Recommendations for the Future of CHIP and Children's Coverage

JANUARY 2017

MACPAC | Medicaid and CHIP Payment and Access Commission

MACPAC

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 USC 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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MACPAC
Medicaid and CHIP Payment and Access Commission

January 17, 2017

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

The Honorable Paul Ryan
Speaker of the House
U.S. Capitol
Washington, DC 20515

Dear Mr. Vice President and Mr. Speaker:

I wish to submit the enclosed package of recommendations concerning the future of the State Children's Health Insurance Program (CHIP) on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC). If adopted, these recommendations will ensure the stability and affordability of coverage for more than 8 million low- to moderate-income children and mitigate budget uncertainty for states as they enter into their budget and planning cycles. MACPAC's recommendations are essential to protecting low- and moderate-income children's access to stable insurance coverage during a time of uncertainty about other sources of coverage. The Commission's core recommendation is to extend federal funding for CHIP for five additional years.

Enacted in 1997 with strong bipartisan support, CHIP is state-administered within federal parameters and jointly financed by states and the federal government. The program operates in every state and U.S. territory and it, along with Medicaid, has been widely credited with helping to reduce the number of uninsured children in the United States—from 10 million in 1997 to 3.3 million in 2015. The federal government currently matches state spending at rates ranging from 88 percent to 100 percent. In fiscal year (FY) 2015, CHIP spending totaled approximately $14 billion, with about 71 percent paid by the federal government and 29 percent by the states and territories.

Although the CHIP legislative authorization does not expire, without congressional action, states will not receive any new federal funds for CHIP beyond September 30, 2017. MACPAC has found that if CHIP funding is not renewed, many of the children covered under separate CHIP will lose their health coverage. Some of these children may be eligible for private coverage. However, their families would have to pay considerably more than they would under CHIP, potentially creating barriers to needed coverage and access to health and developmental services. Moreover, CHIP often covers services that are unavailable through other coverage. Those covered by Medicaid-expansion CHIP would not lose coverage but there would be a significant shift in the funding obligation for their coverage to the states.

In addition to the five-year extension of CHIP funding, MACPAC recommends:

- extending the current CHIP maintenance-of-effort (MOE) provision for three additional years, through FY 2022, to ensure a stable source of health care coverage for children;
- extending the current federal CHIP matching rate through FY 2022 while the MOE is in place;
- establishing new demonstration grants to states to support the development and testing of state-based, seamless systems of coverage for low- and moderate-income children;
- ending waiting periods in CHIP and eliminating CHIP premiums for children in families with incomes below 150 percent of the federal poverty level to minimize the potential for gaps in children's coverage and reduce uninsurance;
- enabling states to use Express Lane Eligibility permanently to streamline and facilitate the CHIP and Medicaid application process; and,
- providing five years of additional funding for grants to support outreach to and enrollment of Medicaid- and CHIP-eligible children, for the Childhood Obesity Research Demonstration project, and for the Pediatric Quality Measures Program—three programs that have been renewed with CHIP in previous years.

CHIP has provided health insurance to millions of children whose families otherwise could not afford it and has had strong bipartisan support throughout its history. At this time, the urgency of congressional action to preserve health insurance coverage for the nation's low- and moderate-income families cannot be overstated. On behalf of MACPAC, I encourage you to consider legislation affecting the future of children's coverage and to adopt these recommendations as soon as possible.

Sincerely,

Sara Rosenbaum, JD
Chair

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Recommendations

1.1 Congress should extend federal CHIP funding for a transition period that would maintain a stable source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.

1.2 Congress should extend federal CHIP funding for five years, through fiscal year 2022, to give federal and state policymakers time to develop policies and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.

1.3 In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP matching rate, currently in effect through FY 2019, for three additional years, through fiscal year 2022.

1.4 To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP. (This recommendation was first made in the Commission's March 2014 report to Congress.)

1.5 In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums. (This recommendation was first made in the Commission's March 2014 report to Congress.)

1.6 Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support state efforts to develop, test, and implement approaches to providing for CHIP-eligible children seamless health coverage that is as comprehensive and affordable as CHIP.

1.7 Congress should permanently extend the authority for states to use Express Lane Eligibility for children in Medicaid and CHIP. (The Commission noted its support for this policy in a 2014 letter to the Secretary of HHS [MACPAC 2014c].)

1.8 The Secretary of the U.S. Department of Health and Human Services, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of Education should, not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.

1.9 Congress should extend funding for five years for grants to support outreach and enrollment of Medicaid and CHIP eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures program, through fiscal year 2022.

Key Points

- The State Children's Health Insurance Program (CHIP) has played an important role in providing insurance coverage and access to health care for low- and moderate-income children since its enactment in 1997. In fiscal year (FY) 2015, about 8.4 million children were enrolled in CHIP.
- CHIP is permanently authorized, but current law only provides federal funding to states through FY 2017. Five states are expected to spend their remaining CHIP allotments by December 2017; 29 states and the District of Columbia are expected to spend their remaining CHIP allotments by March 2018.
- Since funding for CHIP was last renewed by the Medicare and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), MACPAC's analysis has focused on both what would happen in the current-law scenario under which federal CHIP funding comes to an end, and on the steps that should be taken to meet the health and developmental needs of low- and moderate-income children in the future if federal program funding is extended, including the role of CHIP in providing children's coverage.
- Key findings from this analysis are:
  - CHIP has reduced uninsurance among children in families with incomes below 200 percent of the federal poverty level (FPL).
  - CHIP coverage is more affordable, with respect to both premiums and out-of-pocket cost sharing expenses, for families than either exchange or employer-sponsored coverage.
  - Although most sources of coverage include major medical benefits (i.e., inpatient and outpatient hospital services, physician services, and prescription drugs), CHIP and Medicaid are more likely to cover oral health services, audiology, and hearing aids relative to exchange plans and employer-sponsored insurance.
  - Children with CHIP coverage are more likely to have a usual source of care, including dental care, and more likely to have had a well-child visit in the past year relative to children without insurance.
- It is the Commission's view that the development of a more seamless system of children's coverage is needed. Such a system would provide comprehensive and affordable coverage for low- to moderate-income children, removing the potential for gaps in coverage and care that can affect children as they transition among different sources of publicly and privately financed health insurance.
- Uncertainty about the stability of the coverage market, now heightened by potential action by the 115th Congress on proposals to repeal the law underpinning the workings of the exchange market and change the structure and financing of the Medicaid program, have led the Commission to recommend extending CHIP at this time.

Key Points (continued)

- The Commission recommends an extension of CHIP funding for five years to ensure that low- and moderate-income children retain access to affordable and comprehensive insurance coverage, maintaining the gain in coverage secured over the past 20 years.
- In order to provide a stable source of children's coverage and give federal and state policymakers time to develop policies and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children, the following changes should be made:
  - fund CHIP through fiscal year 2022; and
  - extend the current CHIP maintenance of effort and 23 percentage point increase in the federal CHIP matching rate for three years, through fiscal year 2022.
- The Commission also recommends creating and funding a children's coverage demonstration grant program to support state efforts to develop, test, and implement approaches to providing CHIP-eligible children with seamless health coverage that is as comprehensive and affordable as CHIP. State innovation will be a key driver in improving the system of coverage for low- and moderate-income children, and federal support of those efforts would ease financial barriers to states that aspire to transform their children's coverage systems.
- The Commission reiterates its support for the elimination of waiting periods in CHIP, aligning separate CHIP premium policies with those of Medicaid, and permanently extending authority for states to use Express Lane Eligibility.
- Finally, the Commission recommends extending funding to support outreach and enrollment of Medicaid- and CHIP-eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program. These programs focus on improving aspects of coverage or care for children enrolled in Medicaid or CHIP and have been renewed along with CHIP funding in previous years.

The Future of CHIP and Children's Coverage

Since its enactment with bipartisan support in 1997, the State Children's Health Insurance Program (CHIP) has played an important role in providing insurance coverage and access to health care for millions of low- and moderate-income children with incomes above Medicaid eligibility levels. During these years, the share of uninsured children in the typical CHIP income range, that is, those with family incomes above 100 percent but below 200 percent of the federal poverty level (FPL), has fallen dramatically—from 22.8 percent in 1997 to 6.7 percent in 2015 (Cohen et al. 2016). In fiscal year (FY) 2015, about 8.4 million children were enrolled in CHIP compared to nearly 37 million children in Medicaid (MACPAC 2016a).

In addition to providing access to affordable coverage, CHIP improves access to care for enrolled children. For example, children with CHIP coverage are more likely than children without insurance to have a usual source of care, including dental care, and more likely to have had a well-child visit in the past year (Harrington et al. 2014). Access to and use of health care services by children with CHIP are generally comparable to that of children with employer-sponsored coverage, although comparisons between these two coverage sources are complex. (Cornachione et al. 2016, MACPAC 2012). CHIP also plays an important role in the financial security of low- and moderate-income families. Family spending on children's health care decreases when families gain CHIP or Medicaid coverage. CHIP and Medicaid coverage are also associated with a decreased likelihood that a family has unpaid medical bills and faces household bankruptcy (Wherry et al. 2016).

Congress now faces an important decision regarding the future of the program and its approach to providing a stable, affordable, and adequate source of coverage to millions of America's children. Although CHIP is permanently authorized, current law provides federal CHIP funding to states only through FY 2017. Since funding for CHIP was last renewed by the Medicare and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), MACPAC has focused considerable attention on determining what it considers the best approach to take going forward. Our analysis has focused on both what would happen under the current-law scenario under which federal CHIP funding comes to an end, and on the steps that should be taken to meet the health and developmental needs of low- and moderate-income children in the future if federal program funding is extended, including the role of CHIP in providing children's coverage.

MACPAC's deliberations, going back to 2013, have considered CHIP in context: a relatively small program of public coverage, serving children in families whose incomes are too high for Medicaid, but for whom employer-sponsored coverage is unavailable, unaffordable, or inadequate. The Commission's deliberations have assumed that other current coverage sources, including Medicaid and subsidized exchange coverage, remain available for children. For example, we have looked to the possibility of better integrating CHIP with exchange markets given that federal subsidies for such coverage are available to eligible individuals and families with incomes between 100 and 400 percent FPL. Those analyses, however, identified serious concerns about the quality and affordability of exchange coverage as compared to CHIP, concerns that led the Commission to recommend an extension of CHIP in its June 2014 report, and that informed the work of the Commission as it considered policy options for the period ahead.

Now, uncertainty about the stability of the exchange market, further heightened by potential action by the 115th Congress on proposals to repeal the law underpinning the workings of this market and to change the structure and financing of the Medicaid program, have led the Commission to once again recommend extending CHIP. Specifically, as described in greater detail below, the Commission recommends that funding be extended for a period

of five years, through FY 2022. Such an extension would ensure the stability of children's coverage during a time in which the coverage environment could change significantly, and would also be responsive to the pressing concerns of states as they begin budget and policy planning for the next fiscal year and beyond.

The Commission continues to hold that a more seamless system of children's coverage should be developed—a system that would provide comprehensive and affordable coverage for low- to moderate-income children and remove the potential for gaps in coverage and care that can affect children as they transition among different sources of publicly and privately financed health insurance. Such a system would promote greater integration and alignment between Medicaid, CHIP, and other insurance sources and would smooth out transitions that occur when families experience changes in income and employment (e.g., by moderating differences in out-of-pocket spending required for children). In addition, the Commission continues to be troubled by the fact that many low- and moderate-income children do not benefit from the value and security offered by CHIP coverage because CHIP eligibility levels vary widely from state to state (MACPAC 2016b). This means that for families at the same income level, children in some states are eligible for CHIP while children in other states are not. Their families must instead obtain costlier, potentially less comprehensive coverage for the children through other sources.

The Commission's long-range vision looks to a system that ensures sufficient coverage, in terms of both benefits and affordability, to appropriately meet the needs of the nation's children. We also look to states as potential laboratories of innovation for improvements in children's coverage, including alignment of children's coverage with state-focused efforts to organize and improve their health insurance markets to promote coverage and improve population health.

In the short term, however, two things are clear: first, health insurance markets will likely face substantial changes over the next few years. Second, current funding for CHIP will be exhausted before such changes are fully realized. The design of specific solutions to address the shortcomings of children's coverage concerns and weighing the merits and costs of different approaches will require additional time for analysis and planning. Given uncertainty about the future structure of the market for publicly financed health insurance coverage going forward and the urgency of addressing the impending end to CHIP funding, the Commission finds that the existing approach to children's coverage should be maintained while these broader questions are addressed. The Commission urges Congress to act as soon as possible to extend CHIP funding so that both families and states have assurances that CHIP will be maintained during this time of uncertainty.

This special report presents the Commission's recommendations on the future of CHIP as well as several companion recommendations to move toward a more seamless system of children's coverage. We begin by summarizing recent work of the Commission that has informed our present deliberations and our conclusions. The analyses and conclusions cover the program's impact on children's coverage, our expectation of the likely scenario should CHIP funding not be renewed, and the relative advantages of CHIP when compared to other sources of coverage. We then present each of the recommendations and its rationale along with our assessment of its implications for the federal government, states, beneficiaries, and providers and plans. Appendix A provides an overview of CHIP and Appendix B provides state CHIP eligibility and enrollment information.

MACPAC Analysis and Deliberation

MACPAC has been considering the future of CHIP and children's coverage for a number of years. In 2014, the Commission began thinking more broadly about how to meet the needs of low- and moderate-income children in an evolving coverage environment that under current law includes Medicaid, CHIP, exchange coverage, and employer-sponsored insurance. In its March 2014 report to Congress, the Commission stated its view that regardless of what form children's coverage takes, it must be affordable and offer comprehensive coverage, and it should maintain a program design that allows state flexibility, one of the key features that led to all states adopting CHIP in the late 1990s (MACPAC 2014a). In its June 2014 report, the Commission recommended two years of additional funding, with an expectation that this amount of time would be sufficient to resolve the open questions regarding the longer-term structure of publicly subsidized children's coverage (MACPAC 2014b).

In 2015 and early 2016, the Commission's analysis focused on the following:

- the likely impact on children's insurance status should CHIP funding not be renewed;
- comparisons of out-of-pocket spending between CHIP and both exchange coverage and employer-sponsored insurance;
- analysis of differences in benefits between CHIP and other sources of coverage; and
- an examination of network adequacy under these different types of insurance coverage (MACPAC 2016c, 2015).

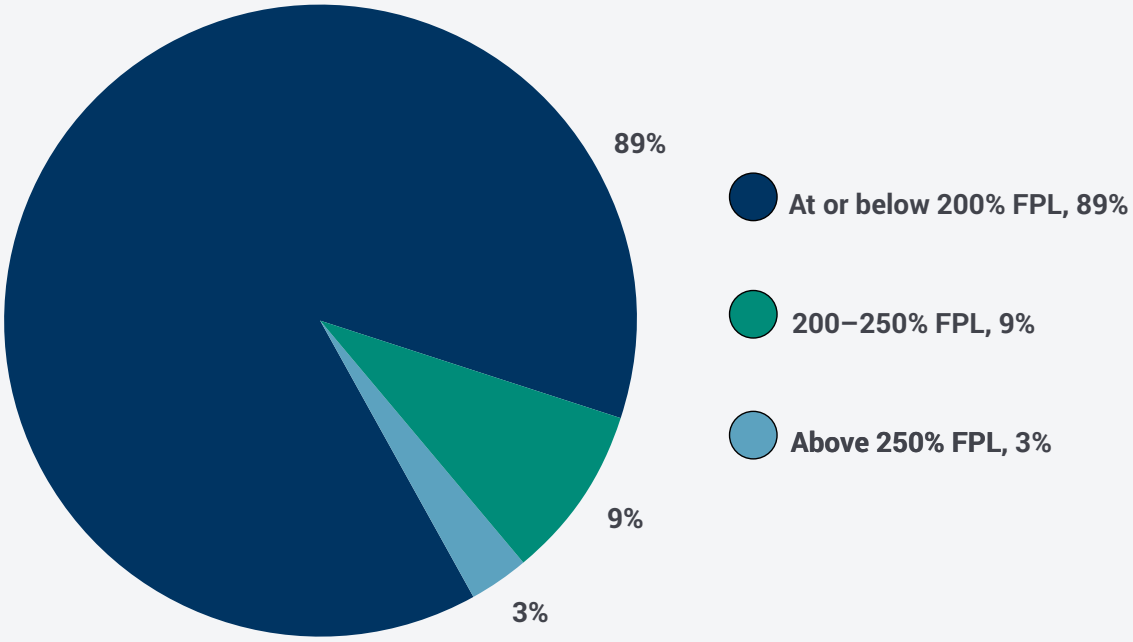
Our conclusions based on this work are presented below.

CHIP has reduced uninsurance among children in families with modest incomes

CHIP was created as part of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). To encourage states to participate, Congress provided them with enhanced federal financing for CHIP and gave them greater flexibility in designing CHIP than they had with Medicaid. In 1997, it was uncertain how many states would respond to this new federal funding opportunity, but by FY 2000, every state and territory (including the District of Columbia) had children enrolled in CHIP-financed coverage. States can design CHIP as an expansion of Medicaid, as a separate program, or as a combination of both. Currently, ten states, including the District of Columbia, and five territories operate CHIP entirely as a Medicaid expansion; two states operate CHIP entirely as separate programs; and 39 states operate a combination program. In states operating a Medicaid-expansion program, federal Medicaid rules generally apply. Of the 8.4 million children enrolled in CHIP-funded coverage in 2015, 3.7 million were enrolled in separate CHIP and 4.7 million in Medicaid-expansion CHIP (MACPAC 2016a).[1] CHIP has enjoyed bipartisan support from Congress, which most recently renewed federal funding for two years, under MACRA, through FY 2017.

CHIP, along with Medicaid, is widely credited with helping to reduce uninsurance among children. Since CHIP's enactment, the share of all children age 0–17 that were uninsured fell about 9 percentage points from 13.9 percent in 1997 to 4.5 percent in 2015.[2] The decline was even greater for those with family incomes at or above 100 percent FPL but below 200 percent FPL (Cohen et al. 2016). Unlike Medicaid, CHIP does not impose on states the requirement to cover children up to a specific income level, and it gives them flexibility in setting income eligibility at levels they deem most appropriate for their coverage market and state environment. Income eligibility levels vary widely across the states, with upper limits currently ranging from 170 percent to 400 percent FPL (MACPAC 2016b). Nevertheless, the vast majority of states (89 percent) set income eligibility at or below 200 percent FPL in FY 2013 (Figure 1).

FIGURE 1. Child Enrollment in CHIP-Financed Coverage, by Family Income as a Percentage of FPL, FY 2013



Notes: FPL is federal poverty level. FY is fiscal year. Includes separate and Medicaid-expansion CHIP. In the Statistical Enrollment Data Systems (SEDS), Delaware, Nevada, North Carolina, Oklahoma, South Carolina, and South Dakota reported CHIP enrollees above 200 percent FPL, and Kansas reported CHIP enrollees above 250 percent FPL; however, CHIP in these states is reported only to cover individuals at or below these levels. The numbers here were altered to put all of the enrollees in Delaware, Nevada, North Carolina, Oklahoma, South Carolina, and South Dakota at or below 200 percent FPL and all Kansas enrollees at or below 250 percent FPL. Components may not sum to 100 percent due to rounding. In 2013, in the 48 contiguous states and the District of Columbia, 200 percent FPL was $22,980 for an individual plus $8,040 for each additional family member.

Source: MACPAC, 2014, analysis of CHIP SEDS data from the Centers for Medicare & Medicaid Services as of March 4, 2014.

CHIP is more affordable than other sources of coverage

MACPAC's analyses found that for children in the CHIP income eligibility range, CHIP coverage is considerably less costly to families, with respect to both premiums and out-of-pocket cost sharing, than exchange or employer-sponsored coverage (MACPAC 2016c, 2015).[3] For example, in 2015, the combined premiums and cost sharing of separate CHIP in 36 states averaged $158 per year per child. Most of that spending was for premiums ($127), with the remainder being spent on cost sharing ($31). On average in these 36 states, separate CHIP enrollees faced cost sharing of 2 percent of covered medical benefits, with the plans covering 98 percent—that is, separate CHIP coverage had an effective actuarial value of 98 percent. By contrast, if these same children were enrolled in employer-sponsored insurance, they would have faced an estimated $891 per year per child in average annual out-of-pocket spending ($603 for premiums and $288 in cost sharing), and if enrolled in the second lowest cost silver exchange plan, they would have faced

an estimated $1,073 per year per child ($806 for premiums and $266 in cost sharing). The effective actuarial value averaged 81 percent in employer-sponsored insurance plans and 82 percent in second lowest cost silver exchange plans, with families responsible for the remaining 18 percent to 19 percent through cost sharing (MACPAC 2016c).

While premiums and cost sharing are permitted for children in separate CHIP (capped at 5 percent of family income), they generally are prohibited for children in Medicaid.

CHIP benefits are generally more generous than those offered by other sources of coverage

MACPAC's comparison of benefits in separate CHIP, Medicaid (including Medicaid-expansion CHIP), exchange plans, and employer-sponsored insurance found that covered benefits vary within each source—between states for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans (MACPAC 2015). Most separate CHIP, Medicaid, exchange, and employer-sponsored insurance plans cover major medical benefits, such as inpatient and outpatient care, physician services, and prescription drugs. Children enrolled in Medicaid-expansion CHIP are entitled to all Medicaid services, including early and periodic screening, diagnostic, and treatment services.

Like Medicaid, separate CHIP covers pediatric dental services. By contrast, dental benefits are offered as a separate, stand-alone insurance product in most exchanges and employer-sponsored coverage, requiring families to pay separate premiums and cover cost sharing expenses. More than half of all employer-sponsored plans (54 percent) do not include pediatric dental coverage. Of the employers that offer separate dental coverage, many require an additional premium (MACPAC 2016d).

CHIP also covers many services important to children's healthy development that are not always available in exchange plans. For example, all separate CHIP and Medicaid programs cover audiology exams, and 95 percent of separate 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 (MACPAC 2015). Among employer-sponsored health plans, 34 percent cover pediatric audiology exams and 43 percent cover hearing aids (MACPAC 2015).

The Commission also looked at how CHIP provider networks compare to those of other sources of coverage. Under federal law, CHIP managed care is subject to the same federal provisions that establish standards for Medicaid managed care (§ 2103(f)(3) of the Social Security Act (the Act)). These provisions require states to establish "standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity" (§ 1932(c)(1)(A)(i) of the Act). CHIP regulations also specify that a state must ensure "access to out-of-network providers when the network is not adequate for the enrollee's medical condition" (42 CFR 457.495).

Advocates have suggested that separate CHIP networks are better than Medicaid or exchange plan networks because they are similar to private plan networks or because they are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, we found little empirical evidence to either support or refute this assertion.

Recommendations for the Future of CHIP and Children's Coverage

For much of 2016, the Commission focused its efforts on assessing a range of policy options for the future of CHIP funding and children's coverage. Before deciding on the specific recommendations included in this report, the Commission considered a number of broad options, including: permitting CHIP funding to expire; extending CHIP funding; expanding mandatory Medicaid coverage of children; enhancing exchange coverage; permitting states to use CHIP

funds to purchase exchange coverage; and creating a new waiver authority focused on promoting seamless children's coverage.

In weighing the benefits and drawbacks of the options, the Commission considered several criteria: the effects on coverage, affordability, adequacy of benefits, impact on states and state flexibility, federal and state spending, and simplicity. The Commission drew upon findings from its own analyses as well as those of external policy and health services researchers, such as the evaluation of CHIP mandated by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) (Harrington et al. 2014). The Commission also took into account the views and information offered by stakeholders. From the time the Commission began its deliberation to the time it developed its final recommendations, changes in the policy environment occurred that could significantly alter the coverage context for children. It is important to note that the Commission's recommendations were made in the context of current law, but with the understanding that the incoming Congress is likely to take up proposals to make substantial changes, both to health insurance markets and to Medicaid.

The Commission's recommendations, rationale, and implications are described below. In this recommendation package, the Commission reiterates its 2014 recommendations to eliminate CHIP waiting periods and premiums for children in families with incomes below 150 percent FPL, as well as its prior support for permanently extending Express Lane Eligibility authority. Although the Commission is not recommending any particular offset at this time, the Commission has compiled a list of savings proposals previously identified in legislative proposals, in President's budgets, and by others. It is important to note that the Commission has not analyzed the merits of these proposals or voted on them, and is not endorsing any specific proposal on the list.

Recommendation 1.1

Congress should extend federal CHIP funding for a transition period that would maintain a stable source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.

Rationale

This recommendation calls for extending federal CHIP funding because other currently available sources of coverage for CHIP-eligible children do not provide affordable or comprehensive coverage. Extending CHIP ensures that eligible low- and moderate-income children will retain access to affordable insurance coverage, maintaining the gains in coverage secured over the past 20 years.

The Commission has discussed at length the need to develop a seamless, coordinated system of children's coverage rather than indefinitely maintain CHIP as a distinct program. However, uncertainty about other sources of coverage and the approaching exhaustion of federal CHIP funding leads the Commission to conclude that at this time, extending CHIP is the better choice for maintaining children's access to coverage.

CHIP cannot continue in its current state unless federal funding is renewed. If federal CHIP funding is exhausted, the 41 states with separate CHIP will not have to maintain that coverage. Children covered in Medicaid-expansion CHIP will not become uninsured because the maintenance-of-effort (MOE) provision requires states to continue that coverage through FY 2019. However, MOE coverage is funded at the regular Medicaid matching rate, which is lower than the CHIP matching rate for these children, putting new fiscal pressures on states.

MACPAC analysis, published in our March 2015 report to Congress, projected that if federal CHIP funds were exhausted and no new federal funding was provided, 3.7 million children would lose access to separate CHIP, of which an estimated 1.1 million children would become uninsured (MACPAC 2015). The remaining children 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

employer-sponsored insurance. These estimates assumed the availability of Medicaid and subsidized exchange coverage for children, as under current law.

The projected increase in the number of uninsured children is not because such children are not eligible for other coverage, but rather because their families cannot afford it. Among the 1.1 million children projected to become uninsured, 59.1 percent are expected to be eligible for a parent's employer-sponsored insurance but will not enroll because of the high cost of premiums and other out-of-pocket cost sharing. The remaining 40.9 percent of the children expected to become uninsured will be eligible for subsidized exchange coverage (MACPAC 2015). About 63 percent of these families are not expected to have to make additional premium contributions for adding children to their coverage. For the remaining 37 percent of children who will have to make additional premium contributions, these contributions—although lower than would be required for employer-sponsored insurance—are higher than required by CHIP (MACPAC 2015).

Even for those families who are able to pay higher premiums to remain insured, concerns about access remain. The higher level of cost sharing at the point of service that is required by other coverage sources will increase the financial burden on low- and moderate-income families, and this has the potential to impede children's access to care (MACPAC 2016c, MACPAC 2016d).

Under current law, 5 states are expected to spend their remaining CHIP allotments by December 2017 and 29 states and the District of Columbia are expected to spend their remaining CHIP allotments by March 2018.[4] Although current law provides no new CHIP allotments in FY 2018, if states are experiencing shortfalls in their CHIP allotments, they can receive redistribution funds from the unspent CHIP allotments of other states after two years have passed (Appendix C). However, the amount of available redistribution funds from FY 2016 unspent allotments is less than in previous years. The current CHIP matching rate is 23 percentage points greater than historical rates, and this has resulted in states spending their federal CHIP allotments faster than in prior years. For example, in FY 2015, $12.6 billion in CHIP allotments were unspent, but in FY 2016, $7.5 billion in CHIP allotments were unspent. In addition, MACRA reduced by one-third the amount of unspent CHIP funding that can be spent in FY 2018. Finally, the child enrollment contingency fund, also available to states that exhaust their CHIP allotments and have CHIP enrollment that exceeds a target level, is not available after FY 2018. Therefore, the Commission urges Congress to act swiftly to renew CHIP funding.

Implications

Federal spending. Extending federal CHIP funding would increase federal spending because of the substantial federal contribution toward covering states' CHIP costs, including the 23 percentage point increase in the CHIP matching rate.

States. An extension of federal CHIP funding would permit states to continue providing CHIP-funded coverage to low- and moderate-income children. An extension would help mitigate the risk of increased state Medicaid and uncompensated care spending if CHIP funding was not renewed.

Enrollees. An extension of federal CHIP funding would mean that CHIP enrollees could retain their CHIP coverage, unless their circumstances change in ways that affect their eligibility.

Plans and providers. Extending CHIP funding would ensure that the plans and providers currently participating in CHIP could continue to provide services to the CHIP-enrolled population without disruption.

Recommendation 1.2

Congress should extend federal CHIP funding for five years, through fiscal year 2022 to give federal and state policymakers time to develop policies for and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.

Rationale

A five-year extension of CHIP funding would provide a longer period relative to the most recent funding renewal, recognizing the considerable work needed to address a more comprehensive approach to children's coverage. It would also ensure that coverage remains available for the vulnerable population of low- and moderate-income children while federal and state policymakers discuss and debate changes in other sources of coverage, including exchange markets and Medicaid.

In its June 2014 report to Congress, the Commission anticipated that a two-year transition period would be sufficient to address concerns regarding the affordability and adequacy of children's coverage. It also stated that if more time was required to ensure that needed reforms were implemented, then an additional extension of CHIP funding should be considered. Meanwhile, the future of other sources of coverage—small group and individual markets—remains unsettled. In addition, Congress is poised to consider substantial changes to Medicaid. At this time, it is not possible to know the precise nature or extent of any such changes, or the timing for instituting them. The recommendation for a five-year extension recognizes the considerable work needed to formulate a more comprehensive approach to children's coverage. A longer-term extension of CHIP will provide a stable source of coverage for low- and moderate-income children while policymakers determine the future of subsidized health insurance.

Extending CHIP for five years also provides budgetary predictability for states. In addition, during this five-year period, states will be key partners in developing new approaches for improving children's coverage systems and may opt to design and implement such strategies. As described below, the Commission also recommends the creation of planning and implementation grants for the development of state-based approaches (see Recommendation 1.6). A five-year CHIP funding extension would provide time for states to implement new approaches and gain experience with them while ensuring a stable source of coverage for children. These state experiences could inform the development of federal policy.

Implications

Federal spending. Extending federal CHIP funding for an additional five years, along with the accompanying recommendations in this report affecting the MOE and the CHIP matching rate, is projected to increase federal spending. The Congressional Budget Office (CBO) estimates this recommendation would increase net federal spending above the agency's current law baseline by approximately $13.2 billion over the five-year period of FYs 2017–2021 and approximately $18.7 billion over the ten-year period of FYs 2017–2026. This estimate reflects congressional budget rules that require the agency to assume in its current-law spending baseline that federal CHIP funding continues beyond FY 2017 at $5.7 billion each year.

States. An extension of federal CHIP funding would permit states to continue providing CHIP-funded coverage to low- and moderate-income children. An extension would help mitigate the risk of increased state Medicaid and uncompensated care spending if CHIP funding were not renewed.

Enrollees. An extension of federal CHIP funding would mean that CHIP enrollees could retain their CHIP coverage, unless their circumstances change in ways that affect their eligibility.

Plans and providers. Extending CHIP funding would ensure that the plans and providers currently participating in CHIP could continue to provide services to the CHIP-enrolled population without disruption.

Recommendation 1.3

In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP

matching rate, currently in effect through FY 2019, for three additional years, through FY 2022.

Rationale

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) put in place an MOE provision effective through FY 2019 that requires states to maintain the CHIP eligibility levels in place on March 23, 2010. The MOE also prohibits states from adopting eligibility and enrollment standards or methodologies that are more restrictive than those in place prior to the enactment of the ACA (§ 2105(d)(3) of the Act). The purpose of this provision is to ensure that children do not lose coverage during a time when changes to other aspects of the program are underway, such as the creation of new eligibility and enrollment systems and the introduction of new methods for making eligibility determinations.

The ACA also increased the federal CHIP matching rate, known as the enhanced federal medical assistance percentage (E-FMAP), by 23 percentage points in FYs 2016–2019. The CHIP matching rate varies by state, currently ranging from 88 percent to 100 percent (Appendix D). Eleven states and the District of Columbia have an E-FMAP of 100 percent, 20 states receive an E-FMAP equal to or greater than 90 percent, and 19 have an E-FMAP between 88 percent and 90 percent. Prior to FY 2016, the CHIP E-FMAP ranged from 65 percent to 81 percent.

This recommendation calls for extending the CHIP MOE for three additional years to protect the stability of children's coverage. An extension of the CHIP MOE through FY 2022 is needed given the uncertainty in the coverage environment, the lack of comparable coverage alternatives for children, and the importance of maintaining the gains made in children's coverage. The CHIP MOE will keep coverage for low- and moderate- income children stable during this time of uncertainty and change.

This recommendation also calls for extending the 23 percentage point increase to the federal CHIP matching rate for three years, through FY 2022, to align with the recommended extension of the CHIP MOE. In the Commission's view, a federal requirement such as the MOE should be accompanied by federal funding.

The Commission is aware of concerns that the increase in the E-FMAP has not resulted in widespread coverage or care improvements for children enrolled in CHIP, suggesting that the matching rate could be restored to its prior level without affecting the number of children covered by CHIP or the quality of that coverage. On the other hand, the increase to the CHIP E-FMAP is believed to have influenced decisions in Florida and Utah in 2016 to expand Medicaid and CHIP coverage to lawfully residing immigrant children without requiring the five-year wait period (CCF 2016). An estimated 1,000 children in Utah and 17,000 in Florida are expected to gain coverage as a result of these policy changes (CCF 2016). Moreover, in July 2016, Arizona, which currently has an E-FMAP of 100 percent, reinstated CHIP, which the state expects to cover approximately 30,000 to 40,000 children (CMS 2016a).

The Commission spent significant time considering approaches for the CHIP MOE and the federal CHIP matching rate, carefully weighing the need for stabilizing children's coverage with the desire to return flexibility to states for the management of their programs. In the course of this discussion, some commissioners raised concerns that if the CHIP MOE requirement was not extended, states would cut eligibility levels in response to budgetary constraints. Others expressed strong reservations about extending the MOE requirement, noting this would give the federal government more authority over the program and limit state flexibility in a program designed to be a federal-state partnership. Several commissioners also argued for reducing the federal CHIP matching rate back to its historical levels, noting both the lack of evidence that the 23 percentage point increase had resulted in significant improvements to children's coverage and the importance of states sharing responsibility for the costs of CHIP.

The Commission considered various phased approaches to modifying the MOE and to reducing the level of the increase to the E-FMAP while

adhering to the principle that any changes to the MOE provision should not lead to reductions in children's coverage levels. However, it was unclear what modifications to the MOE could meet this standard while providing desired flexibility. Ultimately, the Commission concluded that protecting children's coverage should take precedence over promoting state flexibility at this time of great uncertainty in health insurance markets. In the future, when the scope and design of new public approaches to coverage are in place and stable, policymakers may wish to reconsider how to balance these objectives.

Implications

Federal spending. Extending the current CHIP MOE and the 23 percentage point increase in the CHIP E-FMAP through FY 2022 would result in increased federal CHIP spending. As stated above in Recommendation 1.2, the CBO estimates that this recommendation, along with the accompanying recommendations for a five year extension of federal CHIP funding, would increase net federal spending above the agency's current-law baseline by approximately $13.2 billion over the five-year period of FYs 2017–2021 and approximately $18.7 billion over the ten-year period of FYs 2017–2026. This estimate reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2017 at $5.7 billion each year.

Under current law, states would have the opportunity to roll back coverage after FY 2019 and the federal CHIP match would return to its traditional level, reducing federal spending. On the other hand, it is important to note that increased CHIP spending would be offset by reductions in federal spending for Medicaid or subsidized exchange coverage, which many children would have qualified for in the absence of CHIP.

States. This recommendation would require states to maintain CHIP for three additional years within current MOE rules, and would provide states an increase to the federal CHIP matching rate in FYs 2020–2022.

Enrollees. Enrollees will continue to have coverage beyond FY 2019, through FY 2022.

Plans and providers. Extending the CHIP MOE would ensure that the plans and providers currently participating in CHIP could continue to provide services to the CHIP-enrolled population without disruption.

Recommendation 1.4

To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP. (This recommendation was first made in the Commission's March 2014 report to Congress.)

Rationale

States are required to have methods in place to prevent substitution of public coverage for private coverage and some, to satisfy this requirement, stipulate that a child be without private coverage for a specified period of time before enrolling in CHIP. Such waiting periods may not exceed 90 days, and there are several mandatory federal exemptions, resulting in relatively few children being subject to CHIP waiting periods (MACPAC 2014a).[5] As of November 2016, 36 states, including the District of Columbia, do not have waiting periods (CMS 2016b).

In its March 2014 report to Congress, the Commission recommended the elimination of waiting periods, citing four primary reasons. First, eliminating CHIP waiting periods will reduce uninsurance and improve the stability of coverage. This is because waiting periods cause children to be uninsured before they can be eligible for CHIP. Children who are subject to waiting periods are at risk of becoming uninsured and of churning back and forth between CHIP and other coverage, which can disrupt care (MACPAC 2014a).

Second, although CHIP waiting periods were instituted to deter crowd-out of private coverage, it is not clear that they have been effective. The limited research on CHIP waiting periods has reached contradictory conclusions, primarily

because researchers are using different data sources (MACPAC 2014a). In addition, the potential pool of children who might be targeted by this strategy is small—estimates suggest that only a small percentage of uninsured children in the CHIP income range had employer-sponsored coverage in the prior 90 days.

Third, eliminating CHIP waiting periods is consistent with the Commission's goal of more simplified and coordinated policies across various programs. Neither exchanges nor Medicaid require waiting periods, and eliminating CHIP waiting periods would make this aspect of CHIP consistent with those programs. And fourth, eliminating CHIP waiting periods will reduce administrative burden and complexity for families, states, health plans, and providers.[6]

Congressional action to end CHIP waiting periods would be consistent with the trend in state actions on this policy. For example, of the 37 states that began 2013 with CHIP waiting periods, 21 eliminated those waiting periods by 2016 (CMS 2016b). States have eliminated their CHIP waiting periods because of the resulting short-term transitions between exchange coverage and CHIP, to reduce the additional administrative burden on states, and because of the many exemptions (for example, having special health care needs or losing coverage due a change in parental employment) among those who would otherwise face a CHIP waiting period (Caldwell 2013a).

Implications

Federal spending. This recommendation would increase federal spending in FY 2017 by $50 million to $250 million, based on ranges provided by the CBO. Over the five-year period of FYs 2017–2021, this recommendation would increase federal spending by less than $1 billion.

States. Ending the use of CHIP waiting periods would simplify eligibility and reduce the administrative burden associated with determining which children are subject to CHIP waiting periods (as well as the federal and state exemptions). In states currently using CHIP waiting periods, eliminating these waiting periods could increase state CHIP spending because of the additional months of CHIP coverage. However, at least one state predicted that little additional cost would result from eliminating the CHIP waiting period, considering the administrative cost and burden of administering the policy and the relatively small number of children who would gain additional coverage (Caldwell 2013b).

Enrollees. Because many children can be exempted from CHIP waiting periods, the primary impact of eliminating the waiting period would be relieving families of the administrative burden of verifying their exemption and allowing them to avoid any associated delays in coverage. For children who are subject to a CHIP waiting period and not currently exempt, eliminating waiting periods would reduce the risk that they will go uninsured during a transition in coverage.

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

Recommendation 1.5

In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums. (This recommendation was first made in the Commission's March 2014 report to Congress.)

Rationale

States are allowed to impose premiums and cost sharing in separate CHIP, but under Medicaid-expansion CHIP, they must adhere to federal Medicaid rules, which allow limited or no premiums and cost sharing. For all children with CHIP coverage, the combined total of premiums and cost sharing may not exceed 5 percent of family income. As of

January 2016, 26 states required premiums and 25 required cost sharing in separate CHIP (Brooks et al. 2016).

When CHIP was enacted, the ability to charge premiums and cost sharing was a key component of the flexibility provided to states. Although CHIP premiums can help to offset state and federal costs of coverage and signal to enrollees the importance of their contribution to the cost of coverage, in practice these premiums are relatively modest, and much lower than typical private coverage premiums. However, even at relatively low levels, premiums can increase uninsurance among children in families with income below 150 percent FPL (MACPAC 2014a).

Eliminating CHIP premiums for families with incomes under 150 percent FPL would reduce uninsurance and align CHIP premium policies with Medicaid policies for lower-income children. Compared to higher-income enrollees, families with incomes below 150 percent FPL are more price sensitive and less likely to take up CHIP coverage for their children when a premium is required (Abdus et al. 2013, Herndon et al. 2008). The CHIP premiums charged in this income range, generally less than $10 per month, are so small that they would not represent a significant revenue loss to states if they were eliminated—especially as this also removes states' burden in collecting and administering these premiums (Kenney et al. 2007).

This recommendation would affect the eight states that continue to charge CHIP premiums to enrollees in families with incomes below 150 percent FPL. In 2014, MACPAC estimated that there were approximately 110,000 children in families with incomes below 150 percent FPL who would be subject to CHIP premiums (MACPAC 2014a). This recommendation does not call for any change to CHIP's premium policies for families with incomes above 150 percent FPL, which is the income range for the majority of CHIP enrollees subject to premiums.

Implications

Federal spending. CHIP matching funds would be available for any increase in state CHIP spending due to loss of premiums or increased enrollment, up to the point at which states have expended their allotments. CBO estimates that this recommendation would have increased federal spending by less than $50 million in FY 2017 and by less than $1 billion over the five-year period of FYs 2017–2021. These are the smallest non-zero ranges provided by CBO. This estimate does not exceed $1 billion over the ten-year period of FYs 2017–2026.

States. Only eight states charge premiums to enrollees in families with incomes below 150 percent FPL for separate CHIP coverage (Brooks et al. 2016). Due to the transition of CHIP-enrolled children below 138 percent FPL from separate CHIP to Medicaid-expansion CHIP, the number of children in families with incomes below 150 percent FPL that are subject to CHIP premiums is shrinking considerably.

Ending the use of CHIP premiums would affect these states in three ways. First, states would lose a small amount of revenue from premiums currently paid by families with incomes under 150 percent FPL. Second, states would likely realize administrative savings associated with no longer collecting these CHIP premiums. The amount of revenue from CHIP premiums obtained from families with incomes below 150 percent FPL is relatively small compared to the administrative costs of collecting them (Kenney et al. 2007). Third, some increased CHIP spending would result from increased enrollment, from children otherwise prevented from enrolling by the premiums.

Enrollees. If states no longer charge CHIP premiums to families with incomes below 150 percent FPL, an estimated 110,000 children would be exempted from CHIP premiums. As a result of ending these premiums, additional children might also enroll in CHIP, reducing uninsurance but also private coverage (Abdus et al. 2013, Herndon et al. 2008).

Plans and providers. Plans would no longer have to obtain premiums from newly exempted families,

which would reduce administrative burden and increase enrollee retention. Ending CHIP premiums for families with incomes below 150 percent FPL might also increase CHIP enrollment in the eight affected states.

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

Recommendation 1.6

Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support state efforts to develop, test, and implement approaches to providing for CHIP-eligible children seamless health coverage that is as comprehensive and affordable as CHIP.

Rationale

This recommendation calls for establishing planning and implementation demonstration grants to support interested states in developing and testing models for improved coverage systems that specifically focus on children. Such models could be developed using existing state plan and waiver authorities, such as those available under Sections 1115 and 1332 of the Act.

It is the Commission's view that state innovation will be a key driver in improving the system of coverage for low- and moderate-income children, and that federal support of those efforts is critical. The children's coverage demonstration grant program would ease financial barriers to states wishing to transform their children's coverage system. Developing options for a seamless system of coverage across available coverage sources that ensures CHIP-eligible children have affordable and comprehensive coverage will require resources for research and analysis of markets, needs assessments, stakeholder and expert engagement, as well as legal, regulatory, policy, and cost analyses. Without federal funding, these analyses may not be feasible for states to pursue. Because such activities are typically not eligible for federal match under state plan authority, states have used waiver authority and grant funding to finance these planning activities.

The models through which states would achieve this goal will provide information on how new systems of children's coverage could be implemented, their effects, and scalability to other states. For example, many states implemented Medicaid managed care delivery systems through demonstrations, which, with increased state experience, have become a permanent feature of the program. Congress has a track record of providing funding to support state planning and implementation efforts to transform health care coverage and delivery, for example:

- States had the opportunity to apply for planning grants to develop state plan amendments for implementing health homes for enrollees with chronic conditions (§ 1945 of the Act).[7] States used these funds to hire contractors; to conduct feasibility studies, consumer and provider outreach, and training; and to develop reporting systems (CMS 2010).
- Some states received federal financial support to transition from institution-based to community-based long-term care systems through the Real Choice Systems Change grant program (Shirk 2007). States used grant funds to develop the necessary regulatory, administrative, program, and funding infrastructure around such transitions, but not to fund services (CMS 2006).[8]
- The State Innovation Model initiative provided grants to states to design and test alternative payment or new service delivery models that would reduce program expenditures while preserving or enhancing the quality of care (§ 1115A(a)(1) of the Act) (Spencer and Freda 2016). The model design grant awards were intended to support state planning activities to develop a state health care innovation plan. These activities included stakeholder engagement, analysis of state and federal policy and regulation, and gap analyses of the resources necessary to implement a payment or delivery model (CMS 2012).[9]

Implications

Federal spending. The children's coverage demonstration grant program would likely increase federal spending by the total amount appropriated for the grants. There could also be downstream federal spending effects related to increased enrollment depending on systems of coverage implemented by states under these demonstrations.

States. This recommendation would enable states to engage in planning and implementation activities for a more seamless system of children's coverage that they might otherwise have forgone. This recommendation would result in greater state experience with innovative systems of children's coverage and understanding of their effects in participating states.

Enrollees. Enrollees in participating states could experience some changes in coverage, including smoother transitions between coverage and less drastic changes in cost sharing and coverage of benefits from one coverage source to another. Enrollees would remain insured and their coverage would remain as comprehensive and affordable as CHIP.

Plans and providers. Plans and providers currently participating in coverage sources could continue that coverage without disruption. They may experience some changes related to how much enrollee out-of-pocket costs are allowed and how they are paid, and changes in the delivery of services for children who transition in or out of the plan or practice.

Recommendation 1.7

Congress should permanently extend the authority for states to use Express Lane Eligibility for children in Medicaid and CHIP. The Commission noted its support for this policy in a 2014 letter to the Secretary of the U.S. Department of Health and Human Services (MACPAC 2014c).

Rationale

Express Lane Eligibility (ELE) authority allows states to streamline their Medicaid and CHIP application processes and has resulted in favorable gains in coverage and administrative savings. Specifically, ELE permits states to rely on findings from another program designated as an Express Lane agency when making Medicaid and CHIP eligibility determinations (including renewals of eligibility), without regard to differences in rules between the programs for counting income and household composition. Other Express Lane agencies include the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program (NSLP), and Head Start. CHIPRA created the state plan option for ELE, authorizing it through FY 2013. Most recently, MACRA extended authority for the ELE option for children in Medicaid or CHIP through September 30, 2017 (it had been scheduled to expire on September 30, 2015).

As of January 1, 2016, eight states use ELE for children at Medicaid enrollment, five states use ELE for CHIP enrollment, seven states use ELE for children at Medicaid renewal, and three states use ELE for CHIP renewal (KFF 2016). A federal evaluation indicated that as of December 2013, nearly 1.4 million children enrolled in Medicaid or CHIP and retained coverage through ELE processes.

Federal evaluations have found that some states reported that implementing ELE resulted in administrative savings, although states generally lacked data to support these findings (OIG 2016, Hoag et al. 2013). For example, one state reportedly saved $7.3 million between 2011 and 2014, and another state reported that the Medicaid agency saved $25.77 per initial enrollment and $5.15 per renewal. Savings were the result of reduced staff time to complete eligibility determinations due to simplified enrollment processes, according to state reports (OIG 2016).

The Commission recommends permanently extending ELE authority because of the favorable enrollment gains and administrative savings reported by states that implemented the ELE policy

option. The ELE option is consistent with MACPAC's view that stability of children's coverage during a period of flux in coverage markets is critical. Streamlined processes, in which enrollment in coverage is not dependent on families supplying or resupplying documentation to states for initial eligibility determinations or renewals, reduce the risk of children losing their coverage for administrative reasons, thus stabilizing their coverage status.

An extension of ELE authority is necessary to allow states to maintain coverage gains. Without an extension, states that have implemented this option would be likely to incur additional costs in reverting to legacy eligibility processes. Should authority for the ELE option expire, the states that have implemented this option could only continue to do so under a Section 1115 waiver.

This recommendation presumes that ELE does not result in additional incorrect eligibility determinations.

Implications

Federal spending. CBO estimates that this recommendation would result in net federal spending of approximately $400 million over the five-year period of FYs 2017–2021, and approximately $1.1 billion over the ten-year period of FYs 2017–2026. Increased federal spending is expected to result from increased enrollment and retention of Medicaid- and CHIP-eligible children. This estimate is similar to CBO's estimates of the President's FY 2017 budget (CBO 2016).

States. This recommendation would allow states currently using ELE in Medicaid or CHIP to continue to do so, and additional states could adopt the policy. If authority for the ELE option expires, the states that have implemented this option could only continue to do so under a Section 1115 waiver. Otherwise, they would have to revert to non-ELE eligibility processes, which may require states to hire additional staff to conduct eligibility determinations. For example, Louisiana was able to reduce its eligibility workforce by about 200 positions when it implemented ELE without reducing enrollee access to coverage (Kennedy 2014). Louisiana may need to re-hire many of these staff to process applications and renewals if ELE authority is not extended. In addition, ELE may produce administrative savings for states when compared to traditional enrollment methods (Hoag et al. 2013).

Enrollees. Automated ELE processes can increase enrollment of children in Medicaid and CHIP and possibly lead to reductions in churn and uninsurance because it allows states to rely on eligibility findings from other agencies (Hoag et al. 2013).The effect on children enrolled in Medicaid and CHIP of a permanent extension of ELE authority for states, however, will differ depending on their state of residence. Children in states that have implemented ELE will continue to experience a more streamlined eligibility determination or renewal process. Families would not be required to reproduce certain eligibility documentation they had already provided to other agencies. Due to this administrative simplicity, enrollees could experience shorter wait times to enroll in coverage, undergo less churn, and benefit from continuity of care with their medical providers.

Plans and providers. If authority for ELE is extended, plans and providers could benefit from a more stable enrollee population with less churn.

Recommendation 1.8

The Secretary of the U.S. Department of Health and Human Services, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of Education, should, not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.

Rationale

Express Lane authority does not allow other designated assistance programs to consider Medicaid eligibility determination findings. ELE streamlines the application process when families

have applied to partner agencies before applying to Medicaid and CHIP, but not when families apply to Medicaid or CHIP before applying to partner agencies. For example, Colorado allows families to use eligibility findings from the NSLP to facilitate enrollment in CHIP (CMS 2016c). Families that apply for NSLP go through one application process to determine their eligibility for both programs. On the other hand, a family that applies for CHIP first still has to complete a separate application process for NSLP. This creates additional administrative burden for families and for state agencies, which have to gather and verify documentation twice.

In light of the Commission's findings on ELE authority, more information is needed to understand the changes necessary to modify ELE authority so that designated programs can use Medicaid or CHIP eligibility determination information. Specifically, the report should describe the legislative and regulatory changes necessary to allow designated programs to use publicly subsidized health program findings to determine eligibility for other programs. The report should also assess the operational challenges and technical feasibility of this policy, and evaluate the implications of broadening ELE authority.

This recommendation builds on the Commission's recommendation that ELE authority be made a permanent state option. The report would explore how such a policy would reduce administrative burden for families who seek health coverage first, and then seek the support of other designated programs such as SNAP, NSLP, or Head Start. The report should also assess how to reduce administrative burden for states by allowing them to use one eligibility determination for multiple programs no matter which program a family approaches first.

Implications

Federal spending. CBO estimates that a report to Congress would result in negligible federal costs, although the responsibility for such a report would increase the administrative effort for the Secretary, as well as for the Secretaries of Agriculture and Education.

States. In completing the report, the Secretary is likely to consult with state agencies that administer Medicaid, CHIP, and other designated ELE programs. States may be asked to provide information on program eligibility requirements, families' eligibility information that is collected by each program's application process, and the changes necessary to use eligibility determination from one program to satisfy application requirements of another.

Enrollees. The Secretary's report would not have a direct effect on Medicaid and CHIP enrollees. Over time, however, the report could recommend policies that would streamline the application process and reduce administrative burden for enrollees.

Plans and providers. The Secretary's report would not have a direct effect on Medicaid and CHIP managed care plans or health care providers.

Recommendation 1.9

Congress should extend funding for five years for grants to support outreach and enrollment of Medicaid and CHIP eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program, through fiscal year 2022.

Rationale

The Commission is recommending extending funding for these programs, which in previous years has been renewed along with CHIP funding. These programs focus on improving aspects of coverage or care for children enrolled in Medicaid or CHIP.

Grants to support outreach and enrollment of Medicaid- and CHIP-eligible children. In addition to providing a source of coverage for low- and moderate-income children, the enactment of CHIP created incentives for states to proactively search for CHIP- and Medicaid-eligible children who are uninsured and to enroll them in coverage rather than waiting for children and their families to initiate the process. To support such proactive efforts, CHIPRA established outreach and enrollment grants, appropriating $100 million for FYs 2009–2013.

Funding was most recently renewed under MACRA at $40 million for FYs 2016–2017. These funds provide support to states, tribes, and community-based organizations for a variety of outreach and enrollment activities. Funds have also supported a national outreach and enrollment campaign (CMS 2016d).

State officials have reported that the CHIPRA outreach and enrollment grants have helped to support their own outreach efforts, which would have to be scaled down without federal funding; these grants have also supported the efforts of community-based organizations that are sometimes coordinated with the state (Harrington et al. 2014). Such grants are needed to maintain the historic successes in finding and enrolling eligible children and in helping them retain coverage at renewal. Arguably, the children who remain uninsured are the hardest to reach and thus sustained efforts are required to encourage them to enroll. Efforts are typically directed at teens, Latino children, children in families with mixed citizenship status, and children in families with mixed eligibility for Medicaid and CHIP (KCMU 2013, Kenney et al. 2010).

Without such funding, reduced attention to outreach could lead to increased uninsurance among children, reversing gains made in recent years. Absent such grants, state spending on outreach and enrollment would be limited by federal law to the 10 percent cap on CHIP administrative spending.

The Childhood Obesity Research Demonstration project. The Childhood Obesity Research Demonstration (CORD) was established in CHIPRA to identify health care and community strategies to combat childhood obesity in children age 2–12 who are enrolled in or eligible for Medicaid or CHIP (Dooyema et al. 2013). Funding for this effort was most recently extended under MACRA, at $10 million for the period of FYs 2016–2017.

In 2015, an estimated 10.8 percent of Medicaid and CHIP enrollees age 0–18 were obese (MACPAC 2016e). One estimate places the annual health care costs for children treated for obesity covered by Medicaid at about $6,700 per child, compared to about $3,700 for those under private coverage. The national cost of childhood obesity is estimated at approximately $11 billion for children with private insurance and $3 billion for those with Medicaid (Marder and Chang 2006).

CORD project grantees are evaluating whether multi-level, multi-setting approaches that integrate primary care with public health strategies can improve health behaviors and reduce childhood obesity. For example, the second phase of CORD grants, which began in June 2016, focuses on preventive services to individual children and families in Arizona and Massachusetts, a change from the community-wide public health interventions funded in the first phase.

The demonstration uses a consistent set of outcome and process measures across all projects in addition to measures that are unique to each funded project (Sebelius 2014a). An evaluation is underway and so far suggests favorable outcomes; however, final results will not be available until spring 2017.

The Commission supports continued research into strategies aimed at reducing and preventing childhood obesity among children enrolled in Medicaid and CHIP. Continued federal funding is important to efforts to develop and test strategies to reduce childhood obesity, as well as disseminating results.

The Pediatric Quality Measures Program. The 2009 renewal of CHIP funding focused federal attention and resources on measuring the quality of pediatric care. In 2009, the Centers for Medicare & Medicaid Services (CMS) developed a core set of children's health care quality measures for children in Medicaid and CHIP, the first focused effort to measure the quality of publicly funded children's health care in a consistent way on a national level. Since 2010, state participation in reporting the voluntary core set of child health measures has increased; by FY 2014, all 50 states and the District of Columbia reported at least one measure (CMS 2016e, CMS 2011). The number of measures reported by each state has also increased, from a median of 10 in FY 2010 to a median of 16 in FY 2014 (CMS 2016e, CMS 2011). The core set for children's measures has grown from

an initial list of 24 measures in 2010 to 26 measures in 2016 (CMS 2016f).

CHIPRA also established the Pediatric Quality Measures Program (PQMP) to improve and strengthen the initial child core set. In its initial phase, the PQMP funded seven Centers of Excellence, which brought together experts, including researchers, providers, state Medicaid and CHIP officials, and patient and family advocates, to develop and improve pediatric quality measures (AHRQ 2016, Sebelius 2014b). MACRA extended funding of $20 million over fiscal years 2016 and 2017. Measures developed include prenatal care screening, alcohol and drug screening of depressed adolescents, prevention and appropriateness of asthma-related emergency department use, and identification of children with disabilities. In its current phase, the PMQP is focused on disseminating and implementing the quality measures developed by the Centers of Excellence.

Current PMQP grantees are assessing the feasibility and usability of the measures at the state, health plan, and provider levels (AHRQ 2016). An extension of PQMP funding will allow the Secretary to continue to develop, test, validate, and disseminate new child health quality measures, and to continue revising existing measures for children enrolled in Medicaid and CHIP. In a November 2014 letter to Congress, MACPAC stated that the needed investments in quality measurement are relatively small, but that they are important investments in the program, not only for those whose care is financed by Medicaid and CHIP but also for taxpayers (MACPAC 2014d). In the letter, MACPAC noted several key areas in which ongoing work is needed to build on the progress made to improve quality of care for those with Medicaid and CHIP coverage, including strengthening CMS's capacity to calculate quality measures for states, improving quality measures for individuals with disabilities, and expanding the use of core quality measures in state quality improvement efforts. Continuation of the PQMP could also support efforts to measure and improve care provided to children with special health care needs enrolled in Medicaid and CHIP coverage.

Implications

Federal spending. Extending funding for outreach and enrollment grants, CORD projects, and the PQMP is projected to increase federal spending by $175 million over five years (FYs 2018–2022). There is also likely to be some associated burden related to administering the grant application process, providing technical assistance to grantees, and overseeing evaluation efforts. Successful project management could not continue without federal administrative support for these programs.

States. A funding extension is likely to have different implications for states depending on state interest in these programs. An extension would ensure support for state- and community-based efforts to perform outreach and enrollment activities. States can use CORD grant funds to design and test new interventions to reduce childhood obesity. In addition, an extension of federal support for continued improvement of pediatric quality measures may encourage more states to participate in voluntary reporting. As more states report on more measures, they can use this information to target quality improvement efforts for child health and compare their performance with that of other states.

Enrollees. The implications of a funding extension for families and enrollees will differ depending on states' current and future interest in these programs. A funding extension will allow states to continue their outreach, enrollment, and renewal efforts, which help children gain or maintain CHIP coverage. For children in Massachusetts and Texas, which are operating CORD demonstration projects, extended funding could maintain access to project activities such as nutritional counseling and clinic screenings. Extended funding for PQMP is likely to have little direct effect on enrollees, but who likely would benefit indirectly from continued federal focus on improving the quality of children's health care.

Plans and providers. Extending funding for these programs could allow plans and providers to use grant funds to undertake outreach and enrollment activities, to partner with states to design and test new strategies to reduce childhood obesity,

to develop new pediatric quality measures, and to revise existing pediatric quality measures. Extended funding would also ensure that plans and providers engaged in these efforts could continue them without disruption. Funding for PQMP could increase administrative burden for health plans, if states implement reporting requirements for new measures in Medicaid and CHIP managed care contracts. On the other hand, increased reporting could shed light on the quality of care plans that providers are providing to enrollees, either by documenting issues or successes.

Federal Budget Implications

When making recommendations, the Commission considers the budgetary consequences and consults with the Congressional Budget Office to obtain cost estimates. The Congressional Budget Office estimates that the combined federal costs of MACPAC's recommendations will be approximately $13.2 billion for the five-year period FY 2017 through 2021, and approximately $18.7 billion for the ten-year period of FY 2017 through 2026.

Although certain members of MACPAC's congressional committees of jurisdiction have requested that MACPAC recommend budgetary offsets for recommendations that would increase federal spending, the Commission is not prepared to recommend any particular offsets at this time. Instead we have compiled a list of previous savings proposals that have been scored by CBO as well as proposals that have been offered in the President's budget, introduced as legislation, and developed by others (Appendix E). The methodology for inclusion of proposals on this list is described in the appendix.

The Commission has not voted on nor has it endorsed any specific proposal on this list. Moreover, MACPAC has not analyzed the merits or effects of these proposals on the availability of coverage to low-income individuals, access to care, or benefits nor their potential impact on states, health plans, providers, or others. Such effects would not be apparent in the cost savings estimate alone. As such, the list should be viewed with caution.

In the statute creating MACPAC, Congress charges the Commission with reviewing Medicaid and CHIP policies, including their relationship to access and quality of care for Medicaid beneficiaries. Therefore all of the proposals on this list are Medicaid or CHIP policies; in considering policies that increase federal Medicaid or CHIP spending, Congress could choose to enact other proposals affecting spending or revenues, including those from outside CHIP or Medicaid.

Endnotes

[1] CMS believes these totals are accurate. However, according to CMS, reporting challenges in FY 2015 may have impacted separate CHIP and Medicaid-expansion CHIP enrollment totals.

[2] The National Center for Health Statistics reports insurance coverage data collected in the National Health Interview Survey using the age range of 0 through 17 years.

[3] On November 25, 2015, the U.S. Department of Health and Human Services (HHS) released a congressionally mandated study of whether exchange benefits and cost sharing are comparable to separate CHIP (CMS 2015). Consistent with MACPAC's findings, HHS found that no exchange plans are comparable to CHIP with respect to premiums and cost sharing. The HHS study also looked at covered benefits and found that benefit packages in CHIP are generally more comprehensive for dental, vision, and habilitation services and are more comprehensive for children with special health care needs than exchange plans. For benefits typically covered by commercial plans, such as physician, laboratory, and radiological services, HHS found that coverage is similar between CHIP and exchange plans. This is also consistent with MACPAC's prior analyses (CMS 2015, MACPAC 2015).

[4] This MACPAC estimate is based on FY 2017 CHIP allotments.

[5] Children must be exempted from the waiting period if any of the following applies: (1) the additional out-of-pocket premium to add the child to an employer plan exceeds 5 percent of income; (2) a parent is eligible for subsidized exchange coverage because the premium for the parent's self-only employer-sponsored coverage exceeds 9.5 percent of income; (3) the total out-of-pocket premium for employer-sponsored family coverage exceeds 9.5 percent of income; (4) the employer stopped offering dependent coverage (or any coverage); (5) a change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (regardless of potential eligibility for COBRA coverage); (6) the child has special health care needs; or (7) the child lost coverage due to the death or divorce of a parent.

[6] In addition, because most of the states with CHIP waiting periods rely on the federally facilitated exchange, which is generally not able to determine CHIP eligibility where waiting periods exist, CHIP waiting periods are a barrier to streamlined, coordinated eligibility determinations (HHS 2013).

[7] The federal government made $500,000 in federal matching funds available to states as planning grants to support efforts to develop a state plan amendment (§ 1945(c)(3) of the Act). Twenty states received health home planning grants, and CMS approved 28 state plan amendments from 20 states as of July 2016 (CMS 2016g).

[8] Between 2001 and 2004, grant awards ranged from $300,000 to $800,000 to be used over a three- or four-year period; beginning in 2005, fewer grants were awarded, but the grant amounts were larger and generally for a five-year period (CMS 2016h). States had to contribute 5 percent in non-federal share to the total grant award (Shirk 2007). In total, CMS awarded more than $288 million to states between 2001 and 2010 (CMS 2016h).

[9] In the two grant award phases since 2012, the Center for Medicare & Medicaid Innovation has awarded model design grants ranging from $750,000 to $3 million to 36 states and 3 territories. Model design grantees are expected to complete a state health care innovation plan and apply for model testing grants in subsequent rounds of funding (CMS 2016i).

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Dissenting Statement

I have been asked by the Chair to provide a brief discussion for the record of my reasons for dissenting from the Commission's recommendations that were brought to a vote during the December 15, 2016 meeting. Before doing so I will state that my dissent should not be interpreted as a repudiation of the CHIP program. I support and applaud the important access to health care it has provided to millions of children over the last two decades. Rather, I dissent from the Commission's recommendations for specific Congressional action regarding the future of the program.

Recommendation 1.1: I agree that Congress should extend federal CHIP funding for a transition period, during which time alternative approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children can be developed and tested, while maintaining a stable source of children's coverage.

Recommendation 1.2: I disagree that the extension should be for five years. The next Congress will undertake comprehensive health care reform and is expected to replace or repeal elements of the ACA. One of the critical failures of the ACA was to integrate CHIP and deliver affordable, high-quality children's coverage to working families. The Commission has discussed and reported the benefit gaps and affordability challenges for children under the ACA in its June 2014, March 2015, and March 2016 reports to Congress. Perpetuating CHIP as a freestanding program means that many families who do not qualify for CHIP will continue to pay higher premiums for less comprehensive exchange coverage. Rather than extending CHIP for five years, Congress should use the upcoming legislative opportunity to ensure there is what the Speaker of the House Paul Ryan has called "a better way" designed specifically for all the children of working families.

Recommendation 1.3: I also disagree with the first component of this recommendation, which calls for a five-year extension of the current CHIP MOE. The MOE freezes states in place and renders them unable to adapt to the changing health insurance landscape they confront. It effectively disenfranchises the voters and their representatives in individual states by holding hostage federal funding. States have demonstrated a vibrant capacity to innovate in health care funding and delivery. Regarding the second component, I am entirely opposed to extending the increase to the E-FMAP rate for five years. I find the Commission's rationale unpersuasive. An E-FMAP of 100 percent federalizes what should be a state-directed program and leaves states with no skin in the game. I see no evidence that these billions of dollars of unrestricted funding have produced any meaningful change in children's health outcomes. These funds should be redeployed by Congress for some more useful, well-documented purpose, such as reducing the premiums paid by working families for their children's health care coverage.

Recommendation 1.6: I am very supportive of creating and funding a demonstration grant program to support state innovation in children's coverage. Such a demonstration would likely require removal of the MOE requirements.

I support the program improvements and extensions outlined in the Commission's Recommendations 1.4, 1.5, and 1.7 through 1.9.

In summary, while I concur with many of the Commission's recommendations in this special report, I am constrained to dissent from the package as a whole. At this point in time, Congress should leverage its current focus on health policy to consider what has enabled CHIP to maintain unwavering bipartisan support for two decades. It should incorporate those success factors—chief among them being a child-

centered focus and state flexibility—into the insurance reforms it seeks to enact in the next session. And it should explicitly and mindfully address the need that all of America's children have for comprehensive, affordable, high-quality health care.

Christopher Gorton, MD, MHSA
Commissioner

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on CHIP. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Future of CHIP and Children's Coverage

1.1 Congress should extend federal CHIP funding for a transition period that would maintain a stable source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.

1.2 Congress should extend federal CHIP funding for five years, through fiscal year 2022 to give federal and state policymakers time to develop policies for and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.

1.3 In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP matching rate, currently in effect through FY 2019, for three additional years, through FY 2022.

1.4 To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP. (This recommendation was first made in the Commission's March 2014 report to Congress.)

1.5 In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums. (This recommendation was first made in the Commission's March 2014 report to Congress.)

1.6 Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support state efforts to develop, test, and implement approaches to providing for CHIP-eligible children seamless health coverage that is as comprehensive and affordable as CHIP.

1.7 Congress should permanently extend the authority for states to use Express Lane Eligibility for children in Medicaid and CHIP. (The Commission noted its support for this policy in a 2014 letter to the Secretary of the U.S. Department of Health and Human Services [MACPAC 2014c].)

1.8 The Secretary of the U.S. Department of Health and Human Services, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of Education, should, not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.

1.9 Congress should extend funding for five years for grants to support outreach and enrollment of Medicaid and CHIP eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program, through fiscal year 2022.

16	Yes
1	No
0	Not Voting

Yes: Burwell, Carte, Cohen, Cruz, Douglas, George, Gold, Gray, Lampkin, Martínez Rogers, Milligan, Retchin, Rosenbaum, Szilagyi, Thompson, Weil

No: Gorton

Appendix A:

Overview of CHIP

Appendix A: Overview of CHIP

The State Children's Health Insurance Program (CHIP), created in 1997, is a joint federal-state program established to provide coverage to uninsured children in families whose incomes are too high to qualify for Medicaid. In fiscal year (FY) 2015, 8.4 million children and 4,200 pregnant women received CHIP-funded coverage.[1]

History and Impact of CHIP

CHIP was created as part of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). To encourage states to participate, CHIP provided states with enhanced federal financing and greater flexibility in program design compared to Medicaid. At the time, it was uncertain how many states would respond to this new federal funding opportunity. By FY 2000, however, every state, territory, and the District of Columbia had children enrolled in CHIP-financed coverage.

Since the enactment of CHIP, the number of children lacking health insurance has declined substantially from 10 million children in 1997, many of whom were in working families with incomes just above their states' Medicaid eligibility levels, to 3.3 million in 2015 (Cohen et al. 2016, Martinez and Cohen 2012). Seventy percent of this decline was due to additional enrollment of children in Medicaid rather than CHIP; however, this increase is often attributed to the availability of a new source of coverage and the new focus, concurrent with CHIP's passage, on reaching out to eligible uninsured children (Dubay et al. 2007).

Since CHIP's enactment in 1997, federal funding for the program has been renewed several times, most recently by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), which extended funding for FYs 2016–2017 (Box A-1).

Key CHIP Design Features

CHIP covered 8.4 million children at a total combined state and federal cost of $13.7 billion in FY 2015; this makes it a relatively small program compared to Medicaid, which covered 81.0 million individuals with

BOX A-1. Legislative History of Federal CHIP Funding Renewals

- The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) authorized and funded CHIP for ten years, FYs 1998–2007.
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) extended funding through March 31, 2009.
- The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) extended funding through FY 2013.
- The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended) extended funding through FY 2015.
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended funding through FY 2017.

combined federal and state spending totaling $556.0 billion that same year (MACPAC 2016a, MACPAC 2016b). As with Medicaid, CHIP is administered by states within federal rules, and states receive federal matching funds for program spending. CHIP, however, differs from Medicaid in a variety of ways.

Program design

CHIP gives states flexibility to create their programs as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches. For states with Medicaid-expansion CHIP, federal Medicaid rules generally apply. Separate CHIP generally operates under a separate set of federal rules that allows states to design benefit packages that look more like commercial insurance than Medicaid. Under separate CHIP, states may also charge premiums, create waiting periods, and brand and market their programs separately from Medicaid.

As of January 2016, 10 states (including the District of Columbia) and 5 territories ran CHIP as a Medicaid expansion, 2 states operated separate CHIP and 39 states operated a combination program. Of the 8.4 million children enrolled in CHIP-funded coverage during FY 2015:

- 40.0 percent (3.4 million) were children age 0–18 in separate CHIP;
- 56.0 percent (4.7 million) were children in Medicaid-expansion CHIP; and
- 3.9 percent (0.3 million) were unborn children in separate CHIP (Appendix B).

Nearly every state that was once categorized as having only separate CHIP now has a combination program. This shift to combination programs is due to the implementation of two provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that required states to move some separate CHIP enrollees into Medicaid:

- a mandatory income disregard equal to 5 percent of the federal poverty level (FPL) that effectively raised Medicaid (and CHIP) eligibility levels by 5 percentage points; and
- a mandatory transition from separate CHIP into Medicaid of 6- to 18-year-olds in families with incomes between 100 percent and 133 percent FPL (the so-called stairstep children).

Eligibility. Individuals who meet Medicaid program criteria (including the criteria for Medicaid-expansion CHIP) are entitled to Medicaid coverage, but there is no individual entitlement to coverage in separate CHIP. Similarly, funding is not open-ended.

To be eligible for CHIP, a child must be considered a targeted low-income child, that is, a child under the age of 19 with no health insurance who would not have been eligible for Medicaid under the state rules in effect on March 31, 1997. States may also extend CHIP eligibility to children of state employees.[2]

While Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no mandatory income level up to which CHIP must extend coverage. State-set upper eligibility limits for children's CHIP eligibility range from 170 percent FPL in North Dakota ($41,310 for a family of four in 2016) to 400 percent FPL in New York ($97,200 for a family of four in 2016). (See Appendix B for state CHIP eligibility levels in 2016.) Although many states offer CHIP coverage at higher income levels (generally with higher premiums or cost sharing), 89 percent of the children enrolled in CHIP-financed coverage had incomes at or below 200 percent FPL in FY 2013, and 97 percent were at or below 250 percent FPL (Table A-1).

The federal CHIP statute limits states' upper income eligibility to 200 percent FPL, or, if higher, 50 percentage points above states' pre-CHIP Medicaid levels. However, prior to the ACA, states had flexibility in how they counted income so they could effectively expand to any income level. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) amended the CHIP statute

TABLE A-1. Enrollment in CHIP by Family Income, FY 2013

Family income as a percentage of FPL	Percentage of CHIP enrollees
Total	**100.0%**
At or below 200 percent FPL	88.8
Above 200 percent through 250 percent FPL	8.6
Above 250 percent FPL	2.6

Notes: FY is fiscal year. FPL is federal poverty level.
Source: MACPAC 2014.

so that states covering children above 300 percent FPL would receive the regular Medicaid matching rate instead of the enhanced CHIP matching rate (§ 2105(c)(8) of the Social Security Act (the Act)).[3]

In 2015, all but two states had upper income eligibility limits at or above 200 percent FPL, including:

- 23 states covering children with family income from 200 to 249 percent FPL; and
- 26 states (including the District of Columbia) covering children at or above 250 percent FPL.

Under the ACA, states must maintain their 2010 eligibility levels through FY 2019 for children in both separate CHIP (as long as funding exists) and Medicaid (including Medicaid-expansion CHIP), a requirement referred to as the maintenance-of-effort (MOE) provision (§ 2105(d)(3) of the Act).

Pregnant women and unborn children. CHIP also funds coverage of pregnant women through a state plan option or through continuation of an existing Section 1115 waiver. Under the CHIP state plan option created in CHIPRA, states may provide comprehensive health care coverage for uninsured, targeted low-income pregnant women (§ 2112 of the Act). To provide this coverage, state Medicaid programs must cover pregnant women with incomes up to 185 percent FPL (or up to the eligibility level the state had in place on July 1, 2008, whichever is higher). The CHIP upper income eligibility limit for pregnant women cannot be higher than the limit set for children, and states may not impose policies such as enrollment caps on targeted low-income pregnant women or children (§ 2112(b) of the Act). States can also use Section 1115 demonstration waivers to provide CHIP-funded coverage to pregnant women. Four states—Colorado, New Jersey, Rhode Island, and Virginia—enroll pregnant women in CHIP-funded coverage (MACPAC 2016c). Colorado, New Jersey, and Rhode Island use the CHIP state plan option, while Virginia provides the coverage under a Section 1115 waiver.

Under separate CHIP, states may cover pregnant women regardless of immigration status through the unborn child option by revising the definition of the term child in federal regulations to include the period from conception to birth (CMS 2009, 2002). In FY 2015, 15 states provided separate CHIP coverage to approximately 327,000 unborn children (Appendix B). Unborn children accounted for the entirety of separate CHIP enrollment in Arkansas, Minnesota, Nebraska, and Rhode Island. The largest enrollments of unborn children in FY 2015 were in California and Texas.

Waiting periods. Because there is no individual entitlement to CHIP coverage, states with separate CHIP may use strategies to limit enrollment such as waiting periods, which is the length of time that children must be without employer-sponsored insurance before enrolling in CHIP. Currently, a state's ability to institute new eligibility restrictions is constrained by the MOE provision, but states may continue using waiting periods they previously had in place. In 2016, 15 states had CHIP waiting

periods, down from 37 states in 2013 (CMS 2016, MACPAC 2014). To reduce complexity and to promote continuity of coverage for children, MACPAC recommends that Congress eliminate CHIP waiting periods altogether. (MACPAC 2014).

Premiums and cost sharing. States with separate CHIP are also permitted to charge premiums and require cost sharing, which is generally prohibited for children in Medicaid. Thirty states charge premiums or enrollment fees for children enrolled in CHIP, including four states with Medicaid-expansion CHIP. Of these states, 26 charge monthly or quarterly premiums and 4 charge annual enrollment fees. States often charge higher premiums as family income rises. As of January 2016, in states with separate CHIP, premiums ranged from $12 to $40 per child, with a median monthly premium of $17 for children in families with incomes at 151 percent FPL. For families at 251 percent FPL, premiums ranged from $9 to $61 per child, with a median monthly premium of $25 (Brooks et al. 2016).

Twenty-five states with separate CHIP require cost sharing for at least some types of services. For example, 20 states impose cost sharing for non-preventive physician visits, and 20 states have cost sharing for non-emergency use of the emergency department for children with family income at 201 percent FPL (Brooks et al. 2016). States often also require some cost sharing for inpatient hospital visits, emergency room visits, and prescription drugs (Cardwell et al. 2014). CHIP is more likely to charge copayments for services than other forms of cost sharing like deductibles or coinsurance (Bly et al. 2014, McManus and Fox 2014).

Combined expenses for separate CHIP premiums and cost-sharing expenses may not exceed 5 percent of a family's income, although many states have lower caps (Cardwell et al. 2014).

Covered benefits. States with separate CHIP can model their plan's benefits on specific private insurance plans, a package equivalent to one of those benchmarks, or Secretary-approved coverage. Federal rules require that separate CHIP covers dental services, well-baby and well-child care (including age-appropriate immunizations), and emergency services. In 2013, all states covered inpatient and outpatient services, physician services, clinic services, laboratory and X-ray services, and prescription drugs in seperate CHIP, although some states applied benefit limits (Cardwell et al. 2014).

The most flexible benefit design option for separate CHIP is Secretary-approved coverage, which is the most common approach. As a result of this flexibility, covered benefits in CHIP differ substantially from state to state. Fourteen states use a Secretary-approved benefit package for seperate CHIP that is similar to Medicaid (Cardwell et al. 2014).

Children in Medicaid-expansion CHIP are protected by federal Medicaid benefit requirements and cost-sharing limitations. They are entitled to all of Medicaid's mandatory services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, generally without any enrollee cost sharing.

Financing

CHIP is jointly financed by the states and the federal government. State CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's, subject to the cap on their allotment. Spending for FY 2015 totaled $13.7 billion ($9.7 billion federal, $4.0 billion state). Under current law, CHIP allotments are provided through FY 2017.

CHIP matching rate. Regardless of program design, state CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's. CHIP's enhanced federal medical assistance percentage (E-FMAP) varies by state. In FYs 2016 through 2019, the CHIP matching rate is increased by 23 percentage points from its prior level, ranging from 88 percent to 100 percent. Twelve states have a federal E-FMAP of 100 percent, 20 states receive a federal E-FMAP equal to or greater

than 90 percent, and 19 have a federal E-FMAP between 88 percent and 90 percent. Historically, CHIP matching rates ranged from 65 percent to 81 percent, compared to a 50 percent to 73 percent matching rate for children in Medicaid (Appendix D).

CHIP allotments. Unlike Medicaid, federal CHIP funding is capped. Federal CHIP funds are allotted to states based on their recent CHIP spending adjusted annually to account for child population growth and medical inflation (Appendix C). States have two years to spend each allotment, with unspent funds available for redistribution to other states that experience shortfalls.

States that exhaust their CHIP allotments and have CHIP enrollment that exceeds a target level are also eligible for contingency fund payments in FY 2017, in addition to redistribution funds. MACRA reauthorized payments from the contingency fund through FY 2017, so under current law, contingency funds will not be available starting in FY 2018 (MACPAC 2011).

Without an extension of CHIP funding, when states exhaust their CHIP funding after FY 2017, the ACA's MOE provision requires Medicaid-expansion CHIP to continue those children's Medicaid coverage through FY 2019 at Medicaid's lower federal matching rate. As federal CHIP funding is exhausted, a state's separate CHIP is no longer subject to the MOE; as states close down separate CHIP, most enrollees could qualify for subsidized exchange coverage or employer-sponsored coverage, although some may not enroll and could become uninsured. Under current law, 5 states are expected to spend their remaining FY 2016 and FY 2017 CHIP allotments by December 2017, and 29 states and the District of Columbia, are expected to exhaust their CHIP allotments by March 2018.

Endnotes

[1] Enrollment data for pregnant women include women covered by the CHIP state plan option and section 1115 waivers.

[2] A state may elect this option if it can demonstrate that it has consistently contributed to the cost of employee coverage since 1997 with increases for inflation or that its state employee health plan's out-of-pocket costs pose a financial hardship for state employees. The ACA established this state plan option (CMS 2011).

[3] Exceptions were provided for a state that, as of CHIPRA's enactment date (February 4, 2009), was already above 300 percent FPL (New Jersey) or had enacted a state law to submit a plan for federal approval to go above 300 percent FPL (New York).

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Appendix B:

Eligibility and Enrollment

Appendix B: CHIP Eligibility and Enrollment

TABLE B-1. CHIP Eligibility Levels (2016) and Enrollment (FY 2015) by State

State	Program type[1] (as of July 1, 2016)	Children in Medicaid-Expansion CHIP[1]				Children in separate CHIP							Total CHIP-funded child enrollment[4]
						Separate CHIP: Age 0–18[2]				Separate CHIP: Unborn		Total separate CHIP enrollment	
		Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Eligibility[3]	Enrollment		
Total	–	–	–	–	**4,702,185**	–	–	–	**3,362,642**	–	**327,175**	**3,689,817**	**8,397,651**
Alabama	Combination	–	–	107–141	45,697	142–312	142–312	142–312	87,346	–	–	87,346	**133,043**
Alaska	Medicaid expansion	159–203	159–203	124–203	10,182	–	–	–	–	–	–	–	**10,182**
Arizona[5]	Combination	–	–	104–133	37,412	148–200	142–200	134–200	1,399	–	–	1,399	**38,811**
Arkansas	Combination	–	–	107–142	108,706	143–211	143–211	143–211	–[6]	209	3,365	3,365	**112,071**
California[7,8]	Combination	208–261	142–261	108–261	1,787,470	262–317	262–317	262–317	2,461	317	122,197	124,658	**1,912,128**
Colorado	Combination	–	–	108–142	23,687	143–260	143–260	143–260	62,446	–	–	62,446	**86,133**
Connecticut	Separate	–	–	–	–	197–318	197–318	197–318	24,884	–	–	24,884	**24,884**
Delaware	Combination	194–212	–	110–133	238	–[9]	143–212[9]	134–212[9]	16,141	–	–	16,141	**16,379**
District of Columbia	Medicaid expansion	206–319	146–319	112–319	10,676	–	–	–	–	–	–	–	**10,676**
Florida	Combination	192–206	–	112–133	134,708	–[9]	141–210[9]	134–210[9]	293,386	–	–	293,386	**428,094**
Georgia	Combination	–	–	113–133	53,906	206–247	150–247	134–247	176,909	–	–	176,909	**230,815**
Hawaii	Medicaid expansion	191–308	139–308	105–308	27,239	–	–	–	–	–	–	–	**27,239**
Idaho	Combination	–	–	107–133	8,937	143–185	143–185	134–185	25,576	–	–	25,576	**34,513**
Illinois	Combination	–	–	108–142	113,105	143–313	143–313	143–313	191,328	208	26,138	217,466	**330,571**
Indiana	Combination	157–208	141–158	106–158	69,462	209–250	159–250	159–250	31,098	–	–	31,098	**100,560**
Iowa	Combination	240–375	–	122–167	21,777	–[9]	168–302[9]	168–302[9]	60,880	–	–	60,880	**82,657**
Kansas	Combination	–	–	113–133	54	167–238	150–238	134–238	77,085	–	–	77,085	**77,139**
Kentucky	Combination	–	142–159	109–159	50,926	196–213	160–213	160–213	36,050	–	–	36,050	**86,976**
Louisiana	Combination	142–212	142–212	108–212	122,878	213–250	213–250	213–250	3,498	209	9,238	12,736	**135,614**
Maine	Combination	–	140–157	132–157	13,440	192–208	158–208	158–208	8,870	–	–	8,870	**22,310**
Maryland	Medicaid expansion	194–317	138–317	109–317	142,327	–	–	–	–	–	–	–	**142,327**
Massachusetts[10]	Combination	185–200	133–150	114–150	79,299	201–300	151–300	151–300	76,519	200	13,123	89,642	**168,941**
Michigan[11]	Combination	195–212	143–212	109–212	29,226	–	–	–	85,302	195	5,171	90,473	**119,699**
Minnesota	Combination	275–283[12]	–	–	474	–	–	–	–	278	3,361	3,361	**3,835**
Mississippi	Combination	–	–	107–133	30,819	205–209	144–209	134–209	56,286	–	–	56,286	**87,105**
Missouri	Combination	–	148–150	110–150	38,600	197–300	151–300	151–300	39,744	300	–[13]	39,744	**78,344**
Montana	Combination	–	–	109–143	16,008	144–261	144–261	144–261	29,253	–	–	29,253	**45,261**
Nebraska	Combination	162–213	145–213	109–213	55,515	–	–	–	4,613[14]	197	2,090	6,703	**62,218**

TABLE B-1. (continued)

State	Program type[1] (as of July 1, 2016)	Children in Medicaid-Expansion CHIP[1]				Children in separate CHIP							Total CHIP-funded child enrollment[4]
						Separate CHIP: Age 0–18[2]				Separate CHIP: Unborn		Total separate CHIP enrollment	
		Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Eligibility[3]	Enrollment		
Nevada	Combination	–	–	122–133	17,763	161–200	161–200	134–200	44,145	–	–	44,145	**61,908**
New Hampshire	Medicaid expansion	196–318	196–318	196–318	16,651	–	–	–	–	–	–	–	**16,651**
New Jersey	Combination	–	–	107–142	100,826	195–350	143–350	143–350	114,365	–	–	114,365	**215,191**
New Mexico	Medicaid expansion	200–300	200–300	138–240	17,155	–	–	–	40[14]	–	–	40	**17,195**
New York	Combination	–	–	110–149	235,945	219–400	150–400	150–400	394,787	–	–	394,787	**630,732**
North Carolina	Combination	194–210	141–210	107–133	134,413	–	–	138–211	100,237	–	4[15]	100,241	**234,654**
North Dakota	Combination	–	–	111–133	–	148–170	148–170	134–170	4,955	–	–	4,955	**4,955**
Ohio	Medicaid expansion	141–206	141–206	107–206	181,100	–	–	–	–	–	–	–	**181,100**
Oklahoma	Combination	169–205	151–205	115–205	174,167	–	–	–	208[16]	205	16,483	16,691	**190,858**
Oregon[17]	Combination	133–185	–	100–133	–	186–300	134–300	134–300	115,726	185	6,143	121,869	**121,869**
Pennsylvania	Combination	–	–	119–133	64,638	216–314	158–314	134–314	229,704	–	–	229,704	**294,342**
Rhode Island	Combination	190–261	142–261	109–261	29,948	–	–	–	1376[14]	253	–[18]	1,376	**31,324**
South Carolina	Medicaid expansion	194–208	143–208	107–208	98,336	–	–	–	–	–	–	–	**98,336**
South Dakota	Combination	177–182	177–182	124–182	12,441	183–204	183–204	183–204	3,775	–	–	3,775	**16,216**
Tennessee[19]	Combination	–	–	109–133	17,971	196–250	143–250	134–250	78,731	250	9,513	88,244	**106,215**
Texas	Combination	–	–	109–133	336,769	199–201	145–201	133–201	614,417	202	98,437	712,854	**1,049,623**
Utah	Combination	–	–	105–133	27,762	145–200	145–200	139–200	27,523	–	–	27,523	**55,285**
Vermont	Medicaid expansion	237–312	237–312	237–312	4,766	–	–	–	–	–	–	–	**4,766**
Virginia	Combination	–	–	109–143	86,551	144–200	144–200	144–200	102,815	–	–	102,815	**189,366**
Washington	Separate	–	–	–	–	211–312	211–312	211–312	37,883	193	8,154	46,037	**46,037**
West Virginia[20]	Combination	–	–	108–133	15,242	159–300	142–300	134–300	33,036	–	–	33,036	**48,278**
Wisconsin	Combination	–	–	101–151	96,973	– [9]	187–301[9]	152–301[9]	67,845	301	3,758	71,603	**168,576**
Wyoming[21]	Combination	–	–	119–133	–[22]	155–200	155–200	134–200	–[22]	–	–	–[22]	**5,649**

Notes: FY is fiscal year. FPL is federal poverty level. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but separate CHIP for the second half), the individual would only be counted in the most recent category. Enrollment data shown in the table are as of July 2016, the most current enrollment data available; states may subsequently revise their current or historical data.

– Dash indicates that state does not use this eligibility pathway.

[1] Under CHIP, states have the option to use an expansion of Medicaid, separate CHIP, or a combination of both approaches. Ten states (including the District of Columbia) are Medicaid expansions and two states are separate CHIP only (Connecticut and Washington). There are combination programs in 39 states; among those, 11 consider themselves to have separate programs but are technically combinations due to the transition of children below 133 percent FPL from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, Wyoming). Medicaid-expansion CHIP eligibility ranges of 5 percentage points attributable to the mandatory 5 percent disregard are not shown. For states that have different CHIP-funded eligibility levels for children age 6–13 and age 14–18, this table shows only the levels for children age 6–13. For example, Oklahoma offers CHIP-funded Medicaid coverage to children age 6–14 with family income 115–205 percent FPL, and to 14- to 18-year-olds with family income 65–205 percent FPL. Tennessee offers CHIP-funded Medicaid coverage to children age 6–14 with family income from 109–133 percent FPL and 14–19 year olds with family income 29–133 percent FPL.

[2] CHIP eligibility levels as of July 2016.

[3] Separate CHIP eligibility for children birth through age 18 generally begins where Medicaid coverage ends (as shown in the previous columns). For unborn children, there is no lower bound for income eligibility if the mother is not eligible for Medicaid.

[4] Total exceeds the sum of Medicaid expansion and separate CHIP columns due to only total CHIP enrollment being reported for Wyoming.

[5] Arizona closed separate CHIP (KidsCare) to new enrollment in January 2010. The state reinstated the program on September 1, 2016.

[6] Although Arkansas transitioned its Medicaid-expansion CHIP to separate CHIP effective January 1, 2015, the state continued to report enrollment for children age 0–18 years under Medicaid-expansion CHIP.

[7] California has separate CHIP in three counties only that covers children up to 317 percent FPL.

[8] Due to reporting system updates, California CHIP enrollment totals are estimates as a result of the exclusion of certain unborn CHIP enrollees in reporting.

[9] Separate CHIP in Delaware, Florida, Iowa, and Wisconsin covers children age 1–18.

[10] Certain enrollees who should have been assigned to CHIP were assigned to Medicaid beginning in the second quarter of 2014, making FY 2015 totals artificially low.

[11] CHIP-funded Medicaid Michigan enrollees are included in Medicaid enrollment counts rather than in CHIP for FY 2015. Therefore, the CHIP enrollment totals are artificially low and the Medicaid enrollment totals are artificially high. Michigan transitioned its separate CHIP into Medicaid-expansion CHIP effective January 1, 2016.

[12] In Minnesota, only infants (defined by the state as being under age two) are eligible for Medicaid-expansion CHIP up to 283 percent FPL.

[13] Missouri began covering unborn children effective January 1, 2016, however the state has not reported enrollment for this coverage group.

[14] Separate CHIP enrollment figures in Nebraska, New Mexico, and Rhode Island are for the states' §2101(f) coverage group under the Patient Protection and Affordable Care Act. Section 2101(f) required that states provide separate CHIP coverage to children to who lost Medicaid eligibility (including through Medicaid-expansion CHIP) due to the elimination of income disregards under the modified adjusted gross income (MAGI) based methodologies. Children covered under §2101(f) remained eligible for such coverage until their next scheduled renewal or their 19th birthday, or until they moved out of state, requested removal from the program, or were deceased. Coverage under §2101(f) has now been phased out.

[15] North Carolina does not provide unborn children separate CHIP coverage. Errors in enrollment data reported are likely due to data quality issues.

[16] Separate CHIP enrollment in Oklahoma is for children enrolled in the state's premium assistance program.

[17] Certain Oregon enrollees who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FY 2014 and FY 2015.

[18] Lack of enrollment for separate CHIP unborn coverage in Rhode Island is likely due to data quality issues.

[19] While Tennessee covers children with CHIP-funded Medicaid, enrollment is currently capped, except for children who roll over from traditional Medicaid.

[20] West Virginia's enrollment totals are artificially high because children who transitioned between CHIP and Medicaid are reported in both programs, rather than the program they were last enrolled.

[21] CMS's FY 2015 children's enrollment report considers these values to be estimates.

[22] Due to inconsistencies between the Statistical Enrollment Data System data and the Centers for Medicare & Medicaid Services' FY 2015 children's enrollment report, we do not report enrollment for Medicaid expansion and separate CHIP. We only report total CHIP enrollment as provided in CMS's FY 2015 children's enrollment report.

Sources: Personal communication with CMS staff on December 2, 2016 and December 9, 2016. For numbers of children: MACPAC, 2016, analysis of CHIP Statistical Enrollment Data System from Centers for Medicare & Medicaid Service as of July 1, 2016; MACPAC, 2016, *MACStats: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, https://www.macpac.gov/publication/child-enrollment-in-chip-and-medicaid-by-state/. For eligibility levels: MACPAC, 2016, *MACStats: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, https://www.macpac.gov/publication/medicaid-and-chip-income-eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-children-and-pregnant-women-by-state/.

Appendix C:

Federal CHIP Allotments

Appendix C: Federal CHIP Allotments

TABLE C-1. Federal CHIP Allotments by State, FYs 2015–2017 (millions)

State	FY 2015 federal CHIP allotments	FY 2016 federal CHIP allotments[1]	FY 2017 federal CHIP allotments
Alabama	$172.9	$457.3	$319.7
Alaska	23.9	20.4	32.6
Arizona	80.7	123.7	206.4
Arkansas	94.0	174.5	194.4
California	1,744.1	1,995.2	2,668.6
Colorado	157.5	228.3	254.4
Connecticut	48.1	61.9	77.4
Delaware	20.3	38.5	35.3
District of Columbia	20.7	25.6	42.5
Florida	566.0	595.0	686.6
Georgia	410.6	418.2	404.8
Hawaii	46.3	46.3	52.3
Idaho	66.2	66.4	82.9
Illinois	361.4	406.2	547.4
Indiana	162.9	165.7	191.1
Iowa	126.0	147.6	145.7
Kansas	85.1	112.2	124.7
Kentucky	171.9	232.0	268.2
Louisiana	180.1	238.9	358.8
Maine	27.4	32.3	35.7
Maryland	234.3	290.8	295.9
Massachusetts	413.8	535.8	671.3
Michigan[2]	118.6	592.6	264.8
Minnesota	41.1	98.6	115.2
Mississippi	226.2	246.7	316.8
Missouri	163.2	172.9	175.2
Montana	91.7	95.8	103.5
Nebraska	69.7	78.2	72.5

TABLE C-1. (continued)

State	FY 2015 federal CHIP allotments	FY 2016 federal CHIP allotments[1]	FY 2017 federal CHIP allotments
Nevada	$43.1	$63.3	$70.0
New Hampshire	20.0	39.2	38.2
New Jersey	344.8	406.8	462.9
New Mexico	73.6	122.5	136.0
New York	972.8	1,074.6	1,233.5
North Carolina	395.0	448.2	479.5
North Dakota	21.0	21.2	21.9
Ohio	342.8	352.6	409.3
Oklahoma	173.1	189.2	249.0
Oregon	193.5	211.3	249.8
Pennsylvania	371.1	365.1	527.3
Rhode Island	46.0	65.4	72.8
South Carolina	142.9	162.0	154.2
South Dakota	18.9	23.6	26.9
Tennessee	198.1	213.3	465.0
Texas	1,068.7	1,345.1	1,382.1
Utah	59.1	148.9	131.6
Vermont	15.6	29.3	30.2
Virginia	247.6	265.2	291.1
Washington	129.0	215.3	242.5
West Virginia	55.2	65.4	61.0
Wisconsin	221.2	225.8	224.5
Wyoming	11.4	10.9	12.6
Subtotal	**$11,089.2**	**$13,761.9**	**$15,716.6**
American Samoa	1.7	2.1	2.9
Guam	5.9	8.0	26.6
N. Mariana Islands	1.2	1.0	6.7
Puerto Rico	183.2	179.8	192.5
Virgin Islands	5.0	5.3	6.9
Total	**$11,286.1**	**$13,958.3**	**$15,952.1**

Notes: FY is fiscal year.

[1] Per statute, FY 2015 and FY 2016 federal CHIP allotments were both based on each state's prior-year federal CHIP spending. In addition, because a 23 percentage point increase in the CHIP matching rate went into effect in FY 2016, the FY 2016 allotments were calculated by increasing federal CHIP spending by each state in FY 2015 as if the 23 percentage point increase in the CHIP matching rate had been in effect in FY 2015. The FY 2016 allotment-increase factor was then applied, which was approximately 5 percent for most states.

[2] In FY 2015, Michigan was poised to exhaust its federal CHIP allotments. As a result, the state requested and qualified for federal CHIP contingency funds totaling $52.6 million (§ 2104(n) of the Social Security Act (the Act)). Because the contingency fund payment was insufficient to eliminate the state's shortfall, Michigan also qualified for $61.5 million in redistribution funds (§ 2104(f) of the Act). The combination of contingency and redistribution funds eliminated the state's shortfall. The only other state ever to qualify for contingency funds was Iowa in FY 2011, but Iowa did not then require redistribution funds.

Sources: MACPAC, 2016, analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) data as of December 13, 2016. Personal communication with Centers for Medicare & Medicaid Services staff on December 8, 2016.

Appendix D:

CHIP Enhanced Federal Medical Assistance Percentages

Appendix D: CHIP Enhanced Federal Medical Assistance Percentages

TABLE D-1. CHIP Enhanced Federal Medical Assistance Percentages by State, FYs 2015–2017

State	E-FMAPs for CHIP		
	FY 2015[1]	FY 2016[2]	FY 2017[2]
All states (median)	**70.8%**	**93.8%**	**94.0%**
Alabama	78.3	100.0	100.0
Alaska	65.0	88.0	88.0
Arizona	77.9	100.0	100.0
Arkansas	79.6	100.0	100.0
California	65.0	88.0	88.0
Colorado	65.7	88.5	88.0
Connecticut	65.0	88.0	88.0
Delaware	67.5	91.4	90.9
District of Columbia	79.0	100.0	100.0
Florida	71.8	95.5	95.8
Georgia	76.9	100.0	100.0
Hawaii	66.6	90.8	91.5
Idaho	80.2	100.0	100.0
Illinois	65.5	88.6	88.9
Indiana	76.6	99.6	99.7
Iowa	68.9	91.4	92.7
Kansas	69.6	92.2	92.4
Kentucky	79.0	100.0	100.0
Louisiana	73.4	96.6	96.6
Maine	73.3	96.9	98.1
Maryland	65.0	88.0	88.0
Massachusetts	65.0	88.0	88.0
Michigan	75.9	98.9	98.6
Minnesota	65.0	88.0	88.0
Mississippi	81.5	100.0	100.0
Missouri	74.4	97.3	97.3
Montana	76.1	98.7	98.9

TABLE D-1. (continued)

State	E-FMAPs for CHIP		
	FY 2015[1]	FY 2016[2]	FY 2017[2]
Nebraska	67.3%	88.8%	89.3%
Nevada	75.1	98.5	98.3
New Hampshire	65.0	88.0	88.0
New Jersey	65.0	88.0	88.0
New Mexico	78.8	100.0	100.0
New York	65.0	88.0	88.0
North Carolina	76.1	99.4	99.8
North Dakota	65.0	88.0	88.0
Ohio	73.9	96.7	96.6
Oklahoma	73.6	95.7	95.0
Oregon	74.8	98.1	98.1
Pennsylvania	66.3	89.4	89.3
Rhode Island	65.0	88.3	88.7
South Carolina	79.5	100.0	100.0
South Dakota	66.2	89.1	91.5
Tennessee	75.5	98.5	98.5
Texas	70.6	93.0	92.3
Utah	79.4	100.0	100.0
Vermont	67.8	90.7	91.1
Virginia	65.0	88.0	88.0
Washington	65.0	88.0	88.0
West Virginia	80.0	100.0	100.0
Wisconsin	70.8	93.8	94.0
Wyoming	65.0	88.0	88.0

Notes: FY is fiscal year. FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). The E-FMAP determines the federal share of both service and administrative costs for CHIP, subject to the availability of funds from a state's federal allotments for CHIP.

Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent. In FYs 2016 through 2019, the E-FMAPs are increased by 23 percentage points. For additional information on Medicaid FMAPs, see https://www.macpac.gov/subtopic/matching-rates/.

E-FMAPs for the territories are not included. In FY 2015, all territories had an E-FMAP of 68.5 percent, and in FY 2016 and 2017, 91.5 percent.

[1] In FY 2015, states received the traditional CHIP E-FMAP.

[2] Under the ACA, beginning on October 1, 2015, and ending on September 30, 2019, the enhanced FMAPs are increased by 23 percentage points, not to exceed 100 percent, for all states.

Sources: Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, ASPE FMAP reports for 2015, 2016, and 2017, https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages (for FY 2017), http://aspe.hhs.gov/health/reports/2015/FMAP2016/fmap16.cfm (for FY 2016), http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.pdf (for FY 2015).

Appendix E:

Existing Proposals for Medicaid and CHIP Savings

Appendix E: Existing Proposals for Medicaid and CHIP Savings

At the request of some members of MACPAC's congressional committees of jurisdiction, the Commission has compiled a list of Medicaid and CHIP proposals, previously introduced in Congress or developed by others, that are estimated to generate program savings. The Commission has not voted on nor has it endorsed any specific proposal on this list. Moreover, MACPAC has not analyzed the merits or effects of these proposals on the availability of coverage to low-income individuals, access to care, or benefits nor their potential impact on states, health plans, providers, or others. Such effects would not be apparent in the cost savings estimate alone. As such, the list should be viewed with caution.

Sources for identifying cost-saving proposals include:

- legislative proposals (from the 112th, 113th, and 114th Congresses);
- other options that have been scored by the Congressional Budget Office (CBO) since 2010;
- proposals that have been offered in the President's budgets since 2008; and
- recommendations by the Government Accountability Office (GAO) and U.S. Department of Health and Human Services Office of the Inspector General (OIG).

Criteria for inclusion in the table below are:

- the proposal's estimated cost savings are quantified;
- the estimated cost savings do not exceed the estimated increase to federal spending for the Commission's recommendations in this report; and
- the proposal has not already been enacted or implemented.

Given these criteria, we excluded proposals for which savings are not quantified or that generate a level of savings substantially greater than the estimated cost of the Commission's recommendations. We also excluded proposals that are not scorable under Congressional scorekeeping guidelines, which prohibit the counting of budgetary savings when funds are provided in authorizing legislation for administrative or program management activities, including antifraud efforts (CBO 2014). For example, the President's budget for fiscal year (FY) 2017 included non-scorable proposals such as expand funding for Medicaid program integrity ($0.6 billion in non-scorable savings over 10 years).

In addition, we report estimates as reported in the source notation. The adoption of other policies since these scores were initially developed could result in changes to the estimates if reanalyzed.

In the statute creating MACPAC, Congress charges the Commission with reviewing Medicaid and CHIP policies, including their relationship to access and quality of care for Medicaid beneficiaries. Therefore, all the proposals on this list are Medicaid or CHIP policies. In considering policies that increase federal Medicaid or CHIP spending, Congress could choose to enact other proposals affecting spending or revenues, including those from outside CHIP or Medicaid.

TABLE E-1. List of Existing Proposals Estimated to Generate Medicaid and CHIP Savings

Proposal	Source of proposal	Estimated savings (over 10 years[1])	Source of savings estimate[2]
Drug payment policy			
Modify the ACA Medicaid rebate formula for new drug formulations (i.e., line extension drugs)	FY 2017 President's budget	$6.5 billion[3]	CBO[4]
Exclude brand name and authorized generic drug prices from the Medicaid federal upper limit for drug rebate calculations	FY 2017 President's budget	$1.0 billion	CBO[4]
Other payment policies			
Require remittances for medical loss ratios of less than 85 percent in Medicaid and CHIP managed care	FY 2017 President's budget	$6.3 billion	CBO[4]
Permanently extend DSH allotment reductions (current reductions end after FY 2025)	FY 2017 President's budget	$0.7 billion	CBO[4]
Apply a hospital-specific upper payment limit (UPL) rather than an aggregate UPL	Office of Inspector General (OIG)	$3.87 billion over five years	OIG
Eliminate graduate medical education supplemental payments in Medicaid	FY 2009 President's budget	$1.78 billion over five years	FY 2009 President's budget[5]
Eliminate payments for school-based administrative and transportation costs	FY 2009 President's budget	$3.645 billion over five years	FY 2009 President's budget[5]
Eligibility policy			
Change modified adjusted gross income rules to account for lottery winnings and other lump sum income across multiple months on a prorated basis	H.R. 4725	$475 million	CBO
Remove state option to increase the limit on home equity that is not considered an asset for aged and disabled eligibility determinations	FY 2009 President's budget	$480 million over five years	FY 2009 President's budget
Change FMAP for specific services, populations, or other			
Eliminate the newly eligible FMAP for prisoners in correctional facilities	H.R. 4725	$2.0 billion	CBO

TABLE E-1. (continued)

Proposal	Source of proposal	Estimated savings (over 10 years[1])	Source of savings estimate[2]
Change FMAP for specific services, populations, or other (continued)			
Apply a single blended FMAP rate to Medicaid and CHIP (with a four-year transition period)	FY 2013 President's budget	$17.9 billion	FY 2013 President's budget
Eliminate special Medicaid administrative match rates above the regular 50 percent administrative matching rate	FY 2009 President's budget	$5.5 billion over five years	FY 2009 President's budget
Reduce the 90 percent FMAP for family planning services to the standard medical matching rate	FY 2009 President's budget	$3.3 billion over five years	FY 2009 President's budget
Reduce the FMAP for targeted case management services to administrative matching rate rather than medical matching rate	FY 2009 President's budget	$1.1 billion over five years	FY 2009 President's budget
Reduce the FMAP for qualifying individual program from 100 percent to the state's regular medical matching rate	FY 2009 President's budget	$200 million over five years	FY 2009 President's budget
Financing changes			
Reduce the safe harbor threshold for provider taxes from 6 percent to 5.5 percent	H.R. 4725	$4.6 billion	CBO
Reduce the safe harbor threshold for provider taxes from 6 percent to 5 percent	CBO[6]	$15.9 billion	CBO

Notes: ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). FY is fiscal year. CBO is Congressional Budget Office. DSH is disproportionate share hospital. FMAP is federal medical assistance percentage.

[1] Five-year savings estimates are provided when ten-year estimates are not available.

[2] Cost savings estimates produced by CBO are provided when available. CBO provides budgetary and economic analyses in support of the congressional budget process.

[3] This proposal included a provision to exempt abuse deterrent formulations, which has since been enacted by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-19). This savings estimate has not been updated to reflect this. CBO separately scored the provision to exempt abuse deterrent formulations as adding $75 million in federal spending over 10 years.

[4] Savings estimates produced by CBO may vary from the source of the proposal due to differences in assumptions.

[5] This proposal was included in the President's FY 2009 budget, which referred to a savings estimate provided in the President's FY 2008 budget.

[6] This proposal was included in CBO's *Options for reducing the deficit: 2017 to 2026* (CBO 2016f).

Sources: CBO 2016a, 2016b, 2016c, 2016d, 2016e, 2016f, 2015; OIG 2015; and HHS 2012, 2008.

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Appendix F

Authorizing Language from the Social Security Act (42 USC 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 quarternary 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 USC 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

Sara Rosenbaum, JD (Chair), 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 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 National Academy of Medicine (formerly the Institute of Medicine), 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.

Marsha Gold, ScD (Vice Chair), is an independent consultant and senior fellow emerita 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, 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, and director of policy analysis and program evaluation at the Maryland Department of Health and Mental Hygiene. Dr. Gold is on the editorial board of *Health Affairs and Health Services Research*. She received her doctorate of science in health services and evaluation research from the Harvard School of Public Health.

Brian Burwell is vice president, community living systems, at Truven Health Analytics in Cambridge, Massachusetts. Mr. Burwell conducts research and provides consulting services, policy analysis, technical assistance in financing and delivery of long-term services and supports, and data analysis related to integrated care models for dually eligible beneficiaries and managed long-term services and supports. He has been with Truven Health Analytics and its predecessor companies for 30 years. Mr. Burwell received his bachelor of arts degree from Dartmouth College.

Sharon Carte, MHS, recently retired as executive director of the West Virginia Children's Health Insurance Program, having served there 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.

Andrea Cohen, JD, is vice president, office of transformation, at NYC Health + Hospitals, the largest public hospital system in the country. Previously, she served as senior vice president for program at the United Hospital Fund, directing the Fund's program work and overseeing grant-making and conference activities. From 2009 to 2014, she was the 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 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 in 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's degree program 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, and access to oral health care among underserved populations, as well as on 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.

Toby Douglas, MPP, MPH, is senior vice president for Medicaid solutions at Centene Corporation. Before joining Centene, he was an independent consultant and senior advisor for Sellers Dorsey, assisting organizations involved with Medicaid, health insurance exchanges, and Medicare. Previously, Mr. Douglas was a long-standing state Medicaid official, serving for 10 years as an executive in California Medicaid. He served as director of the California Department of Health Care Services and was director of California Medicaid for six years, during which time he also served as a board member of the National Association of Medicaid Directors and as a State Children's Health Insurance Program (CHIP) director. Earlier in his career, Mr. Douglas worked for the San Mateo County Health Department in California, as a research associate at the Urban Institute, as a consultant on pharmacy utilization with Kaiser Permanente Consulting, and as a VISTA volunteer. He received his master of public policy and master of public health from the University of California, Berkeley.

Leanna George is the parent of a teenager with a disability who is covered under Medicaid and a child covered under CHIP. A resident of Benson, North Carolina, Ms. George serves on the Johnston County Consumer and Family Advisory Committee, which advises the Board of the County Mental Health Center. She also serves on the Alliance Innovations Stakeholders Group, which advises a Medicaid managed care organization and the state of North Carolina about services and coverage for developmentally disabled enrollees, and on the Client Rights Committee of the Autism Society of North Carolina, a Medicaid provider agency.

Christopher Gorton, MD, MHSA, is the president of public plans at Tufts Health Plan, a non-profit health plan in Massachusetts, Rhode Island, and New Hampshire. Previously, Dr. Gorton was chief executive officer (CEO) of a regional health plan that was acquired by the Inova Health System of Falls Church, Virginia. Other positions have included vice president for medical management and worldwide health care strategy for Hewlett Packard Enterprise Services and president and chief medical officer for APS Healthcare, a behavioral health plan and care management organization based in Silver Spring, Maryland. After beginning his career as a practicing

pediatrician in federally qualified health centers in Pennsylvania and Missouri, Dr. Gorton served as chief medical officer in the Pennsylvania Department of Public Welfare. Dr. Gorton received his degree in medicine from Columbia University's College of Physicians and Surgeons and his master of health systems administration from the College of Saint Francis in Joliet, Illinois.

Herman Gray, MD, MBA, is president and CEO of United Way for Southeastern Michigan. Prior to assuming this post in September 2015, he served as executive vice president for pediatric health services for the Detroit Medical Center, a position he accepted after eight years as CEO and president of the Detroit Medical Center Children's Hospital of Michigan. At Children's Hospital of Michigan, 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 Detroit Medical Center 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 and 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 and *Modern Healthcare's* Top 25 Minority Executives in Healthcare Award and is a member of the board of trustees for the Skillman Foundation. He received his medical degree from the University of Michigan and his master of business administration from the University of Tennessee, and he completed his pediatrics training at the Children's Hospital of Michigan/Wayne State University.

Stacey Lampkin, FSA, MAAA, MPA, is an actuary and principal with Mercer Government Human Services Consulting, where she leads actuarial work for several state Medicaid programs. She previously served as actuary and assistant deputy secretary for Medicaid finance and analytics at Florida's Agency for Health Care Administration and as an actuary at Milliman. She has also served as a member of the Federal Health Committee of the American Academy of Actuaries (AAA), as vice chairperson of AAA's Uninsured Work Group, and as a member of the Society of Actuaries project oversight group for research on evaluating medical management interventions. Ms. Lampkin is a fellow in the Society of Actuaries and a member of the AAA. She received her master of public administration from Florida State University.

Charles Milligan, JD, MPH, is CEO of UnitedHealthcare Community Plan of New Mexico, a Medicaid managed care organization with enrolled members in all Medicaid eligibility categories (including dually eligible beneficiaries and adults in Medicaid expansion programs) that provides somatic, behavioral, and managed long-term services and supports. Mr. Milligan is a former state Medicaid and CHIP 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 at Baltimore County, 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, is executive vice president for health sciences and CEO of The Ohio State University Wexner Medical Center in Columbus. Dr. Retchin's research and publications have addressed costs, quality, and outcomes of health care as well as workforce issues. From 2003 until his appointment at Ohio State in 2015, he served as senior vice president for health sciences at Virginia Commonwealth University (VCU) and as 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.

Norma Martínez Rogers, PhD, RN, FAAN, is a professor of family nursing at The University of Texas 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 in the health care system and is the founder and president of the National Latino Nurse Faculty Association. She has initiated a number of programs at The University of Texas Health Science Center, including a mentorship program for retention of minorities in nursing education. She was a founding board member of the Martínez Street Women's Center, a non-profit organization that provides 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 her master of science in psychiatric nursing from The University of Texas Health Science Center at San Antonio and her doctorate in cultural foundations in education from The University of Texas at Austin.

Peter Szilagyi, MD, MPH, is professor of pediatrics, executive vice chair, and vice chair for research in the Department of Pediatrics at the Mattel Children's Hospital at the University of California, Los Angeles (UCLA). Prior to joining UCLA, 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. From 1986–2014, he served as 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.

Penny Thompson, MPA, is principal of Penny Thompson Consulting, LLC, and provides strategic advice and solutioning services in the areas of health care delivery and payment, information technology development, and program integrity. Previously, she served as deputy director of the Center for Medicaid and CHIP Services at the Centers for Medicare & Medicaid Services (CMS). Ms. Thompson has held senior positions in management consulting and information technology companies, and was director of health care strategy and planning for Hewlett Packard's health care business unit. In addition, she previously served as CMS's director of program integrity and as chief of the health care branch within the Office of Inspector General at the U.S. Department of Health and Human Services. Ms. Thompson received her master of public administration from The George Washington University.

Alan Weil, JD, MPP, is editor-in-chief of *Health Affairs,* a multidisciplinary peer-reviewed health policy journal, in Bethesda, Maryland. He is an elected member of the National Academy of Medicine and served six years on its Board on Health Care Services. He is a trustee of the Consumer Health Foundation and a member of the Kaiser Commission on Medicaid and the Uninsured. He previously served as executive director of the National Academy for State Health Policy, director of the Urban Institute's Assessing the New Federalism Project, executive director of the Colorado Department of Health Care Policy and Financing, and assistant general counsel in the Massachusetts Department of Medical Security. He received a master's degree from Harvard University's John F. Kennedy School of Government and a law degree from Harvard Law School.

Biographies of Staff

Annie Andrianasolo, MBA, is the 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 Johns Hopkins Carey Business School.

Amy Bernstein, ScD, MHSA, is a 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 Johns Hopkins University.

Kirstin Blom, MIPA, is a principal analyst. Before joining MACPAC, Ms. Blom was an analyst in health care financing at the Congressional Research Service (CRS). Before that, Ms. Blom worked as a principal analyst at the Congressional Budget Office, where she estimated the cost of proposed legislation on the Medicaid program. Ms. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office (GAO). She holds a master of international public affairs from the University of Wisconsin, Madison.

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 worked on several federal government projects, including projects 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.

Madeline Britvec is MACPAC's research assistant. Prior to joining MACPAC, she held internships at the U.S. Chamber of Commerce, International Bridges to Justice, and CBS Detroit. Ms. Britvec holds a bachelor of arts in economics and applied statistics from Smith College.

Kacey Buderi, MPA, is an analyst. Prior to joining MACPAC, she worked in the Center for Congressional and Presidential Studies at American University and completed internships in the office of U.S. Senator Ed Markey and at the U.S. Department of Health and Human Services (HHS). Ms. Buderi holds a master of public administration and a bachelor of arts in political science, both from American 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 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.

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.

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 holds 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.

Angelica Hill, MA, is the communications and graphic design specialist. Prior to joining MACPAC, she worked as the membership and programming coordinator for the Public Access Corporation of the District of Columbia (DCTV) and held a similar position at Women in Film and Video. Ms. Hill holds a master of arts in producing for film and video from American University and a bachelor of arts in communications from Howard University.

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