FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

The Children's Health Insurance Program: Why CHIP Is Still Critical for Kids

Background

Enacted in 1997 with bipartisan support from then-President Bill Clinton and then-Speaker of the U.S. House of Representatives Newt Gingrich, the Children's Health Insurance Program (CHIP) was devised to address a critical gap in health coverage for children in low-income working families. CHIP covers those who earn too much to qualify for Medicaid but not enough to be able to purchase health insurance coverage on their own. CHIP's supporters recognized the value of investing in children's coverage to make sure that all children have access to the medical care they need to grow up to become healthy and productive adults.

By every measure, CHIP has been enormously successful, reducing the number of low-income uninsured children by more than 50 percent, and spurring the enrollment of our nation's most vulnerable children into both CHIP and Medicaid. Because of these programs, today 93 percent of children in America have health insurance coverage, with approximately 58 percent getting their health coverage through Medicaid or CHIP.

Now that the Affordable Care Act (ACA) is in effect, health coverage stakeholders and policymakers alike have asked whether CHIP is still important in the post-ACA coverage world. The simple answer is yes. Because Medicaid and CHIP were already doing a good job covering kids, the ACA built on top of these programs, embedding CHIP into the reformed health system. However, CHIP is not an entitlement program – funding for CHIP is not permanent – so new funds will be needed after September 30, 2015 if the program is to continue into the future. One thing is clear, if CHIP funding is not renewed before it expires, millions of children who rely on CHIP would be left without affordable coverage or any coverage at all.

Here are some of the reasons CHIP remains an essential source of coverage for children in America and why Congress must act immediately to extend funding for CHIP beyond FY 2015:

CHIP works for children. In 1997, before states began implementing CHIP programs, 23 percent of children in America at or below 200 percent of the Federal Poverty Level (FPL) were uninsured. By 2010, the uninsured rate for children had fallen to 10 percent, with an 85 percent participation rate for children eligible for CHIP and Medicaid programs. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), in FY 2012 there were 8.4 million children enrolled in CHIP and 31.7 million children in Medicaid. Together these programs provide coverage for more than half of all children in the U.S. It is important to note recent gains in CHIP and Medicaid occurred at a time when private, employer-sponsored coverage was in decline.

CHIP is popular among the public. The American people overwhelmingly support CHIP's continuation. In a 2012 election eve poll by Lake Research Partners, support among voters for extending CHIP was at 83-13 percent, including 86-10 percent among women and 75-21 percent among Republicans. In a May 2014 poll conducted by American Viewpoint, voters favored extending funding for CHIP by a 74-14 percent margin, including 66-19 percent among Republicans.

Without renewed funding for CHIP beyond FY 2015 the rate of uninsured kids will skyrocket. Without an extension of funding beyond FY 2015, the CHIP program would be totally eliminated by mid-2016. The federal investment in CHIP would be cut from $21 billion in FY 2015 to $0 by FY 2016, causing serious coverage disruptions for the 10.2 million children estimated by the Congressional Budget Office (CBO) to be enrolled in CHIP in FY 2015. And millions of these children who lose CHIP would have no other coverage option to turn to. This dramatic

termination of CHIP would be an enormous step backwards for children, reversing a decades-long trend of significant coverage gains for kids.

States have almost two decades of experience with CHIP. CHIP is a federal-state partnership designed to give governors broad flexibility in administering their CHIP programs. The federal government provides enhanced matching payments to states to operate their CHIP programs; on average, the federal government picks up 70 percent of program costs. In order to participate in CHIP, states must meet minimum benefit requirements. CHIP's unique structure has helped states manage the costs of uncompensated care while reducing the numbers of uninsured kids and improving health outcomes. CHIP has been a winner for states and children alike.

CHIP has a higher actuarial value than QHPs, making CHIP's out-of-pocket costs significantly lower. An actuarial value study of 35 states conducted by the Wakely Consulting Group in July 2014 found that CHIP plans have significantly lower average cost sharing than the ACA's qualified health plans (QHPs). The average annual cost sharing for a child in CHIP is estimated at $66 for households with incomes of 160% FPL and $97 for those at 210% FPL. In contrast, the average cost sharing for a child in a QHP is estimated at $446 annually for households with incomes of 160% FPL and $926 for those at 210% FPL. In every state reviewed by Wakely children in CHIP could see up to a ten-fold increase in the cost-sharing they pay if they are transitioned to a QHP. By every measure, a family's out-of-pocket costs in CHIP are significantly lower than in the Marketplace. If CHIP is not funded beyond FY 2015 and issues around affordability of Marketplace coverage are not remedied, the lack of affordable options for families will cause a significant decline in children's coverage.

Without CHIP it is estimated that the "family glitch" could cause nearly two million children could become uninsured. The U.S. Government Accountability Office (GAO) estimates that approximately 1.9 million kids would lose access to affordable coverage if CHIP funds run out because of the so-called "family glitch." The family glitch stems from an "affordability test" in the ACA, which bases coverage affordability for a family on the cost of employee-only coverage and not on how much it actually costs for a family to buy coverage. Specifically, if an employee's offer of self-only coverage is less than 9.5 percent of family income that offer is deemed "affordable" for the entire family even if the cost of family coverage, which is typically three times as expensive as individual coverage, takes up much more than 9.5 percent of family income. Families that do not meet the "affordability test" are not eligible for ACA subsidies. The most likely scenario for employees who have an "affordable" offer of self-only coverage is that the employee will take coverage for themselves but would not be able to afford the more expensive coverage for their family. This would leave children without affordable employer-sponsored coverage and locked out of subsidized Marketplace coverage. As long as CHIP funding is extended, a large portion of the children who are likely to fall into the "family glitch" will be eligible for CHIP and have CHIP as a backstop. However, if CHIP funding is not extended by Congress, almost two million currently-insured children could lose coverage altogether.

CHIP plans provide better cost-sharing and lower premiums. Under CHIP, states have broad flexibility to design their programs and set enrollment fees, premiums, deductibles, coinsurance, and copayments for children and pregnant women enrolled in CHIP. CHIP premiums often are determined on a sliding scale and cost-sharing is capped at 5 percent of total income. The majority of states actually have adopted coverage that is more generous than the benchmark option and cost-sharing limits in practice fall well below the 5 percent cap. For example, Texas caps cost-sharing expenses at 1.25 percent of income for families at or below 150 percent FPL. Even though more than half of states charge premiums in CHIP, the costs are usually nominal and typically do not apply to those with the lowest incomes. According to Kaiser State Health Facts, in January 2013, 33 states charged premiums for CHIP with the average maximum monthly premium at $42.

CHIP benefits are stronger and more comprehensive. With its pediatric-focus, CHIP goes above and beyond many private insurance plans in addressing the unique needs of children. In states that operate CHIP through their Medicaid program, children are guaranteed access to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) services. States with separate CHIP programs must cover well-baby and well-child care; immunizations; inpatient and outpatient hospital services; physicians' surgical and medical services; and laboratory; x-ray; dental; and emergency services. In almost every state, CHIP services are provided through private sector managed care insurance plans. According to the Wakely study, CHIP covers more child-specific services with fewer limits than QHPs. While CHIP and QHPs provide similar coverage for routine care, CHIP does a better job covering services like pediatric dental, vision, hearing, autism services and habilitation.

CHIP assures a pediatric-appropriate network of providers. States have almost two decades of experience ensuring that CHIP plans offer provider networks that are pediatric-focused, including access to pediatricians, pediatric specialists, children's hospitals, community health centers, and school-based health providers – all of which have expertise in meeting the unique health care needs of children. While the QHPs in the Marketplace must meet important criteria to ensure access to high quality care, they are simply not designed with the needs of children in mind like CHIP is.

Premature termination of CHIP will move millions of children into QHPs before comparable coverage is available to meet their needs. Moving kids into the ACA's QHPs would not only be a major disruption for children, families would have to pay more for insurance for their children (even when taking tax credits into account) and children would have access to a much less robust set of benefits and fewer pediatric providers. If CHIP expires, CBO estimates that 40 percent of kids in CHIP would move into QHPs where they would face increased cost-sharing and reduced benefits, 30 percent would get coverage through the private insurance market, and 30 percent would become uninsured – this means that 100 percent of children currently covered in CHIP would be worse off. While there will be opportunities to improve policy around benefits and affordability issues in 2016, it is clear that if CHIP funding is not extended millions of children would experience a significant setback in terms of their coverage. CHIP must continue at least until it is clear that Marketplace coverage is comparable to what children get through CHIP and Medicaid.

No other insurance is available for low-income families which protects children like CHIP does. Recognizing the significant gap in benefits and cost-sharing between current coverage for children under CHIP and Medicaid and coverage offered through the Marketplace, Congress included language in the ACA to prevent the premature transition of children from CHIP and Medicaid to the Marketplace. Specifically, the ACA requires the HHS secretary to certify those QHPs that are comparable to CHIP to prevent children from moving into QHPs unless the coverage is comparable. These certifications are due April 1, 2015 but it is clear from preliminary comparisons between CHIP plans and QHPs that currently there are no QHPs available that are comparable to CHIP in terms of cost-sharing and benefits.

Marketplace plans are more costly than CHIP plans to the federal government. A 2009 CBO cost estimate of the Senate amendment to the ACA that extended CHIP funding through FY 2015 (CHIP funding would have expired in 2013) showed that CHIP is less costly than coverage provided through the Marketplace. Therefore, if CHIP funding is not extended and children are moved to coverage in the Marketplace the cost to the federal government would be greater than if children continued to be covered in CHIP. It does not make sense for children to move into the QHPs until it is clear that they will not lose ground in terms of affordability and benefits, especially if Marketplace coverage means a greater cost to the federal government. In addition, we note that informal CBO scoring estimates prepared for MACPAC in 2014 indicate the cost of a straight CHIP funding extension ranges from $0-5 billion in actual savings up to $5-10 billion, depending on the length of the extension and whether the extension takes into account some ACA interaction. Given this estimate, it is clear that a low-cost or no-cost CHIP extension would be sound investment in the health and well-being of our nation's children.

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CHIP is good for kids, good for families, good for states, and good for taxpayers. CHIP is a model program that has reduced the numbers of uninsured children to record lows, even during the economic crisis that began in 2008. CHIP has a long history of bipartisan support from lawmakers on both sides of the aisle who decided that providing health coverage for our children is a critical investment for America and its future.

If funding for CHIP is not extended, important gains in children's coverage would be lost. While the ACA holds great promise for the millions of Americans who have lacked an affordable coverage option, especially uninsured adults, it will take time and experience to know how the ACA's new coverage options, eligibility rules, enrollment systems, policies and procedures, benefits, plans and provider networks are working to meet the unique health and developmental needs of children. During this transition time, it would be a mistake to tamper with the programs that have been so successful in covering children. Children must continue to have access to stable coverage through proven programs like CHIP. Children must not be left worse off.

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