

# What's Next for New York's Child Health Plus Program?



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# What's Next for New York's Child Health Plus Program?

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**A u g u s t 2 0 1 5**

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# Contents

<b>FOREWORD</b>	<b>iv</b>
<b>ACKNOWLEDGMENTS</b>	<b>iv</b>
<b>INTRODUCTION</b>	<b>1</b>
<b>BACKGROUND</b>	<b>1</b>
<b>NEW YORK'S CHP PROGRAM TODAY</b>	<b>1</b>
<b>NEW YORK WITHOUT CHP</b>	<b>3</b>
Eligibility and Enrollment	3
Benefits	4
Networks	5
Cost	6
<b>DECISIONS AHEAD FOR CHP</b>	<b>9</b>
Eligibility	10
CHP and Risk Pooling	10
CHP as a Stand-alone Program	10
<b>CONCLUSION</b>	<b>11</b>
<b>METHODOLOGY</b>	<b>14</b>
<b>REFERENCES</b>	<b>16</b>

## Foreword

During our annual Medicaid conference last month, the Fund celebrated the 50<sup>th</sup> anniversary of the Medicaid program. With this issue brief, we mark another milestone—the 25<sup>th</sup> anniversary of New York’s Child Health Plus (CHP) program.

Capping a multi-year campaign by children’s health advocates, CHP was enacted in 1990—well before the federal Children’s Health Insurance Program was created—and was a cornerstone of the late Governor Mario M. Cuomo’s Decade of the Child agenda. *What’s Next for New York’s Child Health Plus Program*, co-authored by Peter Newell and Nikhita Thaper, examines the role this successful and popular program plays now, when subsidized coverage for families is available on New York’s Exchange, and identifies the issues policymakers will have to grapple with going forward, as Congress will once again consider, in 2017, whether to continue federal matching funds.

This report reflects a new focus by UHF on children’s health care, and we look forward to an ongoing dialogue with you on these issues.

JAMES R. TALLON, JR.  
President  
United Hospital Fund

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## Introduction

Supporters of New York’s Child Health Plus (CHP) program cheered in April 2015 when federal matching funds were extended for two more years.<sup>1</sup> With no “Plan B” developed in case of an extended Congressional stalemate, nearly 280,000 children in New York were at risk of losing health coverage, part of the total of 3.7 million children nationwide enrolled in the joint state-federal Children’s Health Insurance Program (CHIP).<sup>2</sup> The agreement only ensures funding until September 2017, however, short of the four-year extension sought by advocates. Funding and other details for New York’s own program—last renewed just a few months after the launch of New York’s Affordable Care Act (ACA) Exchange—must also be revisited in 2017.<sup>3</sup>

In this issue brief, we examine the decisions New York faces as it considers the future of CHP, in light of uncertainties that lie ahead on the federal level, and a coverage landscape that has changed considerably with the implementation of the ACA. Our review was informed by conversations with regulators, advocates, policymakers, and health plans, and based on an analysis that compares key features of CHP to other coverage options available to New York families.

## Background

New York’s pioneering Child Health Insurance Plan (later renamed Child Health Plus) was enacted in 1990, well before the federal program was created.<sup>4</sup> The \$20 million program<sup>5</sup> subsidized a limited benefit package for children under the age of 13, ineligible for Medicaid, and living in families earning less than 185 percent of the federal poverty level (FPL)—about \$24,800 for a family of four in 1991. Age limits and income eligibility crept up over time and benefits were added as well. In 1997, the federal State Children’s Health Insurance Program (SCHIP)<sup>6</sup> provided matching funds to support New York’s now more-comprehensive benefits;

its 2009 renewal provided additional federal funds to support expanded eligibility for New York’s growing program, now a “combination” model covering children through a separate CHP program and expanded Medicaid eligibility.<sup>7</sup> Affordable Care Act provisions adopted in 2010<sup>8</sup> increased Medicaid eligibility for children and, importantly, also increased New York’s federal matching rate for CHP by 23 percentage points, to 88 percent, beginning in 2015.<sup>9</sup> The ACA also requires states to maintain existing eligibility levels until 2019, but federal funding is scheduled to lapse again in 2017. These seemingly contradictory ACA provisions reflect unreconciled differences between the House and Senate versions of health care reform.<sup>10</sup> Since time ran out before differences could be ironed out, this unresolved tension hangs over ongoing deliberations about the future of CHIP.<sup>11</sup>

## New York’s CHP Program Today

About 280,000 children were enrolled in New York’s separate CHP program through 16 participating CHP managed care plans in June 2015, a nearly one-third decline from a high-water mark of 416,000 in October 2011, though much of this drop is attributed to increased enrollment of children in Medicaid due to increases in Medicaid eligibility levels for children.<sup>12,13,14</sup> Overall, CHP covered about 6 percent of children in New York State in 2013, compared to employer-sponsored (45 percent) and Medicaid (39 percent) coverage (see Figure 1). Despite its smaller overall share, CHP is popular throughout the state. Queens (39,503) and Kings (37,451) counties had the largest number of CHP members, accounting for most of New York City’s total of 104,500 members. But New York City represents only about 37 percent of total CHP enrollment statewide, a ratio that is roughly the reverse of that seen for overall enrollment in the Medicaid Managed Care program, which is split about 60/40

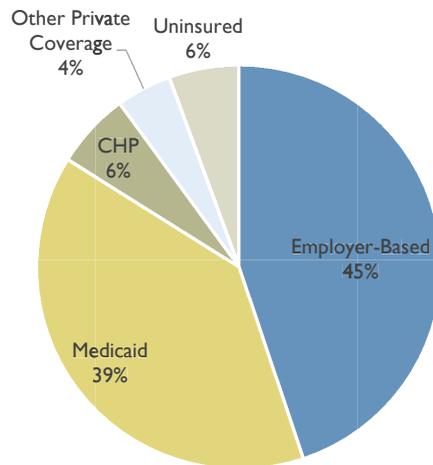
between New York City and the rest of the state.<sup>15</sup> Suffolk (33,353 CHP members) and Nassau (24,704) counties posted the third and fourth highest enrollment totals among counties; when combined with Westchester, Putnam, and Rockland counties, this group of five of the state's top six counties in per capita personal income account for about 29 percent of total enrollment.<sup>16</sup>

Families earning under 160 percent FPL (\$38,800 for a family of four) pay nothing for coverage, with sliding-scale premiums above that level ranging from \$9 per month per child (up to a maximum of \$27), to a high of \$60 per month (up to a maximum of \$180) at up to 400 percent FPL (\$97,000 for a family of four), the highest eligibility level in the nation. Almost 85 percent (219,000) of CHP enrollees reside in households earning less than 300 percent FPL, three-quarters in households earning less than 250 percent (see Figure 2), and State officials

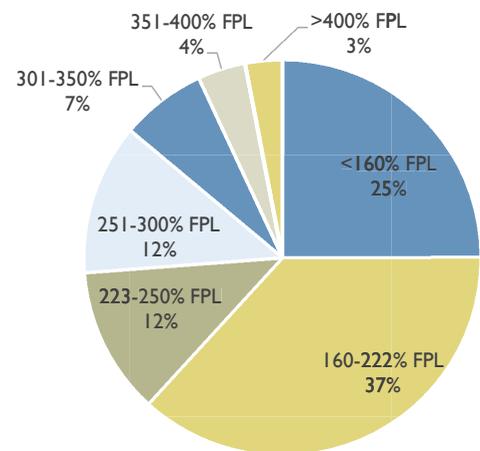
estimate that just less than one half earn less than 200 percent of FPL. For the limited number of families purchasing coverage without subsidies, monthly premiums in 2014 ranged from a low of \$141 per month to a high of \$275.<sup>17</sup> No cost-sharing of any kind is charged in CHP, regardless of income, in part because of the difficulty in tracking out-of-pocket costs in order to meet the federal requirement that overall enrollee spending not exceed 5 percent of household income.

As of June 2015, Fidelis Care (76,188 CHP members) and Amerigroup (43,926), two health plans with significant Medicaid but no or limited commercial membership, posted the highest CHP enrollment.<sup>18</sup> Fidelis reported \$113.2 million in 2013 revenues for its 66,158 CHP subscribers, with less than 10 percent (\$10.4 million) from subscriber premiums and nearly all the rest from State capitation payments.<sup>19</sup> New York appropriated a total of \$1.2 billion to

**Figure 1. Distribution of Children's Coverage, New York State, 2013-14**



**Figure 2. Child Health Plus Enrollment, New York State, by Household Income (% FPL)**



Sources, Figure 1: For enrollment in employer-sponsored and other private coverage, and the number of uninsured children, Kaiser Family Foundation State Health Facts. Health Insurance Coverage of Children 0-18. <http://kff.org/other/state-indicator/children-0-18/?state=ny> ; for enrollment in Medicaid, New York State Department of Health. January 28, 2015. Average Monthly Medicaid Beneficiaries by Category of Eligibility by Social Services District, October 2014-December 2014. [https://www.health.ny.gov/statistics/health\\_care/medicaid/quarterly/ssd/2014/q4/beneficiaries.htm](https://www.health.ny.gov/statistics/health_care/medicaid/quarterly/ssd/2014/q4/beneficiaries.htm) ; for enrollment in CHP, New York State Department of Health. December 2014. Child Health Plus Program: Table of Enrollment by Insurer. [https://www.health.ny.gov/statistics/child\\_health\\_plus/enrollment/docs/2014-12.pdf](https://www.health.ny.gov/statistics/child_health_plus/enrollment/docs/2014-12.pdf)

Source, Figure 2: Letter from Courtney Burke, New York State Deputy Secretary of Health, to the Honorable Ron Wyden, Chairman of the Senate Committee on Finance, the Honorable Fred Upton, Chairman of the House Energy and Commerce Committee, the Honorable Orrin Hatch, Ranking Member of the Senate Committee on Finance, and the Honorable Henry Waxman, Ranking Member of the House Energy and Commerce Committee. September 4, 2014. <http://energycommerce.house.gov/sites/repUBLICANS.energycommerce.house.gov/files/letters/20141203-CHIP-Letter-Responses-4.pdf>

support the CHP program in the current 2016 fiscal year, a 20 percent increase over last year, made up of \$717.1 million in expected federal support and \$481.9 million in State funds.<sup>20</sup>

## **New York without CHP**

Had Congress failed to reach an agreement to reauthorize funding for CHIP in 2015, progress in increasing coverage rates for children would have been lost.<sup>21</sup> A study released by the Medicaid and CHIP Payment and Access Commission (MACPAC), a nonpartisan advisory agency established by Congress, estimated that 1.1 million of the 3.7 million children enrolled in separate CHIP programs like New York's would become uninsured should the federal program lapse.<sup>22</sup> Although New York differs from many states in terms of its eligibility policies for CHP and Medicaid and other factors, the national projections in the MACPAC study, when applied to New York, translate to 86,500 children (30.9 percent) left without coverage in the state.<sup>23</sup>

In this context, examining the impact of a federal CHIP sunset is a useful exercise, because it sharpens the understanding of what CHP provides for New York and clarifies decisions policymakers might face during the next funding cycle. Without CHP, some families would look to cover dependents through an employer. Others would shop for coverage from a qualified health plan (QHP) offering coverage through New York State of Health (NYSOH), the state's Exchange or "marketplace." In 2016, NYSOH will offer a revised menu of products because of New York's decision to implement the Basic Health Program (BHP) option available to states under the ACA.

Although many details are not yet available, New York's BHP will be the sole subsidized coverage option for adults in households earning up to 200 percent FPL who are ineligible for Medicaid but eligible to purchase coverage through the Exchange. Because the CHP eligibility level (400 percent FPL), exceeds the BHP eligibility

level (200 percent FPL), children in households eligible for BHP will be enrolled in CHP and adults will be enrolled in the BHP. New York could consider changing CHP eligibility standards, however, so that children would be enrolled with the adults in the household in the BHP. Adults who become covered under the program in 2016 will face much lower premiums and cost sharing compared to coverage through a QHP, reducing their overall cost burden.

The addition of the BHP also triggers another change. Currently, cost-sharing reductions are available through NYSOH for households earning from 100 to 250 percent FPL, and premium subsidies are available for households earning up to 400 percent FPL. Starting in 2016, however, just one level of cost-sharing reduction will be available, for households earning from 200 to 250 percent of the FPL, and premium subsidies for QHPs will be available for households earning between 200 percent and 400 percent FPL.<sup>24</sup> Our analysis includes comparisons between CHP and both the new BHP product that will be available and current QHP subsidy levels, in order to broadly explore State options if CHP funding is eliminated. In addition to these cost comparisons, we also focus on differences in benefits, networks, eligibility, and enrollment.

## **Eligibility and Enrollment**

Eligibility is an important consideration and the first area we examine in comparing CHP and theoretical alternative coverage options. Under CHP requirements, children must be under the age of 19, ineligible for Medicaid, and residents of New York State. New York reported that 11 percent of CHP members (32,088) were unqualified immigrants, eligible for CHP as state residents but ineligible for federal matching payments and thus funded only with State dollars.<sup>25</sup> CHP is available to children year-round, without specified enrollment periods.

Eligibility requirements for QHP coverage through NYSOH are different from CHP

requirements in some important ways. First, enrollment in individual coverage is limited to an annual open enrollment period; for 2016, it begins on November 1, 2015, and ends on January 31, 2016. (“Special enrollment periods,” however, allow enrollment throughout the year in circumstances such as birth or adoption, the loss of other health coverage, or a change in eligibility for financial assistance. When one family member becomes eligible in such a case, all family members are eligible.)

A second difference is that only U.S. citizens or “lawfully present” non-citizens are allowed to purchase coverage from a QHP or in the BHP,<sup>26</sup> but not all eligible purchasers are also eligible for premium and cost-sharing subsidies that make the coverage affordable.

Under a federal rule, subsidized coverage in NYSOH is not available to employees and their family members if they have access to affordable employer-sponsored coverage. “Affordable,” however, is defined as the cost of single or “self-only” employer coverage that does not exceed 9.56 percent of the household’s income, rather than the cost of coverage for the whole family (this policy results in what is known as “the family glitch”).<sup>27</sup> A federal survey estimates that New York families contributed an average of \$1,300 for single employer coverage in 2013, compared to \$4,232 for family coverage, with some families paying twice that amount.<sup>28</sup>

In the absence of CHP, many New York families will look to the Exchange to purchase coverage—but won’t do so, because the cost is too high without subsidies. Pending federal legislation would correct the family glitch and provide Exchange subsidies if family coverage from employers is not affordable, but the future of this provision is uncertain.<sup>29</sup>

Employers establish eligibility rules for their workers’ coverage, consistent with State and federal rules, choose plans and products, and determine how much they will contribute toward that coverage. Under the ACA, larger

employers are required to offer coverage that meets minimum standards to employees and dependents, and they may face penalties if employees access subsidized coverage through the Exchange.

## Benefits

Advocates have cited benefit differences between CHP and Exchange coverage as a key reason for continued CHP funding.<sup>30</sup> Although there are some limitations inherent in benefit comparisons, our review of a range of documents outlining benefits in CHP and for QHPs found the differences to be minor between very comparable benefit packages; new BHP benefits are also modeled on the QHP benefit package, with some additional benefits for special eligible populations.<sup>31</sup> These findings echo a 2013 federal study<sup>32</sup> comparing CHP benefits in five states (including New York) to the “benchmark plans” selected by those states as the basis for coverage in the individual and small group markets under the ACA, and in fact some of the differences have been narrowed.

Both QHPs (as a result of New York’s long-standing “Well-Child” benefit mandate) and CHP carriers in New York provide important screening, immunization, and developmental assessments based on standards promulgated and updated regularly by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.<sup>33,34</sup> QHP coverage, however, must be updated every six months to include new recommendations on primary and preventive care issued by the United States Preventive Services Task Force. Vision, dental, and hearing benefits are very similar for QHP and CHP members, though access to dental benefits is a bit more complicated.

Federal rules require Exchanges to offer pediatric dental coverage as one of the ten Essential Health Benefits (EHBs), and also require Exchanges to offer stand-alone dental plans to consumers for purchase. When setting up its Exchange, New York selected the

CHP dental benefit as the basis for child dental coverage. That benefit is required in all individual coverage offered off the Exchange, unless applicants prove they already have the coverage. But on the Exchange, as long as stand-alone pediatric or family dental coverage (which must include pediatric dental, but might also include additional benefits) is available, QHPs are not required to offer the benefit under federal rules, and parents are not required to purchase it. Coverage including the pediatric dental benefit is offered by QHPs throughout the state, but since stand-alone coverage is available (often through the same dental plans subcontracted to provide the benefit as part of comprehensive coverage), many plans do not include the benefit as part of the QHP package. When dental coverage is purchased separately, it typically will have a separate deductible and premium, and cost-sharing features that differ from the underlying coverage. Some families may have another source of dental coverage, or may prefer to purchase coverage for the whole family or a plan with additional benefits. In 2014, Exchange enrollment was split almost equally between QHPs offering pediatric dental coverage as an embedded benefit and those that did not.

In other areas, CHP coverage has been updated to match commercial coverage standards. Coverage requirements were recently updated to reflect mental health parity standards first adopted in the commercial market, as well as the commercial market mandate for autism services. Some analyses have highlighted the 60-visit “per-condition per-lifetime” limit for QHP coverage of physical and occupational therapy in the benchmark plan chosen by New York, but CHP coverage requirements typically include a “short-term” limitation for these services, and some plans have 40-visit limits.<sup>35</sup> CHP provides slightly more generous coverage of orthotic devices, but prosthetic coverage is comparable, with QHPs providing coverage for cranial prostheses (e.g., wigs), excluded under CHP. Both programs also provide full prescription drug

coverage, though CHP also covers over-the-counter medications ordered in writing by a physician.

While CHP might be slightly more generous in certain benefits, such as durable medical equipment or hearing aids, QHPs include some benefits not required in a CHP package, such as coverage for up to 200 days at a skilled nursing facility and 60 visits per lifetime per condition for habilitative therapy outside the context of autism services. They may also include benefits such as telemedicine, urgent care, and a wellness benefit with reimbursement for a family gym membership, children’s sports team fees, or alternative medicine.

It is difficult to compare benefits in CHP against benefits offered through employer coverage. EHBs are the basis of small group coverage on and off the Exchange, but they are not required to be included in fully insured large group plans, so these plans might not include all of the benefits that make up QHP coverage.<sup>36</sup> That’s also the case for self-insured plans, which are exempt from State regulation on benefits and other areas, and subject to some ACA requirements like free primary and preventive care, but not others, such as EHBs.

## Networks

Provider networks are another important consideration when comparing CHP to QHPs or other options, but exact comparisons are difficult. A health plan’s orientation and market concentration also are reflected, and networks can vary based on regional differences as well. Upstate health plans, for example, show a high degree of overlap among providers participating in commercial and public program networks.<sup>37</sup> For health plans active in the Medicaid Managed Care program, that same network will often form the core of its CHP network, while a health plan or QHP prominent in the commercial market might rely on those providers as the backbone of their CHP network. Historically, CHP, modeled on a commercial

product, had a reputation among providers as a more attractive program due to higher reimbursement rates, which can translate to broader provider networks. That dynamic may be changing, however, with the larger role Medicaid Managed Care plans are playing in the CHP market, and consolidation. Empire BCBS, for example, long the highest-enrollment CHP plan despite not participating in the Medicaid program, recently completed the transition of its CHP enrollees to HealthPlus Amerigroup, a sister insurer, within the same holding company, specializing in public programs. The reimbursement rates health plans use for providers are not regulated by the State, and are not publicly available.

An exact comparison of a CHP network to a QHP network would require a sophisticated data analysis of the hundreds of thousands of records health plans submit to regulators to describe their networks. But based on the guidelines and standards regulators use for those submissions, it is fair to say the “floor” for networks used for CHP, QHPs, and commercial health plans is very similar.<sup>38</sup> Through regulatory authority, contract provisions, or both, the New York State Department of Health, Department of Financial Services, and NYSOH all enforce broad general standards requiring a sufficient number and type of providers to meet enrollees’ health care needs. More detailed standards require reporting of a core listing of 55 “required providers” and 75 “required services” with only minor differences between the kinds of plans. Similar standards ensure that enrollees have a choice of three primary care providers within 30 minutes or 30 miles, for example; one general hospital per county if one is available, and up to three in larger counties; two primary care dentists, one pediatric dentist, and an oral surgeon; and two providers within core specialties. With the exception of pediatrics and pediatric surgery, regulations do not require specific provider-to-enrollee ratios for the more than 30 kinds of pediatric specialties reported in the filings, though for those two specialties ratios were

lower for CHP and Medicaid than for commercial HMO coverage. With regard to network access, contracts with CHP plans also include standards for timely appointments, which are not included in QHP certification, though access standards are sometimes part of accreditation reviews for insurers participating in NYSOH.

While CHP and BHP plans only provide in-network coverage, out-of-network coverage is available from QHPs serving western New York and the Albany area, but not in other parts of the state. The trend toward narrow or “tailored” networks in QHPs, and in commercial products generally, is a source of concern for CHP supporters, who worry that these smaller networks will not include high-quality specialty providers or that they will lead to long delays in accessing needed services. Improved and timely disclosure about networks has emerged as an important consumer focus<sup>39</sup> across the board, and would help families make decisions about QHPs. One recent study developed a “t-shirt size” system of estimating the general size of QHP networks.<sup>40</sup>

## Cost

As discussed earlier, CHP is an affordable option for many New York families, as cost sharing is not permitted at any income level, and generous subsidies hold premiums down for enrollees in households earning up to 400 percent FPL. Experts agree that both premiums and cost sharing would increase for families without the federal CHIP program.<sup>41</sup> How premiums and cost sharing would increase would depend on the options families chose for alternative coverage, and on their individual circumstances.

Families forced to cover their children through dependent coverage offered by an employer—including those in the family glitch category—would see some of the stiffest increases. Although it is not clear how many New York families would find themselves locked out of QHP subsidies, national estimates<sup>42</sup> applied to

New York's CHP program suggest that about 91,280 children would switch to employer coverage.<sup>43</sup> The same study estimated that, nationally, these families would incur an average of over \$3,700 in out-of-pocket premium increases alone, not counting cost-sharing expenses, with some families paying much less and others much more, depending on which type of dependent coverage was available (e.g., family coverage versus a less costly employee/child tier policy) and the level of the employer's contribution. Another study predicted "sharply higher costs" for these families, particularly those switching to high-deductible plans that are increasing their market share.<sup>44</sup>

In the absence of CHP, a second group of families would shop for child-only coverage from QHPs. As shown in Table 1, families eligible for the deepest level of Exchange subsidies would face a \$63 monthly premium for the second-

lowest silver plan instead of their free CHP coverage, and a family at 160 percent of the FPL would see their premium rise from \$9 to \$94 per month per child.

Table 2 shows the significant increases in cost sharing that would accompany these premium increases. Although a family at 140 percent FPL would not be subject to deductibles, copayments of \$10 for primary care and \$20 for specialty care would apply along with other cost sharing, until an out-of-pocket maximum of \$1,000 is reached. Putting these cost-sharing amounts in perspective, a 2014 report found that per capita out-of-pocket costs for children covered by employer-sponsored insurance averaged \$427 in 2012, up 6 percent from the year before.<sup>45</sup> Although a broad range of primary and preventive care services are not subject to cost sharing under the ACA, parents of children with serious medical conditions or in the higher

**Table 1. Child in CHP vs. Child Only in QHP: Premiums**

% FPL	Child in CHP	Child Only in QHP
140%	Free	\$62.80
160%	\$9.00	94.40
200%	9.00	136.66
250%	15.00	136.66
300%	30.00	136.66
350%	45.00	136.66
400%	60.00	136.66

Note: See Methodology

**Table 2. Child in CHP vs. Child Only in QHP: Cost Sharing**

% FPL	Child in CHP			Child Only in QHP		
	Copayment for PCP/Specialist	Out-of-Pocket Maximum	Deductible	Copayment for PCP/Specialist	Out-of-Pocket Maximum	Deductible
140%	No cost sharing in CHP.			\$10/\$20	\$1,000	\$0
160%				15/35	2,000	250
200%				15/35	2,000	250
250%				30/50	5,200	1,200
251-400%				30/50	5,500	2,000

Note: See Methodology

income levels for CHP eligibility would incur out-of-pocket costs that would exceed their current CHP premiums many times over.

Another group to consider are parents already enrolled in a QHP, who would have to switch their child to the plan under a parent/child policy. As Table 3 shows, this group of parents would fare well on premiums, since the monthly CHP premium would no longer be “stacked” on top of their NYSOH premium. Since ACA subsidies cap premiums at a percentage of household income, a single parent in a 160 percent FPL household already enrolled in NYSOH could add any number of children for the same \$94 monthly premium they would otherwise pay for their single coverage, whereas today, the parent would pay \$94 for individual coverage, and another \$9 per month for a separate policy for each child, up to a maximum of three children. A lower-income couple insured by a QHP with a two-adult policy that adds

children would receive the same benefit, as the income-based premium cap covers the new cost of family coverage, making the additional child or children “free.”

Once subsidies expire at 400 percent FPL, however, family coverage would cost about 50 percent more than coverage for two adults, and cost sharing would be a different story. As Table 4 shows, out-of-pocket maximums soar to \$11,000 at 400 percent FPL, and deductibles reach \$4,000 for family coverage. A policy that doesn’t take effect (except for primary and preventive care) until a family incurs \$4,000 in expenses is so vastly different from CHP coverage that it makes comparing benefits seem like an empty exercise, given the barriers to access that these costs constitute.

The introduction of BHP coverage through NYSOH in 2016 for lawfully present adults earning less than 200 percent FPL and

**Table 3. Child in CHP and Adult in QHP vs. Parent and Child in QHP: Premiums**

% FPL	Child in CHP and Adult in QHP	Parent and Child in QHP
140%	\$62.80	\$62.80
160%	103.40	94.40
200%	174.38	165.38
250%	278.64	263.64
300%	403.67	373.67
350%	481.21	436.21
400%	557.96	497.96

Note: See Methodology

**Table 4. Child in CHP and Adult in QHP vs. Parent and Child in QHP: Cost Sharing**

% FPL	Child in CHP and Adult in QHP			Parent and Child in QHP		
	Copayment for PCP/Specialist	Out-of-Pocket Maximum	Deductible	Copayment for PCP/Specialist	Out-of-Pocket Maximum	Deductible
140%				\$10/\$20	\$2,000	\$0
160%	No cost sharing in CHP. An adult in QHP would incur the same cost sharing as “Child Only” in QHP, shown on the right-hand side of Table 2.			15/35	4,000	500
200%				15/35	4,000	500
250%				30/50	10,400	2,400
251–400%				30/50	11,000	4,000

Note: See Methodology

ineligible for Medicaid adds a new dynamic. Although children are not currently eligible in the program, costs for adults are reduced substantially compared to QHPs. As shown in Table 5, premiums for BHP (with the same benefit package as a QHP) are closer to those charged under the CHP program, but with some cost sharing introduced (Table 6). Although there are no deductibles, enrollees at the higher income limit may incur out-of-pocket costs of up to \$2,000.

It is clear that without CHP, overall costs for most families seeking coverage for children would increase dramatically in New York. This should not come as a surprise. New York is the only state that extends subsidies to families earning as much as 400 percent of the FPL, one of six states allowing families to buy into the unsubsidized benefit package, and one of twelve states with separate CHP programs with no cost sharing.<sup>46,47</sup> Still, the extent of the difference in cost sharing for lower-income families, between CHP and QHPs or alternative coverage types, is staggering, and surely the reason behind national estimates of large increases in uninsured rates for children should CHIP lapse. There is a consensus that the cost increases families would face should CHP sunset will lead to lower rates

of coverage, particularly among lower-income families. Although rates of private coverage sometimes increase when the costs of public coverage increase, this does not offset the loss of public coverage, one recent study found.<sup>48</sup> At the same time, increased cost sharing is historically linked to consumers skipping both low- and high-value services, such as preventive care.<sup>49</sup> Specific evidence is more limited for children, but studies have found that rates of exacerbation for children with asthma, for example, increase with greater cost sharing for drugs.<sup>50</sup> Families with children with chronic diseases go to great lengths to access services, just as some families make financial sacrifices to maintain coverage; however, if healthier children drop out first, premiums for the remaining families might increase further.<sup>51</sup>

## Decisions Ahead for CHP

Despite CHP's declining enrollment and many similarities with coverage available through the Exchange, it continues to play a critical role in New York's coverage continuum in the post-ACA landscape: it is a source of coverage for children whose immigration status makes them ineligible for the Exchange, a protector of affordable coverage for families shut out of ACA subsidies by the

**Table 5. CHP vs. BHP: Premiums**

% FPL	CHP	BHP
150% and below	Free	Free
151–159%	Free	\$20.00
160–200%	\$9.00	\$20.00

Note: See Methodology

**Table 6. CHP vs. BHP: Cost Sharing**

% FPL	CHP			BHP		
	Copayment for PCP/Specialist	Out-of-Pocket Maximum	Deductible	Copayment for PCP/Specialist	Out-of-Pocket Maximum	Deductible
150% and below	No cost sharing in CHP.			\$0	\$200	\$0
151–200%				15/25	2,000	0

Note: See Methodology

family glitch, and a provider of coverage more affordable for all enrollees than NYSOH or commercial coverage, with a Medicaid-like cost-sharing structure for families at all income levels. It is known in some quarters as the “program that runs itself,” and many wish that CHP would run forever as a stand-alone program, part of a growing menu of programs in New York varying only slightly based on the age or income of enrollees; that may be the best result. Waiving the requirement to offer child-only coverage through a QHP was an option New York unsuccessfully pursued early in implementation, and that may resurface, though Congressional action would apparently be necessary. Still, key features of the historical ACA coverage expansion cannot be ignored, and the recent Congressional funding extender provides the luxury of a brief window in which to examine where CHP fits in going forward, and how it best serves New York families.

### Eligibility

At its inception, CHP filled a pressing need—coverage for uninsured lower-income children ineligible for Medicaid—with commercial market features that appealed to families uncomfortable with the “stigma” of enrolling in Medicaid. Now, CHP is one of several products available in NYSOH, a “no wrong door” market organizer offering subsidized and non-subsidized QHPs to children and families, with comprehensive benefits at much more affordable premiums than pre-ACA plans; a BHP for adults earning up to 200 percent FPL, starting next year; and Medicaid coverage for children under 1 year old in families earning up to 223 percent FPL or between ages 1 and 19 in families at 154 percent FPL.

The availability of these new options through the Exchange gives rise to many questions. Is 400 percent FPL the proper eligibility ceiling for deeply subsidized premiums for children in New York State? Would lower-income CHP members be better served in the Medicaid program, or by, perhaps, joining their parents in the BHP, if the

program was expanded to children? With comprehensive QHP coverage available on and off the Exchange, what is the policy rationale to continue requiring CHP plans to offer full-premium policies without cost sharing to families regardless of income? Without CHP, how would children ineligible for QHPs through the Exchange access coverage that is affordable?

### CHP and Risk Pooling

CHP supporters cite the program’s single-minded focus on children as one of its greatest strengths, but that approach limits an important tool available to organize insurance markets efficiently: risk pooling. Currently, premium rates are developed for the CHP program based on the experience of all children enrolled. If CHP enrollees were instead pooled with adults in the BHP or with families enrolled in QHPs, the experience of both of these pools would be improved from an actuarial perspective, and overall premium rates would likely be reduced. Because children eligible for CHP premium subsidies are ineligible for subsidized coverage in QHPs, only 10,649 individuals under the age of 18 were reported enrolling in QHPs through New York’s Exchange as of March 2015, with about 4,000 covered under child-only policies.<sup>52</sup> Since the creation of the BHP will add a new smaller stand-alone pool of coverage without a risk-adjustment mechanism and reduce enrollment in the Exchange by nearly half, merging CHP with one or both of these pools would help stabilize rates in either or both markets during a transition period.

### CHP as a Stand-alone Program

Many decision points on CHP’s future lead to the question of whether CHP best serves New York families as a stand-alone program or whether there are alternatives to consider. States are beginning to answer this question. California has gradually shifted CHIP enrollees to Medicaid, though its state CHIP program only covers children in families earning up to 250 percent FPL.<sup>53</sup> Arizona drew criticism from

advocates when it suspended its CHP program entirely, relying on Exchange coverage for children who do not qualify for Medicaid.<sup>54</sup> But since the clearest benefit to CHP is how it enhances the affordability of coverage, one option yet to be fully explored is maintaining CHP as the centerpiece of New York's historic commitment to insuring children, but seeking federal approval to use CHP funding to subsidize premiums and cost sharing for other sources of coverage—for example, QHPs or off-Exchange plans.

There are many examples of subsidy programs in other states, and in New York itself. Massachusetts, for example, used funds from its Medicaid waiver to subsidize Exchange coverage for lower-income residents.<sup>55</sup> New York suspended the Family Health Plus program after the ACA took effect, but replaced it with wrap-around premium subsidies of QHP coverage for enrollees.<sup>56</sup> Although currently unused, New York's CHP program authorizes premium subsidies for other coverage and the Medicaid program provides premium assistance for employer-sponsored coverage when cost effective.<sup>57</sup> Many questions would need to be resolved, however, to determine if this approach would pass muster.

One question to answer is whether the off-Exchange market is a viable source of coverage for children who don't meet the eligibility standards for the Exchange, and this will depend on the documentation and enrollment procedures health plans use.

Second, significant thought would need to be given to the complex mechanics of a CHP-based premium and cost-sharing subsidy program, how it would be administered, and whether the existing statutory authority would be adaptable enough to meet goals such as reducing unacceptable cost sharing and premiums for children covered in QHPs, and solving the family glitch problem. Some have suggested that so-called Section 1332 waivers available to states under the ACA beginning in 2017 might help

states like New York to revamp their CHP programs, and address other ACA shortcomings at the same time.<sup>58</sup>

Some advantages of this approach are evident. New York could leverage both ACA subsidy funds and (possibly) employer contributions. As noted earlier, risk pools would be deepened, leading to more stable and perhaps more affordable premiums. This approach would also eliminate one of the drawbacks of CHP, split coverage for families. Families with children eligible for CHP cannot purchase one policy through NYSOH that covers all family members, and New York's comparatively high income limit for CHP has likely created many split-coverage families. Whole-family coverage is not as important to many families as affordable premiums if parents are forced to choose between the two,<sup>59</sup> but it makes sense for many reasons, such as establishing relationships with provider groups that know and treat the whole family, a single monthly premium payment, easier communication and scheduling, and convenience.

## Conclusion

While the next "sunset" of federal funding isn't until October 2017—right around the corner, in other words—State policymakers will also need to revisit CHP that year, as part of larger Health Care Reform Act financing system discussions, and a number of programmatic issues will require their attention. With only minor differences between CHP and QHP benefits, the purpose of maintaining a separate CHP benefit rather than reconciling the two is one issue, given the redundancies and added cost. Reviewing premiums and cost-sharing levels for CHP, which will have been in place for nearly a decade come 2017, will be another.

The increase in health care costs over that period is reason enough for a review. Although some advocates recall a goal of capping CHP premiums at 2 percent of family income, CHP premiums today rarely exceed a fraction of 1

percent of household income, compared to the ACA premium cap range of from 2 percent at 138 percent FPL to 9.5 percent at 400 percent FPL. Yet 2013 filings from a representative sampling of nine CHP plans show that about 35,000 CHP members were discontinued for “failure to pay family share of premium,” which represented about 15 to 35 percent of the total disenrollment among these plans in all categories.<sup>60</sup> It is likely that many of these families were able to reenroll in the program, and that other factors besides affordability contributed to the nonpayment, such as poor access to banking services, or an incomplete understanding of the value of coverage, compared to paying out of pocket for services when the need arises. But the rate of nonpayment calls for a fresh look at the current standards for premiums and cost sharing, and some creative thinking about how and when they are collected and when they are applied.

While CHP is due for some fine-tuning, there is ample reason to consider the larger issues discussed earlier as well. Although the coupling of the CHP and Medicare Sustainable Growth Rate sunsets led to a fortuitous straight extender, the next time around might be different. When President Obama signed the 2009 CHIPRA law extender in the teeth of the national recession, for example, it ended a two-year stalemate involving presidential vetoes, override efforts, and state lawsuits challenging a controversial federal CHIP regulation.<sup>61</sup>

One key issue in the dispute was the extent to which state CHIP programs were insuring children with an option of employer-sponsored coverage. Although New York has gradually purged the CHP program of waiting periods designed to prevent “crowd out” of employer coverage, that issue might resurface. In addition, a “discussion draft” advanced by senior House and Senate committee chairs prior to this year’s funding extender included provisions to roll back the higher CHIP matching rate generally, reduce federal matching funds for enrolled children in households earning between 250 and 300

percent FPL, and eliminate funding entirely for children in families earning over 300 percent FPL.<sup>62</sup> With potential changes or the elimination of the federal CHIP program possible the next time around, it would be prudent to consider a State response; just prior to the most recent CHP extender, State officials noted that at least a year’s lead time would be required to prepare for the loss of federal matching funds. The upcoming funding and renewal cycle for 2017 involves some additional uncertainty as well. A new President, 34 newly elected U.S. Senators, and a new class in the House will consider the future of not just CHIP but also the ACA.

A second consideration involves how best to invest scarce state resources. CHIP is a real bargain for states, particularly given the recent increase in the federal match, which has led New York State budget officials to reduce future spending projections.<sup>63</sup> Under the current system, a reduction in State spending for CHP brings a reduction in federal matching funds. At the same time, ACA subsidies that New Yorkers might receive for their children are reduced because of the CHP funds that flow to the State. But the State appropriation approached \$500 million in 2015, and the federal matching formula may change. Fiscal savings played at least a small role in California’s decision to convert its combined CHP program to a Medicaid program. And New York has repeatedly dipped in to CHP funding over the years to meet other pressing needs, although health plans have borne the brunt of the cuts through rate freezes or reductions.<sup>64</sup>

If there were a way to meet children’s health needs more efficiently, it would free up resources for other purposes. BHP enrollees earning 151 percent of FPL, for example, will pay \$15 copayments for doctor visits and a \$150 coinsurance charge for an inpatient admission; healthy parents are important for healthy children too. In some ways, the decision facing New York with CHP parallels the decision it faced with its Elderly Pharmaceutical Insurance Coverage Program (EPIC). When drug benefits

were added through the Medicare Part D program, the forerunner EPIC program was eventually reframed to provide targeted subsidies of Part D premiums and cost sharing for beneficiaries. ACA subsidies and increased Medicaid eligibility also led to fiscal decisions to curtail the HealthyNY program, which resembled Exchange coverage, and to replace the Family Health Plus program with the more fiscally advantageous Basic Health Program.

A 2012 review of New York's CHP program<sup>65</sup> found stakeholders to be "unanimous in their belief" that CHP "would continue on, in one form or another, regardless of whether or not Congress reauthorized the program" because it predated the federal program and enjoys such wide support. That strong support is still evident today, but it is worth remembering that New York's CHP program only covered outpatient primary and preventive care initially, and it was many years before inpatient care, mental health, and vision and dental services were added. Given the difficulty of going it alone on a comprehensive CHP benefit package, and contentious past CHIP renewal battles in Washington, it might also be prudent to prepare for contingencies. As

the last cycle approached this past April, New York was in the midst of implementing the BHP, the new public program reducing QHP costs for lower-income adults, for which children were not eligible, and eliminating subsidy levels for lower-income families and children accessing coverage through the Exchange.

CHP backers of all stripes are proud that, despite the smaller size of the program, it's often the point of the spear when it comes to children's health issues. But as enrollment declines and new programs are created, the effort and energy that led to the creation of the program is focused on keeping CHP intact, rather than improving children's coverage overall. The discussion of the next state-level CHP funding extender in 2017, for example, could serve as an important vehicle for reevaluating children's health coverage across the spectrum—CHP, QHP, employer-sponsored insurance, and Medicaid—to assess whether current benefits and payment policies are supporting the delivery of health care for children that best addresses their health and developmental needs. Such an undertaking would be an appropriate way to acknowledge CHP's 25th anniversary.

## Methodology

Various sections of this report and accompanying tables provide comparisons between Child Health Plus (CHP) and other sources of coverage, such as qualified health plans (QHPs) purchased from New York's Exchange, New York State of Health (NYSOH). Following is a description of some of the data sources and methodology used in these comparisons.

### Benefits

For CHP, the main source of information on benefits was the set of contractual requirements for participating health plans issued by the New York State Department of Health (DOH).<sup>66</sup> We also examined member handbooks issued by health plans, and State and federal statutory and regulatory requirements. Data sources for QHP and Basic Health Program (BHP) products included the 2015 and 2016 Invitation for Participation in NY State of Health; information on EHBs from federal regulators; benefit descriptions accessed through tools available at NYSOH; New York State Department of Financial Services (DFS) filing guidance for health plans, such as Accident and Health Products Checklists and Outlines; health plan websites, member handbooks, and marketing materials; and New York Insurance Law statutory provisions and DFS regulations.<sup>67,68,69,70,71</sup>

### Networks

Data sources for networks included the DOH Provider Network Data System Data Dictionary, version 6.9; the CHP contract; NYSOH Invitation from 2015 and 2016 and relevant attachments; DFS Network Adequacy and Out-of-Network Guidance; relevant New York State Public Health Law and Insurance Law provisions and underlying regulations; and personal communication with DFS and DOH officials and health plan representatives.<sup>72,73</sup>

## Premiums and Cost Sharing

**Rating Tiers.** According to New York State's uniform family-tier rating methodology, the NYSOH child-only premium must be set at 41.2 percent of the corresponding individual product. Since it is the basis for subsidy calculations under the ACA, we used the second-lowest silver tier individual product (from Albany County), priced at \$331.71; we multiplied it by 0.412 to estimate a child-only rate of \$136.66.<sup>74</sup> Similarly, NYSOH's parent and child(ren) rate is priced to reflect a relativity of 1.70, resulting in a premium of \$563.91. The couple premium reflects a relativity of 2.0, which resulted in a couple rate of \$663.42; and the family premium (two adults and one or more children) was \$945.37, based on a relativity of 2.85.<sup>75,76</sup>

**Premiums.** To calculate the subsidized child-only premium, we used the annual income for a household of two individuals at various percentages of the 2014 Federal Poverty Level (FPL).<sup>77,78</sup> We used calculations based on the federal poverty guidelines, and premium calculators available from New York State of Health and the Kaiser Family Foundation to develop examples of household incomes for families of different sizes that are equivalent to percentages of the FPL. It is important to note that 2014 federal poverty guidelines are used for eligibility determinations for QHPs in the Exchange, while 2015 guidelines are used for CHP and Medicaid, and that different methods of calculating these equivalents result in slightly different dollar amounts. Examples of the 2014 equivalents for QHPs for households of different sizes are shown in the table below. We then multiplied these household incomes by the corresponding premium cap percentage. (The premium cap is in place so individuals with incomes from 100-400 percent FPL do not have to pay more than a certain percentage of their income in health insurance premiums.<sup>79</sup>) We then divided the total by 12 to find the

subsidized monthly premium for a child-only plan. We used the same process to find subsidized parent-and-child premiums for a two-person household as well as couple and family premiums for three-person households.

For example, at 160 percent FPL, the annual income for a three-person household is approximately \$31,600. To find the subsidized monthly premium, we multiplied \$31,600 by 4.46 percent, the premium cap at 160 percent FPL, and divided the total by 12 months. This yielded a monthly subsidized family premium of \$117.45.

To find premiums for households with one parent accessing health insurance through the New York exchange and one child in CHP, the subsidized individual premium for a single adult (in a two-person household) was added to the CHP premium per child in the corresponding income level.<sup>80</sup>

For example, when estimating the CHP child and NYSOH individual adult premium at 160 percent FPL, first we found the NYSOH premium for a single adult in a two-person household based on the methodology above. That premium, \$94.40, was added to the premium for one child in CHP at 160 FPL, which is \$9. In this situation, the total cost for premiums was \$103.40.

In BHP, premiums for individuals with earnings below 150 percent FPL are free and premiums for individuals at between 150 and 200 percent FPL are \$20.

**Cost Sharing.** In NYSOH health plans, enrollees pay a portion of the cost of medical services through various forms of cost sharing in addition to their monthly premium payments.<sup>81</sup> For example, individuals with standard silver tier plans, earning between 150 and 200 percent FPL, are responsible for a \$250 deductible, a \$2,000 out-of-pocket maximum, and copayments for primary care physicians (\$15) and specialists (\$35), generic prescription drugs (\$9), inpatient admissions (\$250), and inpatient and outpatient surgery (\$75).<sup>82</sup> Because a family plan deductible and out-of-pocket maximum are double the amount set for an individual plan, families enrolled in a standard silver plan, earning between 150 and 200 percent FPL, are responsible for a \$500 deductible and a \$4,000 out-of-pocket maximum.<sup>83</sup>

There is no cost sharing in CHP. In a CHP child and NYSOH adult household scenario, single-adult cost sharing would apply. In the BHP, there are no deductibles. Individuals earning from 138 percent FPL to 150 percent FPL are responsible for a \$200 out-of-pocket maximum, with limited cost sharing for prescription drugs. Individuals earning between 150 and 200 percent FPL are responsible for a \$2,000 out-of-pocket maximum; copayments include \$15 for primary care physicians and \$25 for specialists, \$6 for generic prescription drugs, \$150 for inpatient admissions, and \$50 for inpatient and outpatient surgery.<sup>84</sup>

**Table 7. Income and Household Size Equivalents Based on 2014 U.S. Federal Poverty Guidelines**

Family Size	Percent of Federal Poverty Level						
	140%	160%	200%	250%	300%	350%	400%
2	\$22,100	\$25,400	\$31,500	\$39,300	\$47,200	\$55,100	\$62,900
3	27,800	31,600	39,500	49,500	59,300	69,200	79,200
4	33,300	38,100	47,600	59,600	71,500	83,400	95,400

Source: New York State of Health, 2015 Tax Credit and Premium Estimator. [www.healthbenefitexchange.ny.gov/calculator](http://www.healthbenefitexchange.ny.gov/calculator)

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- <sup>6</sup> Title XXI of the Social Security Laws, United States Code sections 1397aa-1397mm, subchapter XXI, chapter 7, Title 42. [http://www.ssa.gov/OP\\_Home/ssact/title21/2100.htm#ft1](http://www.ssa.gov/OP_Home/ssact/title21/2100.htm#ft1)
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- <sup>9</sup> CHIP enhanced FMAP and Maintenance of Effort provisions can be found in the Social Security Act, Sections 2105(b) and (d), as added by Section 2101 of the Affordable Care Act.
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<sup>14</sup> New York State Department of Health. 13ADM-03. September 25, 2013. Medicaid Eligibility Changes Under the Affordable Care Act (ACA) of 2010. [http://www.health.ny.gov/health\\_care/medicaid/publications/adm/13adm3.htm](http://www.health.ny.gov/health_care/medicaid/publications/adm/13adm3.htm); Center for Medicaid and CHIP Services. State Medicaid and CHIP Income Eligibility Standards. <http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf>

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<sup>16</sup> United States Department of Commerce. Bureau of Economic Analysis. New York State Personal Income Summary for 2013: Personal Income, Population, Per Capita Personal Income by County. <http://www.bea.gov/itable/iTable.cfm?ReqID=70&step=1#reqid=70&step=30&isuri=1&7022=20&7023=7&7024=non-industry&7033=1&7025=4&7026=xx&7027=2013&7001=720&7028=3&7031=36000&7040=-1&7083=levels&7029=20&7090=70>

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<sup>19</sup> Annual Medicaid Managed Care Operating Report, 2013. New York State Catholic Health Plan (Fidelis Care).

<sup>20</sup> Aid to Localities Budget, A.3003-C/S.2003-C, Chapter 53 of the Laws of 2015.

<sup>21</sup> Rudowitz R, S Artiga, and R Arguello. March 2014. *Children's Health Coverage: Medicaid, CHIP and the ACA* [Issue Brief]. Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/>

<sup>22</sup> Dubay L, M Buettgens, and GM Kenney. March 2015. *Estimates of Coverage Changes for Children Enrolled in Separate Children's Health Insurance Programs in the Absence of Additional Federal CHIP Funding—Key Findings and Methodology*. The Urban Institute: Report to the Medicaid and CHIP Payment and Access Commission. <https://www.macpac.gov/wp-content/uploads/2015/03/Estimates-of-Coverage-Changes-for-Children-Enrolled-in-Separate-Childrens-Health-Insurance-Programs-in-the-Absence-of-Additional-Federal-CHIP-Funding.pdf> The report accompanying this microsimulation includes a detailed discussion on assumptions about take-up of public and private coverage, and limitations of the estimates.

<sup>23</sup> The MACPAC study estimates that 30.9 percent of children enrolled in separate state CHIP programs nationally would become uninsured if the federal program expired. Applying that figure to New York's rounded CHP enrollment of 280,000 produces the estimate of 86,500 children losing coverage.

<sup>24</sup> New York State of Health. May 15, 2015. 2016 Invitation for Participation in NY State of Health. <http://info.nystateofhealth.ny.gov/invitation>

<sup>25</sup> Letter from Courtney Burke, New York State Deputy Secretary of Health, to the Honorable Ron Wyden, Chairman of the Senate Committee on Finance, the Honorable Fred Upton, Chairman of the House Energy and Commerce Committee, the Honorable Orrin Hatch, Ranking Member of the Senate Committee on Finance, and the Honorable Henry Waxman, Ranking Member of the House Energy and Commerce Committee, September 4, 2014. <http://energycommerce.house.gov/letter/responses-bipartisan-bicameral-letters-governors-regarding-chip>

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