Introduction

Over its nearly 20 year history, the Children’s Health Insurance Program (CHIP) has been widely viewed as a successful way to provide appropriate and affordable health coverage to children in families with low to moderate incomes who do not qualify for Medicaid. But with federal CHIP funding currently scheduled to expire in September 2017, the future of the program is uncertain. Moving forward, policymakers must consider the role of CHIP within the context of additional coverage sources available through the Affordable Care Act (ACA).

In May 2016, the National Academy for State Health Policy (NASHP) convened a group of stakeholders including state officials from Medicaid, CHIP and health insurance exchanges, health policy researchers and advocates to explore ways to maintain affordable and comprehensive children's coverage, and those discussions are reflected in this brief. This most recent meeting built upon a similar one convened in September 2015, which also examined options for the future of children’s coverage in light of its uncertain future. The results of that stakeholder group’s discussions, summarized in this March 2016 NASHP brief, lay out an initial framework of potential policy options. This current brief explores in more depth how these options might be implemented.
Children’s Health Coverage: Current Context, Potential Changes, and Coverage Differences

In 2014, it was estimated approximately 4.5 million children were uninsured; this is a decrease from 2013, when approximately 5.4 million lacked health coverage. Children receive health insurance coverage through a range of public and private sources—Medicaid, CHIP, employer-sponsored insurance (ESI), as well as exchange coverage through the ACA’s qualified health plans (QHPs).²

Children currently covered through CHIP would likely experience different coverage scenarios if federal funding for CHIP is not extended. If federal CHIP funding ends, Medicaid expansion CHIP programs³ are required through the ACA’s maintenance of effort (MOE) provision to maintain eligibility levels for children through 2019.⁴ However, the 42 states with separate CHIP programs can limit enrollment in these programs if federal CHIP funds are not available.
The vast majority of children enrolled in CHIP are in families with incomes at 200% of the federal poverty level (FPL) or lower (approximately $48,000/per year for a family of four.) If federal funding for CHIP ends, children in separate CHIP programs could enroll in qualified health plan (QHP) coverage through the exchange. But even if families are eligible for advanced premium tax credits (APTC) and cost sharing reductions (CSR), affordability of this coverage remains a concern as numerous analyses comparing QHP coverage, benefits and cost sharing to CHIP have found some notable differences between them.5

In general, families would experience significantly higher out-of-pocket cost sharing in QHP coverage as compared to CHIP. In examining both premiums and cost sharing, a March 2016 Medicaid and CHIP Payment and Access Commission (MACPAC) analysis found that children in subsidized exchange coverage would have average annual out-of-pocket spending of $1,073, as compared to average yearly costs of only $158 in CHIP.6 Some families face even higher out-of-pocket costs for their children because they are caught in the “family glitch.” The family glitch occurs because the ACA’s definition of affordable coverage is based on cost of ESI for the employee only and does not take into account the cost of dependent coverage. Thus a parent with access to affordable ESI needs to purchase dependent coverage out-of-pocket without financial assistance, making QHPs for children even more expensive.

With regard to benefits, exchange coverage is required to include the essential health benefits (EHB) package, defined by each state’s benchmark plan selection. The EHB covers most major medical services and does include a category of benefits for pediatric services. However, certain benefits such as audiology exams and hearing aids are more frequently covered by CHIP than QHPs. Dental benefits are also much less frequently available through QHPs without an additional cost.7 Further, CHIP programs are more likely to have fewer limits on benefits than QHPs and offer greater coverage of child-specific services.8 For example, other benefits that are typically covered in QHPs but are more robustly covered in CHIP include autism services, physical, occupational and speech therapies, durable medical equipment, and habilitation services.9

The ACA required the Secretary of the Department of Health and Human Services (HHS) to determine whether benefits and cost sharing in QHPs are comparable to those provided in separate CHIP programs. This review was released in November 2015,10 and the results reinforce earlier findings. Specifically HHS found that average out-of-pocket spending would be higher in QHPs than in CHIP and that the amount of medical costs that would be covered by a health plan—the actuarial value—is significantly greater in CHIP than in the lowest cost silver QHP plan. The analysis also found that CHIP offers more comprehensive coverage of child-specific benefits, such as dental, vision, and habilitative services, as well as services for children with special health care needs.

Potential State Options to Ensure Strong Children’s Coverage into the Future

Whether CHIP remains a fully funded federal block grant program or not, children currently move among coverage programs as family income changes. This, coupled with the potential of losing CHIP funding, invites a policy discussion about how QHP coverage through exchanges might be strengthened to meet the needs of lower income children and their families. To do so both the breadth and affordability of pediatric benefits must be addressed, and these considerations have brought to the surface issues that require deeper analysis. First, some policy analysts have raised concerns about the possible implications
of anti-discrimination provisions in the ACA related to age pursuant to benefits. A second issue is the feasibility of increasing financial assistance for children’s coverage.

The anti-discrimination reference is within the minimum standards established by the ACA for EHB-governed plans, which state that in defining the essential health benefits “the Secretary shall…not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.” This language makes some state officials hesitant to tailor or enhance benefits for children fearing the same enhancements will need to be provided for adults, which could become costly. However, the minimum standards also direct the HHS Secretary to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups” in defining the EHB. Leading health policy legal expert, Sara Rosenbaum, further notes that in addition to children being signaled out for special recognition, “the statutory EHB categories specifically identify pediatric coverage as a distinct benefit class.” States have discretion to design their QHP benefit package using their typical employer plan as a reference, but Rosenbaum notes “states must make certain modifications to conform to the EHB benefit classes.” State officials are looking for clarification from the Centers for Medicare and Medicaid Services (CMS) to interpret if the law prohibits tailoring benefits for children. If not, there is interest in exploring different ways CHIP can inform the design of pediatric benefits in the exchange.

Excerpt from ACA’s Section 1302 – Requirements for the Essential Health Benefits

(4) REQUIRED ELEMENTS FOR CONSIDERATION—In defining the essential health benefits under paragraph (1), the Secretary shall— (A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category; (B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life; (C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.

Use CHIP to Improve Benefits in Exchanges

Even if federal funding for CHIP is not continued beyond FY2017, CHIP can inform policy considerations related to exchange benefit design. With children as the core of its focus, CHIP can serve as a strong standard for improving exchange coverage for children. To date, exchange coverage is not designed with an emphasis on children’s health care needs. While one of the EHB categories is pediatric services that specifically include oral and vision care, the overall definition and scope of EHB pediatric services beyond these services is not clearly outlined.

Although the EHB-governed exchange plans include a broad range of services, CHIP benefits are generally more comprehensive, especially in terms of audiology and services for children with special health care needs, such as autism and various therapies (e.g. physical, occupational, and speech) that can be especially important for addressing health needs at critical stages in a child’s development. An analysis of states’ EHB benchmark plans suggests that pediatric coverage lacks comprehensiveness and
consistency across states, and that some plans exclude services related to pediatric developmental and mental health conditions. Additionally, while pediatric oral care is required within the pediatric services category of the EHB, exchange plans do not have to cover this benefit if there are stand-alone dental plans available on the exchange. Those stand-alone plans may not be affordable for many families. Also, although some states have opted to embed pediatric dental coverage into the QHP benefit, the majority of states do not.

Exchange coverage also may not provide the periodicity or intensity of benefits needed for children in comparison to CHIP coverage. For example, children’s audiology services have been found to be much more limited in QHPs than in CHIP, but they are very important in identifying potential hearing loss. Detecting hearing issues early on in a child’s life is critical to ensuring that children who may need hearing aids receive appropriate treatment, particularly because they are in the process of developing their language skills. State legislatures could mandate that health plans include a more robust periodicity schedule for certain benefits that are essential to childhood development. However this could result in significant cost increases for the state. Specifically, federal regulations indicate that unless benefits are necessary to comply with federal EHB requirements, states are expected to cover the associated costs for any benefit mandates passed after December 31, 2011. Therefore this may not be a feasible option for states due to budget constraints unless the federal government allows states to strengthen the EHB benchmark’s pediatric services.

Use CHIP a QHP Benchmark Plan
One possible option that was identified previously in NASHP’s brief, Using CHIP and the ACA to Better Serve Children Now and in the Future, that could improve health benefits for both children and adults in exchange plans would be to permit states to select their CHIP plan as a state’s EHB benchmark plan. To implement this option, federal regulations would need to be modified to add CHIP to the list of federally approved benchmark plans from which states can select to define their EHB. States would then need to select CHIP as their benchmark option, which would mean making changes to the benefits provided by all EHB-governed plans.

This approach to establish CHIP as an EHB benchmark would address concerns about the ACA’s anti-discrimination requirements that benefits cannot be denied by age, since the benchmark would apply to all enrollees. However, as identified by the stakeholder group, adopting CHIP’s generally richer benefit package as the EHB benchmark would likely increase the cost of exchange coverage, particularly because there would be enhanced services available to adults as well as to children. There is concern that offering more robust benefits, even by simply increasing the periodicity/schedule of services, would be cost prohibitive for states. These costs also could be substantial because it would include adult dental coverage. Making changes to the states EHB benchmark would also likely increase health plan’s administrative costs to implement the benefit package across the market.

Rather than using CHIP as the benchmark to define the state’s overall EHB package, a potentially more feasible solution would be to permit states to use CHIP as a benchmark to more clearly define the scope of the required EHB pediatric services category. Supporters of this approach note that the ACA includes an explicit requirement for pediatric services that would likely preempt any claim of age discrimination. The stakeholder group strongly supported this as a way to ensure strong children’s coverage in the exchanges. This option would also require federal approval, but it could be a way to more clearly define the EHB pediatric services category. If services are within the parameters of the
EHB as defined by the benchmark, they are not considered additional mandates and states would not be responsible to pay for them. So, this approach of further defining a required class of EHB services within a state’s benchmark would not be a financial burden to states.

Some federal policymakers have already expressed support for this concept. In May 2016, a group of Senate Democrats sent a letter to HHS Secretary Burwell to request the creation of a national, standardized definition for the EHB pediatric services category. One of their recommendations for creating a standard EHB pediatric services definition to ensure that pediatric coverage is comprehensive and consistent is to allow states to use their CHIP plan to define the benefit parameters.

While this option has the benefit of adding clarity to the scope of the EHB’s pediatric services category and easing the transition for CHIP-covered children to exchange coverage, there are several potential drawbacks: impact on premiums; affordability and administrative complexity. States would need to provide oversight of and health plans would need to administer multiple benchmark plans—an overall EHB benchmark and an additional benchmark that defines the pediatric services category. However, this may not be a significant issue because many states have already had experience with managing additional benchmark plans for pediatric vision and/or oral care. Because many commercial benchmark plans did not originally include pediatric vision or oral health care services, HHS required states to choose a supplemental plan to define these services if they were not part of the state’s chosen benchmark. States were given the option of choosing either the Federal Employees Dental and Vision Insurance Program (FEDVIP) or CHIP to supplement the EHB benchmark. Thus many states have experience implementing supplemental benchmarks, and some states continue to use them for these services. However if CHIP were adopted as the pediatric services supplemental benchmark, states would no longer need separate plans to define pediatric dental or vision care because of CHIP’s robust coverage of these services.

If CHIP were used either as or within the EHB benchmark there would need to be adjustments made to the costs of the QHP coverage. Premiums may increase, as the CHIP benefit is more robust than the benchmark plans currently being used. So, while this approach aims to strengthen the benefits offered through the EHB, it does not address affordability.

**Offer CHIP through Exchanges as Child-only plan**

For many child health policy experts, including some participating in NASHP’s stakeholder workgroup, the notion of selling the state’s CHIP plan through the exchange as a child-only plan holds promise. The ACA requires all QHPs to sell child-only plans, which are individual plans available for families to purchase for their children even if parents are not buying coverage. Currently child-only plans are the same plans sold to adults and both children and adults are in the same risk pool. But the ACA rating rules allow that coverage to be provided at lower cost to children.

Specifically, there is an “age curve” established through federal guidance that is used to help determine premium cost ratios (often referred to as ratings) for people of different ages. Based on federal guidance finalized in 2013, children from birth through age 20 have a rating of .635, and the rate for individuals aged 21 through 24-years-old is 1.0; the ratings incrementally increase from age 25 (rated 1.004) through 64-years-old (rated 3.0). In August 2016, CMS released proposed guidance that if finalized, will increase the child rating for plan year 2018, but it remains lower than the adult ratings.
Even though the premiums for child-only plans sold through exchanges cost less than the plans sold to adults, they are still expensive, especially for families with low to moderate incomes currently being served by CHIP. For families eligible for APTC that will subsidize premium costs for the whole family this option may be affordable. But for many families, the ACA's family glitch will create even more affordability challenges. Currently CHIP is an important coverage solution for those that qualify, and without it more children are expected to lose coverage.

Apart from changing the law or amending federal guidance to eliminate the family glitch, which would increase costs for the federal government, one solution may be to sell CHIP plans through the exchange as a 'child only' plan and create a risk pool just for children. A child-only risk pool may keep costs for the child-only plans lower than if adults are in the same risk pool. Children in CHIP and private coverage are generally considered to be healthy and tend to have lower health care costs. This is particularly true because many states have Medicaid programs that provide coverage for children who have substantial health care needs regardless of their family income. And because a large insurance risk pool with a disproportionate share of high-risk individuals will have higher premiums than will one with more low-risk individuals, it is appealing to explore a child-only risk pool in exchanges. Since all states are now operating a CHIP program and many deliver its services using commercial carriers, those plans potentially could be added as an exchange option.

Pursuing this option would require federal support to make the necessary policy changes as well as testing, and conducting an actuarial study. Statutory language in the ACA does not explicitly support altering or differentiating the benefits of the child-only plan from those offered to adults; nor is there explicit language allowing an exchange to separate the child-only plan enrollees into their own risk pool apart from the broader QHP one that includes more expensive adults.

Implementing changes to the child-only plan could have additional policy implications. If using CHIP creates richer benefits in the child-only plan compared to other available QHPs, there may be anti-discrimination questions raised that are similar to those previously noted within the benchmark discussion. And while creating a child-only risk pool could help reduce premium costs for children, what if enrollment in the child-only plans is low? Would a small risk pool increase costs for those enrolled in the plans? If creating risk pools just for children in exchanges does help to reduce premium costs for child-only plans, perhaps those facing the family glitch can better afford coverage for their children even without APTC. It is also important to consider how shifting children from the larger exchange risk pool into their own would affect the entire exchange population. This could be a less attractive option for state and federal exchange officials who may be interested in making risk pools larger, more robust, and not divided. Would it be more expensive for adult enrollees to be in an adult-only risk pool? Given how few children are currently enrolled in exchanges, it may not make a noticeable difference for adult premiums to separate children from their risk pool. This policy option requires more analysis and an actuarial projection.

Affordability and Increasing Financial Assistance for Families
Any policy alternative to the current CHIP program will confront the issue of affordability since CHIP is a deeply subsidized program. To estimate differences in cost sharing, MACPAC compared the actuarial values of separate CHIP plans and subsidized qualified health plans in Colorado, Illinois, Kansas, New
York, and Utah. It found that for families living between 101 to 150% FPL, CHIP actuarial values range from 99 percent to 100 percent compared to 94 percent in qualified health plans; for families living between 151 to 200% FPL, CHIP actuarial values range from 98 percent to 100 percent compared to 87 percent in qualified health plans; and for families living between 201 to 250% FPL, CHIP actuarial values range from 90 percent to 100 percent compared to 73 percent in qualified health plans. All the proposals above do not answer how to assure families have a similar level of subsidy to CHIP to make coverage affordable. How can the states and the federal government help bridge the affordability gap for low to moderate income families without CHIP?

For children whose parents have access to ESI, eliminating the family glitch that often makes coverage unaffordable for children, would be an important but insufficient step. One analysis of coverage projections indicates that if CHIP was to end, but the family glitch is resolved there would still be approximately one million children previously enrolled in CHIP that would be uninsured. Studies show significant differences in cost sharing between the exchange and CHIP will remain a significant barrier for families when it comes to affording QHPs. Should states define EHB benchmarks using CHIP to include stronger pediatric benefits or tailor benefits in child only plans, that alone will not make coverage affordable. Low to moderate-income families will need additional subsidies to help families purchase coverage for their children.

**Use CHIP Funds to Further Subsidize Exchange Coverage**

Some states may be able to use their state portion of CHIP funds to help subsidize families purchasing exchange coverage for their children within a certain income range. However, no state will be able to do so at the level CHIP currently provides, as it is a federal-state jointly funded program. The ACA’s 23 percent increase in federal matching funds for CHIP, which provides important fiscal relief for states, significantly reduces state budget outlays and thus limits the amount of funding states’ would have available for this purpose. The law outlines that states are due the 23 percent increase through September 2019, so state budgets for 2017 (and most are already planning for 2018) reflect this expectation and have allocated funds accordingly. As a result, states have less to contribute towards subsidies for children’s coverage should CHIP end.

Should federal policymakers choose to transition CHIP from a stand alone block grant to better integrate it with exchange coverage, it may be more feasible to reallocate the approximately $13 billion in federal funds currently supporting CHIP to help families purchase exchange coverage. State and federal policymakers could consider continuing CHIP funding and using it instead to supplement exchange coverage. However, the mechanism by which to provide these additional subsidies will need to be considered, as will the associated cost.

Perhaps the simplest way to provide families with additional subsidies for their children to gain coverage through the exchange is do so by increasing their APTC or CSR. There was more support from the stakeholder group for increasing the amount of CSR to reduce the out-of-pocket costs for children’s care than there was for increasing APTC. There would need to be more significant legal, policy, and systems changes to provide additional funds for children’s coverage through APTC than there would be using CSR. The CSR subsidies are currently available to families with income at or below 250% FPL, which is the same income range as the majority of children enrolled in CHIP. As noted, to make QHPs affordable for children in low and moderate income families there will need to be additional funds allocated, but the CSR structure for providing the subsidy already exists.
Financial and policy analyses are needed to understand the potential impact of reallocating federal CHIP funds to increase CSR. Will policymakers wish to continue CHIP or better integrate it with other health coverage affordability programs? If the latter, funds must be available if families will have the same level of cost protection as afforded them through CHIP. Would the current federal CHIP funding provide additional subsidy for all of the children who may seek exchange coverage if CHIP as we know it were to end? If so, would the subsidy be enough to help families afford exchange coverage? Would the reallocated funds need to be provided to families on a sliding fee scale to make the biggest impact? If so, would there need to be changes to eligibility systems?

**Create Children’s Coverage Demonstrations**

As policymakers confront the decision of CHIP reauthorization, questions arise about how children in low to moderate income families should best be served and, if CHIP ends, where and how they will receive benefits like those CHIP provides. Given the new affordability programs within the ACA, might there be opportunities to integrate coverage for those children into other, existing programs? Considering the uncertainties about state options if CHIP ends, it may be appropriate to launch state-level children’s coverage innovation and demonstration projects. Federal officials could give states authority (with guardrails) to test different approaches for using federal and state money to provide children with coverage in this new health care environment.

This may be a particularly opportune time to test such an option because the ACA’s MOE requirement for children ends in 2019, as does the 23 percent bump in federal matching funds. These provisions within the ACA have helped to keep children’s coverage strong, but given the different economic and policy environments in the states the expiration of these policies could result in some states rolling back children’s coverage. But an opportunity to experiment with new approaches to cover children while the MOE protection and increased federal funding remains may have particular appeal. And it may be possible for Congress to extend CHIP authorization until those demonstrations are complete and evaluated.

A new demonstration program could allow some states to restructure and subsidize exchange coverage; others may seek to engage businesses/employers to provide family coverage with subsidies for children; others may build upon their Medicaid programs; or try something completely new. While this option holds promise to implement and begin to test new approaches to determine how best to assure affordable and appropriate coverage for low to moderate income children into the future, it requires both time and federal funding.

**Conclusion**

Federal CHIP funding is only appropriated for one more federal fiscal year, yet many policy and operational questions remain on how best to maintain the gains we have made in covering and caring for children in low to moderate income families. As noted throughout this paper, there may be opportunities to leverage within the ACA framework to ensure children have coverage and access to high quality pediatric care that can support their growth and development. Realizing this vision requires that changes be made to existing exchange coverage. A new demonstration program encouraging innovation in children’s coverage could be used to explore utilizing CHIP’s benefit package and identifying ways to provide families with CHIP eligible children additional subsidy. However, it will take longer than a year to explore new approaches. Any decision Congress makes about the future of CHIP should assure that children continue to receive benefits that CHIP has successfully provided since its enactment nearly 20 years ago.
May 2016 Future of Children’s Coverage Stakeholder Group Discussion Participants

- Jessica Altman, Chief of Staff, Pennsylvania Insurance Department
- Sharon Carte, Executive Director, WV CHIP and Commissioner, Medicaid and CHIP Payment and Access Commission
- Susan Coburn, CHIP Policy Analyst, Vermont Agency of Human Services
- Heather Foster, Vice President, Marketplace Policy, Association for Community Affiliated Plans
- Christina Goe, General Counsel, Montana State Auditor
- Allison Heyne, Health Programs Unit Supervisor, Colorado Department of Health Care Policy and financing
- Genevieve Kenney, Senior Fellow, The Urban Institute
- Eugene Lewit, Consulting Professor, Health Research and Policy, Stanford University
- Amy Lutsky, Deputy Director, Division of State Coverage Programs, Centers for Medicare and Medicaid Services
- Rebecca Matthews, Chief Executive Officer, Florida Healthy Kids Corporation
- Rebecca Mendoza, CHIP Director and Director of Marketing and Enrollment Services Division, Virginia Department of Medical Assistance Services
- Rene Mollow, Deputy Director, Health Care Benefits and Eligibility, California Department of Health Care Services
- Gary Parker, CHIP and Hoosier Healthwise Director, Indiana Medicaid
- Rebecca Pasternik-Ikard, State Medicaid Director, Oklahoma Health Care Authority
- Trish Riley, Executive Director, National Academy for State Health Policy (Facilitator)
- Sara Rosenbaum, Professor of Health Policy, Milken Institute of Public Health, George Washington University
- Robin Rudowitz, Associate Director, Kaiser Commission on Medicaid and the Uninsured
- Anne Schwartz, Executive Director, Medicaid and CHIP Payment and Access Commission
- Susie Scott, CHIP Manager, Wyoming Department of Health
- Colleen Sonosky, Associate Director, Division of Children’s Health Services, DC Department of Health Care Finance
- JoAnn Volk, Research Professor, Georgetown University Center on Health Insurance Reforms
- Kelly Whitener, Associate Professor of the Practice, Georgetown University Center for Children and Families

Endnotes

1. While the focus of this paper is on children covered through CHIP, stakeholders noted that in some states CHIP provides coverage for pregnant women, and that it is important to recognize that there may be similar issues to consider for that population should they also need to transition to exchange coverage.


3. States have the option to use CHIP funds to cover their CHIP population within Medicaid, and these CHIP-funded Medicaid expansion programs offer CHIP-eligible children the same benefits as provided through Medicaid. States can also choose to create separate CHIP programs, which give states more flexibility within broad federal rules and guidelines to design benefit packages and cost sharing requirements. States can also choose to implement a combination of both approaches for their CHIP population.

4. If federal CHIP funding ends, Medicaid expansion CHIP programs would receive the regular Medicaid federal match rate for enrollees rather than CHIP’s enhanced match.


8. The Wakely Consulting Group’s report defines child-specific benefits as the following: “Child-specific benefits are those that are less likely to be consistently covered and have larger variation in limits and exclusions. They are also benefits that are considered more important when considering health care for children.” (23).


14. Ibid.


27. Congressional Budget Office (CBO), "Detail of Spending and Enrollment for the Children's Health Insurance Program—CBO's March 2016 Baseline." Available at: https://www.cbo.gov/sites/default/files/51296-2016-03-CHiP.pdf

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