STATE HEALTH POLICY

Briefing

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How CHIP Can Help Meet Child Specific Requirements and Needs in the Exchange: Considerations for Policymakers

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STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Through NASHP's ongoing children's coverage work, we examined how the Children's Health Insurance Program (CHIP)—a tested program that has served children for the past 15 years—can be used as a model to meet the Affordable Care Act's (ACA) child-specific requirements for health insurance exchanges. States' separate CHIP programs are often more closely aligned with private market coverage offering federally identified benchmark benefit plans or approved alternatives and are usually delivered by managed care plans. CHIP can be used in defining benefits and engaging health plans and providers to serve children's coverage in exchanges. This *State Health Policy Briefing*, supported by the David and Lucile Packard Foundation, explores ways officials can use CHIP as a resource for ensuring children accessing coverage through the exchange have benefits and providers that meet their unique health needs.

There are multiple reasons for states to consider in how to use the Children's Health Insurance Program (CHIP) to meet exchange requirements specific to children within the Patient Protection and Affordable Care Act (ACA). Children have unique developmental and health care coverage needs that CHIP has 15 years of experience in addressing. These needs are recognized in the ACA by a number of provisions intended to support good children's coverage as new policies and systems of health insurance are implemented. Essential pediatric benefits must be included in health plans both inside and outside of the health insurance exchanges (exchanges). Exchanges must offer a child-only plan option, a provision that is particularly important for many children that have complex family coverage situations. Should states exhaust their CHIP allocations, CHIP-eligible children

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can enroll in qualified health plans (QHP) through exchanges. However, the Secretary of Health and Human Services (HHS) must certify that QHPs offer benefits and cost-sharing comparable to CHIP before children can transition to the exchange. Should federal CHIP funding not be renewed post October 2015, exchanges and QHPs will need to be well equipped to provide coverage to the low income children previously served through this program tailored to their needs. Certainly through 2015, and beyond if CHIP funding is extended, it is also important to consider ways to promote continuity of coverage and care for children who will churn between CHIP and the exchange due to fluctuating family incomes or that age out of CHIP. Given its successful track record in providing child-focused coverage, particularly in CHIP programs that are separate from Medicaid and often more aligned with private market coverage, CHIP can be a resource, model and mechanism to help fulfill child specific requirements of the ACA.

Developed by the National Academy for State Health Policy (NASHP) through the support of the David and Lucile Packard Foundation, this brief explores how states may be able to use CHIP to help meet some of the child-specific requirements for exchanges in the ACA. Options for doing so include:

- using CHIP as a model for pediatric benefits and providers in the exchange;
- using CHIP funds to provide premium assistance for eligible children to buy exchange coverage that would allow families to be insured by one coverage program; and
- using CHIP to wrap around Essential Health Benefit (EHB) benchmark benefits to ensure children's unique health needs are met.

This brief is based on analysis of statutes, regulations, and other federal guidance for both CHIP and exchanges, as well as key informant interviews conducted by a team of NASHP analysts identified in the acknowledgements. In addition to state CHIP and exchange officials, NASHP identified and interviewed national and state children's health and private insurance experts to discuss the options and practicality of linking CHIP to the exchange. For a detailed comparison of CHIP and exchange requirements see: *Selected CHIP and Exchange Requirements: Alignment and Considerations: A Companion to How CHIP Can Help Meet Child Specific Requirements and Needs in the Exchange*, the companion piece to this brief.

Child Specific Coverage Requirements for Exchanges

Children have specific healthcare needs related to their growth and development that are distinct from those of adults. These child-specific needs are recognized in the ACA through a number of requirements affecting health insurance exchange offerings. These provisions, summarized below, include child-specific benefits, child-only health plans, and CHIP comparable coverage that must be offered through exchanges in the event state CHIP funding is exhausted.

Essential Health Benefits

Beginning in 2014, non-grandfathered plans in the individual and small group markets both inside and outside of exchanges, Medicaid benchmark and benchmark-equivalent, and the Basic Health Programs must cover EHB.[1] The ACA requires that EHB be comprised of ten benefit categories, two of which are particularly important to meeting children's health needs. These are pediatric services, including but not limited to oral and vision services, as well as habilitative services that are critical for children with special health care needs due to chronic illnesses or disabling conditions. In addition, plans inside and outside exchanges must offer, without cost sharing, preventive services for children based on *Bright Futures* guidelines developed by the Health Resources and Services Administration.[2]

Child-only Plans

Issuers of QHPs must offer a child-only plan at the same actuarial level as other plan offerings in an exchange. The requirement means that if an insurer offers a silver-level plan in an exchange, that insurer must offer a silver-level plan that is available only to children up to 21 years old.[3] Child-only plans will be especially important to families facing complex coverage scenarios. These scenarios include families where a child doesn't live with one or both parents or when a parent is covered by an employer's plan that does not include dependent coverage. It is estimated that approximately 40 million children may face at least one complex coverage scenario that can make it challenging for their families to obtain health insurance.[4] The child-only plan is one way the exchange can mitigate potential coverage gaps for children.

Exchange Coverage Comparable to CHIP

The Affordable Care Act extended CHIP funding through September 2015; whether it will be extended after that is unknown. Should a state's CHIP allotment run out, ACA directs

states to establish procedures to enroll CHIP-eligible children into the exchange.[5] Prior to this transition, the HHS Secretary must certify that the exchange offers coverage comparable to CHIP in both benefits and cost sharing.[6] The Centers for Medicare and Medicaid Services (CMS) has not yet issued guidance in this area.

CHIP as a Tool to Meet Exchange Requirements

Although the requirements noted above are new with the ACA, states can use their experience and lessons learned in covering children and from operating CHIP programs to help inform their decisions for implementing exchange coverage. CHIP has been a trusted program providing health coverage to children for 15 years. Targeted to children with family incomes at or below 200 percent of the Federal Poverty Level (FPL)[7], in some states the program currently reaches children with incomes up to 400 percent FPL, comparable to the income range for subsidized exchange coverage. All states and the District of Columbia currently operate one or more CHIP programs, including programs that expand Medicaid coverage. Thirty-nine states have separate CHIP programs, which generally tend to be more like private coverage than Medicaid, and therefore may be more easily aligned with exchange requirements. Separate CHIP programs offer federally identified benchmark benefit plans or approved alternatives, usually require premiums and cost sharing and are usually delivered by managed care organizations.[8],[9] These features make CHIP well suited to serve as a model for or be adapted to QHPs that will be offered beginning in 2014. Adopting CHIP features in QHPs will not only serve children well in 2014, but also will lay a strong foundation for QHP coverage for children who may need to transition from CHIP into the exchange in the future. Thus, QHPs can be well positioned to meet the Secretary's CHIP comparability certification.

Ensuring children have access to benefits and providers that meet their distinct health needs is important across all coverage types from Medicaid to the exchange. Pediatric services are explicitly required essential health benefits. Federal guidance also requires QHPs to ensure there are sufficient numbers and variety of providers, including Essential Community Providers (ECP). [10] Officials responsible for implementing exchanges can look to CHIP as a model for both pediatric benefits and children's health care providers. The current federal approach being used to define the EHB is based on the CHIP benchmark approach.[11] In addition, CHIP programs are responsible for maintaining an appropriate provider network that includes access to preventative and primary care services for children. Given tight timelines, exchange officials may want to pursue adopting the separate CHIP program's already established benefit package to define the pediatric services category within the EHB. Exchanges may also want to engage CHIP managed care plans or go directly to state CHIP provider networks to participate in the exchange.

Benefits

U.S. Health and Human Services is charging states with defining their EHB primarily by selecting a benchmark plan to serve as a "reference plan" that reflects a "typical employer plan."[12] However, HHS also recognized that benchmark options may not include all 10 EHBs, and thus states may need to define and supplement the selected benchmark to encompass all 10 categories of services required by the ACA, [13] particularly habilitative and pediatric services requirements.[14] Indeed, a 2012 review of benchmark plan options in five states compared to their CHIP and Medicaid benefits commissioned by the American Academy of Pediatrics (AAP) found CHIP covered the 10 EHB categories more completely than the benchmark plan options.[15] The review confirmed that benchmark plan options fall short in both covering pediatric and habilitiative services. In addition, the benchmark plan benefits for mental health and substance abuse, including behavioral health treatments, are much more limited, if available at all, compared to CHIP. Services like psychological testing and psychotherapy that are important to youth of all ages, but particularly to adolescents, are either not covered or are limited in scope. The study also identified services within the rehabilitative benefit category that are not covered or that offer limited coverage, such as occupational therapy and speech therapy. Therefore, it is likely that most states will need to supplement their EHB standard benchmarks to meet the minimum ACA benefit requirement.

Use CHIP to Define the EHB Pediatric Benefit

Given the acknowledgement by the federal government, the expectation of child health experts and confirmation provided by the AAP study that the EHB benchmark plan options will fall short of meeting the required 10 categories of services, particularly those for children, it will be important for state officials to closely examine the selected benchmark plan's pediatric and habilitative benefits. In doing so, state officials should note the ACA requires they "take into account the health care needs of diverse segments of the population, including children" when defining their EHB.[16] Considering this and other child specific

requirements within the ACA, the law appears to support states' flexibility to define QHP benefit design to accommodate the special needs of children.[17]

While the EHB requirements do not apply to CHIP, state's separate programs generally cover these benefits[18],[19] making CHIP an attractive option to help states supplement their selected benchmark and fully define the pediatric services category of the EHB. The Center for Consumer Information and Insurance Oversight (CCIIO) within CMS explicitly offered states' separate CHIP programs as one possibility for supplementing pediatric oral health benefits. Also, notably, the AAP study found that the five state's separate CHIP programs benefits include habilitative services that are important for children with special health care needs.

Use CHIP to Wrap-Around QHP Benefits

Another option states may want to pursue to ensure low-income children are receiving comprehensive child-specific benefits even if they are enrolled in a QHP is to use Medicaid or CHIP funds to wrap benefits around those offered through the QHP. Offering wrap-around benefits separate from a premium assistance program (discussed in a subsequent section of this brief) is another option for states that could promote continuity of care across insurance coverage programs in meeting children's specific needs.

States have experience providing supplemental coverage by wrapping around benefits or cost sharing for children who are eligible for Medicaid but are enrolled in private insurance. There is a lack of definitive evidence on the success of these programs in supplementing commercial coverage for children. Some studies have found that wrap around programs can result in high administrative costs.[20] However, the ACA introduces a framework for providing coverage that may support Medicaid and CHIP in providing wrap-around benefits for children in the exchange. States that engage Medicaid- and CHIP-contracted health plans to participate in the exchange as QHPs may find the administrative complexity for providing wrap-around coverage is diminished. As of January 2013, three states (California, Massachusetts, and Vermont) are considering using wrap-around benefits to help defray cost sharing and ensure comprehensive benefits for low-income individuals (adults and children) in the exchange.[21]

Provider Networks

In addition to focusing on benefit design that meets children's health needs, it will be important to ensure that QHPs offer access to health care providers well equipped to serve children and youth. CHIP programs have experience ensuring provider network adequacy with a focus on children's needs. Exchanges may want to consider engaging CHIP health plans and their provider networks to participate as QHPs to ensure there is age appropriate access to care for children. Short of that, CHIP programs have lessons to share in regards to ensuring network adequacy for specific populations.

Federal regulations require exchanges to ensure the provider network of each QHP meets specific standards.[22] These standards include maintaining sufficient number and variety of providers in QHP networks and specifically note the importance of available providers who specialize in mental health and substance abuse. Federal CHIP network adequacy requirements are broad and states differ in how they implement them. However, provider adequacy requirements that govern Medicaid managed care plans also extend to CHIP managed care plans.[23] The 2008 survey of CHIP programs conducted by NASHP found 30 states use contracted health plans to deliver separate CHIP program services.[24] Similar to the requirements of the exchange, CHIP managed care plans are required to offer an appropriate range of services and access to preventive and primary care for the population expected to enroll in the service area, and must maintain a sufficient number, mix, and geographic distribution of providers of services.[25]

The ACA also requires that QHPs contract with "…a sufficient number and geographic distribution of essential community providers (ECPs), where available…" These providers are defined as those that serve predominantly low-income individuals, including those providers that qualify for 340B drug discounts. Federal rules give states and QHPs a great deal of flexibility in determining the number and types of providers they will contract with to meet the essential community providers requirement.[26] Separate CHIP programs are not required to contract with or cover services provided by ECPs.[27] However, according to a survey of CHIP programs, federally qualified health centers (FQHCs) were used in 81 percent of separate CHIP programs with fee-for-service (FFS) delivery systems and in 57 percent of separate CHIP programs utilizing managed health plans.[28] The survey also found that 62 percent of separate CHIP programs using FFS systems use school-based health centers and 28 percent using managed care plans do as well.[29] So, in practice, many CHIP programs may be able to meet the QHP requirement for ECPs. CHIP programs may also help in ensuring QHPs include pediatric specialists and

subspecialists in their networks given the program's focus on serving children.

Over the years CHIP programs have implemented a number policies to ensure access to health care services both for enrollees in managed care plans and in Primary Care Case Management (PCCM) models. They include availability of 24-hour coverage,[30] requirements around wait times and number of enrollees per primary care provider, and geographic proximity to providers in both rural and urban areas.[31] Even if CHIP provider networks don't participate in a state's exchange, states may want to use similar or adopt CHIP's policies aimed at ensuring access to providers.

Seamless Coverage

In addition to ensuring QHPs can meet children's needs, incorporating CHIP benefits and provider networks into the exchange may also improve continuity of coverage. Many states are seeking ways to ensure that individuals who move between Medicaid, CHIP and exchanges do so with little or no coverage disruption. The federal government has also expressed a goal of seamlessness across coverage programs. Easing transitions across coverage types and seeking ways to ensure seamlessness will help maintain continuity of care. Oregon and Nevada officials are requesting that the health plans that deliver services in the state's Medicaid and CHIP programs also participate in the states' exchanges. Children in families with fluctuating income or children aging out of the CHIP program could transition into the exchange and enroll in the same health plan with no interruption to their health care.

Premium Assistance

Premium assistance is another way to use CHIP and Medicaid to ensure children have appropriate coverage while reducing the potential for complex coverage issues for families also accessing insurance through the exchange. States have experience designing and operating premium assistance programs either using Medicaid or CHIP funds to purchase private coverage (usually through an employer sponsored plan) if the state finds it to be cost effective. Premium assistance allows children who are eligible for public coverage to participate in the private market. In many cases, state CHIP premium assistance plans make it possible for low-income families, children and their parents, to be insured on the same plan when they wouldn't be otherwise. In a proposed rule released on January 22, 2013, CMS offers states the option to use existing premium assistance authority to purchase coverage for Medicaid and CHIP eligible individuals through a QHP.[32] Premium assistance can help children and parents enroll in the same health plan through the exchange even if the children are eligible for CHIP and their parents are eligible for subsidized coverage through the exchange.

The Urban Institute draws attention to the large numbers of children in complex coverage scenarios under the ACA.[33] These scenarios include parents and children eligible for different types of coverage and children living apart from one of their parents. It is estimated that more than half of all children face at least one complex coverage scenario and they are more likely to be uninsured than other children.[34] These families may experience barriers in navigating different coverage programs resulting from different eligibility and enrollment systems. These families may also find it difficult to understand different insurance plans and their different cost sharing structures.

Using CHIP funds to pay QHP premiums may help families with complex coverage scenarios by allowing everyone in the family to participate in a single QHP. The state would need to follow federal requirements for premium assistance programs that include providing wrap-around benefits, cost sharing assistance and demonstrating cost effectiveness.[35]

Summary: How States Can Use CHIP in the Exchange

There are multiple areas that need officials' attention to implement health care reform; using CHIP in one or more ways to meet the child specific requirements in the exchange may be attractive. States may want to consider the following:

- *Using the separate CHIP benefit package to define the "pediatric services" category within the EHB.*

States may be able to take advantage of the flexibility afforded them by using the already established, time-tested separate CHIP benefit package in their or another state to define the pediatric services category of the EHB. States can also use CHIP benefits to contribute to defining the EHB's habilitative benefit category as well. Using separate CHIP benefits in the EHB allows states to ensure children's unique health needs are met, as required by the ACA, without needing to design a new benefit from scratch. Using the CHIP benefit will also position states well to meet the HHS certification that QHPs are comparable to CHIP, which would allow a state to transition children eligible for CHIP to the exchange should the state's CHIP allotment run out. HHS has not yet released guidance

regarding the comparability certification, but the ACA explicitly states that a QHP must be comparable in both benefits and cost sharing. Using CHIP benefits to define the pediatric services of the EHB will likely be one way to meet an important component of that certification.

Also, once the EHB—including the pediatric services category—is established, it will be used for both standard QHPs and for child-only plans that are available only to youth up to age 21.[36] These required child-only plans will be important to families facing complex coverage scenarios, particularly for parents enrolled in employer-sponsored insurance that doesn't include dependent coverage.

- *Engaging health plans and their provider networks that are contracted to deliver CHIP services to participate as QHPs in the exchange.*

There are multiple potential benefits to engaging CHIP health plans and provider networks to participate in the exchange. First, exchange officials may find that the provider networks that have been designed to provide care for children help to meet the QHP network adequacy requirements, possibly including the requirement for ECPs. Also, using the same plans in different program coverage types will help children that transition between CHIP and the exchange minimize disruption and improve continuity of care. Finally, this is one way to ensure QHP networks include providers that can meet children's unique developmental and health needs.

- *Implementing premium assistance by using CHIP funds to purchase coverage in the exchange.*

Premium assistance is one way parents and children eligible for two different coverage programs can have the convenience of one health plan for the family. Parents and their CHIP-eligible children can be enrolled in the same QHP in an exchange. The parents would receive the advanced premium tax credit (APTC) for which they are eligible and CHIP funds would pay QHP premiums for the children.

- *Using CHIP to wrap-around QHP coverage.*

Some states may find that using CHIP to wrap-around their base EHB benchmark plan is another way to ensure there is a comprehensive pediatric benefit available through the exchange. States exploring this option will need to understand the limitations of the pediatric services provided through the EHB to identify how CHIP could best supplement them. Coordinating the provision of the wrap-around benefits, monitoring how they are used and tracking the administrative costs to provide them will be important for states pursuing this option.

Conclusion

Considering both CHIP's role over the past 15 years in providing child-focused coverage and child-specific exchange requirements from pediatric benefits to child-only plans, there are compelling reasons for states to consider how CHIP can help implement children's coverage in the exchanges. This brief explored several options for using CHIP as a tool to meet children's needs, as well as ACA requirements for the exchange. These options include adopting the CHIP benefit package to define pediatric services in the EHB and engaging CHIP health plans and providers to participate in the exchange. Other options include using CHIP to provide premium assistance or wrap-around benefits to ensure children enrolled in the exchange have coverage that meets their unique needs.

States operating a separate CHIP Program	
Alabama	Montana
Arizona	Nevada
California*	New Jersey
Colorado	New York
Connecticut	North Carolina
Delaware	North Dakota
Florida	Oregon
Georgia	Pennsylvania
Idaho	South Carolina
Illinois	South Dakota
Indiana	Tennessee
Iowa	Texas
Kansas	Utah
Kentucky	Vermont
Louisiana	Virginia
Maine	Washington
Massachusetts	West Virginia
Michigan	Wisconsin
Mississippi	Wyoming
Missouri	

Note: Does not include 4 states which operate separate programs only for "unborn children"
* State is eliminating separate program and transitioning children to Medicaid CHIP Expansion Program
Source: Catherine Hess et.al., *Charting CHIP IV: A Report on State Children's Health Insurance Programs Prior to Major Federal Policy Changes in 2009 and 2010* (Washington, DC: National Academy for State Health Policy, 2011), 9.

Using the list that identifies states currently operating separate CHIP programs, exchange officials can determine whether to look to their own state or a neighboring one to learn more about how best to use CHIP to meet the ACA's child requirements for their exchange. For more information about CHIP, check out the resources about the program on NASHP's website (www.nashp.org). One resource in particular that may be helpful is Charting CHIP IV: A Report on State Children's Health Insurance Programs Prior to Major Federal Policy Changes in 2009 and 2010. This report provides an analysis of 46 state survey responses to paint a detailed picture of the CHIP program that includes information on CHIP benefits and service delivery.

Along with the companion side-by-side analysis of CHIP and exchange requirements, NASHP intends this brief will stimulate state consideration of how CHIP might be utilized as a resource in designing some elements of QHPs. The progress the nation and states have made in reducing rates of uninsurance among children and the promise of exchanges in serving as gateways to affordable coverage for individuals and families demands no less. To further explore the options and facilitate their consideration and operationalization NASHP will continue work in this area.

Endnotes

1 U.S Department of Health and Human Services, *Federal Register* 78, no.537 (February 25, 2013).

2 Launched by HRSA's Maternal and Child Health Bureau in 1990, the Bright Futures initiative is focused at the American Academy of Pediatrics and a collaborative of other federally- and State-funded Bright Futures projects. For more information - http://www.brightfutures.org/

3 *Patient Protection and Affordable Care Act* (ACA), Public Law 111-148, 111th Cong., 2nd sess., (23 March 2010), sec. 1302(f).

4 Stacey McMorrow, Genevieve M. Kenney, and Christine Coyer, *Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas* (Washington, DC: The Urban Institute, 2012). http://www.urban.org/UploadedPDF/412561-Addressing-Barriers-to-Health-Insurance-Coverage-Among-Children.pdf

5 ACA, Section 2101(3)(A)

6 ACA, Section 10203 (C)

7 SSA, Section 2110 (c) (4)

8 Catherine Hess et al., *Charting CHIP IV: A Report on State Children's Health Insurance Programs Prior to Major Federal Policy Changes in 2009 and 2010* (Washington, DC: National Academy for State Health Policy, 2011). http://www.nashp.org/sites/default/files/charting.chip.IV.chi.programs.pdf

9 John McInerney, *SCHIP Delivery Systems* (Washington, DC: National Academy for State Health Policy, 2007). http://www.nashp.org/publication/schip-delivery-systems

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14 Ibid.

15 Peggy McManus, *A Comparative Review of Essential Health Benefits Pertinent to Children in Large Federal, State, and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans* (Washington, DC: American Academy of Pediatrics, 2012). http://www.aap.org/en-us/about-the-aap/aap-press-room/Documents/AAP_EHB_Report_FinalPress.pdf

16 ACA Section 1302(b)(2)

17 Wendy Lazarus, memorandum from Sara Rosenbaum, The George Washington University, *Child-only plan provisions of the ACA in the context of essential health benefits*, Aug. 12, 2012.

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19 Catherine Hess et al., *Charting CHIP IV: A Report on State Children's Health Insurance Programs Prior to Major Federal Policy Changes in 2009 and 2010*, 74 – 84.

20 Genevieve M. Kenney, and Stan Dorn, *Health Care Reform for Children with Public Coverage: How Policymakers Maximize Gains and Prevent Harm* (Washington, DC: The Urban Institute, 2009).

21 Jason Millman. "Exchange Week: Smoothing the Transition." *Politico*, 28 Jan 2013. Retrieved February 1, 2013. https://www.politicopro.com/story/healthcare/?id=18487

22 U.S Department of Health and Human Services, *Federal Register 77*, no. 59 (March 27, 2012).

23 *Social Security Act* (SSA), Public Law 111-148, 111th Cong., 2nd sess., (23 March 2010), sec. 1932(b)(5).

24 Catherine Hess et al., *Charting CHIP IV: A Report on State Children's Health Insurance Programs Prior to Major Federal Policy Changes in 2009 and 2010*

25 SSA, sec. 1932(b)(5)

26 U.S. Department of Health and Human Services, *Federal Register 77*, no. 59 (March 27, 2012)

27 Catherine Hess et al., *Charting CHIP IV: A Report on State Children's Health Insurance Programs Prior to Major Federal Policy Changes in 2009 and 2010*, 91.

28 Ibid.

29 Ibid.

30 Ibid.

31 Embry M. Howell, Ashley Palmer, and Fiona Adams, *Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future* (Washington, DC: The Urban Institute, 2012). http://aspe.hhs.gov/health/reports/2012/riskbasedmanagedcare/rpt.pdf

32 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register* 78, no. 14 (January 22, 2013).

33 Stacey McMorrow, Genevieve M. Kenney, and Christine Coyer, *Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas* (Washington, DC: The Urban Institute, 2012).

34 Stacey McMorrow, Genevieve M. Kenney, and Christine Coyer, *Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas;* Stacey McMorrow and Genevieve M. Kenney. PowerPoint Presentation. "Coverage for Children: Opportunities and Challenges under the ACA." Presented at NASHP Meeting, Maximizing Enrollment, Washington DC, January 10, 2013.

35 Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* (Washington, DC: U.S. Department of Health and Human Services, 2012).

36 Wendy Lazarus, memorandum from Sara Rosenbaum, The George Washington University, *Child-only plan provisions of the ACA in the context of essential health benefits*, Aug. 12, 2012.

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