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Report to Congressional Requesters

October 2019

CHILDREN'S HEALTH INSURANCE PROGRAM

Efforts to Measure and Address Potential Substitution for Private Health Insurance

Accessible Version

GAO-20-12

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GAO Highlights

Highlights of GAO-20-12, a report to congressional requesters

Why GAO Did This Study

CHIP is a public insurance program established in 1997 that finances health care for over 9 million low-income children whose household incomes do not qualify them for Medicaid. States have flexibility in structuring their CHIP programs under broad federal requirements, and their income eligibility limits vary. Policymakers have had concerns that some states' inclusion of children from families with higher income levels could result in some families substituting CHIP for private insurance (i.e., crowd-out). Crowd-out may occur when, because of CHIP availability, (1) employers make decisions about offering health insurance; or (2) employees make decisions about enrolling in employer-sponsored health insurance.

GAO was asked to examine CHIP crowd-out. This report describes (1) the information on potential indicators of crowd-out reported by states and estimates of crowd-out; and (2) the procedures CMS and states use to address potential crowd-out.

GAO reviewed federal laws and guidance and state CHIP documentation, including their 2017 annual reports (the latest available at the time of GAO's review); conducted a literature review of studies published between 2013 and 2018; and interviewed CMS officials, stakeholders from national health policy organizations, and researchers. GAO also interviewed a non-generalizable selection of officials from nine states chosen to obtain variation in CHIP programs, such as income eligibility levels and geography.

HHS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-20-12. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Limited information exists about Children's Health Insurance Program (CHIP) crowd-out—that is, substituting CHIP for private health insurance. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), asked the 42 states that have separate CHIP programs to report on two crowd-out indicators for the 2017 annual reports: (1) the percentage of individuals who are enrolled in CHIP that have access to private health insurance and (2) the percentage of CHIP applicants who cannot be enrolled because they have private health insurance. The 2017 reports showed that:

- 4 states reported 0.5 percent to 7 percent of CHIP applicants had access to private health insurance; and
- 21 states reported denying CHIP enrollment to 0 percent to 18 percent of applicants because they had private insurance.

Not all of these 42 states reported on these indicators and GAO found that those that do may calculate them differently. CMS officials acknowledged that not all states report on these indicators; however, they noted that states operating separate CHIPs have other processes in place to prevent children with other health insurance from enrolling in CHIP. Further, some states may have other processes for directly measuring CHIP crowd-out. GAO also identified three studies published between 2013 and 2018 that estimated CHIP crowd-out. However, these studies used different methods to calculate crowd-out, and as a result produced varied estimates. For example, one study attributed a portion of increased enrollment in CHIP and other public insurance to crowd-out, while another study found no evidence of crowd-out.

According to CMS's 2017 annual reports and other information, the 42 states with separate CHIP programs reported implementing at least one of six types of crowd-out prevention procedures.

Crowd-Out Prevention Procedures among 42 States with Separate CHIP Programs

Crowd-out prevention procedure	Number of states
Enrollment application asks applicant about other private or group health insurance coverage for parents and children.	42 states
State charges enrollment fees, premiums, or other cost sharing (such as coinsurance, copayments, or deductibles).	35 states
State matches applicants to a database that identifies other sources of health insurance coverage.	16 states
State requires child to be uninsured for up to 90 days prior to being eligible for CHIP enrollment.	15 states
State measures against a threshold of unacceptable crowd-out and takes additional action if that threshold is exceeded.	15 states
State assists enrollees in their purchase of available private health insurance.	8 states

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services, state Children's Health Insurance Programs (CHIP), and a Kaiser Family Foundation and Georgetown Center for Children and Families survey on Medicaid and CHIP programs. | GAO-20-12

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Abbreviations

ACS	American Community Survey
AHRQ	Agency for Healthcare Research and Quality
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
FPL	federal poverty level
MACPAC	Medicaid and CHIP Payment and Access Commission
MEPS	Medical Expenditure Panel Survey
PPACA	Patient Protection and Affordable Care Act

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

October 11, 2019

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

The Honorable Pat Roberts
United States Senate

The Children's Health Insurance Program (CHIP), a joint federal-state program, was established in 1997 to initiate and expand the provision of health assistance to certain uninsured, low-income children. The program finances health care for over 9 million children whose household incomes are too high for Medicaid eligibility, but may be too low to afford private insurance.[1] A state has three options for designing its CHIP program: (1) Medicaid expansion CHIP, where CHIP operates as an extension of the state's Medicaid program; (2) separate CHIP, where CHIP operates separately from its Medicaid program; or (3) combination CHIP, in which a state operates both.

CHIP funding is available to states for targeted low-income children who meet certain income eligibility standards. The minimum required income eligibility level for CHIP is 133 percent of the federal poverty level (FPL)—an annual income of about $34,248 for a household of four persons in

[1]CHIP was established pursuant to the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552 (codified as amended at 42 U.S.C. §§ 1397aa et seq.). Medicaid was established pursuant to the Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343 (codified as amended at 42 U.S.C. §§ 1396 et seq.). Medicaid is a joint federal-state program that finances medical assistance, including health care for low-income and medically needy individuals, including children. Similar to Medicaid, CHIP program expenditures are shared between states and the federal government with each state's share determined by a formula that compares a state's per capita income to the national average. Federal matching rates for CHIP are higher than Medicaid matching rates and federal funding for CHIP is capped.

Private health insurance may include insurance provided to employees by an employer, referred to as employer sponsored insurance, or which individuals purchase directly from an insurer.

2019; however, states have established upper income limits ranging from 170 percent to 400 percent of the FPL.[2] Policymakers have had longstanding concerns that some states' inclusion of children in CHIP from families with higher income levels—who may have a greater likelihood of having private health insurance—could result in substituting CHIP for private insurance: a phenomenon known as crowd-out.[3] When crowd-out occurs, public financing is used to insure children in low-income families when private financing is available. CHIP crowd-out may occur when, because of CHIP availability, (1) employers modify or decide not to offer health insurance to their employees or to their dependents; or (2) employees drop or decide not to enroll themselves or their children in insurance offered by their employers.

Medicaid expansion CHIP programs—including those in combination states—are not required by law to prevent crowd-out, but may implement procedures to do so to the extent consistent with Medicaid statute. States with separate CHIP programs—that is, states with only separate CHIP programs and combination CHIP states that operate separate CHIP programs—are required to take steps to prevent crowd-out. These states are required to submit CHIP plans that describe reasonable crowd-out prevention procedures to the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), which oversees CHIP and provides guidance to states in how to administer their CHIP programs.[4] Additionally, these states must report

[2]The Patient Protection and Affordable Care Act (PPACA) required states to expand Medicaid income eligibility for children aged 6 to 18 from up to 100 percent of the FPL to up to 133 percent of the FPL; however, some states allow children in families with higher incomes to enroll in Medicaid. In addition, PPACA requires all states to employ a 5 percent income disregard. The effect of this income disregard is that states' upper income limits for CHIP are also increased by 5 percent. See: Pub. L. No. 111-148, § 2001(a)(5)(A), 124 Stat. 119, 274 (2010)) (codified as amended at 42 U.S.C. § 1396a(l)(2)(C)) (2010) (effective 2014, income level of 133 percent of FPL); Pub. L. No. 111-152, § 1104(e), 124 Stat. 1029, 1034 (2010) (codified at 42 U.S.C. § 1396a(e)(14)(I)) (5 percent income disregard). The FPL is updated annually to reflect changes in the cost of living and varies according to family size.

[3]At CHIP's inception, Congress had concerns about potential crowd-out. For example, the original statute establishing CHIP required states to include in their CHIP plans a description of procedures to be used to ensure that CHIP coverage does not substitute for coverage under group health insurance. Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552, 554 (codified in pertinent part at 42 U.S.C. § 1397bb(b)(3)(C)).

[4]See 42 U.S.C. § 1397bb(b)(3)(C); 42 C.F.R. § 457.805(a) (2018). States with combination CHIP programs operate both a separate CHIP program and a Medicaid expansion CHIP program. Combination states are only required to implement crowd-out procedures for their separate CHIP programs.

annually to CMS on the effectiveness of their policies for discouraging crowd-out.[5] For example, states report on several indicators of potential crowd-out. Actions that states have used to prevent crowd-out include denying CHIP coverage for applicants with private health insurance, and charging premiums for CHIP coverage, which can make CHIP costs more comparable to private health insurance costs.

In the past, researchers and federal agencies have estimated the extent to which crowd-out may occur, but these estimates have varied. For example, in 2007, the Congressional Budget Office reviewed 10 studies concerning crowd-out and estimated that for every 100 children who enrolled in public insurance as a result of CHIP being established, 25 to 50 fewer children were covered by private insurance.[6] However, other studies have reported lower estimates of crowd-out. One 2014 study estimated crowd-out to be as low as 4 percent nationally, while a 2013 study reported that state officials in Florida and Michigan estimated that 1.9 percent and 0.01 percent of applicants, respectively, dropped private insurance because they qualified for CHIP.[7]

Changes in federal law over the last decade have affected the types of health insurance offered to families, as well as how some families pay for or enroll in private and public health insurance—all of which could affect CHIP enrollment. For example, the Children's Health Insurance Program Reauthorization Act of 2009 made bonus payments available to states to simplify eligibility determinations in Medicaid and CHIP, and to increase

[5]See 42 C.F.R. §§ 457.750(a)(2).

[6]The Congressional Budget Office reports that the crowd-out studies it reviewed used various approaches to estimate crowd-out. For example, one approach sought to estimate the reduction in private coverage associated with both the increase in enrollment in CHIP and the increase in enrollment in Medicaid that is attributable to CHIP. Another approach sought to estimate the reduction in private coverage associated just with the increase in enrollment in CHIP. A final approach examined the share of CHIP enrollees who had private coverage before enrolling in CHIP. See Congressional Budget Office, *The State Children's Health Insurance Program*, 2970 (Washington, D.C.: May 2007).

[7]See the following studies contracted by the Office of the Assistant Secretary for Planning and Evaluation, within HHS: M. Harrington, et al., *Children's Health Insurance Program Reauthorization Act (CHIPRA) Mandated Evaluation of the Children's Health Insurance Program: Final Findings* (Ann Arbor, Mich.: Mathematica Policy Research, 2014), 37-44; and I. Hill, et al., *CHIPRA Evaluation of the Children's Health Insurance Program: Cross Cutting Report on Findings from Ten State Case Studies* (Ann Arbor, Mich.: Mathematica Policy Research, 2013), 59-63.

the enrollment and retention of children in Medicaid.[8] Additionally, the Patient Protection and Affordable Care Act (PPACA) required most citizens and legal residents of the United States to maintain health insurance or pay a tax penalty, a requirement known as the individual mandate.[9] Further, PPACA provisions established federal financial assistance for certain families to offset the cost of health insurance purchased through a health insurance exchange established under PPACA. Specifically, refundable tax credits are available for certain families—with incomes from 100 to 400 percent of the FPL who do not have access to affordable minimum essential health insurance coverage through an employer and do not qualify for Medicaid—to purchase private health insurance from a health insurance exchange in their state.[10] Some state officials and researchers attribute recent increases in CHIP enrollment to other PPACA provisions, such as those that required states to consolidate and automate their application systems for CHIP and other public insurance, because parents, in exploring health insurance options for themselves and their families, learned about CHIP eligibility for their children.[11]

[8]Pub. L. No. 111-3, § 104, 123 Stat. 8, 17 (codified as amended at 42 U.S.C. § 1397ee(a)(3)).

[9]Pub. L. No. 111-148, §§ 1501(b), 10106(b)-(d), 124 Stat. 119, 244, 909, 910 (2010) as amended by Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1032, 1034 (2010) (codified as amended at 26 U.S.C. § 5000A). However, beginning January 1, 2019, applicable penalty amounts were reduced to zero. See Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017) (codified at 26 U.S.C. § 5000A(c)).

[10]Pub. L. No. 111-148, §§ 1401 (a), 10105(a)-(c), 10108(h)(1), 124 Stat. 213, 906, 914 as amended by Pub. L. No. 111-152, § 1001 (a), 1004, 124 Stat. 1029, 1030, 1034 (codified as amended at 26 U.S.C. § 36B). PPACA requires employers with a certain number of employees to offer their full-time employees minimum essential health insurance coverage under an employer-sponsored plan and to face tax penalties if at least one such employee received an advance premium tax credit. See Pub. L. No. 111-148, §§ 1513(a), 124 Stat. 253 (codified at 26 U.S.C. § 4980H(a)). Eligibility for this credit is in part based on the affordability of the employer-sponsored health insurance; that is, insurance where premiums do not exceed a specified percentage of an employee's income: currently 9.86 percent of the employee's gross income. See 26 U.S.C. § 36B(c)(2)(C).

[11]See Pub. L. No. 111-148, § 1413, 124 Stat. 233 (codified at 42 U.S.C. § 18083). When parents apply for insurance through these automated systems, their children are automatically screened for different types of publicly financed health insurance and benefits at the same time. In some cases, a child may first be screened for Medicaid eligibility, and if the child is not determined to be eligible for Medicaid, the child will be assessed for CHIP eligibility. Therefore, when we refer to CHIP applicants we are referring to children that have been screened for CHIP eligibility.

To help Congress further understand CHIP crowd-out, you asked us to describe factors that may affect crowd-out, and CMS's and states' current crowd-out prevention procedures. This report describes

(1) information on potential indicators of crowd-out reported by states and estimates of crowd-out, and

(2) the procedures CMS and states use to address potential crowd-out.

To describe information on potential indicators of crowd-out reported by states and estimates of crowd-out, we reviewed relevant laws, CHIP regulations, and CMS guidance, as well as states' CHIP plan amendments and 2017 CHIP annual reports.[12] In addition, we interviewed CMS officials to understand the agency's requirements regarding the collection and use of information on CHIP crowd-out from states and any efforts to measure the extent to which crowd-out occurs. We conducted semi-structured interviews with a non-generalizable sample of officials from nine states, and reviewed the CHIP plans for these selected states to understand how they collect and report information about crowd-out.[13] Because of the variation in CHIP programs across states, to obtain a mix of perspectives regarding CHIP crowd-out and their procedures to prevent it, we selected nine states based on their CHIP income eligibility levels, type of CHIP program structure (Medicaid expansion CHIP, separate CHIP, or combination CHIP), geographic region, use of a waiting period as a crowd-out prevention procedure, and CHIP

[12]States must submit a CHIP plan to CMS that must include a description of procedures to be used to address crowd-out. States must submit state plan amendments for CMS's approval to make changes to their CHIP plans. Each fiscal year, states are required to assess their CHIP programs and submit an annual report to the Secretary of HHS. We reviewed CHIP annual reports and CHIP state plan amendments that describe state crowd-out procedures for all 50 states and the District of Columbia. In this report, we count the District of Columbia as a state.

[13]We reviewed CHIP plans for the nine states we selected: California, Florida, Kansas, Maryland, New Mexico, New York, Ohio, Pennsylvania, and Texas.

enrollment.[14] The states selected include three Medicaid expansion CHIP states (Maryland, New Mexico, and Ohio); three combination CHIP states (California, Florida, and New York); and three states (Kansas, Pennsylvania, and Texas) that had identified themselves as separate CHIP states, but are considered by CMS to be combination states.

To obtain a broad perspective on concerns about crowd-out, approaches used to measure crowd-out, and crowd-out estimates, we reviewed published literature from 2013 through 2018 that estimated crowd-out. To identify this literature, we searched multiple research databases for studies and, based on our review of the article abstracts, identified 30 articles that discussed CHIP crowd-out, among other things.[15] We reviewed each study to determine if it estimated CHIP crowd-out and identified 18 articles with results related to crowd-out estimates. We examined the methodologies of these 18 studies and identified three that provided reliable crowd-out estimates related to CHIP specifically and were not excluded for other reasons.[16] We also interviewed stakeholders and researchers from the Agency for Healthcare Research and Quality (AHRQ); the Georgetown University Health Policy Institute Center for

[14]To determine if a state operated a separate CHIP, we used CMS documentation that grouped states into four categories: (1) Medicaid expansion CHIP, (2) separate CHIP, (3) considered by the state to be separate CHIP, or (4) combination CHIP. In selecting a sample of states, our separate CHIP category combined separate CHIP and those considered by the states to be separate CHIP. According to CMS, states that consider themselves to be separate CHIPs—including the three we selected—are technically combination CHIPs, because the expansion of Medicaid income eligibility under PPACA resulted in children in those states transitioning from CHIP to Medicaid.

[15]We also identified articles that examined factors that may affect CHIP crowd-out or examined the effectiveness of crowd-out procedures. Databases searched included the following: Ageline & CINAHL, ECONLIT, Embase®, EMCare®, MEDLINE®, the National Technical Information Service, NEXIS, PAIS International, ProQuest, ProQuest Congressional, PsycINFO, Scopus, SciSearch®, Social SciSearch®, and Web OF Science.

[16]We excluded 15 of the 18 articles from our analysis for several reasons, including the article discussed the effect of specific health policies, such as PPACA implementation or Medicaid expansion, on changes to public or private health insurance markets, but did not provide any crowd-out estimates or crowd-out estimates specific to the children they studied; the focus of the article was on crowd-out in Medicaid or crowd-out among adult populations, and not specific to CHIP crowd-out or crowd-out among children; or because of limitations of the methodology used to estimate crowd-out. For example, we excluded two studies that estimated crowd-out at higher income levels only, and, thus, did not provide an overall estimate of crowd-out, or that focused on Medicaid crowd-out. To avoid duplication, we excluded policy brief papers or fact sheets derived from articles already included in the literature review.

Children & Families; Urban Institute; National Governors Association; the National Association for States Health Policy; the University of Michigan at Ann Arbor; and the Medicaid and CHIP Payment and Access Commission (MACPAC).

To describe the procedures CMS and states use to address potential CHIP crowd-out, we reviewed applicable laws, CHIP regulations, and CMS guidance, as well as state CHIP plans, state CHIP plan amendments, and states' 2017 CHIP annual reports, the latest available at the time of our review.[17] We also interviewed officials from CMS, our nine selected states, and the stakeholders and researchers identified above. In addition, we reviewed the same 30 articles from our literature review and identified two that also estimated the effectiveness of specific prevention procedures on crowd-out. We also reviewed CHIP enrollment applications to determine if states ask applicants about access to other health insurance.

To provide information on children's health insurance and employer sponsored insurance in the appendixes of this report, we report data from the American Community Survey (ACS) and the Medical Expenditure Panel Survey (MEPS) Household Component.[18] We assessed the reliability of these national survey data by reviewing related documentation, performing data reliability checks, and interviewing relevant agency officials with knowledge of the survey data. On the basis of these steps, we determined that the data were sufficiently reliable for the purposes of our reporting objectives. To provide information on trends in employer sponsored insurance, we also reviewed and summarized reports from AHRQ that analyzed MEPS Insurance Component data.[19]

[17]We reviewed state CHIP plans that describe state crowd-out procedures for our nine selected states.

[18]The ACS is a nationally representative annual survey conducted by the U.S. Census Bureau that collects information from survey respondents, such as each individual's type of health insurance coverage (if any) as of the date of the survey, disability status, age, and state of residence. MEPS is a nationally representative survey administered by AHRQ. The MEPS Household Component collects data from households about their health status and health care service utilization, among other information. MEPS Household Component data are collected in five rounds of interviews that take place over a two and a half year period.

[19]MEPS Insurance Component data are based on an annual survey of private and public-sector employers administered by AHRQ.

We conducted this performance audit from July 2018 to October 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CHIP Variation

States have three options for designing their CHIP programs: Medicaid expansion CHIP, separate CHIP, and combination CHIP.

- **Medicaid expansion CHIP.** States may operate CHIP as an extension of their Medicaid programs. Under Medicaid expansion CHIP, states expand income eligibility levels for children beyond those of the state's Medicaid program. Medicaid expansion CHIP programs must follow Medicaid rules, including providing all Medicaid covered benefits to enrolled children.
- **Separate CHIP.** States may operate their CHIP programs separate from their Medicaid programs. In so doing, the states are not required to follow the same rules as Medicaid; thus, these states have some additional flexibility in designing CHIP, such as determining which benefits to offer and how, if at all, to charge premiums.
- **Combination CHIP.** States may have a combination program, where they operate a separate CHIP program, as well as a Medicaid expansion CHIP program, each for a different population of children. For example, some states that operate combination CHIP programs apply different age or income eligibility requirements for their Medicaid expansion CHIP and separate CHIP programs.

Similar to Medicaid, CHIP program expenditures are shared between the states and the federal government, but federal matching rates for CHIP

are higher than for Medicaid and federal funding for CHIP is capped, with states receiving annual CHIP allotments.[20] The type of CHIP program a state designs may affect the amount of federal funding available to that state in the event the state exhausts available CHIP funding for the year. A state with a Medicaid expansion CHIP program that exhausts available CHIP funding may apply Medicaid funds at the Medicaid matching rate to remaining expenses for enrolled children for that year. However, a state with a separate CHIP program that exhausts available funding would not have access to such funding.[21]

In general, states administer CHIP under broad federal requirements that permit flexibility in how they design their programs, including in the services they cover, their upper income eligibility limits, and the fees they charge to participate. In terms of income eligibility, as of January 2019, 19 states, including the District of Columbia, had CHIP upper income eligibility limits of 300 percent of the FPL or higher compared with 32 states whose CHIP upper income eligibility limits were below 300 percent of the FPL.[22] (See fig. 1.)

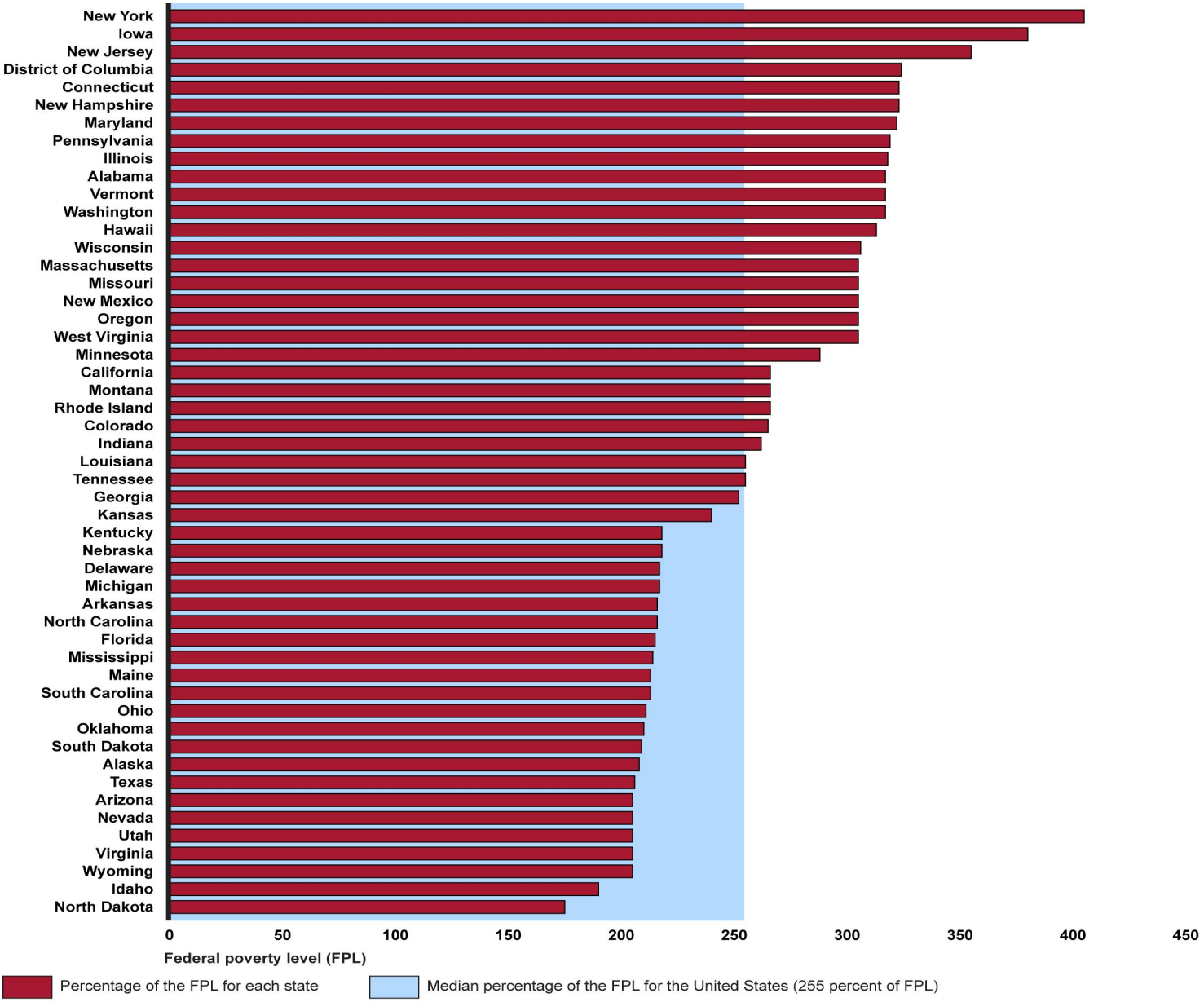
[20]Federal matching rates for CHIP are established under a formula that increases the federal share under the Medicaid matching rate by 30 percentage points, with an overall federal share that may not exceed 85 percent. In addition, in federal fiscal year 2020, states are to receive an 11.5 percent increase in their CHIP matching rates up to a maximum rate of 100 percent. See 42 U.S.C. § 1397ee(b).

[21]In the event a state with a separate CHIP program exhausts available CHIP funding, the state must establish procedures to screen enrolled children for Medicaid eligibility and enroll them in Medicaid, if eligible. The state also must establish procedures to screen children found ineligible for Medicaid for eligibility for subsidized coverage in a qualified health plan offered through a marketplace established under PPACA. 42 U.S.C. § 1397ee(d)(3)(B).

[22]CHIP defines targeted low-income children to include certain standards for financial need: those in families earning at or below 200 percent of the FPL; those residing in a state with no Medicaid applicable income level; or those residing in a state with a Medicaid applicable income level whose family income exceeds that level, but not by more than 50 percentage points, or whose family income does not exceed the state's Medicaid eligibility limits in place as of June 1, 1997. See 42 U.S.C. § 1397jj(b)(1); 42 C.F.R. § 457.310(b)(1) (2018). At a minimum, children in families with incomes up to 133 percent of the FPL (effectively 138 percent of the FPL when accounting for the 5 percent income disregard required by PPACA) are eligible for Medicaid; however, some states allow children in families with higher incomes to enroll in Medicaid. See 42 U.S.C. §§ 1396a(l)(2)(C), (e)(14)(I).

Figure 1: Upper Income Eligibility Limits for the Children's Health Insurance Program as of January 2019

The upper income eligibility limit—the threshold above which an individual is no longer eligible for the Children's Health Insurance Program (CHIP)—is defined as a percentage of the federal poverty level (FPL), which is updated annually. Minimum income eligibility for CHIP generally begins above the upper income eligibility limit for Medicaid.



Source: GAO summary of information from Kaiser Family Foundation. | GAO-20-12

Notes: CHIP upper income eligibility limits and the national median of those limits were reported in T. Brooks, L. Roygardner, and S. Artiga, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey* (San Francisco, Calif.: Kaiser Family

Foundation, 2019). Upper income eligibility limits represent the highest threshold for each state, and include the 5 percent income disregard required by the Patient Protection and Affordable Care Act, but may not apply to children of all ages. For example, the upper income eligibility limit in Iowa is 380 percent of the FPL; however, this limit only applies to infants aged 0 to 1 year old.

In addition, states can charge beneficiaries fees for CHIP coverage. These fees can vary depending on whether they are enrollment fees, premiums, or other types of cost sharing. Among the states that charge CHIP premiums, the premiums can vary based on family income and the number of children in CHIP. (See table 1.) Although states may charge premiums or have other cost sharing, according to CMS, CHIP provides more affordable coverage than is generally available in the private health insurance market.[23]

Table 1: Number of States that Charge Premiums and Median Monthly Premiums for the Children's Health Insurance Program at Selected Federal Poverty Levels, 2019

Percentage of FPL	Number of states that charge a premium	Median monthly premium (dollars)	States charging premium
151	9	15	Arizona, Delaware, Florida, Georgia, Idaho, Massachusetts, Missouri, Nevada, Utah
201	19	25	Arizona, California, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maine, Michigan, Massachusetts, Missouri, Nevada, New Jersey, New York, Utah, Vermont, Wisconsin
251	16	45	California, Connecticut, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Missouri, New Jersey, New York, Pennsylvania, Vermont, Washington, West Virginia, Wisconsin
301	13	50	Connecticut, Illinois, Iowa, Maryland, Massachusetts, Missouri, New Jersey, New York, Pennsylvania, Vermont, Washington, West Virginia, Wisconsin
351	2	166	New Jersey, New York

Source: GAO summary of information from Kaiser Family Foundation. | GAO-20-12

Note: Premium information was summarized from T. Brooks, L. Roygardner, and S. Artiga, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey* (San Francisco, Calif.: Kaiser Family Foundation, 2019). Of the 26 states requiring premiums in the Children's Health Insurance Program (CHIP), four states charge premiums for children in Medicaid expansion CHIP and 22 states charge premiums in separate CHIP. Data excludes four states charging annual enrollment fees (Alabama, Colorado, North Carolina, and Texas). Nevada and Utah require quarterly premiums that have been calculated to monthly equivalents. Not all states charge premiums at all income levels identified in the table. For example, some states only require premiums for families with incomes above a certain level. Specifically,

[23]See CMS, *Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans, November 25, 2015,* accessed July 31, 2019, https://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf.

Louisiana only charges a premium for families at or above 251 percent of the federal poverty level (FPL). Additionally, upper income levels vary by state, so not all states enroll children in families with income levels identified in the table.

CHIP Crowd-Out

CHIP crowd-out may occur when employers modify or decide not to offer health insurance to their employees or to their dependents, because of CHIP availability. For example, employers who are aware of CHIP may decide not to offer health insurance to employees or their dependents due to concerns about the costs of providing insurance, especially for smaller sized firms, or as a result of changes in federal or state policies, such as requirements resulting from PPACA.

Crowd-out may also occur when employees drop or decide not to enroll in insurance offered by their employers and enroll their children in CHIP, because of CHIP availability. As we have identified in prior work, assessments of the potential for crowd-out must take into account an understanding of the extent to which private health insurance is available and affordable to low-income families who qualify for CHIP.[24]

National survey results show that private health insurance is the most prevalent source of insurance for children; however, there is substantial variation across states in coverage rates. Additionally, the extent to which employers offered individuals insurance varies by family income. For additional information on factors that may affect crowd-out, see appendix I. For information on sources of health insurance for children under age 19, including CHIP and employer sponsored insurance, see appendix II.

[24]See GAO, *State Children's Health Insurance Program: CMS Should Improve Efforts to Assess whether SCHIP Is Substituting for Private Insurance,* GAO-09-252 (Washington, D.C.: Feb. 20, 2009).

In this report, private insurance is said to be available to individuals if their employers offered health insurance and if these individuals and their families were eligible for this benefit. Affordability refers to the capacity of low-income families to purchase available private health insurance. For example, if available insurance is not affordable, families may decline such insurance regardless of CHIP, and by definition, crowd-out would not occur.

The type of CHIP program a state designs affects its responsibilities for monitoring and mitigating the potential for CHIP crowd-out. The 42 states with separate CHIP programs—including those in combination CHIP states—are required to submit CHIP plans that describe reasonable procedures to prevent crowd-out and to report annually to CMS on certain crowd-out related indicators, such as the number of CHIP applicants with access to private health insurance; however, CMS provides states flexibility to decide which crowd-out prevention procedures to use.[25] For example, states can require CHIP applicants to undergo a period of uninsurance prior to enrollment, known as a waiting period, to deter families that have access to private health insurance from dropping that insurance to enroll in CHIP. In contrast, states are not required to take steps to prevent crowd-out for their Medicaid expansion CHIP programs and may only do so if consistent with the Medicaid statute, or if under an approved section 1115 demonstration, which allows states to implement policies that waive certain Medicaid requirements.[26]

For states with separate and combination CHIP programs, CMS provides general guidance for minimizing crowd-out, which the agency has modified over time. (See table 2 for a description of the crowd-out related responsibilities.) For example, in 2013, CMS issued regulations to align with a PPACA provision for health plans and health insurance issuers that limited waiting periods to a maximum of 90 days, and established mandatory waiting period exemptions.[27] The regulations also eliminated the application of a CHIP policy requiring that states with separate CHIP

[25]Combination CHIP states are required to take these steps for their separate CHIP programs.

[26]Section 1115 of the Social Security Act (codified at 42 U.S.C. § 1315) allows the Secretary of HHS to waive certain Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that in the Secretary's judgment are likely to promote Medicaid objectives. For example, state Medicaid expansion CHIP programs operating under a section 1115 waiver may implement a waiting period if authorized under that waiver, which would not otherwise be allowed in Medicaid.

[27]See Pub. L. No. 111-148, §§ 1201(4), 10103(b), 124 Stat.161, 892 (codified in pertinent part at 42 U.S.C. § 300gg-7); 78 Fed. Reg. 42160, 42313 (Jul. 15, 2013) (codified as amended at 42 C.F.R. § 457.805 (2018)). A CHIP waiting period may not be imposed on any child meeting one or more specified conditions, known as exemptions. Examples of exemptions include (1) the cost of family coverage that includes the child exceeds 9.56 percent of the household income, (2) the employer stopped offering coverage of dependents under an employer-sponsored plan, and (3) the child has special health care needs, among others. States can also institute other exemptions. See 42 C.F.R. § 457.805(b)(3) (2018).

programs have different crowd-out prevention procedures in place for children at different income levels.[28] In making this change, CMS noted that available research called into question the prevalence of crowd-out. CMS indicated that its policy still required states to monitor crowd-out and, if a high rate of crowd-out were to occur, states should consider implementing prevention procedures, such as public outreach about other health care options available in the state.[29]

[28]See 78 Fed. Reg. 42180 (Jul. 15, 2013) (preamble, II.A.7). Effective January 2014, this modified CMS's prior policy requiring states to have different procedures for monitoring based on different income levels. Specifically, CHIP policy had required states that provide CHIP coverage to children between 200 and 250 percent of the FPL to monitor crowd-out and identify specific strategies to limit it if levels become unacceptable. In addition, the policy had required states that provide CHIP coverage above 250 percent of the FPL to describe how they monitor crowd-out and to implement specific strategies to prevent it. 66 Fed. Reg. 2490, 2602 (Jan. 11, 2001) (preamble, II.G.2)).

[29]According to CMS officials, CHIP programs are not required to monitor changes in the employer sponsored insurance market regarding crowd-out.

Table 2a: State Crowd-Out Prevention Related Responsibilities by Type of Children's Health Insurance Program

CHIP program type	Responsibilities	
n/a	Crowd-out prevention	Eligibility
Medicaid expansion CHIP	• Not applicable. A state is not required to have crowd-out prevention procedures in place, or describe such procedures used to CMS in their state plan; thus, CMS does not expect these states to report on such procedures annually. • State may apply for a section 1115 waiver to use any crowd-out procedures that do not follow traditional Medicaid rules, such as a waiting period.[a]	• State may enroll children who are uninsured or who have private health insurance.[b]

Separate CHIP	• State is required to
	  • have at least one procedure for monitoring crowd-out in place in order to report on the effectiveness of its crowd-out prevention procedures;
	  • describe their crowd-out prevention procedures in their state plan and to inform CMS of any changes to their crowd-out procedures by submitting a plan amendment to CMS;[c] and
	  • annually report to CMS on its crowd-out prevention procedures.
	• If the state
	  • establishes a period of uninsurance prior to CHIP enrollment (waiting period), the period cannot exceed 90 days.
	  • uses a premium assistance program, they must evaluate and report the amount of crowd-out that occurs as a result of the program and the effect of the program on access to insurance.
		• State may only enroll children who are uninsured.
		• According to CMS officials, if the child gains private health insurance during CHIP enrollment, the state may be required to disenroll the child from CHIP.[d]

Table 2b: State Crowd-Out Prevention Related Responsibilities by Type of Children's Health Insurance Program

CHIP program type	Responsibilities
Combination CHIP	• Medicaid expansion CHIP programs in combination CHIP states must adhere to the crowd-out prevention and eligibility responsibilities for Medicaid expansion CHIP programs described in this table. • Separate CHIP programs in combination CHIP states must adhere to the crowd-out prevention and eligibility responsibilities for separate CHIP programs described in this table.

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS). | GAO-20-12

[a]Section 1115 of the Social Security Act (codified at 42 U.S.C. § 1315) allows the Secretary of the Department of Health and Human Services to waive certain Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that in the Secretary's judgment are likely to promote Medicaid objectives. For example, state Medicaid expansion Children's Health Insurance Programs (CHIP) operating under a section 1115 waiver may implement a waiting period, if authorized under that waiver, which would not otherwise be allowed in Medicaid.

[b]Medicaid enrollees are permitted to have private health insurance. Therefore, states may enroll children with private health insurance into Medicaid expansion CHIPs or states may continue to provide Medicaid expansion CHIP coverage to children who subsequently gain private health insurance, but the state must claim federal funds at the Medicaid matching rate for these children. In contrast, the state may claim the enhanced federal matching rate for uninsured children enrolled in Medicaid expansion CHIP, according to CMS officials.

[c]All states submit state plans to CMS, which describe how they intend to administer their CHIP programs. The state plan is a formal, written agreement between a state and the federal government and approved by CMS.

[d]If the state has a 12-month continuous eligibility period, according to CMS officials, it must continue to provide CHIP coverage as a secondary payer to a CHIP enrollee who gains private health insurance until the end of the continuous eligibility period. If the state does not have 12-month continuous eligibility, it must disenroll CHIP enrollees who gain private health insurance.

In response to crowd-out related recommendations we made in 2009, CMS modified its guidance to collect additional information from states in their 2009 through 2013 annual reports on how they assess the availability and affordability of private health insurance for CHIP applicants.[30] For example, from 2009 through 2013, states were required to report to CMS if the state's CHIP application asked if applicants had access to private health insurance. Additionally, states that operated a waiting period without affordability exceptions were asked if the state collected data on the cost of health insurance for an individual or family. However, CMS officials stated that the agency eliminated the questions regarding affordability of private health insurance in 2013, as part of efforts to update the electronic system states use to submit their CHIP annual reports to reflect PPACA enrollment simplification and coordination requirements. CMS officials said some of the questions were duplicative of other state reporting requirements and other questions were deemed irrelevant in light of the establishment of affordability exceptions to waiting periods.

Limited Information Exists on the Extent of CHIP Crowd-Out

States reported indicators of potential crowd-out to CMS in their annual reports, although some do not report on these indicators and those that do may calculate them differently. The states also varied in the extent to which they have processes for directly estimating crowd-out; however, CMS officials and officials in selected states told us they understand the occurrence of crowd-out to be low. Further, we identified few published research studies that directly estimated crowd-out; each used different methodologies, resulting in varied estimates.

[30]See GAO-09-252.

Some States Report Information on Two Indicators of Potential CHIP Crowd-Out; One Selected State Directly Measures Crowd-Out

States with separate CHIP programs—including those in combination states—are required to annually report indicators of potential crowd-out; states must also describe in their CHIP plans other indicators of potential crowd-out they collect. CMS's 2017 CHIP annual report asks these states to report on crowd-out related questions, including two indicators of crowd-out: (1) the percentage of individuals who enrolled in CHIP that have access to private health insurance, and (2) the percentage of CHIP applicants who cannot be enrolled, because they have private health insurance—an indicator of potential crowd-out averted.[31] However, not all states with separate CHIP programs track and report information related to these two indicators of potential crowd-out, and those that do may calculate these indicators differently.[32] For example, of the 42 states with separate CHIP programs, the 2017 annual reports showed the following:

- Four of the 42 states reported that they tracked the number of individuals who have access to private health insurance; the remaining 38 states either did not report tracking this information or did not respond to this question. Of the four states tracking this information, the percentages reported ranged between 0.5 percent and 7 percent of CHIP applicants who have access to private health insurance.
- Twenty-one of the 42 states reported that they tracked the percentage of applicants who could not be enrolled in CHIP because they were enrolled in private health insurance; the remaining 21 states did not report this percentage to CMS. This is a measure of crowd-out averted due to state oversight of its enrollment process. The

[31]CMS modified the 2018 CHIP annual report to ask states to report on the percentage of individuals "screened for CHIP eligibility" who cannot be enrolled because they have group health plan coverage.

[32]According to CMS officials, the agency allows states to determine how they calculate and report some crowd-out information on the annual reports. For example, officials noted that CMS allows states to determine the methodology states use to calculate the percentage of children screened for CHIP eligibility that cannot be enrolled because of other coverage.

percentages reported by the 21 states tracking this information ranged from 0 percent in several states to 18 percent in one state.

Among the states that reported they do not track individuals with access to private insurance and did not provide a percentage of applicants not enrolled in CHIP because of enrollment in private health insurance, five states indicated that either their electronic eligibility systems did not allow them to capture this information or the data to report this information were not available. CMS officials acknowledged that not all states report on these indicators; however, they noted that states operating separate CHIPs have other processes in place to prevent children with other health insurance from enrolling in CHIP.[33]

Further, some states that operate separate CHIP programs describe approaches for directly estimating crowd-out in their CHIP plan amendments. The results of these estimates are not reported to CMS unless they reach a threshold defined by each state. In 2013, CMS required separate CHIP states to submit state plan amendments to CMS to update their eligibility-related policies, including their crowd-out prevention procedures. In response, 17 of the 42 states submitted these amendments and described approaches they would use to directly measure crowd-out.[34] For example:

- Colorado reported conducting a biennial survey to estimate the percentage of enrollees who dropped group health insurance without good cause to gain eligibility for CHIP, according to its CHIP plan.
- Connecticut reported comparing the number of children denied CHIP enrollment because they were enrolled in private health insurance to

[33]CMS officials we spoke to said they monitor states' responses to these questions to identify data changes from year-to-year and will contact the states if and when it notices significant data changes. CMS officials said they also monitor the annual report against the crowd-out prevention procedures described in the state plans.

[34]We reviewed the state plan amendments states submitted to CMS that described if and how states planned to measure crowd-out. We did not independently confirm whether all 17 states that described approaches for measuring crowd-out are currently measuring crowd-out. However, two of our sample states submitted such amendments, but are not currently measuring crowd-out. Officials in one state told us they stopped using this approach in 2016 after their state legislature eliminated the state's 6-month waiting period. Officials in the second state told us they had not established specific mechanisms to track crowd-out, because the vast majority of their CHIP enrollees (about 99 percent) are enrolled in their Medicaid expansion CHIP program and, thus, would not expect that the remaining 1 percent of those in their separate CHIP program would result in any significant volume of CHIP crowd-out.

those same applicants who reapplied for CHIP 6 months later, but did not have private health insurance.

The crowd-out threshold defined by Colorado and Connecticut is 10 percent; therefore, if these states' crowd-out estimates were to exceed 10 percent, each state would collaborate with CMS to identify other procedures to reduce crowd-out.[35] According to CMS officials, no state using this approach to estimate crowd-out has exceeded the percentages established or expressed concerns with crowd-out.

States we interviewed varied in the extent to which they estimate crowd-out; however, most states did not view crowd-out to be of concern. Among our six selected states with separate CHIP programs, one state—New York—directly measures crowd-out. New York asks applicants that dropped their private insurance in the last three months the reasons why they dropped this coverage, which includes responses such as the family's preference for the child to have CHIP benefits over their previously held private health insurance. New York state officials told us they consider instances of crowd-out to include when individuals drop private insurance because CHIP costs and benefits are more favorable. For the last 9 months of 2014, the officials estimated crowd-out in New York to be about 1.9 percent. If New York estimates crowd-out to be higher than 8 percent, state officials told us they will report this to CMS and work with CMS on implementing additional crowd-out prevention procedures.[36] Officials from the other five selected states said they do not actively measure crowd-out, some of them citing limited resources and difficulties developing estimates, and noted that crowd-out was not a high priority for them, because they did not think crowd-out was prevalent in their states. For example, officials from two states said they had not heard any concerns regarding crowd-out from their state legislature, state insurance agencies, or others. CMS officials also told us that no state had reported concerns about crowd-out.

[35]For the 17 states that described how they measure crowd-out, the crowd-out thresholds identifying unacceptable levels of crowd-out range from 8 percent (in New York) to 15 percent (Georgia and Mississippi).

[36]CMS's 2013 final rule on waiting periods states that the agency considers monitoring of crowd-out to be a sufficient approach for addressing crowd-out and that if monitoring demonstrates a high rate of crowd-out, CMS expects that the state will consider strategies to address crowd-out, such as improving public outreach about the range of health insurance options available in that state. 78 Fed. Reg. 42180 (Jul. 15, 2013) (preamble, II.A.7).

Research on CHIP Crowd-Out Is Limited, Used Different Methods, and Resulted in Varied Estimates; Researchers and Others Identified Challenges in Making Such Estimates

Our review identified few research studies that directly estimated CHIP crowd-out. Specifically, we identified three research studies published from 2013 to 2018; each used different methods and arrived at varying estimates of crowd out.[37]

- One study estimated crowd-out across 15 states that expanded their CHIP income eligibility requirements between 2008 and 2012 by examining health insurance enrollment changes in a sample of children after they became newly eligible for CHIP.[38] This study estimated that public insurance among children under age 19 increased about 2.9 percentage points during this period, and private insurance decreased by 1.8 percentage points. The study reported that 63 percent of the 2.9 percentage point increase in public insurance was due to crowd-out. The researchers also produced state-level estimates for the effects of CHIP income eligibility expansions on insurance coverage in newly eligible children. These estimates varied by state, suggesting that crowd-out also varies by state. In particular, three states had an increase in public insurance ranging from about 4 to 12 percentage points, and three states had a decrease in private insurance that ranged from about 7 to 14 percentage points.[39] The researchers noted they did not account for

[37]The three studies we examined use different population-based methods to estimate crowd-out: difference-in-difference, synthetic control method, and the selection correction regression model. They also examine CHIP crowd-out in different states and used different national survey data as the basis for their estimates. For example, one study used data from the ACS and two used data from both the Current Population Survey—sponsored by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics—and the MEPS Insurance Component.

[38]See I.M. Goldstein, et al., "The Impact of Recent CHIP Eligibility Expansions on Children's Insurance Coverage: 2008-2012," *Health Affairs,* vol. 33, no. 10 (2014): p. 1861-1867. This study used the difference-in-difference methodology to estimate crowd-out. Increases in CHIP upper income eligibility limits generally result in more children becoming eligible for CHIP.

[39]In the remaining instances, the state-level estimates were not statistically significant from zero at $p < 0.05$.

factors that may have caused privately insured individuals to increase their use of public insurance, such as changes in the affordability of private health insurance.

- Another study estimated the effect of CHIP income eligibility expansions on crowd-out in Illinois.[40] This study examined the differences in public and private health insurance between children in Illinois, where CHIP income eligibility was expanded, and children from a combination of other states that did not expand CHIP—and were chosen to resemble the demographic characteristics and health insurance profile of Illinois. This study found a 6.5 percentage point increase in CHIP enrollment in 2010 among families between 200 percent and 300 percent of the FPL, and estimated that 35 percent of this increase in CHIP enrollment was due to crowd-out. At other income levels higher than 300 percent of the FPL, the study found either no net effect on private health insurance, or an increase.
- The third study estimated public and private insurance under different CHIP income eligibility thresholds and different premium schedules.[41] While the study estimated that a CHIP expansion from 200 to 400 percent of the FPL with no premium contribution and a 4 month waiting period increased CHIP enrollment by about 4.5 percentage points and decreased private coverage by about 2.2 percentage points, these estimates do not provide evidence of crowd-out, because the differences in these percentage point estimates were not statistically significant.[42]

[40]See James Lo, "How Do Public Health Expansions Vary by Income Strata? Evidence from Illinois' All Kids Program," *Inquiry*, vol. 50, no. 1 (2013): p. 27-46. This study used the synthetic control method to estimate crowd-out.

[41]See C.R. Gresenz, et al., "Income Eligibility Threshold, Premium Contributions, and Children's Coverage Outcomes: A Study of CHIP Expansions," *Health Services Research*, vol. 48, no. 2 (2013). The objective of this study was to understand the effects of CHIP income eligibility thresholds and premiums on health insurance coverage among children. This study used a selection correction model to estimate crowd-out. Approximately 71 percent of the children that were simulated to be eligible for public insurance had a zero premium for CHIP.

[42]Crowd-out can be measured as the change in private insurance divided by the change in public insurance or the fraction of children taking up public insurance who, in the absence of a public health insurance option, would have taken up private health insurance instead. These point estimates suggest that 50 to 75 percent of the increase in public insurance was due to crowd-out; however, this computation is not statistically significant. The authors note that the point estimates of changes in uninsurance and public coverage are consistent with a 2012 study they published.

Although not reporting direct estimates of CHIP crowd-out, we identified other studies that provide related information. For example:

- In one study, researchers surveyed the parents of current and former CHIP enrollees in 10 states to examine access to private coverage for children enrolled in CHIP. This study found that about 13 percent of new CHIP enrollees had private health insurance in the year before enrolling in CHIP.[43] Among the 13 percent, about 18 percent reported that they dropped their private health insurance, because CHIP was more affordable, and about 5 percent dropped their private health insurance, due to a preference for CHIP. The authors noted that access to private coverage among CHIP enrollees is low and when access is available, affordability is a serious concern for parents. The authors concluded that this suggests limited potential for crowd-out.
- A study published in 2015 that surveyed the parents of about 4,100 new CHIP enrollees to understand why children enrolled in CHIP, among other things, found that 35 percent of these parents reported applying for CHIP, because it was more affordable than the other health insurance options they could obtain for their children.[44]

Representatives from national organizations, researchers, and CMS officials we interviewed noted some of the challenges measuring the extent of CHIP crowd-out, including the limitations of available data sources; however, they did not consider crowd-out to be prevalent. For example:

- Some data sources do not separately collect or categorize CHIP information. For example, the ACS does not specifically ask respondents if their children have health insurance through CHIP; thus, researchers have to manipulate the data to separate CHIP coverage from other forms of public health insurance, such as Medicaid.

[43]See S. McMorrow, et al., "Access to Private Coverage for Children Enrolled in CHIP," *Academic Pediatrics*, vol. 15, no. 3 Supplement (2015). The study classified the following reasons for ending private health insurance and enrolling in CHIP as a preference for CHIP: dropped plan to qualify for CHIP; employer plan changed, was less desirable or less generous; CHIP costs less; and CHIP has better benefits.

[44]See C. Trenholm, M. Harrington, and C. Dye, "Enrollment and Disenrollment Experiences of Families Covered by CHIP," *Academic Pediatrics*, vol. 15, no. 3 Supplement (2015).

- The methodologies available to separate CHIP from Medicaid respondents have many limitations, according to researchers and U.S. Census Bureau officials we contacted. Accurate crowd-out estimates require researchers to account for the reasons why someone dropped his or her health insurance and enrolled in CHIP, and this information is not captured by national surveys. Researchers may also vary in what they consider to be crowd-out; for example, some may not consider dropping private health insurance and enrolling a child in CHIP because of a job loss or change in employment to constitute crowd-out. Others do not consider it to be CHIP crowd-out when parents drop their private health insurance and enroll in CHIP, because CHIP is more affordable.
- CMS officials also noted complexities in measuring crowd-out—such as variation in definitions of crowd-out and methodologies for measuring it—and they said that the agency has not conducted or commissioned its own evaluation. However, CMS officials reiterated that no state has reported concerns with crowd-out and based on their review of studies conducted by researchers understand that its prevalence is likely low.

CMS Tracks States' Procedures to Address Potential CHIP Crowd-Out; States Ask Applicants about Other Sources of Coverage and Use Cost-Sharing Provisions

CMS monitors states' CHIP crowd-out prevention procedures and offers technical assistance, while states ask CHIP applicants about other sources of health care coverage, and use waiting periods and cost-sharing procedures, such as enrollment fees and premiums. Several state officials we interviewed told us that their crowd-out prevention procedures are effective; however, they could not speak to the effectiveness of any particular procedure and few studies have examined the issue.

CMS Tracks States' CHIP Crowd-Out Procedures Primarily to Identify Inconsistencies in States' Reporting and Provide Technical Assistance upon Request

CMS officials told us that they track the information states submit about their CHIP crowd-out prevention procedures as part of their annual report review process to identify any inconsistencies between the information contained in their state plans and the information submitted in states' annual reports, among other reasons.[45] When CMS officials identify any noticeable differences in the information reported by states from year-to-year in the annual reports—such as the percentage of CHIP applicants with access to private insurance—they told us they follow-up with the state to obtain additional information about these differences, and, if needed, advise states on ways they can prevent crowd-out.[46] CMS officials also told us they provide technical assistance, when requested, to assist states in developing crowd-out prevention procedures. For example, CMS officials said they provided states with technical assistance after issuing regulations in 2013 on the use of waiting periods that also required states to update their state plan amendments. CMS officials said they have no plans to develop additional strategies for collecting states' crowd-out information, because states have not reported crowd-out to be a concern, and there is no need to re-examine states' oversight if prevalence as measured in research is likely low.

[45]Each state and territory must assess the operation of its state child health plan in each federal fiscal year and report to the Secretary, by January 1 following the end of the federal fiscal year, on the results of the assessment. 42 U.S.C. § 1397hh(a). Each such report must include, to the extent applicable, a description of state activities designed to reduce the number of uncovered children in the state. 42 U.S.C. § 1397hh(e)(6). States fulfill this requirement by submitting a state annual report to CMS.

[46]CMS officials stated that they do not review these reports for substitution trends on an annual basis.

All States with Separate CHIP Programs Reported Implementing at Least One CHIP Crowd-Out Prevention Procedure, Such as Cost Sharing

All 42 states with separate CHIP programs reported to CMS that they had implemented at least one of the following six types of procedures to prevent crowd-out: (1) asking about other health insurance and denying CHIP coverage if other sources of health insurance are identified; (2) implementing cost sharing for CHIP coverage; (3) conducting database checks for other health insurance; (4) implementing a waiting period for CHIP coverage; (5) measuring crowd-out and taking steps if certain thresholds are exceeded; and (6) offering premium assistance for private health insurance.[47] The majority of these states (36 of the 42 states with separate CHIP programs) implemented at least three crowd-out procedures. All 42 states with separate CHIP programs asked applicants about other insurance coverage on their CHIP applications to deny applicants CHIP coverage if private insurance coverage was found, and CMS officials told us that 35 of those states required CHIP enrollees to pay premiums or make other financial contributions to the cost of the coverage.[48] (See table 3.) Among our six selected states with separate CHIP programs, there were differences in how some crowd-out procedures were implemented. For example, three states conducted database checks to see if applicants had other sources of health insurance; however, one state checked prior to enrollment, another checked at enrollment and during application renewal, and one state ran weekly checks.[49] Among our six selected states with separate CHIP

[47]Separate CHIP programs generally operate under a separate set of federal rules that allow states to design benefit packages that may look more like private insurance plans than Medicaid. For example, under cost sharing, states may charge enrollment fees, premiums, or impose other cost sharing (such as coinsurance, copayments, or deductibles). Under premium assistance, states subsidize enrollees in their purchase of private health insurance, if cost effective to the state, and if private health insurance provides comparable coverage to CHIP. States have implemented premium assistance programs to promote the continuation of coverage of private health insurance among CHIP-eligible families. Combination CHIP states are required to take steps to prevent potential crowd-out for their separate CHIP programs, and Medicaid expansion CHIP programs are not required by law to prevent crowd-out.

[48]Some states did not require premiums for all families at all incomes levels.

[49]Except where law requires other procedures (such as for citizenship and immigration status information), the state may accept attestation of information needed to determine the eligibility of an individual for CHIP. See 42 C.F.R. § 457.380(a) (2018).

programs, none planned to change procedures to prevent potential crowd-out.

Table 3: State Crowd-Out Prevention Procedures among 42 States with Separate Children's Health Insurance Programs

Crowd-out prevention procedures		Number of states using procedure
Asking about other health insurance	State enrollment application asks applicant about other private or group health insurance coverage for parents and children and, depending on the answer, denies access to CHIP coverage if other private health insurance coverage is found.	42 states[a]
Implementing cost sharing	State charges enrollment fees, premiums, or other cost sharing (such as coinsurance, copayments, or deductibles) for CHIP coverage.	35 states[b]
Conducting database checks for other health insurance	State checks applicants against a database that identifies whether the applicant has other private health insurance coverage.	16 states[c]
Implementing a waiting period	State requires child to be uninsured from private health insurance for up to 90 days prior to being eligible for CHIP enrollment.	15 states[c]
Taking action when crowd-out exceeds threshold	State measures against a threshold of unacceptable crowd-out defined by each state and if that threshold is exceeded, works with CMS to identify and implement additional strategies to reduce crowd-out.	15 states[d]
Offering premium assistance	State subsidizes enrollees in their purchase of available private health insurance.	8 states[c]

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS), CHIP programs, and a Kaiser Family Foundation and Georgetown Center for Children and Families survey on Medicaid and CHIP programs. | GAO-20-12

[a]To obtain information on whether states ask about other health insurance, we reviewed states' Children's Health Insurance Program (CHIP) enrollment applications.

[b]To obtain information on cost sharing, we reviewed the results of a state survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families and considered information provided by CMS officials. See T. Brooks, et al., *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey* (San Francisco, Calif.: Kaiser Family Foundation, 2018).

[c]To obtain information on waiting periods, database checks, and premium assistance, we reviewed states' 2017 annual CHIP reports.

[d]To obtain information on measuring crowd-out, we reviewed states' CHIP plans. States that monitored crowd-out without setting a threshold were not included.

Among the 42 states with separate CHIP programs, some crowd-out prevention procedures vary or have changed over time. For example, while many states use a private company to collect state and national health insurance coverage information to conduct database checks, another state developed a database that contains information on insurance coverage available through over 40,000 employers in the state. Additionally, prior to 2014, 36 states imposed waiting periods, during which applicants could not have health insurance for a specified time before CHIP enrollment, to prevent crowd-out. In 2017, 14 states used waiting periods. Prior to PPACA and the implementation of CMS regulations that limited waiting periods to 90 days, waiting periods could range from 1 to 12 months. After CMS updated its regulation, 21 states eliminated their waiting periods and five states shortened them.

Among our four selected states with separate CHIP programs that shortened or eliminated their waiting periods, none of the state officials expressed concerns that this change contributed to CHIP crowd-out. Administering a waiting period may involve the state tracking or determining whether the applicant meets any of the state and federal waiting period exemptions, the number of months for the waiting period before the applicant can be enrolled in CHIP, and informing the federally facilitated exchange if an exemption to the waiting period applies to the applicant.[50] As a result, some officials noted that reducing waiting periods eased their state's administrative burdens, as well as eliminated gaps in children's health insurance.[51]

Among the four selected states, officials from New York said they eliminated their waiting periods because, after undergoing the various administrative steps to verify each application and apply the waiting period, the majority of the CHIP applicants met at least one waiting period exemption.[52] However, three of the selected states with separate CHIP programs maintained waiting periods, and state officials from Texas told us that few individuals met the waiting period exemptions.[53] Some state officials told us they attributed waiting periods—which require children to go uninsured for a period of time—to gaps in health care, and their states

[50]A child is exempt from the waiting period if: the additional out-of-pocket premium to add the child to an employer plan exceeds 5 percent of income; the child's parent is eligible for subsidized exchange coverage, because the premium for the parent's self-only employer-sponsored coverage is determined unaffordable; the total out-of-pocket premium for employer-sponsored family coverage exceeds 9.56 percent of income; the employer stopped offering coverage of dependents; a change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (regardless of potential eligibility for COBRA coverage); the child has special health care needs; or the child lost coverage due to the death or divorce of a parent. Prior to the issuance of these regulations in 2013, many CHIP programs had already implemented some of the federal exemptions listed above. See 42 C.F.R. § 457.805(b)(3) (2018).

[51]For additional information on administrative burdens related to waiting periods, see Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2014).

[52]Prior to the establishment of federal exemptions to CHIP waiting periods implemented on January 1, 2014, states could establish their own waiting period exemptions.

[53]Both the Texas and Florida CHIP programs had waiting periods of 90 days or less prior to when CMS updated its regulation and did not change their waiting periods after the update. After the implementation of new CMS regulations, Kansas reduced its waiting period from 8 months to 90 days. Kansas state officials told us that they did not have any concerns about the change to their waiting period.

eliminated the waiting period in an attempt to provide continuity in children's access to health care.

Although not required by law, officials from two of our selected states with Medicaid expansion CHIP programs told us their states previously had approved 1115 demonstration waivers permitting their states to use a CHIP waiting period, but eliminated them in 2013 and 2014 to close gaps in children's health insurance coverage.[54] Currently, these states use similar procedures as separate CHIP states to prevent crowd-out, according to state officials.[55] Of our three selected states with Medicaid expansion CHIP programs, one state monitors CHIP enrollment trends; a second state requires its managed care organizations to check CHIP enrollees for other sources of insurance as part of their claim processing activities; and one state conducts database checks for other health insurance at the time of enrollment and re-enrollment.

The Effect of States' Procedures to Prevent CHIP Crowd-Out is Unclear, as Relatively Few Studies Have Examined the Issue

The effect of some of the states' procedures on preventing CHIP crowd-out is unclear and, according to selected state officials and stakeholders, some crowd-out prevention procedures may have unintended consequences. For example, state officials and stakeholders told us waiting periods result in coverage gaps, which, as one stakeholder noted, could be catastrophic for a family with a sick child who would not have

[54]CMS officials told us that, as of April 2019, none of the Medicaid expansion CHIP programs have implemented crowd-out prevention procedures that require a CMS-approved 1115 demonstration waiver, such as a waiting period, and they were unaware of any Medicaid expansion CHIP programs with plans to apply for a waiver.

[55]If a state with a Medicaid expansion CHIP program learns that a CHIP applicant or a CHIP enrollee has other health insurance, CMS officials told us the state must claim Medicaid matching funds, instead of CHIP matching funds.

coverage during the waiting period.[56] Several CHIP officials we interviewed believed their procedures are effective in preventing crowd-out; however, they either had not studied the effectiveness of their procedures or could not speak to the effectiveness of any particular procedure.

Relatively few of the studies we reviewed examined the effectiveness of state procedures for preventing crowd-out. Specifically, two studies looked at this issue. Both studies concluded that cost-sharing procedures, such as premiums, can reduce the potential for crowd-out among higher-income CHIP-eligible families.

- A 2014 study used CHIP-related data from 2003 and found that CHIP premiums discourage individuals with private health insurance from dropping their insurance to enroll in CHIP.[57] The study compared health insurance outcomes across 19 states for children with incomes slightly above states' CHIP income eligibility thresholds with children in families with incomes slightly below the thresholds.[58] The results indicated that there is an association between CHIP premiums and private insurance coverage; that is, a $1 increase in the CHIP premium above the income cut-off is associated with a 2.2 percentage point higher probability of the child being privately insured for families within 15 percent of the upper income level, and a 1.7 percentage point higher probability for families within 25 percent of the upper income level. These findings suggest that private health insurance may be a preferable alternative for CHIP eligible families at higher income levels who face higher CHIP premiums.
- A 2013 study used survey data from 50 states and the District of Columbia from 2002 to 2009 to estimate the effect CHIP premium

[56]In a 2014 report to Congress, MACPAC recommended eliminating waiting periods for all CHIP applicants and CHIP premiums for families with incomes under 150 percent of the FPL, because it could reduce uninsurance for children, as well as administrative burdens for states and families. According to MACPAC, CHIP waiting periods reflect the initial design of the CHIP program and concerns that public coverage would crowd out private coverage. However, they reported that many children are eligible for exchange coverage and CHIP waiting periods require children to go between exchange coverage (or uninsurance) and CHIP.

[57]See S. Nikolova and S. Stearns, "The Impact of CHIP Premium Increases on Insurance Outcomes among CHIP Eligible Children," *Health Services Research*, vol. 14, no. 101 (2014): p. 4.

[58]Upper income levels and premiums vary by state.

contributions have on enrollment in CHIP, private insurance, and rates of uninsurance among children in families with income eligibility levels of 200 to 400 percent of the FPL.[59] The study found that if CHIP programs expand eligibility to those at higher income levels and charge those families a higher premium, the families may be more likely to choose private health insurance, nullifying the effects of CHIP expansion among higher income families.

Agency Comments

We provided a draft of this report to HHS for review and comment. The department provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of CMS, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or at yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff that made key contributions to this report are listed in appendix III.

Carolyn L. Yocom
Director, Health Care

[59]See C.R. Gresenz, et al., "Income Eligibility Thresholds," pp. 884-904.

Appendix I: Crowd-Out and Trends in Children's Health Insurance and Employer Sponsored Health Insurance

Crowd-out may occur when employers modify or decide not to offer health insurance to their employees or to their dependents because of Children's Health Insurance Program (CHIP) availability. For example, employers who are aware of CHIP may decide not to offer health insurance to employees due to concerns about the costs of providing insurance, especially for smaller sized firms, or as a result of changes in federal or state policies, such as requirements resulting from the Patient Protection and Affordable Care Act (PPACA).

For example, PPACA required employers with a certain number of employees to offer their full-time employees a health insurance option meeting certain criteria, including affordability, or face tax penalties.[1] Some researchers and policymakers expressed concern that this requirement may encourage employers to change how they offer insurance to employees, such as no longer offering family and dependent coverage, instead only offering health insurance to the employees, thereby causing employees with children to seek public insurance or insurance through health insurance exchanges.[2] Other researchers and

[1]Specifically, these employers must offer their full-time employees minimum essential health insurance coverage and face tax penalties if at least one such employee receives an advance premium tax credit. See Pub. L. No. 111-148, §§ 1513(a), 10106(e)-(f)(2), 124 Stat. 253, 910, amended by Pub. L. No. 111-152, § 1003, 124 Stat. 1029, 1033 (2010) (codified as amended at 42 U.S.C. § 4980H(a)). Eligibility for the advance premium tax credit is, in part, based on the affordability of the employer-sponsored insurance. See 26 U.S.C. § 36B(c)(2)(C); Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 8544 (Feb. 12, 2014).

[2]See, for example, T. Buchmueller, C. Carey, and H. Levy, "Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act?" *Health Affairs*, vol. 32, no. 9 (2013), pp. 1522-1530; and B.D. Sommers, M. Shepard, and K. Hempstead, "Why Did Employer Coverage Fall in Massachusetts After the ACA? Potential Consequences of a Changing Employer Mandate," *Health Affairs*, vol. 37, no. 7 (2018), pp. 1144-1152.

organizations point to PPACA increasing the availability of private health insurance offered by employers and through health insurance exchanges,

particularly in areas and among populations where employer sponsored health insurance may not be as readily available.[3]

Crowd-out may also occur when employees drop or decide not to enroll in insurance offered by their employers and enroll their children in CHIP because of CHIP availability; however, as we have reported in the past, assessments of crowd-out should consider the affordability and availability of the employer sponsored insurance. For example, families with access to employer sponsored insurance may find CHIP more affordable or find CHIP benefits more comprehensive than employer sponsored insurance. Alternatively, they may find that CHIP provides better access to services specific to their child's health care needs. For example, an evaluation of CHIP published in 2014 found that CHIP enrollees had better access to dental benefits than children with private insurance, although they were less likely to have a regular source of medical care and nighttime or weekend access to a provider.[4]

[3]PPACA directed each state to establish an exchange—referred to as a state-based exchange—or elect to use the federally facilitated exchange established by the Department of Health and Human Services. See Pub. L. No. 111-148, §§ 1311, 1321, 10104(e)-(h), 10203(a), 124 Stat. 173, 186, 900, 901, 927 (codified at 42 U.S.C. §§ 18031, 18041).

See R. Garfield, K. Orgera, and A. Damico, *The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act* (San Francisco, Calif.: Kaiser Family Foundation, 2019); The Urban Institute, *Losses of Private Non-Group Health Insurance a Key Driver Behind 2017 Increase in Uninsurance* (Washington, D.C.: The Urban Institute, 2018); J. M. Haley, et al., "Medicaid/CHIP Participation Reached 93.7 Percent Among Eligible Children In 2016," *Health Affairs*, vol. 37, no. 8 (2018): pp. 1194 and 1197; and Center for Children and Families, Georgetown University Health Policy Institute, *Nation's Progress on Children's Health Coverage Reverses Course* (Washington, D.C.: Georgetown University Health Policy Institute, 2018).

[4]See Assistant Secretary for Planning and Evaluation, "CHIPRA Mandated Evaluation," p. xviii. For related research on CHIP benefits, see C. Trenholm, M. Harrington, and C. Dye, "Enrollment and Disenrollment Experiences of Families Covered by CHIP," *Academic Pediatrics*, vol. 15, no. 3 Supplement (2015); Congressional Budget Office, "The *State Children's Health Insurance Program,"* Pub. No. 2970 (Washington, D.C.: May 2007); and S. McMorrow, et al., "Access to Private Coverage for Children Enrolled in CHIP," *Academic Pediatrics*, vol. 15, no. 3 Supplement (2015).

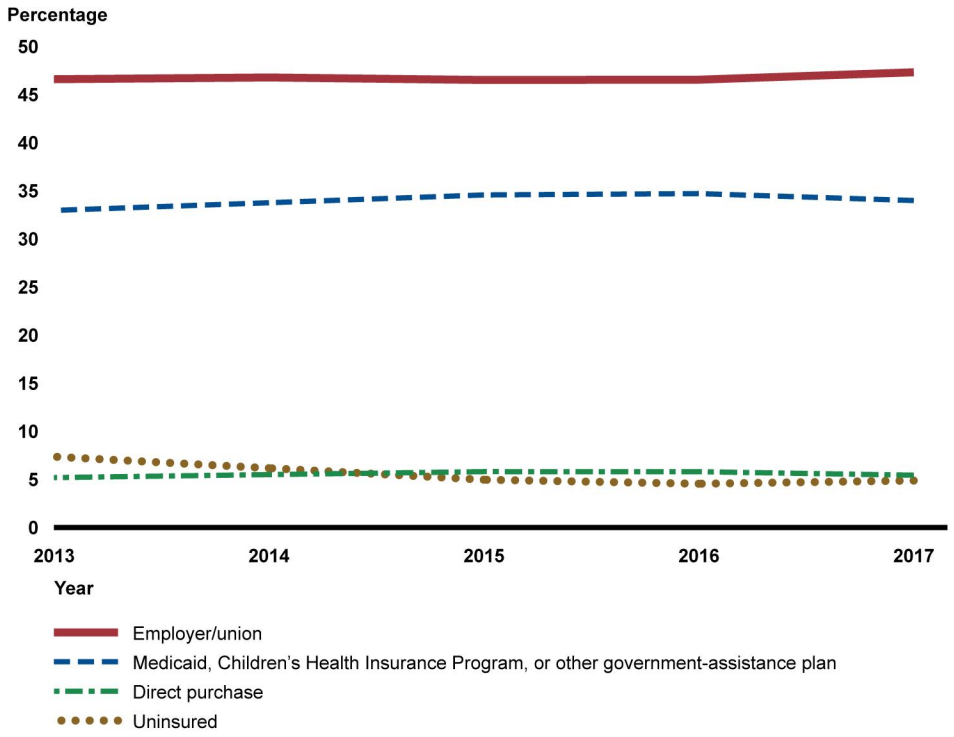
As we have identified in prior work, assessments of the potential for crowd-out must take into account an understanding of the extent to which private health insurance is available and affordable to low-income families who qualify for CHIP.[5] American Community Survey (ACS) data showed that for 2013 through 2017, the most prevalent source of insurance for children in the United States under the age of 19 was private health insurance available through a parent's employer or union.[6] (See fig. 2.)

[5]See GAO-09-252.

In this report, private insurance is said to be available to individuals if their employers offered health insurance and if these individuals and their families were eligible for this benefit. Affordability refers to the capacity of low-income families to purchase available private health insurance. For example, if available insurance is not affordable, families may decline such insurance regardless of CHIP, and by definition, crowd-out would not occur.

[6]See appendix II for the percentage of children insured through Medicaid or CHIP, through private health insurance, and who are uninsured, by state.

Figure 2: Percentage of Children under Age 19 in the United States by Primary Source of Health Insurance, 2013 through 2017

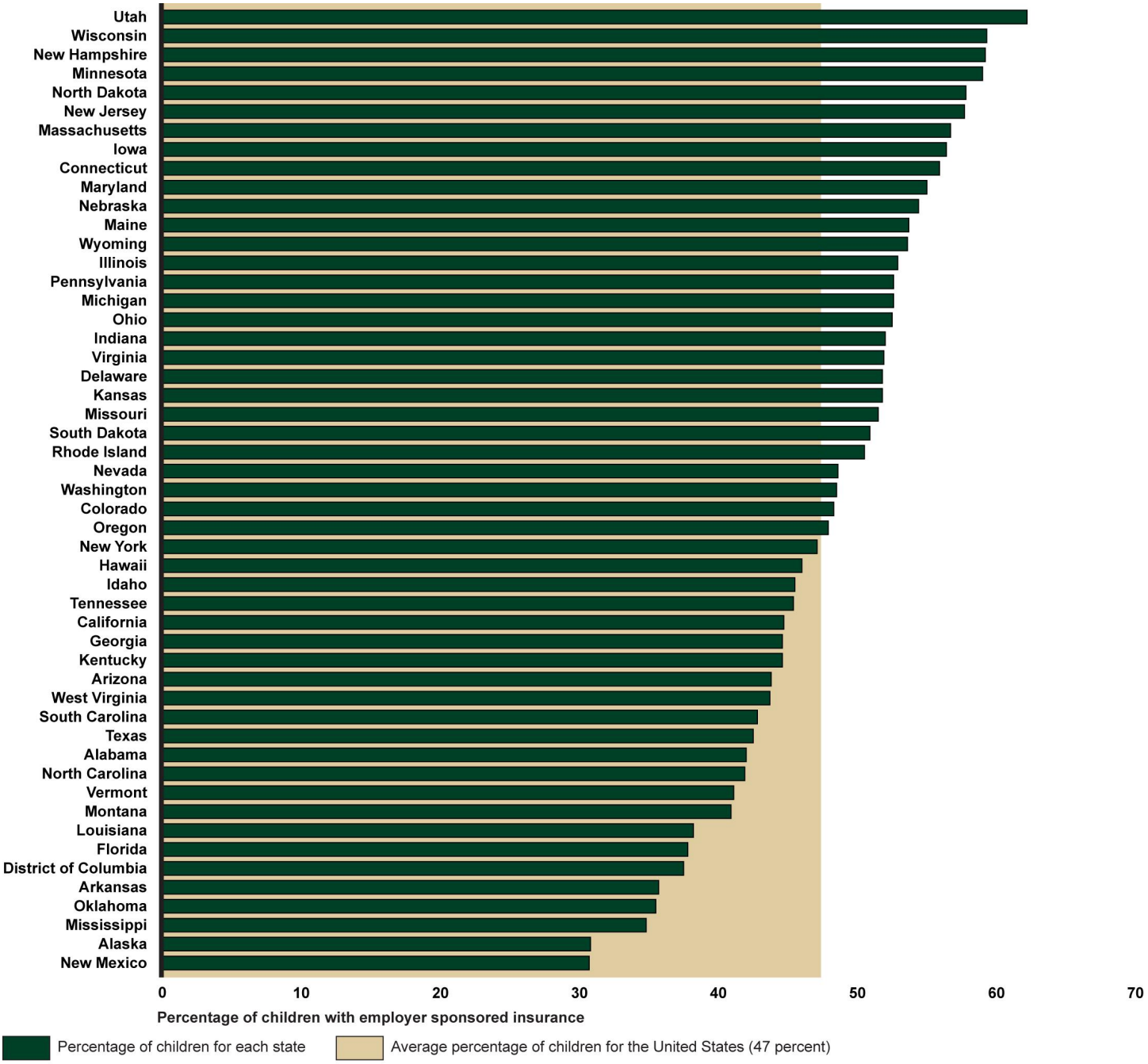


Source: GAO analysis of U.S. Census Bureau data. | GAO-20-12

Note: Estimates are based on the U.S. Census Bureau's American Community Survey (ACS) data. Health insurance categories are based on those identified by ACS respondents. Employer/union insurance is coverage offered through one's own employment or a relative's and by an employer or union. Direct purchase insurance is purchased directly from an insurance company by an individual or an individual's relative. Medicaid and the Children's Health Insurance Program includes any kind of government-assistance plan for those with low incomes or a disability. The uninsured category reflects ACS respondents that did not identify as having a source of health insurance. ACS respondents self-identify insurance, and they may incorrectly classify their coverage, resulting in underestimates in the Medicaid category, in particular. The estimates in this figure have margins of error at the 95 percent confidence level within +/- 0.28 percentage points. Data in the figure does not include respondents that identified more than one source of insurance.

Although private health insurance is the most prevalent source of insurance for children, there is substantial variation across states in coverage rates. (See fig. 3.) For example, in eight states, fewer than 40 percent of children were insured through an employer in 2017. In contrast, in Utah, more than 60 percent of families with children were insured by an employer in 2017.

Figure 3: Percentage of Children under Age 19 in the United States with Employer Sponsored Insurance as their Primary Source of Health Insurance in 2017



Source: GAO analysis of U.S. Census Bureau data. | GAO-20-12

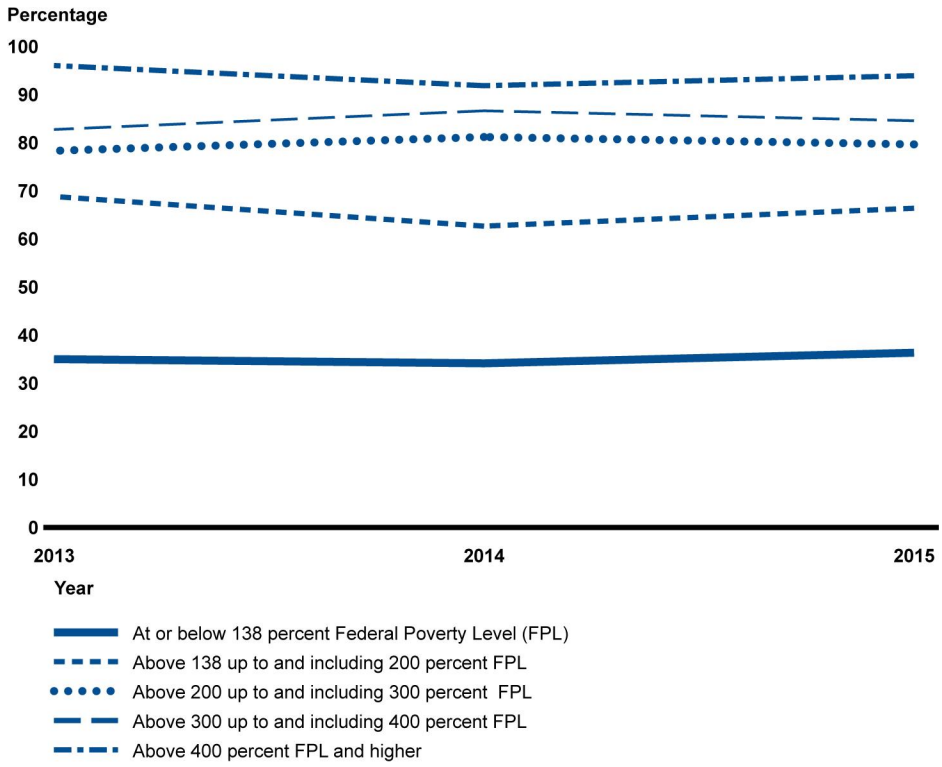
Note: Estimates are based on the U.S. Census Bureau's American Community Survey (ACS) data. Health insurance categories are based on those identified by ACS respondents. Employer sponsored insurance is coverage offered through one's own employment or a relative's and by an employer or union. ACS respondents self-identify insurance, and they may incorrectly classify their coverage. Data in the figure does not include respondents that identified more than one source of insurance. The estimates in this figure have margins of error at the 95 percent confidence level within +/- 5 percentage points.

Medical Expenditure Panel Survey (MEPS) data show that the extent to which employers offered individuals insurance in 2013 through 2015 varied by family income.[7] For example, MEPS Household Component data—which includes information on whether individuals were offered insurance by their employers—show that over 90 percent of families with incomes greater than 400 percent of the federal poverty level (FPL) were offered insurance by their employers from 2013 through 2015. The percentage of families offered insurance by their employers ranged from about 35 percent for families with incomes less than or equal to 138 percent of the FPL to about 85 percent for families with incomes above 300 and less than 400 percent of the FPL. (See fig. 4.) An Agency for Healthcare Research Quality (AHRQ) analysis of MEPS Insurance Component data—which includes information on whether employers offered insurance to their employees and the cost of that insurance—shows that in 2017, 24.2 percent of small employers (less than 50 employees) with a predominately lower-wage workforce offered their employees health insurance compared with 57.6 percent for small employers with a higher-wage workforce.[8] In contrast, in 2017, offer rates at larger employers—that is, employers with more than 50 employees—was 94 percent for those with predominately lower-wage employees and 98.7 percent for large employers with predominately higher wage employees.

[7]The MEPS Insurance Component is an annual survey of private- and public-sector employers that collects information about employer-sponsored health insurance offerings, such as the type of plans offered and the benefits associated with these plans. See Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey Insurance Component 2017 Chartbook*, AHRQ Publication No. 18(19)-0034 (Rockville, Md.: October 2018).

[8]AHRQ defines employers in terms of the percentage of their employees who earned less than $12 per hour in 2017. Specifically, AHRQ separates employers into two categories: (1) establishments with 50 percent or more of their employees earning less than $12 per hour; and (2) establishments with less than 50 percent of their employees earning less than $12 per hour. AHRQ found that offer rates at low-wage employers declined between 2014 and 2015, and has not changed significantly between 2015 and 2017.

Figure 4: Percentage of Families with Children under Age 19 Offered Health Insurance from Their Employer, 2013-2015, by Family Poverty Level, Nationally



Source: GAO analysis of Agency for Healthcare Research and Quality (AHRQ) data. | GAO-20-12

Note: Estimates are based on the Household Component of the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey. Offers of health insurance indicate whether the person was offered insurance at their current main job. We used 138 percent of the federal poverty level (FPL) to indicate the minimum required income eligibility level for the Children's Health Insurance Program accounting for the 5 percent income disregard required by the Patient Protection and Affordable Care Act. The estimates in this figure have standard errors at the 95 percent confidence level within +/- 5 percentage points.

With regard to affordability, the MEPS Insurance Component data show that average employee premium contributions for family coverage from 2013 through 2017 increased.[9] Over this period, employees who work for employers with a predominantly lower-wage workforce—that is, employers that paid 50 percent or more of their workforce $12 or less per hour—contributed a larger amount and percentage of premiums to their employer-sponsored insurance than did employees who work for non-

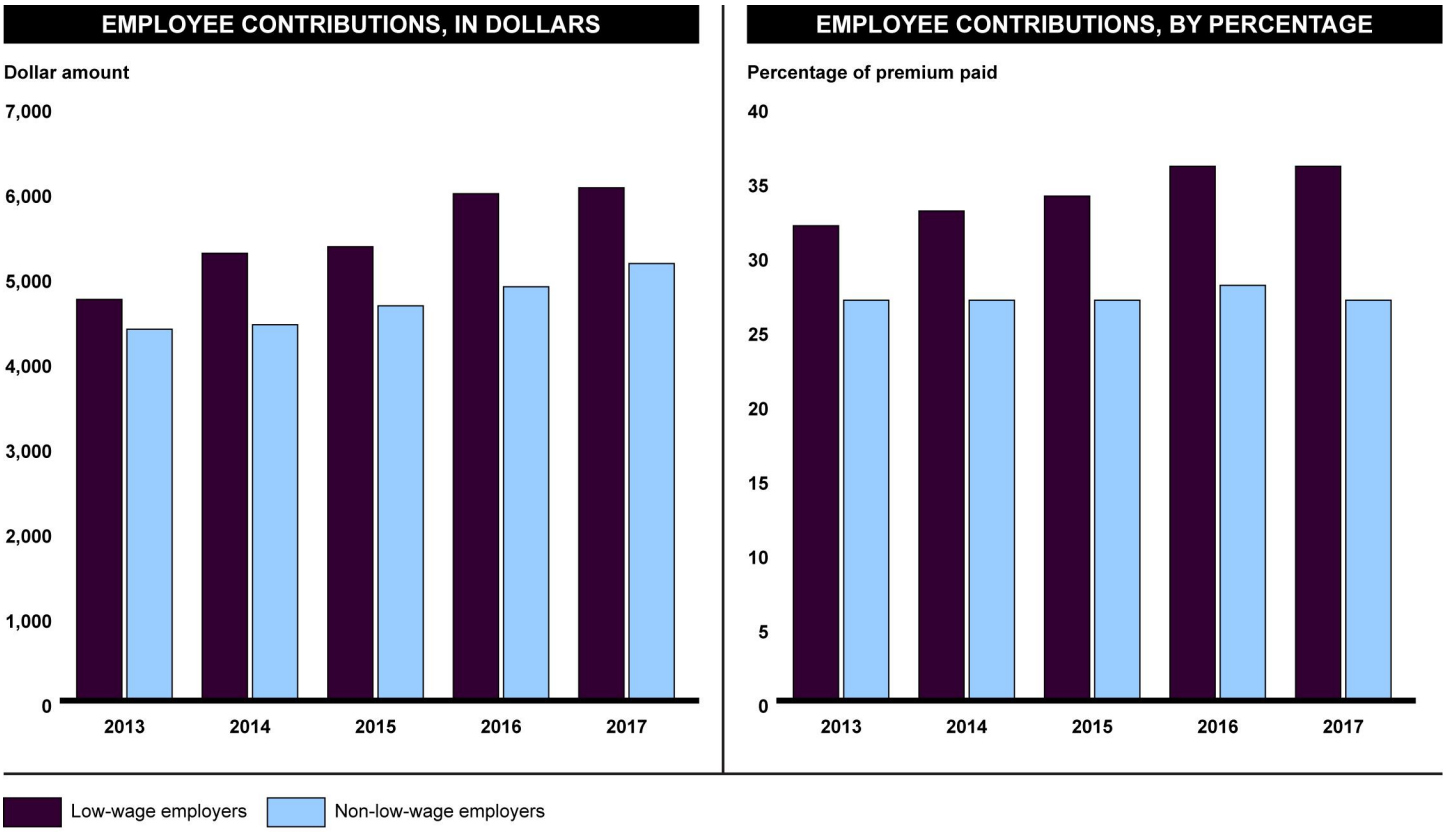
[9]According to AHRQ, this trend has been present since 2004.

low-wage employers.[10] (See fig. 5.) MEPS Insurance Component data also show that employees who work at establishments with a predominately lower-wage workforce enroll in insurance offered by their employers at a lower rate than employees of other establishments, though it is not known if this is due to affordability reasons.[11] Finally, MEPS Insurance Component data show that the percentage of employees with deductibles and the amount of the deductibles have increased from 2004 to 2017. Between 2013 and 2017, average family deductibles increased about 36 percent, from $2,491 in 2013 to $3,396 in 2017.

[10]Average employee premium contributions also vary by other characteristics. For example, AHRQ reported that average premiums for family coverage in 2017 ranged from a high of $6,533 in Delaware to a low of $3,646 in Michigan.

[11]For example, among employers with fewer than 50 employees, 58.3 percent of eligible employees at employers that paid 50 percent or more employees $12 per hour or less were enrolled in their employer's health insurance in 2017, compared with 71.9 percent of eligible employees at employers who paid less than half of their employees less than $12 per hour.

Figure 5: Average Annual Employee Premium Contribution for Family Health Insurance by Employer Type, 2013-2017



Source: GAO analysis of Agency for Healthcare Research and Quality (AHRQ) data. | GAO-20-12

Note: Estimates are based on the Insurance Component of AHRQ's Medical Expenditure Panel Survey, as reported in AHRQ, *Medical Expenditure Panel Survey Insurance Component 2017 Chartbook*, AHRQ Publication No. 18(19)-0034 (Rockville, Md.: October 2018). Percentages are computed as a total of employer and employee contributions to the premium. Low-wage employers are employers that paid 50 percent or more of their workforce $12 or less per hour. Non-low-wage employers are employers that paid less than half of their workforce $12 or less per hour.

In addition, research published in 2018 on high deductible health insurance plans showed both increasing enrollment in these plans and that larger employers (1,000 or more employees) contributed more toward health insurance premiums for these plans than smaller

employers (less than 25 employees).[12] For example, according to this study:

- From 2006 to 2016, there was a 35 percentage point increase (11.4 percent to 46.5 percent) in enrollees in high-deductible health plans, with enrollees from smaller employers more likely to be enrolled in these plans compared with enrollees from larger employers (56.4 percent of enrollees from small firms compared with 42 percent of enrollees from large firms).[13]
- A lower percentage of enrollees from the smaller firms had a plan with an employer-funded account, which defray health care costs, compared with enrollees from larger firms. For example, in 2016, only about one-third of enrollees in high-deductible health insurance plans from the smallest employers had an employer funded account to help pay for medical expenses compared with 89.3 percent of enrollees from the largest employers.[14] High-deductible health insurance plan enrollees of the smallest employers were also more likely to not have the choice of an alternative plan type compared with enrollees from the largest employers.

[12]AHRQ defines high-deductible health insurance plans as plans with deductibles at or above annual thresholds set by the Internal Revenue Service for plans to qualify for health savings accounts. For example, in 2018 and 2019, the deductible thresholds were $1,350 for single coverage and $2,700 for family coverage.

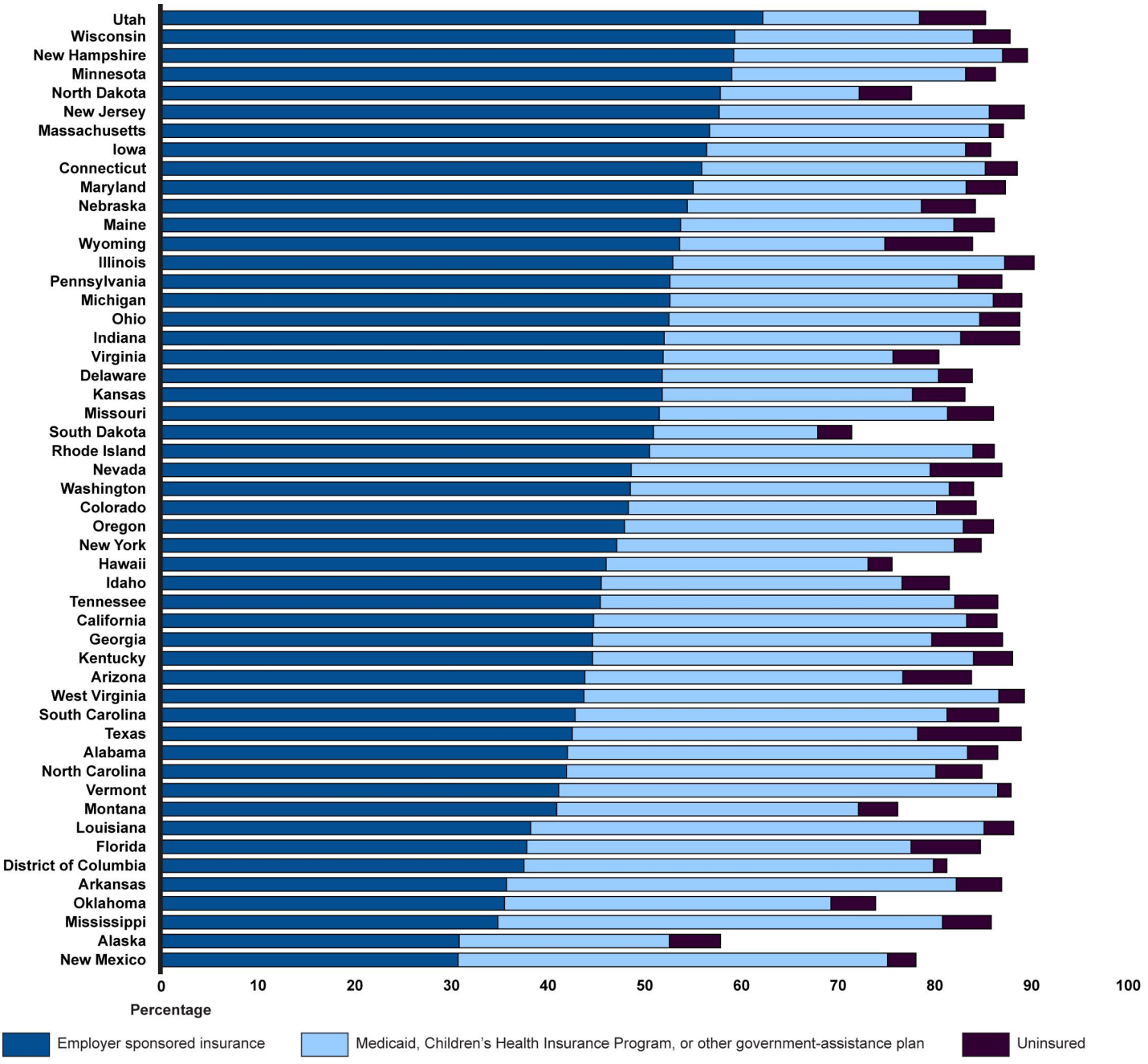
[13]See G.E. Miller, et al., "High-Deductible Health Plan Enrollment Increased From 2006 to 2016, Employer-Funded Accounts Grew in Largest Firms," *Health Affairs*, vol. 37, no. 8.

[14]See Miller, "High-Deductible Health Plan Enrollment," p. 5.

Appendix II: Source of Health Insurance for Children under Age 19 by State in 2017

Although private health insurance is the most prevalent source of insurance for children, there is substantial variation across states in coverage rates. Figure 6 provides information on the percentage of children under age 19 insured through employer sponsored insurance, Medicaid, and the Children's Health Insurance Program, as well as those who were uninsured in 2017.

Figure 6: Source of Health Insurance for Children under Age 19 by State in 2017



Source: GAO analysis of U.S. Census Bureau data. | GAO-20-12

Note: Estimates are based on the U.S. Census Bureau's American Community Survey (ACS) data. Health insurance categories are based on those identified by ACS respondents within each state.

Employer sponsored insurance is coverage offered through one's own employment or a relative's and by an employer or union, and does not include other insurance, such as military health care coverage through TRICARE. Medicaid and the Children's Health Insurance Program includes any kind of government-assistance plan for those with low incomes or a disability. The uninsured category reflects ACS respondents that did not identify as having a source of health insurance. ACS respondents self-identify insurance, and they may incorrectly classify their coverage, resulting in underestimates in the Medicaid category, in particular. The estimates in this figure have margins of error at the 95 percent confidence level within +/- 5.2 percentage points. Data in the figure does not include respondents that identified more than one source of insurance.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov.

Staff Acknowledgments

In addition to the contact named above, individuals making key contributions to this report include Shannon Legeer (Assistant Director), Toni Harrison (Analyst-in-Charge), Mollie Lemon, and Courtney Liesener. Also contributing were Alison Binkowski, George Bogart, Jill Center, Leia Dickerson, Giselle Hicks, Drew Long, Kristeen McLain, Yesook Merrill, Jasleen Modi, Vikki Porter, Lisa Rogers, and Merrile Sing.

Appendix IV: Accessible Data

Data Tables

Accessible Data for Figure 1: Upper Income Eligibility Limits for the Children's Health Insurance Program as of January 2019

State	Federal poverty level (FPL)
New York	405
Iowa	380
New Jersey	355
District of Columbia	324
Connecticut	323
New Hampshire	323
Maryland	322
Pennsylvania	319
Illinois	318
Alabama	317
Vermont	317
Washington	317
Hawaii	313
Wisconsin	306
Massachusetts	305
Missouri	305
New Mexico	305
Oregon	305
West Virginia	305
Minnesota	288
California	266
Montana	266
Rhode Island	266
Colorado	265
Indiana	262
Louisiana	255
Tennessee	255

State	Federal poverty level (FPL)
Georgia	252
Kansas	240
Kentucky	218
Nebraska	218
Delaware	217
Michigan	217
Arkansas	216
North Carolina	216
Florida	215
Mississippi	214
Maine	213
South Carolina	213
Ohio	211
Oklahoma	210
South Dakota	209
Alaska	208
Texas	206
Arizona	205
Nevada	205
Utah	205
Virginia	205
Wyoming	205
Idaho	190
North Dakota	175
United States average	255

Accessible Data for Figure 2: Percentage of Children under Age 19 in the United States by Primary Source of Health Insurance, 2013 through 2017

Year	Employer/Union	Medicaid, CHIP, other	Direct purchase	Uninsured
2013	46.6	32.96	5.19	7.36
2014	46.78	33.76	5.5	6.17
2015	46.52	34.57	5.81	4.97
2016	46.55	34.71	5.8	4.55
2017	47.32	33.99	5.44	4.88

Accessible Data for Figure 3: Percentage of Children under Age 19 in the United States with Employer Sponsored Insurance as their Primary Source of Health Insurance in 2017

State	Percentage
Utah	62.2
Wisconsin	59.3
New Hampshire	59.2
Minnesota	59
North Dakota	57.8
New Jersey	57.7
Massachusetts	56.7
Iowa	56.4
Connecticut	55.9
Maryland	55
Nebraska	54.4
Maine	53.7
Wyoming	53.6
Illinois	52.9
Pennsylvania	52.6
Michigan	52.6
Ohio	52.5
Indiana	52
Virginia	51.9
Delaware	51.8
Kansas	51.8
Missouri	51.5
South Dakota	50.9
Rhode Island	50.5
Nevada	48.6
Washington	48.5
Colorado	48.3
Oregon	47.9
New York	47.1
Hawaii	46
Idaho	45.5
Tennessee	45.4

State	Percentage
California	44.7
Georgia	44.6
Kentucky	44.6
Arizona	43.8
West Virginia	43.7
South Carolina	42.8
Texas	42.5
Alabama	42
North Carolina	41.9
Vermont	41.1
Montana	40.9
Louisiana	38.2
Florida	37.8
District of Columbia	37.5
Arkansas	35.7
Oklahoma	35.5
Mississippi	34.8
Alaska	30.8
New Mexico	30.7
United States average	47

Accessible Data for Figure 4: Percentage of Families with Children under Age 19 Offered Health Insurance from Their Employer, 2013-2015, by Family Poverty Level, Nationally

Year	at or below 138	above 138 up to 200	Above 200 up to 300	Above 300 up to 400	Above 400 and greater
2013	35	68.81	78.31	82.74	96.04
2014	34.13	62.65	81.18	86.63	91.85
2015	36.33	66.37	79.65	84.56	93.92

Accessible Data for Figure 5: Average Annual Employee Premium Contribution for Family Health Insurance by Employer Type, 2013-2017

Year	Dollar amount (low)	Dollar amount (non-low)
2013	4,733	4,384
2014	5,276	4,435

Year	Dollar amount (low)	Dollar amount (non-low)
2015	5,354	4,658
2016	5,978	4,882
2017	6,048	5,156

Accessible Data for Figure 6: Source of Health Insurance for Children under Age 19 by State in 2017

State	Private Insurance	Medicaid, CHIP or other	Uninsured
Utah	62.2	16.21	6.84
Wisconsin	59.3	24.66	3.81
New Hampshire	59.2	27.8	2.58
Minnesota	59	24.18	3.08
North Dakota	57.8	14.38	5.41
New Jersey	57.7	27.92	3.63
Massachusetts	56.7	28.93	1.46
Iowa	56.4	26.78	2.6
Connecticut	55.9	29.31	3.31
Maryland	55	28.23	4.07
Nebraska	54.4	24.21	5.58
Maine	53.7	28.26	4.18
Wyoming	53.6	21.22	9.08
Illinois	52.9	34.32	3.04
Pennsylvania	52.6	29.82	4.51
Michigan	52.6	33.44	2.95
Ohio	52.5	32.14	4.15
Indiana	52	30.67	6.1
Virginia	51.9	23.76	4.76
Delaware	51.8	28.57	3.5
Kansas	51.8	25.88	5.43
Missouri	51.5	29.8	4.76
South Dakota	50.9	16.98	3.52
Rhode Island	50.5	33.44	2.2
Nevada	48.6	30.92	7.41
Washington	48.5	33	2.5
Colorado	48.3	31.89	4.09

State	Private Insurance	Medicaid, CHIP or other	Uninsured
Oregon	47.9	35.04	3.12
New York	47.1	34.9	2.8
Hawaii	46	27.08	2.49
Idaho	45.5	31.1	4.9
Tennessee	45.4	36.66	4.45
California	44.7	38.58	3.14
Georgia	44.6	35.08	7.32
Kentucky	44.6	39.39	4.05
Arizona	43.8	32.88	7.11
West Virginia	43.7	42.91	2.65
South Carolina	42.8	38.45	5.35
Texas	42.5	35.72	10.71
Alabama	42	41.38	3.13
North Carolina	41.9	38.2	4.78
Vermont	41.1	45.39	1.39
Montana	40.9	31.19	4.07
Louisiana	38.2	46.89	3.06
Florida	37.8	39.74	7.18
District of Columbia	37.5	42.35	1.39
Arkansas	35.7	46.51	4.7
Oklahoma	35.5	33.75	4.62
Mississippi	34.8	45.98	5.06
Alaska	30.8	21.74	5.29
New Mexico	30.7	44.4	2.95

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