FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

The Basics of the Children's Health Insurance Program
What Every Staffer Needs to Know about CHIP

What is CHIP?

The Children's Health Insurance Program (CHIP) was enacted by a bipartisan group of lawmakers as part of the Balanced Budget Act of 1997 (P.L. 105-33) to provide funding to states to reduce the numbers of uninsured children. CHIP focuses on low-income children, especially those in working families who don't have access to job-based coverage, who earn too much to qualify for Medicaid but not enough to afford private insurance. Since the creation of CHIP, the uninsured rate for children has declined from almost 14% to a record low of 7% in 2012. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), in FY 2012 there were 8.4 million children enrolled in CHIP.

In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) (P.L. 111-3) reauthorized CHIP and provided $32.8 billion to fund the program for an additional five years. In 2010, the Affordable Care Act (ACA) (P.L. 111-148) extended CHIP's authorization through 2019 with funding through September 30, 2015. Congress must take action to extend CHIP if the program is to continue beyond this funding deadline.

How does CHIP financing work between the federal government and the states?

Unlike Medicaid, CHIP was originally funded as a 10-year capped block grant to states rather than as an individual entitlement program. Under CHIP, each state is given a certain amount of money per year, determined by a formula that was established by Congress. A state receives federal matching funds up to its annual allotment and is able to use this money over a two-year period. After the two-year period, unspent funds are redistributed to states that spent their entire allotments. If these states are unable to spend the redistributed funds within a certain period of time, the funds are returned to the United States Treasury.

To give states incentives to cover this targeted population of near-poor low-income children, the federal government provides states with an enhanced matching rate in comparison to Medicaid. The matching rate, called the Federal Medical Assistance Percentage (FMAP), for CHIP ranges from 65%-81.5% of total program costs – significantly higher than the 50%-74% Medicaid FMAP. To qualify for federal matching funds, states must submit, and the Centers for Medicare and Medicaid Services (CMS) must approve, state plans that describe the state program, and outline strategic objectives and performance goals. States must contribute to the federal funds they receive for covering eligible children in order to receive the enhanced federal matching rates for CHIP.

Total federal funding for CHIP was $9.2 billion in FY 2013.

How is CHIP implemented in the states?

CHIP offers states broad flexibility to design and implement their programs, provided they meet certain minimal standards. In setting up their CHIP programs, states have the option to expand coverage for children by building off of their Medicaid program, creating a new stand-alone CHIP program, or using a combination approach.

Currently, 7 states and D.C. operate CHIP through their Medicaid program (AL, DC, HI, MD, NH, NM, OH, and SC); 15 states operate a separate CHIP program (AL, AR, CO, CT, GA, KS, MS, OR, PA, TX, UT, VT, WA, WV, and WY); and 28 states use a combination approach (AR, CA, DE, FL, ID, IL, IN, IA, KY, LA, ME, MA, MI, MN, MO, MT, NE, NV, NJ, NY, NC, ND, OK, RI, SD, TN, VA, and WI).

States that operate their CHIP programs through their existing Medicaid program are required to provide Early and Periodic Screening, Diagnosis, and Treatment (EPDST) services for CHIP enrollees. EPSDT includes regular developmental screenings; vision, dental, and hearing assessments; and any medically-necessary health care services. A different and more limited federal standard applies to states that operate separate CHIP programs, though states must comply with minimum benefit requirements, including required coverage for well-baby and well-child care; immunizations; inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory; X-ray; dental; and emergency services.

Under CHIP, states have the flexibility to determine program administration and pricing guidelines, such as whether to charge enrollment fees, premiums, deductibles, coinsurance, and copayments and, if so, how much. The majority of states have adopted coverage that is more generous than the CHIP benchmark option and cost-sharing limits in practice fall well below CHIP's 5% cap on out of pocket cost limit for families.

States also have flexibility to establish their own eligibility criteria for CHIP, including qualifying income levels – up to 200% FPL or 50% above the Medicaid cut off. Upper limits for CHIP income eligibility ranges from 175% FPL to 405%. Almost 90% of kids who rely on CHIP are in families with incomes below 200% FPL ($39,580 for a family of three).

States also are permitted to adapt coverage based on a child's age. In many states, the youngest children have the broadest eligibility parameters, with income criteria becoming more restrictive as children age.

It is important to note that the principal way care is delivered to CHIP enrollees is through private managed care organizations, where the state contracts with health plans to provide services to eligible children.

How is CHIP different than other coverage?

Because it is designed specifically to meet the health and developmental needs of children, CHIP ensures that children have access to pediatric-specific benefits and provider networks. This means that CHIP often goes above and beyond most typical private insurance plans in addressing the unique needs of low-income children. CHIP also has a 5% cap on out of pocket limit on costs for families regardless of the number of children covered to ensure that coverage is affordable. While more than half of states charge premiums in CHIP (from $10-$33 per month), the costs are determined on a sliding scale and typically do not apply to those with the lowest incomes. States that operate CHIP plans through Medicaid follow Medicaid parameters and do not charge any cost-sharing. Almost all of the states that operate separate CHIP programs impose some form of cost-sharing. As of January 2013, 30 states required premiums and 27 states required copayments for children in CHIP. It is also important to note that CHIP allows year-round enrollment so eligible children can sign up at any point during the year.

What would happen if CHIP funding is not renewed by Congress?
Without an extension of funding beyond September 30, 2015, CHIP would be cut from $21.1 billion back to $0 by FY 2017. According to Congressional Budget Office (CBO) estimates, inaction by Congress would result in 12.7 million children enrolled in FY 2015 being at risk of losing their CHIP coverage in 2016. Millions of these children who lose CHIP would have no other coverage option to turn to. This decline in coverage would be an enormous step backwards for children.

How would CHIP kids fare if they were moved into ACA Marketplace coverage?
A recent actuarial value analysis by Wakely Consulting Group compared CHIP with ACA qualified health plans (QHPs) in 35 states and found that across every category, almost without exception, CHIP is more affordable for families with significantly lower cost-sharing and it provides more comprehensive benefits for children, especially children with special health care needs. In every state included in the Wakely study, if children were transitioned to QHPs, they would face significantly higher out of pocket costs with fewer covered child-specific benefits than what children currently get in CHIP.

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First Focus urges Congress to extend CHIP funding for four years to ensure that children's coverage remains strong. CHIP has a proven track record of providing high quality, cost-effective coverage for low-income children in working families. It is a model program that has reduced the numbers of uninsured children to record lows, even during the economic crisis that began in 2008. Funding for CHIP must continue so that coverage is not disrupted for the eight million kids who rely on CHIP for their health care. If Congress does not extend CHIP funding beyond the current September 30, 2015 expiration, important gains in health care coverage for children will be lost.

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August 2014