Children’s Health Insurance Program: Federal Funding Should Be Renewed

KEY TAKEAWAYS

CHIP provides coverage for eight million low income children in all 50 states, Washington DC, and U.S. territories.

CHIP coverage helps low-income working families afford health care for their children.

We urge Congress to extend CHIP funding for five years, consistent with the recommendations of the Medicaid and CHIP Payment and Access Commission (MACPAC).
Background

The Children’s Health Insurance Program (CHIP) is a state-federal program authorized by Congress in 1997. CHIP was designed to provide health insurance coverage for children in families that have too much income to qualify for Medicaid but do not have access to affordable health insurance coverage. The program has helped reduce the rate of uninsured children from 13.9 percent in 1997 to 4.5 percent in 2015.\(^1\) Most recent data shows that over 8.4 million children were enrolled in CHIP sometime in 2015.\(^2\)

Structure

States are given three options in structuring their CHIP programs:

- Provide CHIP through Medicaid,
- Create a separately administered CHIP program with income standards that complement the state’s Medicaid eligibility levels for children, or
- Adopt a combination of both (e.g., expand Medicaid eligibility level for children and create a separate CHIP program for those with higher incomes).

Currently eight states and the District of Columbia have CHIP programs through Medicaid; two states have only separate CHIP programs, and 40 states have a combination of the two.\(^3\)

Eligibility

CHIP covers low-income children up to age 19 who are ineligible for Medicaid and lack other health insurance coverage. Within federal limits, states set the income standards for eligibility:

- Two states have income limits at less than 200 percent of the federal poverty level (FPL),
- 30 states have income limits between 200 percent FPL and 300 percent FPL, and
- 18 states and the District of Columbia have income limits above 300 percent FPL.\(^4\)

Although many states have higher limits, 89 percent of the children enrolled in CHIP-financed coverage were from families with incomes at or below 200 percent FPL in FY 2014, and 97 percent were at or below 250 percent FPL.\(^5\)

CHIP is also an important source of maternal health coverage. States may use CHIP funds to cover low-income pregnant women and unborn children. Four states (CO, NJ, RI, VA) provide CHIP-funded coverage to pregnant women and 15 states cover pregnant women through the unborn child (AR, CA, IL, LA, MA, MI, MN, NE, OK, OR, RI, TN, TX, WA, WI).\(^6\)

Benefits

The scope of CHIP benefits can vary depending on the state’s program structure. Children enrolled in CHIP through Medicaid receive the same array of benefits as children enrolled in the regular state Medicaid program (e.g., Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services). States have greater flexibility in determining benefit coverage for children in a separate CHIP program. States can elect one of three benefit options (the standard Blue Cross/Blue Shield PPO offered under the Federal Employees Health Benefits Program, the health coverage generally available to state employees, or the HMO plan with the highest commercial enrollment in the state) as a reference plan to determine their CHIP benefit coverage, although states must cover certain services such as emergency services, well baby care, immunizations, and dental services.
Premiums and Cost Sharing

States that operate separate CHIP programs are permitted to implement premiums and cost sharing up to a combined limit of five percent of the family’s income. Twenty-two states charge premiums, averaging $17 to $102 a month, depending on family income, and four states charge an annual enrollment fee, ranging from $35 to $105. Twenty-five states also require some type of cost sharing, such as co-payments for non-preventive physician visits or non-emergency trips to the ER.

Financing

The federal government reimburses states for their CHIP spending at a higher matching rate than for Medicaid, called the enhanced federal matching assistance percentage (E-FMAP). In fiscal years 2016 through 2019, federal law increases the E-FMAP by 23 percent, not to exceed 100 percent for any state. The state pays the remaining difference as its share of the match.

Federal funding for CHIP is determined by Congress, which sets a national appropriation for a fiscal year. For example, in FY 2016, total national funding was $14.4 billion. States are then allotted funds based on the state’s actual prior use of CHIP funds, adjusted annually for child population growth and medical inflation. States have two years to spend each allotment, with unspent funds available for redistribution to other states that experience shortfalls. Since 2009 annual federal CHIP expenditures have been significantly less than the national appropriation.

Delivery of Services

The dominant vehicle for providing services to CHIP children is private health plans. Eighty percent of the children in separate CHIP programs are enrolled in health plans. States establish standards that CHIP health plans must follow to ensure their provider networks give children timely access to adequate care, as required by federal law.

Improved Health and Access to Care

Numerous studies have shown that CHIP works for children. In Oregon, parents of CHIP enrollees were more likely to report their child was in good or stable health after being enrolled in the program for a year. In New York, children with special health care needs that were enrolled in CHIP experienced substantial improvements in access to care: unmet needs for prescription medications declined from 36 percent to 9 percent among the previously uninsured; and unmet needs for specialty care declined 48 percent to 10 percent for those previously uninsured and 32 percent to 2 percent for those with mental/behavioral conditions. A California study found that, following CHIP implementation, children with certain health conditions that are responsive to outpatient care experienced decreased hospitalization, suggesting that primary care access and quality for low-income children improved.

Children enrolled in CHIP experience benefits that extend beyond health. In California, children enrolled in CHIP demonstrated “significant, sustained gains” in their ability to pay attention in class and keep up in school activities. Children enrolled in the Kansas CHIP program for more than a year missed fewer days of school because of injury or illness.

Implications of Expiring CHIP Funding

Federal funding for CHIP expires on September 30, 2017. The impact on state CHIP programs will vary according to their structure; however, all states are projected to run out of CHIP federal funds in FY 2018 if funding isn’t extended (see Table 1). Under the ACA maintenance of effort provision, states must maintain their eligibility standards and processes for children in Medicaid.
and CHIP that were in place in 2010 to September 30, 2019. However, the states that operate a separate CHIP program are allowed to end coverage when federal funding runs out. States operating CHIP through an expansion of Medicaid must continue providing coverage through FY 2019, but they will receive the lower Medicaid match rate instead of the enhanced CHIP match rate.

Table 1: Projected Exhaustion of Federal CHIP Funds in Fiscal Year 2018

<table>
<thead>
<tr>
<th>Quarter of Fiscal Year</th>
<th>Number of States</th>
<th>States</th>
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<tbody>
<tr>
<td>First Quarter</td>
<td>4</td>
<td>Arizona, District of Columbia, Minnesota, and North Carolina</td>
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<tr>
<td>(Oct – Dec 2017)</td>
<td></td>
<td>Alaska, Arkansas, California, Colorado, Connecticut, Delaware,</td>
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<td></td>
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<td>Florida, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Massachusetts,</td>
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<td></td>
<td></td>
<td>Mississippi, Missouri, Montana, Nevada, New York, Ohio, Oregon,</td>
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<td>Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia,</td>
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<td></td>
<td></td>
<td>and Washington</td>
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<td>Second quarter</td>
<td>27</td>
<td>Alabama, Georgia, Illinois, Indiana, Iowa, Maine, Maryland, Michigan,</td>
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<tr>
<td>(Jan – March 2018)</td>
<td></td>
<td>Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota,</td>
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<td></td>
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<td>Oklahoma, South Carolina, Tennessee, Texas, West Virginia, and</td>
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<td>Wisconsin</td>
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<tr>
<td>Third quarter</td>
<td>19</td>
<td>Wyoming</td>
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<td>(April – June 2018)</td>
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<tr>
<td>Fourth quarter</td>
<td>1</td>
<td>Wyoming</td>
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<tr>
<td>(July – Sept. 2018)</td>
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Source: Medicaid and CHIP Payment and Access Commission

Children Would Lose Health Care Coverage

In 2015, MACPAC estimated that 3.7 million children would lose their CHIP coverage if funding expired. This includes 1.1 million children who would become uninsured; the remaining children are likely to obtain coverage from other payers—an estimated 1.4 million (36.5 percent) through subsidized health insurance exchange coverage and 1.2 million (32.6 percent) through a parent’s employer-sponsored insurance. CHIP coverage is significantly more affordable for families than commercial coverage. The average out-of-pocket cost for families with a child enrolled in CHIP is $158 per year, including premiums and cost sharing. The average out-of-pocket cost for a child enrolled in subsidized Exchange coverage would be $1,073 for the second lowest cost silver plan. Costs could quickly rise for a child that has an acute health event, or a chronic condition, putting coverage out of reach for some families. CHIP coverage remains the best option for low-income families seeking affordable care for their children.
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Conclusion

In light of the health and wellness benefits for children, and the access to affordable coverage that CHIP provides for families, we urge Congress to authorize a five-year funding extension, consistent with recommendations of the Medicaid and CHIP Payment and Access Commission (MACPAC). During this time of transition for the nation’s health care system, it is more important than ever to maintain coverage for children.

Related Topic

Endnotes