The Pennsylvania CHIP Waiver: What Does It All Mean?

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Recently, the Centers for Medicare and Medicaid Services (CMS) approved a request from Pennsylvania Governor Tom Corbett that would permit families between 100% and 133% of the federal poverty level the choice (at least for 2014) to remain in their current CHIP plan rather than transition back to Medicaid, as was required under the Affordable Care Act. While other states were transitioning children in this same income bracket back to Medicaid without question, Governor Corbett challenged conventional thinking due to the popularity of CHIP in Pennsylvania and the concern about "administrative churn" and burden associated with the transition back to Medicaid.

So what does it all mean? As I pointed out in a blog that I penned for Penn's Leonard Davis Institute just a couple of weeks ago when Governor Corbett first proposed the idea of a waiver, this issue is a bit more nuanced than one might think. In fact, the divide between traditional Medicaid and CHIP services for children whose families fall between 100% and 133% of the federal poverty level (about 30,000 to 40,000 children in PA in 2014) raises important policy questions about the value of a full Early Periodic Screening, Diagnosis, and Treatment (EPSDT) entitlement of all necessary services to children in the Medicaid program vs. participation in a commercial insurance plan that will be subject to some benefit limitations and cost-sharing to families. Sure, there were some political optics surrounding the waiver request, but it also shines a spotlight on some genuine concerns for children and families and how best to insure children and provide adequate access to high-quality services over the long term.

In a perfect world, one would argue that Medicaid and its generous EPSDT benefit would unquestionably be better for children. The EPSDT entitlement has been especially important for the minority of children with special healthcare needs to ensure that they can access a full array of services to meet their needs. But, in reality, eroding Medicaid reimbursement rates for children's providers has led to shrinking provider networks, calling into question whether for many children, the benefits of Medicaid are more imagined than real. Conversely, Pennsylvania's CHIP program, like many CHIP programs that have expanded child coverage through commercial insurance, has preserved fairly comprehensive benefits and has exposed children in those plans to wider provider networks (particularly for subspecialty services) than they could find in the Medicaid program. If Medicaid reimbursement rates for children's services continue to erode over the long-term (excluding a temporary respite through ACA-mandated rate increases for 2013 and 2014), we need to examine which program would offer the best access to high quality services for most children.

The fact that CMS decided to grant Pennsylvania a waiver suggests, at least for the time being, the question of what's best for children remains somewhat open for discussion. But beyond 2014, the uncertainty returns, and

then some. The CHIP program is up for Congressional reauthorization and is not funded beyond 2015. The decision to move children between the 100% to 133% federal poverty level brackets into the Medicaid program could be viewed as a first step toward doing away with the CHIP program, by partitioning CHIP enrollees between Medicaid and Insurance Exchange plans. At the time the ACA was passed, this had merit, in an effort to reduce the number of plans that families would have to navigate as their employment, income, and family composition changed. But our early experience with the Exchange Plans is already raising red flags when it comes to coverage for children. While benefits seem to be similar, cost-sharing may be higher and provider networks may be narrower than are available in current CHIP plans that provide coverage through commercial insurance.

So in the end, is the CMS waiver a win for children? I think at this point it is a draw. It is too soon to tell and highly dependent on how the public and private insurance marketplaces play out over the coming months. But the answer to the question “What’s best for children?” should be based on whether they are no worse off than they were before healthcare reform and, if anything, whether they are in a stronger place. If CHIP is reauthorized, it will be a worthy debate as to whether children between 100% and 133% of the federal poverty level should be retained in that program, particularly if there are no protections to the continued eroding Medicaid reimbursement rates for children’s services. If CHIP is not reauthorized, the early evidence would suggest that we need to consider re-appropriating those funds to help underwrite new protections in Insurance Exchanges that would ensure that all families have access to affordable coverage, limit cost-sharing, and protect their access to high-quality services in strong and diverse provider networks. That would be the ultimate win for children.

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