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August 29, 2011

State Health Insurance Exchanges and Children's Coverage: Issues for State Design Decisions

Executive Summary

As states consider implementation options under the Affordable Care Act, they face a series of critical decisions that will affect the design of insurance exchanges. Many of those decisions have the potential to affect health insurance options for children and how they obtain and retain coverage.

Insurance policies for children will be sold through exchanges, either as part of family coverage or as an individual children's plan. As states weigh various design options, the impact on children should be considered. States may pursue several goals with respect to children and exchanges, including:

- **Promoting Continuity of Coverage.** As family income fluctuates, children may transition from Medicaid into and the exchange and back again. To prevent churn and the associated administrative problems, states can make a priority of ensuring continuity of care between exchanges and Medicaid/CHIP. They can do that by requiring health plans and providers to participate in all three markets, or creating incentives for them to do so; they can implement a Basic Health Plan, through which families can remain together in one plan; or they can assess provider market characteristics and establish incentives for providers to participate in more than one market.
- **Creating a One-Stop Portal for Public Programs.** If states are interested in creating a one-stop portal, they may want to consider horizontally integrating all social services programs, instead of vertically integrating eligibility and enrollment in Medicaid, CHIP, and exchanges. With horizontal integration, there would be one IT system, with one application for enrollment. Given that children are often enrolled in more than one social service program, horizontal integration eases the burden on families that are applying for multiple programs for their children. It can, however, be extremely resource intensive, with high start-up costs and a potential for increased enrollment across all programs.
- **Maintaining Benefit Packages and Cost-Sharing Requirements.** Once benefit and cost-sharing structures are more clearly defined, governors may want to compare those structures with existing state Medicaid and CHIP eligibility and cost-sharing provisions. Such a comparison can identify areas where children transitioning between Medicaid/CHIP and exchanges could experience large changes in coverage and financial accountability. States should also consider which state benefit mandates they will continue to provide (e.g., autism services for children) and assess the costs of continuing to provide those services.

- **Emphasizing Outreach Activities.** If states are interested in promoting exchange insurance options, they will want to consider how to educate the public about health reform. States can design marketing campaigns for education, target outreach for specific populations, and consider how to use consumer assistance grants and “navigator” programs most effectively. States can also draw from previous experiences and apply best practices from outreach campaigns designed during CHIP implementation to publicize, and enroll children in, public coverage.

This issue brief was developed based on input during a daylong meeting hosted by the National Governors Association Center for Best Practices. Participants at the meeting included state government officials, general health care experts, federal representatives, and individuals from nonpartisan health policy institutions.

Introduction

Health benefit exchanges (“exchanges”) are a central component of the Patient Protection and Affordable Care Act (ACA). Policymakers have focused on the effect of exchanges on uninsured adults, but the ACA will also affect health coverage for low-income children. As states begin to plan for implementation of the ACA, they face a series of critical decisions that will define the exchange, how it is governed and operated, and how it will relate both to the commercial insurance market and to public health benefit programs. Many of the decisions have the potential to affect health insurance options for children.

This issue brief was developed based on a daylong meeting intended to provide states with a framework for understanding how exchange design decisions could influence children's coverage. Participants at the meeting included state government officials, health care experts, and federal representatives. The issue brief begins with a summary of how the ACA will affect health insurance options for children. It then addresses in greater detail the following goals that affect exchange design decisions:

- Promoting continuity of coverage;
- Creating a one-stop portal for public programs;
- Maintaining benefit packages and cost-sharing requirements; and
- Emphasizing outreach activities.

Shifts in Children's Coverage: 2011–2019

Medicaid and CHIP currently provide health insurance coverage for nearly 30 million children, representing one-third of all children and more than half of low-income children in the United States. Children with Medicaid and CHIP coverage have minimal cost-sharing requirements and receive a comprehensive benefit package that includes health screenings, physician and hospital visits, dental and vision care, and treatment considered medically necessary regardless of the condition. The vast majority of the exchange population will be adults. But uninsured children, and in some cases CHIP-eligible children and many parents, may obtain family coverage by enrolling in subsidized plans offered through the exchange.

The specific provisions in the Affordable Care Act that affect children's coverage include:

1. Beginning in 2014, Medicaid will be required to cover children in families with incomes up to 133 percent of the federal poverty level (FPL), with an additional 5 percent gross income disregard.

2. The ACA extends the CHIP program and provides federal funding through fiscal year (FY) 2015. In FYs 2015–2019, the ACA increases the federal matching rate for CHIP by 23 percentage points, up to a cap of 100 percent. However, federal funding is only available through FY 2015, so the program's long-term status is dependent on future congressional action.
3. In 2014, insurance exchanges will be established through which individuals and families can purchase coverage, with premium and cost-sharing credits available for those with incomes up to 400 percent of FPL. Subsidies are available only to individuals who purchase insurance through the exchange.
4. Through September 30, 2019, states must maintain Medicaid and CHIP eligibility procedures and standards that were in place for children on the date of enactment. There is an exception for CHIP: if CHIP funding is inadequate to provide coverage to all eligible children in a state, the state may shift children out of CHIP. States are required first to screen those children for Medicaid, and if they are not eligible, to transition them to exchange coverage or other available coverage.
5. ACA simplifies and streamlines eligibility across Medicaid, CHIP, and the exchanges to facilitate enrollment in public programs and subsidized coverage. Starting in 2014, states must use modified adjusted gross income (MAGI) to determine income eligibility for Medicaid and CHIP for most applicants. This standard will align with the exchanges' income definition and end the use of asset tests and certain income disregards for most Medicaid and CHIP enrollees.
6. Certain individuals will continue to be screened under existing Medicaid eligibility rules, including asset tests. Those populations include individuals eligible for Medicaid based on eligibility for other federal or state programs, the elderly, individuals eligible for Medicare cost sharing, individuals applying for long-term care and community-based waiver services, the medically needy, and individuals applying for Medicare prescription drug subsidies.

As a result of the ACA's various eligibility provisions, states should expect to see the following shifts in children's coverage after 2014:

1. Children between the ages of 6 and 19 with family incomes up to 133 percent of FPL will transition from CHIP to Medicaid in states with current Medicaid income limits for children lower than 133 percent of FPL; and
2. Under the new MAGI income eligibility rules, which only allow for a 5 percent income disregard, some children may shift from Medicaid to CHIP in states that have generous Medicaid income disregards.

In addition, a significant number of uninsured children are eligible for Medicaid or CHIP but are not enrolled. As a result of health reform and accompanying outreach activities to increase awareness of insurance expansions, an estimated 5 million eligible but currently unenrolled children are expected to sign up for Medicaid or CHIP.

Effects on Family Coverage

Children and their parents frequently have different sources of coverage today, and that will continue to be the case. Currently uninsured parents of children enrolled in Medicaid and CHIP may gain coverage in the exchange, but in many cases the children and their parents will be covered under different programs. The ACA preserves existing Medicaid and CHIP coverage for children through FY 2019; adults with incomes above 133 percent of FPL will have access to subsidized coverage through exchanges beginning in 2014. As a result, in some families—for example, a family with income at 225 percent of the federal poverty level, in a state with CHIP

eligibility extended to 250 percent of FPL—the parents will receive subsidized coverage through an exchange plan, while their children will obtain coverage via Medicaid or CHIP.

In addition, some children will have access to exchange subsidies for which their parents do not qualify and will enroll in “child-only” plans. The most likely circumstance involves children of undocumented immigrants, who will be prohibited from purchasing exchange coverage for themselves. Some parents also will have access to employer-sponsored insurance that does not include dependent coverage at an affordable price. In such a case, the parents would have employer/group coverage and could purchase exchange-based coverage for their child.

Coverage Transitions

Also important is that as a family's income changes, its coverage options may change as well. As a result, children and parents could move from Medicaid and CHIP into the exchanges, and vice versa. It is particularly likely at lower income levels that family incomes will fluctuate, resulting in changing coverage options for children, parents, or both. These transitions in coverage would likely be accompanied by changes in benefits and in cost sharing. Changes in coverage may also involve changes in provider networks, raising concerns about continuity of care, an area of special concern for children in the midst of a treatment plan. For families obtaining coverage through an exchange, increased income or family status changes could bring lower premium subsidy assistance and higher cost-sharing levels.

Exchange Design Considerations

Children are at risk of “falling through the cracks” if states do not put safeguards in their insurance exchange designs. For example, in a newly insured family in which the parents are enrolled through the exchange and the children are in Medicaid/CHIP, confusion may arise about different provider networks and cost-sharing requirements. Additionally, for a child who transitions between public programs and the exchange, plans, provider networks, benefits, and cost sharing may not be aligned, leading to interrupted treatment programs and worse health outcomes.

If a state chooses to operate an exchange, there will be two important issues to consider with respect to children:

1. *Market and policy decisions*, including whether to combine individual and small-group exchanges and how to set rules governing exchange participation by plans, risk adjustment, and the role of brokers in the exchange; and
2. *Operational decisions* about how to perform essential exchange functions (customer service, eligibility determination, and outreach) and establish application and enrollment processes that are integrated with state Medicaid and CHIP programs.

Without question, this is an oversimplification of a large, complex, and interrelated set of planning tasks. Many states are now analyzing the pros and cons of different approaches, using research, data analysis, and stakeholder input. However, the two categories are important for states in their consideration of how exchange decisions will affect children's coverage. The following sections describe areas in which the interplay between the exchanges and Medicaid and CHIP is especially significant and how state decisions could affect children's coverage and benefits. Because of the complexity of these issues and the important role that federal guidance and rule making will play in defining state options, specific design choices are presented in some cases; in others, issues that are important to monitor are described. There are also numerous

issues that must be addressed in the case of a federally run exchange, but at this time it is not feasible to discuss them because we do not yet know what a federally run exchange will look like.

Promoting Continuity of Coverage

If a state chooses to make continuity of coverage between Medicaid, CHIP, and the exchange a priority, it can use its leverage to establish a process for selecting the “qualified” health plans (QHPs) that will be available through the exchange to promote that objective. States have wide latitude in determining whether to limit or expand health plan choices, depending on their own priorities for the exchange. In general, some states will want to use exchanges to expand the choice of health plans for individual or group purchasers. In that case they may not find continuity of coverage as easy to achieve, compared to other states that prioritize continuity of coverage and multiple market participation.

If a state chooses to make continuity of coverage a priority, that also has implications for children and families. How health plan choices in the exchange market compare to those under Medicaid and CHIP—whether they are similar or different—will depend on whether or not a state prioritizes continuity across all markets.

Plan Participation in the Exchange

States have the option to address continuity of care for individuals in Medicaid, CHIP, and the exchange based on health plan selection. Depending on a state's current market and strategic priorities, health plan participation may be different across the three entities. States that want to enable families with different sources of coverage to have access to the same health plans may be interested in establishing more commonality across markets. States that wish to establish a common set of health plan choices could:

- Require exchange plans to participate in Medicaid and CHIP as a condition of exchange participation;
- Require Medicaid or CHIP health plans to participate in the exchange market through Medicaid and CHIP contract requirements; and
- Favor, via health plan selection and auto-assignment/enrollment, healthplans that participate in all three markets (Medicaid, CHIP, exchanges).

In some states, there would be practical and principled challenges to prioritizing continuity of coverage by engineering plan choices. For example, states may value community or provider-based Medicaid health plans that do not have the capacity to participate in the exchange. For those states, plan participation is more desirable than continuity and seamless coordination between Medicaid/CHIP and exchanges.

Adoption of the Basic Health Plan

Another option for states under the ACA is to establish a Basic Health Plan (BHP), whereby states can offer Medicaid-like coverage to individuals between 133 percent and 200 percent of FPL who are ineligible for Medicaid and do not have access to affordable employer-sponsored insurance. States will receive 95 percent of the value of the federal subsidies that would otherwise have been provided to enrollees. They can use those funds, in combination with member premiums, to pay for coverage.

States that choose to implement a BHP are required to do so through a competitively procured health plan (or plans). That presents an opportunity, during the contracting phase, to emphasize continuity of care and to build in requirements for common health plans across different markets, at least for individuals and families in the lower income bracket. Assuming that CHIP funding is

extended, the BHP will be primarily a coverage option for adults. However, if a state adopts the BHP option, as with health plan selections in exchanges, the BHP could be structured in a way to keep families below 200 percent of FPL together in one health plan, across Medicaid, CHIP, and the BHP. That would be beneficial for children.

The BHP option may be attractive to states that are interested in prioritizing continuity of coverage for a variety of reasons, but states will need to assess their ability to manage the costs of the program and the impact of carving out this population from other populations in their markets. The option requires that states offer generous benefits with very limited cost sharing, and it also limits member premiums. In addition, participants in the NGA experts meeting noted that valid concerns exist about a BHP's effect on the exchange, and those need to be analyzed. The concerns are generally about the impact of removing the 133 percent to 200 percent of FPL population entirely from the exchange. First, that could affect the attractiveness of the exchange to health plans, if the population eligible for subsidized coverage is significantly reduced. Second, removing a large population from the exchange could affect, positively or negatively, the exchange risk pool. Finally, the size of the exchange affects operation costs and potentially its plan for financial sustainability.

Provider Network Issues

The experts meeting raised the issue of provider versus plan loyalty, in the context of continuity of coverage. Typically, children and families are likely to care more about maintaining relationships with providers than with health plans. In general, states may want to assess the characteristics of their particular provider market and monitor closely how new plans are developing with those characteristics in mind.

Common provider networks across the exchange and public programs are one way to address this situation. Several other steps that governors could take to address continuity of care issues were discussed during the meeting, including:

- Setting provider network adequacy standards (e.g., child-specific provider requirements) in the exchange, Medicaid, or CHIP that would lead to overlapping networks;
- Analyzing the overlap in provider networks across exchange plans, Medicaid, and CHIP to understand deficiencies, identify the circumstances in which networks do not overlap, and address the issues raised; and
- Developing connectivity for record transfers and other tools to apply in cases when provider network contracting is different.

Creating a One-Stop Portal for Public Programs

Streamlining and coordinating eligibility and enrollment among the exchanges, Medicaid, and CHIP are ways to provide a gateway to health coverage by making sure that families are enrolled in the correct form of coverage (whether commercial health insurance or public benefit programs). Some states may be interested in expanding this concept to coordinate eligibility for all public programs, including Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). The ACA requires states to develop an eligibility process for health coverage that is consumer oriented, that maximizes the use of technology, and that reduces the burdens on individuals to obtain and retain coverage.

As they begin to design and implement new eligibility systems and processes, states will need to consider the following steps:

- Develop or enhance an online application website;

- Determine whether to modify existing eligibility systems or create a new, statewide eligibility system for the exchange, Medicaid, and CHIP;
- Determine appropriate roles and responsibilities for the exchange, Medicaid, and CHIP in the eligibility determination process;
- Modify state law to implement federal changes in eligibility rules; and
- Implement data matching to replace paper documentation with electronic information.

The specific issues related to designing an application to achieve a single portal for enrollment in all programs are discussed below.

Application Design and Program Integration

Although states have the option of adopting the single application to be developed by U.S. Department of Health and Human Services (HHS), governors who choose to develop state-specific applications will face important choices concerning how much information to gather from applicants and the sequence of that information on the application. The information to be gathered depends, at least in part, on the number and type of programs included in the eligibility determination. All states must vertically integrate their eligibility process by ensuring seamless eligibility and enrollment for individuals across the exchanges, Medicaid, and CHIP, but those that are interested in a one-stop public program portal may also horizontally integrate eligibility across both health and social services programs, including SNAP, TANF, and others.

Benefits of horizontal integration that the experts meeting noted include easing the burden on applicants interested in multiple programs and increasing take-up rates for programs by eligible applicants, whereas vertical integration only allows individuals easy access to public or private insurance, depending on their eligibility status. However, horizontal integration requires gathering more information on the application, is resource intensive, creates a more complex and detailed application for individuals attempting to enroll in multiple programs with different eligibility requirements, and eventually may result in higher state fiscal obligations, as more people enroll in programs.

During the process of designing the application, it will be important for governors to assess carefully how the eligibility simplification requirements will affect resources and whether sufficient interest and support exist to warrant pursuing a portal system that horizontally integrates all public programs.

Maintaining Benefit Packages and Cost-Sharing Requirements

The design of benefit packages and cost sharing in the exchange will have important implications for children, especially children with special health care needs (CSHCN), and for those who transition from public coverage to the exchange.

Essential Health Benefits and Benefit Packages

Medicaid and CHIP cover a robust package of health services for children, with very low or no cost sharing. For the exchanges, qualified health plans (and other nonexempt health plans) are required to cover essential health benefits, which will be defined by federal regulations. Certain services geared specifically toward children, such as newborn care and oral and vision care, are included in the Affordable Care Act definition, as are a comprehensive group of preventive care and screening services (referred to as “Bright Futures”), with no cost sharing.

By 2012, HHS is expected to issue federal guidance that defines services to be provided as “essential health benefits,” modeled after the scope of benefits in a typical employer plan. States

will want to monitor closely how HHS defines these services and incorporates guidelines from Bright Futures. Experts at the NGA meeting noted that states should consider how different decisions about benefit requirements would affect children's coverage in the exchange, as well as how they would affect children moving between programs. The larger the difference among benefit packages in Medicaid, CHIP, and the exchange, the greater will be the challenges of meeting all the needs of children with special health care needs in the essential benefits package.

Governors should pay close attention to the forthcoming federal guidance on essential health benefits to understand its impact on larger market forces, prices, and the availability of insurance. Governors may also want to compare potential or proposed exchange packages with existing state Medicaid and CHIP benefits.

State Health Insurance Mandates

States may require health plans to offer more generous benefit packages than those established by HHS, but they will have to bear the cost of additional required benefits for all individuals (not just the subsidized population) in the exchange. How the cost of state-mandated "extra" benefits will be determined has not been defined, except that HHS will establish their actuarial value. States, based on federal guidance, will also have to establish a process to adjust premiums or pay health plans, which will likely be administratively complicated.

Many states have existing insurance mandates that may not be included in the definition of "essential health benefits," leaving governors with the difficult choice of eliminating such mandates or paying for them within limited state budgets. The cost of state insurance mandates is presently borne by the market in the form of incremental premium increases. Moreover, a number of states have in place mandated benefits that are primarily targeted to or used by children, such as autism services. States that want to maintain a robust benefit package will need to evaluate how federal guidance treats any state-mandated benefits, assess the cost of continuing to require them, determine whether to continue or eliminate the required benefits, and take legislative action as necessary.

Cost-Sharing Assistance Comparisons

State-based exchanges can include premium assistance and reduced out-of-pocket expenses on a sliding scale for many participating individuals. Even with that assistance, however, cost sharing can be formidable for low-income families and children, especially if a child has a chronic condition or is a high user of health care services. By comparison, Medicaid and CHIP have very low levels of cost sharing for children and families. Families with children that transition from Medicaid/CHIP to the exchange may experience "sticker shock" from the increased cost-sharing levels and may not obtain the care needed to manage their conditions.

Experts noted during the meeting that as benefit plans and cost-sharing structures for exchange plans become more clearly defined, governors may want to compare them with existing state Medicaid and CHIP eligibility and cost-sharing levels to understand areas where children and families could experience transitions that significantly alter cost-sharing requirements. In addition, within the exchange, premium and cost-sharing requirements change significantly as family income goes up or down. Although the exchange is responsible for determining subsidy levels for exchange purchasers, it is unclear how the exchange will be expected, under federal rules, to account for and act on changed circumstances in a family. Again, governors should monitor how that process is defined.

Emphasizing Outreach Activities

Public programs like CHIP and Medicaid have engaged in outreach strategies to identify and assist eligible individuals to enroll. State-based exchanges are required to institute grant programs

for “navigators” to help consumers understand their health plan options. Starting in 2010, consumer assistance grants were made available to states to support or establish offices of health insurance consumer assistance or ombudsman programs. States will have to consider how to combine these tactics successfully, based on each state's strategic priorities.

States hold some responsibility for educating the public about health reform in general, as well as for marketing the exchange as an option for insurance coverage to ensure that enrollment is sufficient to make it viable. Governors interested in increasing enrollment and in educating people about new health care options may wish to design broad education and marketing campaigns, as well as targeted outreach for specific populations. To encourage children's coverage, states should apply lessons and best practices derived from past outreach efforts for CHIP. Throughout CHIP implementation and reauthorization, researchers found that outreach for one program resulted in increased enrollment for all programs. That may translate into children enrolling in CHIP and parents in the exchange, but it accomplishes the overall goal of increased health insurance coverage.

In many states brokers play a crucial role in the market, and they likely will play an invaluable role in educating people about the exchange. As states consider how to involve brokers in broader education and outreach efforts, they may wish to consider how to leverage their access to and familiarity with health insurance to improve outreach efforts to children.

Conclusion

As states begin to plan and design their exchanges, they will face a number of choices that will shape how children will obtain and retain coverage. Design features could mitigate instability that can result when parents and children have different coverage and when family members move between existing insurance programs. Operational imperatives surrounding eligibility and enrollment systems and new outreach and education efforts will undoubtedly affect existing processes for enrolling children in public programs. New coverage options, benefit structures, and technology solutions that emanate from the exchange deserve to be carefully assessed to understand any unique impacts on children of decisions about exchange design and operations and the relationship of the exchange to other public programs. Finally, federal rule making will play a critical role in a number of these issues, and governors should consider each major component as it emerges.