenings, immunizations (including pediatric), and infertility treatments.

Most employer-sponsored insurance plans cover inpatient and outpatient services, physician services, and prescription drugs (Table 3-1). Autism services are covered by about 69 percent of plans in small firms and 80 percent of plans in large firms. Half of all plans cover applied behavioral analysis therapy. More than half of all plans (54 percent) do not include coverage for dental services. Of the employers that offer separate dental coverage, many require an additional premium.

Although the ACA does not mandate many specific benefits, it does require that employer-sponsored insurance plans provide actuarial value of at least 60 percent in order to meet the minimum value threshold to be considered creditable coverage.¹³ Most employer-sponsored insurance enrollees—98 percent—were enrolled in plans with 80 percent actuarial value or higher in 2011 (ASPE 2011a).

Comparison of CHIP Coverage to Other Sources of Coverage

How a child will fare in his or her transition from CHIP to another source of coverage will depend on individual circumstances—income, health status, state of residence, plan choice, even a parent’s employer (if employer-sponsored insurance is

available). Nonetheless, broad comparisons can be drawn between the different sources of coverage (Table 3-1). Most major medical services are covered by all sources of coverage. The story is less clear for other benefits, such as autism services, audiology exams, and hearing aids, which are more frequently covered in CHIP than by ESI or exchange plans. These benefit comparisons should be considered cautiously, as they are complicated by a number of factors (described in the next section).

Coverage for most major medical benefits is consistent across sources of coverage. In most cases, children transitioning from separate CHIP to Medicaid, exchange plans, or employer-sponsored insurance will have access to inpatient and outpatient hospital services, physician services, durable medical equipment, and prescription drug services.

For other benefits, coverage varies. Dental benefits are available in separate CHIP coverage and Medicaid (as an EPSDT benefit), but some families might incur additional premiums and cost sharing to access services in exchange plans and employer-sponsored insurance. Audiology exams are covered by all separate CHIP programs and Medicaid, but were covered by fewer than 40 percent of exchange and ESI plans.

At least half of the plans in each of the different sources of coverage cover certain benefits. Coverage for autism services, applied behavioral analysis therapy, and hearing aids varies across different sources of coverage. For example, applied behavioral analysis therapy is offered by 58 percent of state CHIP programs, 57 percent of exchange plans, and 50 percent of ESI plans.

Although most separate CHIP programs may cover the 10 essential health benefits, there are few mandates and states can reduce the number and scope of covered benefits. In particular, as federal CHIP funds diminish, states may opt to limit covered benefits rather than discontinue their separate CHIP programs.

TABLE 3-1. Coverage of Selected Benefit Categories, by Source of Coverage

Benefit category	Separate CHIP	Medicaid	Exchange plans	Employer-sponsored insurance plans
	Percent of states with some coverage in this benefit category	Percent of states with some coverage in this benefit category	Percent of essential health benefit benchmarks with some coverage in this benefit category	Percent of plans with some coverage in this benefit category
Physician services	100%	100%	100%	100%*†
Durable medical equipment and other medically related or remedial devices	100	100	100	67 ^{1*} 97 [‡]
Inpatient services	100	100	100	98 (small firms); 99 (large firms) [‡]
Inpatient mental health services	100	100	100	99*
Outpatient services	100	100	100	97 (small firms); 98 (large firms) [‡]
Outpatient mental health services	100	100	100	85*
Prescription drugs	100	100	100	99 [§]
Emergency medical transportation	100	100	100	64 ^{2*}
Autism—general	82	NA ³	77	69 (small firms); 80 (large firms)
Autism—applied behavioral analysis therapy	58	NA ³	57	50 [‡]
Audiology services—exams	100	NA ⁴	37	34 ^{5#}
Audiology services—hearing aids	95	NA ⁴	54	43 [‡]
Physical therapy	100	71 ⁶	100	99 [‡]
Occupational therapy	100	67 ⁶	100	92 [‡]
Speech therapy	100	71 ⁶	100	85 [‡]
Dental	100	94 ⁶	40	46 [‡]
Pediatric vision—exams	100	100	100	44 [‡]

Notes: EHB is essential health benefit. NA is not applicable.

The table presents the percent of states, EHB benchmarks, or ESI plans with some coverage in the benefit category listed. Covered benefits are available to all enrollees and not limited to children, unless otherwise noted. There are several additional limitations (described in further detail below) to the data presented in this table. Although the benefit category may be covered, the amount or scope of coverage available can vary by state and plan. Benefit categories are broad and may not include coverage of specific benefits. Some benefits are only available when determined medically necessary. Although a benefit may be listed as covered, this does not guarantee that an individual will be able to access that coverage, depending on health status or condition.

¹ Of the workers' plans reviewed by the U.S. Department of Labor (DOL), 67 percent explicitly listed durable medical equipment as a covered benefit category, 33 percent did not mention durable medical equipment in plan documentation, and none excluded durable medical equipment coverage. Because specific benefits can often fall under different benefit categories, it is possible, for example, that some plans will cover diabetes supplies (e.g., test strips, glucose meter, syringes) under the prescription drug or a diabetes care management benefit category, or breast pumps under a prenatal or maternity care benefit category, while other plans categorize these items as durable medical equipment. On the other hand, it is possible that some plans exclude certain items from coverage.

² Of the workers' plans reviewed by the DOL, 64 percent explicitly listed ambulance services as a covered benefit category, 35 percent did not mention ambulance services in plan documentation, and none excluded ambulance service coverage. As noted above, specific benefits can be categorized different ways, for example, plans might cover ambulance services or emergency medical transportation under the broader emergency benefits category. On the other hand, it is possible that some plans exclude ambulance services.

TABLE 3-1 (continued)

³ Although autism services are not listed as a covered benefit category in the Medicaid statute, states may provide coverage under the following categories: services of other licensed practitioners, preventive services, therapy services, and home- and community-based services, a benefit listed under Section 1915(i) of the Social Security Act.

⁴ Although audiology services are not listed as a covered benefit category in the Medicaid statute, states may provide coverage under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit or under the category of other diagnostic, screening, preventive, and rehabilitative services.

⁵ Thirty-four percent of private health insurance plans covered audiology exams for children. Plans reviewed by McManus (2001) listed audiology exams as a covered benefit or covered exams under the preventive services benefit. Forty-nine percent of private insurance plans did not specify whether audiology exams were covered, and 17 percent of plans specifically excluded exams.

⁶ Medicaid is required to cover medically necessary services for children under the EPSDT benefit even if a particular service is not listed in the Medicaid state plan. Therefore, coverage might be available to children even though dental, physical therapy, occupational therapy, and speech therapy are optional benefits in traditional Medicaid.

Sources: For CHIP: Cardwell et al. 2014; for Medicaid: KCMU 2014; for exchange plans: Bly et al. 2014; for employer-sponsored insurance: *DOL 2011, †BLS 2009, ‡Mercer 2011, §Claxton et al. 2014, ||Mercer 2009, #McManus 2001.

More limited coverage of some benefits in the exchanges concerns the Commission to the extent that children currently enrolled in CHIP will not have access to benefits they need. For example, children likely to have CHIP coverage report higher unmet need for dental care than those who are privately insured, and might lose dental coverage if they transition from CHIP to exchange coverage.

Limitations of the Comparison

Benefit comparisons across sources of coverage can be complicated by different factors and therefore should be interpreted with caution. Determining whether an individual has access to certain services is more complicated than knowing whether a benefit is covered. For example, cost-sharing requirements and utilization management practices (including prior authorization requirements) may be designed to encourage or discourage use of certain services.¹⁴ Comparisons raised in this chapter should be considered along with the limitations described below.

Scope of coverage. Even though our analyses reflect when a benefit is offered, data are not

available on other policies that affect the extent to which a service is actually available. Each source can define the scope of coverage or can limit how much of a service an individual is entitled to receive. Benefits can be limited to an aggregate value, number of visits, or duration of time. For example, the CHIP program in New York makes physical therapy services available within a certain time limit, while the benchmark plan allows up to a certain number of visits per condition. Notwithstanding this limitation, CHIP programs tend to apply fewer benefit limits for certain benefits than exchange plans (Bly et al. 2014). Medicaid programs may apply benefit limits within federal parameters, but could be required to provide services beyond these limits as part of the EPSDT benefit if the services were considered medically necessary.

Medical necessity. Determinations of medical necessity can affect use of services even when a benefit is considered covered. Medicaid, CHIP, employer-sponsored plans, and exchange plans all have the ability to limit coverage so that it is only available when medically necessary. For example, a plan might require that a physician prescribe physical therapy before an individual can access that benefit. On the other hand, medical necessity can also be used to expand benefits (IOM 2012).

Individuals may be eligible for non-listed services deemed medically necessary (typically by a doctor or health care provider) if coverage documentation does not specifically exclude these services. In other cases, individuals can appeal for additional benefits beyond established limits by claiming that services are medically necessary, for example, when an individual's need exceeds plan limits. Although there is no national standard for medical necessity (IOM 2012), many determinations of medical necessity are assisted by nationally recognized software programs that rely on clinical standards to guide their determinations.

Benefit categories. The analyses presented in this chapter consider benefit categories rather than individual benefits. Benefit category descriptions often lack specificity that would be useful in making comparisons across sources of coverage. For example, we have compared coverage of autism services, and in doing so, we relied on states' essential health benefit benchmark summaries that specifically note that this coverage is included.¹⁵ However, the range of services used to treat autism is broad, and can range from social skills building to treatment planning; it includes physical, occupational, and speech therapies as well as other services.¹⁶ Our data sources do not say specifically what services are included within the category of general autism services, and benefits in this category could vary widely by state, coverage program, and health plan.

Possible Approaches for Addressing Comparability of Benefits

There are several ways to structure policy options for closing the benefit gaps described above so that children transitioning from separate CHIP to other sources of coverage would not face less generous coverage in the future. Some options would increase costs for federal government

alone, while others would also increase costs for state governments and enrollees, including those who receive premium tax credits and those who pay full premiums in exchange plans. Policymakers will have to weigh these costs with the comprehensiveness of coverage available in publicly subsidized programs and employer-sponsored insurance. In the months ahead, the Commission will examine a range of policy options, such as those described below, in greater depth for their feasibility, complexity, and implications (including additional costs) for children and families and for federal and state governments.

Change the essential health benefit definition of pediatric services. Essential health benefit regulations require that pediatric services include at least dental and vision services. But the statute and regulations do not limit pediatric services to these two benefits. The Secretary of the U.S. Department of Health and Human Services (the Secretary) could choose to reevaluate the definition of pediatric services, and in doing so, consider including in the definition some specific benefits that are more frequently covered by CHIP than exchange plans (e.g., audiology services).

Establishing additional benefit requirements for the pediatric services essential health benefit could provide more comprehensive coverage for children in individual and small group plans, including exchange plans. In particular, it could improve the comparability of coverage for children transitioning from CHIP to exchange plans, especially those children with frequent and ongoing health care needs that are beyond routine care in terms of scope and quantity. We note that providing additional coverage through the pediatric services essential health benefit would mean additional coverage for all children in the exchange because there is no way to target this policy option exclusively to children who were previously enrolled in CHIP. On the other hand, this policy option could be targeted to children with special health needs if the definition of pediatric services were to include medically necessary services for children with

such needs. This policy does not address concerns about the separate offering and additional cost of pediatric dental coverage because these services are already an essential health benefits requirement (see below).

This policy approach has implications for state and federal governments as well. States have the authority to regulate commercial insurance, although the ACA established a new paradigm of federal health insurance regulations for the individual and small group markets. New federal requirements would limit a state's authority and flexibility to define coverage available in that state. Additional benefits would also be likely to increase premiums for exchange plans, which would affect individuals purchasing exchange plans without federal subsidies. This option could also increase federal costs, because it would require the federal government to increase premium subsidies for individuals receiving them.

Provide states the option of establishing a pediatric-specific essential health benefits benchmark. All exchange plan benefits, whether offered in a general exchange plan or a child-only plan, are based on the same essential health benefit benchmark established by the state. This benchmark is modeled on a previously existing commercial plan. Policymakers could consider providing states the option of establishing a separate pediatric-specific essential health benefit benchmark in addition to their general essential health benefit benchmark, and allow states to select CHIP coverage (including Secretary-approved coverage) to serve as a pediatric-specific essential health benefit benchmark.¹⁷

A pediatric-specific benchmark could improve coverage available to children, although the impact would vary by state. States that define the benchmark to include additional benefits, such as audiology services or non-emergency medical transportation, could make their coverage more comprehensive relative to general essential health benefit benchmarks. On the other hand, this policy

would likely have no effect on access to dental coverage, which is already a required essential health benefit. This policy approach would also preserve state flexibility in defining the coverage available in each state, although it might not have an effect on pediatric coverage if a state chose not to implement a separate pediatric-specific benchmark.

Finally, a pediatric-specific benchmark could increase exchange plan premiums and therefore require increased federal subsidies. As previously noted, additional benefits would likely increase the premiums and subsequently increase federal spending on premium subsidies while reducing out-of-pocket spending for families in need of the newly covered benefits. This policy approach could also increase the administrative burden for states and the federal government.

Require all exchange plans to embed pediatric dental coverage. Although pediatric dental services is a required essential health benefit, plans are not required to offer the benefit if stand-alone dental plans are available in an exchange. Coverage for dental benefits was often separate from medical coverage in the individual market and employer-sponsored insurance prior to the ACA, and the decision to include stand-alone dental plans in exchanges preserves this market. Current policy could be changed to require all exchange plans to include dental coverage for children in their exchange offerings. California and Connecticut already require this in their state-based exchanges, although this is a new requirement for California, having just been implemented for the 2015 plan year. Some plans embed coverage by offering the benefit themselves, while other plans subcontract with a dental insurer to provide the benefit.

This policy would ensure that children enrolled in exchange plans have access to dental coverage. Embedded plans are eligible for premium subsidies, unlike stand-alone dental plans purchased in conjunction with a medical plan. Embedding dental coverage within a medical plan might increase the affordability of the coverage and increase

the likelihood that a family would secure dental coverage. The policy would affect all families purchasing coverage through exchanges, although it might be possible to target children who were previously enrolled in CHIP.

This policy approach would increase premium subsidies (for the same reasons as noted above), thereby increasing costs to the federal government. As with all federal mandates, this policy would limit states' ability to regulate insurance coverage. And it is unclear what effect, if any, this policy would have on the dental insurance market. Stand-alone dental plans offered through exchanges become irrelevant for children to some extent if all exchange plans include embedded pediatric dental coverage, although the market for adult dental coverage would remain.

Providing wrap-around coverage for benefits.

Medicaid wrap-around benefit coverage could be developed to provide benefits in areas where there are gaps. This policy option would allow Medicaid to provide wrap-around benefits to a primary source of coverage if a certain benefit were not covered. For example, Medicaid could pay for autism services if a child were enrolled in an exchange plan that did not cover these services. Models for wrap-around coverage exist within Medicaid and CHIP already, as discussed in Chapter 5 of this report. For example, young adults enrolled in the Arkansas private-option Section 1115 Medicaid waiver are covered by exchange plans, but they receive EPSDT benefit coverage through the state's fee-for-service Medicaid program.¹⁸

One of the challenges of this policy option is that it would impose additional administrative burden for Medicaid programs and exchange plans. Medicaid agencies and exchange plans would have to share eligibility information and coordinate which services would be covered by the exchange plan and which would be covered by Medicaid. This would also mean that children and families would have to go through two eligibility determinations in order to be eligible for both exchange plan and

Medicaid coverage. This option could also have implications for continuity of care, for example, if a provider were to participate in an exchange plan network but not in Medicaid.

This policy option would address the issue of gaps in covered benefits for children transitioning from CHIP to other coverage sources. While the option would make coverage more comprehensive for children, it would likely increase costs for states and the federal government. The magnitude of any cost increase is likely to be a factor of how comprehensive the benefit design of wrap-around coverage would be. For example, wrap-around coverage could be designed to provide specific benefits (e.g., audiology exams only), CHIP benefits, or Medicaid benefits, including EPSDT coverage. The policy could be designed to target families at certain income levels, but it might be more difficult to target this policy based on health needs.

This option would require changing the provision of current law that prohibits the receipt of exchange subsidies for those with Medicaid coverage.¹⁹ Some states have used Section 1115 waivers to provide wrap-around Medicaid benefits to exchange enrollees. Aside from these waivers, legislative action would be required to implement this policy option.

Augment existing exchange subsidies to include the cost of stand-alone dental plans. Increasing the amount of exchange subsidies available to individuals and families to include the cost of stand-alone dental plans could help families purchase dental coverage. This option is discussed in detail in Chapter 2.

Endnotes

¹ MACPAC has previously discussed the states' role in benefit design in CHIP programs and defining benefit standards for exchange plans (MACPAC 2014). For example, states can implement a Medicaid-expansion CHIP program in which federal Medicaid rules apply, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Essential health benefits do not apply to CHIP. For more information on benefit design, see Chapter 1 of the June 2014 *Report to the Congress on Medicaid and CHIP*.

² As with all benefits, there is variation in how states and plans describe coverage available within a benefit category. For example, some plans describe certain medical supplies such as glucose test strips or insulin syringes as disposable medical supplies, while others cover these supplies under prescription drug or durable medical equipment benefits.

³ The Cardwell et al. (2014) analysis did not examine the full scope of EPSDT benefits in separate CHIP programs. Less is known about how EPSDT is implemented within separate CHIP than in Medicaid.

⁴ States can define the breadth of Medicaid coverage (i.e., amount, duration, and scope) as long as it is adequate to reasonably achieve its purpose, although the state may limit coverage of a service based on criteria such as medical necessity or through utilization control measures. So while a benefit may be covered in a state, there is some variation in the amount of that benefit an enrollee can receive.

⁵ The ten essential health benefits are:

- (1) ambulatory patient services;
- (2) emergency services;
- (3) hospitalization;
- (4) maternity and newborn care;
- (5) mental health and substance use disorder services including behavioral health treatment;
- (6) prescription drugs;
- (7) rehabilitative and habilitative services and devices;
- (8) laboratory services;
- (9) preventive and wellness services and chronic disease management; and
- (10) pediatric services, including oral and vision care.

⁶ The four benchmark options, outlined in statute, are: any of the three largest small group plans offered in a state, any of the three largest health plans offered to state employees, any of the three largest health plans offered to federal employees, or the largest non-Medicaid HMO operating in a state.

⁷ Some research indicates that habilitative services are sometimes available under rehabilitative benefits (ASPE 2011b).

⁸ The regulation defines habilitative services as those which generally refer to health care services that help a person learn new skills and functioning for daily living (CMS 2015). These services could include speech, physical therapy, or occupational therapy designed to help an individual acquire new skills (CMS 2015). The regulation also prohibits plans from imposing habilitative benefit limits that are less favorable than any such limits imposed on rehabilitative benefits. For plan years beginning on or after January 1, 2017, exchange plans cannot impose a combined benefit limit on rehabilitative and habilitative benefits (CMS 2015).

⁹ California and Connecticut require that insurers embed pediatric dental coverage in their exchange offerings.

¹⁰ Four states (Colorado, Kentucky, Nevada, and Washington) have laws that require families and individuals to purchase dental coverage for children when it is not embedded within an exchange plan (Yarbrough et. al. 2015, Snyder et al. 2014).

¹¹ Families purchasing a second-lowest-cost silver exchange plan without pediatric dental coverage would need to pay an additional premium for stand-alone dental coverage, meaning their total premium costs would exceed the ACA's expected premium contribution amount for their income level. If families purchase an exchange plan with premiums less than the second-lowest-cost silver plan and there is any tax credit remaining after it is first applied to the cost of the exchange plan, then the tax credit can be applied to the cost of the stand-alone dental plan (45 CFR 155.340(e)).

¹² Some mandates may not apply to self-funded or self-insured plans, in which the employer assumes direct financial responsibility for employee claims. Covered workers in large firms (those with 200 or more employees) are more likely to be in a self-funded plan than covered workers in small firms (81 percent vs. 15 percent) (Claxton et al. 2014).

¹³ When the minimum value regulations took effect, it became apparent that employer-sponsored plans could meet requirements without covering inpatient care. More recent HHS regulations now require that such plans cover both hospitalizations and physician services (CMS 2015).

¹⁴ Cost sharing and affordability concerns are discussed in more detail in Chapter 2.

¹⁵ Essential health benefit benchmarks 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 essential health benefit definitions. As a result, actual coverage may vary from the essential health benefit benchmark used for comparison.

¹⁶ Some of the services used to treat autism spectrum disorders may also be used to treat other developmental disorders. Thus, the coverage of autism services may affect more families than those with children that have a diagnosis of autism spectrum disorder.

¹⁷ Under current law, states can choose the same plan to serve as the benchmark for their separate CHIP program and as the essential health benefit benchmark for exchange plans. However, there is not a separate benchmark specific to children, and current law does not allow states to choose Secretary-approved CHIP coverage, the most common benefit design in separate CHIP programs, to serve as the essential health benefit benchmark.

¹⁸ Arkansas and Iowa have waivers that provide premium assistance for adults to purchase exchange plans, and provide EPSDT benefits to 19- and 20-year-olds through fee-for-service Medicaid. For more information, see Chapter 5 of this report.

¹⁹ Individuals who are eligible for other insurance that qualifies as minimum essential coverage, such as Medicaid, are ineligible for subsidized exchange coverage (26 CFR 1.36B(c)(2)(B)).

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CHAPTER 4

Provider Networks and Access: Issues for Children's Coverage

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Key Points

- The adequacy of exchange plan networks for children has been a key feature of discussions concerning children who may move from separate CHIP programs to exchange plans if CHIP funds are exhausted during fiscal year 2016. At issue is whether such networks will be sufficient for the needs of these children. However, there is little research to determine whether network differences among Medicaid, CHIP, and exchange plans would significantly affect children's timely access to appropriate care.
- Network adequacy standards are one of many tools used to help ensure access to care. The design of provider networks must take into account the medical needs of children in different stages of development as well as the supply and distribution of providers who care for them. The needs of children with special health care needs, who comprise almost one quarter of CHIP enrollment, are also important to consider.
- Monitoring network adequacy is an important component of program oversight, particularly because plans across all payer types increasingly rely on narrow networks to control costs. Federal network adequacy requirements are similar for CHIP, Medicaid, and exchange plans, but specific monitoring activities vary.
- While plans and consumers look for adequate provider networks at a reasonable cost, plans face constraints in building their networks. For example, providers that are the only facility of their type in a region may demand higher rates than a plan is willing or able to pay. In addition, plans contracting with specialists who care for high-risk patients may attract a greater share of children with such needs, placing the plan at a financial disadvantage relative to plans with fewer such enrollees.
- Consumers need accurate information about networks to help them evaluate which networks are most likely to meet their needs and to inform them about the mechanisms for securing specialty care services when medically necessary.
- Ensuring network adequacy is an essential component, but not the sole component, in a strategy for making care accessible. Payers and issuers need other tools to ensure accessible care and for monitoring both process as well as outcome measures. More work needs to be done in order to develop appropriate access metrics and monitoring plans.
- MACPAC will continue to monitor network adequacy issues with a particular emphasis on children's access, measures of network adequacy, network transparency, and ways in which plans and payers can balance access, quality, and cost.

CHAPTER 4: Provider Networks and Access: Issues for Children's Coverage

Network adequacy and access to care affect the quality of health care received by all children, whether they are enrolled in Medicaid, the State Children's Health Insurance Program (CHIP), or exchange plans. If CHIP funding is exhausted in 2016, a projected 3.7 million children will lose their separate CHIP coverage. Of these, an estimated 1.4 million, or 36.5 percent, are likely to enroll in subsidized exchange coverage, as described in Chapter 1. Commission discussions on the future of CHIP have raised concerns about whether the provider networks used by exchange plans are adequate to address the health care needs of children enrolled in separate CHIP. Although we have little definitive evidence regarding network differences among exchange plans, Medicaid, and CHIP, we have identified a number of issues that must be weighed when considering the adequacy of provider networks for children in general and for children in exchange plans in particular.¹

Oversight of network adequacy is essential for ensuring access to care for an insured population. MACPAC began reporting findings about our research into network adequacy for children in its June 2014 *Report to the Congress on Medicaid and CHIP* (MACPAC 2014). We have extended this work by further analyzing children's health care needs, evaluating federal regulations on network adequacy, and convening a roundtable with experts in pediatric care and network adequacy. We have found a general lack of research on the adequacy of provider networks for children and a specific lack of information to answer the question of whether CHIP networks or exchange plan networks are better suited for children. MACPAC's work to date raises several key policy issues: how market conditions

affect issuers' ability to create networks, how to ensure appropriate access to specialty care, how to measure network adequacy, how to ensure network transparency, and how plans and payers can balance access, quality, and cost in network design.

Ensuring the adequacy of networks is a complex task and is one of the many tools that payers use to ensure appropriate access to care. In recent years, plans across all payer types have increasingly relied on narrow networks to control costs (Corlette et al. 2014a). Exchange plans are still relatively new, and not enough time has passed to examine network and access issues for children in these plans. At present, research is insufficient to definitively conclude whether differences among Medicaid, CHIP, and exchange plan networks are significant enough to affect children's access to care. To help fill this information gap, MACPAC convened an expert roundtable in late 2014 to identify the following: (1) the effects of provider network design and regulation on children transitioning between exchange plans, CHIP, and Medicaid; (2) strategies to ensure that provider networks are adequate to meet the needs of children; and (3) the appropriate balance between regulatory oversight and plan flexibility with regard to designing networks that balance access, quality, and cost of premiums. The roundtable discussion raised a number of issues, some of which we explore in this chapter; it also highlighted the need to collect additional information before making specific policy recommendations.

This chapter focuses on children who may move from CHIP to exchange plans if CHIP funding ends under current law.² The chapter presents MACPAC's analysis of network adequacy to date, informed by research into children's health needs and the regulation of networks as well as findings from the roundtable meeting. We begin by summarizing the health needs of children and how these relate to network design, and then provide information on the supply and distribution of providers for children. We then examine specific issues in designing and regulating provider networks in Medicaid, CHIP, and exchange plans.

Network adequacy and its effects on access are an important part of the discussion of the future of CHIP. Other entities, including the U.S. Government Accountability Office, the National Association of Insurance Commissioners, and the Office of Inspector General of the U.S. Department of Health and Human Services are currently engaged in the study of network adequacy and access to services. The Commission looks forward to the results of these efforts as well as others that can shed light on this important issue.

Network Composition Depends on Provider Supply and Needs of the Insured

Network design must balance two key factors: which providers are needed to ensure access for the insured population, and which providers are available and willing to contract with the health plan. These factors affect a health plan's ability to create a network at a cost that is acceptable to the plan, providers, and those paying premiums. Children's medical needs vary as they grow, and even relatively healthy children occasionally need access to pediatric subspecialists. Therefore, the medical needs of children, as well as the supply and distribution of providers who care for them, are relevant to the creation of adequate networks.

Children's health care needs

The unique characteristics of children's health care needs have been divided into four categories: (1) developmental change, (2) differential epidemiology, (3) demography, and (4) dependency (Forrest et al. 1997). There is also a need for a particular focus on children with special health care needs, who comprise almost a quarter of CHIP-enrolled children. Each category of characteristics has important implications for the adequacy of provider networks for children.

Developmental change. Childhood is a period of rapid growth and development, and therefore health services for children focus both on enhancing this development and on detecting and ameliorating conditions that can impede it and result in lifelong morbidity (Stille et al. 2010). In addition to treatment of illness and injury, access to primary care for children provides a venue for promoting normal development and to prevent and detect developmental delays. Children with identified or suspected developmental delays often need access to pediatric subspecialists who can assist in the diagnosis and treatment of conditions that contribute to these delays. In addition, children in different stages of development, from infants born prematurely to adolescents, have physiologic developmental differences that affect their need for subspecialty care. All these children can benefit from access to other health care providers—speech, occupational, and physical therapists, audiologists, and mental health providers.

Differential epidemiology. The epidemiology of disease in children differs significantly from that of adults, particularly for chronic conditions. Although roughly one-quarter of children have special health care needs, these needs represent many relatively rare conditions, such as neurological impairments or genetic disorders, spread throughout the population, with relatively fewer concentrations of specific conditions as compared to adults (Stille et al. 2010). But like adults, a small proportion of children accounts for the majority of child health costs in public insurance programs: 10 percent of children account for over 70 percent of the costs (Kenney et al. 2009). As a result, a given population of children can require access to a wide variety of pediatric medical and surgical specialists, and the need for different types of specialists is likely to vary over time.

Demography. In 2012, 22 percent of children under age 18 lived in poverty, compared with 14 percent of adults age 18 to 64 and 9 percent of adults age 65 and older (DeNavas-Walt et al. 2013). Children in low- and moderate-income families—those expected to churn between Medicaid, CHIP, and

exchange plans—are disproportionately from racial and ethnic minority groups (Harrington et al. 2014, Kids Count Data Center 2014a). Among children who had been enrolled in a CHIP program for at least 12 consecutive months, almost three-quarters were from racial or ethnic minority groups, compared to 47 percent of all children (Harrington et al. 2014, Kids Count Data Center 2014b).

Dependency. Because children depend on their families to navigate the health care system, the needs of low-income and minority families are important considerations in the creation of adequate networks for children. These considerations include the location of medical facilities near public transportation as well as cultural and language competency.

Children with special health care needs. Children with special health care needs require more medical care, often need more specialized care, and have higher expenditures than children without special needs. In the National Survey of Children's Health, determination of special health care needs is based on five questions that ask about children's ongoing use of medications, whether they use more medical, educational, or mental health care than other children their age, whether they receive ongoing therapy, and whether they have ongoing emotional, behavioral, or mental health problems.³ According to MACPAC's analysis of this survey, almost one-quarter of children likely to be covered by CHIP (probable CHIP-enrolled children) and one-quarter of children likely to be covered by Medicaid (probable Medicaid-enrolled children) reported special health care needs compared to 19 percent for privately insured children.⁴ The types of care that these children may require is an important consideration for network design.

Supply and distribution of health care providers for children

The design of provider networks for children must also consider the supply and distribution

of providers. The overall supply of primary care pediatricians per child more than doubled from 32 pediatricians per 100,000 children in 1975 to 78 pediatricians per 100,000 children in 2005, presumably offsetting any potential adverse effects on children's access to primary care resulting from a drop in the number of family physicians providing care to children (Freed and Stockman 2009). However, there is substantial geographic variation in the supply of primary care providers for children. The variation in the supply of primary care pediatricians and family physicians can be greater than 600 percent across local primary care markets, and an estimated 1 million children live in areas in which there are no local pediatricians or family physicians (Shipman et al. 2011). The geographic distribution of children's hospitals, where many children access pediatric specialists, is similarly varied.

Historically, the majority of outpatient specialty care services for children have been delivered by nonpediatric specialists; however, by the end of 2006, the percentage of office visits to pediatric subspecialists was nearly equal to the percentage of office visits for nonpediatric specialists (Freed et al. 2010a). It is likely that this trend has been driven by a combination of factors, including the increased availability of treatments and survival rates among children with complex and rare conditions that require training in pediatrics (Cohen 2011).

Most pediatric subspecialties are characterized by both extremely low numbers of practitioners and extreme geographic concentration. Many pediatric subspecialties include fewer than 1,000 physicians nationwide, and nearly all of these physicians practice in urban tertiary care centers (Mayer 2006). Similarly, inpatient care for children with chronic conditions is increasingly concentrated in children's hospitals (as opposed to community hospitals) (Berry et al. 2013). Even care for children with common conditions appears to be increasingly more concentrated in larger hospitals (Hasegawa et al. 2013, Lopez et al. 2013). This

trend toward consolidation may further exacerbate geographic disparities.

Despite the potential of nurse practitioners and physician assistants to augment the primary and specialty care workforce for children, research suggests that there is an insufficient supply of these providers caring for children to have a widespread effect on access to care (Freed et al. 2011, Freed et al. 2010b).⁵ At this time, reliable data about the supply and distribution of other providers who care for children, such as physical, occupational, and speech therapists, is not readily available.

The availability of dentists is also important to children's healthy development. Many children see general dentists, who can perform most of the care they require. However, children with complicated dental problems or special health care needs require access to pediatric dentists. Some states have explored teledentistry for areas with an insufficient supply of dentists. When a state allows teledentistry, dental hygienists are able to offer an expanded array of on-site services with off-site support from dentists, who are able to bill for their services.⁶ Other states allow dental therapists and dental hygienists to provide some services to Medicaid and CHIP enrollees (GAO 2010).⁷

Federal and State Regulation of Provider Networks in Medicaid, CHIP, and Exchange Plans

As discussed in MACPAC's June 2014 *Report to the Congress on Medicaid and CHIP*, federal network adequacy regulations are similar among Medicaid, CHIP, and exchange plans. Federal law makes CHIP managed care subject to the same federal regulations that establish standards for Medicaid managed care (§2103(f)(3) of the Social Security Act) (MACPAC 2014). Federal rules also govern minimum network adequacy standards

for exchange plans. These federal requirements are broad standards, however, and in many cases states establish substantially more detailed requirements for network adequacy. In addition, states running a state-based exchange can issue their own regulations that comply with federal network adequacy requirements. Similarly, states running a plan management partnership exchange can recommend exchange plan certification to the U.S. Department of Health and Human Services (CMS 2013b).

Network adequacy oversight and monitoring

Regulators can help ensure access by overseeing and monitoring network adequacy regulations. Methods of oversight and monitoring vary in CHIP, Medicaid, and exchange plans. The Centers for Medicare & Medicaid Services (CMS) recently issued new guidance for exchange plan issuers.

Medicaid and CHIP. Enforcement and monitoring mechanisms for Medicaid and CHIP network adequacy vary by state and include the state contracting process, requirements for managed care organization reporting, and federally required external quality reviews of network adequacy that must take place at least once every three years. However, plan reporting requirements vary widely, and several states do not validate plan data but instead allow for plan self-attestation (OIG 2014). The Office of Inspector General (2014) notes that typical review methods used by external quality review organizations include examining plans' policies and procedures and interviewing plan personnel. The Office of Inspector General has expressed concern that the low number of violations of access standards identified by states suggests that the access-verification strategies of states and external quality review organizations may be inadequate (OIG 2014).

Exchange plans. In final guidance for exchange plan issuers in the federally facilitated

marketplaces for the 2016 plan year, CMS stated that it will continue to use the “reasonable access” standard to identify networks that do not provide access without unreasonable delay as required by regulation (45 CFR 156.230(a)(2)). Each issuer will be required to submit detailed provider network data as part of the exchange plan certification application, including information on providers, facilities, and pharmacies. The letter also reminds plans that they must meet network adequacy standards continually throughout the year, not just at certification.⁸ CMS intends to monitor network adequacy throughout the year and mentions complaint tracking as one method for doing so. CMS also stated that it will use information about networks that it learns in the certification process to help develop future network adequacy standards (CMS 2015a).

Essential community providers (ECPs) are providers that primarily serve low-income and medically underserved individuals. Plan requirements for ECPs in 2016 will be similar to the ones in force in 2015: (1) plans must contract with 30 percent of available ECPs in their service area; (2) good faith contracts must be offered to all available Indian health providers in the service area; and (3) contracts must be offered to at least one ECP in each ECP category in each county in the service area, if an ECP in each category is available and provides services that the plan covers. If a plan cannot meet this standard, it must submit a narrative justification (CMS 2015a).

Because children's hospitals are just one of several ECP providers in the hospitals category, issuers are not required to contract with a children's hospital to meet these standards. Under the alternate standard, plans that use employed physicians or a single contracted medical group can meet the standard if 30 percent of their employed or contracted providers are in areas where 30 percent or more of the population is below 200 percent of the federal poverty level (FPL), or if they submit a narrative justification (CMS 2015a). The requirement to offer contracts in good faith

to available Indian health providers and at least one ECP per ECP category does not apply to these issuers (CMS 2015a).

CMS requires stand-alone dental plans to meet the same network adequacy standards that apply to exchange plans, except that stand-alone dental plans do not have to offer a contract to at least one provider in each ECP category in each county in the service area, because not all providers in all ECP categories offer dental services (CMS 2015a).

CMS published a final rule that also addresses several aspects of network adequacy in February (CMS 2015b). In this rule, CMS noted that it will wait until the National Association of Insurance Commissioners completes work on its Managed Care Plan Network Adequacy Model Act before proposing any significant change to network adequacy regulations for exchange plans. In the meantime, CMS will continue to use the reasonable access standard and urges state-based exchanges to do the same. The rule amended 45 CFR 156.230 to clarify that a provider network consists only of contracted in-network providers, meaning that available out-of-network providers cannot be counted towards satisfaction of network adequacy requirements (CMS 2015b). In the preamble to the rule, CMS also encouraged exchange plans that rely on a provider network to offer new enrollees the option of staying with their current providers for a transitional period of at least 30 days. CMS is considering whether regulations are needed for transitional periods (CMS 2015b).

The new rule also put in place new requirements for exchange plan provider directories, including a requirement to include provider details such as specialties, locations, and whether or not they are accepting new patients. Plans must update the directory regularly (the preamble suggests once a month) and make it accessible to the general public without requiring an account or insurance policy number. The rule also strengthens the ECP standard effective January 1, 2016 by specifying that entities described in Title X and 340B of the Public Health

Service Act are ECPs, whether or not they receive federal grants under that law (CMS 2015b).

Network design: Issues for plans and consumers

Health plans and consumers share the desire for contracted networks of conveniently located providers sufficient to meet patients' clinical needs at a reasonable cost. However, providers may not be located where needed, willing to contract at the offered rates, or accepting new patients.

Payers also have a strong interest in the networks. They would like to keep premiums low regardless of whether insurance is being purchased by an employer on behalf of its employees, by a state on behalf of Medicaid enrollees, or by an individual through the exchange. Many of the traditional mechanisms used by commercial health insurance issuers to lower premiums were limited or eliminated by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). These include denying policies to those with pre-existing conditions, increasing premiums based on health status, and excluding benefits such as maternity services or prescription drugs (Corlette et al. 2014b). This leaves provider payment and the design of provider networks among the few mechanisms left that issuers can use to lower premium costs, and this situation increases the tension between affordability and access. Specific challenges in network design and potential mitigations are summarized below.

Limited negotiating power. Plans may have less control over the number, type, and distribution of providers in a given network than network adequacy regulations may presume. For example, it may be difficult to contract with providers that are highly specialized or are the only facility of their type for a region, such as a children's hospital.⁹ These providers may have sufficient market power to be able to demand higher rates than Medicaid, CHIP, or exchange plans are willing or able to pay.¹⁰

In some cases, rules intended to promote access, such as the requirement that plans contract with ECPs, create their own challenges with respect to network design. Such providers are necessary for access in many low-income and medically underserved communities. However, some plans have characterized the ECP requirement as potentially harmful because it can distort market dynamics in communities with other available provider groups. As one plan representative at the roundtable said, "In my network, I have to contract with FQHCs because I wouldn't have a network otherwise."¹¹

To counterbalance areas in which they have limited negotiating power and still maintain a sufficient provider network that is affordable, insurers may seek to negotiate better payment rates where there is greater supply by contracting with a limited number of providers and negotiating lower fees in exchange for higher volume (Howard 2014). Narrow network designs also give issuers the opportunity to offer plans that include providers who meet specific access and quality benchmarks, although this does not currently seem to be a widespread practice (Corlette et al. 2014a, 2014b; Howard 2014). Insurers may also contract with alternate providers where possible, for example lower-cost community hospitals rather than academic medical centers, although these trade-offs may have consequences for patient satisfaction.

Provider unwillingness to contract. Even when sufficient specialists exist, some may not wish to contract with plans, regardless of payer, or will contract with an insurer but will not accept new patients. For example, Medicaid health plans have found that some providers do not want their names to appear in network directories because they do not want to attract large numbers of Medicaid patients. Others are willing to accept some Medicaid patients on a case-by-case basis but not as part of a network, but it is not yet clear whether this dynamic will also affect exchange plan network development. Provider unwillingness to contract has been a particular problem with dental

participation in Medicaid and CHIP, and access to these services is of particular concern for low- to moderate-income children. Dental participation rates in both Medicaid and CHIP remain low, although it is too early to measure dental provider participation in exchange plans (GAO 2010).

Providers consider comparative payment rates and administrative burdens when deciding whether to participate with a particular insurer. Health plans can improve provider willingness to contract by offering higher payments rates on a case-by-case basis or by implementing strategies to reduce the administrative burden on providers.

In addition, where insurers are unable to provide access to certain services or providers on a contracted basis, they must still have mechanisms to provide medically necessary covered services to enrollees. Health plans can develop single-case agreements with providers on an as-needed basis for specific patients as a necessary but imperfect method of ensuring beneficiaries' access to care. However, these agreements can be administratively difficult for plans and providers, and if the responsibility for requesting these arrangements falls to families, the arrangements can be burdensome to consumers as well.

Care coordination and emerging care delivery models could also ameliorate the effects of provider shortages and improve quality of care overall. When specialist supply is limited or not geographically accessible, plans and specialists can assist primary care providers in keeping care local, when feasible, by coordinating care, incorporating telemedicine, and providing training and direct consultative support to primary care providers. Traditional measures of network adequacy involving time and distance would need modification in order to capture these services.

Adverse risk selection. Plans that are successful in contracting with certain pediatric provider groups or subspecialists who care for high-risk, high-cost patients may find themselves at a financial

disadvantage if they attract high proportions of children with chronic conditions or specialty care needs.¹² Improvements to risk adjustment may be necessary to prevent undue financial burden on plans contracting with relatively high proportions of specialists. Conversely, there is also a concern that exchange plans, which are generally not designed for children, could discourage enrollment of children with special needs by not contracting with appropriate providers.

Accurate provider information. Consumer advocates highlight the consumer's need for information about network design—both when choosing a plan and when choosing a provider. Both decisions may affect access. Plans with narrow networks may be less costly, but may exclude certain providers. And consumers can have difficulty predicting the types of providers their families will need in a given year or how much medical care they will consume. Some consumers balance the competing elements of cost and network design when choosing a health plan. Others are specifically interested in picking a plan based on whether its network meets their predicted health care needs.

Provider directories, whether printed or online, are currently the only source of information for consumers about available providers. Keeping such directories accurate can be challenging as providers enter or leave a network or close their practices to new patients at various points throughout the year. Providers may not update plans about their participation or availability to accept new patients, and not all plans publish updates as timely as consumers would prefer. Moreover, directories may not be sufficiently detailed, for example, they might not provide information on specialized expertise with certain conditions. Thus, directories are not a panacea; consumers are likely to need additional information and assistance from plans, states, and advocates to understand whether the provider network in a plan will meet their needs.

Network Adequacy Does Not Equal Access

While network adequacy is an essential component of access, it is not the only component—ensuring access requires other strategies as well. Networks that are deemed adequate based on the likely needs of the covered population may not actually ensure access to timely, integrated care for patients with special health care needs. Although narrow networks might impose limits on consumer choice and access, broader networks and their sometimes higher premiums do not guarantee access or quality of care. In order to determine whether network adequacy standards are effective, payers and issuers need other tools to ensure accessible care and must monitor both process and outcome measures. These tools might include the following:

- examining claims, Healthcare Effectiveness Data and Information Set (HEDIS), or Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores;
- monitoring the number of appeals and grievances filed and how they were resolved. This can also provide a measure of enrollees' ability to access care (including consumer complaints and complaints from advocacy organizations); or
- conducting secret shopper surveys, in which state or plan staff call practices to assess whether the practice is taking new patients, how long it takes to get a new appointment, and other measures of access.

More work needs to be done in order to develop appropriate access metrics and monitoring plans. The types of approaches described above have the potential to be effective in pinpointing access issues, but they can also be resource intensive and cost prohibitive for states or plans to conduct on a routine basis. In addition, when considering access for children, existing child-specific case-

mix adjustment methods must be strengthened to account for underlying differences in the health status of enrolled populations. Only then can outcome measures be reliably used to assess the adequacy of access to care for children. Thus, purchasers will need to ensure that effective and appropriate tools are developed, selected, and implemented. This may be challenging for Medicaid and exchange plans, which are governed by both state and federal rules.

Conclusion

Network design is a critical part of access. Consumers depend on states, plans, and the federal government to enforce minimum standards so they can understand the insurance products they purchase and inform themselves about the trade-offs between cost and broadness of networks. Because a significant portion of probable CHIP-enrolled children report special health care needs, access to pediatric subspecialists will likely be important for their care. Regional concentration of specialists can exacerbate access issues, so careful consideration of network adequacy requirements is needed to ensure that those who require pediatric subspecialists can access them in a timely and efficient manner.

Our understanding of network adequacy will continue to evolve as more information about provider participation in exchange plans becomes available. MACPAC will continue to monitor network adequacy issues with a particular emphasis on children's ability to access specialty care, the development of meaningful and accurate measures of network adequacy, network transparency, and how plans and payers will balance access, quality, and cost.

Endnotes

¹ One small piece of evidence regarding network similarities is the extent to which issuers of separate CHIP programs using managed care also issue exchange plans. This varies by state. In Utah, all separate CHIP issuers also participate in the exchange. In 18 states, there is some overlap, and in six states, there is no overlap (Kanchinadam 2014, NASHP 2014). Even though benefits, cost sharing arrangements, and providers can differ among plans offered by the same issuer, the fact that the plans are administered by a common issuer may be beneficial for children transitioning between programs.

² The outcome of *King v. Burwell*, heard by the Supreme Court in March 2015, will also affect children's eligibility for coverage if CHIP ends under current law. At issue in this case is whether federal tax subsidies for coverage purchased through exchanges established by the federal government are permissible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

³ MACPAC analysis of the National Survey of Children's Health 2011-2012.

⁴ In its analysis of the National Survey of Children's Health, MACPAC sought to identify children likely to be covered by CHIP by using separate CHIP income levels to distinguish among children at higher and lower family income levels in states with separate CHIP programs. This analysis divided children identified as having respondent-reported Medicaid or CHIP coverage into those whose family incomes were above the Medicaid threshold and those whose family incomes were below. This threshold differs by age group in most states, with older children needing to have a higher percentage of the federal poverty level than younger children. For example, in Alabama, children under age 6 with respondent-reported Medicaid or CHIP coverage who lived in families below 133 percent FPL were assigned to the probable Medicaid category; children under age 6 with respondent-reported Medicaid or CHIP living in families above 133 percent FPL were assigned to probable CHIP. Respondent children from Alabama age 6 or over in families below 100 percent FPL were assigned to probable Medicaid; children from Alabama age 6 or over living in families above 100 percent FPL were assigned to probable CHIP. This method allows for a crude comparison

of utilization and access between children likely to have Medicaid and those likely to be covered by their state's separate CHIP program. Children in states with no separate CHIP program who reported Medicaid or CHIP coverage were all assigned to the probable Medicaid group.

⁵ The Public Health Service Act, as amended by the ACA, stipulates that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law," but it does not require a health plan to contract with any willing provider and does not prohibit varying reimbursement rates (§2706(a) of the Public Health Service Act). A U.S. Department of Health and Human Services interpretation of this provision states that plans are not required to accept all types of providers in their networks (CMS 2013a). Insufficient data exist to clarify the effects of this provision on the participation of other medical professionals in qualified health plans at this time.

⁶ For example, see California Assembly Bill Number 1174, signed into law on September 27, 2014.

⁷ The ACA authorizes demonstration projects to train alternative dental health care providers for the purpose of increasing access to dental care in rural and underserved communities (§5304 of the ACA, codified at 42 U.S.C. 256g-1). These projects have not yet been funded.

⁸ While up-front assessment of network adequacy is important, these assessments are not necessarily valid throughout the plan year. Ongoing monitoring is important because providers enter and leave networks throughout the year.

⁹ One additional concern is that if a plan does not contract with a children's hospital, enrollees may not have access to the hospital's employed physicians.

¹⁰ The Supreme Court heard oral arguments in *Armstrong v. Exceptional Child Center* in January 2015. At issue in this case is whether Medicaid providers may sue a state to enforce federal Medicaid payment law (42 U.S.C. §1396a(a)(30)(A)) when Congress did not create an enforceable right under that statute.

¹¹ Federally Qualified Health Centers (FQHCs) are a type of ECP.

¹² Not enough is known about whether children treated by pediatric subspecialists have better outcomes. For example, studies suggest that children with asthma and those undergoing surgery have better outcomes when treated by pediatric subspecialists, but the evidence on quality outcomes with other medical subspecialists is inconclusive (Mayer et al. 2009).

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CHAPTER 5

Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market

Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market

Key Points

- Premium assistance—the use of Medicaid funds to purchase private market plans—is one approach that states may use to expand the program to previously ineligible, low-income adults. Arkansas and Iowa are using premium assistance to purchase plans on the exchange through Section 1115 research and demonstration waivers, and other states have expressed interest in this approach.
- States cite various rationales for considering premium assistance, including easing the transition from Medicaid to exchange plan eligibility and improving access to care by enrolling individuals in private market plans. Additionally, relying on the private market could enable states with limited managed care or provider capacity to serve the influx of new enrollees. States also point to the potential for Medicaid enrollees to substantially increase enrollment in the exchanges, which in turn could improve the risk pool and encourage issuer participation.
- Under premium assistance, state Medicaid programs do not retain authority over many aspects of care, which they would oversee under most Medicaid managed care contracts. Instead, they are essentially buying coverage in a separate system that was not specifically designed for a Medicaid population.
- While the approved premium assistance waivers retain certain protections for exchange plan enrollees—including retroactive coverage, benefit appeals rights, and exemptions for medically frail enrollees—they have notable differences from traditional Medicaid. For example:
 - Enrollees will no longer be entitled to non-emergency medical transportation in Iowa, although Medicaid will continue to provide certain benefits not covered by exchange plans, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for young adults in both states.
 - Iowa and Arkansas also are instituting new approaches to cost sharing that could affect enrollment and utilization, although Medicaid's limit to 5 percent of income remains in force.
- Federal policy requires Section 1115 waivers to be budget neutral, which means that federal Medicaid spending must be equal to or less than it would be without the demonstration. Whether states actually achieve budget neutrality will depend on the costs of coverage, the health of the population that enrolls, and the interactions with other federal programs.

CHAPTER 5: Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market

Premium assistance, or the state purchase of private market plans on behalf of Medicaid enrollees, is attracting interest as an alternative to expanding traditional Medicaid coverage to previously ineligible low-income adults.¹ After the U.S. Supreme Court ruling in June 2012 effectively made Medicaid expansion an option for states, two of the 28 states moving forward have taken this approach. Through Section 1115 research and demonstration waivers, Arkansas and Iowa are using Medicaid funds to purchase exchange plans for residents who are newly eligible for Medicaid.² While the premium assistance approach is not new to Medicaid, it previously has served a relatively small number of enrollees, with most programs covering fewer than 2,000 people and primarily those with employer-sponsored coverage (GAO 2010). The extension of premium assistance to the purchase of exchange plans raises a number of considerations for the program.

Medicaid has long served as a payer of last resort for low-income people who have limited insurance options, including families with children, pregnant women, individuals age 65 and older, and people with disabilities. However, with the extension of Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) to low-income adults, the majority of whom historically were excluded from the program, the role of Medicaid as a coverage source and a payer in the health care system has expanded. Estimates suggest that almost half of those gaining health insurance coverage in 2015 (relative to the pre-ACA baseline) are expected to enroll in

Medicaid and the State Children's Health Insurance Program (CHIP) (CBO 2014). With the movement of Medicaid enrollees into the exchange market through premium assistance, Medicaid will serve as a larger purchaser of coverage with the potential to alter exchange markets by broadening the risk pool and affecting premiums and competition.

The broader use of premium assistance also moves the program further away from a source or a negotiator of Medicaid-specific coverage toward more of a purchaser of private market coverage. While most Medicaid enrollees currently receive their benefits through private managed care plans, the contracts give states control over how services are provided and access is assured. Additionally, states have oversight authority and can require certain data reporting to ensure program integrity. In contrast, in the premium assistance approach, Medicaid agencies no longer have direct authority over the plans and are instead buying coverage in a separate system designed for a non-Medicaid population. This extension into the exchange market and the shift in the state agencies' role leads to a number of questions regarding the use of exchange plans to provide coverage for Medicaid enrollees.

While the approved waivers mostly maintain states' requirements to provide Medicaid benefits and cost-sharing protections to exchange plan enrollees, there are several notable differences from traditional Medicaid. These variations are not unique to the premium assistance approach as other states, such as Michigan and Pennsylvania, have secured waivers to test alternatives to a straight Medicaid expansion by altering their cost-sharing or benefit design. But as they are not purchasing exchange plans for Medicaid enrollees, they are not the focus of this chapter.

In the Arkansas and Iowa premium assistance waivers, there are some instances where Medicaid continues to provide benefits not covered by exchange plans, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19- and 20-year-olds. In other instances, benefits,

such as non-emergency medical transportation (NEMT), were waived and the enrollees will no longer be entitled to them. In terms of cost sharing, Medicaid's limit to 5 percent of income remains, but both states are instituting new approaches to cost sharing that could affect enrollment and utilization. Consumer protections, such as retroactive coverage, benefit appeals rights, and exemptions for the medically frail, remain in place in these waivers.

Moreover, while press accounts and discussions of premium assistance often focus primarily on its appeal to voters and legislators in some states, there are a number of other rationales that are driving interest in the approach. States cite the potential to smooth the transitions for individuals moving from Medicaid to exchange plan eligibility. States also have suggested that enrolling Medicaid-eligible individuals in private market plans with commercial provider networks will improve their ability to access care. States that have limited managed care or provider capacity may turn to the private market to serve the expanded Medicaid population. Finally, as mentioned, there is the potential for Medicaid enrollees to substantially increase enrollment in the exchanges, perhaps altering the risk pool and attracting additional issuers (Allison 2014, CMS 2014a, and CMS 2014b).

The expanded use and mandatory nature of the recent premium assistance models raise a number of important policy considerations and areas for monitoring.³ While it will be several years before the data are available that can provide a full assessment, raising questions now can help guide future analysis and evaluation. This chapter provides a brief overview of the history of the use of private plans in Medicaid and then lays out questions surrounding the use of premium assistance for the new adult group as well as the possibility of extending it further. Specifically, the chapter examines:

- differences between the use of managed care in Medicaid and the use of premium assistance to purchase exchange plans;
- reasons states might choose premium assistance to expand Medicaid;
- differences between Medicaid and premium assistance on benefits and cost sharing;
- protections that remain available to Medicaid enrollees;
- potential cost implications and effect on the broader exchange market; and
- the need for a thorough evaluation of this approach to expansion.

How Medicaid Managed Care and Premium Assistance Differ on State Oversight and Payment Policy

Medicaid has a long history of offering private insurance through managed care and premium assistance.⁴ However, while both approaches involve the purchase of coverage offered by private plans, there may be fundamental differences in terms of the state's oversight and management functions as well as the method for determining payments. The majority of Medicaid enrollees receive their benefits through private managed care plans, which contract directly with state Medicaid programs and must comply with state and federal Medicaid purchasing requirements. In contrast, in the premium assistance approach, states buy coverage through a separate system (such as the exchanges or employer-sponsored coverage) that was designed to serve a non-Medicaid population. Below we discuss the extent of the use of managed care compared to premium assistance, the varying degrees of oversight in each, and their differing methods for determining plan payments.

While a few states have been using managed care in Medicaid since the early years, many states instituted large expansions of Medicaid managed care beginning in the mid-1990s. As of fiscal year

2011, approximately half of Medicaid enrollees were in comprehensive risk-based managed care and 72 percent were served through some form of managed care arrangement (MACPAC 2014).⁵ Additionally, the vast majority of individuals made newly eligible for Medicaid in 2014 also are expected to obtain benefits under a managed care arrangement (Sommers et al. 2013). States have pursued the use of managed care for a number of reasons, including their belief that it provides better care coordination and improved program accountability for access and quality. By paying managed care organizations (MCOs) a set rate per member per month (or capitated payment), states can also capitalize on more predictable budgetary expenditures, while still maintaining program management and oversight (MACPAC 2011).

State contracts with MCOs establish the terms under which the plans will deliver services to enrollees and serve as a mechanism to enforce both state and federal standards. Although the terms of each contract are governed in part by federal rules, states have considerable flexibility in determining particular parameters within established guidelines. As such, there is variation among the states as to the specificity and complexity of contract requirements. For example, the plans are responsible for establishing and maintaining provider networks, but the states can stipulate certain network standards and must ensure that the networks meet minimum federal requirements in order to assure appropriate access. States also establish contract provisions relating to improved care and accountability. For example, states can require plans to assign each member to a primary care physician and to provide care coordination and management. Additionally, states can establish quality and performance standards and data collection and reporting requirements in order to monitor whether the plans are meeting the contract requirements. Finally, state contracts with MCOs describe the sanctions or other enforcement mechanisms states can apply if the contract terms are not met.

The direct purchase of private market plans through premium assistance has been relatively limited, despite having been permissible within federal requirements since the enactment of Medicaid. While many states have chosen to implement premium assistance programs, most have enrolled fewer than 2,000 people and generally have been limited to employer-based plans, as very few states have chosen to provide assistance for the purchase of individual policies. The low enrollment likely is due to three key factors. The first relates to eligibility—a limited number of Medicaid-eligible persons have access to comprehensive employer-sponsored coverage, and, prior to the ACA, it was difficult for many people to qualify for individual market coverage (GAO 2010 and GAO 2009). Specifically, many individual market plans were not required to cover comprehensive benefits and were allowed to exclude persons for a variety of reasons, including pre-existing conditions (Doty et al. 2009). Second, premium assistance requires states to make a determination of cost-effectiveness, meaning that covering an individual in an employer-based or other private market plan would need to cost the same or less than providing comparable coverage in Medicaid. In making this assessment, states also need to factor in the administrative costs of the program as well as any costs to wrap around benefits or cost sharing. Cost-effectiveness often was hard to achieve as the use of deductibles and higher cost sharing has increased in employer-sponsored plans (KFF and HRET 2014). In the individual market, plans typically had high premiums and deductibles because they had been rated based on a person's demographic, health, and other characteristics (Doty et al. 2009). Finally, the programs were complicated to administer, as states are required to provide wrap-around coverage for benefits that are not covered in the private market plan, cover the cost of any additional premiums and cost sharing, and complete an assessment of cost-effectiveness.

The ACA changed the insurance coverage landscape, making the use of premium assistance through the purchase of individual market plans

a more viable option. By mandating a core set of comprehensive benefits and setting a cap on out-of-pocket costs, as well as restricting the use of individual rating and discrimination based on preexisting conditions, many of the earlier obstacles to the purchase of individual market plans faded. The U.S. Department of Health and Human Services (HHS) issued regulations in July 2013 allowing for the enrollment of individuals eligible for Medicaid in plans in the individual market, including enrollment in exchange plans, under certain conditions (42 CFR 435.1015). While states can use existing statutory authority to enroll individuals into exchange plans, no state has done so in part because Section 1115 demonstration waivers allow them to test additional features, including mandatory enrollment of adults in the expansion group, imposition of higher cost sharing for some enrollees, restrictions on mandatory benefits, and changes to provider payment rules. Other states have expressed interest in using Section 1115 waiver authority for premium assistance demonstrations, although, as of January 2015, only Arkansas and Iowa have received approval for their waivers.⁶

Typically, state Medicaid agencies have direct oversight of the Medicaid delivery system through agreements with fee-for-service providers or contracts with MCOs (42 CFR 438.6).⁷ However, in both traditional employer-focused premium assistance programs and exchange plan-based premium assistance demonstrations, Medicaid is purchasing another source of coverage and does not directly contract with the insurers; therefore, Medicaid regulations do not apply. Employers (in the case of employer-sponsored insurance), state departments of insurance, and state or federal exchanges (in the case of exchange plans) all have roles in establishing insurance standards such as provider network composition, claims payment timeliness and accuracy, utilization management, financial solvency, and customer service. While these standards may or may not align with state and federal Medicaid rules, a state Medicaid agency could, in its role as purchaser, establish an independent relationship with the plans to institute such standards.

In addition, state Medicaid agencies that provide direct Medicaid or contract with MCOs have access to a variety of data for monitoring and oversight, including claims or encounter data, provider enrollment data, and payment and coverage policies, although there are limitations and timeliness concerns with these data. Medicaid MCOs are required to collect and report on enrollee and provider characteristics, including encounter data that detail enrollee service use (42 CFR 438.242). Medicaid programs that purchase exchange plans may not have access to the same level of information on service use, provider payment, or coverage and utilization management policies. The waivers require the memoranda of understanding (MOU) between the state Medicaid agencies and the exchange plans to include reporting and data requirements that are necessary to monitor and evaluate the premium assistance approach. Since no such MOUs have yet been made public, however, it is not clear what level of data access and oversight authority the Medicaid agencies will have. Additionally beyond these MOUs, the state department of insurance could require exchange plans to share data and performance information with Medicaid.⁸

Medicaid managed care and premium assistance coverage also differ in how they set payments to plans. Medicaid programs use a variety of methods to set capitation rates for their managed care plans, but all are required to pay rates within an actuarially sound range (42 CFR 438.6(c)). Among 20 states with comprehensive managed care highlighted in a recent report, 13 used an administrative process in which a specific rate is set by the state and offered to plans, 4 used a competitive bidding process, and 3 used a negotiation process (Courtot et al. 2012). Regardless of the approach, the capitation rate for a Medicaid managed care plan is based on the estimated cost of serving a specific population of Medicaid enrollees. In contrast, premiums for exchange plans and other private market plans are determined using the rating rules that apply to that market, and their prices reflect the cost of the entire population—both Medicaid and non-Medicaid—in that market.

Reasons States Might Choose Premium Assistance

Most accounts of the adoption of premium assistance have highlighted some states' desire to rely on a private insurance model to provide coverage for the Medicaid expansion population. This private market focus also aligns with the view held by some that Medicaid was designed for the most vulnerable and that the private market may better serve the majority of adults. However, there are a number of other compelling rationales for choosing an alternative approach to the expansion that relies on exchange plans beyond the appeal of purchasing a private market plan. They include: reducing churning between plans, improving access to providers, supplying a delivery system in states that do not otherwise have the capacity in their Medicaid program, and strengthening the exchanges by increasing the number of enrollees and participating issuers.

Due to changes in income and family circumstances, an estimated 6.9 million people are expected to move from Medicaid coverage to exchange coverage or vice versa each year (Buettgens et al. 2012). Referred to as churning, this movement between programs increases administrative costs and disrupts continuity of care (MACPAC 2013). Premium assistance may lessen the impact of churn because, if Medicaid-eligible individuals are enrolled directly into exchange plans, they can stay in the same plan even if their income increases and they lose Medicaid coverage. In Arkansas, enrollees have a choice of at least two exchange plans and the networks are required to be the same as those offered to non-Medicaid enrollees (CMS 2014a). In Iowa, enrollment currently is limited to one exchange plan or the state's Wellness plan, following the withdrawal of one of its carriers from the market (Iowa 2014a and CMS 2014b).⁹ If enrollees choose to remain with the same exchange plan as their Medicaid eligibility changes, and the transfer between Medicaid and exchange enrollment is

seamless, gaps in coverage resulting from system or other coordination issues that might occur in other states could be minimized. At this point, no data are available that would allow for the examination of changes in eligibility between programs and continuity of coverage, although historically, transitions between Medicaid and CHIP have resulted in gaps in coverage (Harrington et al. 2014).

There are other approaches to minimizing the impact of churn besides premium assistance. For example, states could require or encourage health plans to offer products across payers.¹⁰ By encouraging issuers to offer plans in both the Medicaid and exchange markets, disruption in coverage and discontinuity of care for enrollees moving between Medicaid plans and exchange plans could be minimized. The extent to which this will actually work depends upon whether or not the plans offered to the Medicaid population are the same as those offered to consumers using premium tax credits to purchase exchange plans. For example, if the networks are not the same in both plans, an enrollee might be forced to change providers when moving from Medicaid to exchange coverage, even if the individual stays with the same carrier. This same issue could arise in the premium assistance approach if the plans available to the Medicaid-eligible population are not the same as those available to the exchange-eligible population. An alternative option for mitigating the impact of coverage changes is to establish transition plans for individuals moving between coverage sources.¹¹

Another argument often made in support of premium assistance is that it will improve Medicaid enrollees' access to providers. Medicaid must provide enrollees with access to care comparable to that of the general population (§1902(a)(30)(A)). Through the use of premium assistance, the assumption is that the purchase of a commercial product, by definition, is providing this equal access. Additionally, states have suggested that, by paying higher commercial or commercial-like rates to providers through the exchange plans,

access will improve as a result (Allison 2014). Just one-third of physicians accept new Medicaid patients, with payment rates that are typically below commercial levels cited as a reason for low participation (Decker 2012). While payment rates are proprietary, there have been indications that exchange plans may pay higher rates than Medicaid, but lower than other private payers, such as employer-based coverage (Pittman 2013). When enrolling in an exchange plan, a Medicaid beneficiary could have more options for providers if there is a wide range of plans with robust networks to choose from. As mentioned, in the two existing waivers, enrollees are required to have the choice of at least two exchange plans, although, as noted above, currently only one exchange plan is available in Iowa (CMS 2014a and CMS 2014b).

There are yet little data to evaluate the extent to which premium assistance affects access, and despite regulatory protections, there have been reports of access and network limitations in both Medicaid and exchange plans.¹² For many services, Medicaid enrollees have access comparable to similarly situated adults with employer-based coverage, although there are areas for improvement (MACPAC 2012). (Comparisons to the individual market, which is most similar to exchange plan coverage, are not available.) Moreover, insurers often design exchange plans with narrower networks relative to other private plans as a cost-containment strategy, having few other options to limit costs with the ACA's prohibition on preexisting condition exclusions and rate setting based on health status (Corlette et al. 2014 and McKinsey 2013). As a result, in-network provider participation may be limited, and the cost sharing for out-of-network care far higher.¹³ While there is anecdotal information, in the form of complaints, about the narrow networks and lack of transparency around which providers are in- or out-of-network, there is limited evidence yet as to the overall impact of these things on access and utilization.^{14, 15} Beyond provider participation and network assessments, another measure of the adequacy of Medicaid and exchange plan coverage may be whether or not

enrollees are able to access the care they need in a timely fashion. Data made available through ongoing surveys of enrollees and comparisons across eligibility categories will be important to monitor whether access is a problem in Medicaid and exchange plans.

In addition to the potential to reduce churn and improve access, the use of premium assistance may be appealing for states because of constraints on existing Medicaid provider capacity and the composition of their exchange market. Specifically, in states where providers are unable to absorb the new patient population or in cases where there is limited or no managed care infrastructure, it may be difficult for a state to expand Medicaid using its existing provider network. Using exchange plans that may pull from a different provider pool could result in broader access for enrollees who otherwise may have difficulty finding a provider. Additionally, premium assistance may be attractive to states as a means of expanding the risk pool purchasing coverage in the exchanges. For example, in states where the uninsured population is lower income, adding the Medicaid-eligible population to the exchange market may help bolster enrollment. Depending on the composition of the population, this may improve the risk pool (for example, if the Medicaid population is younger than other exchange enrollees) and may encourage additional insurers to join the exchange.

How Medicaid and Premium Assistance Differ on Benefits and Cost Sharing

Certain federal Medicaid benefit requirements and premium and cost-sharing protections are not mandated in exchange plans. In approving premium assistance waivers, however, the Centers for Medicare & Medicaid Services (CMS) has said states must arrange with exchange plans to provide any necessary wrap-around benefits and

cost sharing, or seek to waive them (CMS 2013b). Because of these conditions, premium assistance involves more than the purchase of a commercial insurance plan and differs from traditional Medicaid in several ways described in greater detail below. It also is important to note that benefit and cost-sharing waivers are not unique to the use of premium assistance.

Comparison of benefits in Medicaid and exchange plans. Medicaid enrollees who come in through the new adult eligibility pathway are statutorily required to receive the alternative benefit package (ABP). The ABP must cover certain services, such as family planning services and supplies, and EPSDT services for children under age 21. It also must comply with mental health parity rules and provide the 10 essential health benefits (EHB) also required in exchange plans (42 CFR 440.345 and 42 CFR 440.347). In contrast, exchange plans are required to offer only the 10 EHBs, although the package includes benefits that are optional under traditional Medicaid, such as rehabilitative services (45 CFR 156.110). By choosing to define the ABP as the package covered by the exchange plans, states adopting the premium assistance approach to Medicaid expansion will either need to cover any missing benefits or secure a waiver of benefit requirements from CMS, in addition to the waiver of other provisions that may be required to provide exchange plan premium assistance.¹⁶

Medicaid includes benefits important to high-need, low-income populations that are unavailable in exchange plans. For example, EPSDT includes periodic screening services, such as a comprehensive physical exam including a health and developmental history as well as vision, dental, and hearing services. Under EPSDT, states also are required to provide any additional services that are medically necessary to diagnose, treat, correct, or reduce any conditions discovered, regardless of whether or not these services are covered in the state's plan (42 CFR 441.50-441.62). Both Arkansas and Iowa are required to wrap EPSDT benefits, meaning that each state will provide unavailable

services through their fee-for-service systems to those 19- and 20-year-olds enrolled in exchange plans. Enrollees will receive both an exchange plan insurance card and a Medicaid client identification number (CIN); information on how to use this number for wrapped benefits, as well as which services are covered directly through Medicaid, will be provided through the eligibility notice (CMS 2014a and CMS 2014b).¹⁷

States also must ensure that Medicaid enrollees have the necessary transportation to medical examinations and treatment (42 CFR 440.170(a)). This benefit is most often used to get to behavioral health (including mental health services and substance abuse treatment) and dialysis appointments (MJS & Company 2014). NEMT is not typically provided by commercial insurers and is important for Medicaid enrollees who may not be able to attend an appointment or face an increased financial burden if transportation is not provided (MACPAC 2012). Additionally, the lack of transportation may impact provider willingness to participate if large numbers of enrollees do not show up for scheduled appointments. Iowa secured a temporary, one-year waiver of NEMT and was required to evaluate the impact of the waiver on access to care (CMS 2014b). In its September 2014 request to continue the exclusion in year two, the state reported that enrollees are using services and therefore access has not been affected without NEMT. Even so, almost half (between 42 and 49 percent) of enrollees needed assistance, either from a friend or family member or through public transportation, to get to a health care visit in the last six months, and between 8 and 18 percent always needed assistance (Iowa 2014c). Despite the concerns these data raise regarding beneficiary access, CMS granted an extension of the NEMT waiver until July 31, 2015 to allow for additional data collection (CMS 2014b). Arkansas received approval for an amendment to require prior authorization for NEMT, but will continue to provide the benefit, when authorized, through its fee-for-service system (CMS 2014a).

States adopting premium assistance also must make other operational decisions regarding benefits, including the approach to wrapping benefits and how to educate consumers and providers about accessing services. While Arkansas and Iowa are providing wrap-around coverage through their fee-for-service systems, states also could carve out certain benefits, such as NEMT, and offer them through a managed care organization. Arkansas and Iowa are required to send enrollees details on the services covered outside the exchange plans as well as post the information on their states' Medicaid websites and provide the information through call centers and exchange plan issuers. Medicaid's prior experience with premium assistance yielded little information regarding individuals' access to wrapped benefits or the administrative process that ensuring access entails. As such, examination of these will be important in monitoring and evaluating these demonstrations.

Cost-sharing requirements in premium assistance

waivers. States adopting the premium assistance approach to expansion also are pursuing waivers of Medicaid premium and cost-sharing protections so that all enrollees pay something, even nominally, toward the cost of coverage.¹⁸

The notion of personal responsibility in the form of financial contribution resonates deeply with some policymakers, and the pursuit of financial responsibility among enrollees is not limited to the premium assistance approach to expansion.

States already can require certain groups of Medicaid enrollees to pay cost sharing, but are precluded from charging premiums for enrollees with income at or below 150 percent of the federal poverty level (FPL) (42 CFR 447.55). Per-service charges are limited to nominal amounts for individuals with income at or below 100 percent FPL and are prohibited for certain services (42 CFR 447.56(a)(2)). Additionally, all cost sharing (including premiums and per-service charges) incurred by members of a family is subject to an aggregate limit of 5 percent of the family's income, and the state

must have a process in place to track spending toward the limit that does not rely on documentation from the enrollee (42 CFR 447.56(f)).

While not fully aligning, a number of states have obtained waiver authority to alter the Medicaid premium requirements to be more consistent with exchange plan premium and cost sharing rules. For non-Medicaid exchange plan enrollees with household income less than 133 percent FPL, the expected contribution toward premiums is 2 percent of income (26 CFR §1.36B-3(g)(2)). In Iowa, beneficiaries with income between 100 and 138 percent FPL will pay \$10 per month.¹⁹ Premiums will be waived for all enrollees in the first year of eligibility and waived in subsequent years if enrollees self-attest to financial hardship or undertake certain healthy behaviors, such as a health risk assessment and an annual wellness exam (CMS 2014b).²⁰ The state will monitor who completes the assessment or exam through vendor and provider reports, claims submissions, and self-reports. Enrollees have the full year, plus a 30-day grace period, to comply. In future years, the state intends to add the ability for enrollees to earn financial rewards for completion of other healthy behaviors, such as a smoking cessation program (CMS 2014d).

States also are interested in testing different approaches to cost sharing that mimic private-sector practices, such as requiring enrollees to contribute a certain amount toward an account similar to a health savings account (HSA) that can later be used to pay for per-service charges. Arkansas has received approval for an amendment to its waiver for the use of Independence Accounts for those enrolled in exchange plans. Enrollees will be charged monthly contributions ranging from \$5 for those with income above 50 percent FPL to \$25 for those at 133 percent FPL (CMS 2014a). Technically, the amounts paid into the savings account will go toward copayments that are in line with existing Medicaid requirements; however, requiring monthly payments regardless of service use is similar to charging premiums,

although enrollees cannot be denied eligibility for nonpayment.

Both states are limiting enrollee exposure to out-of-pocket spending. In Iowa, the state will be charging premiums in lieu of other cost sharing (except for a copayment for non-emergency use of the emergency department). Additionally, individuals who participate in healthy behaviors will be exempt from premium payments. Arkansas secured an amendment to its waiver to implement an HSA-like account. The approved amendment stipulates that no household shall pay more than 2 percent of income toward the monthly contributions and cost-sharing provisions are consistent with Medicaid requirements (CMS 2014a). In both states, the 5 percent of income aggregate cap remains in force.

There is a potential risk to these approaches, as increased cost sharing can discourage people from seeking coverage and needed care, and financial incentives for healthy behaviors have shown limited success. Specifically, studies have found that charging low-income families premiums depresses enrollment by serving as a barrier to both obtaining and retaining coverage (Snyder and Rudowitz 2013, Abdus et al. 2014, and Wisconsin 2014); and although per-service cost sharing has been shown to reduce the use of less-essential services, it can also serve as a deterrent to seeking needed care and may result in the use of more expensive services (Snyder and Rudowitz 2013 and Swartz 2010). Additionally, the use of financial incentives for healthy behaviors has had mixed results in other states (Blumenthal et al. 2013). Close monitoring of the impact of premiums and other cost sharing on enrollment, access, and utilization, as well as the use of incentives to reduce enrollees' financial liability, will help inform further demonstrations.

Protections Available to Medicaid Enrollees

A number of consumer protections are preserved in the existing premium assistance waivers, and while important, these provisions may complicate program administration and raise costs. Specifically, although there is no consensus on the most accurate approach, states must establish policies and procedures to identify medically frail individuals, who are exempt from enrollment. Additionally, retroactive eligibility for Medicaid is maintained, and, in both Arkansas and Iowa, enrollees will access benefits through Medicaid until enrollment in the exchange plan is effectuated. Finally, despite enrollment in private exchange plans, enrollees retain their grievance and appeals rights, although states may delegate certain appeal responsibilities.

Exemptions for people identified as medically frail.

States adopting premium assistance must identify medically frail individuals among those now eligible for Medicaid and give them the option of enrolling in the traditional Medicaid plan (42 CFR 440.315).²¹ States have discretion in determining how these individuals will be identified, which might include self-identification, provider identification, or a review of claims information by either the issuer or the state. In Iowa, there are three ways that an enrollee may become medically exempt—through a member survey, provider attestation or referral, or through a retrospective claims analysis (Iowa 2014d). In Arkansas, applicants are identified through a screening questionnaire or must seek a determination of medical frailty (CMS 2014a). There are concerns about self-identification as an approach to identifying the medically frail because self-reports of health status may be unreliable when individuals are seeking benefits, especially given the historic exclusion of coverage for preexisting conditions in insurance. There also are concerns about relying on claims analyses. If this analysis is left to the plans, there is a financial incentive to move those with certain conditions to

traditional Medicaid, regardless of whether or not they fit the criteria of medically frail.

Retroactive coverage. Medicaid coverage is effective as of the date of application or the first day of the month in which an application is filed, whereas exchange plan eligibility is prospective, meaning that, coverage will begin, at the earliest, on the first day of the next month (42 CFR 435.915 and 45 CFR 155.420(b)(1)). As such, there is a potential for misalignment in coverage effectuation dates. In addition, Medicaid coverage must extend three months retroactively if the individual would have been eligible during that time—a requirement that remains in place for the premium assistance programs in Arkansas and Iowa (42 CFR 435.915). This provision may protect beneficiaries from certain out-of-pocket costs by allowing medical care received prior to application to be covered by Medicaid, a benefit to the provider who saw these patients as well. As such, in a premium assistance approach to coverage, states may need to cover beneficiaries in their fee-for-service programs until exchange plan enrollment takes effect and also retrospectively. There is precedent for this as states using managed care or presumptive eligibility will typically cover individuals in fee for service while managed care enrollment or a full determination is effectuated. In both Arkansas and Iowa, enrollees are able to access benefits through Medicaid retrospectively and until enrollment in the exchange plan is finalized (CMS 2014a and CMS 2014b).

Appeal rights. Medicaid applicants and beneficiaries have a right to adequate notice and the opportunity to challenge an adverse state action before an impartial party. Enrollees also continue to receive treatment while an appeal is pending (42 CFR 431.200-250). In addition, Medicaid enrollees in managed care must have access to plan-level procedures to appeal decisions made by the MCO, for example, denial of a requested service (42 CFR 438.400-424). Standard appeals should be resolved within 45 days, but MCOs must have in place a process for expedited review (42 CFR 438.408-410). Exchange

plans, like all individual and group plans, are required to have an internal claims process as well as to give access to an external review process (45 CFR 147.136). While eligibility appeals across programs are required to be coordinated, there is no such requirement for denial of benefits or claims appeals (45 CFR 155.510). States may delegate certain appeal responsibilities to the department of insurance or another state agency. As such, while enrollees' Medicaid appeals rights are maintained, it is unclear who appeals should be directed to, if and how they will be coordinated, and who bears ultimate responsibility for adjudication. Therefore, enrollees' ability to navigate the appeals process will need to be monitored.

Cost Implications of Premium Assistance

A key question about premium assistance models are their cost compared to that of traditional Medicaid. Federal policy requires Section 1115 demonstration waivers to be budget neutral, meaning that federal Medicaid spending under the demonstration is equal to or less than it would be in that state without the demonstration.²² Whether or not that proves to be the case will be a function of several factors, including the costs of coverage, the population that enrolls, and whether the larger impact on federal spending is considered.

Using premium assistance to purchase private market plans—which, historically, have been more expensive than Medicaid, due in part to higher provider payment rates—would likely be more costly (Ku and Broaddus 2008). On the other hand, by continuing to serve medically frail individuals (those with the highest needs) in traditional Medicaid, it is more likely that the cost per person will be higher in comparison to those enrolled through premium assistance.

Additionally, providing Medicaid enrollees coverage through an exchange plan might be a cost-effective

approach if other factors, such as the composition of the exchange, are taken into consideration.²³ In the case of Arkansas, an additional 200,000 people who would have been covered in the Medicaid program are enrolled in exchange plans (Ramsey 2014). As a result, enrollment in the exchange substantially increased, which has the potential to lead to a healthier risk pool (ASPE 2014).²⁴ Additionally, if larger numbers of enrollees are expected in the exchange, more issuers may be interested in capturing a piece of the market, thereby increasing competition as they join. Finally, as a large purchaser in the exchange, Medicaid may be in a position to negotiate lower rates. These factors may lead toward lower premiums overall.²⁵

The impact on the broader exchange market suggested in Arkansas may not be the case for other states, in part due to the size and health status of the expansion group as compared to those enrolling in the exchange. In Iowa, only individuals between 100 and 138 percent FPL are enrolled in exchange plans, and an insurer participating in the premium assistance plan has reported that the population is higher cost than the company's other exchange business (Pradhan 2014). However, it is not known what impact this has had on the broader exchange market given the smaller share of enrollees the program represents.

The federal government currently is paying the full cost of coverage for newly eligible individuals in the adult expansion group, although this matching rate will begin to decrease in 2017, requiring a state contribution of 10 percent in 2020 and onwards. Therefore, the cost of exchange plan coverage, with the added expense of benefit and cost-sharing wraps—especially compared to traditional Medicaid on a per-person basis—is an important consideration for both states and the federal government as the merits of premium assistance are weighed.

Need for Thorough Evaluation

To date, premium assistance has never been attempted on such a scale, and this approach to coverage could be informed by a robust evaluation as required under the statute and regulations. Specifically, because Section 1115 waivers are experiments, pilots, or demonstration programs, they require evaluation (42 CFR 431.424). Important factors to consider in an evaluation of premium assistance include:

1. the extent to which the approach results in covering more individuals than would have been the case without the expansion;
2. the effect on access to care;
3. whether enrollees are able to access necessary benefits through a wrap, and the process for administering the wrap;
4. the effect on access to care from restricting the use of non-emergency medical transportation;
5. the impact of premiums, cost sharing, and incentives for healthy behaviors on enrollment and service utilization;
6. whether exchange plan enrollment eases transitions and improves continuity of coverage and care as enrollee income changes;
7. the accuracy of the medically frail exemption screening and the health of those enrolled in premium assistance compared to traditional Medicaid;
8. the larger effect on the exchange market in terms of competition and costs as a result of purchasing exchange plans for the Medicaid population; and
9. the overall costs to the state and federal Medicaid program and federal spending generally.

The terms and conditions of the waivers include evaluation requirements, although the specific research questions and design are settled through a subsequent approval process. States must submit an evaluation design plan that includes a discussion of the hypotheses, the data and methods of collection, how the impact of the waiver will be isolated, and a timeline (42 CFR 431.424). Updates on enrollment will occur earlier on in the evaluation process, with implementation updates and outcomes data coming later. Final reports will not be due to CMS until the end of 2017 and must be available publicly.

While not the only purpose, the evaluations will look at whether or not the waivers were cost effective in a manner that takes into account both the initial and the longer-term costs and implications, such as health outcomes. There also are specific research questions that the evaluations will be designed to answer, for example, whether premium assistance beneficiaries have equal or better access to care, fewer gaps in coverage, continuity of provider access, and satisfaction with services. Additionally, the evaluations will examine whether enrollees, such as young adults entitled to EPSDT, are able to access benefits through the wrap. In Iowa, the state will also investigate whether the lack of NEMT poses a barrier to access as well as the impact of premiums and the incentives for healthy behaviors (CMS 2014a, CMS 2014b, ACHI 2014, and IPPC 2014).²⁶

Neither the Arkansas nor the Iowa evaluation plan requires an examination of the effectiveness of their approaches to identifying the medically frail. However, Iowa is planning on examining the medically frail population to assess its access to care and detail the services provided that would not have been provided under the waiver, and Arkansas indicates that additional refinements may be made to its screening approach after data on the results and actual utilization become available (IPPC 2014 and ACHI 2014). Arkansas also has identified a number of supplemental hypotheses for future examination, including looking at the impact on the exchange market (ACHI 2014).

Additionally, Mathematica Policy Research has been awarded a contract by CMS to conduct a national examination of Section 1115 waivers.²⁷ Initially, the evaluation will examine implementation, primarily through the use of interviews and state documents, to assess the variation in state designs. The outcome focus of the evaluation will not begin until 2016, with public results likely in 2019. This portion of the evaluation will assess the differences in outcomes between premium assistance and traditional Medicaid in terms of take-up, access, quality, and spending (Irvin 2014).

As with all evaluations, there will be limitations on the strength and generalizability of their conclusions. Both states have unique characteristics that make it difficult to extend conclusions to the country as a whole. For example, Arkansas was a fee-for-service state prior to the expansion, which may lead to differing results when comparing costs to what would have occurred in a managed care state. Iowa chose to enroll only those who would have been eligible to enroll in an exchange plan if there was no Medicaid expansion (those with income between 100 and 138 percent FPL), limiting the population subject to the demonstration, although perhaps to one that is more similar to a commercial population. There also is the added difficulty of identifying and collecting data on an appropriate comparison group, which is especially acute in Arkansas given the state's low Medicaid eligibility thresholds prior to the expansion. Finally, isolating the effect of the premium assistance approach, or any other waiver feature, will be complex given the other payment initiatives (such as the State Innovation Models [SIM] grants) occurring at the same time.

Conclusion

The purchase of exchange plans for Medicaid enrollees is a new phenomenon, with coverage available in just two states since January 1, 2014. Therefore, little data are available to judge the

relative impact. Each waiver includes an evaluation that will provide a more thorough assessment of the approach, and there is widespread interest among the research and policy community more generally to have a better understanding of the impact of premium assistance. As such, while data currently may be limited, it is expected that more will become available given this broad interest.

A complete assessment of the questions raised here regarding the adequacy, continuity, and cost of premium assistance also will help to address whether its use should be broadened in Medicaid and CHIP. Of the 22 states that have not expanded Medicaid, some may seek alternative approaches. For example, the governor of Utah has proposed an expansion that would include the purchase of exchange plans for Medicaid enrollees (Utah 2014).

The premium assistance model also is relevant beyond newly eligible adults. For example, there have been discussions of the use of premium assistance in the exchanges for children now covered by CHIP.²⁸ The experience of Medicaid-eligible adults enrolled in exchange plans could help inform the viability of such an approach for children. In addition, beginning in 2017, states may seek innovation waivers to develop alternative approaches to meeting the ACA coverage goals. The plan must be at least as comprehensive and affordable as coverage under the ACA and cover as many residents, and it must not increase the federal deficit. Premium assistance also could play a role in these so-called super waivers.

Looking forward, MACPAC will continue to monitor the implementation of the premium assistance option in Arkansas and Iowa, as well as any additional states that choose such an approach, reporting on any available data regarding the impact of the waivers and the potential implications for Medicaid and the broader exchange market.

Endnotes

¹ The new adult group consists of non-elderly adults previously ineligible for Medicaid, specifically adults without dependent children with incomes at or below 138 percent FPL and parents with incomes above pre-ACA eligibility thresholds, but at or below 138 percent FPL.

² Arkansas is enrolling all adults in the new adult group in exchange plans, except for the roughly 10 percent of individuals who qualify as medically frail. Iowa is purchasing exchange plans for Medicaid-eligible individuals with incomes between 100 and 138 percent FPL who do not have access to cost-effective employer-sponsored insurance (those who would have been eligible to enroll in exchange coverage if the state had chosen not to expand Medicaid), with traditional Medicaid covering those in the new adult group below 100 percent FPL.

³ In traditional premium assistance models, enrollment could be mandatory or voluntary depending upon the authority under which the program operated and state policy. For example, under Section 1906A Health Insurance Premium Payment Programs, individuals could be required to enroll in employer-sponsored coverage if the option was deemed cost effective by the state. Under the 1115 waiver in Arkansas, enrollment in an exchange plan is mandatory except for enrollees who are medically frail. In Iowa, after one of the two exchange plans withdrew from the market, the state will no longer require enrollees with income above 100 percent FPL to enroll in an exchange plan as a condition of eligibility. Instead, enrollees will have a choice between the remaining exchange plan or the state's Wellness plan, designed for those in the new adult group with income up to 100 percent FPL.

⁴ Other instances of overlap between Medicaid and the private market exist. For example, Medicaid serves as the payer of last resort for individuals who have another source of coverage, as statute requires health insurers and other third parties, such as workers' compensation, to pay claims prior to the Medicaid program covering the cost of any care received by the enrollee. Medicaid also provides supplemental coverage for individuals, such as children, who have special health care needs but whose private plans do not provide the depth of benefits they need. Additionally,

Medicaid covers Medicare Part A and Part B premiums and cost-sharing expenses for certain groups of low-income Medicare beneficiaries through the Medicare Savings Programs (MSPs).

⁵ This includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs.

⁶ New Hampshire submitted a Section 1115 waiver request on November 20, 2014, to use a premium assistance model for its expansion beginning in 2016.

⁷ If the alternative benefit package is delivered through an MCO, states must comply with the managed care rules (42 CFR 440.385).

⁸ Both Arkansas and Iowa are operating in partnership with the federal exchange and maintaining plan management functions for the exchange plans sold. This oversight authority would likely enable the department of insurance to require exchange plan issuers to share additional plan data with the Medicaid agency (CMS 2014c and CMS 2013a).

⁹ CoOpportunity Health withdrew its participation in the Iowa waiver as of the end of November 2014. The enrollees covered by the issuer were transitioned to the Iowa Wellness Plan (the portion of the waiver covering those with income below 100 percent FPL not enrolled in exchange plans) as of December 1. New enrollees will have the choice of receiving coverage through the remaining plan, Coventry, or enrolling in the Wellness Plan. As of December 2014, CoOpportunity Health is no longer offering plans for non-Medicaid individuals in the Iowa exchange either (Iowa 2014b).

¹⁰ In Minnesota, for example, HMOs cannot obtain a license to sell private plans unless they are fully participating in Medicaid (Buettgens et al. 2012). Considerable overlap already exists between the exchange markets and Medicaid. For the 2014 open enrollment period, 41 percent of exchange plan issuers also operated Medicaid managed care plans in the states, although in 18 states there was no overlap in issuers (ACAP 2013).

¹¹ Another option is for states to establish transition plans for individuals moving between coverage sources. For example, Maryland recently enacted legislation that allows those with acute conditions or serious chronic conditions, pregnancy, or mental health or substance use disorders to

continue to receive services from an out-of-network provider for a limited time (Maryland Health Progress Act of 2013, H.B. 228). In 2015, Delaware will require its exchange plans to have transition plans for those who become eligible or lose eligibility for a public health program, which must include a transition period for prescription drugs (Delaware 2014).

¹² Medicaid must provide access to care comparable to that of the general population. Medicaid managed care plans must maintain a sufficient number, mix, and geographic distribution of providers and cover out-of-network services if the network is unable to provide them (42 CFR 438.206-207 and 42 CFR 438.52). Federal rules require exchange plans to offer networks that are sufficient in number and types of providers, including those that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay, but do not require an out-of-network option except in cases of emergency (45 CFR 156.230). They also must provide access to essential community providers (45 CFR 156.235).

¹³ With prior plan approval in both Medicaid managed care and exchange plans, it is possible to obtain care outside of the network if there is no in-network provider who can provide the specific benefit or services needed; however, seeking care out of network when there are in-network providers available is not an option in Medicaid managed care, although may be an option in some exchange plans (typically with higher cost sharing).

¹⁴ Arkansas is among the states that require insurance carriers to include all providers in their networks if they meet certain conditions (including accepting the plan's rates as payment), and as a result, plans in Arkansas may be less likely to have narrow networks (Noble 2014). Access to providers may unfold differently in states that do not have such a requirement.

¹⁵ There is also a question of how to compare the adequacy of networks. Typical measures of network adequacy include time and distance standards to providers, wait times for appointments, provider to patient ratios, and the inclusion of certain safety net providers. However, there are no consistent standards for these measures used across states, such as one primary care provider for every 100 enrollees. A recent HHS Inspector General (OIG) report found that state provider access standards for Medicaid

managed care vary widely and are not specific to the type of provider or area of the state (OIG 2014).

¹⁶ Access to out-of-network family planning services also is preserved. Specifically, if family planning services are sought from an out-of-network provider, the state's fee-for-service Medicaid program will cover those services. Premium assistance enrollees also must have access to at least one exchange plan that contracts with at least one federally qualified health center (FQHC) or rural health center (RHC).

¹⁷ Iowa requested a waiver of EPSDT for 19- and 20-year-olds in its expansion population, but it was not granted (Iowa 2013).

¹⁸ Under Section 1115 authority, the Secretary can waive premium requirements; however, Section 1916(f) sets limits on changes that can be made to cost-sharing provisions through a waiver.

¹⁹ The premiums in Iowa constitute about 1 percent of an individual's income between 100 and 133 percent FPL. Iowa's original approval letter restricted the state from imposing premiums that exceeded those in the exchange and the special terms and conditions specified that premiums could not exceed 2 percent of income (CMS 2013c). The waiver terms were revised, allowing for the imposition of \$10 monthly premiums (CMS 2014b).

²⁰ The hardship exemption in Iowa is only effective for the month requested and not for the entire year; however, enrollees are able to self-attest to a financial hardship each month.

²¹ Certain groups are exempt from enrollment in the ABP, an exemption that applies if a state adopts an ABP that does not align with the state's Medicaid program, including when the state is using an exchange plan premium assistance approach to coverage. Given that many exempt individuals may be eligible for coverage under another eligibility pathway (e.g., disability-related coverage), the exempt population most likely to be enrolled in the new adult group is the medically frail. The federal definition of medically frail includes individuals with disabling mental health disorders, chronic substance use, serious and complex medical conditions, a physical or mental disability that significantly impairs their ability to perform one or more

activities of daily living, or other special medical needs (42 CFR 440.315(f)).

²² While the actual cost to enroll the demonstration population in exchange plans is known, it is not possible to compare the cost to the same population enrolled in direct Medicaid coverage because that group did not exist prior to 2014 (and will not exist in states that enroll the entire expansion population in exchange plans). Therefore, CMS has allowed states to estimate costs for the expansion population, then adjust that limit if actual costs under the demonstration are higher than initially projected. In September 2014, the U.S. Government Accountability Office (GAO) raised concerns that this approach increases the risk that these demonstrations will not be budget neutral (GAO 2014).

²³ Under the regulations governing premium assistance in the individual market, the purchase of such coverage must also be cost effective (42 CFR 435.1015(a)(4)). This means that the total cost of purchasing such coverage, including administrative expenditures, the costs of paying all excess cost-sharing charges, and the costs of providing wrap-around benefits, must be comparable to the cost of providing direct coverage under the state plan. Both Arkansas and Iowa received waivers of this provision, although were required to establish an alternative method for determining cost effectiveness (CMS 2014a and CMS 2014b).

²⁴ Outside the Medicaid expansion population, the number of individuals who had selected an exchange plan in Arkansas between October 1, 2013 and March 31, 2014 was 43,446.

²⁵ While there is little evidence to this point, the Arkansas waiver suggests that the demonstration also will lead to more competitive premium pricing by doubling the size of the population enrolled (CMS 2014a). The idea of additional carriers joining the exchange market has been discussed by former Arkansas Medicaid Director Andy Allison (Allison 2014).

²⁶ Arkansas also is required to evaluate whether enrollees have appropriate access to NEMT. However, the amendment in Arkansas requiring the use of Independence Accounts did not require evaluation of the new cost-sharing approach, although it may be added into the evaluation plan at a later date.

²⁷ The evaluation is examining four types of Section 1115 waivers, including premium assistance and healthy behaviors/value-based purchasing initiatives as well as delivery system reform incentive payments (DSRIP) and managed long-term services and supports (MLTSS).

²⁸ For example, at its December 2014 meeting, the Commission discussed the use of a premium assistance approach to supplement the benefits and cost sharing for children who move from CHIP coverage to exchange plans following the expiration of CHIP funding.

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CHAPTER 6

Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care

Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care

Key Points

- Since its enactment in 1965, Medicaid has played a role in paying for some Medicare premiums and cost sharing for certain low-income Medicare beneficiaries.
- Today, almost 20 percent of Medicare beneficiaries receive assistance with Medicare premium or cost-sharing assistance either through one of the four separate Medicare Savings Programs or through full Medicaid benefits. This is valuable assistance with Medicare's out-of-pocket costs, as more than three-quarters of dually eligible beneficiaries have incomes below \$15,000.
- The Commission is concerned, however, that current Medicaid policies regarding Medicare cost sharing may reduce access to care for dually eligible Medicare beneficiaries relative to their non-dually eligible counterparts.
- Since 1997, the Medicaid statute has explicitly allowed states to pay less than the full Medicare cost-sharing amount if it would lead a provider to receive more than the state's Medicaid rate for the same service. And although Medicaid payment is only one factor that may affect access to care, new research conducted for MACPAC finds that paying a higher percentage of Medicare cost sharing increases dually eligible beneficiaries' likelihood, relative to that of non-dually eligible Medicare beneficiaries, of using selected Medicare outpatient services and decreases the use of safety net provider services.
- Additionally, the administrative complexity associated with processing claims can hinder Medicaid payment for cost sharing and contribute to access barriers for dually eligible beneficiaries.
- Current interest in redesigning Medicare's cost-sharing policies provides an opportunity to reexamine the roles of both Medicare and Medicaid in providing assistance for low-income Medicare beneficiaries.
- Changes to Medicaid's coverage of Medicare's out-of-pocket costs must be considered in conjunction with changes to Medicare payment and how revisions to either program would affect beneficiaries, providers, and federal and state budgets.
- Future Commission work will focus on eligibility and enrollment issues related to Medicare Savings Programs, and areas where Medicaid policy changes can improve access for low-income Medicare beneficiaries.

CHAPTER 6: Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care

Medicare and Medicaid together play a role in providing access to necessary health services for the 10.7 million low-income seniors and people with disabilities who are dually eligible for both programs (MACPAC 2014a). For these dually eligible individuals, Medicare is the primary payer for services such as physician visits, hospital stays, post-acute skilled care, and prescription drugs. State Medicaid programs wrap around Medicare's coverage, providing financial assistance in the form of payment of Medicare premiums and cost sharing (including deductibles and coinsurance) as well as benefits not covered by Medicare, such as long-term services and supports. Dually eligible beneficiaries are among the poorest and sickest individuals covered by either Medicare or Medicaid, and they rely on this joint coverage to meet their health care needs.

Despite successfully reducing beneficiaries' out-of-pocket health care costs, Medicaid's provision of benefits for low-income Medicare beneficiaries warrants further examination. One aspect to consider is whether certain policies regarding Medicaid payment of Medicare cost sharing may reduce access by creating disincentives for providers to serve people who are enrolled in both Medicare and Medicaid.¹ As a result of federal budget reconciliation legislation passed in 1997, the Medicaid statute allows states to pay less than the full Medicare cost-sharing amount if it would lead a provider to receive more than the state's Medicaid rate for the same service. For selected services in 2012, Medicaid fee-for-service (FFS) physician fees averaged 66 percent of Medicare

physician fees. This means that Medicaid payment for cost sharing associated with Medicare services provided to dually eligible beneficiaries is almost always less than what would have been paid for Medicare beneficiaries without Medicaid coverage (Zuckerman and Goin 2012).

Charged with assessing access and payment issues under Medicaid, MACPAC is responsible for examining the impact of this policy on beneficiaries, providers, states, and the federal government. While the lesser-of policy that allows states to pay less than the full Medicare cost-sharing amount may help states moderate spending, new MACPAC research, described in this chapter, concludes that the policy may create access barriers for dually eligible beneficiaries. There also are administrative difficulties with Medicaid's payment of Medicare cost sharing that warrant the attention of policymakers. For example, the processes used to pay Medicare cost-sharing amounts involve claims transfers between Medicare and Medicaid and, in some cases, duplicate submissions of claims that may be inefficient for both states and providers.

However, it is important to recognize that Medicaid's coverage of Medicare premiums and cost sharing for dually eligible beneficiaries reflects an evolving 50-year relationship between Medicaid and Medicare, and between the federal government and the states. Given the interconnected nature of the programs and their wide-ranging impacts, changes to Medicaid's coverage of Medicare's out-of-pocket costs cannot be considered in isolation, nor without an examination of how they would affect beneficiaries, providers, and federal and state budgets. Given current policy interest in redesign of Medicare's cost-sharing policies, it is the Commission's view that the role of both Medicare and Medicaid in providing assistance for low-income Medicare beneficiaries should be reexamined.

The Commission has a continuing focus on issues affecting dually eligible beneficiaries, including Medicaid's payment of Medicare cost sharing. In

its March 2013 report to Congress, the Commission examined Medicaid's role in covering Medicare cost sharing and documented states' payment policies. Here, we examine the effects of those policies on access to care. This chapter begins with a brief overview of Medicaid assistance for low-income Medicare beneficiaries, describing the legislative history of the Medicare Savings Programs (MSPs) and other relevant provisions. Next, it highlights findings from a new analysis conducted for MACPAC on the effect of states' Medicaid payments for Medicare cost sharing on dually eligible beneficiaries' use of selected outpatient Medicare services. It then reviews the administrative processes used to pay Medicare cost-sharing amounts. It concludes with a discussion of Medicaid's role in covering Medicare costs in an evolving health care system.

History of Medicaid Assistance for Low-Income Medicare Beneficiaries

Medicare's out-of-pocket costs can be a financial burden for low-income beneficiaries. In 2014, Medicare Part B's yearly deductible and monthly premiums together exceeded \$1,400 for most beneficiaries (CMS 2014a). Individuals dually eligible for Medicare and Medicaid are particularly vulnerable to these costs, as many of them have extremely low annual incomes. More than three-quarters (79 percent) of all dually eligible beneficiaries had an annual income less than \$15,000 in 2012 (CMS 2012). For the 10.7 million beneficiaries who were dually eligible in 2013, Medicaid is an important supplement to Medicare coverage.

When enacted in 1965, one of Medicaid's roles for dually eligible beneficiaries was to provide assistance with their out-of-pocket Medicare costs. At the time, Medicare had no means testing provisions, and Medicaid was the vehicle

for assisting those with low incomes. Over time, both programs have evolved, with Medicaid covering additional Medicare beneficiaries and costs, and Medicare implementing its own income-based policies.

Today, almost 20 percent of Medicare beneficiaries receive Medicare premium or cost-sharing assistance through the four separate MSPs or through non-MSP eligibility for full Medicaid benefits (MedPAC and MACPAC 2015). The MSPs are those for:

- qualified Medicare beneficiaries (QMBs);
- specified low-income Medicare beneficiaries (SLMBs);
- qualifying individuals (QIs); and
- qualifying disabled and working individuals (QDWIs).

This section discusses major milestones in the history of Medicaid's role in serving low-income Medicare beneficiaries, which highlights the importance of considering future changes in the context of both programs, as responsibility for coverage and financing of various benefits for this population have shifted over time (Table 6-1). It also highlights MSP eligibility criteria (Table 6-2). MACPAC's March 2013 *Report to the Congress on Medicaid and CHIP* provides more detailed information on the MSPs.

Original Medicare buy-in for beneficiaries receiving cash assistance. Since the inception of the Medicare and Medicaid programs in 1965, Medicaid has paid Medicare premiums for certain low-income Medicare beneficiaries. This is referred to as Medicare buy-in. In addition to Medicare Part B premiums, the original Medicaid statute also provided for payment of Part A and Part B deductibles and other cost sharing for dually eligible beneficiaries. Under this provision, states and the federal government jointly finance Medicare beneficiary premiums and cost sharing (beneficiaries overall currently pay 25 percent

TABLE 6-1. Legislative Milestones in Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries

1965	The Medicare and Medicaid programs were enacted as Title XVIII and Title XIX, respectively, of the Social Security Act of 1965 (P.L. 89–97). For low-income individuals entitled to both Medicare and Medicaid, the statute provided for Medicaid payment of Part B premiums as well as Part A and Part B deductibles and other cost sharing. However, it only allowed states to receive federal matching payments for Part B premiums paid on behalf of individuals receiving cash assistance through certain means-tested programs.
1967	The Social Security Amendments of 1967 (P.L. 90–248) prohibited federal financial participation for Medicaid services that could have been paid for by Medicare Part B if an individual had been enrolled.
1986	The Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) created the qualified Medicare beneficiary (QMB) program as a state option.
1988	The Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100–360) enacted provisions that required states to cover QMBs.
1989	The Omnibus Budget Reconciliation Act of 1989 (P.L. 101–239) created the qualified disabled and working individuals (QDWI) program and prohibited providers from billing QMB beneficiaries for any amount that exceeds the Medicare rate.
1990	The Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) established the special low-income Medicare beneficiary (SLMB) program.
1997	The Balanced Budget Act of 1997 (P.L. 105–33) created the qualified individuals (QI) program; provided states the option to pay the lesser of (1) the full amount of Medicare deductibles and coinsurance or (2) the amount, if any, by which Medicaid's rate for a service exceeds the amount already paid by Medicare; and specified that providers cannot bill beneficiaries for the difference between the Medicaid payment and the full Medicare cost-sharing amount when Medicaid pays less than the full amount of Medicare cost sharing.
2003	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173) established the Medicare Part D program and the Part D low-income subsidy (LIS) program, and also required higher-income Medicare beneficiaries to pay a higher percentage of the Part B premium.

Notes: This table includes legislative milestones relating only to Medicaid coverage of premiums and cost sharing for low-income Medicare beneficiaries. Legislation and provisions relating to other benefits and eligibility for these individuals are not included in this table.

Source: MACPAC 2013.

of per capita Part B costs, previously 50 percent when Medicare was enacted), and Medicare is the primary payer for Medicare-covered services (O'Sullivan 2004). The original Medicare buy-in only allowed states to receive federal matching payments for Part B premiums paid on behalf of individuals receiving cash assistance through certain means-tested programs. This group included the lowest-income Medicaid beneficiaries and excluded individuals with higher incomes, such as those who spend down to a medically needy

eligibility level through out-of-pocket payments for health care or who qualify at a higher eligibility level but contribute most of their income toward nursing home costs (Carpenter 1998).

QMB program for all individuals in poverty.

Under the Omnibus Budget Reconciliation Act of 1986 (OBRA 86, P.L. 99-509), Medicaid coverage of Medicare costs was expanded by way of the qualified Medicare beneficiary program. The QMB program now requires states to cover Medicare

Part B premiums, as well as Medicare Part A and Part B deductibles and coinsurance, for Medicare beneficiaries with incomes up to 100 percent of the federal poverty level (FPL) and limited assets. The QMB program also pays Part A premiums for beneficiaries who do not qualify for premium-free Medicare Part A. The QMB program is the largest of all the MSPs, enrolling 6.9 million individuals in 2013 (MACPAC 2014a).

OBRA 86 initially created the QMB program as a state option, but it became mandatory in 1988, through the Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360). When Congress made the QMB program mandatory, it did so under the assumption that the new costs of covering these individuals would be offset by decreases in Medicaid spending resulting from Medicare service expansions, including a prescription drug benefit. However, less than two years after its enactment, the Medicare service expansions of the MCCA were repealed. As a result, Medicaid's QMB expansion costs were not offset, and states faced an additional financial burden (Carpenter 1998).

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) also amended Medicare to prohibit providers from billing QMB beneficiaries for any amount that exceeds the Medicare rate, a practice sometimes referred to as balance billing. Later, the Balanced Budget Act of 1997 (BBA, P.L. 105-33) specified that providers cannot bill beneficiaries for the difference between the Medicaid payment and the full Medicare cost-sharing amount when Medicaid pays less than the full amount of Medicare cost sharing. As a result of these policies, providers may not receive the full Medicare rate (which is the sum of Medicare program payment plus the beneficiary cost-sharing liability) when serving dually eligible beneficiaries.

Expansion of coverage for working individuals with disabilities. OBRA 89 established the qualifying disabled and working individual program to allow people with disabilities who have incomes up to 200 percent FPL and limited assets to maintain

Medicare Part A coverage after returning to work. The QDWI program only pays for Medicare Part A premiums. It is the smallest MSP, enrolling fewer than 200 beneficiaries in 2013 (MACPAC 2014a).

Changes to cover premiums for additional beneficiaries through the SLMB and QI programs and reduce states' obligations for Medicare cost sharing. Medicaid's role in paying for Medicare premiums grew further through the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508). OBRA 90 created the specified low-income Medicare beneficiary program, which provides Medicaid coverage of Medicare Part B premiums for Medicare beneficiaries with incomes between 101 and 120 percent FPL and limited assets. In 2013, 1.3 million individuals were enrolled in the SLMB program (MACPAC 2014a).

Medicaid's role was again expanded in 1997 when the qualifying individual program was established in the BBA. The QI program requires Medicaid coverage of Medicare Part B premiums for Medicare beneficiaries who have incomes between 121 and 135 percent FPL and limited assets, and who are otherwise ineligible for Medicaid. In 2013, there were approximately 600,000 individuals enrolled in the QI program (MACPAC 2014a).²

The QI program was designed to have a minimal financial impact on states by providing them with 100 percent federal financing through capped allotments and the ability to impose annual limitations on the number of individuals enrolled in the QI program. If a state exceeds its allotted amount, it is fully responsible for payment of QI enrollees' additional Medicare Part B premiums. Funding is allocated yearly and is dependent on congressional appropriations and program reauthorizations (MACPAC 2013). Although states have sometimes run short on QI funds, allotments have been adjusted across states to mitigate any impacts, and the appropriation amounts have been increased over time (CMS 2010). Most recently, the Protecting Access to Medicare Act of 2014 (P.L. 113-93) extended the program until March 31, 2015.

In 1997, the BBA created one other financial protection for states by providing them with the authority to pay less than the full amount of Medicare cost sharing for dually eligible beneficiaries if the provider payment would exceed the state's Medicaid rate for the same service. This provision is discussed in further detail later in this chapter.

Transfer of responsibility for drug coverage from Medicaid to Medicare Part D. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also referred to as the Medicare Modernization Act, MMA, P.L. 108–173), primary responsibility for dually eligible beneficiaries' drug coverage shifted from Medicaid to a new Medicare Part D. However, states were required to maintain a financial contribution for dually eligible beneficiaries' drug costs in the form of phased-down state contributions (often referred to as clawback payments) to the federal government.

In addition, MMA for the first time created two income-related provisions in Medicare. The first required higher-income Medicare beneficiaries to pay a higher percentage of the Part B premium. (A similar policy was later extended under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) to Medicare Part D.) The second income-related provision established the Part D low-income subsidy (LIS) program, which helps pay for Medicare Part D premiums and cost sharing for low-income Medicare beneficiaries. Individuals participating in the QMB, SLMB, or QI MSPs and dually eligible beneficiaries who receive full Medicaid benefits through a non-MSP pathway are automatically eligible for the Part D LIS program.

Not all dually eligible beneficiaries qualify for MSPs. Although legislative changes have expanded Medicaid's original Medicare buy-in provision, states also pay for Medicare premiums and cost sharing outside of the MSPs. In 2013, 1.9 million Medicare beneficiaries received full Medicaid benefits, but had incomes too high to qualify for premium and cost-sharing assistance through a MSP. These dually eligible beneficiaries qualify

for Medicaid through pathways that include the medically needy option, the special income level option for institutionalized individuals, and home and community-based services waivers. States pay Medicare cost sharing for these individuals through the state's Medicaid plan, but may elect to pay only for Medicare services that are also covered by the state's Medicaid program (MACPAC 2013).³ For these beneficiaries, states may use their own funds to pay for Medicare premiums. Unlike the QMB, SLMB, QDWI, and QI programs, federal matching is only available under Medicaid for Medicare premium costs in these situations if the beneficiary is a recipient of cash assistance, including State Supplementary Payments and Temporary Assistance for Needy Families (OIG 2013a).

State Medicaid Payment Amounts for Medicare Cost Sharing

States are not obligated to pay the full amount of Medicare cost sharing if the provider payment would exceed the state's Medicaid rate for the same service. With the enactment of the mandatory QMB program in 1988, state Medicaid programs were required to pay for QMB Medicare cost sharing, but the law did not specify whether states were obligated to pay the full amount or only up to the state Medicaid rate. In 1991, the guidance issued by the Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services) allowed states to pay less than the full Medicare cost-sharing amount. As a result, providers brought lawsuits arguing that this guidance, and states' practice of paying less than the full Medicare cost sharing amount did not fulfill states' obligations under their Medicaid plans to pay for Medicare cost sharing for QMBs. Federal court decisions were mixed and created uncertainty with regard to how much states must pay for Medicare cost sharing (MACPAC 2013). However, as previously noted, in 1997, BBA granted

TABLE 6-2. Medicaid Eligibility and Benefits by Type of Dually Eligible Beneficiary

Type	Full or partial Medicaid benefits	Federal income and resource limits for eligibility (individual/couple) in 2014	Benefits	Number of beneficiaries in 2013 (millions)
Medicare Savings Program (MSP) beneficiaries				
Qualified Medicare beneficiaries (QMB)	Partial: QMB only	<ul style="list-style-type: none"> • At or below 100% of the federal poverty level (FPL) • \$7,160/\$10,750 	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part A premiums (if needed) • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program) 	1.4
	Full: QMB plus	<ul style="list-style-type: none"> • At or below 100% FPL • \$2,000/\$3,000 	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part A premiums (if needed) • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D) • All Medicaid-covered services 	5.5
Specified low-income Medicare beneficiaries (SLMB)	Partial: SLMB only	<ul style="list-style-type: none"> • 101%–120% FPL • \$7,160/\$10,750 	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part B premiums 	1.0
	Full: SLMB plus	<ul style="list-style-type: none"> • 101%–120% FPL • \$2,000/\$3,000 	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid • All Medicaid-covered services 	0.3
Qualified individuals (QI)	Partial	<ul style="list-style-type: none"> • 121%–135% FPL • \$7,160/\$10,750 	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part B premiums 	0.6
Qualified disabled and working individuals (QDWI)	Partial	<ul style="list-style-type: none"> • At or below 200% FPL • \$4,000/\$6,000 	Lost Medicare Part A benefits due to their return to work but eligible to purchase Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> • Medicare Part A premiums 	Fewer than 200 individuals

TABLE 6-2. (continued)

Type	Full or partial Medicaid benefits	Federal income and resource limits for eligibility (individual/ couple) in 2014	Benefits	Number of beneficiaries in 2013 (millions)
Non-MSP beneficiaries				
Other full benefit, dually eligible beneficiaries	Full	<ul style="list-style-type: none"> Income limit varies, but generally at or below 300% of the federal Supplemental Security Income benefit rate (about 225% FPL for an individual) \$2,000/\$3,000 	Eligible under a mandatory or optional Medicaid pathway, not eligible for MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> At state option, certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid All Medicaid-covered services 	1.9

Notes: Medicaid benefits for dually eligible beneficiaries are jointly financed by the federal government and states. Resource limits for QMB, SLMB, and QI are adjusted annually for inflation. Not all income and resources (e.g., the value of a house, vehicle, etc.) are counted toward limits. In addition, states may use less restrictive methodologies for counting income and resources and can eliminate asset tests, which enables them to expand eligibility above the limits shown here. Eleven 209(b) states may use more restrictive limits and methodologies when determining eligibility for full Medicaid benefits.

Sources: CMS 2014b; MACPAC 2014a; MedPAC and MACPAC 2015.

explicit authority to states to use the lesser-of policies. Since this time, states have had the option to pay, for a given Medicare service received by a dually eligible beneficiary, the lesser of (1) the full amount of Medicare deductibles and coinsurance or (2) the amount by which Medicaid's rate for the same service exceeds what Medicare has already paid (this amount is zero in cases where Medicaid's rate is lower than Medicare's payment).

MACPAC's March 2013 *Report to the Congress on Medicaid and CHIP* documents states' lesser-of payment policies. In 2012, 39 states chose to use lesser-of policies for at least one service type, which would lead them to pay less than the full Medicare cost-sharing amount when the payment rate for Medicaid is lower than for Medicare. While the number of states with lesser-of policies that allow them to pay less than the full Medicare cost-sharing amount has grown since 1997, a recent MACPAC examination of state websites indicates that there have been few changes since MACPAC's 2012 review.

Although the BBA allows states to achieve savings by paying less than the full amount of Medicare cost sharing, there is evidence that these policies reduce dually eligible beneficiaries' use of certain outpatient Medicare services. However, the magnitude and direction of this effect varies by provider and service type.

Analysis of the Effect of State Medicaid Payment for Medicare Cost Sharing on the Use of Certain Outpatient Services

While MACPAC documented state policies in its March 2013 report, it did not examine the effect of these payment policies on access to care at that time. More recently, MACPAC contracted with RTI International (RTI) to analyze the effects of

states' Medicaid payment policies for Medicare cost sharing on access to selected Medicare services for dually eligible beneficiaries with FFS coverage, including office-based and other outpatient evaluation and management (E&M), prevention, federally qualified health center (FQHC), rural health clinic (RHC), and psychotherapy visits (Haber et al. 2014a). These services were selected for analysis because they are considered indicators of realized access to primary care and other forms of outpatient services, and can be assessed using claims (Kennell and Associates 2011). Overall, outpatient services represent 30 percent of Medicare spending on FFS full-benefit dually eligible beneficiaries (MedPAC and MACPAC 2015). And they are important entry points into the health care system. The study did not look at the impact of lesser-of policies on provider participation, which can be considered another measure of access.

Data and methods. Medicare and Medicaid Analytic eXtract (MAX) enrollment and claims data from 2009 for beneficiaries with FFS coverage were examined to determine the association between the percentage of Medicare cost sharing covered by state Medicaid payments and utilization of selected Medicare outpatient services. The effect of cost-sharing payments on the likelihood that a dually eligible beneficiary used a particular service was estimated using multivariate analyses. Non-dually eligible Medicare beneficiaries served as a comparison group to control for other state factors that might influence utilization differences across states.

A total of 20 states were included in the analyses of E&M and safety net provider services, and 18 states were included in the analysis of outpatient psychotherapy services. Individuals enrolled in Medicare Advantage (MA) or comprehensive Medicaid managed care plans were excluded. (For complete study methodology and results, see Haber et al. 2014a.)

Findings: The relationship between state policy and actual payments for cost sharing. The study first

examined the average percentage of Medicare cost sharing covered by Medicaid payments for office-based E&M and outpatient psychotherapy visits. In all states examined, including those identified in MACPAC's earlier work as paying cost sharing in full, Medicaid payments in 2009 covered less than 100 percent of the full Medicare cost-sharing amount.⁴ In 2009, cost-sharing payments for office-based E&M services in full payment states ranged from 65 to 98 percent of Medicare cost-sharing amounts. In states that reported a policy of paying less than 100 percent of Medicare cost sharing (lesser-of policy states), cost sharing payments for E&M office visits ranged from 11 to 93 percent, with most states paying less than 50 percent of the cost sharing.

With few exceptions, Medicaid cost-sharing payment percentages were higher for office-based E&M services compared to outpatient psychotherapy services. In 2009, cost-sharing payments for outpatient psychotherapy in full payment states ranged from 15 to 71 percent. In lesser-of payment states, cost sharing payments for outpatient psychotherapy ranged from 2 to 70 percent (Haber et al. 2014a).

Findings: Effects of payment policies on the use of providers and services. The study then looked at the effects of the payment policies on access to health care providers and services. The analyses show that paying a higher percentage of Medicare cost sharing increased dually eligible beneficiaries' likelihood, relative to non-dually eligible Medicare beneficiaries, of having office and other outpatient E&M visits and using preventive services, but decreased their likelihood of using safety net provider services. Also, paying a higher percentage of Medicare cost sharing increased dually eligible beneficiaries' likelihood, relative to non-dually eligible Medicare beneficiaries, of receiving outpatient psychotherapy. For example, if Medicaid pays 20 percent of Medicare cost sharing, the predicted percentage of dually eligible beneficiaries with an office or outpatient E&M visit is 82.6 percent. However, if Medicaid pays 100 percent of Medicare cost sharing, the predicted percentage of dually eligible beneficiaries with an office or

TABLE 6-3. Predicted Share of Dually Eligible and Non-Dually Eligible Beneficiaries with a Medicare Visit at 20 Percent and 100 Percent Medicaid Payment of Medicare Cost Sharing

Type of Medicare visit	Predicted percentage of beneficiaries with a visit						Relative to non-dually eligible, predicted percentage point effect on share of dually eligible beneficiaries with a visit when moving from 20% to 100% Medicaid payment (difference in difference)
	Medicaid pays 20%			Medicaid pays 100%			
	Dually eligible	Non-dually eligible	Difference	Dually eligible	Non-dually eligible	Difference	
Any office or outpatient E&M	82.6	87.3	-4.7	84.8	84.2	+0.5	+5.3
Any office or outpatient E&M with PCP	64.9	74.4	-9.3	68.8	70.0	-1.2	+8.1
Any FQHC or RHC	7.7	3.6	+4.1	7.4	6.3	+6.3	-2.9
Any outpatient psychotherapy	3.7	2.1	+1.6	5.9	1.7	+1.7	+2.6

Notes: E&M is evaluation and management; PCP is primary care provider; FQHC is federally qualified health center; RHC is rural health clinic. Multivariate regression model results were used to predict utilization for dually eligible and non-dually eligible beneficiaries assuming the Medicaid payment percentages shown, with all other independent variables set to the average value of the study population. All predicted effects are statistically significant at $p < 0.05$ level.

Source: Haber et al. 2014b.

TABLE 6-4. Predicted Effects of Moving from Varying Levels to 100 Percent Medicaid Payment of Medicare Cost Sharing on the Share of Dually Eligible Beneficiaries with a Medicare Visit, Relative to Non-Dually Eligible Medicare Beneficiaries

Type of Medicare visit	Predicted percentage point effect on share of dually eligible beneficiaries with a visit when moving from lower percentage to 100% Medicaid payment of Medicare cost sharing, relative to non-dually eligible						
	Medicaid payment percentage for Medicare cost sharing						
	20%	30%	40%	50%	66%	80%	90%
Any office or outpatient E&M	+5.3	+4.6	+4.0	+3.3	+2.3	+1.3	+0.7
Any office or outpatient E&M with PCP	+8.1	+7.1	+6.1	+5.1	+3.5	+2.0	+1.0
Any FQHC or RHC	-2.9	-2.6	-2.3	-2.0	-1.4	-0.9	-0.4
Any outpatient psychotherapy	+2.6	+2.3	+2.0	+1.7	+1.2	+0.7	+0.4

Notes: E&M is evaluation and management; PCP is primary care provider; FQHC is federally qualified health center; RHC is rural health clinic. Multivariate regression model results were used to predict utilization for dually eligible and non-dually eligible beneficiaries assuming the Medicaid payment percentages shown, with all other independent variables set to the average value of the study population. All predicted effects are statistically significant at $p < 0.05$ level.

Source: Haber et al. 2014b.

outpatient E&M visit is 84.8 percent. Relative to non-dually eligible Medicare beneficiaries, this represents a 5.3 percentage point increase in the share of dually eligible beneficiaries with an office or outpatient E&M visit (Table 6-3). Presumably, beneficiaries' ability to access services in part reflects the providers' responses to payment amounts.

In addition, predicted utilization rates for Medicare services vary when moving from a range of Medicaid cost-sharing payment percentages (20, 30, 40, 50, 66, 80, and 90 percent) to 100 percent (Table 6-4). As expected, moving from 20 to 100 percent Medicaid payment of Medicare cost sharing had the greatest effect on utilization across all Medicare services examined. Moving from 90 to 100 percent Medicaid payment of Medicare cost had the smallest effect.

- **Evaluation and management services.** In 2009, relative to non-dually eligible Medicare beneficiaries, paying 100 percent of the Medicare cost-sharing amount, compared to paying 50 percent, increased the likelihood that a dually eligible beneficiary had any office or other outpatient E&M visit by 3.3 percentage points; for 100 percent compared to 20 percent, the increase was 5.3 percentage points. The findings also suggest that, in 2009, paying 100 percent of the cost-sharing amount, compared to 50 percent, increased dually eligible beneficiaries' likelihood of having a primary care physician visit by 5.1 percentage points; for 100 percent compared to 20 percent, the increase was 8.1 percentage points. However, it is unclear whether these results would differ in later years due to changes in Medicaid payment policy. During calendar years (CY) 2013 and 2014, all state Medicaid programs were required to raise to Medicare levels payments to primary care physicians for certain primary care services. This is referred to as the Medicaid primary care payment increase (CMS 2013a). (The Medicaid primary care payment increase is discussed in detail in Chapter 8.)
- **Preventive services.** Relative to non-dually eligible Medicare beneficiaries, the predicted percentage of dually eligible beneficiaries receiving a flu shot was 2.8 percentage points higher with 100 percent coverage of Medicare cost sharing, compared to 66 percent coverage, in 2009. A similar, but smaller, effect was noted for mammogram services. In 2009, 100 percent coverage of Medicare cost sharing increased the likelihood of female dually eligible beneficiaries receiving a mammogram by 0.8 percentage points, compared to 66 percent coverage and relative to Medicare beneficiaries.
- **Safety net provider services.** The analysis found that, in 2009, relative to non-dually eligible Medicare beneficiaries, paying 100 percent of the Medicare cost sharing amount, compared to 50 percent, decreased the likelihood that a dually eligible beneficiary had received care at a safety net provider by 2.0 percentage points; for 100 percent compared to 20 percent, the decrease was 2.9 percentage points. With regard to this finding, it is possible that dually eligible beneficiaries found it more difficult to access care from office-based providers when Medicaid paid a lower percentage of Medicare cost sharing (Rosenbaum and Shin 2011).
- **Cost sharing and the use of outpatient psychotherapy services.** Paying a higher percentage of Medicare cost sharing was associated with an increased likelihood that dually eligible beneficiaries received outpatient psychotherapy, relative to non-dually eligible Medicare beneficiaries. In 2009, relative to non-dually eligible Medicare beneficiaries, paying 100 percent of the Medicare cost-sharing amount compared to 50 percent increased the likelihood of a dually eligible beneficiary having any outpatient psychotherapy by 1.7 percentage points; for 100 percent compared to 20 percent, the increase was 2.6 percentage points. However, it is unclear whether

these results would differ in later years due to changes in Medicare payment policy. In 2009, the time period for the analysis, Medicare paid 50 percent of the Medicare fee schedule amount for mental health services. MIPPA gradually increased Medicare's payment of mental health services, and, beginning in 2014, Medicare paid 80 percent of the fee schedule amount, which is the same rate as for any other Medicare Part B claim (CMS 2009).

- **Number of visits.** Paying a higher percentage of Medicare cost sharing did not have a significant effect on the annualized number of outpatient E&M visits or safety net provider visits, among those already using those services. However, the annualized number of outpatient psychotherapy visits overall was greater at higher Medicaid payment percentages for Medicare cost sharing.

Results from this study are consistent with an earlier study that found that access to outpatient physician visits for dually eligible beneficiaries was reduced relative to non-dually eligible beneficiaries in states that limited their Medicare cost-sharing payment amounts (Mitchell and Haber 2003). However, neither of these two studies examined the effects of Medicaid payment policies for Medicare cost sharing on dually eligible beneficiaries' use of institutional providers, such as hospitals or nursing facilities. As discussed below, institutional providers may receive Medicare bad debt payments that help to offset unpaid cost-sharing amounts.

Administration of Payments for Medicare Cost Sharing

In addition to access barriers created by state Medicaid policies on Medicare cost sharing, inefficient billing processes for certain providers serving dually eligible beneficiaries may also limit access to care. Providers also cite patient non-compliance, delayed payments, and paperwork

requirements as other factors influencing their participation in Medicaid (MACPAC 2013).

Claims payment processes. Regardless of whether or not states have a policy to pay less than the full Medicare cost-sharing amount, procedures for state payment of Medicare cost sharing may vary depending on whether an individual is enrolled in Medicare FFS or a Medicare Advantage managed care plan. Among the 9.6 million dually eligible beneficiaries in CY 2010, 7.6 million were enrolled exclusively in FFS Medicare and 2 million were enrolled for at least part of the year in a Medicare Advantage plan. Of those in an MA plan, 1.5 million were in an MSP or full-benefit Medicaid category that made them eligible for Medicaid payment of Medicare cost sharing (MACPAC 2014b). The remaining individuals were eligible only for Medicaid payment of Medicare premiums.

Nearly all states have implemented automatic crossover systems for most types of Medicare FFS claims, which allow providers to submit a claim for a dually eligible beneficiary only to Medicare. Once the FFS claim is submitted, Medicare pays its portion and then automatically forwards the claim to the state to enable Medicaid to pay the deductible and coinsurance amounts. Automatic crossover systems are intended to minimize the need for providers to self-report Medicare claims data and improve the accuracy of Medicaid payments for dually eligible beneficiaries. However, these automatic systems are new in some cases and states may experience difficulties with implementation (NYSOSC 2013). Regardless of whether a crossover system is automatic, it may be difficult to determine an appropriate payment amount in states with lesser-of policies if their Medicaid payment methodologies differ from those used by Medicare (OIG 2013b).

Additionally, in some cases, FFS claims do not cross over automatically to Medicaid, and providers must submit separate claims for Medicare cost-sharing amounts directly to the Medicaid program. This can occur with new enrollees before Medicare

lists them as having Medicaid, when a provider bills Medicare with a national provider identifier number that has not been reported to the state Medicaid program, when there are incorrect or missing taxonomy codes, or due to technical problems (Colorado Department of Health Care Policy and Financing 2015, Illinois Department of Healthcare and Family Services 2015, North Carolina Department of Health and Human Services 2015, CMS 2013b, New York Department of Health 2010).

Because Medicare Advantage plans may pay providers amounts that differ from Medicare FFS, Medicaid payment of Medicare cost sharing for dually eligible beneficiaries enrolled in Medicaid Advantage plans also may differ. In addition, Medicare Advantage claims may not automatically cross over to Medicaid, and providers may be required to separately submit claims for Medicare Advantage beneficiaries' Medicare cost sharing to the Medicaid program. In lieu of paying these claims directly, some states contract with and pay a capitated rate for Medicare Advantage plans to directly administer Medicare cost-sharing payments to providers on behalf of the plans' dually eligible enrollees.

Both states and providers may have difficulty with Medicaid payment of Medicare cost sharing for dually eligible beneficiaries in Medicare Advantage plans. Because states do not have access to Medicare Advantage plans' provider fee schedules, they may not be able to determine how much the state actually owes for a given claim. In this situation, providers must be able to submit documentation of the Medicare Advantage plan's payment to the state Medicaid program in order to obtain payment for any Medicare cost sharing. This can be problematic for providers, as they may also be paid a capitated rate by the Medicare Advantage plan and may not be able to identify the plan payment for a particular service (CMS 2008).

In any case, Medicaid payment amounts for Medicare cost sharing for dually eligible beneficiaries will depend on the Medicare

Advantage plan's contracted Medicare rate and the amount of cost sharing, both of which may differ from Medicare FFS amounts. In states with a policy to pay less than the full Medicare cost-sharing amount, both the state and any state-contracted Medicare Advantage plans may limit their payment of Medicare cost sharing to the lesser of the full amount or the amount, if any, by which the Medicaid rate exceeds the Medicare Advantage plan's contracted rate for the services (Arizona Health Care Containment System 2014).

Medicare bad debt payments. Medicare also plays a role in paying for some uncompensated amounts resulting from states paying less than the full Medicare cost-sharing amount through bad debt payments to certain providers. Providers cannot directly bill dually eligible beneficiaries for any outstanding portion of Medicare cost sharing that Medicaid does not pay. However, certain providers (hospitals, skilled nursing facilities, swing bed hospitals, critical access hospitals, federally qualified health centers, rural health centers, community mental health centers, and end stage renal disease facilities) can receive bad debt payments from Medicare to help recoup these costs (CMS 2013c). Medicare will pay these providers 65 percent of these otherwise allowable costs for all Medicare beneficiaries (Middle Class Tax Relief and Job Creation Act of 2012 [P.L. 112-96], CMS 2013c). Medicare bad debt payments can reduce the amount of unpaid cost sharing for some providers (CMS 2013c, MACPAC 2013). As an alternative to back-end payments for bad debt resulting from state Medicaid policies, some have suggested that up-front payment of dually eligible beneficiaries' cost sharing would be more direct and administratively efficient (Burke and Prindiville 2011). Additionally, up-front payments would eliminate providers' need to carry the cost until bad debt payments are made, potentially improving access by increasing providers' willingness to participate in the program.

Conclusion

The Commission's concerns regarding current policies on Medicaid payment of Medicare cost sharing are twofold. First, the lesser-of policies permitted by the BBA reflect Medicaid's longstanding practice of paying physicians less than Medicare. While this policy allows flexibility in how states pay for Medicare cost sharing, there is evidence that paying less than the full Medicare cost-sharing amount has a negative effect on access to care for dually eligible beneficiaries. Second, the complex administrative processes used to pay Medicare crossover claims may unnecessarily hinder payment to some providers and could, therefore, also contribute to barriers to access.

The Commission discussed several policy options for addressing these issues within the context of Medicaid, for example, requiring the program to pay the full amount of Medicare cost sharing on behalf of some or all dually eligible beneficiaries for targeted services or for all services. However, this could result in providers receiving higher payments for dually eligible Medicaid beneficiaries relative to non-dually eligible Medicaid beneficiaries, which raises questions of equity within the Medicaid population. The Commission also discussed the broader impact of low Medicaid physician fees on access to care for all Medicaid beneficiaries.

It is the Commission's view that changes to Medicaid policies regarding Medicare cost sharing must be considered in the context of broader discussions of how best to provide cost-sharing assistance to low-income Medicare beneficiaries. Although payment is only one factor that may affect access to care, the Commission remains concerned that current Medicaid policies regarding Medicare cost sharing may have a negative effect on access to care for dually eligible Medicare beneficiaries relative to their non-dually eligible counterparts.

Policymakers are discussing revisions to the structure of the Medicare benefit. These include proposals to increase income-adjusted premiums

under Medicare Part B and Part D, combining Medicare deductibles, and creating an out-of-pocket maximum for beneficiaries (OMB 2014, Davis et al. 2013, MedPAC 2012, KFF 2011, BPC 2010). Since Medicaid pays for certain dually eligible beneficiaries' Medicare premiums, as well as some of their cost sharing, such changes in Medicare policy would have implications for Medicaid's coverage and financing of dually eligible beneficiaries. As the Medicare policy discussions—particularly those related to benefit redesign—unfold, Medicaid's role in paying for Medicare premiums and cost sharing should be reexamined.

It is also important to recognize that while state Medicaid payment policies on Medicare cost sharing may affect dually eligible beneficiaries' access to care, other low-income Medicare beneficiaries who do not receive MSP or full-benefit Medicaid coverage face out-of-pocket costs for Medicare premiums and cost sharing that can present a substantial financial burden and potentially limit their access to necessary services. Low enrollment of eligible individuals has been an ongoing problem for the MSPs, which can be a result of varying state MSP eligibility policies, lack of program awareness, and burdensome enrollment processes. Without access to the financial assistance offered by the MSPs and full Medicaid benefits, some low-income Medicare beneficiaries may avoid seeking care (Komisar et al. 2005).

Future Commission work will include examinations of MSP eligibility and enrollment issues, and focus on areas where Medicaid policy changes may be most advantageous and cost effective in improving access to coverage and services for low-income Medicare beneficiaries.

Endnotes

¹ Section 1900(b) of the Social Security Act on MACPAC's duties reads:

"...(2) Specific topics to be reviewed.—Specifically, MACPAC shall review and assess the following:

...(G) Interactions with Medicare and Medicaid.—consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

...(11) Consultation and coordination with MedPAC.—

(A) In general.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) Information sharing.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

...(13) Coordinate and consult with the Federal Coordinated Health Care Office.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals."

² The Balanced Budget Act of 1997 (BBA, P.L. 105-33) created the Qualifying Individual-2 program (QI-2). The QI-2 program covered Medicare Part B premiums for beneficiaries dually eligible for Medicare and Medicaid with incomes between 135 and 175 percent FPL. However, the

federal authority for QI-2 expired on December 31, 2002, and the program was terminated (BBA, P.L. 105-33).

³ Services for adults under age 65 residing in certain psychiatric facilities is one example of a situation where Medicare may cover a service but Medicaid does not. Current federal law prohibits federal Medicaid reimbursement for people age 22 (and age 21 under certain circumstances) to 64 who reside in a facility defined by Medicaid as an institution for mental diseases (IMD). However, Medicare will cover 190 days in a psychiatric hospital, which could include facilities defined by Medicaid as IMDs, across a person's lifetime (CMS 2015).

⁴ This may result from factors such as providers failing to submit crossover claims that are not automatically transferred from Medicare to Medicaid and technical difficulties processing claims.

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CHAPTER 7

A Framework for Evaluating Medicaid Provider Payment Policy

A Framework for Evaluating Medicaid Provider Payment Policy

Key Points

- MACPAC's payment policy framework provides an anchor for our future efforts to assess the relationship of various approaches to payment and delivery system reform to the statutory principles of economy, quality, access, and efficiency.
- Using this framework, we hope to pinpoint the payment approaches that best address efficiency and economy while promoting access to quality services and appropriate utilization.
- Economy, quality, and access are discrete but related outcomes of payment policies. It is necessary, therefore, to consider the relationships of the principles to each other rather than attempt to evaluate them individually. Efficiency is not only a component of quality, economy, and access; it also is the overarching goal of payment policy.
- MACPAC is collecting the following information to support this analysis:
 - states' payment methodologies for various provider types;
 - comparative information on payment rates and methodologies across states and payers, provider costs, and the share of provider revenue that the payments represent; and
 - payment's effect on outcomes, including recommendations for appropriate measures and comparisons to other states and payers.
- Where quantitative data are insufficient, MACPAC will use other information to estimate the direction and magnitude of payment policy effects in promoting economy, quality, and access; determine appropriate metrics; and identify where better data are needed.
- For novel or emerging payment approaches, the framework recommends examining the goals, proposed methods, and anticipated effects of a policy to draw conclusions about how well it supports statutory principles.

CHAPTER 7:

A Framework for Evaluating Medicaid Provider Payment Policy

The Medicaid program is a major payer of health care services in the United States, accounting for 15 percent of total health care spending in 2012. This share is projected to rise to nearly 18 percent over the next decade, primarily due to enrollment growth (OACT 2014). As MACPAC has documented in other reports, Medicaid is a dominant payer for obstetrics, pediatrics, behavioral health, and long-term services and supports (LTSS), as well as a critical source of revenue for safety-net providers, including public hospitals, community health centers, and children's hospitals (MACPAC 2011). All told, in fiscal year (FY) 2013, Medicaid expenditures totaled \$460 billion, 58 percent of which were federal dollars.

Given Medicaid's size and anticipated growth, both federal and state policymakers are seeking to maximize the efficiency of its spending. After years of focusing primarily on prices, state Medicaid programs increasingly are adopting more sophisticated purchasing strategies emphasizing value. Payment policy can be a powerful lever to contain costs and improve access to and quality of care. Even so, most Medicaid policies, like most other payers' policies, continue to incentivize volume and not value (Bachrach 2010a).

The foundational statutory provision that governs payment for all Medicaid-covered services under the state plan is Section 1902(a)(30)(A) of the Social Security Act (the Act). As described in MACPAC's March 2011 *Report to the Congress on Medicaid and CHIP*, the statute identifies several fundamental aims for Medicaid payment policy:

- assure that payments promote efficiency, quality, and economy;

- avoid payment for unnecessary care; and
- promote access within geographic areas equal to the general population.

There is little federal regulation addressing these payment principles and states have considerable flexibility in the design of policies to achieve these aims. In May 2011, the Centers for Medicare & Medicaid Services (CMS) published a draft regulation that would implement a process for states to consider the impact of fee-for-service payment rates on access to care, but has not finalized the proposed rule to date (CMS 2011). While CMS has stated that Section 1902(a)(30)(A) of the Act and the requirements of the proposed rule apply to Medicaid services paid through a state plan under fee for service and not services provided through managed care arrangements, we believe that the principles are broadly applicable to the analysis of all Medicaid payments.

In the absence of detailed administrative rules, legal challenges (mainly by providers) have been used to determine the criteria by which these principles should be applied (Bachrach 2010b) (Box 7-1). These court rulings generally address payment levels, not methodologies, and do not necessarily help policymakers develop policies for payment or delivery systems that appropriately balance among the different aims articulated in statute or among various stakeholders, including providers, beneficiaries, and taxpayers.

This chapter describes how MACPAC will evaluate and compare Medicaid payments, but we also believe it will allow state and federal policymakers to weigh the effect of payment policies not just on bottom-line spending but on the fundamental aims of efficiency, economy, quality, access, and avoidance of unnecessary utilization. While there is no consensus on the correct amounts or methods of payment—and, given the heterogeneity of state Medicaid programs, a variety of approaches is probably appropriate—there is value in assessing different payment methods through a consistent

BOX 7-1. Recent Federal Court Activity on Medicaid Payment Adequacy

In January 2015, the U.S. Supreme Court heard arguments in the case of *Armstrong v. Exceptional Child Care, Inc.* to determine whether the Supremacy Clause of the U.S. Constitution (which gives the federal Constitution and federal laws precedence over state laws) grants providers the right to sue states over Medicaid payment adequacy. Importantly, the Court declined to consider whether Medicaid payment rates in the *Armstrong* case complied with 1902(a)(30)(A), instead focusing solely on whether providers can bring suit.

This is the same issue that the U.S. Supreme Court considered, but ultimately did not rule upon, in *Douglas v. Independent Living Center of Southern California* (2012). In the *Douglas* case, the Court agreed to hear the case prior to a final CMS decision on several Medicaid rate reductions proposed by the state of California. When CMS approved the reduction prior to the Court rendering a decision, the Court found the case to be in “a different posture” and declined to rule. (In a dissent, four justices found that the Supremacy Clause did not give providers the right to sue.)

In the *Armstrong* case, Idaho, with the support of 29 other states, contends that only CMS has the authority to decide whether Medicaid rates are sufficient and that private parties may not bring suit. States are concerned that a ruling in favor of providers would result in numerous lawsuits, circumventing state decisions made under CMS oversight.¹

lens. A payment assessment framework helps policymakers consider whether a particular provider payment methodology, whether under fee-for-service or risk-based arrangements, is consistent with the fundamental aims of Medicaid payment policy or more or less likely to promote those aims when compared to alternative approaches. The goal is to get past the work of describing the elements or purpose of specific approaches to address the policy questions MACPAC first raised in our March 2011 report:

- What is the relationship of payment to access and quality?
- Which payment innovations best address efficiency and economy while promoting access to high-quality health care services and appropriate use of those services?

Answering these questions requires data regarding the statutory aims: efficiency, economy, quality, access, and avoidance of unnecessary utilization.

In some cases, state and federal administrative data—including claims, quality measures, and cost reports—may allow for quantitative analyses. In other cases, particularly for emerging payment models, we may need to rely more on qualitative methods to inform discussion.

In addition to introducing MACPAC’s Medicaid payment assessment framework, which builds on work started in 2010 and draws on findings from a variety of research projects, this chapter also:

- reviews each of the statutory principles for Medicaid payment and potential data sources;
- describes components of MACPAC’s Medicaid provider payment assessment framework; and
- explains how we will apply the framework in practice.

Medicaid Payment Policy Principles

As noted above, the Medicaid statute identifies several aims of Medicaid payment policy: to promote efficiency, economy, quality, access, and to safeguard against unnecessary utilization. A framework for assessing Medicaid payments, therefore, requires a consistent understanding of these statutory principles, against which specific policies can be evaluated. States use a variety of payment methodologies in Medicaid (Box 7-2).

Economy, quality, and access are three distinct but related outcomes of payment policies and

are discussed individually below. Efficiency is a measure of value that takes into account both cost (economy) and outcomes (access, quality, and appropriateness of service use). As a result, it is necessary to consider the relationships of the statutory principles to each other, rather than attempt to evaluate each of them individually.

Analyzing the elements of payment policy is problematic due to the lack of data. In our March 2011 report to Congress, MACPAC found that no sources of systematic and comprehensive Medicaid payment information exist, and the lack of timely and reliable sources of data is a major challenge for payment analysis (MACPAC 2011). Since then, MACPAC has developed new data to

BOX 7-2. Types of Medicaid Payments

Medicaid, like most other health care payers, uses a variety of payment approaches for different types of providers and for different kinds of services. These include:

- **fee-for-service payments** with payment for each service determined based on a fee schedule, relative value scale, percent of charges, or other basis;
- **per day, per visit, or per encounter payments**, which include all services rendered during the relevant period;
- **per episode or bundled payments**, which include services associated with a specific procedure or diagnosis, usually over more than one day, and which can be narrow (e.g., only inpatient services) or broad (e.g., inpatient, outpatient, and ancillary services);
- **capitation, premium, or global payments** that provide an individual with coverage for a defined set of benefits (whether or not they are used) for a specific time period (generally one month); and
- **supplemental or incentive payments** not directly related to a service, but generally to a provider characteristic (e.g., serves a disproportionate share of uninsured patients, located in a rural area, serves as a primary care case manager) or a desired outcome (e.g., achieves certain utilization or spending targets, performs well on quality measures).

While CMS has indicated that Section 1902(a)(30)(A) of the Act does not directly apply to payments for services provided through managed care arrangements, the principles described can be useful in evaluating all types of payment. Certain payment types are subject to additional statutory and regulatory requirements, as described in Chapter 5 of MACPAC's March 2011 report to Congress.

support discrete analyses of Medicaid payment policies and their effects on spending, quality, and access. We will continue to collect information and develop more effective measures. Specific examples of the types of information needed to better evaluate the degree to which Medicaid payments meet statutory requirements are provided below.

Economy

The level of payment, or payment rate, can be considered the most basic measure of economy and is essential to an assessment of payment efficiency, a measure of value that compares what is spent (economy) to what is obtained (quality, access, utilization). Typically, an analysis of whether a health care payment is economical includes comparison to the cost to provide a given service and comparison to what other payers (e.g., other states, Medicare, commercial insurance) pay for a comparable service in a given geographic area.

While the term economy has not been explicitly defined for Medicaid payment, both statutory and regulatory requirements affect payment levels for certain providers. The original statutory requirements for economical payment were based on providers' costs, with states required to pay institutional providers their "reasonable costs." Later, this requirement was loosened to require payments that were "reasonable and adequate" to meet the costs of "efficiently and economically operated facilities." Eventually, however, the explicit link to provider costs was dropped entirely and, instead, states were required to develop rates through a public consultation process. To the extent they exist, regulatory requirements for economical payments are based on a comparison to Medicare payment levels. Specifically, the upper payment limit for aggregate Medicaid payments to facility providers is based on a reasonable estimate of what Medicare would pay for the equivalent services.

Other statutory payment requirements similarly rely on either providers' costs or Medicare payment levels. For example, Medicaid statutory payment requirements based on costs include:

- federally qualified health center payments, which are based on each provider's individual costs for providing services;
- disproportionate share hospital payments, which are limited to an individual hospital's uncompensated care costs; and
- Medicaid managed care payments, which the statute requires to be actuarially sound, defined by the American Academy of Actuaries as "provid(ing) for all reasonable, appropriate, and attainable costs" incurred by plans.

Those based on comparisons to Medicare payment include:

- Medicaid hospice payments may not be lower than what Medicare would pay.
- Primary care services provided by qualified providers were paid at Medicare rates in 2013 and 2014.

Assessing the economy of Medicaid payment typically requires knowing the amount of Medicaid payment and either the providers' costs to provide a given service or the amounts paid by others for the same or a comparable service. When considered in isolation, however, measures of economy provide limited insight into whether payments are appropriate, particularly if there are concerns about the benchmarks (e.g., provider costs) themselves. The total amount of Medicaid payment is the most readily available data element related to economy. All states are required to report aggregate spending by type of service on the quarterly CMS-64 expense form, which states are required to submit to CMS as an accounting of expenditures eligible for federal match. These data provide basic information on the aggregate

amount that each state spends for a given service and could be used to develop, for example, state spending amounts per enrollee for a particular type of service.

States also are required to submit claims and eligibility data to CMS through the Medicaid Statistical Information System (MSIS) each quarter allowing, in many cases, for examination of the amount that states pay an individual provider for a specific service in fee for service. Together, these data sources can be used to examine total benefit spending by major eligibility category (as MACPAC publishes as part of MACStats) and could also be used to examine spending for specific types of service by eligibility category.

However, each of these data sources has significant limitations. First, as discussed extensively in MACPAC's March 2014 report, most states make a significant amount of lump-sum supplemental payments, particularly to hospitals. While these payments generally are reported in the aggregate on the CMS-64, they are not reported at the provider level in a readily accessible format and cannot be reliably distributed across subgroups of enrollees (e.g., by eligibility category). CMS has indicated that it is working on resolving these issues, primarily through the implementation of the Transformed Medicaid Statistical Information System (T-MSIS). Further, for services provided to enrollees in Medicaid managed care plans, encounter data often do not include the amounts paid to providers. Without such data, analyses of Medicaid payment would exclude data regarding the majority of enrollees in many states.

Data on providers' costs are available for some types of providers. Most hospitals and nursing facilities, for example, are required by the Medicare program to submit annual cost reports to the federal government. While the reports are not designed to capture Medicaid costs specifically, and individual state definitions of allowable Medicaid costs vary, such cost reporting allows for some analysis of the relationship between

Medicaid payment and provider costs across states. Some states also collect hospital-level cost and revenue data and make these data available for analysis. However, even when there is standardized reporting of financial data at the state or federal level, such information generally is not sufficient to analyze costs at the service level. Further, there is little standardized information regarding the costs for most other types of Medicaid providers, making it rarely possible to compare provider payment amounts to the related costs.

Information on the amounts paid by commercial payers usually is not available, but service-level payment rates for Medicare often are used as a comparator for Medicaid. For example, states were required to temporarily increase payment rates for certain primary care services to Medicare levels to promote primary care physician participation in Medicaid (MACPAC 2013). States may also compare their payment rates to Medicaid payment rates in bordering states. Information on provider payments made by other payers, including exchange plans, is not widely available. Some databases have been developed recently with detailed information on provider charges, but the relationship between billed charges and fees paid by insurers is not always known (GAO 2011). In a number of states, all-payer claims databases are being developed but, at present, their utility for Medicaid analyses remains limited. Comparisons of payments across payers also can be complicated by variations in both the health status of the covered populations and in definitions of the covered service. For example, sicker patients might be more expensive to treat and, therefore, higher payments for those patients may be appropriate. In such cases, comparisons should account for the acuity of patients. Another source of complication is variation in service definitions. Payment for a day of nursing facility care, for example, might be higher in a state that includes payment for therapies and medical equipment in its rate, compared to a state that does not.

Access

In its March 2011 report to Congress, the Commission presented a framework for examining access to services in Medicaid and the State Children's Health Insurance Program (CHIP) (MACPAC 2011). The Commission's access framework takes into account three elements: enrollees, including their unique and diverse characteristics and health needs; availability of necessary services; and utilization of services by enrollees. In addition, the Commission noted that evaluation of access must include consideration of the appropriateness of services and settings—consistent with the statutory requirement that Medicaid payment should “safeguard against unnecessary utilization”—as well as the efficiency, economy, and quality of care. All of these elements must be considered when evaluating whether Medicaid and CHIP enrollees have adequate access to health care services that are economical and produce positive outcomes.

The equal access provision of the Act, requiring payment to be “...sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area,” was added in 1989 (P.L. 101-239). While the 1989 law also included a requirement for states to demonstrate compliance with the access requirement for obstetrical and pediatric services, this requirement was repealed in 1997 after states reported significant difficulty with compliance. In May 2011, CMS released a proposed rule that would, for the first time, create regulatory requirements for states to demonstrate appropriate access to Medicaid covered services paid under fee for service. This proposed rule would require states to analyze access based on enrollee needs, availability of providers and services, and utilization of services, and to submit related data in conjunction with state plan amendments that reduce rates or restructure payment in circumstances that could result in access issues (Box 7-3).

While the proposed rule does not apply to services paid for under managed care arrangements, there are separate regulatory requirements for network adequacy and availability of services under 42 CFR 438. For example, states contracting with managed care plans must ensure that each plan maintains and monitors a network of appropriate providers sufficient to provide adequate access to all services covered under the contract, taking into consideration anticipated enrollment, expected utilization, the characteristics and health care needs of enrollees, and the location of providers and Medicaid enrollees.

Various data sources could be used to assess access consistent with the Commission's framework. For provider supply and participation, for example, national (e.g., National Ambulatory Medical Care Survey) and state-specific surveys could be used to develop such measures as provider-to-population ratios and changes in provider enrollment and participation. Further, a variety of state-specific measures related to provider availability could be available through current state Medicaid information systems.

Data regarding enrollees' use of health care services generally are available to states through claims systems and to the federal government through state MSIS data submissions. Because a comparison to the general population is a key element of the equal access provision, however, survey data may also be required for populations for whom claims data are not accessible, including commercially insured populations. The appropriateness of utilization should also be considered (e.g., analyses of emergency department use and hospital admissions for potentially preventable conditions.)

Each of these data sources has limitations. For example, as previously noted, surveys and studies specific to the Medicaid program are sparse and often outdated, and sample sizes often do not permit examination of access for subgroups of enrollees. State administrative data are of varying

BOX 7-3. Proposed Rule Regarding Methods for Assuring Access to Covered Medicaid Services

In the May 6, 2011 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published a notice of proposed rulemaking regarding methods for assuring access to covered Medicaid services provided on a fee-for-service basis. Specifically, the proposed rule would create a standardized, transparent process for states to follow as part of their broader efforts to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area” as required by section 1902(a)(30)(A) of the Social Security Act. The proposed rule also would require states to collect enrollee and stakeholder feedback regarding access and to conduct a public review process prior to submitting state plan amendments that propose Medicaid provider payment rate reductions or changes in the provider payment structure.

The proposed rule would fill the gap in federal guidance regarding the types of information states were expected to analyze and monitor in determining compliance with statutory access requirements. CMS stated that this lack of guidance complicated its review of state plan amendments (SPAs) relating to changes in provider payment rates and had been cited in litigation relating to Medicaid provider payments.

States would be required to determine appropriate data elements that address enrollee needs, availability of care and providers, and utilization of services. This and other information that the state believes to be relevant would be periodically analyzed by states to demonstrate and monitor sufficient access to care. The data and analysis would be made available to the public and furnished to CMS as requested in the context of a SPA that reduces provider rates or restructures provider payments in circumstances that could result in access issues, or as part of ongoing program reviews. The rule would not require that states use uniform data elements or standard analyses to demonstrate and monitor access, so there potentially could be a unique method in each state for assuring access under the regulation.

CMS received 181 comments on the proposed rule from a variety of stakeholders, including providers and provider associations, consumer groups, and states. Many commenters supported the proposed rule and some suggested additional factors that should be considered as part of the evaluation of provider payment, such as efficiency, economy, or quality. Several providers and provider associations submitted comments in support of the proposed regulation and encouraged CMS to require states to use clear and consistent access measures or to provide additional federal guidance on acceptable levels and measures of access. Several states raised concerns that the proposed rule would not reduce the potential for litigation and pointed out that the process and timing for the proposed access studies would be administratively cumbersome for states to implement and difficult to coordinate with the legislative cycle. The proposed rule had not been finalized as of March 2015.

Source: Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Medicaid program; Methods for assuring access to covered Medicaid services. Proposed rule. *Federal Register* 76, no. 88 (May 6): 26342-26362. <http://www.regulations.gov/#!documentDetail;D=CMS-2011-0062-0001>.

levels of quality, particularly for managed care enrollees, and typically do not include comparison groups. There also are some Medicaid services, such as non-emergency transportation, that do not have a commercial or Medicare equivalent. Thus, it may be difficult to determine whether access issues are specific to the Medicaid program or system-wide within a given geographic area (MACPAC 2013).

Quality

Medicaid is intended to provide not just access to care, but access to quality care. Although definitions of quality may emphasize different aspects in different contexts, quality care is generally considered to be safe, effective, patient-centered, timely, equitable, and reliable (IOM 2001). HHS defines the goal of quality efforts as “ensuring that all patients receive the right care, at the right time, in the right setting, all the time” (AHRQ 2011). Quality is related to the goals of access and efficiency, as well as to the statutory requirement that states develop methods to safeguard against unnecessary utilization of care and services.

Quality measurement is a necessary component of payment and delivery reforms intended to improve efficiency, but definitions and measures for different aspects of health care quality vary (AHRQ 2014). As MACPAC noted in its March 2012 report to Congress, identifying appropriate quality metrics for Medicaid enrollees, particularly people with disabilities, presents challenges because of their diverse needs. For example, people with disabilities have more complex health conditions and greater functional needs, and use many more medical and other health-related services than do other Medicaid enrollees, yet it is not clear whether commonly used quality measures adequately assess quality of care for these individuals (MACPAC 2012).

In an effort to develop more consistent and robust quality metrics for Medicaid (and in compliance with statutory requirements), CMS released a core

set of measures for children enrolled in Medicaid and CHIP in December 2009 and for adults enrolled in Medicaid in January 2012. However, these quality measures currently are voluntary, and many measures are not being reported. (In 2013, states reported a median of 16 of the 26 core measures for children and 16 of the 26 adult core measures.) In addition, the adult measures do not currently include measures specific to people with disabilities and other populations receiving LTSS, although states are beginning to pilot test new tools that may support these measures. Many states require Medicaid managed care plans to use the standardized Healthcare Effectiveness Data and Information Set (HEDIS) measures to report on quality. While the HEDIS measures are widely used measures of quality in health insurance, they have some of the same limitations as other measure sets (e.g., no measures relating to home and community-based services).

Many payment reforms are intended to improve quality by encouraging providers to be accountable for transitions between settings of care and to better coordinate care for patients with complex and chronic conditions. However, there are few consistent metrics to measure the success of these efforts, particularly those that are clearly linked to payment. For example, 9 million adults are eligible for both Medicaid and Medicare, and CMS has implemented a large-scale demonstration program intended to better align the financial incentives for providers to integrate primary care, other acute care, behavioral health services, and long-term services and supports (CMS 2014a). The quality metrics being used in these demonstrations vary considerably, which will make it difficult to compare the effect of different payment approaches on outcomes (Zainulbhai et al. 2014).

In the Medicaid program, collecting complete and timely quality data is further complicated by limitations and variations in state data systems. Quality improvement efforts and specific quality measures can use a variety of data sources, including administrative data (the information contained in eligibility, claims, and encounter files),

clinical data (from medical records), and patient-reported outcomes. Of these, administrative data are the most widely available and can be used to calculate measures of process and appropriateness of care. For example, claims data include details on use of services that can be used to examine receipt of recommended care, such as well-child care and preventive dental visits. While states and providers continue to implement electronic health records and health information exchanges to improve the timeliness and availability of clinical data, there are few sources of robust clinical data to support quality measurement.

Quality measurement in Medicaid remains challenging for several reasons. Many Medicaid enrollees are eligible for short periods of time or may cycle in and out of the program or between Medicaid and other sources of coverage, making it difficult to reliably measure the effect of a Medicaid payment policy on quality (Ku 2013). State Medicaid programs (not national insurers) are the dominant purchaser of some services, such as home and community-based services (HCBS), and there is little standardization in the measures for these services (Lind 2013). Even quality measures that are widely used, such as measures for common health conditions like asthma, diabetes, and heart failure, may not be comparable for certain subgroups of Medicaid enrollees, particularly those with disabilities or who rely on LTSS. Most Medicaid enrollees are enrolled in managed care plans but, in many states, some services (e.g., behavioral health, dental) remain in fee for service or are provided through specialty managed care plans, making it difficult to link quality outcomes with a particular delivery and payment approach. Finally, the science of measuring transitions of care and person-centeredness is still evolving, particularly for goals that go beyond clinical outcomes, such as quality of life, autonomy, and social supports (LTQA 2011). All of these challenges make it difficult for policymakers to better align payment incentives to improve quality or to assess the relationship between payment and quality.

Efficiency

Medicaid payment should provide access to the appropriate amount of high-quality care, at the appropriate time, and in the appropriate setting, while controlling overall costs. In other words, Medicaid payment should be efficient. A 2010 report commissioned by the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services defined state Medicaid efficiency as “that which produces better outcomes for a given level of spending relative to other states or similar outcomes for lower costs” (Lipson 2010). This definition, which was selected based on Medicaid’s role as a health care payer, accounts for each of the required statutory principles. Assessing Medicaid payment efficiency, therefore, requires measures of economy, access, and quality—and the same data limitations that affect these measures affect the measurement of efficiency as well.

Analyses of efficiency could include comparisons of access or outcomes across states or payers relative to the amount of payment for services. For example, the Medicare Payment Advisory Commission (MedPAC) commonly considers the appropriateness of providing particular services in a particular setting (e.g., hospital outpatient department) compared to others that may be less expensive (e.g., physician’s office). In some states, including Arkansas and Tennessee, Medicaid programs have begun directly comparing the amounts paid for specific episodes of care (e.g., deliveries, joint replacement), identifying significant variation even after accounting for patient complexity and outliers.

Many other states are attempting to reform their Medicaid payment methods to encourage greater efficiency. In 32 states, these efforts have been supported through State Innovation Model (SIM) grants awarded by the CMS Center for Medicare and Medicaid Innovation and totaling nearly \$1 billion (CMS 2014b). In addition to the episode-based payment models mentioned previously, states are experimenting with global budgeting, accountable care models with shared savings, and a variety

of financial incentives to encourage greater care coordination. All of these approaches are designed to provide financial incentives for greater efficiency—improved outcomes for lower cost. At the same time, it is important to recognize that Medicaid is only one payer and, in many cases, not the dominant payer for particular providers. It is important, therefore, to keep in mind that efforts to reform the broader health care system cannot be evaluated based solely on their result for any one payer, including Medicaid. Many of the state reform efforts are intended to be multi-payer and, in fact, this is an explicit goal of the SIM initiative.

Other Payment Policy Goals

It is worth noting that, in addition to the explicit statutory goals for Medicaid payment described in §1902(a)(30)(A) of the Act, Medicaid policymakers may consider several other factors when developing payment policies. These include:

- **Administrative simplicity.** Given constraints on state administrative capacity, states may prefer to develop or maintain payment policies that are straightforward to implement and administer.
- **Program integrity and transparency.** States may consider the potential for waste, fraud, and abuse when designing and implementing a payment policy and seek payment methodologies that are more transparent or easier to audit.
- **Budget predictability.** States may develop payment methodologies that transfer insurance risk to third parties, leaving states responsible for costs associated with enrollment growth, but not for unexpected increases in medical spending.
- **Broader health policy goals.** Policymakers may develop payment methods to support health policy goals, such as workforce development, public health, and stability of safety net providers.

- **Alignment with other payers.** States may seek to align payment policies with other payers (e.g., Medicare, state employee insurance plans, commercial insurers) to leverage purchasing power and reduce administrative burden on providers.
- **Fairness.** States may opt for payment methods that pay providers similar amounts for similar patients or services, regardless of setting or provider type.

Finally, it must be acknowledged that states' Medicaid payment policies reflect state-specific approaches to non-federal financing. For example, it is common for states to use revenue generated by a health care related tax to support payments to the class of providers paying the tax. In such cases, the net payment received by the providers is less than payment data might indicate. In other cases, localities may contribute non-federal share through intergovernmental transfers or certified public expenditures. Due to the way these contributions are captured in different systems, the total payment for these services also may be different from that indicated by available payment data.

Applying the Framework

The Commission's framework provides a foundation for our future efforts to assess the consistency of particular Medicaid payment policies relative to statutory principles of economy, quality, and access and to assess their overall efficiency. This framework builds on work MACPAC has conducted over the past several years to collect and document different aspects of Medicaid payment policy, including details for specific provider and service types. MACPAC will continue to update and add to our payment policy research to inform application of the framework. Specific information we will continue to collect includes:

- **Payment methodology:** What is the payment for? To whom is it made? How is the rate

or fee determined? Did the state develop the payment method or adopt a method established by other payers? Does the methodology account for the relative acuity of enrollees? What information is used to adjudicate a claim or authorize a payment?

- **Payment amount:** What is the payment amount? How does this amount compare to other states and other payers (e.g., Medicare or exchange plans)? How much provider revenue derives from Medicaid? How does this amount compare to the provider's cost, and is cost an appropriate benchmark? What is the effect of any supplemental payments?
- **Outcomes related to the payment:** What are the appropriate measures to evaluate the effect of the payment on access and quality and overall program spending? What payment-related data are available? What outcomes data are available? What comparative information is available from other payers?

MACPAC currently is conducting a number of projects to evaluate various Medicaid payment policies. We are interested in learning more about differences in service-level inpatient hospital payments across states and compared to other payers. MACPAC has collected information on state-level inpatient payment methodologies for all 51 state Medicaid programs and is now developing an index of fee-for-service inpatient hospital payment amounts across states, controlling for certain demographic factors and case mix to provide an indicator of the relative economy of payments across states. By combining information on payment amounts (economy) from the index with information on outcomes (quality and access) from other sources, the Commission potentially could assess the relative efficiency of different inpatient payment methodologies.

The Commission also is interested in reviewing managed care payment methods. In March 2014, we convened a roundtable discussion of the

technical issues involved in capitation rate setting and ways that federal and state governments can use capitation payment levers to drive greater value. The discussion topics included payment methodologies, including rate setting for low-income adults covered under Medicaid expansion groups, rate setting for enrollees in managed long-term services and supports (MLTSS) programs, and risk sharing; payment amounts, including medical loss ratios; and payment outcomes, including pay-for-performance and value-based purchasing. Through this roundtable discussion, the Commission was able to identify a number of additional research questions and potential policy recommendations to support more efficient and accurate capitation rate setting, such as studying MLTSS rate-setting methods to determine if certain incentive structures are better than others in promoting a shift to more cost-effective care and improved outcomes. MACPAC will continue to investigate state payment reforms, including capitated arrangements and other innovative models that seek to reward value instead of volume.

The Commission will complement quantitative information on payment policy outcomes with other available information to inform assessments of specific Medicaid payment policies. As noted above, MACPAC has access to certain information such as fee-for-service payment amounts, utilization, and total spending. However, other information, such as capitation payment rate schedules or provider-level supplemental payment amounts, are held by individual states but not readily available for analysis, so more work must be done to collect and evaluate them. In addition, some outcomes data, such as quality measures, may be available but often are much older than payment information. While it may be difficult to obtain sufficient quantitative information to make clear-cut assessments of the effects of a given payment policy, particularly at the individual state level, the Commission will use available information to estimate the direction and magnitude of payment policy effects on economy, quality, and access; determine the appropriate metrics and data points

to measure the effects; and identify where better data or more appropriate metrics are needed to inform the development of those tools.

MedPAC has long employed a similar approach to assessing payment adequacy and updating payments in Medicare. MedPAC's responsibilities are somewhat different from MACPAC's—MedPAC is explicitly required to inform Congress whether the uniform set of Medicare payments for the current year are adequate to cover the costs of efficient providers and how much payments should change in the coming year. Its payment adequacy framework, described in its March 2014 *Report to the Congress on Medicare Payment Policy*, includes examination of the capacity and supply of providers, quality of care, providers' access to capital, and Medicare payments and provider costs (MedPAC 2014). However, MedPAC acknowledges that the relevance, availability, and quality of data on these four elements varies depending on the payment and provider type being considered, meaning that it often must make decisions and recommendations on payment adequacy with incomplete information. MACPAC will take a similar approach, assembling the best data available and considering the various factors outlined here when making payment policy recommendations.

To support meaningful analyses of Medicaid payment, the Commission will continue to fill data gaps where possible and use qualitative methods to assess policies when the data do not support quantitative analysis. For novel or emerging payment approaches, the Commission can examine the goals, proposed methods, and anticipated effects of a policy to draw conclusions about the consistency of the payment method with the statutory principles based on the incentives that the method creates. The Commission will:

- consider whether the stated goals are consistent with each of the statutory principles or appropriately balance among them where they are in conflict;

- assess the degree to which the design of a payment policy relates to the stated goals and consider whether the data and metrics associated with a given policy are appropriate or realistic; and
- identify what other types of data or measures would be needed to assess the effect of a policy on the statutory principles in order to inform potential recommendations.

It also will be important to consider the effects of payment policies over time, recognizing that policy changes take time to fully implement and the effects may not be immediately apparent. Further, states' payment reform efforts often involve multiple simultaneous policy changes and, thus, it may be necessary to consider any individual change in context.

Next Steps

MACPAC's payment policy framework provides an anchor for our future efforts to assess systematically the relationship of various payment and delivery system approaches to the statutory principles of economy, quality, access, and efficiency. Using this framework, we hope to pinpoint the payment approaches that best address efficiency and economy while promoting access to quality services and appropriate utilization.

The Commission will continue to collect additional information on payment methods and levels that will inform our analyses of Medicaid payment policies and their effects on spending, quality, and access. We will continue to point out important gaps in federal data sources and make recommendations where appropriate. The Commission also will collect more information and develop better measures to more precisely evaluate the degree to which Medicaid payments meet statutory requirements.

Endnotes

¹ *Armstrong v. Exceptional Child Center, Inc., et al.*, 14-15, (SCT July 7, 2014). <http://www.supremecourt.gov/search.aspx?filename=/docketfiles/14-15.htm>.

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CHAPTER 8

An Update on the Medicaid Primary Care Payment Increase

An Update on the Medicaid Primary Care Payment Increase

Key Points

- The Medicaid primary care payment increase, which temporarily raised Medicaid fees for primary care services to Medicare levels, expired on December 31, 2014. MACPAC conducted semistructured interviews with Medicaid officials, plan administrators, and provider organizations in eight states during the summer of 2014 to shed light on whether they thought the temporary increase affected access to primary care and to help us understand states' implementation experiences.
- In those interviews, states, Medicaid managed care plans, and provider organizations reported the following:
 - Early operational issues delayed initial payments to providers, but were largely resolved by the summer of 2014.
 - The payment increase took effect in fee for service and Medicaid managed care at different times in four of the seven states. Some providers found these separate implementation time frames confusing.
 - The payment increase had little to no effect on Medicaid provider participation rates according to state and Medicaid managed care officials.
 - There was no change in primary care service use while the payment increase was in effect according to interviewees in six of the eight states.
- Whether the primary care payment increase affected access to primary care remains unclear.
 - Studies in other states found that providers increased the number of Medicaid patients they were willing to see, or that Medicaid appointment availability increased concurrent with the payment increase.
 - However, the eight states interviewed reported to MACPAC that the payment increase had little effect on recruiting Medicaid primary care providers, as few providers who participated in the increase were new to Medicaid. Moreover, some providers may not have been aware of the payment increase.
- Now that the primary care payment increase has expired, states are taking different approaches to their Medicaid payment policies:
 - At least twenty-four states reverted to their previous primary care physician payment rates.
 - Fourteen states will continue to pay primary care physicians at higher levels in 2015 than their pre-2013 levels although not necessarily as high as Medicare. One state, Alaska, paid higher Medicaid rates to primary care providers than Medicare paid prior to the payment increase, and will continue to do so.

CHAPTER 8:

An Update on the Medicaid Primary Care Payment Increase

The Medicaid primary care payment increase, a provision in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that temporarily raised certain Medicaid physician fees, expired on December 31, 2014. The provision required that all state Medicaid programs increase payment for certain primary care services to Medicare payment levels during calendar years 2013 and 2014. The payment increase was intended to address the need to maintain provider networks for those currently enrolled in Medicaid in light of the ACA-mandated expansion of Medicaid eligibility (later made optional by the U.S. Supreme Court), which was expected to cover millions of additional enrollees. This increase in payment rates was fully federally funded; to date, the federal government has spent \$7.1 billion on increased payments for services, and this total is expected to grow as states continue processing eligible claims (MACPAC 2015).¹

Although the provision seemed like a straightforward rate increase, it proved complicated to implement. States had to identify eligible providers and maintain separate fee schedules to pay eligible providers the enhanced rate while paying ineligible providers a lower rate, and they had to work with their Medicaid managed care organizations (MCOs) to do the same for their providers. State, plan, and provider-organization representatives expressed concerns from the outset that these operational issues might overwhelm any effect of the payment increase on access to primary care (MACPAC 2013).

The results of emerging research are inconclusive on whether the payment increase had an effect on access to primary care in Medicaid. We

interviewed state Medicaid agencies, Medicaid MCOs, and provider organizations between June and September 2014. We learned that although early operational issues had largely been resolved, uneven implementation led to payment delays. These delays, combined with the short time frame in which the provision was in effect, made it difficult to measure its effects before it expired. Most states have not evaluated the effect of the payment increase on provider participation, and data required for federal evaluations are not yet available. Even though evidence of the effect of the payment increase is mixed, some states are continuing to pay Medicaid primary care providers at higher rates even without the enhanced federal matching funds.

This chapter builds on earlier Commission work that examined states' planning efforts and early issues they encountered while implementing the Medicaid primary care payment increase. We begin with a review of the statutory and regulatory requirements for states and the decisions states made as they implemented the payment increase. We then present findings from recent MACPAC interviews with state Medicaid agencies, managed care plans, and provider organizations that we conducted prior to the provision's expiration. We also present early findings from research conducted by other organizations. We conclude by briefly discussing possible implications of the temporary primary care payment increase on future policy development.

Statutory and Regulatory Requirements

The Centers for Medicare & Medicaid Services (CMS) published a final rule for the implementation of the primary care payment increase provision in November 2012, less than two months before the provision was to take effect. The rule specified the types of services and providers to which the temporary payment increase would apply. CMS responded to implementation questions

by providing additional subregulatory guidance. Several statutory and regulatory requirements are described below.²

The payment increase was limited to evaluation and management services (Current Procedural Terminology codes 99201–99499) and vaccine-administration services and counseling related to children’s vaccines (Current Procedural Terminology codes 90460, 90461, and 90471–90474).

Providers were eligible for the payment increase if they were practicing primary care and specializing in family medicine, general internal medicine, or pediatric medicine or in a subspecialty recognized by one of three physician-certifying boards.³ Other health professionals could be eligible if they provided primary care services under the supervision of an eligible physician. Providers were also required to self-attest to their eligibility by providing evidence of board certification in one of the specialties or subspecialty designations or attest that they practiced primary care and had an eligible claims history.⁴

States were required to review a statistically valid sample of the physicians who received the higher payments in calendar years 2013 and 2014 to retrospectively verify their eligibility for the payment.

States also had to submit information to CMS about physician participation and beneficiary use of services. Specifically, states were required to submit provider participation information as of July 1, 2009, and for calendar year 2013 as well as service utilization information for corresponding time periods, at a time to be specified later by CMS (42 CFR 447.400(d)). However, as noted in MACPAC’s June 2013 *Report to the Congress on Medicaid and CHIP*, these data would not be available until after the provision expired at the end of 2014.

States were required to submit a state plan amendment with their proposed implementation procedures by March 31, 2013. Nearly all state plan amendments were approved by June 2013.

Implementation of the payment increase was more complicated in state managed care programs than in fee-for-service programs because Medicaid MCOs use a variety of methods to pay physicians, including subcapitation arrangements, bundled payments, or proprietary fee schedules not aligned with the Medicaid fee schedule. In order to implement the payment increase, states and their Medicaid MCOs had to develop a methodology to identify the services covered by the payment, calculate the amounts owed, and verify that the plans paid the enhanced primary care rate to eligible providers. States also had to develop a methodology to adjust capitation payments paid to MCOs to reflect the rate increase. These methodologies were then submitted as part of the standard CMS review of MCO contracts during 2013 and 2014.

As noted in MACPAC’s June 2013 report, states had difficulty complying with the regulations and associated requirements to file state plan amendments and amend MCO contracts. MACPAC conducted semistructured interviews with state Medicaid officials, Medicaid MCOs, and provider organizations in six states and the District of Columbia between mid-October 2012 and January 2013, when the provision was being implemented. In those interviews, states reported that the late publication of the final regulation gave them little time to be ready to make increased payments on January 1, 2013. States also reported difficulty identifying eligible providers and implementing the increase within their MCOs. In many states, the provision required complex system modifications to the Medicaid Management Information Systems used to process and adjudicate claims.

MACPAC’s June 2013 report also highlighted the importance of conducting a comprehensive evaluation of the effect of the primary care payment increase, ideally using national claims data and adjusting for other factors, such as enrollment changes due to Medicaid expansion. The report stressed that provider enrollment data and patient load data could provide insight into whether provider participation changed and

BOX 8-1. State Implementation Decisions about the Primary Care Payment Increase

State Medicaid agencies have flexibility to establish their own payment methods and policies within broad federal parameters. In light of this flexibility, the regulations gave states some options for implementing the primary care payment increase. A review of the approved state plan amendments for the primary care payment increase showed variation in how states implemented the provision. Some examples are listed below:

- Thirty-four states planned to pay at the office-setting rate rather than make site-of-service adjustments.
- Fifteen states implemented a statewide average rate across all counties rather than implement all Medicare geographic adjustments.
- Thirty-four states planned to implement the payment increase on a per claim basis, while 16 states planned to make a lump-sum supplemental payment.
- Forty-two states indicated that some new services had been added to the fee schedule after July 1, 2009, although these were typically Current Procedural Terminology codes not in use prior to that date.
- Nearly all states excluded certain codes from the payment increase; the services excluded and the number of codes varied by state.

whether providers saw a larger share of Medicaid patients relative to their patients with other sources of coverage. The Commission noted that these data would not be available until well after the provision expired at the end of 2014.

Update on Experiences with Implementation: MACPAC Interviews

MACPAC conducted semistructured follow-up interviews with officials in eight states (Alabama, Kentucky, Michigan, Missouri, New Mexico, Rhode Island, Virginia, and Washington).⁵ Twenty-nine interviews were conducted between July and September 2014. Interviewees included state Medicaid officials and technical staff, operations

and policy staff from Medicaid MCOs, and provider organizations, including state medical societies, primary care associations, and pediatric associations. Respondents were asked to draw on their experiences and, to the extent possible, available data in answering interview questions. Interviewees were assured that their responses would not be attributed to them by name, or to their organization.

These interviews were intended to shed light on whether states thought that the temporary increase had an effect on access to primary care and to help us understand state experiences during implementation. The responses made clear that states experienced some operational challenges initially, and that increased payments to providers were delayed in most states. States reported that the payment increase had, at best, a modest effect on provider participation, although states

were cautious in attributing increases in provider participation solely to the payment increase.

Operational challenges had largely been resolved.

Every state we interviewed reported experiencing some operational challenges as they implemented the payment increase. For example, some states reported initial challenges in identifying eligible providers, either because they did not have specialty or board certification information on file or because they thought information from CMS on the parameters for determining physician eligibility lacked clarity.⁶ States also reported experiencing additional administrative burden in establishing the self-attestation process. Nearly all states took the lead in collecting attestation forms and reporting physician eligibility to MCOs, and this created some challenges for states with MCOs that used different provider identification numbers although these issues were resolved quickly. States and MCOs reported that adjusting the state payments to the MCOs was another challenge. States and MCOs had to determine the share of the capitation payment that was attributable to eligible primary care services. Coming to a CMS-approved methodology took considerable time and effort.⁷

Timeliness of payments. Most states reported making the first increased payments (including retroactive payments) in May 2013 or later. States attributed the delayed payments to the late publication of the final rule and the operational challenges they faced in implementing the payment increase. Some respondents, including state officials and provider organizations, expressed concern that these delays may have initially cast doubt among providers over whether they would receive a payment increase. They also noted that payment delays shortened the window in which providers experienced the increase and cited this as a factor that may have limited any effect the increase had on provider behavior.

The payment increase was implemented at different times in fee for service and Medicaid managed care plans in four of the seven states

interviewed. Some providers found the separate implementation time frames confusing, according to a few states and provider organizations.

Effect on provider participation. States and Medicaid MCO officials interviewed reported that the payment increase had little to no effect on provider participation rates in Medicaid.⁸ Of the eight states surveyed, two states reported no change in provider participation rates; three states said that provider enrollment increased from 2012 to 2013; and the other three states said that they thought that provider enrollment had increased, but that they did not monitor provider enrollment figures closely. Seven MCOs (in five states) reported no noticeable change in provider enrollment. Nearly all of the respondents in the states reporting actual or presumed increases in provider enrollment cautioned that the increases could not be solely attributed to the provision. Other factors may also have had an effect on provider participation, such as Medicaid expansion and other state efforts to improve access to primary care services for Medicaid enrollees.

Some of the states reported that their enrollees had adequate access to care prior to the payment increase. These states reported that Medicaid represented a large share of their state's health insurance coverage, and gave this as a reason for high provider participation. For example, one state pointed to state regulations that require providers participating in an insurance carrier's commercial market must also participate in that insurer's Medicaid market if the insurer offers a Medicaid plan.

Provider participation in the payment increase varied by state. Four states reported that between 23 and 92 percent of eligible providers completed attestations.⁹ All states said that few physicians who completed self-attestations were new to Medicaid. One state estimated that fewer than 1 percent of those who completed self-attestations were new to Medicaid, and several other states provided similarly low estimates.

In addition to provider participation, Medicaid patient load can be considered an indicator of access.¹⁰ All states and MCOs reported that they did not have data to determine whether providers increased their Medicaid patient loads, and providers reported that they had not increased their Medicaid patient loads.

Amount of increase for primary care services.

While the amount of the payment increase for each service could be easily determined, quantifying the amount of additional payments made to individual providers as a result of this provision was challenging for most interviewees.¹¹ For example, states either did not routinely track payments made at the individual provider level or lacked MCO data to provide a complete provider-level estimate. Provider associations in two states had attempted to estimate how much providers had received on average, but ultimately determined that data were unavailable.

Effect on primary care service use. Two states reported an increase in use of primary care services. These states reported increases of between 1 and 7 percent in the use of primary care services in both fee for service and managed care programs.¹² Participants in the remaining six states reported that there was no change in primary care service use during the time the provision was in effect. As with provider participation data, states cautioned that changes in primary care service use could not be solely attributed to the provision. Provider organizations reported that they did not have data to assess the effect of the payment increase on delivery of primary care services.

State Experiences with Implementation: Other Research

When considered alongside the work commissioned by MACPAC, early research is mixed on whether the primary care payment increase

affected access to primary care. On the one hand, studies in some states demonstrate that provider participation has increased concurrent with the payment increase. For example, one study found that appointment availability increased for new Medicaid patients in 10 states, even while new appointment availability did not change for privately insured patients (Polsky et al. 2015). Further, the increase in appointment availability was greater in states with larger increases in primary care payments (Polsky et al. 2015). An Ohio State Medical Association survey of providers in Ohio found that 38 percent accepted a greater number of Medicaid patients because of the primary care rate increase, although these figures should be interpreted with caution given that the survey response rate was about 8 percent (OSMA 2014). Providers in Washington attributed an increased willingness to see new Medicaid patients or to continue seeing current Medicaid patients to the payment increase (Patterson et al. 2014). Some provider associations have collected anecdotal reports that the payment increase enabled them to hire new staff or upgrade facilities (AAP 2014).

On the other hand, some states reported no change in provider participation. In fact, states interviewed by MACPAC reported that most attestations were completed by providers who participated in Medicaid prior to the payment increase. Moreover, providers may not have been aware of the provision (Crawford and McGinnis 2014). One study found that providers lacked awareness of key provisions of the increase, including requirements for physician eligibility and for Medicaid MCOs to make increased payments, and that this lack of awareness may have been greater among independent providers and providers in small groups (Patterson et al. 2014). And in Washington, 40 percent of providers did not know or were not sure whether they or their practice had received increased Medicaid primary care payments (Patterson et al. 2014).

Evaluation

Most state Medicaid officials did not conduct their own evaluations as to whether the temporary increase in certain Medicaid physician fees had an effect on access to primary care. They noted that the complexity of the analysis—specifically, controlling for all of the changes the Medicaid program was undergoing concurrent with the increase—would be a challenge, and that they lacked staff resources to conduct such a study.

The U.S. Department of Health and Human Services has commissioned the RAND Corporation to study the issue. The RAND Corporation plans to use IMS Health physician and drug data to evaluate the effect of the provision within the context of the Medicaid expansion.¹³ Results may shed more light on the provision's effects, but these will not be available until later in 2015.

Because there is little hard evidence to make definitive statements about the effect of the provision on provider participation and access to care at the state level or across states, it is difficult to use the experience of the temporary payment increase to inform policy decisions regarding a renewal or expansion of the provision.

Medicaid Primary Care Rates in 2015

Even without firm evaluation results, six states (Alabama, Colorado, Iowa, Maryland, Mississippi, and New Mexico) are continuing to pay for primary care services at the Medicare level (Galewitz 2014).¹⁴ These payment increases will be funded at the states' usual matching rate. Alaska continues to offer rates that are higher than Medicare as they did prior to implementation of the provision (Smith et al. 2014). An additional eight states (Connecticut, Delaware, Hawaii, Maine, Michigan, Nebraska, Nevada, and South Carolina) are continuing to pay at higher rates, although not necessarily as high as

Medicare (Smith et al. 2014, CDSS 2014, SCDHHS 2014). For example, one state interviewed by MACPAC plans to maintain primary care rates at a level halfway between the pre-2013 rates and the current Medicare rates. Although states could not quantify its effects in MACPAC interviews, some states perceived the increase to have strengthened primary care networks and improved the state's relationship with providers and wanted to maintain the momentum of these perceived effects.

Some states are expanding the eligibility of certain providers. For example, obstetricians, gynecologists, and psychiatrists in South Carolina and advanced practice registered nurses in Connecticut will be eligible for enhanced primary care payments (SCDHHS 2014, CDSS 2014).

Rates in at least 24 states reverted to their previous levels on January 1, 2015. Medicaid officials and provider organizations reported that they lacked state funds to continue offering increased rates without the enhanced federal match. Respondents in two of the five states interviewed by MACPAC reported that state legislative action to continue the rates without enhanced federal funding was defeated.

Looking Forward

The Commission will continue to explore issues relating to the primary care payment increase and what effect, if any, this policy had and might continue having on access to primary care in Medicaid. Given that several states will continue to pay at enhanced rates in 2015 while others revert back to lower rates, we have an opportunity to examine the effects of such increases over a longer time period and possibly even compare data from states maintaining the increase with data from states that revert back to pre-2013 rates. The Commission will also continue to review any emerging research and evaluations of the primary care payment increase.

Endnotes

¹ Even though the provision was only in effect for calendar years 2013 and 2014, states have up to two years to submit claims for federal reimbursement for Medicaid services, including services eligible for the primary care payment increase.

² A more thorough description of the statutory and regulatory provisions of the primary care payment increase can be found in MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*.

³ The three boards were the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (APS), and the American Osteopathic Association (AOA). The ABMS recognizes approximately 5 eligible family medicine, 20 internal medicine, and 20 pediatric subspecialties. The AOA recognizes 11 internal medicine and 5 pediatric subspecialties. CMS published additional information in a question and answer document (CMS 2012) and clarified in subregulatory guidance that allergists also qualify for enhanced primary care payments (CMS 2013).

⁴ Physicians were able to self-attest to their eligibility if at least 60 percent of their billed codes for the prior year (or the previous month, for newly participating physicians) were those to which the increased rates applied (i.e., evaluation-and-management services and vaccine-administration services and counseling related to children's vaccines). For more information, see MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*.

⁵ States were selected to represent a range of policy choices and health system characteristics that could affect the ease of implementation and effectiveness of the primary care payment increase. The following criteria were used: Medicaid managed care penetration rate, baseline primary care payment rates, proportion of office-based physicians accepting new Medicaid patients, proportion of the state's population living in a health professional shortage area, implementation of ACA Medicaid expansion, census region, and participation in MACPAC's first primary care payment increase interviews. West Virginia declined to participate, and Washington was interviewed instead.

⁶ Only two states reported having specialty and board certification information for physicians on file. Most states reported that lack of clear information from CMS on the parameters for the payment increase contributed to challenges of determining eligibility and delays in implementation. For example, states requested clarification as to whether providers in certain settings (i.e., rural health clinics, federally qualified health centers) were eligible and whether certain subspecialties were eligible. Some states also noted that as they were implementing the process necessary to identify eligible providers, CMS clarified that allergists were also eligible, which caused further delays to system modifications (CMS 2013).

⁷ Many of the challenges reported by states in implementing the provision within fee for service extend to managed care, including identifying eligible providers, modifying administrative systems, and coordinating attestation.

⁸ Provider participation has historically been considered an indicator of access to care. For more information on this, please see MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*.

⁹ Three states were unable to determine how many providers would have been eligible for the primary care payment increase, and therefore could not report the percentage of eligible providers who completed self-attestation.

¹⁰ Medicaid patient load for a specific provider is the share of that provider's patients who have Medicaid coverage relative to his or her share of patients with other sources of coverage or payment.

¹¹ The increase per service was significant in most states and could be easily discerned from fee schedules. Vaccine-administration codes increased by 37 to 52 percent. The increase among three commonly billed office visit codes ranged from 23 percent to over 90 percent in three states (Michigan, Rhode Island, and Washington). On the other hand, rates for office visits in New Mexico did not increase. And the rate for a commonly billed emergency department visit code increased by more than two-thirds in four states (Michigan, Missouri, Rhode Island, and Washington). These increases should be considered cautiously in light of the fact that some states may have experienced large fee-for-service rate increases, while enrollee numbers in those programs were low compared to the high percentage of enrollees in managed care.

¹² The reported increase in service use was observed as an increase in the number of paid procedures provided to enrollees.

¹³ IMS Health, Danbury, CT, is a medical and health information and technology company. A description of their information sources is available at <http://www.imshealth.com/portal/site/imshealth/menuitem.3e17c48750a3d98f53c753c71ad8c22a/?vgnextoid=abb6e590cb4dc310VgnVCM100000a48d2ca2RCRD&vgnnextfmt=default>.

¹⁴ Alabama and New Mexico were among our interviewees and confirmed that they planned to continue the primary care payment increase through 2015.

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Appendix

Authorizing Language from the Social Security Act (42 U.S.C. 1396)

Medicaid and CHIP Payment and Access Commission

- (a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as “MACPAC”).
- (b) DUTIES.—
- (1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—
- (A) review policies of the Medicaid program established under this title (in this section referred to as “Medicaid”) and the State Children’s Health Insurance Program established under title XXI (in this section referred to as “CHIP”) affecting access to covered items and services, including topics described in paragraph (2);
 - (B) make recommendations to Congress, the Secretary, and States concerning such access policies;
 - (C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC’s recommendations concerning such policies; and
 - (D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.
- (2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:
- (A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—
 - (i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;
 - (ii) payment methodologies; and
 - (iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).
 - (B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

- (C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.
 - (D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.
 - (E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.
 - (F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.
 - (G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.
 - (H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.
- (3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—
- (A) review national and State-specific Medicaid and CHIP data; and
 - (B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.
- (4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.
- (5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—
- (A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include

such recommendations as MACPAC deems appropriate.

- (B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

- (A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

- (i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).
- (ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:
 - (I) Data relating to changes in the number of uninsured individuals.
 - (II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.
 - (III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services.
 - (IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.
- (iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.
- (iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

- (7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.
 - (8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term “appropriate committees of Congress” means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.
 - (9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.
 - (10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.
 - (11) CONSULTATION AND COORDINATION WITH MEDPAC.—
 - (A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as “MedPAC”) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.
 - (B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.
 - (12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.
 - (13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.
 - (14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.— MACPAC’s authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary’s authority to carry out Federal responsibilities with respect to Medicaid and CHIP.
- (c) MEMBERSHIP.—
- (1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

- (A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.
- (B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.
- (C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.
- (D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

- (A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.
 - (B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.
- (4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

- (5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.
- (6) MEETINGS.—MACPAC shall meet at the call of the Chairman.
- (d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—
- (1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);
 - (2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;
 - (3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));
 - (4) make advance, progress, and other payments which relate to the work of MACPAC;
 - (5) provide transportation and subsistence for persons serving without compensation; and
 - (6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.
- (e) POWERS.—
- (1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.
 - (2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—
 - (A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;
 - (B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and
 - (C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

- (3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.
- (4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.
- (f) FUNDING.—
 - (1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.
 - (2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.
 - (3) FUNDING FOR FISCAL YEAR 2010.—
 - (A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, \$9,000,000.
 - (B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, \$2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.
 - (4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Sharon Carte, MHS, has served as executive director of the West Virginia Children's Health Insurance Program since 2001. From 1992 to 1998, Ms. Carte was deputy commissioner for the Bureau for Medical Services, overseeing West Virginia's Medicaid program. Previously, she was an administrator of skilled and intermediate care nursing facilities and a coordinator of human resources development in the West Virginia Department of Health. Ms. Carte's experience includes work with senior centers and aging programs throughout West Virginia as well as with policy issues related to behavioral health and long-term services and supports for children. She received her master of health science from the Johns Hopkins University School of Hygiene and Public Health.

Donna Checkett, MPA, MSW, is vice president of business development for Aetna's Medicaid division. Previously, she was Aetna's vice president for state government relations, focusing on the company's response to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) at the state insurance and Medicaid level. As chief executive officer of Missouri Care, a managed Medicaid health plan owned by the University of Missouri-Columbia Health Care, Ms. Checkett originated and directed all aspects of the plan. For eight years, Ms. Checkett directed the Missouri Division of Medical Services (Medicaid), where she implemented a managed care program for more than 50 percent of the beneficiaries and oversaw several significant optional eligibility expansions. Ms. Checkett's peers elected her chair of the National Association of State Medicaid Directors and she also was a member of the National Governors Association Medicaid Improvements Working Group, where the initial focus was on the use of Section 1115 waivers for health system reform purposes. She received a master of public administration from the University of Missouri-Columbia and a master of social work from The University of Texas at Austin.

Andrea Cohen, JD, is senior vice president for program at the United Hospital Fund, a nonprofit health services research and philanthropic organization whose mission is to shape positive change in health care for New Yorkers. She directs the Fund's program work and oversees grant making and conference activities. From 2009 to 2014, she served as director of health services in the New York City Office of the Mayor, where she coordinated and developed strategies to improve public health and health services. Prior professional positions include counsel with Manatt, Phelps & Phillips, LLP; senior policy counsel at the Medicare Rights Center; health and oversight counsel for the U.S. Senate Committee on Finance; and trial attorney with the U.S. Department of Justice. She received her law degree from Columbia University School of Law.

Gustavo Cruz, DMD, MPH, is an oral health policy consultant and senior advisor to Health Equity Initiative, a professional membership organization in New York City that brings together community leaders and professionals in diverse fields to promote innovations in health equity. He also serves as resident advisor to the Dental Public Health Residency at Lutheran Medical Center and as adjunct associate professor in the Department of Epidemiology and Health Promotion at New York University College of Dentistry (NYUCD). Dr. Cruz was a Robert Wood Johnson Foundation Health Policy Fellow from 2009–2010, working in the office of the Secretary of the U.S. Department of Health and Human Services. Subsequently, he served as chief of the Oral Health Branch, Bureau of Health Professions, at the Health Resources and Services Administration. He previously served as director of public health and health promotion at NYUCD and as governing faculty of New York University's Master in Global Public Health. Dr. Cruz has conducted numerous research studies on the oral health of U.S. immigrants, oral health disparities, oral and pharyngeal cancers, access to

oral health care among underserved populations as well as the effects of race, ethnicity, acculturation, and culturally influenced behaviors on oral health outcomes and health services utilization. He received his degree in dentistry from the University of Puerto Rico and his master of public health from Columbia University's School of Public Health. He is a diplomate of the American Board of Dental Public Health.

Patricia Gabow, MD, was chief executive officer of Denver Health from 1992 until her retirement in 2012, transforming it from a department of city government into a successful, independent governmental entity. She is a trustee of the Robert Wood Johnson Foundation, serves on the Institute of Medicine (IOM) Roundtable on Value and Science Driven Health Care, and on the National Governors Association Health Advisory Board. Dr. Gabow is a professor of medicine at the University of Colorado School of Medicine and the author of *The Lean Prescription: Powerful Medicine for Our Ailing Healthcare System*, as well as over 150 articles and book chapters. She has received the American Medical Association's Nathan Davis Award for Outstanding Public Servant, the Ohtli Award from the Mexican government, the National Healthcare Leadership Award, the David E. Rogers Award from the Association of American Medical Colleges, and the Health Quality Leader Award from the National Committee for Quality Assurance (NCQA). She was elected to the Association for Manufacturing Excellence Hall of Fame for her work on applying the Toyota Production Systems lean manufacturing principles to health care. Dr. Gabow received her medical degree from the University of Pennsylvania School of Medicine.

Marsha Gold, ScD, is a senior fellow emeritus at Mathematica Policy Research, where she previously served as a lead investigator and project director on research in the areas of Medicare, Medicaid, managed care design and delivery system reform in both public and private health insurance, and access to care. Other prior positions include director of research and analysis at the

Group Health Association of America, assistant professor with the Department of Health Policy and Administration at The University of North Carolina at Chapel Hill, and director of policy analysis and program evaluation at the Maryland Department of Health and Mental Hygiene. Dr. Gold is on the editorial boards of *Health Affairs* and *Health Services Research*. She received her doctorate of science in health services and evaluation research from Harvard School of Public Health.

Herman Gray, MD, MBA, is executive vice president for pediatric health services for the Detroit Medical Center (DMC). Prior to assuming this responsibility in 2013, he served as CEO/president of the DMC Children's Hospital of Michigan (CHM) for eight years. At CHM, Dr. Gray also served as chief operating officer, chief of staff, and vice chief of education in the Department of Pediatrics. He also served as vice president for graduate medical education (GME) at the DMC and associate dean for GME at Wayne State University School of Medicine. Dr. Gray has served as the chief medical consultant at the Michigan Department of Public Health, Children's Special Health Care Services, as well as vice president/medical director of clinical affairs at Blue Care Network, a subsidiary of Blue Cross Blue Shield of Michigan. He has received the Michigan Hospital Association Health Care Leadership Award, *Modern Healthcare's* Top 25 Minority Executives in Healthcare Award, and is a member of the board of trustees for the Children's Hospital Association and the Skillman Foundation. He received his medical degree from the University of Michigan, a master of business administration from the University of Tennessee, and completed his pediatrics training at the Children's Hospital of Michigan/Wayne State University.

Mark Hoyt, FSA, MAAA, was the national practice leader of the Government Human Services Consulting group of Mercer Health & Benefits, LLC, until his retirement in 2012. This group, which has worked with over 30 states, helps states purchase health services for Medicaid and the State Children's Health Insurance Program (CHIP).

Mr. Hoyt joined Mercer in 1980 and, starting in 1987, worked on government health care projects, including developing strategies for statewide health reform, evaluating the impact of different managed care approaches, and overseeing program design and rate analysis for Medicaid and CHIP. Mr. Hoyt is a fellow in the Society of Actuaries and a member of the American Academy of Actuaries. He received a bachelor of arts in mathematics from the University of California, Los Angeles and a master of arts in mathematics from the University of California, Berkeley.

Yvette Long is the parent of a 16-year-old with chronic health issues who is covered by Medicaid. Ms. Long serves as a case manager with the Philadelphia Welfare Rights Organization. She is chair of the Consumer Subcommittee of the Pennsylvania Medical Assistance Advisory Committee, which advises the state about major initiatives of the Pennsylvania Medicaid program. She also is on the board of the Pennsylvania Legal Aid Network, which oversees administration of the state's legal aid programs.

Charles Milligan, JD, MPH, is senior vice president of enterprise government programs at Presbyterian Healthcare Services in Albuquerque, NM, where he is a member of the leadership team focused on delivery system and payment reform efforts at a large, integrated delivery system. Mr. Milligan was a former state Medicaid director in New Mexico and Maryland. He also served as executive director of the Hilltop Institute, a health services research center at the University of Maryland, and as vice president at The Lewin Group. Mr. Milligan directed the 2005–2006 Commission on Medicaid and has conducted Medicaid-related research projects in numerous states. He received his master of public health from the University of California, Berkeley and his law degree from Harvard Law School.

Sheldon Retchin, MD, MSPH, was recently appointed executive vice president for health sciences and chief executive officer of The Ohio State University Wexner Medical Center in Columbus. Dr. Retchin's

research and publications have addressed the costs, quality, and outcomes of care as well as workforce issues. From 2003 until he began his appointment at Ohio State, he served as senior vice president for health sciences at Virginia Commonwealth University (VCU), and CEO of the VCU Health System, in Richmond, Virginia. Dr. Retchin also led a Medicaid health maintenance organization with approximately 200,000 covered lives through which, for 15 years, he and his colleagues helped manage care for 30,000 uninsured individuals in the Virginia Coordinated Care program. Dr. Retchin received his medical degree from The University of North Carolina School of Medicine and his master of science in public health from The University of North Carolina School of Public Health.

Patricia Riley, MS, is executive director of the National Academy for State Health Policy. Previously, she was a senior fellow of health policy and management at the Muskie School of Public Service, University of Southern Maine. Following her tenure as director of the Maine Governor's Office of Health Policy and Finance, she was the first distinguished visiting fellow in state health policy at The George Washington University, where she serves as a lecturer. She was a principal architect of the Dirigo Health Reform Act of 2003, which was enacted to increase access, reduce costs, and improve quality of health care in Maine. Under four Maine governors, she held appointed positions, including executive director of the Maine Committee on Aging, director of the Bureau of Maine's Elderly, associate deputy commissioner of health and medical services, and director of the Bureau of Medical Services, which is responsible for the Medicaid program and health planning and licensure. As a member of Maine's Commission on Children's Health, Ms. Riley participated in drawing up the state's CHIP plan. She is a member of the Kaiser Commission on Medicaid and the Uninsured and has served as a member of the IOM's Subcommittee on Creating an External Environment for Quality and its Subcommittee on Maximizing the Value of Health. Ms. Riley also has served as a member of the board of directors

of NCQA. She received her master of science in community development from the University of Maine.

Norma Martínez Rogers, PhD, RN, FAAN, is a professor of family nursing at The University of Texas (UT) Health Science Center at San Antonio. She has held clinical and administrative positions in psychiatric nursing and at psychiatric hospitals, including the William Beaumont Army Medical Center in Fort Bliss during Operation Desert Storm. She is dedicated to working with those who face health disparities and is the founder and president of the National Latino Nurse Faculty Association. She has initiated a number of programs at the UT Health Science Center at San Antonio, including a mentorship program for retention of minorities in nursing education. She was a founding board member of a non-profit organization, Martínez Street Women's Center, designed to provide support and educational services to women and teenage girls. Dr. Martínez Rogers is a fellow of the American Academy of Nursing and a past president of the National Association of Hispanic Nurses. She received a master of science in psychiatric nursing from the UT Health Science Center at San Antonio and her doctorate in cultural foundations in education from The University of Texas at Austin.

Sara Rosenbaum, JD, is founding chair of the Department of Health Policy and the Harold and Jane Hirsh Professor of Health Law and Policy at The George Washington University Milken Institute School of Public Health. She also serves on the faculties of The George Washington University Schools of Law and Medicine. Professor Rosenbaum's research has focused on how the law intersects with the nation's health care and public health systems, with a particular emphasis on insurance coverage, managed care, the health care safety net, health care quality, and civil rights. She is a member of the IOM and has served on the boards of numerous national organizations, including AcademyHealth. Professor Rosenbaum is a past member of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on

Immunization Practices and also serves on the CDC Director's Advisory Committee. She has advised Congress and presidential administrations since 1977 and served on the staff of the White House Domestic Policy Council during the Clinton administration. Professor Rosenbaum is the lead author of *Law and the American Health Care System*, published by Foundation Press (2012). She received her law degree from Boston University School of Law.

Diane Rowland, ScD, is executive vice president of the Henry J. Kaiser Family Foundation and executive director of the foundation's Kaiser Commission on Medicaid and the Uninsured. She is a nationally recognized health policy expert with a distinguished career in public policy and research focusing on health insurance coverage, access to care, and health care financing for low-income, elderly, and disabled populations. She has directed the Kaiser Commission on Medicaid and the Uninsured since 1991 and overseen the foundation's health policy work on Medicaid, Medicare, private insurance, global health and HIV, women's health, and disparities since 1993. A noted authority on Medicaid, Medicare, and health care policy, Dr. Rowland frequently testifies and has published widely on these issues. Appointed in 2009 as the inaugural chair, Dr. Rowland continues to serve as the chair of MACPAC. Dr. Rowland is an elected member of the IOM and holds a bachelor's degree from Wellesley College, a master of public administration from the University of California, Los Angeles, and a doctor of science in health policy and management from the Johns Hopkins University.

Peter Szilagyi, MD, MPH, was recently named vice chair for clinical research in the Department of Pediatrics at the University of California, Los Angeles. Until that appointment, he served as chief of the division of general pediatrics and professor of pediatrics at the University of Rochester and as associate director of the Center for Community Health within the University of Rochester's Clinical Translational Research Institute. His research has addressed CHIP and child health insurance; access

to care; quality of care; and health outcomes, including the delivery of primary care with a focus on immunization delivery, health care financing, and children with chronic disease. For the past 18 years, he was chairman of the board of the Monroe Plan for Medical Care, a large Medicaid and CHIP managed care plan in upstate New York. He is editor-in-chief of *Academic Pediatrics* and has served as the president of the Academic Pediatric Association. Dr. Szilagyi received his medical and public health degrees from the University of Rochester.

Steven Waldren, MD, MS, is director of the Alliance for eHealth Innovation at the American Academy of Family Physicians. He sits on several advisory boards dealing with health information technology (IT), and he was a past co-chair of the Physicians Electronic Health Record Coalition, a group of more than 20 professional medical associations addressing issues around health IT. He received his medical degree from the University of Kansas School of Medicine. While completing a post-doctoral National Library of Medicine medical informatics fellowship, he completed a master of science in health care informatics from the University of Missouri-Columbia. Dr. Waldren is a co-founder of two start-up companies dealing with health IT systems design: Open Health Data, Inc., and New Health Networks, LLC.

Biographies of Staff

Annie Andrianasolo, MBA, is executive assistant. She previously held the position of special assistant for global health at the Public Health Institute and was a program assistant for the World Bank. Ms. Andrianasolo has a bachelor of science in economics and a master of business administration from the Johns Hopkins Carey Business School.

Amy Bernstein, ScD, MHSA, is policy director and contracting officer. She manages and provides oversight and guidance for all MACPAC research, data, and analysis projects, including statements of work, research plans, and all deliverables and products. She also directs and conducts policy analyses. Her previous positions have included director of the Analytic Studies Branch at the U.S. Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, and senior analyst positions at the Alpha Center, the Prospective Payment Assessment Commission, the National Cancer Institute, and the Agency for Healthcare Research and Quality (AHRQ). Dr. Bernstein earned a master of health services administration from the University of Michigan School of Public Health and a doctor of science from the School of Hygiene and Public Health at the Johns Hopkins University.

James Boissonnault, MA, is chief information officer. Prior to joining MACPAC, he was the information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he also worked on several federal government projects, including those for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

Vincent Calvo is administrative assistant. Previously, he was an intern at Financial Executives International, where he researched the impact of health and tax laws on Fortune 500 companies. Mr. Calvo holds a bachelor of science from Austin Peay State University.

Kathryn Ceja is director of communications. Previously, she served as lead spokesperson for Medicare issues in the Centers for Medicare & Medicaid Services (CMS) press office. Prior to her tenure in the press office, Ms. Ceja was a speechwriter for the Secretary of the U.S. Department of Health and Human Services (HHS) as well as the speechwriter for a series of CMS administrators. Ms. Ceja holds a bachelor of arts in international studies from American University.

Veronica Daher, JD, is a senior analyst. Previously, she was a health policy analyst for the Health Safety Net program at the Massachusetts Executive Office of Health and Human Services, where she focused on developing policy in response to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Her work now focuses on how the ACA is affecting Medicaid and CHIP. Ms. Daher received her law degree from the University of Richmond and a bachelor of arts from the University of Virginia.

Nicholas Elan is research assistant. Prior to joining MACPAC, he interned with the Congressional Research Service, where he analyzed costs for individual market health insurance plans offered on the ACA exchanges. Mr. Elan has a bachelor's degree in philosophy from Princeton University.

Benjamin Finder, MPH, is a senior analyst. His work focuses on benefits and payment policy. Prior to joining MACPAC, he served as an associate director in the Health Care Policy and Research Administration at the District of Columbia Department of Health Care Finance, and as an

analyst at the Henry J. Kaiser Family Foundation. Mr. Finder holds a master of public health from The George Washington University, where he concentrated in health policy and health economics.

Moira Forbes, MBA, is a policy director, focusing on payment policy and the design, implementation, and effectiveness of program integrity activities in Medicaid and CHIP. Previously, she served as director of the division of health and social service programs in the Office of Executive Program Information at HHS and as a vice president in the Medicaid practice at The Lewin Group. At Lewin, Ms. Forbes worked with every state Medicaid and CHIP program on issues relating to program integrity and eligibility quality control. She has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes has a master of business administration from The George Washington University and a bachelor's degree in Russian and political science from Bryn Mawr College.

April Grady, MPAff, is a policy director. Prior to joining MACPAC, Ms. Grady worked at the Congressional Research Service and the Congressional Budget Office, where she provided non-partisan analyses of Medicaid, private health insurance, and other health policy issues. She has held positions at the LBJ School of Public Affairs at The University of Texas at Austin and Mathematica Policy Research. Ms. Grady received a master of public affairs from the LBJ School of Public Affairs and a bachelor of arts in policy studies from Syracuse University.

Benjamin Granata is finance and budget specialist. He reviews financial documents to ensure completeness and accuracy for processing and recording in the financial systems. Mr. Granata graduated from Towson University with a bachelor's degree in business administration, specializing in project management.

Martha Heberlein, MA, is a principal analyst. Prior to joining MACPAC, she was the research manager at the Georgetown University Center for Children and Families, where she oversaw a national survey on Medicaid and CHIP eligibility, enrollment, and renewal procedures. Ms. Heberlein received a master of arts in public policy with a concentration in philosophy and social policy from The George Washington University and a bachelor of science in psychology from James Madison University.

Joanne Jee, MPH, is a principal analyst focusing on CHIP and children's coverage. Prior to joining MACPAC, she was a program director at the National Academy for State Health Policy, where she focused on children's coverage issues. Ms. Jee also has been a senior analyst at the U.S. Government Accountability Office (GAO), a program manager at The Lewin Group, and a legislative analyst in the HHS Office of Legislation. Ms. Jee has a master of public health from the University of California, Los Angeles and bachelor of science in human development from the University of California, Davis.

Sarah Melecki, MPAff, is an analyst providing support on a variety of issues, including the ACA's Medicaid expansion, Medicaid adult dental coverage, and Medicaid behavioral health services. Prior to joining MACPAC, she worked on the health team at Consumers Union, where she covered ACA implementation and health care cost drivers. Ms. Melecki also has served as district director to Texas state representative Jessica Farrar. She holds a master of public affairs from the LBJ School of Public Affairs at The University of Texas at Austin and a bachelor of arts in political science from the University of Nebraska.

Robert Nelb, MPH, is a senior analyst. Prior to joining MACPAC, he served as a health insurance specialist at CMS, leading projects related to CHIP and Medicaid Section 1115 demonstrations. Mr. Nelb has a master of public health and a bachelor's degree in ethics, politics, and economics from Yale University.

Saumil Parikh, MBA, is IT specialist. Previously, he was a network and system administrator at CBH Health, and an IT support specialist at Emergent Biosolutions, focusing on IT system administration, user and network support, general projects, and team leadership. He also worked at Vesta, Inc. in a similar role. Mr. Parikh holds a master of business administration in information systems and a bachelor of arts in computer networking from Strayer University.

Chris Park, MS, is a senior analyst. He focuses on issues related to managed care payment and Medicaid drug policy and provides data analyses using Medicaid administrative data. Prior to MACPAC, he was a senior consultant at The Lewin Group, where he provided quantitative analyses and technical assistance on Medicaid policy issues, including Medicaid managed care capitation rate setting and pharmacy payment and cost-containment initiatives. Mr. Park holds a master of science in health policy and management from the Harvard School of Public Health and a bachelor of science in chemistry from the University of Virginia.

Chris Peterson, MPP, is a principal analyst. Prior to joining MACPAC, he was a specialist in health care financing at the Congressional Research Service, where he worked on major health legislation. Prior to that, he worked for AHRQ and the National Bipartisan Commission on the Future of Medicare. Mr. Peterson has a master of public policy from Georgetown University and a bachelor of science in mathematics from Missouri Western State University.

Ken Pezzella is chief financial officer. He has more than 10 years of federal financial management and accounting experience in both the public and private sectors. Mr. Pezzella also has broad operations and business experience, and is a proud veteran of the U.S. Coast Guard. He holds a bachelor of science in accounting from Strayer University.

Anne L. Schwartz, PhD, is executive director. She previously served as deputy editor at *Health Affairs*; vice president at Grantmakers In Health, a national organization providing strategic advice and educational programs for foundations and corporate giving programs working on health issues; and special assistant to the executive director and senior analyst at the Physician Payment Review Commission, a precursor to the Medicare Payment Advisory Commission (MedPAC). Earlier, she held positions on committee and personal staff for the U.S. House of Representatives. Dr. Schwartz earned a doctorate in health policy from the School of Hygiene and Public Health at the Johns Hopkins University.

Anna Sommers, PhD, MS, MPAff, is a principal analyst. Previously, she held research positions at the Center for Studying Health System Change (HSC), the Hilltop Institute at the University of Maryland, and the Urban Institute. At HSC, she published Medicaid briefs on high-cost use, specialty care access, and physician workforce, and led design of the Autoworkers Health Care Survey. At Hilltop, she led an evaluation of New Mexico's CHIP program and served as senior consultant on a range of analyses for Maryland's Medicaid program and the Maryland Health Services and Cost Review Commission. Dr. Sommers has a doctorate and a master of science in health services research, policy, and administration from the University of Minnesota School of Public Health, and a master of public affairs from its Hubert H. Humphrey Institute of Public Affairs.

Mary Ellen Stahlman, MHSA, is policy and congressional affairs director. Previously, she held positions at the National Health Policy Forum, focusing on Medicare issues including private plans and the Medicare drug benefit. She served at CMS and its predecessor agency—the Health Care Financing Administration—for 18 years, including as deputy director of policy. Ms. Stahlman received a master of health services administration from The George Washington University and a bachelor of arts from Bates College.

James Teisl, MPH, is a principal analyst focused on issues related to Medicaid payment and financing. Previously, he was a senior consultant with The Lewin Group and also has worked for the Greater New York Hospital Association and the Ohio Medicaid program. Mr. Teisl received a master of public health from the Johns Hopkins Bloomberg School of Public Health.

Kristal Vardaman, MSPH, is a principal analyst focused on long-term services and supports and on high-cost, high-need populations. Previously, she was a senior analyst at the GAO and a consultant at Avalere Health. Ms. Vardaman holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of science from the University of Michigan. She currently is pursuing a doctorate in public policy from The George Washington University.

Ricardo Villeta, MBA, is deputy director for operations, finance, and management with overall responsibility for management of the MACPAC budget and resources. Mr. Villeta directs all operations related to financial management and budget, procurement, human resources, information technology, and contracting. Previously, he was the senior vice president and chief management officer for the Academy for Educational Development, a private, non-profit educational organization that provided training, education and technical assistance throughout the United States and in more than 50 countries. Mr. Villeta holds a master of business administration from The George Washington University and a bachelor of science from Georgetown University.

Katie Weider, MPH, is a senior analyst. She focuses on issues related to individuals who are eligible for both Medicaid and Medicare. Prior to joining MACPAC, she served as a senior research assistant at The George Washington University and as a health policy intern for U.S. Senator Chuck Grassley (R-IA). Ms. Weider received a master of public health from The George Washington University and

a bachelor's degree in health science and public health from Boston University.

Eileen Wilkie is the administrative officer and is responsible for human resources, office maintenance, and coordinating travel and Commission meetings. Previously, she held similar roles at National Public Radio and the National Endowment for Democracy. Ms. Wilkie has a bachelor's degree in political science from the University of Notre Dame.



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MACPAC

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1800 M Street NW
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