

# Extending the Children's Health Insurance Program: High Stakes for Families and States

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## ABSTRACT

**ISSUE:** Congress must decide whether to extend federal funding authority for the Children's Health Insurance Program (CHIP), which ends September 30, 2017. CHIP operates much like Medicaid, providing federal matching payments for state program expenses, although CHIP's funding rate is higher than the federal rate paid for traditional Medicaid and was further enhanced under the Affordable Care Act. States can use their CHIP funds to expand Medicaid, operate separate CHIP programs, or combine the two approaches. Today CHIP covers 8.4 million children and provides maternity coverage for approximately 370,000 women.

**GOAL:** To examine the potential effects of ending federal CHIP funding.

**METHODS:** Analysis of legislative and regulatory policy as well as evidence from the literature.

**FINDINGS AND CONCLUSIONS:** Without congressional action, CHIP funds will be virtually gone by summer 2018. The 4.7 million children who receive CHIP coverage through Medicaid will remain entitled to coverage through 2019, but only at normal Medicaid federal matching rates. Among the 3.7 million children enrolled in separate programs, an estimated 1.1 million could lose coverage entirely, while the rest could face reduced coverage and significantly higher out-of-pocket costs. Congress is facing key decisions, including whether to extend funding, if the ACA rate enhancement should continue, and potential changes to eligibility levels.

## KEY TAKEAWAYS

- ▶ If Congress fails to extend CHIP funding, states will run out of federal funds by 2018.
- ▶ Without the CHIP extension, an estimated 1.1 million children could lose coverage entirely, while many others could face reduced coverage and significantly higher out-of-pocket costs.
- ▶ Congress will be deciding whether to extend CHIP funding, the rate of federal matching funds, and potential changes to eligibility levels.



## BACKGROUND

In the fall of 2017, Congress is expected to consider whether to extend funding for the Children’s Health Insurance Program (CHIP). The program enjoys bipartisan support, partly because of its design and flexibility. Senators Orrin Hatch and Ron Wyden recently have announced their intention to jointly introduce a five-year funding extension.<sup>1</sup>

CHIP has been widely recognized for its effectiveness in increasing the number of children with health insurance. Since its 1997 enactment, CHIP has helped lower the proportion of uninsured children by 9 percentage points, from 13.9 percent in 1997 to 4.5 percent in 2015.<sup>2</sup> Extending Medicaid to low-income children also has been shown to have a positive, measurable impact on their health and productivity in later years, as shown in studies of the long-term economic effects of coverage.<sup>3</sup>

### CHIP’s Role in Insuring Children

CHIP provides coverage for children in families that cannot afford health insurance and whose incomes make them ineligible for Medicaid. Compared to Medicaid, CHIP is small. In 2015, the program covered 8.4 million children, compared with 36.8 million enrolled in Medicaid that year. Together Medicaid and CHIP insured 43 percent of all children in 2016 (Exhibit 1). Additionally, CHIP funds maternity care for an estimated 370,000 pregnant women annually.<sup>4,5</sup>

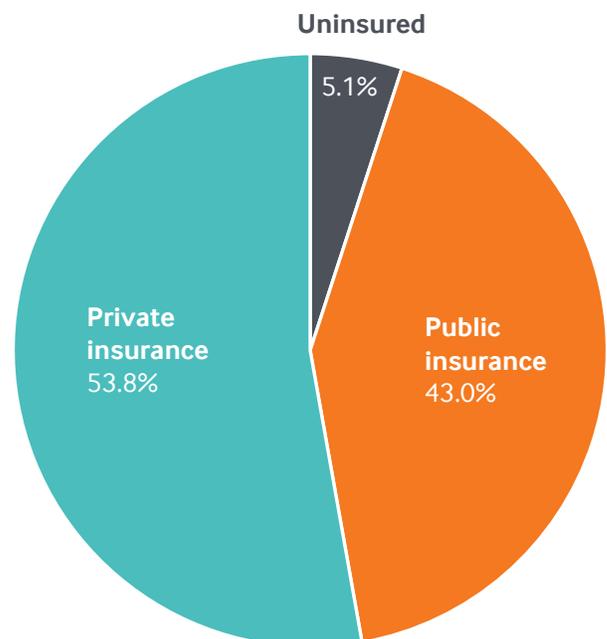
### CHIP’s Funding Structure

CHIP creates financial incentives for states to expand coverage for children. Unlike federal Medicaid funding — which is permanent and not subject to annual limits — federal CHIP funding is subject to both time limits and aggregate funding restrictions. Each state is entitled to annual funding up to an overall limit tied to its historic spending levels, adjusted by an annual growth factor.<sup>6</sup> Additionally, CHIP maintains a special contingency fund for states that exhaust their annual aggregate allotments.<sup>7</sup> CHIP funding has been extended four times since its 1997 enactment, most recently in 2015.<sup>8</sup>

Within this funding structure, CHIP operates much like Medicaid; the federal government pays a percentage of a

state’s total spending. However, CHIP’s federal match rate is higher than the traditional Medicaid rate. This reflects a decision by Congress to encourage states to expand Medicaid for children beyond the federal minimum required by law; such an option existed, but many states had not used it. When CHIP was enacted in 1997, the federal Medicaid eligibility minimum for children was household income up to 133 percent of the federal poverty level (in 2017 dollars, just under \$34,000 for a family of four) for children up to age 6 and then fell to 100 percent of poverty (around \$25,000 for a family of four) for children ages six to 18. Later, the Affordable Care Act expanded mandatory Medicaid eligibility for all children under age 18 to 133 percent of poverty,<sup>9</sup> and also established a maintenance of effort requirement that ensures that states’ 2010 Medicaid and CHIP coverage standards remain in effect through 2019.<sup>10</sup>

Exhibit 1. Insurance Coverage for Children Ages 0–17, 2016



Note: A small number of people were covered by both public and private plans and were included in both categories.

Data: R. A. Cohen, E. P. Zammitti, and M. E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016* (National Center for Health Statistics, May 2017). Public insurance includes CHIP, whether administered as a Medicaid expansion or separately. Private insurance includes plans offered in both the individual and small-group markets.

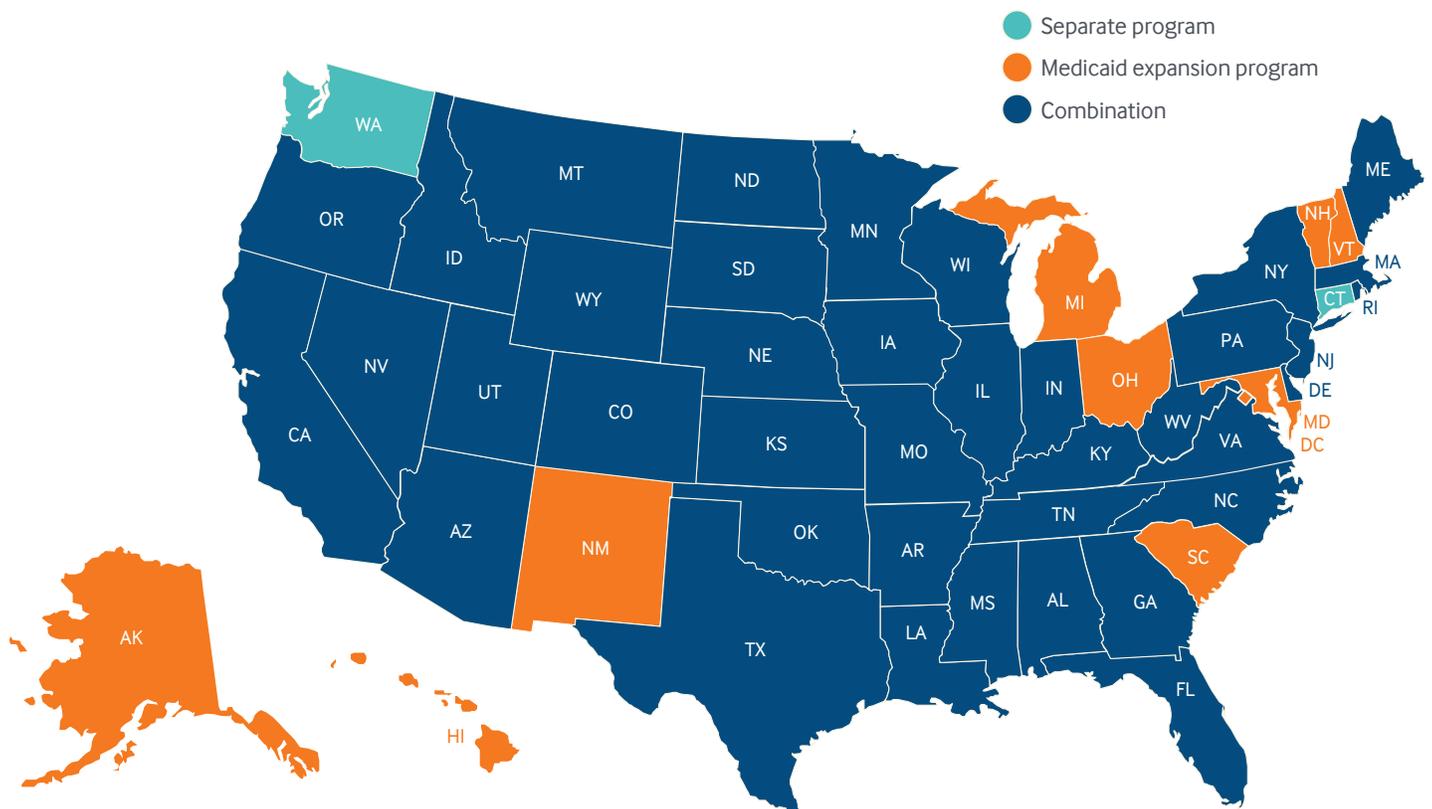
To create incentives to expand insurance coverage for children, CHIP established an enhanced federal matching rate (known as the Enhanced Federal Medical Assistance Percentage, or E-FMAP) that was 15 percentage points higher than the traditional Medicaid rate. It pays about 71 percent of the cost of coverage compared to 56 percent on average for traditional Medicaid.<sup>11</sup> Under the Affordable Care Act, the CHIP E-FMAP was increased by an additional 23 percentage points for 2016 through 2019, making the average ACA-enhanced rate 88 percent, meaning that the federal government pays 88 percent of state CHIP expenditures. In 13 states, the ACA special enhancement means that the federal government will fund CHIP at 100 percent in 2018.<sup>12</sup>

### CHIP’s Flexible Program Design

CHIP provides states with considerable program flexibility. States can use their CHIP allotments to cover children through Medicaid at the enhanced federal matching rate or they can establish separate CHIP programs. In most states, this means the purchase of subsidized private insurance, much like on the ACA’s marketplace. Today, 39 states combine the two approaches (Exhibit 2).

Although most states operate their CHIP programs separately to some degree, the majority of CHIP-enrolled children are covered through Medicaid: of the nearly 8.4 million CHIP-enrolled children, 4.7 million are enrolled

Exhibit 2. State CHIP Program Designs



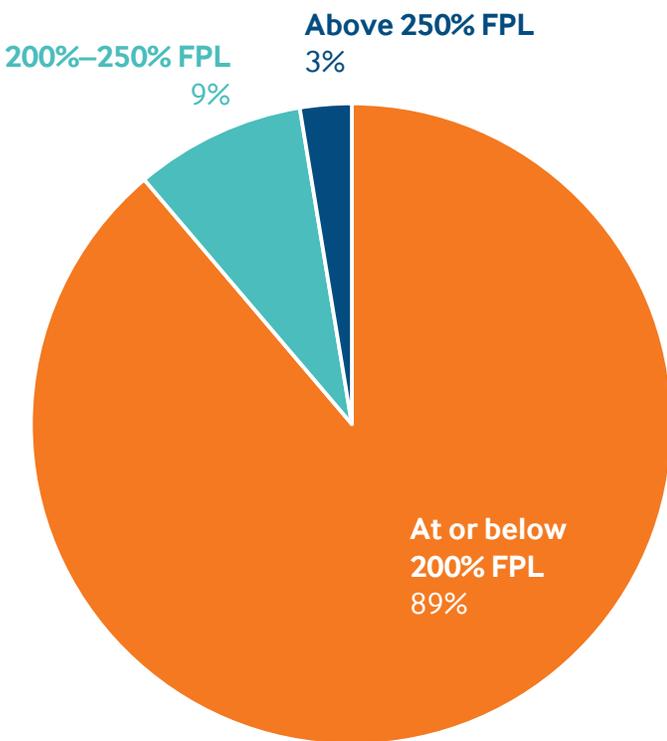
Notes: Data as of July 1, 2016. Under CHIP, states have the option to use an expansion of Medicaid, separate CHIP, or a combination of both approaches. Among the 39 states with combination programs, 11 consider themselves to have separate programs but are technically combinations because of the transition of children below 133 percent of the federal poverty level from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, and Wyoming). Michigan transitioned its separate CHIP into Medicaid-expansion CHIP effective January 1, 2016.

Data: Medicaid and CHIP Payment and Access Commission, *State Children’s Health Insurance Program (CHIP)*, fact sheet (MACPAC, May 2017).

in Medicaid and 3.7 million are covered through separate CHIP plans.<sup>13</sup> All states but Idaho and North Dakota currently set their CHIP upper income thresholds higher than 200 percent of the federal poverty level; that being said, nearly nine of 10 CHIP children live in families with incomes at or below twice the poverty level (\$40,840 for a family of three in 2017) (Exhibit 3).

CHIP benefits vary depending on program design. CHIP children who are covered through Medicaid are entitled to all Medicaid benefits available to children, including Medicaid’s comprehensive early and periodic screening, diagnosis, and treatment (EPSDT) benefit package. Separate CHIP programs more closely mirror the employer-sponsored plan market but also include vision and oral health benefits.

**Exhibit 3. Child Enrollment in CHIP by Family Income, 2013**



Note: FPL = federal poverty level.  
 Data: Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (MACPAC, March 2017).

**CHIP’s Special Protections Against Out-of-Pocket Costs**

CHIP offers special protections against out-of-pocket spending. In the case of Medicaid-enrolled CHIP children with incomes under 150 percent of poverty, premiums are prohibited and cost-sharing is limited. Children enrolled in separate CHIP programs can be charged a modest monthly premium and are protected by a cap that limits their families’ total out-of-pocket spending to no more than 5 percent of household income.<sup>14</sup>

These protections are significant for families, especially those with incomes higher than twice the poverty level. If these families enrolled their children in marketplace plans, they would qualify for limited or no cost-sharing assistance.<sup>15</sup> A study conducted by the Medicaid and CHIP Payment and Access Commission (MACPAC) for Congress found that in 2015, premium-based CHIP plans cost families \$158 annually (\$127 for premiums, \$31 for cost-sharing). Costs in comparable employer plans were \$871 per child (\$603 for premiums, \$288 for cost-sharing); costs in the second-lowest-cost silver marketplace plan averaged \$1,073 (\$806 for premiums, \$266 for cost-sharing).<sup>16</sup> CHIP plans in 36 states with separate CHIP programs had an actuarial value of between 97 percent and 99 percent for children with incomes up to 250 percent of poverty. This figure is far more generous in terms of actuarial value than marketplace plans, which range from 75 percent to 92 percent and drop as income increases slightly.<sup>17</sup> The disparity in value between marketplace plans and CHIP plans may even be greater: CHIP plans include dental coverage, while some marketplace plans do not include oral health benefits. In these situations families must buy a separate plan for which there is no premium subsidy assistance.<sup>18</sup>

The value of CHIP becomes especially important for families with children who have serious and chronic health conditions that require extensive care. One study estimated that if families were moved to marketplace plans, between one-third and one-half of plans would increase their out-of-pocket costs to a level exceeding CHIP’s 5 percent cap.<sup>19</sup>

The positive impact on children’s insurance coverage and out-of-pocket spending led Congress to extend

CHIP funding for two additional years in 2015. That decision was also fueled by lawmakers' desire to mitigate the effects of the ACA's "family glitch,"<sup>20</sup> which denies marketplace subsidies to otherwise-eligible children whose parents can afford employer coverage for themselves but not the cost of family coverage. With the cost of employer-sponsored family coverage exceeding \$18,000 on average in 2016,<sup>21</sup> CHIP's ability to alleviate the impact of the family glitch is critical. The Government Accountability Office has estimated that this gap in the marketplace subsidy system affects about a half-million children; without Medicaid and CHIP, the number of affected children could be four to eight times higher.<sup>22</sup>

## WHAT WILL HAPPEN IF CONGRESS FAILS TO ACT?

Should Congress fail to extend CHIP funding, states will rapidly exhaust their federal allotments. MACPAC estimates that by March 2018, 31 states and the District of Columbia will run out of CHIP funding; by June 2018, all states but Wyoming will be without funding. MACPAC cautions that its projections regarding when federal CHIP funding will run out could understate the problem if, for some reason, enrollment in the coming months exceeds projections.<sup>23</sup> Hurricanes Harvey and Irma appear to have sped up the clock in Texas and Florida because of the greater demand for publicly funded insurance in the wake of the disasters and both states' decisions to ease CHIP enrollment rules to assist families.

It is not clear whether Congress will extend CHIP funding, under what terms it may extend, or if the legislation will become a vehicle for other health reforms, such as incremental changes to stabilize the individual insurance market or a renewed effort to repeal and replace the ACA. The Trump administration has proposed significant reductions to current CHIP funding levels, an end to the ACA's maintenance of effort requirement related to CHIP and Medicaid coverage for children, and a lowering of CHIP's upper income eligibility limit to 250 percent of poverty, which would affect programs in 28 states.<sup>24</sup> By capping eligibility at this level, the administration's recommendation would go further than earlier

congressional proposals that would have allowed states to set higher eligibility standards while lowering the CHIP E-FMAP rate for children with family incomes exceeding the 250 percent threshold.

MACPAC projects significant consequences from the failure to extend CHIP. For the 4.7 million CHIP children covered through Medicaid, the ACA's maintenance of effort requirement will protect their coverage through 2019. However, federal payments to states would drop to the normal Medicaid matching rate, creating a considerable funding shortfall that states would need to offset. For the 3.7 million children covered through separate CHIP programs, all federal funding would cease and states would have to move these children to Medicaid at the normal matching rate, replace separate program funding out of state revenues, or end coverage entirely. MACPAC estimates that ending CHIP funding could translate into a complete coverage loss for 1.1 million children, while millions more would face significantly higher coverage costs.<sup>25</sup> It is not clear how many states would substitute a Medicaid expansion at normal matching rates; as noted previously, prior to CHIP, states had Medicaid expansion options for children that they did not use.

These consequences would come at a time when the future of cost-sharing assistance for marketplace plans is uncertain. Indeed, should Congress renew the repeal-and-replace effort, the future of income-sensitive premiums may be in question. Furthermore, states cannot wait until the last minute to start unwinding their CHIP programs; ending a public program involves months of planning, multiple administrative steps, and enough time to try to help families find alternative coverage through Medicaid, employers, or the marketplace.<sup>26</sup>

## Key Congressional Decisions

***Whether to continue CHIP funding and for how long.*** As noted, ending CHIP funding could lead to coverage losses for more than 1 million children. Unless they are moved to Medicaid, children losing separate CHIP coverage will face higher cost-sharing; these children are overwhelmingly concentrated in families with incomes below twice the

poverty level. MACPAC has recommended extended CHIP funding through 2022, which would be sufficient time to allow lawmakers to address the question of whether CHIP should continue as an independent funding source or incorporated into a larger, more unified health insurance subsidy system that provides equal protection for children. CHIP integration involves working through complex issues: what about families who cannot afford dependent coverage through employer plans? How do we replicate CHIP's generous protections against excessive out-of-pocket costs for medical and oral health care? How can we create a robust market for child-only health plans that is as well-accepted as CHIP, which has been strongly embraced by parents and has high provider participation rates.

***Whether to continue the ACA's additional CHIP funding enhancement.*** The increased CHIP funding rate under the ACA is set to end in 2019. We don't know if Congress will continue to extend this generous enhancement, allow it to lapse, or end it. MACPAC has recommended a phase-out of the ACA enhancement over time.

***Whether to allow for state flexibility.*** CHIP allows for separate state programs to impose a 90-day waiting period before coverage begins. (No such waiting periods are permitted under Medicaid.) Fifteen states continue to maintain such periods, with 12 requiring the full 90 days.<sup>27</sup> Should the program continue to maintain such flexibility? The Trump administration proposes ending state flexibility to help families whose incomes exceed 250 percent of poverty but has offered no analysis of how such a drop in eligibility would affect working families who depend on CHIP to overcome the family glitch. Since the vast majority of CHIP children have family incomes well below the proposed cutoff, the administration's proposal would penalize a relatively small number of families in need.

As MACPAC has noted, Congress also could consider certain types of targeted pilot projects to enable states to better integrate CHIP and marketplace plans. Specifically, Congress might consider federal support for pilots that test how states might use CHIP funding to enhance the

pediatric actuarial value of marketplace plans offering both medical and oral health coverage. Pilots also could test using CHIP funds to help families who cannot afford employer family coverage afford marketplace child-only plans, as a way of managing the family glitch issue. Bringing more children into the marketplace might have the added benefit of improving the overall risk pool, thereby offsetting the cost of higher-value coverage of children, although this theory would require careful testing.

## CONCLUSION

At a time of policy and political uncertainty, CHIP represents an opportunity for Congress to extend, with bipartisan support, a highly popular insurance program that benefits millions of children. Ending CHIP funding and transitioning children to other sources of funding would be enormously complicated; for children with special health care needs, it would be particularly difficult because of differences in coverage rules and provider networks. Quick action on Congress's part is now a matter of great importance.

## NOTES

- <sup>1</sup> U.S. Senate Committee on Finance, “[Hatch, Wyden to Push to Extend CHIP Funding, Provide Additional Protections](#),” Press Release, Sept. 12, 2017.
- <sup>2</sup> Medicaid and CHIP Payment and Access Commission, [Report to Congress on Medicaid and CHIP](#) (MACPAC, March 2017).
- <sup>3</sup> D. W. Brown, A. E. Kowalski, and I. Z. Lurie, [Medicaid as an Investment in Children: What Is the Long-Term Impact on Tax Receipts?](#) (National Bureau of Economic Research, Jan. 2015); and A. Goodman-Bacon, [The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes](#) (National Bureau of Economic Research, Dec. 2016).
- <sup>4</sup> March of Dimes, [CHIP Coverage for Pregnant Women](#) (March of Dimes, Oct. 2013).
- <sup>5</sup> Centers for Medicare and Medicaid Services, [FFY 2015 Number of Children Ever-Enrolled in Medicaid or CHIP](#) (CMS, 2015).
- <sup>6</sup> Medicaid and CHIP Payment and Access Commission, [CHIP Financing](#) (MACPAC, n.d.).
- <sup>7</sup> Ibid.
- <sup>8</sup> [Medicare Access and CHIP Reauthorization Act of 2015, P.L. 114-10](#) (114th Cong., 1st Session).
- <sup>9</sup> Medicaid and CHIP Payment and Access Commission, [Report to Congress on Medicaid and CHIP](#) (MACPAC, March 2017).
- <sup>10</sup> C. Mann, [Center for Medicaid, CHIP and Survey Certification, State Medicaid Directors Letter 11-001](#) (CMS, Feb. 25, 2011).
- <sup>11</sup> Medicaid.gov, [CHIP Financing](#) (Centers for Medicare and Medicaid Services, n.d.).
- <sup>12</sup> Kaiser Family Foundation, [Enhanced Federal Medical Assistance Percentage \(FMAP\) for CHIP, FY 2018](#) (Henry J. Kaiser Family Foundation, n.d.); fully funded states are: Alabama, Arizona, Arkansas, District of Columbia, Georgia, Idaho, Kentucky, Mississippi, New Mexico, North Carolina, South Carolina, Utah, and West Virginia.
- <sup>13</sup> Ibid.
- <sup>14</sup> Georgetown University Health Policy Institute, Center for Children and Families, [Cost Sharing for Children and Families in Medicaid and CHIP](#) (Georgetown University, March 2009).
- <sup>15</sup> Medicaid and CHIP Payment and Access Commission, [Design Considerations for the Future of Children's Coverage: Focus on Affordability](#) (MACPAC, March 2016).
- <sup>16</sup> Medicaid and CHIP Payment and Access Commission, [Report to Congress on Medicaid and CHIP](#) (MACPAC, March 2017).
- <sup>17</sup> Medicaid and CHIP Payment and Access Commission, [Design Considerations for the Future of Children's Coverage: Focus on Affordability](#) (MACPAC, March 2016).
- <sup>18</sup> M. Hensley-Quinn, A. Cardwell, and T. Riley, [Using CHIP and the ACA to Better Serve Children Now and in the Future](#) (National Academy for State Health Policy, March 2016).
- <sup>19</sup> A. Peltz, A. J. Davidoff, C. P. Gross et al., “[Low-Income Children with Chronic Conditions Face Increased Costs if Shifted from CHIP to Marketplace Plans](#),” *Health Affairs*, April 2017 36(4):616–25.
- <sup>20</sup> T. Brooks, “[The Family Glitch](#),” Health Policy Briefs, *Health Affairs*, Nov. 10, 2014.
- <sup>21</sup> Henry J. Kaiser Family Foundation, [2016 Employer Health Benefits Survey](#) (Henry J. Kaiser Family Foundation, Sept. 14, 2016).
- <sup>22</sup> T. Brooks, “[The Family Glitch](#),” Health Policy Briefs, *Health Affairs*, Nov. 10, 2014.
- <sup>23</sup> Medicaid and CHIP Payment and Access Commission, [Federal CHIP Funding: When Will States Exhaust Allotments?](#) (MACPAC, July 2017).
- <sup>24</sup> Kaiser Family Foundation, [Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level, as of January 1, 2017](#) (Henry J. Kaiser Family Foundation, n.d.).
- <sup>25</sup> Medicaid and CHIP Payment and Access Commission, [Federal CHIP Funding: When will States Exhaust Allotments?](#) (MACPAC, July 2017).
- <sup>26</sup> A. Cardwell, [Planning Now: State Policy and Operational Considerations if Federal CHIP Funding Ends](#) (National Academy for State Health Policy, June 27, 2016).
- <sup>27</sup> Medicaid.gov, [Waiting Periods in CHIP](#) (Centers for Medicare and Medicaid Services, n.d.).

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