Research

Primer: The Children's Health Insurance Program (CHIP)

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BACKGROUND

In 1997 Congress passed the Balanced Budget Act (BBA), which established the Children's Health Insurance Program (CHIP). The program was created to address coverage gaps between the poorest populations where children were covered by Medicaid and more affluent families that could afford private health care insurance. As of December 2013, 6 million children were covered under CHIP. In Fiscal Year (FY) 2013, the federal government spent $9 billion to provide that coverage; a number that CBO estimates will increase to $10 billion in 2014 and $11 billion in 2015.[1] Comparatively, the total state share of CHIP was $4 billion in FY 2013.

Program Structure

The CHIP program itself is structured as a federal-state partnership. States may choose how to set up their CHIP programs; whether it is as an extension of Medicaid, as a CHIP-Medicaid partnership, or as an independent, separately branded program.

States may also determine their own eligibility levels to a large extent, and incorporate cost sharing requirements into their programs. Currently eligibility levels begin at 138 percent of the Federal Poverty Level (FPL) and eligibility limits range from 175 percent to 405 percent FPL depending on the state. Half of all states have extended eligibility above 250 percent FPL, though they lose their enhanced federal match rate and only receive Medicaid Federal Medical Assistance Percentage (FMAP) for CHIP enrollees above 300 percent FPL. States may also attach a premium requirement based on the family income of the covered individual.

Financing

Each state is allotted a federal appropriation to support CHIP.[2] Each state receives its allotment based on the FMAP.[3] The FMAP is used to determine the federal match rate for the state Medicaid program, so in order to encourage states to create or expand children's coverage, the CHIP match rate is FMAP plus about 15 percent in additional federal funding.[4] The original FMAP match rate is between 50 and 83 percent, and is determined by a statutory formula based on income:[5]

The CHIP match rate is then increased by a certain percentage based on each state's per capita health care growth, and child population growth over time, and may range from 65 percent to 85 percent. The average CHIP match rate is 71 percent, and states must, on average, contribute 29 percent in order to receive their federal allotment.[6]

Despite the generous FMAP for CHIP, unlike Medicaid, CHIP is not an open-ended entitlement, and funding is capped at the level appropriated by Congress for the program.[7] Should a state face a shortfall even after receiving all available CHIP funds, shortfall funding is available in the form of Child Enrollment Contingency Funds (available when a state's CHIP enrollment exceeded target levels), Redistribution Funds (made available when after two years, unused state CHIP allotments are redistributed to states with shortfalls), and recently, if the others are insufficient, Medicaid match rates for expansion populations under the Affordable Care Act (ACA).

Eligibility

CHIP eligibility begins at incomes of $31,720 and goes as high as $95,400 for a family of four.[8] Infants born to Medicaid eligible women, some children in foster care or adoption programs, and some children with disabilities may also be eligible for CHIP regardless of income. Benefit packages vary by state, but are usually robust and all include Early, Periodic Screening, Diagnosis, and Treatment (EPSDT).[9]

Point of Service Payment

Health care providers are reimbursed by the state either directly if they are fee-for-service, or through a managed care organization (MCO) contracted by the state to manage care costs for Medicaid and CHIP populations. The amount the provider receives for a given service is determined by a fee schedule created by each state that must meet minimum

federal standards. This rate may be based on the costs of providing the service, a review of commercial payers' reimbursement rates, or a percentage of what Medicare pays for equivalent services.[10]

Along with rules guiding physician reimbursement, CMS has imposed maximum nominal out of pocket costs for services paid for by Medicaid and CHIP. For example, in 2013, a service that cost the state $10 or less had a maximum copayment of $0.65, while a service that cost the state $50.01 or more had a maximum out of pocket cost of $3.90. States have the authority to further decrease the out of pocket maximum for care provided to children. There are also maximum nominal deductibles ($2.65) and a maximum managed care copayment ($3.90).[11]

CHIP children who are not covered under a mandatory eligibility group (for example, those over 300 percent FPL) may be given alternative out of pocket maximums. Children's preventive care, hospice care, emergency services, family planning services, and pregnancy-related services are all also exempt from out of pocket costs.[12]

SUBSEQUENT LEGISLATION

The original BBA only provided funding for CHIP through 2007. When the issue of reauthorization came before Congress, negotiations stalled and CHIP funding was simply extended as-is until 2009.

CHIPRA

In 2008, CHIP again came up for debate in Congress, and funding was continued with the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.[13] The legislation broadened eligibility for lawfully residing children and pregnant women, and addressed funding shortfalls. CHIPRA provided bonuses[14] in FY 2009 through FY 2013 for states that increased their Medicaid (*not* CHIP) enrollment among low income children. Bonus eligibility also required implementation of four outreach and enrollment activities such as 12 months of continuous Medicaid and CHIP eligibility, elimination of Medicaid and CHIP asset-testing, elimination of in-person interview requirements, use of joint Medicaid and CHIP applications, implementation of options to ease enrollees' renewal processes, or implementation of an 'express lane eligibility' (ELE) – where documentation from other social programs can automatically qualify a child for CHIP benefits.

The ACA

In 2010 Congress passed the ACA, extending CHIP funding through 2015. The law also provided for a 23 percent FMAP increase in 2016 for CHIP — making the average CHIP enhanced FMAP about 93 percent, and shifting the range upwards to 88-100 percent.[15] The payment to states of that 93 percent is required to match state contributions, and is no longer limited by a FMAP cap.

Though funding was only appropriated through 2015, the ACA contains a Maintenance of Effort (MOE) clause that will require states to continue offering Medicaid and CHIP at current (2010) levels until 2019.[16] This MOE requirement would have a slightly different effect in each state depending on the structure of their program, but in the end the requirement will force Congress to consider reauthorizing CHIP funding for at least another four years, beginning in 2015, or else make changes to the MOE. In states where CHIP is a Medicaid expansion program, CHIP-eligible children will continue to be enrolled in the Medicaid program with a lower federal match without reauthorization, but at a higher cost to the states. In states with independent CHIP programs, the states may roll CHIP-eligible children into Qualified Health Plans in the Exchanges, or impose waiting lists or enrollment caps in order to limit the state's CHIP expenditures, or else create Medicaid screening procedures to deny Medicaid eligible CHIP coverage in order to cope with a loss of CHIP funds.

Because funding only goes through September of 2015, and the ACA alone is insufficient coverage, Congress will have to consider CHIP reauthorization by October of 2015.

The Impact of the ACA on CHIP

Originally, CHIP was designed to target the children of families who could not afford to purchase family health insurance coverage. However, many of those families are now eligible for subsidized health insurance coverage through the Exchange. In the absence of CHIP, the American Action Forum **estimates** that 5.1 million children enrolled in or eligible to enroll in CHIP could obtain affordable health insurance through the exchange.

Unfortunately, coverage options within the ACA will prove to be an insufficient replacement for CHIP, as many children could end up without coverage due to loopholes in the law.

If Congress were to decline to appropriate funds for 2015-2019, some states could be obligated to shoulder the entire financial cost of CHIP according to the administration.[17] Forcing states to carry that burden, of course, is politically infeasible, and so CHIP funding reauthorization must be discussed along with other possible policy changes, such as a

repeal of the MOE, or broader retooling of the CHIP Program.

Additionally, the Obama Administration's interpretation of the ACA results in a loophole in the employer mandate that could leave some children without insurance. If an employer offers 'affordable insurance' to their employee, they have satisfied the employer mandate – there is no requirement that family coverage be offered or deemed affordable.[18] Because, in this scenario, a family member has been offered 'affordable' employer-sponsored insurance, albeit unaffordable for the family, the entire family becomes ineligible for exchange subsidies. According to American Action Forum estimates, this loophole could affect as many as 2.28 million CHIP eligible children – 1.6 million who are currently enrolled in CHIP, and another 645 thousand who are not enrolled but are eligible. In the absence of affordable coverage options on the Exchange, CHIP provides these families with a way to obtain coverage for their children and avoid the individual mandate penalty. However, if CHIP is not reauthorized, these children will lose this coverage option. The impact of the ACA's family glitch will need to be considered during reauthorization conversations.

2015 CHIP REAUTHORIZATION AND CONCLUSION

All of the issues above call for an in-depth discussion on the future of the CHIP program. Reauthorization of CHIP funding should be approached with all of the potential coverage losses in mind, and discussions should be tailored to the specific populations still in need of CHIP post-ACA. Some reauthorization proposals have already been put forward, and more will certainly be forthcoming. CHIP was originally tailored to serve a specific population without adequate coverage options; a successful reauthorization proposal will hew to this framework and target only those populations left vulnerable by the ACA.

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[1] Congressional Budget Office, Update to the Budget and Economic Outlook 2014 (August, 2014), http://www.cbo.gov/sites/default/files/cbofiles/attachments/45653-OutlookUpdate_2014_Aug.pdf.