Testimony

The Children's Health Insurance Program: Status and Outlook

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Chairman Rockefeller, Ranking Member Roberts and members of the subcommittee, thank you for the opportunity to testify on Children's Health Insurance Program (CHIP) today. In my remarks, I will seek to convey three main points about the CHIP program and its future:

- The current budgetary condition of CHIP makes inaction problematic. Instead Congress has an opportunity to review the program and restore it to its original intent.
- A straight funding extension or reauthorization is unwise as CHIP has strayed from its initial targeted design and because of changes forced by the Affordable Care Act (ACA).
- Reauthorization should retain features of the CHIP program that have made it successful, and the program should again be targeted on a specific population.

I will discuss each of these in turn. First, however, some background on the program will be helpful.

Background

Research shows that a lack of health insurance causes unmet medical needs and delays in care for children,[1] demonstrating the need for children to have access to health care services. CHIP is one avenue through which children can gain health insurance in families that may not otherwise be able to provide coverage. However, CHIP should be viewed in the context of the other options available, and with the other federally funded programs that now cover the same population.

CHIP was established by the Balanced Budget Act of 1997, through a bipartisan legislative process that addressed the policy concerns of both sides of the aisle. The program was designed as a block grant, calculating a percentage of funding from the federal government to states based on their CHIP eligible populations. Just as with the Medicaid program, states are provided with federal matching funds—known as the Federal Medical Assistance Percentage (FMAP)—and states receive higher matching rates for CHIP, with the federal government covering about 71 percent of the programs' costs on average. However, as CHIP is an *allotment* to states it does not have an open ended funding stream.[2] CHIP often includes personal responsibility provisions in its financing, incorporating cost-sharing mechanisms for families with higher incomes.

CHIP covered 6 million children as of December 2013.[3] Eligibility rules vary by state, ranging from 138 percent of the Federal Poverty Level (FPL) up to 405 percent FPL depending on the program decisions made by each state.[4] Most states cover above 200 percent FPL, and can receive the increased federal match offered by CHIP up to 300 percent FPL.[5] Some families are subject to cost sharing requirements including monthly premiums and co-pays, depending on the state and the family's financial status. Benefits vary by state but CHIP is known to be a robust program, offering rich benefits and extensive provider networks.

CHIP is a joint federal-state partnership program, and every state participates. Each state has some flexibility over the administrative structure and benefit requirements for their program. The options for structuring the

program include the following: a completely separate CHIP program, an expansion of the state's Medicaid program, or a CHIP-Medicaid partnership. Fifteen states run standalone programs, eight states[6] implement the program through an expansion of Medicaid, and twenty eight states opt for a partnership model.[7]

States that choose to provide CHIP through a stand-alone program can offer a variety of benefits to children. States have the option of providing coverage mirroring Medicaid benefits, using the benefits for a state employee plan, or can even choose an HMO benchmark plan. If states use CHIP funding to expand Medicaid coverage, then Medicaid benefit rules apply and children in CHIP will receive Medicaid benefits. For the majority of states, the choice of a partnership model allows states to provide a combination of the two above approaches.[8]

The Budgetary Outlook

The funding for CHIP is not permanent and appropriation of funds must be authorized by Congress. CHIP was originally scheduled for reauthorization in 2007, and was temporarily extended until 2009 when the Children's Health Insurance Program Reauthorization Act (CHIPRA) was passed. CHIPRA was not a straight extension, and made alterations greatly expanding the entitlement program—including increased eligibility levels, patched funding shortfalls, the removal of insurance crowd-out provisions and the institution of bonus payments for states.

As part of the changes in 2009, CHIP spending was only authorized for an additional four years. This temporary extension was put in place as a way of artificially reducing estimated costs of the program. Unfortunately, lawmakers resorted to budget gimmicks during CHIPRA and the ACA.

The authors of the 2009 CHIPRA bill extended funding for CHIP through FY 2013, and the ACA further extended funding through 2015. These temporary extensions create a need for congressional action in the future to fully fund the program in years to come. The ACA extended CHIP, but only left a portion of spending in the baseline after 2015. This mechanism allowed for the bill's apparent cost to decrease without actually saving money on the program. Instead, the program will just require funding authorizations later down the road.

The CBO estimates that the 2014 cost of covering these children is $10 billion, increasing to $11 billion in 2015.[9] CBO does not fully estimate funding levels for the years 2016-2024 because there is no current funding authorization beyond 2015.

Congress divided the 2015 CHIP appropriation into three parts[10]—one large sum at the beginning of the year at $15.4 billion and two smaller sums totaling $5.7 billion, one in the first half and the other in the second half of the year. Because of budget rules, CBO includes in its baseline only the funding in place immediately prior to the scheduled end of funding. Thus the current budget estimate only assumes that annual appropriations of $5.7 billion will continue—an extrapolation of the annualized authorized funding in the latter half of 2015—and that some already appropriated funding will be spent in 2016. CBO estimates that this amount of funding will not be sufficient to cover all the costs of the program. Thanks to some provisions within the ACA, and this budgetary trick, funding will no longer cover the actual cost of the program; placing states at risk for large budget deficits. Some action must be taken to provide cover for children in need of access to health care and for state budgets.

ACA Challenges and Defining a Tailored Program

As of December 2013, CHIP covered an estimated 6 million children,[11] and the original intent was for CHIP to serve a very specific population.[12] The ACA altered this niche population, changing requirements for

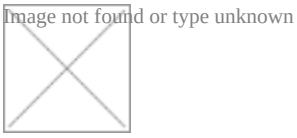
covering these children as well as the number of children that still need coverage. For this reason, a straight reauthorization is not the best decision.

The ACA created a requirement for states to maintain current CHIP eligibility levels until 2019; this is known as the Maintenance of Effort (MOE) requirement. Though states are required to maintain their current eligibility levels until 2019, the ACA only provides funding for CHIP through September of 2015. In the absence of congressional action, states could be required to continue a partnership program without their federal partner for up to four years. Depending on a state's program structure, the MOE liability could leave states covering 100 percent of CHIP funding, or states' funding could be reduced to Medicaid levels, creating large budget deficits at the state level. Even with continued federal funding, the Government Accountability Office estimates that half of all states will scale back CHIP in 2020—the first year where these restrictions are lifted.[13] This is especially of concern for states that used CHIP to fund Medicaid coverage for children up to the minimum eligibility level for premium tax credits in the exchange. Without CHIP funding, AAF estimates[14] that states will be responsible for covering 460 thousand children at a lower matching rate who would otherwise lose access to health insurance coverage.

This scale back of the program will be due in part to another issue within the ACA: the overlapping coverage options available to CHIP families. The ACA's insurance Exchanges exist in every state, and provide subsidies for health insurance premiums to families between 138 and 400 percent FPL—largely the same population as CHIP. This redundancy would lead one to assume the CHIP program is no longer needed because entire families can participate in a plan offered through and subsidized by the insurance Exchange in their state that has been advertised as comprehensive, affordable health care coverage. Unfortunately this is not the case for many children, in part due to what has become known as the family glitch.

Though the ACA mandates that employers offer affordable coverage for their employees, the administration has interpreted this requirement as applying only to the employee, and not extending the same benefits to members of the employee's family.[15] If an employee is offered affordable individual coverage through their place of work, then they *and* their family are no longer eligible for subsidized insurance in the Exchange.

The American Action Forum has estimated[16] that, if CHIP funding is not continued, the family glitch could result in as many as 2.28 million children losing access to health insurance coverage. Of those 2.28 million children, 1.6 million are currently enrolled in CHIP and could fall into this loophole, losing their CHIP coverage, and another 645 thousand are currently uninsured but are CHIP eligible and would lose access to coverage. The coverage gap created by the family glitch and the implications for state Medicaid budgets show how the ACA expanded coverage to new populations, while leaving up to 2.7 million children that have been promised coverage in potential limbo. The following graphic shows the possible coverage options for families and children in CHIP:



As displayed in the chart above, the CHIP population has become fragmented, potentially leaving some children without coverage while others could join their families in Exchange or employer sponsored plans, and leaving some children without any coverage options, despite recent health care reform.

Features to Preserve in CHIP

CHIP was established as a product of bipartisan commitment, and any solution for the program should redirect the program on this path. Over the next few years, Congress will need an example of successful federal program reform with a responsible budgetary approach. For example, the Social Security Disability Insurance Trust Fund will become insolvent in 2016, and funding must be addressed. Congress should use CHIP funding to set the stage for productive, bipartisan solutions.

Along with setting an example for 2015 and 2016 legislative negotiations, this is an opportunity to utilize the successful design of CHIP to refine the population it set out to cover. In the time since its establishment, CHIP has become a swollen program, expanding beyond its original purpose. The changes to the program brought on by the ACA provide a unique opportunity to reassess who needs the program and who may not now that they have other options. Providing the appropriate amount of funding that is directed toward a specific population will preserve the program and its initial intentions for coverage.

One of the virtues of CHIP is that it is a state managed program; within the bounds of limited federal resources, Governors have the ability to design their programs in ways that best fit their state. This could be an extremely useful tool in redesigning the program, gaining insight into the best way to manage funding streams and address populations that may still need coverage in each state. It is important throughout this process to get the funding right for the future CHIP program. CHIP should be redesigned to meet the needs of a post-ACA health care system, while continuing the state determined personal responsibility provisions. Since states are the administrators of the program, any discussions of reauthorization should focus on allowing states to be more innovative and efficient in their ability to charge premiums, copays and enrollment fees. If these policy levers stay in place, states can tailor programs in a way that is beneficial for the program and allows the enrollee and their families to have greater involvement in their health care services.

Conclusion

This is only the first of what will be many discussions regarding options for the future of the CHIP program. This program was originally created in a bipartisan fashion, and any extension of the program should be approached in a bipartisan manner as well. CHIP provides millions of children with health insurance coverage. However, the ACA has changed the health care landscape and the types of coverage available to families, and the CHIP program must change as well.

Subsidized insurance is now available to many families currently enrolled in CHIP, and redundancies in coverage should be considered when making funding decisions, as should the children that are slipping through cracks in coverage created by the ACA. The $10 billion spent on this program in 2014 should not be taken as a given in years to come, and funding should be commensurate with the population needing coverage. CHIP coverage and funding must be assessed in the context of a changed health care landscape.

[1] Journal of Health and Social Policy. *The Impact of Lack of Health Insurance on Children. http://www.tandfonline.com/doi/abs/10.1300/J045v10n02_05#.VAnF0_mwIqc.*