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State Children's Health Insurance Program: An Overview

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Summary

The State Children's Health Insurance Program (CHIP) is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but have no health insurance. CHIP is jointly financed by the federal government and states, and the states are responsible for administering CHIP. In FY2013, CHIP enrollment totaled 8.4 million individuals and CHIP expenditures totaled $13.2 billion.

Under the CHIP program, the federal government sets basic requirements for CHIP, but states have the flexibility to design their own version of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs. Currently, state upper-income eligibility limits for children range from a low of 175% of the federal poverty level (FPL) to a high of 405% of FPL. States may also extend CHIP coverage to pregnant women when certain conditions are met.

States may design their CHIP programs in three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. CHIP benefit coverage and cost-sharing rules depend on program design. CHIP Medicaid expansions must follow the federal Medicaid rules for benefits and cost sharing, which entitles CHIP enrollees to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage (effectively eliminating any state-defined limits on the amount, duration, and scope of any benefit listed in Medicaid statute) and exempts the majority of children from any cost sharing. For separate CHIP programs, the benefits are permitted to look more like private health insurance, and states may impose cost sharing, such as premiums or enrollment fees, with a maximum allowable amount that is tied to annual family income.

The federal government reimburses states for a portion of every dollar they spend on CHIP (including both CHIP Medicaid expansions and separate CHIP programs) up to state-specific annual limits called allotments. The federal share of FY2013 total expenditures was $9.2 billion and the state share was $4.0 billion.

CHIP was enacted in 1997. Since that time, Congress has extended federal CHIP funding. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) extended CHIP funding through FY2015. On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). MACRA repeals the sustainable growth rate (SGR) mechanism (which overrides the reduction in the Medicare physician fee schedule that was set to begin in April 2015) and extends funding for CHIP, among other provisions. Specifically, MACRA extends CHIP funding for two additional years (i.e., through FY2017) and maintains the current allotment formula, including a 23 percentage point increase to the enhanced federal medical assistance percentage (E-FMAP). MACRA also extends the "qualifying state" option, the Child Enrollment Contingency Fund, "Express Lane" eligibility, Outreach and Enrollment Grants, the Pediatric Quality Measures Program, and the Childhood Obesity Demonstration Project.

Although MACRA adds two additional years to federal funding for CHIP (through FY2017), states still need to adhere to the ACA's maintenance of effort (MOE) requirements that are in effect through FY2019. The MOE requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving federal Medicaid payments (notwithstanding the lack of corresponding federal CHIP appropriations for FY2018 and

FY2019). The MOE requirements impact CHIP Medicaid expansion programs and separate CHIP programs differently.

- *For CHIP Medicaid expansion programs*, when federal CHIP funding is exhausted, the CHIP-eligible children in these programs continue to be enrolled in Medicaid but financing switches from CHIP to Medicaid.
- *For separate CHIP programs*, states are provided a couple of exceptions to the MOE: (1) after September 1, 2015, states may enroll CHIP-eligible children into qualified health plans in the health insurance exchanges or (2) states may impose waiting lists or enrollment caps in order to limit CHIP expenditures. In addition, in the event that a state's CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen children for Medicaid eligibility, and enroll those who are Medicaid-eligible. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the Secretary of Health and Human Services (HHS) to be "at least comparable" to CHIP in terms of benefits and cost sharing.

Congress will face a decision with regard to the future of CHIP when federal CHIP funding expires after FY2017. If Congress does not act and federal CHIP funding ends, some CHIP enrollees likely would continue to have coverage through Medicaid as a result of the MOE requirements, but others would need to find another source of health insurance coverage (e.g., employer-sponsored health insurance or through the health insurance exchanges), and some likely would be uninsured. Congress's action or inaction on the CHIP program may affect health insurance options and resulting coverage for targeted low-income children that are eligible for the current CHIP program.

This report describes the basic elements of CHIP, focusing on how the program is designed, who is eligible, what services are covered, how enrollees share in the cost of care, and how the program is financed. The report ends with a brief discussion of the future of CHIP.

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Introduction

The State Children's Health Insurance Program (CHIP) is a federal-state program that provides health coverage to certain uninsured low-income children and pregnant women in families that have annual income above Medicaid eligibility levels, but have no health insurance. CHIP is jointly financed by the federal government and states, and the states are responsible for administering CHIP. Participation in CHIP is voluntary and all states, the District of Columbia, and the territories[1] participate. The federal government sets basic requirements for CHIP, but states have the flexibility to design their own version of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs.

CHIP was established as part of the Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) under a new Title XXI of the Social Security Act (SSA). Since that time, other federal laws have provided additional funding, and made significant changes to CHIP. Most notably, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3) increased appropriation levels for CHIP, and changed the formula for allotments (i.e., federal funds allocated to each state for the federal share of their CHIP expenditures), eligibility, and benefit requirements.[2] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) largely maintains the current CHIP structure through FY2019. The law also extends federal appropriations through FY2015 and requires states to maintain their Medicaid and CHIP child eligibility levels through FY2019 as a condition for receiving Medicaid federal matching funds.[3]

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). MACRA repeals the sustainable growth rate (SGR) mechanism (which overrides the reduction in the Medicare physician fee schedule that was set to begin in April 2015) and extends funding for CHIP, among other provisions. Specifically, MACRA extends CHIP funding for two additional years (i.e., through FY2017) and maintains the current allotment formula with the 23 percentage point increase to the enhanced federal medical assistance percentage (E-FMAP). MACRA also extends the "qualifying state" option, the Child Enrollment Contingency Fund, "Express Lane" eligibility, Outreach and Enrollment Grants, the Pediatric Quality Measures Program, and the Childhood Obesity Demonstration Project.[4]

Congress will face a decision with regard to the future of CHIP when federal CHIP funding expires after FY2017. The health insurance market is far different today than when CHIP was established. CHIP was designed to work in coordination with Medicaid to provide health coverage to low-income children.[5] In general, CHIP allows states to cover CHIP children with no health insurance in families with annual income above state Medicaid eligibility levels. Before

[1] The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

[2] For more information on the changes enacted under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3), see CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker, Elicia J. Herz, and Jane G. Gravelle.

[3] For more information about the changes enacted under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

[4] For more information on the provisions included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), see CRS Report R43962, *H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015*, coordinated by Jim Hahn and Kirstin B. Blom.

[5] For more information about Medicaid, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

CHIP was established, no federal program provided health coverage to children with family with annual incomes above Medicaid eligibility levels. The ACA further expanded the options for children in certain low-income families with incomes above CHIP eligibility levels by offering subsidized coverage for insurance purchased through health insurance exchanges. Congress's action or inaction on the CHIP program will affect the health insurance options available to targeted low-income children and their resulting health coverage.

This report describes the basic elements of CHIP, focusing on how the program is designed, who is eligible, what services are covered, how enrollees share in the cost of care, and how the program is financed. The report ends with a brief discussion of the future of CHIP.

Program Design

States may design their CHIP programs in three ways. They may cover eligible children under their Medicaid programs (i.e., CHIP Medicaid expansion),[6] create a separate CHIP program, or adopt a combination approach where the state operates a CHIP Medicaid expansion and one or more[7] separate CHIP programs concurrently.[8] In all cases, federal CHIP funding is available to pay for the costs for services provided to CHIP children.[9]

State choices for program design impact the coverage that enrollees receive. When states provide Medicaid coverage to CHIP children (i.e., CHIP Medicaid expansion), Medicaid rules (Title XIX of SSA) typically apply. When states provide coverage to CHIP children through separate CHIP programs, Title XXI of SSA rules typically apply. States that want to make changes to their programs beyond what both laws allow may seek approval from the Centers for Medicare and Medicaid Services (CMS) through the use of the Section 1115 waiver authority.[10]

Where relevant, differences between Title XIX and Title XXI of the SSA program rules regarding eligibility, benefit coverage, cost sharing, and financing are summarized in **Table 1**, and highlighted throughout the report.

[6] CHIP Medicaid expansions are not impacted by the ACA Medicaid expansion, under which states have the option to extend Medicaid coverage to most nonelderly, nonpregnant adults with income up to 133% of the federal poverty level (FPL). For more information about the ACA Medicaid expansion, see CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

[7] For example, the state of Florida's CHIP combination program includes a CHIP Medicaid expansion (i.e., Medicaid), and three separate CHIP programs (i.e., MediKids, Healthy Kids, and the Children's Medical Services Network).

[8] States decide on CHIP program design based on a variety of factors including willingness to expand an individual entitlement in the state, desire to offer a program that looks more like private health insurance coverage, etc.

[9] Administrative data permits the federal government and states to track CHIP program enrollment and spending. States use the Statistical Enrollment Data System (SEDS) to report aggregate CHIP and Medicaid child enrollment by program type (Medicaid, CHIP Medicaid expansion, and separate CHIP program), age, gender, and race/ethnicity, among other criteria. States report actual expenditures for Medicaid and CHIP Medicaid expansion programs on the Form CMS 64. Actual expenditures for separate CHIP programs are reported on the Form CMS-37.

[10] Under §1115 of the Social Security Act, the Secretary of Health and Human Services (HHS) may waive CHIP program requirements so states can test new program design options that further the goals of the CHIP program. CHIP 1115 waivers are time limited (up to five years) and must be allotment-neutral to the federal government. In other words, they cannot cost the federal government more than what is available under the state's annual allotment(s) applicable to the fiscal years for which the demonstration is operational. For a list of states with operational CHIP Section 1115 waiver programs, see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

Table 1. Key Differences in Federal Rules Regarding Selected Program Features Between CHIP Medicaid Expansion Programs and Separate CHIP Programs

Program Feature	CHIP Medicaid Expansion	Separate CHIP Program
Eligibility		
Who is eligible?	CHIP children are an optional eligibility group in Medicaid[a] and enrollees must be covered statewide.	Eligibility may vary based on geography, age, annual family income, residency, disability status, access to other health insurance, and duration of CHIP eligibility.
Entitlement Nature	Individual Entitlement.[b]	Not an individual entitlement.
Implications of the ACA maintenance of effort (MOE)[c]	When federal CHIP funding is exhausted, CHIP Medicaid expansion children must continue to be enrolled in Medicaid through September 30, 2019, but the financing switches from CHIP to Medicaid.	States with separate CHIP programs are provided with exceptions to the MOE. When federal CHIP funding is exhausted, states must establish procedures to screen and enroll eligible children in Medicaid. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the Secretary of Health and Human Services (HHS) to be "at least comparable" to CHIP in terms of benefits and cost sharing. If there are no certified plans, the MOE does not obligate states to provide coverage to these children.
Benefits	CHIP children are entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage, which effectively eliminates any state-defined limits on the amount, duration, and scope of any benefit listed in Medicaid statute.	States have more latitude in designing their benefit coverage.
Cost Sharing	Premiums and cost sharing are generally prohibited for CHIP children under age 18.	In general, premiums and cost-sharing may be imposed. Allowable amounts are dependent on annual family income and are subject to an out-of-pocket aggregate limit of 5% of annual family income.
Financing		
Entitlement Nature	Capped entitlement to states appropriated through FY2017.	Capped entitlement to states appropriated through FY2017.
Federal matching rate	Based on Enhanced-Federal Medical Assistance Percentage (E-FMAP) Rate.[d]	Based on Enhanced-Federal Medical Assistance Percentage (E-FMAP) Rate.[d]

Source: CRS analysis of Titles XIX and XXI of the Social Security Act.

Notes: CHIP gives states the flexibility to design their programs as an expansion of Medicaid or as a separate CHIP program, or to adopt a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. State choices for program design have implications for the

federal government, states and beneficiaries. Key differences across various program features are summarized in this table.

a. §1902(gg)(2) includes a Medicaid maintenance of effort (MOE) that requires continuous eligibility standards for Medicaid eligible children (including CHIP Medicaid expansion children) through September 30, 2019, as a condition of receiving federal Medicaid funding.

b. Under Medicaid, individuals who meet the program eligibility requirements and enroll in the program are guaranteed Medicaid coverage.

c. The ACA CHIP MOE (§2105(d)(3)) requires states to maintain income eligibility levels for CHIP through September 30, 2019, as a condition for receiving payments under Medicaid (notwithstanding the lack of corresponding federal appropriations for FY2018 and FY2019).

d. The federal government funds a larger share of CHIP expenditures than Medicaid. From FY2016 through FY2019, the E-FMAP is set to increase by 23 percentage points (not to exceed 100%) for most CHIP expenditures.

As of July 1, 2014, 8 states, the District of Columbia, and the territories had CHIP Medicaid expansions, 13 states had separate CHIP programs,[11] and 29 states used a combination approach.[12] (See **Appendix A**, **Table A-1** for 50-state information on CHIP program design.) FY2013 state-reported CHIP enrollment data (the most recent data available) show that the bulk of CHIP enrollees received coverage through separate CHIP programs (approximately 70%). The remainder received coverage through a CHIP Medicaid expansion.[13] This enrollment distribution has largely held true over the course of the program's history (see **Figure 1** below). However, this landscape likely will change due to modifications to CHIP eligibility rules enacted under the ACA. (For more information on these and other eligibility related requirements, see the "Eligibility" subsection.) Preliminary FY2014 CHIP enrollment data show about half of CHIP enrollees are in CHIP Medicaid expansion programs and about half are in separate CHIP programs.[14]

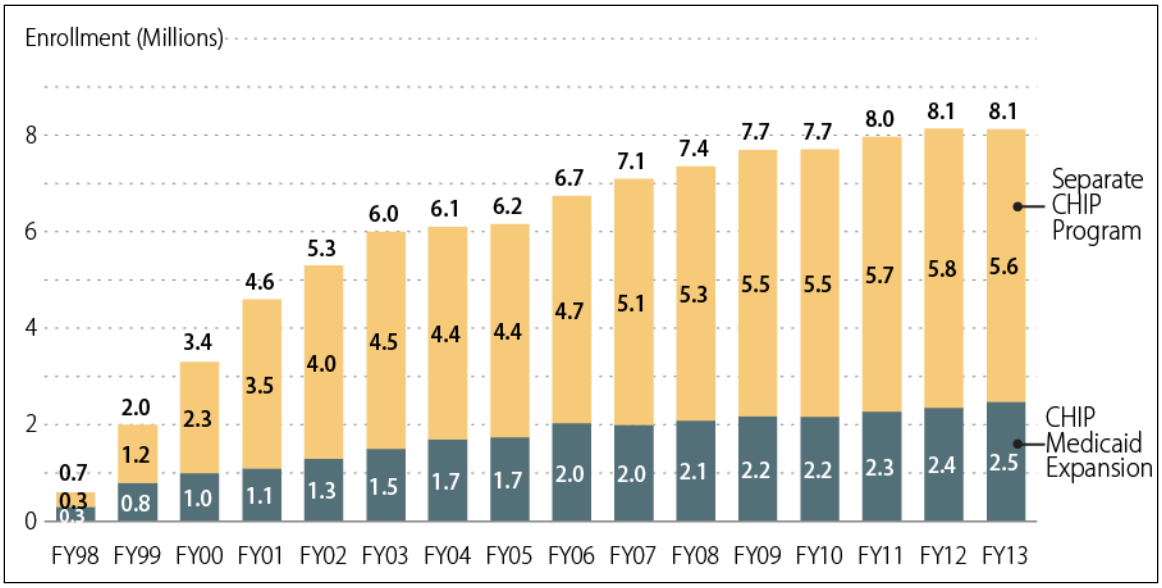
[11] As of July 1, 2014, 2 states (Washington and Connecticut) had separate CHIP programs with no Medicaid expansions. The remaining 11 states (Alabama, Arizona, Georgia, Kansas, Oregon, Mississippi, Pennsylvania, Texas, Utah, West Virginia, and Wyoming) are considered to have separate CHIP programs, but technically these programs are part of combination CHIP programs due to the ACA requirement to transition CHIP children aged 6 through 18 in families with annual income less than 133% of the federal poverty level (based on modified adjusted gross income, or MAGI) to Medicaid, beginning January 1, 2014.

[12] Centers for Medicare & Medicaid Services (CMS), *Children's Health Insurance Program Plan Activity,* as of July 1, 2014.

[13] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, March 2014.

[14] MACPAC, Report to the Congress on Medicaid and CHIP, March 2015.

Figure 1. Number of Children Ever Enrolled in CHIP by Program Type, FY1998-FY2013



Source: CHIP child enrollment counts by program type for fiscal years 1998 through 2011 are from MACPAC, *Overview of Medicaid and CHIP*, January 2013. FY2012 CHIP child enrollment counts by program type are from MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2013, and FY2013 enrollment counts are from MACPAC, *Report to the Congress on Medicaid* and CHIP, March 2014.

Notes: Data are reported by individual states and are representative of children ever enrolled in Medicaid and CHIP as of a specified date. States may subsequently revise their current and/or historical data.

Eligibility

This section describes CHIP eligibility rules. In general, CHIP extends coverage to certain low-income children and pregnant women without health insurance in families with annual family income too high to qualify them for Medicaid. Specifically, Title XXI of the SSA defines a targeted low-income child as one who is under age 19 with no health insurance,[15] and who would not have been eligible for Medicaid under the federal and state rules in effect when CHIP was first initiated in 1997.[16] (Hereinafter, targeted low-income children are referred to as CHIP children, CHIP-eligible or CHIP-enrolled, as applicable.) States have broad discretion in setting their income eligibility standards, and eligibility varies across states. Children under age 19 represent the vast majority of CHIP program enrollment.[17]

[15] States are permitted to require a period of uninsurance (i.e., waiting period) of up to 90 days before a child who is otherwise eligible is permitted to enroll in CHIP. See 78 *Federal Register* 42160, July 15, 2013.

[16] §2110(b) of the Social Security Act.

[17] In the early years of the CHIP program, states were permitted and encouraged to extend coverage to uninsured pregnant women, parents, and childless adults age 19 and over generally through the use of the Section 1115 waiver authority. However, Congress acted to largely limit this practice through a series of laws. The Deficit Reduction Act of 2005 (P.L. 109-171) prohibited the use of CHIP funds from coverage of non-pregnant childless adults in any *new* waivers approved after February 8, 2006. CHIPRA terminated CHIP coverage of nonpregnant childless adults by the end of calendar year 2009, prohibited *new* states from obtaining waivers to extend CHIP coverage to uninsured parents, and phased out coverage of parents altogether by FY2014. States can still extend coverage to adult pregnant women (regardless of their age) under CHIP through a variety of mechanisms. For more information on the predominate pathways states use to extend CHIP coverage to pregnant woman, see the Eligibility subsection entitled, "Pregnant

Children

CHIP Medicaid Expansions

States with a CHIP Medicaid expansion program must follow the eligibility rules of the Medicaid program (see **Table 1**). Because CHIP eligibility builds on top of Medicaid eligibility, the Medicaid child eligibility rules that were in effect when CHIP was established in 1997 represent the Medicaid eligibility ceiling for children.[18]

States with CHIP Medicaid expansion programs may cover CHIP children by expanding their Medicaid programs in the following ways: (1) by establishing a new optional eligibility group for such children as authorized in Title XXI of SSA, and/or (2) by liberalizing the financial rules for any of several existing Medicaid eligibility categories. Many states with CHIP Medicaid expansion programs chose the latter, opting to cover CHIP children under existing Medicaid eligibility pathways, especially Medicaid's poverty-related child groups, rather than by establishing the Title XXI of SSA optional coverage group. Such a strategy reduces the administrative burden of creating and implementing a new coverage group.[19] Regardless of the state's approach, CHIP children are an optional eligibility group in Medicaid and enrollees must be covered statewide.

Separate CHIP Programs

States are permitted to determine the eligibility criteria for the group of CHIP children who may enroll in separate CHIP programs (see **Table 1**).[20] Title XXI of the SSA allows states to use the following factors in determining eligibility: geography (e.g., sub-state areas or statewide), age (e.g., subgroups under 19), income, residency, disability status (so long as any standard relating to disability status does not restrict eligibility),[21] access to or coverage under other health insurance (to establish whether such access/coverage precludes CHIP eligibility),[22] and duration of CHIP eligibility (states must re-determine eligibility at least annually).[23]

Women and Unborn Children."

[18] Federal Medicaid statute establishes mandatory coverage floors (defined as a percentage of the federal poverty level) for its poverty-related pregnant women and children eligibility groups. States are permitted to extend coverage above these federal minimum thresholds which is why there is variability across states in terms of the income eligibility threshold at which CHIP begins.

[19] Because individuals can have other health insurance and still be covered by Medicaid, this approach also allows states to bring into Medicaid otherwise ineligible higher-income children regardless of their other health insurance status. For example, under this strategy, states can provide Medicaid benefits to additional children for whom existing health insurance is limited (sometimes referred to as under-insured). When states liberalize the financial rules for existing Medicaid eligibility groups, the federal share of the costs for services provided to the subset without other health insurance—the CHIP-eligible children—is paid for out of CHIP funds. The federal share of the costs for services delivered to the remaining children with other health insurance is paid for by Medicaid. CHIP Medicaid expansion children represent an optional eligibility pathway under Medicaid.

[20] §2102(b) of the Social Security Act.

[21] States are permitted to offer different benefit packages for children with special needs, as long as the eligibility criteria for that coverage comply with the Americans with Disabilities Act (ADA) requirements for non-discrimination. Source: *The Administration's Responses to Questions About the State Children's Health Insurance Program*, July 29, 1998, Fifth Set.

[22] A CHIP child must not be found eligible for Medicaid, or other group health coverage, for example. See 42 C.F.R. §457.310.

[23] States are permitted to continue coverage for CHIP-eligible children for a period of 12 months regardless of changes in family composition or income that may otherwise affect their eligibility status. While no explicit statutory authority

States can set the upper income level for CHIP children up to 200% of the federal poverty level (FPL), or 50 percentage points above the applicable pre-CHIP Medicaid income level. However, prior to January 1, 2014, states were able to use income disregards,[24] which effectively permitted states to expand eligibility to children under age 19 at whatever level they chose. Two states, New Jersey, and New York, plus one California county used this income-counting methodology[25] to expand their CHIP programs to 355% FPL, 405% FPL, and 416% FPL, respectively.[26] The income-disregard option was eliminated under the ACA.

CHIP Eligibility Changes Under the ACA

Beginning January 1, 2014, the ACA required the federal government and states to rely on modified adjusted gross income (MAGI)[27] income counting rules when determining eligibility for CHIP[28] as well as most of Medicaid's nonelderly populations[29] and subsidized exchange coverage. Under the MAGI rules, a state looks at each individual's MAGI, deducts 5% (which the law provides as a standard disregard), and compares that income to the new income standards set by each state. The transition to MAGI effectively limits CHIP upper income eligibility levels for states by eliminating a state's ability to use income disregards to extend coverage to children in families at higher income levels.[30] Also under the ACA, states are permitted to use CHIP federal

for 12 months of continuous coverage currently exists in CHIP statute, HHS reports that 33 states provided 12 months of continuous coverage to CHIP children in FY2012. Source: MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2013.

[24] Income disregards (including block of income disregards) and deductions effectively increase the amount of income a child's family can have and still be eligible for coverage, as they serve to eliminate from a family's countable income certain expenses, costs or amounts of income.

[25] Medicaid and CHIP financial eligibility requirements place limits on the maximum amount of income (and sometimes assets) individuals may possess to become eligible (often referred to as standards or thresholds). Additional guidelines specify how states should calculate these amounts (i.e., counting methodologies).

[26] Under CHIPRA, new states (in addition to California, New Jersey, and New York) were discouraged from expanding CHIP income eligibility through a policy that required a reduction in federal CHIP payments for coverage of children in families with income above 300% FPL. CHIPRA also included other provisions to provide financial incentives to states to find and enroll Medicaid eligible children at lower income levels through the use of CHIP Performance Bonus Payments. These payments were directed at states that adopted 5 out of 8 enrollment facilitation strategies and that successfully enrolled Medicaid-eligible children over target enrollment levels. These bonus payments expired at the end of FY2013.

[27] MAGI is defined as the Internal Revenue Code's (IRC's) adjusted gross income (AGI) plus certain foreign earned income and tax-exempt interest. AGI reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments, increased by tax-exempt interest and income earned by U.S. citizens or residents living abroad.

[28] §2102(b)(1)(B)(v) of the Social Security Act.

[29] Under the ACA, certain groups are exempt from income eligibility determinations for Medicaid based on MAGI. Prior law's income determination rules will continue to be used for determining eligibility for the following groups: (1) individuals who are eligible for Medicaid through another federal or state assistance program (e.g., foster care children and individuals receiving SSI), (2) the elderly, (3) certain disabled individuals who qualify for Medicaid on the basis of being blind or disabled without regard to whether the individual is eligible for SSI, (4) the medically needy, and (5) enrollees in a Medicare Savings Program (e.g., Qualified Medicare Beneficiaries for whom Medicaid pays Medicare premiums or coinsurance and deductibles). In addition, MAGI does not affect eligibility determinations through Express Lane enrollment (to determine whether a child has met Medicaid or CHIP eligibility requirements), for Medicare prescription drug low-income subsidies, or for determinations of eligibility for Medicaid long-term services and supports.

[30] Under the transition to MAGI, states were given a limited opportunity to expand CHIP eligibility above 200% of the FPL (not to exceed 300% FPL) using the old income counting rules by submitting a state plan amendment (SPA) before December 31, 2013.

matching funds to cover children who lose Medicaid eligibility as a result of the elimination of income disregards.[31]

As a part of a separate provision, the ACA required states to transition CHIP "stairstep" children aged 6 through 18 in families with annual income less than 133% FPL (based on MAGI) to Medicaid, beginning January 1, 2014.[32] According to a recent Medicaid budget survey, 21 states transitioned children from CHIP to Medicaid in 2014 as a result of this requirement.[33] Of the states impacted by this policy, another study estimates that on average 28% (or approximately 562,000 stairstep children) made this transition in January 2014.[34] The purpose of this transition was to ensure uniform child coverage under Medicaid up to 133% FPL (effectively 138% after adjustment for the 5% disregard) across all states.

The ACA also required states to maintain income eligibility levels for CHIP through September 30, 2019, as a condition for receiving payments under Medicaid (notwithstanding the lack of corresponding federal appropriations for FY2018 and FY2019).[35] This provision is often referred to as the ACA Maintenance of Effort (MOE) requirement. (Implications of the MOE requirement for the future of CHIP are discussed in more detail in the financing section below.)

Upper Income Eligibility Levels in CHIP

Statewide upper income eligibility thresholds for CHIP-funded child coverage vary substantially across states, ranging from a low of 175% FPL to a high of 405% FPL. **Appendix A**, **Table A-1** shows state-reported child upper income eligibility levels based on MAGI (adjusted for the 5% disregard), as of January 1, 2014.

To summarize, **Table A-1** shows:

[31]States must provide coverage through a separate CHIP program to children who lose Medicaid as a result of the elimination of income disregards permitted under §2101(f) of the ACA. Coverage for this population will be paid for out of the state's CHIP allotment at the CHIP enhanced match rate and will cease when the last child protected has been afforded 12 months of coverage (expected to be no later than April 1, 2016). While coverage of children protected by 2101(f) is mandated through a separate CHIP program, states may instead continue to provide coverage of these children in the state's Medicaid program. However, if a state chooses the option to maintain Medicaid eligibility for such children, funds through Title XIX of SSA and regular FMAP rates will apply. Sources: Centers for Medicare and Medicaid Services, Medicaid/CHIP Affordable Care Act Implementation: *Children's Health Insurance Program (CHIP) coverage for children who lose Medicaid eligibility due to the elimination of income disregards as a result of the conversion to MAGI. Section 2101(f) of the Affordable Care Act: Answers to Frequently Asked Questions*; April 25, 2013; and *CMS Answers to Frequently Asked Questions: Telephonic Applications, Medicaid and CHIP Eligibility Policy and 75/25 Federal Matching Rate,* August 9, 2013.

[32]Coverage for such children will continue to be paid for out of the state's CHIP annual allotment at the enhanced CHIP matching rate. CMS granted approval for Pennsylvania to delay the transition of CHIP children in families with income less than 133% FPL based on MAGI until FY2015.

[33] Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates and Robin Rudowitz and Laura Snyder, Kaiser Family Foundation, *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, October 2014.

[34] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Aligning Eligibility For Children: Moving the Stairstep Kids to Medicaid*, August 2013.

[35] Specifically, with the exception of waiting lists for enrolling children in CHIP or enrolling CHIP-eligible children in certified exchange plans when federal CHIP funding is no longer available, states cannot implement eligibility standards, methodologies, or procedures that are more restrictive than those in place on March 31, 2010. §2105(d)(3) of the Social Security Act.

- 18 states and the District of Columbia provide coverage above 301% FPL; of these, two states extend coverage above 400% FPL, including New York (405% FPL) and California (416% FPL[36] in one county);
- 9 states provide coverage between 251% FPL and 300% FPL;
- 20 states provide coverage between 201% FPL and 250% FPL; and
- 3 states extend coverage at levels less than 200% FPL, including Idaho (190% FPL), North Dakota (175% FPL), and Arizona (100%).[37]

Despite the fact that 27 states extend CHIP coverage to children in families with annual income greater than or equal to 251% FPL, CMS administrative data show that CHIP enrollment is concentrated among families with annual income at lower levels. FY2013 state-reported administrative data show that approximately 89% of CHIP child enrollees were in families with annual income at or below 200% FPL, and approximately 97% of child enrollees were in families with annual income at or below 250% FPL. (See **Table 2**.) Families with higher income levels are more likely to have access to employer-sponsored insurance coverage.[38] With the enactment of the ACA, families may also have access to subsidized coverage through the exchange. However, such coverage is not always affordable for low-income families. (For more information on the definition of affordability of employer-sponsored insurance coverage as it relates to a family's ability to qualify for subsidized exchange coverage, see the discussion of the "family glitch issue" in the subsection entitled "The Future of CHIP.")

Table 2. Number of Children Ever Enrolled in CHIP by Income Level, FY2013

Income Range (% FPL)	Ever Enrolled	Percentage
0-200	7,243,295	88.5%
201 - 250	724,785	8.9%
251 - 300	165,120	2.0%
301 & Higher	51,791	0.6%
Total	**8,184,991**	**100.0%**

[36] Most counties in California are in the state's CHIP Medicaid expansion program, which extends coverage up to 266% FPL. However, the state had a separate CHIP program that extended CHIP coverage up to 321% FPL in three counties, and up to 416% FPL in one county (Email correspondence with CMS from March 9, 2015 indicates that California's CHIP expansion to 416% FPL in one county was approved by CMS, but never implemented by the state). During FY2013, children in the state's separate CHIP program were transitioned to the state's CHIP Medicaid expansion program.

[37] Federal authority for Arizona's CHIP program to cover children in families with annual income above 100% FPL expired on January 31, 2014. As a result, children in families with income between 100-133% FPL transitioned to Medicaid effective January 1, 2014. Children in families with income over 133% FPL were encouraged to apply for coverage through the health insurance exchange where premium subsidies are available for eligible households. While the state's CHIP program to extend coverage for CHIP-eligible children in families with annual income less than 100% FPL remains in effect, enrollment of new children has been frozen since January 1, 2010. As a result of the enrollment freeze, enrollment in Arizona's CHIP program has dropped from 45.8 thousand in January 2010 to approximately 2.3 thousand in February 2014. Source: Tricia Brooks, Martha Heberlein, and Joseph Fu, Georgetown University Health Policy Institute, Center for Children and Families, *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs*, May 2014.

[38] For more information on the access to private insurance coverage among low-income children in CHIP, see Mathematica Policy Research, *CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings*, August 1, 2014.

Source: Centers for Medicare and Medicaid Services, Child Health Insurance Program Budget Report, based on Form 21E and 64.21E Combined, as of April 2014.

FPL: Federal poverty level.

Figure B-1 through **Figure B-4** of **Appendix B** show the 50-state upper income eligibility levels for children and pregnant women in Medicaid, CHIP, and subsidized exchange coverage, as of January 1, 2014. Variability exists across states in the income eligibility ranges (i.e., income eligibility floors and ceilings) associated with each of the programs. The federal Medicaid statute establishes mandatory coverage floors (defined as a percentage of the federal poverty level) for its poverty-related pregnant women and children eligibility pathways. However, states are permitted to extend Medicaid coverage above these federal minimum levels; this is why there is variability across states in terms of the income eligibility levels at which CHIP begins. For example, the state of Alabama extends Medicaid eligibility to infants in families with annual income less than or equal to 141% FPL, while the state of Iowa extends Medicaid eligibility to infants in families with annual income less than or equal to 240% FPL. In another example, CHIP coverage for children extends to a higher income eligibility threshold than subsidized health insurance exchange coverage in one county in California and in the state of New York (i.e., 416% FPL[39] and 405% FPL, respectively).

It is important to note, however, that not all children with family income at the specified levels are eligible for each of the programs due to program rules that differ for each of these programs. For instance, CHIP is only available to uninsured children, subsidized exchange coverage is not available to individuals with access to minimum essential coverage,[40] and insurance status is not considered when determining Medicaid eligibility.

These figures show both the range of CHIP income eligibility relative to the other programs, and how the programs are envisioned to work together in extending coverage to low-income children and families. CHIP in some states covers a relatively small segment of the income eligibility continuum while CHIP in other states covers a larger segment of the continuum. This is particularly true for infants and pregnant woman. States have used the optional Medicaid eligibility pathways to set higher Medicaid income eligibility levels for infants and pregnant women relative to older children (see **Figure B-1** through **Figure B-4** of **Appendix B**). As a result, CHIP has been used to provide health coverage to older uninsured children to a greater extent.

In general, the Medicaid program is a much larger program than CHIP. Child enrollment in Medicaid, for example, was 38.7 million as compared to 8.1 million in CHIP in FY2013.[41] The figures in **Appendix B**, however, are *not* weighted to reflect program enrollment by state. For example, it is possible that a state with a large uninsured child population but a CHIP program with a relatively narrow income eligibility range may result in a much larger number of CHIP

[39] Email correspondence with CMS from March 9, 2015, indicates that California's CHIP expansion to 416% FPL in one county was approved by CMS but never implemented by the state.

[40] The definition of minimum essential coverage is broad. It includes Medicare Part A, Medicaid, the State Children's Health Insurance Program (CHIP), Tricare, the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.

[41] The enrollment figures reported here represent "ever enrolled" counts which measure the number of children covered by CHIP or Medicaid for any period of time during a given year. These enrollment counts differ significantly from estimates based on "point-in-time" or average annual enrollment measures. Source: MACPAC *Report to Congress on Medicaid and CHIP*, March 2014, Table 4.

program enrollees than a state with a relatively small uninsured child population and a CHIP program with a much broader income eligibility range.[42]

Pregnant Women and Unborn Children

Nineteen states provide coverage to pregnant women under CHIP. The three main ways that states may extend CHIP coverage to pregnant women (regardless of their age) are through (1) the state plan option for pregnant women; (2) the Section 1115 waiver authority; and/or (3) the unborn child pathway.[43] The latter is the predominant pathway used by states for this purpose.

As of January 2014, four states (Colorado, New Jersey, Oregon, and Rhode Island) extended coverage to pregnant women under Section 1115 waiver authority or the CHIP pregnant women state plan option.[44] Under CHIPRA, states are permitted to cover pregnant women through a state plan amendment[45] when certain conditions are met (e.g., the Medicaid income standard for pregnant women must be at least 185% FPL but in no case lower than the percentage level in effect on July 1, 2008; no preexisting conditions or waiting periods may be imposed; and CHIP cost-sharing protections apply). The period of coverage associated with the state plan option includes pregnancy through the postpartum period (roughly through 60 days postpartum), and benefits include all services available to CHIP children in the state as well as prenatal, delivery, and postpartum care. Infants born to such pregnant women are deemed eligible for Medicaid or CHIP, as appropriate, and are covered up to age one year.

As of January 2014, 15 states provide CHIP coverage to pregnant women ages 19 and older by extending coverage to unborn children as permitted through federal regulation. Coverage available to such women may be limited to prenatal and delivery services, but is still used in 15 states because it permits the extension of CHIP coverage to a pregnant woman regardless of her immigration status.[46] See **Figure B-4** for state-specific CHIP eligibility levels for unborn children, pregnant women and deemed newborns, as of January 1, 2014.

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[42] For example, it is possible that a state with a large uninsured child population but a CHIP program with a relatively narrow income eligibility range may result in a much larger number of CHIP program enrollees than a state with a relatively small uninsured child population and a CHIP program with a much broader income eligibility range. For example, in Texas, the CHIP eligibility range appears small by comparison with the CHIP eligibility range in Louisiana (See **Figure B-1**, **Figure B-2**, and **Figure B-3**). However, in FY2013, CMS administrative data show CHIP child enrollment totaling approximately 1 million in Texas as compared with approximately 150,000 in Louisiana (See **Table A-1**).

[43] Prior to the enactment of CHIPRA, legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years in the United States. With the enactment of CHIPRA, states are permitted to provide Medicaid and/or CHIP coverage to children under the age of 21 and pregnant women who are (1) lawfully residing in the United States and (2) otherwise eligible for such coverage. The CHIP state plan option is available to states that (1) elect this state plan option under Medicaid and (2) in the case of lawfully residing pregnant women, elect the CHIP state plan option to provide assistance for pregnant women. As of March 24, 2014, 28 states and the District of Columbia extend Medicaid and/or CHIP coverage to lawfully residing children, and 23 states and the District of Columbia extend Medicaid and/or CHIP coverage to lawfully residing pregnant women. See CMS, *Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women*, at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/lawfully-residing.html.

[44] MACPAC, *Report to Congress on Medicaid and CHIP, March 2014*, Table 9, pp 80-82.

[45] States that wish to make changes to their Medicaid or CHIP state plans must submit a state plan amendment (SPA) to CMS for approval.

[46] MACPAC, *Report to Congress on Medicaid and CHIP, March 2014*, Table 9, pp 80-82.

Benefits

CHIP Medicaid Expansions

As is the case with eligibility, CHIP benefit coverage depends on program design (see **Table 1**). States that use CHIP Medicaid expansion programs must provide CHIP-eligible children with the full range of mandatory Medicaid benefits, as well as all optional services that the state chooses to cover as specified in their state Medicaid plans.[47] As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, states may enroll state-specified groups, including children in CHIP Medicaid expansions, in Alternative Benefit Plans (ABPs).[48] When certain conditions are met, states may also provide premium assistance for health insurance offered through private insurance arrangements for Medicaid children (including CHIP children) and their parents.

For CHIP children, benefits available through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program *must* be provided, whether through traditional state plan coverage or otherwise. The EPSDT program covers health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services. States are required to provide all federally allowed treatment to correct problems identified through screenings. EPSDT sets Medicaid benefit coverage for children (including CHIP children) apart from other sources of health insurance in that it permits coverage of all services listed in Medicaid statute (regardless of whether a given benefit is covered in the state plan) and it effectively eliminates any state-defined limits on the amount, duration, and scope of this benefit.

Separate CHIP Programs

States that offer separate CHIP programs have more latitude in designing their programs.[49] Such states are allowed to determine which services to cover, and may place limits on the services that they offer.

Separate CHIP program rules permit states to elect any of three benefit options:[50]

1. *Benchmark benefit package:* includes one of the following three base benchmark plans:
    - the standard Blue Cross/Blue Shield preferred provider option offered under the Federal Employees Health Benefits Program (FEHBP),
    - the health coverage that is offered and generally available to state employees in the state involved, and/or

[47] Medicaid's mandatory and optional benefits are identified in federal statute and regulations, and include a wide range of preventive, primary, and acute medical services, as well as long-term services and supports (LTSS). States define the specific features of each covered benefit within broad federal guidelines.

[48] The ACA requires Medicaid ABP coverage to include the same essential health benefits (EHBs) provided in exchange plans. For more information about Medicaid benefit coverage, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[49] §2103 of the Social Security Act.

[50] §2103 of the Social Security Act.

- health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

2. *Benchmark-equivalent coverage*: defined as a package of benefits that has the same actuarial value[51] as one of the base benchmark benefit packages listed above. A state choosing to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category," including inpatient and outpatient hospital and physicians' surgical and medical services, lab, x-ray, and well-baby and well-child care, including age-appropriate immunizations. Benchmark-equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, vision services, and hearing services. States are encouraged to cover other categories of service not listed above; and/or
3. *Secretary-approved coverage*: defined as any other health benefits plan that the Secretary of Health and Human Services (HHS) determines will provide appropriate coverage to the targeted population of uninsured children.[52]

Regardless of the choice of program design, all states must cover emergency services, well baby and well child care including age-appropriate immunizations, and dental services.[53] If offered, mental health services must meet federal mental health parity requirements.[54] As with Medicaid, abortions cannot be covered, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life. Finally, when certain conditions are met (e.g., CHIP minimum benefits and CHIP cost-sharing protections), states can also offer premium assistance to pay a beneficiary's share of costs for group (employer-based) health insurance for CHIP children and their parents.[55] According to a recent study of CHIP benefit coverage, 11 states offered premium assistance programs with CHIP federal matching funds in 2013.[56]

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[51] Actuarial value is a summary measure of a plan's generosity, expressed as a percentage of medical expenses estimated to be paid by the issuer for a standard population and set of allowed charges.

[52] Three states, Florida, New York and Pennsylvania were permitted to use the state's health coverage plan that was in place at the time of CHIP's enactment. These benefit packages are often referred to as "grandfathered plans."

[53] Dental services were added as a required benefit for separate CHIP programs under CHIPRA, and include services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. (Dental benefits have always been required for CHIP Medicaid expansion children via EPSDT.)

[54] In the case of a state separate CHIP program that provides medical and surgical benefits as well as mental health or substance abuse disorder benefits, the predominant financial requirements (e.g., deductibles, copayments) and treatment limitations (e.g., number of visits, days of coverage) applicable to such mental health or substance abuse disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations applicable to covered medical and surgical benefits. In addition, there can be no separate cost-sharing requirements or treatment limitations applicable only to mental health or substance abuse disorder benefits. State CHIP Medicaid expansions that include coverage of EPSDT services (as defined in Medicaid statute) are deemed to satisfy these mental health parity requirements. For more information, see CMS Letter to Medicaid Directors and State Health Officials, RE: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans, SHO # 13-001, ACA #24, January 16, 2013, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[55] Historically, it has proved prohibitive for many employer plans and states to meet all of these requirements. To circumvent these restrictions, most states operating CHIP or Medicaid premium assistance programs do so under Section 1115 waiver authority.

[56] Anita Cardwell, et al., National Academy for State Health Policy and Georgetown University Health Policy Institute, Center for Children and Families; *Benefits and Cost Sharing in Separate CHIP Programs*, May 2014.

Data from this study that looked at benefit coverage in 42 separate CHIP programs (in 38 states) indicate that in 2013:

- 25 states chose Secretary-approved coverage;
- 9 states offered benchmark-equivalent coverage;
- 3 states offered coverage available in the largest HMO in the state;
- 3 states offered existing state-based coverage;
- 1 state offered FEHBP-equivalent coverage; and
- 1 state offered state employee coverage.

According to this study, benefits offered under separate CHIP programs ranged from benefit coverage modeled after the state's Medicaid plan[57] to more limited benefit coverage available through the commercial market. The study also found that coverage for basic medical services (e.g., physician, hospital, laboratory, and radiological services) were largely covered without "significant" limitations. States did impose limitations on other types of services (e.g., physical, occupational and speech therapy; orthodontia; hearing aids; and corrective lenses). Finally, only a few services were not covered at all (e.g., care coordination for children with special needs, non-emergency medical transportation).[58]

In FY2013, managed care was the predominant delivery system under CHIP. Administrative data show that approximately 84% of separate CHIP enrollees received coverage under some form of managed care, while the remaining 16% received coverage under a fee-for-service arrangement.[59]

Cost Sharing

As with eligibility and benefits, cost-sharing rules depend on a state's CHIP program design (see **Table 1**). Cost sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan, and may include premiums (usually on a monthly basis), enrollment fees, deductibles, copayments, coinsurance, and other similar charges.

CHIP Medicaid Expansions

CHIP Medicaid expansion children must follow the cost-sharing rules of the Medicaid program.[60] Under these rules, the majority of such children are exempt from cost sharing.[61] However, CHIP Medicaid expansion children may still be subject to service-related cost sharing for non-emergency care provided in an emergency room and for non-preferred prescription drugs.

[57] For example, of the 25 states with Secretary approved coverage, 14 states modeled their coverage after the state's Medicaid program, and 11 of these 14 states offered EPSDT as a part of the state's separate CHIP program benefits.

[58] Anita Cardwell, et al., National Academy for State Health Policy and Georgetown University Health Policy Institute, Center for Children and Families; *Benefits and Cost Sharing in Separate CHIP Programs*, May 2014.

[59] MACPAC, *Report to Congress on Medicaid and CHIP*, March 2014.

[60] §1916 of the Social Security Act.

[61] For more information about Medicaid cost sharing rules, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell. An exception to this rule applies for CHIP-eligible pregnant women and infants with annual income greater than 150% FPL. Such individuals may be charged premiums or enrollment fees in "nominal" amounts. Nominal amounts are set in regulation and range from $1 to $20 per month, depending on monthly family income and family size. States are permitted to charge premiums/enrollment fees that exceed these nominal amounts for certain groups, including CHIP-eligible pregnant women.

In addition, CHIP Medicaid expansion children enrolled in certain Medicaid waiver programs may be subject to cost sharing.

Separate CHIP Programs

If a state implements a separate CHIP program, premiums or enrollment fees may be imposed for program participation, but the maximum allowable amount is dependent on annual family income.[62] Preventive services and pregnancy-related assistance are exempt from cost sharing for all CHIP families regardless of income, and special rules also apply to Indian children.

- *Families with annual income under 150% FPL*: Premiums may not exceed the amounts set forth in federal Medicaid regulations. Additionally, these families may be charged service-related cost sharing, but such cost sharing is limited to (1) nominal amounts defined in federal Medicaid regulations for the subgroup with annual income below 100% FPL, and (2) slightly higher amounts defined in CHIP regulations for families with annual income between 100%-150% FPL.
- *Families with annual income above 150% FPL*: Cost sharing (program participation fees and service-related cost sharing) may be imposed in any amount, provided that cost sharing for higher-income children is not less than cost sharing for lower-income children, subject to the out-of-pocket aggregate limit of 5% of annual family income on all types of cost sharing combined. In addition, states are required to inform families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.[63]

The above-referenced study on 42 separate CHIP programs (in 38 states)[64] indicates that only 2 states (Oregon and South Dakota) did not impose any form of cost sharing in 2013. Thirty separate CHIP programs imposed premiums or program participation fees. According to the study, the median monthly premium per child ranged from $10 for families with annual income less than 150% FPL (in 9 programs) to $33 for families with annual income greater than 301% FPL (in 14 programs). Twenty-eight separate CHIP programs imposed service-related cost sharing in amounts that ranged from a low of $0.50 for an office visit or prescription drug in Georgia, to $200.00 for an inpatient hospital visit in Alabama. While Title XXI sets the annual aggregate limit for all cost sharing charges at 5% of a family's annual income, the study found that 20 programs had cost-sharing limits lower than the 5% cap.[65]

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[62] §2103(e) of the Social Security Act.

[63] CHIP cost-sharing limits do not take into account cumulative out-of-pocket costs that may be required for "split families" for whom, in addition to CHIP, one or more family member(s) may be eligible for subsidized exchange coverage, and/or enrolled in Medicaid and are simultaneously subject to the cost sharing requirements associated with each program. This issue is often referred to as "premium stacking."

[64] Anita Cardwell, Joanne Jee, and Catherine Hess, National Academy for State Health Policy and Joe Touschner, Martha Heberlein, and Joan Alker, Georgetown University Center for Children and Families; *Benefits and Cost Sharing in Separate CHIP Programs*, May 2014.

[65] For more recent information on state changes to cost sharing requirements under Medicaid and CHIP, see Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates and Robin Rudowitz and Laura Snyder, Kaiser Family Foundation, *Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, October 2014. This information has not been summarized here.

CHIP Financing and Expenditures

The federal government and the states jointly finance CHIP.[66] The federal government reimburses states for a portion of every dollar they spend on CHIP (for both CHIP Medicaid expansions and separate CHIP programs) up to state-specific limits called allotments. In FY2013, CHIP expenditures totaled $13.2 billion. The federal share totaled $9.2 billion and the state share was $4.0 billion.[67]

E-FMAP

The federal government pays about 70% of CHIP expenditures, and the federal government's share of CHIP expenditures (including both services and administration) is determined by the enhanced federal medical assistance percentage (E-FMAP) rate. The E-FMAP rate is derived each year by the HHS Secretary using a set formula, and it varies by state.[68] By statute, the E-FMAP (or federal matching rate) can range from 65% to 85%, and in FY2015, the E-FMAP ranges from 65% (13 states) to 82% (Mississippi). See **Table A-2** for states' E-FMAP rates for FY2015.

The ACA included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019. This would increase the statutory range of the E-FMAP rate to 88% through 100%. With this 23 percentage point increase, the federal share of CHIP will be significantly higher, which means states are expected to spend through their limited federal CHIP funding (i.e., state CHIP allotments) faster when the enhanced rate takes effect.

Available Federal Funding

There are three aspects of CHIP federal funding: the national total appropriation amounts, state allotments, and expenditures.

- The federal appropriation is the total amount of federal funds appropriated for CHIP in a fiscal year.
- The state allotments are the federal funds allocated to each state for the federal share of their CHIP expenditures.
- Federal CHIP expenditures are the actual amount of federal funds spent on CHIP.

As **Figure 2** shows, in FY2013, the federal appropriation for CHIP was $17.4 billion, the CHIP allotments to states totaled $8.9 billion, and CHIP federal expenditures totaled $9.2 billion. In FY2013, the federal appropriation was significantly higher than the state CHIP allotments because the formula establishing the state CHIP allotment amounts does not factor in the federal appropriation (explained in more detail below). Also, the FY2013 CHIP federal expenditures were slightly higher than the state CHIP allotments. States have two years to spend their

[66] For more information about federal CHIP financing, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by Alison Mitchell.

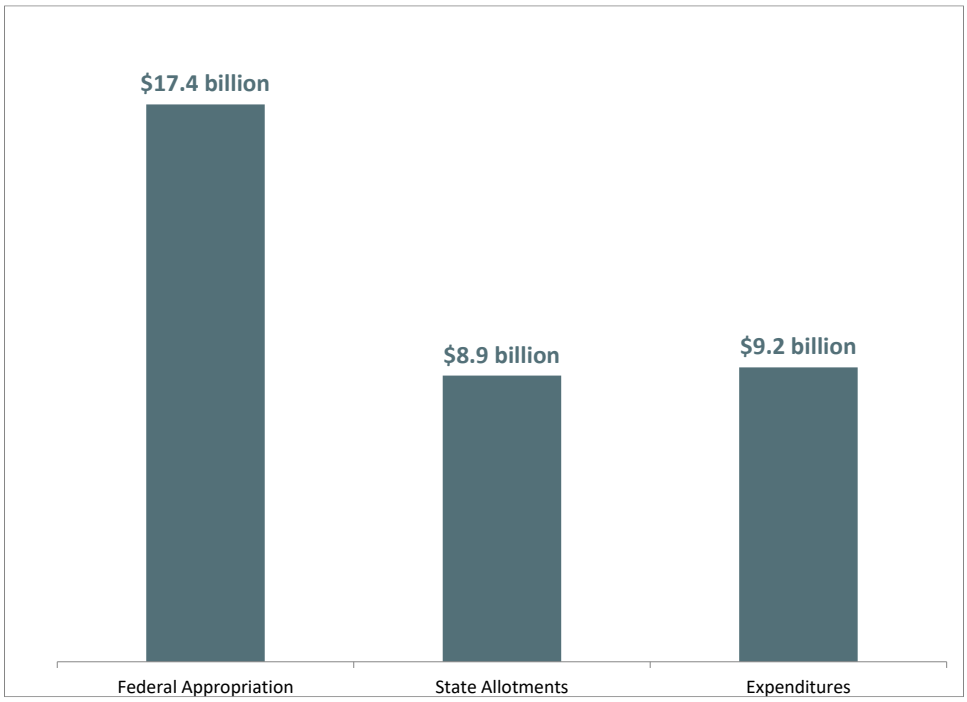
[67] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Form CMS-64 data.

[68] The E-FMAP is calculated by reducing the state share under the FMAP rate (which is the federal matching rate for most Medicaid expenditures) by 30%. For more information about the FMAP rate and how it is calculated, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

allotment funds, and the FY2013 federal CHIP expenditures consist of federal funding from each of the FY2012 and FY2013 state CHIP allotments.

Figure 2. Federal Funding for CHIP

(FY2013)



Source: §2104(a)(16) of the Social Security Act; Department of Health and Human Services' Centers for Medicare & Medicaid Services, "Children's Health Insurance Program (CHIP); Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2013," 78 *Federal Register* 45208, July 26, 2013; Centers for Medicare & Medicaid Services' Office of the Actuary.

Federal Appropriation

The federal appropriation for CHIP is provided in Section 2104(a) of the Social Security Act. This amount is the overall annual ceiling on federal CHIP spending to the states, the District of Columbia, and the territories. CHIPRA increased the annual appropriation amounts substantially beginning in FY2009 and provided appropriations through FY2013. Then, the ACA provided annual appropriation amounts for an additional two years (i.e., through FY2015). MACRA extended the federal appropriations through FY2017, and FY2017 is the last year for which a CHIP appropriation amount is provided. For FY2016 and FY2017, the annual appropriation amounts are $19.3 billion and $20.4 billion,[69] respectively.

If the federal appropriation is not large enough to cover state allotments in any given year, the state allotments would be reduced proportionally. Since FY2009, the federal appropriation amount has been more than sufficient to cover the state allotments.[70]

[69] The FY2017 appropriation is the combination of two half-year appropriations of $2.85 billion from §2104(a) of the Social Security Act plus a one-time appropriation in the amount of $14.70 billion from §301(b)(3) of MACRA.

[70] From FY2002 through FY2008, the federal appropriation amounts were insufficient to cover the full cost of some states' CHIP programs. For FY2002 through FY2005, the amount of redistribution funds from other states was enough

State Allotments

State allotments are the federal funds allocated to each state for the federal share of their CHIP expenditures. CHIPRA established a new allocation of federal CHIP funds among the states based largely on states' actual use of and projected need for CHIP funds.[71] There are two formulas for determining state allotments: an even-year formula and an odd-year formula.[72]

In even years, such as FY2014, state CHIP allotments are each state's previous year *allotment* plus any Child Enrollment Contingency Fund (described below) payments from the previous year adjusted for health care inflation and child population growth in the state. For even years, the formula for CHIP allotments can be adjusted to reflect CHIP eligibility or benefit expansions and increase the allotment amount.

In odd years, state CHIP allotments are each state's previous year *spending* (including federal CHIP payments from the state CHIP allotment, Child Enrollment Contingency Fund payments, and redistribution funds) adjusted using the same growth factor as the even year formula (i.e., health care inflation and child population growth in the state). Since the odd-year formula is based on states' actual use of CHIP funds, it is called the "re-basing year" because a state's CHIP allotment can either increase or decrease depending on each state's CHIP expenditures in the previous year.

State CHIP allotment funds are available to states for two years. As noted above, this explains why federal expenditures are higher than the state allotments in **Figure 2** because the FY2013 federal CHIP expenditures include federal funding from states' FY2012 and FY2013 allotments. In addition, the aggregate state CHIP allotment amounts have been lower than the annual federal appropriation amount because the allotment formulas do not factor in the annual federal appropriation amount, which means the aggregate state allotment amounts could add up to an amount greater than or less than the federal appropriation amount. Since FY2009, the aggregate state CHIP allotment amounts have been significantly lower than the federal appropriation amount.

The allotment is available to states to cover the federal share of both CHIP benefit and administrative expenditures.[73] However, no more than 10% of the federal CHIP funds that a state draws down from its CHIP allotment can be spent on non-benefit expenditures including expenditures for administration, translation services, and outreach efforts.

Shortfall Funding

If a state's CHIP allotment for the current year, in addition to any allotment funds carried over from the prior year, is insufficient to cover the projected CHIP expenditures for the current year, a few different shortfall funding sources are available. These include Child Enrollment Contingency Fund payments, redistribution funds, and Medicaid funds. Since FY2009, only one state and one territory have received shortfall funding.

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to make up the difference, but for FY2006 through FY2008, additional CHIP appropriations were provided to cover the cost of the federal share of CHIP expenditures.

[71] Prior to CHIPRA, funds were allocated to states using a statutory formula based on each state's share of the nation's uninsured children and uninsured low-income children.

[72] §2104(m) of the Social Security Act.

[73] CHIP Medicaid expansion states may use federal Medicaid funds to pay for CHIP administrative expenditures.

Child Enrollment Contingency Fund Payments

Child Enrollment Contingency Fund payments are available to states with both a funding shortfall[74] and CHIP enrollment (for children) that exceeds a target level.[75] As a result, not all states with funding shortfalls are eligible for Child Enrollment Contingency Fund payments.

The contingency fund formula is based on a state's growth in CHIP enrollment and per capita spending. This means that a state may receive a payment from the fund that does not equal its actual shortfall.

Iowa is the only state that has received Child Enrollment Contingency Fund payments since FY2009 when the funds were first available.[76]

Redistribution Funds

After two years, any unused state CHIP allotment funds are redistributed to shortfall states.[77] For redistribution funds, a shortfall state is defined as a state that will not have enough money to meet projected costs in the current year after counting (1) the current year's state allotment, (2) unspent funds from the prior year's state allotment, and (3) available Child Enrollment Contingency Fund payments.

If redistributed funds are insufficient to meet the needs of all shortfall states, each shortfall state receives a proportionate share of the available funds based on the shortfall in each state.

Since FY2009, only Puerto Rico has received redistribution funds.[78]

Medicaid Funds

For states that designed their CHIP program as a CHIP Medicaid expansion or a combination program, if the state is still facing a shortfall after receiving Child Enrollment Contingency Fund payments and redistribution funds, they may receive federal Medicaid matching funds to fund the shortfall in the Medicaid expansion portion of its CHIP program. When Medicaid funds are used to fund CHIP, the state receives the lower regular FMAP rate (i.e., federal Medicaid matching rate) rather than the higher E-FMAP rate provided for other CHIP expenditures. However, while federal CHIP funding is capped, federal Medicaid funding is open-ended, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

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[74] For Child Enrollment Contingency Fund payments, a state has a funding shortfall if a state's current year CHIP allotment plus any unused CHIP allotment funds from the previous year are insufficient to cover the federal share of the state's CHIP program. The definition of shortfall funding for Child Enrollment Contingency Fund payments does not factor in redistribution funds.

[75] §2104(n) of the Social Security Act.

[76] In FY2011, Iowa had a projected shortfall in federal CHIP funding of $3.8 million. Since Iowa's CHIP enrollment exceeded the target level, Iowa was eligible for a Child Enrollment Contingency Fund payment and received $28.9 million. (MACPAC, MAC Basics: Federal CHIP Financing, September 2011; Communication with the Centers for Medicare & Medicaid Services in May 2014.)

[77] §2104(f) of the Social Security Act.

[78] In FY2012 and FY2013, Puerto Rico received $23.7 million and $0.8 million, respectively, in CHIP redistribution funds. (Communication with the Centers for Medicare & Medicaid Services in May 2014.)

Federal CHIP Funds Finance Some Medicaid Expenditures

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, certain states significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997.[79] These states are allowed to use their CHIP allotment funds to fund the difference between the Medicaid and CHIP matching rates (i.e., FMAP and E-FMAP rates respectively) to finance the cost for children in Medicaid above 133% FPL.[80]

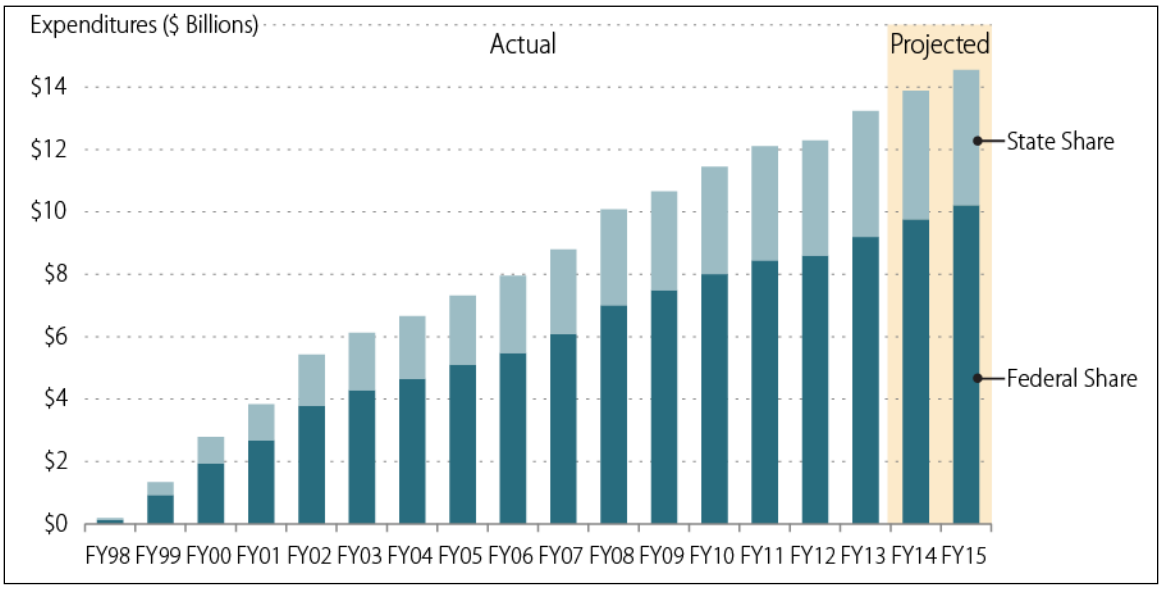
In addition, states may use CHIP allotment funds and receive the more generous E-FMAP rates for (1) expenditures for children aged 6 to 18 in families with annual income up to 133% FPL that had been enrolled in separate CHIP programs who were transitioned to Medicaid on January 1, 2014, as part of the ACA[81] and (2) children that moved from CHIP to Medicaid due to the application of the 5% income disregard.[82]

CHIP Expenditures

Figure 3 shows actual CHIP expenditures (including both the federal and state share) for FY1998 through FY2013 and projected CHIP expenditures for FY2014 and FY2015. See **Table A-2** for CHIP expenditures by state for FY2013.

Figure 3. CHIP Expenditures, Actual and Projected

($ in billions)



Source: Centers for Medicare & Medicaid Services, Medicaid Financial Management Reports from various years.

[79] The following 11 states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.

[80] §2015(g)(4) of the Social Security Act.

[81] The E-FMAP rate is *not* available for children aged 6 to 18 who have access to private health insurance.

[82] Centers for Medicare & Medicaid Services, *Medicaid and CHIP FAQs: Funding for New Adult Group, Coverage of Former Foster Care Children and CHIP Financing*, December 2013.

The Future of CHIP

With federal funding for CHIP set to end after FY2017, Congress will need to decide whether to continue the CHIP program. In considering the future of CHIP, it is helpful to recall why the program was created in 1997: to provide affordable health coverage at a time when there were few other insurance coverage options for low-income children outside of Medicaid. The health insurance market is far different today, with the enactment of the ACA. Now, if CHIP funding is exhausted, current CHIP-eligible children potentially could be eligible for Medicaid, for subsidized coverage in the health insurance exchanges, or for their parent's employer-sponsored insurance coverage, but not all CHIP-eligible children would be eligible for these programs and some could end up being uninsured without the availability of CHIP.

Some argue that it is important to continue providing child-specific safety net coverage because each of the low-income subsidy programs (e.g., CHIP, Medicaid, and subsidized exchange coverage) plays a unique role in the health care delivery system.[83] For instance, greater cost-sharing protections exist for the programs that target families at the lower ends of the income-eligibility spectrum.[84] In addition, some are wary of providing coverage for children in the health insurance exchanges because the exchanges are new and there is little evidence about how coverage in the exchanges compares to CHIP coverage.[85]

With FY2017 being the final year for which federal CHIP funding is provided in statute, Congress's action or inaction will determine the future of CHIP and of health coverage for CHIP children. In considering the future of CHIP, Congress has a number of policy options, including extending federal CHIP funding and continuing the program or letting CHIP funding expire.

Extending Federal CHIP Funding

If Congress decides to extend federal CHIP funding, there are a number of policy options to consider, including the length of the funding extension and whether to make programmatic changes. Funding could be extended for just a few years (e.g., two or four years) or indefinitely, and the extension could maintain, phase down, or eliminate the 23 percentage point increase to the E-FMAP rate. In addition, the extension could make programmatic changes to eligibility, benefit coverage, or other aspects of the program.

If Federal CHIP Funding Expires

Although FY2017 is the last year for which federal CHIP funding is provided under current law, states are expected to have federal CHIP spending in FY2018 because states will have access to

[83] See Tricia Brooks, Martha Heberlein, and Joseph Fu, Georgetown University Health Policy Institute, Center for Children and Families, *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs,* May 2014; Anita Cardwell, et al., National Academy for State Health Policy and Georgetown University Health Policy Institute, Center for Children and Families; *Benefits and Cost Sharing in Separate CHIP Programs*, May 2014; and MACPAC, *Report to Congress on Medicaid and CHIP*, March 2015.

[84] Under CHIP and Medicaid, out-of-pocket spending (including both premiums and cost sharing) is exempt for many children and pregnant women, and when premiums and cost sharing apply, they cannot exceed 5% of the family's income. For the health insurance exchanges, in 2014, the out-of-pocket spending cannot exceed $6,350 for self-only coverage and $12,700 for coverage other than self-only.

[85] MACPAC, *Report to Congress on Medicaid and CHIP*, June 2014; Tricia Brooks, *MACPAC Considers Future of CHIP*, Georgetown University Health Policy Institute's Center for Children and Families, Say Ahhh! Blog, November 22, 2013.

unspent funds from their FY2017 allotments and to unspent FY2016 allotments redistributed to shortfall states (if any).

If Congress takes no action and CHIP funding runs out, states need to adhere to the MOE requirements that are in effect through FY2019.[86] The MOE requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving Medicaid payments (notwithstanding the lack of corresponding federal CHIP appropriations for FY2016 through FY2019).[87] The MOE requirements impact CHIP Medicaid expansion programs and separate CHIP programs differently.[88]

- *For CHIP Medicaid expansion programs*, when federal CHIP funding is exhausted, the CHIP-eligible children in these programs continue to be enrolled in Medicaid but financing switches from CHIP to Medicaid.[89] This switch would cause the federal share of expenditures to decrease from the E-FMAP rate to the regular FMAP rate, which means the cost of covering these children would increase for states.
- *For separate CHIP programs*, states are provided a couple of exceptions to the MOE: (1) after September 1, 2015, states may enroll CHIP-eligible children into qualified health plans in the health insurance exchanges[90] or (2) states may impose waiting lists or enrollment caps in order to limit CHIP expenditures. In addition, in the event that a state's CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen children for Medicaid eligibility, and enroll those who are Medicaid-eligible. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the HHS Secretary.

If no additional federal CHIP appropriations are provided, CHIP children in CHIP Medicaid expansion programs (roughly half of CHIP enrollees)[91] would continue to receive coverage through the Medicaid program through FY2019,[92] but coverage of CHIP children in separate CHIP programs (roughly half of CHIP enrollees)[93] who are not eligible for Medicaid is reliant on whether the children have access to qualified health plans that are certified by the HHS Secretary. Under the MOE, if states do not receive a CHIP allotment, after establishing procedures to enroll

[86] For more information about the ACA MOE requirement and CHIP, see CRS Report R43909, *CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief*, by Alison Mitchell and Evelyne P. Baumrucker.

[87] §2105(d)(3) of the Social Security Act.

[88] The HHS Secretary has not issued guidance regarding the impact of the MOE requirements if federal CHIP funding were to expire.

[89] Both the CHIP MOE under §2105(d)(3) of the Social Security Act and the Medicaid MOE under §1902(gg)(2) of the Social Security Act concurrently apply to the CHIP Medicaid expansion programs.

[90] This option is only available to states if the HHS Secretary certifies that the coverage in the health insurance exchanges is "at least comparable" to CHIP in terms of benefits and cost sharing. However, some children will not be eligible for subsidized exchange coverage due to the "family glitch."

[91] Preliminary FY2014 CHIP enrollment data show about half of CHIP enrollees are in CHIP Medicaid expansion programs and about half are in separate CHIP programs. (MACPAC, *Report to Congress on Medicaid and CHIP*, March 2015.)

[92] CHIP children covered under CHIP Medicaid expansion programs are an optional eligibility group under Medicaid. However, because the Medicaid MOE for children extends through FY2019, states are not permitted to roll back Medicaid eligibility for these children without the loss of all Medicaid federal matching funds.

[93] See footnote 91.

all Medicaid eligible children in Medicaid, states are only required to establish procedures to enroll children in qualified health plans certified by the HHS Secretary. If there are no certified plans, the MOE does not obligate states to provide coverage to these children. If there are certified plans, not all CHIP children will be eligible for subsidized exchange coverage due to the "family glitch,"[94] among other reasons.

Comparing the Coverage Options

Under each of the policy options outlined above under "If Federal CHIP Funding Expires," at least some CHIP enrollees would continue to have coverage through CHIP, Medicaid, the health insurance exchanges, or the employer-sponsored insurance market. However, not all CHIP children would continue to have coverage under each of the policy options.

If the federal CHIP program funding is permitted to expire before (or after) the MOE requirements that are in effect through FY2019, the coverage landscape is expected to change for some portion of the current CHIP enrollees. Although the specific results of coverage projections may look different in future years, it is possible to learn from the information they offer. In anticipation of the FY2015 congressional debate regarding the future of CHIP, the Urban Institute conducted an analysis for MACPAC to generate estimates of the sources of coverage for children in separate CHIP programs who were projected to lose CHIP coverage if federal CHIP funding was exhausted in FY2016.[95] The analysis found that if federal CHIP funding was not renewed and states exhausted their FY2015 federal allotments, approximately two-thirds of current separate CHIP-enrolled children would move to their parent's employer-sponsored insurance coverage (i.e., approximately 1.2 million, or 32.6%) or to subsidized exchange coverage (i.e., approximately 1.4 million, or 36.5%). The remaining one-third of such children (approximately 1.1 million, or 30.9%) would become uninsured in FY2016.[96]

For the children who would receive coverage under alternative coverage options, there would be variation among the coverage in terms of benefits, cost sharing, and financing. With respect to benefit coverage, a recent MACPAC analysis[97] of benefits available under separate CHIP programs, Medicaid, exchange plans, and employer-sponsored insurance found the following:

- Covered benefits vary within each source—between states for Medicaid and CHIP and among plans for exchange plans and employer-sponsored insurance.
- Most CHIP, Medicaid, exchange plans, and employer-sponsored insurance plans cover major medical benefits, such as inpatient and outpatient care, physician services, and prescription drugs.
- Although Medicaid and CHIP cover pediatric dental services, dental benefits are offered as a separate, stand-alone insurance product in most exchanges.

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[94] Subsidized coverage in the health insurance exchanges is not available to individuals with access to affordable health insurance. The "family glitch" results from the definition of *affordable coverage*. Under the ACA, employer-sponsored insurance is considered affordable if employees' premiums contributions for self-only coverage (not family coverage) comprise less than 9.5% of family income. However, there is no limit on the employees' share of premiums for family coverage. Due to the "family glitch," some of the current CHIP enrollees would *not* be eligible for subsidized coverage in the health insurance exchanges based on their parent's access to *affordable* employer-sponsored insurance. For more information about subsidized coverage in the health insurance exchanges, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2014*, by Bernadette Fernandez.

[95] For more information on this analysis, see MACPAC, *Report to Congress on Medicaid and CHIP*, March 2015.

[96] MACPAC, *Report to Congress on Medicaid and CHIP*, March 2015.

[97] Ibid.

- CHIP and Medicaid cover many services that are not always available in exchange plans. For example, all CHIP and Medicaid programs cover audiology exams, and 95% of CHIP programs cover hearing aids. However, only 37% of exchange plan essential health benefit benchmarks cover audiology exams, and only 54% cover hearing aids.
- For other benefits, such as applied behavioral analysis therapy and autism services, coverage varies.

MACPAC's analysis of affordability of exchange coverage for children currently covered by CHIP found that the out-of-pocket costs for CHIP generally are higher than under Medicaid but significantly lower than in the exchanges or under employer-sponsored insurance.[98] When comparing out-of-pocket costs across coverage types, MACPAC found that for families with employer-sponsored insurance, "projected premiums could average $3,751 per year or 9.1% of family income. Families with subsidized coverage on the exchange might see smaller or no premium costs, but they would face much higher cost-sharing amounts (in the form of deductibles and service-level cost-sharing) than under CHIP."[99]

With respect to financing, under CHIP and Medicaid the coverage for CHIP enrollees would continue to be jointly financed by the federal government and states, but moving CHIP children into Medicaid would increase the state share of expenditures for these children. Under the option to move CHIP children into the health insurance exchanges, the federal government alone would fund the subsidized coverage, without any contribution from states. For employer-sponsored insurance coverage, premiums are largely shared by the employer and its employees.

[98] Ibid.

[99] Ibid.

Appendix A. CHIP Data by State

Table A-1 provides FY2013 data by state regarding CHIP program type, income eligibility levels, and enrollment. **Table A-2** shows FY2015 CHIP E-FMAP rates and FY2013 CHIP expenditures (including both federal and state expenditures).

Table A-1. CHIP Program Type, Income Eligibility and Enrollment Information, by State

		FY2013 Program Enrollment[a]			
State and Program Type as of July 1, 2014	Reported Upper Income Level for Children (% FPL)	CHIP Medicaid expansion	Separate CHIP program	Total children enrolled	Pregnant women
Alabama (S*)	317	–	113,490	113,490	–
Alaska (M)	208	16,566	–	16,566	–
Arizona (S*)	205	–	80,238	80,238	–
Arkansas (C)	216	106,413	2,888	109,301	–
California (C)	416	510,424	1,092,859	1,603,283	–
Colorado (C)	265	–	126,169	126,169	4,873
Connecticut (S)	323	–	18,999	18,999	–
Delaware (C)	217	79	13,101	13,180	–
District of Columbia (M)	324	9,057	–	9,057	–
Florida (C)	215	1,072	472,343	473,415	–
Georgia (S*)	252	–	269,906	269,906	–
Hawaii (M)	313	30,979	–	30,979	–
Idaho (C)	190	19,881	25,518	45,399	–
Illinois (C)	318	162,134	174,963	337,097	–
Indiana (C)	255	105,655	46,760	152,415	–
Iowa (C)	380	22,159	61,511	83,670	–
Kansas (S*)	250	–	76,164	76,164	–
Kentucky (C)	218	51,391	32,678	84,069	–
Louisiana (C)	255	140,876	9,092	149,968	–
Maine (C)	213	19,071	10,641	29,712	–
Maryland (M)	322	135,454	–	135,454	–
Massachusetts (C)	305	69,113	79,606	148,719	–
Michigan (C)	217	19,229	70,441	89,670	–
Minnesota (C)	288	91	3,744	3,835	–
Mississippi (S*)	214	–	93,120	93,120	–
Missouri (C)	305	55,017	37,901	92,918	–
Montana (C)	266	–	31,496	31,496	–

State and Program Type as of July 1, 2014	Reported Upper Income Level for Children (% FPL)	FY2013 Program Enrollment[a]			
		CHIP Medicaid expansion	Separate CHIP program	Total children enrolled	Pregnant women
Nebraska (C)	218	53,790	1,993	55,783	–
Nevada (C)	205	–	20,277	20,277	–
New Hampshire (M)	323	19,450	–	19,450	–
New Jersey (C)	355	90,512	116,249	206,761	291
New Mexico (M)	305	9,368	–	9,368	–
New York (C)	405	–	490,114	490,114	–
North Carolina (C)	216	81,656	201,916	283,572	–
North Dakota (C)	175	2,331	8,950	11,281	–
Ohio (M)	211	286,817	–	286,817	–
Oklahoma (C)	210	140,373	7,538	147,911	–
Oregon (S*)	305	–	128,061	128,061	–
Pennsylvania (S*)	319	–	267,073	267,073	–
Rhode Island (C)	266	24,508	2,069	26,577	349
South Carolina (M)	213	76,191	–	76,191	–
South Dakota (C)	209	13,357	4,275	17,632	–
Tennessee (C)	255	22,906	83,567	106,473	–
Texas (S*)	206	–	1,034,613	1,034,613	–
Utah (S*)	205	–	63,001	63,001	–
Vermont (M)	318	–	7,393	7,393	–
Virginia (C)	205	92,690	104,221	196,911	4,636
Washington (S)	305	–	44,073	44,073	–
West Virginia (S*)	305	–	37,065	37,065	–
Wisconsin (C)	306	92,723	74,569	167,292	–
Wyoming (S*)	205	–	8,815	8,815	–
Total		**2,481,333**	**5,649,460**	**8,130,793**	**10,149**

Source: MACPAC, *Report to Congress on Medicaid and CHIP,* March 2014, MACSTATS, Tables 3 and 9, and Centers for Medicare & Medicaid Services (CMS), *Children's Health Insurance Program Plan Activity,* as of July 1, 2014, for information regarding program type.

Notes: State CHIP program type are identified next to the state name with (M) for CHIP Medicaid expansion, (S) for Separate CHIP program, and (C) for a combination of the two approaches. States with (S*) are considered a separate CHIP program by the state, but the CHIP program is technically a combination due to the transition of those aged 6 to 18 up to 133% FPL to Medicaid as required by the ACA.

Enrollment estimates based on ever enrolled data. Enrollment counts reported in the pregnant woman column reflect enrollment estimates associated with states that extend coverage to such individuals through the CHIPRA pregnancy coverage state plan option or through the Section 1115 waiver authority.

State reported Upper Income Level for Children (% FPL) represents the highest income eligibility threshold available in the state either through a CHIP Medicaid expansion, a separate state CHIP, or in combination

states—the highest threshold between the two programs. These thresholds have been certified by the Secretary of Health and Human Services (HHS) as representing the conversion from the state's old income counting rules to the new income counting rules based on MAGI and include the 5% disregard (which the law provides as a standard disregard).

FPL: Federal poverty level.

a. In FY2013, there were 219,473 adults enrolled in the CHIP program. CHIPRA terminated CHIP coverage of nonpregnant childless adults by the end of calendar year 2009, prohibited new states from obtaining waivers to extend CHIP coverage to uninsured parents, and phased out coverage of parents altogether by FY2014. Source: MACPAC, *Report to Congress on Medicaid and CHIP*, March 2014, MACSTATS, Table 3.

Table A-2. E-FMAP Rates and CHIP Expenditures by State

State	FY2015 E-FMAP	FY2013 CHIP Expenditures ($ in millions)		
		Total	Federal	State
Alabama	78.29%	$193.4	$150.8	$42.6
Alaska	65.00	32.8	21.3	11.5
Arizona	77.92	73.9	56.1	17.7
Arkansas	79.62	122.8	95.4	27.4
California	65.00	2,126.8	1,382.4	744.4
Colorado	65.71	227.3	147.7	79.5
Connecticut	65.00	28.0	18.2	9.8
Delaware	67.54	24.6	17.0	7.6
District of Columbia	79.00	18.4	14.5	3.9
Florida	71.80	520.7	367.5	153.2
Georgia	76.86	413.3	313.6	99.7
Hawaii	66.56	40.3	26.6	13.7
Idaho	80.23	60.7	48.3	12.4
Illinois	65.53	517.7	336.4	181.3
Indiana	76.56	157.4	121.2	36.2
Iowa	68.88	134.2	96.2	38.0
Kansas	69.64	75.5	52.5	23.0
Kentucky	78.96	184.8	146.7	38.1
Louisiana	73.44	203.3	148.1	55.2
Maine	73.32	37.2	27.5	9.7
Maryland	65.00	258.4	168.0	90.4
Massachusetts	65.00	573.7	372.9	200.8
Michigan	75.88	147.1	112.5	34.7
Minnesota	65.00	19.5	12.8	6.7
Mississippi	81.51	207.5	168.9	38.6
Missouri	74.42	170.0	124.1	45.8
Montana	76.13	91.5	69.7	21.8

State	FY2015 E-FMAP	FY2013 CHIP Expenditures ($ in millions) Total	Federal	State
Nebraska	67.29	70.1	48.2	21.9
Nevada	75.05	37.2	26.8	10.5
New Hampshire	65.00	16.7	10.9	5.9
New Jersey	65.00	958.0	586.6	371.5
New Mexico	78.76	144.9	110.0	35.0
New York	65.00	959.9	624.0	335.9
North Carolina	76.12	398.0	302.0	96.1
North Dakota	65.00	26.6	17.7	8.9
Ohio	73.85	381.3	284.1	97.2
Oklahoma	73.61	172.6	129.1	43.5
Oregon	74.84	209.4	154.3	55.0
Pennsylvania	66.27	428.0	291.1	136.9
Rhode Island	65.00	81.1	53.7	27.4
South Carolina	79.45	132.5	105.1	27.4
South Dakota	66.15	24.6	17.0	7.6
Tennessee	75.49	259.6	198.0	61.6
Texas	70.64	1,285.0	918.8	366.2
Utah	79.39	68.6	54.0	14.6
Vermont	67.81	9.0	6.2	2.8
Virginia	65.00	301.0	195.7	105.4
Washington	65.02	122.9	79.9	42.9
West Virginia	79.95	57.9	46.5	11.3
Wisconsin	70.79	140.3	100.7	39.6
Wyoming	65.00	16.4	10.7	5.7
Total		**$12,962.4**	**$8,987.9**	**$3,974.5**

Source: Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2014 Through September 30, 2015," 79 *Federal Register* 3385, January 21, 2014; U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Form CMS-64 data.

Notes: This table does not include CHIP expenditures in the territories or CHIP expenditures under §2105(g) of the Social Security Act, which permits 11 qualifying states to use CHIP funds to pay the difference between the FMAP rate (i.e., the federal Medicaid matching rate) and the E-FMAP rate for Medicaid-enrolled, Medicaid-financed children whose family annual income exceed 133% FPL. These are CHIP funds used to finance children in Medicaid, and states are not required to match the federal funds provided in §2105(g) of the Social Security Act.

Appendix B. Upper Income Eligibility Levels in Medicaid, CHIP, and Subsidized Exchange Coverage

State-by-state income eligibility level for Medicaid, CHIP, and subsidized exchange coverage for infants, children aged 1 to 5, children aged 6 to 18, and pregnant women and unborn children are provided in **Figure B-1**, **Figure B-2**, **Figure B-3**, and **Figure B-4** (respectively).

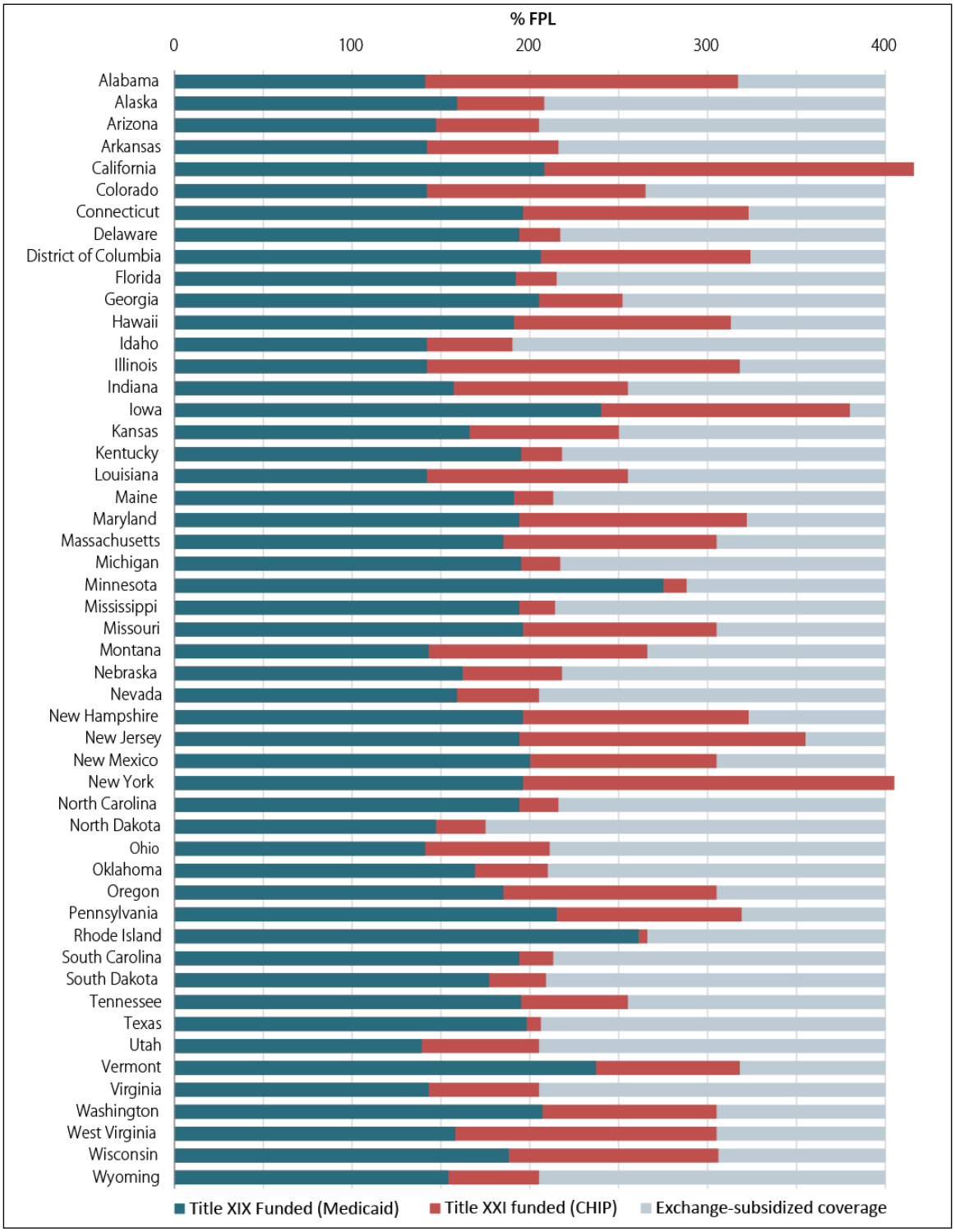
Most children and pregnant women in families with income under 400% of the federal poverty level (FPL) are eligible for Medicaid, CHIP, or subsidized exchange coverage. The income eligibility levels for Medicaid and CHIP vary by state and population (i.e., age of child or pregnant women), and subsidized exchange coverage[100] is available for most children and pregnant women with incomes between 100% FPL and 400% FPL that do not have access to other minimum essential coverage,[101] such as Medicaid or CHIP.

[100] Premium tax credits are provided to certain individuals with household income between 100% and 400% FPL who do not have access to minimum essential coverage, and these individuals with income between 100% and 250% FPL could be eligible for cost-sharing subsidies.

[101] The definition of minimum essential coverage is broad. It includes Medicare Part A, Medicaid, the State Children's Health Insurance Program (CHIP), Tricare, the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group, or large group markets, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.

Figure B-1. Upper Income Eligibility Levels for Infants, as a Percentage of the FPL in Medicaid, CHIP, and Subsidized Exchange Coverage by State

(as of January 1, 2014)



Source: MACPAC, *Report to Congress on Medicaid and CHIP,* March 2014, MACStats, Table 9.

Notes: Upper income levels (% FPL) represent the highest income eligibility threshold available in the state, and include the 5% disregard (which the law provides as a standard disregard).

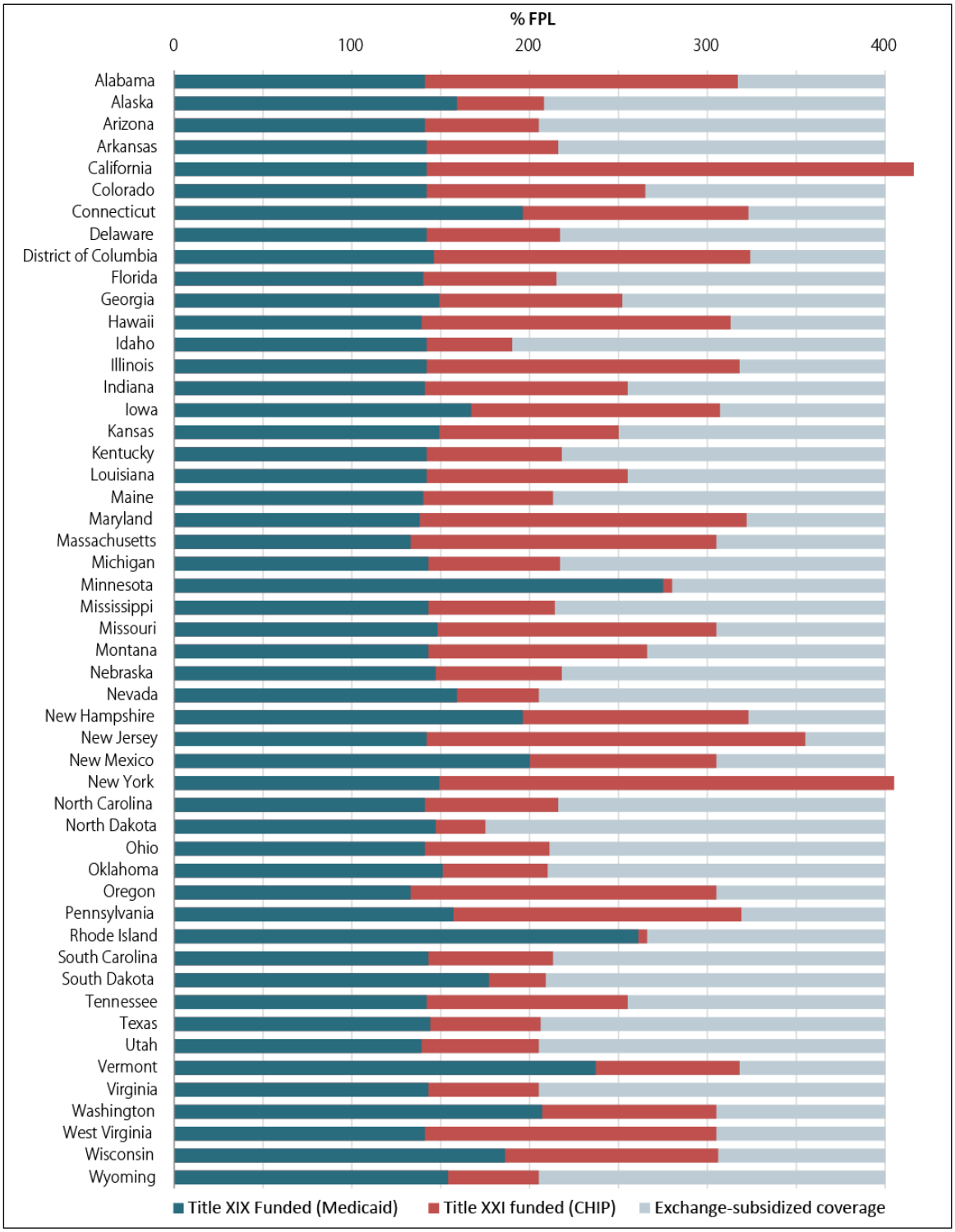
It is important to note that CHIP coverage is limited to uninsured children, so children who have health insurance coverage and fall in the income eligibility range shown for CHIP are nonetheless not CHIP eligible because of their insurance status.

In one county in California and New York, CHIP coverage for CHIP children extends to a higher income eligibility threshold than subsidized exchange coverage (i.e., 416% FPL in one county and 405% FPL, respectively). Email correspondence with CMS from March 9, 2015, indicates that California's CHIP expansion to 416% FPL was approved by CMS but never implemented by the state.

FPL: Federal poverty level.

Figure B-2. Upper Income Eligibility Levels for Children Aged 1 Through 5, as a Percentage of the FPL in Medicaid, CHIP, and Subsidized Exchange Coverage by State

(as of January 1, 2014)



Source: MACPAC, *Report to Congress on Medicaid and CHIP,* March 2014, MACStats, Table 9.

Notes: Upper income levels (% FPL) represent the highest income eligibility threshold available in the state, and include the 5% disregard (which the law provides as a standard disregard).

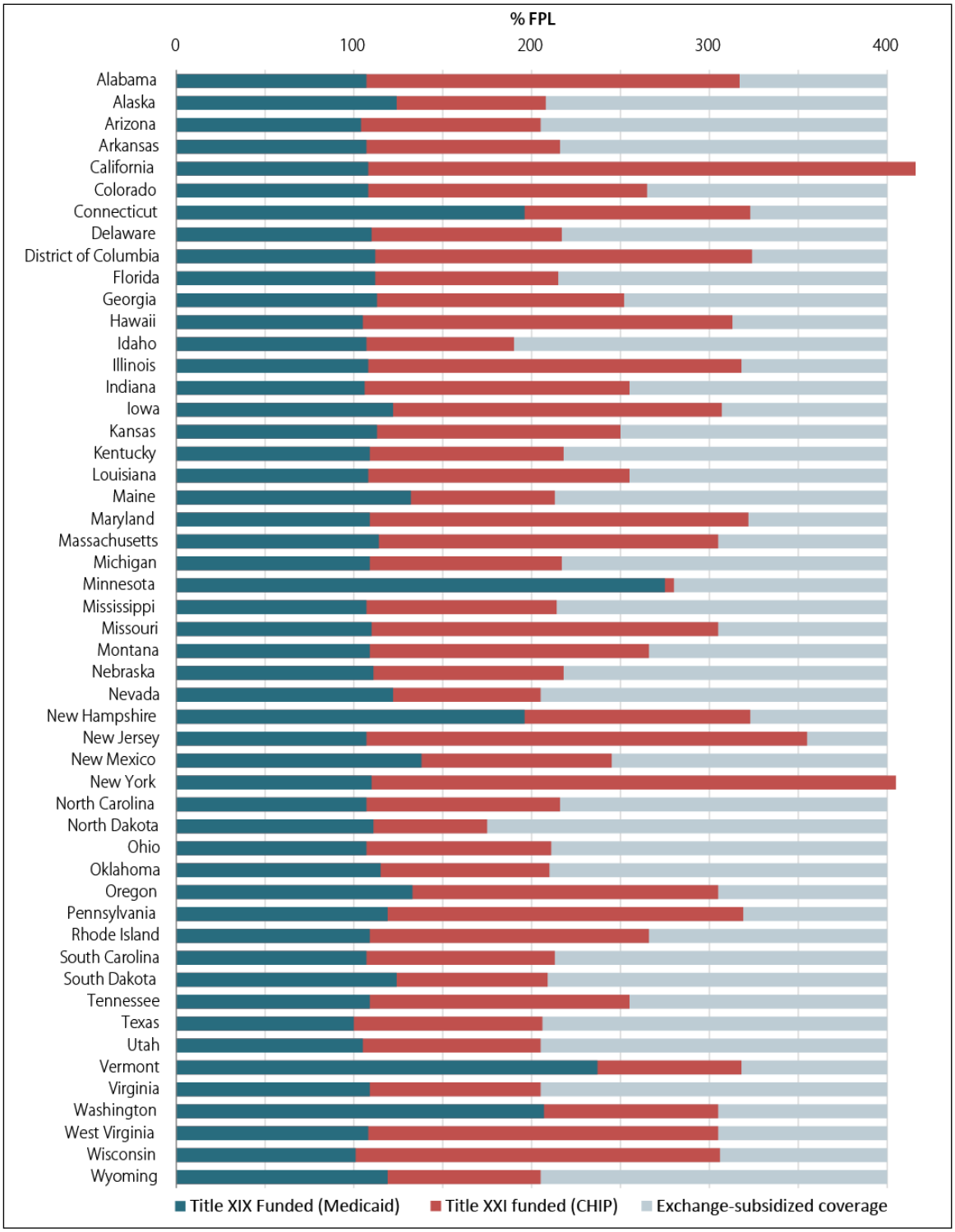
It is important to note that CHIP coverage is limited to uninsured children, so children who have health insurance coverage and fall in the income eligibility range shown for CHIP are nonetheless not CHIP eligible because of their insurance status.

In one county in California and New York, CHIP coverage for CHIP children extends to a higher income eligibility threshold than subsidized exchange coverage (i.e., 416% FPL in one county and 405% FPL, respectively). Email correspondence with CMS from March 9, 2015, indicates that California's CHIP expansion to 416% FPL was approved by CMS but never implemented by the state.

FPL: Federal poverty level.

Figure B-3. Upper Income Eligibility Levels for Children Aged 6 Through 18, as a Percentage of the FPL in Medicaid, CHIP, and Subsidized Exchange Coverage by State

(as of January 1, 2014)



Source: MACPAC, *Report to Congress on Medicaid and CHIP,* March 2014, MACStats, Table 9.

Notes: Upper income levels (% FPL) represent the highest income eligibility threshold available in the state, and include the 5% disregard (which the law provides as a standard disregard).

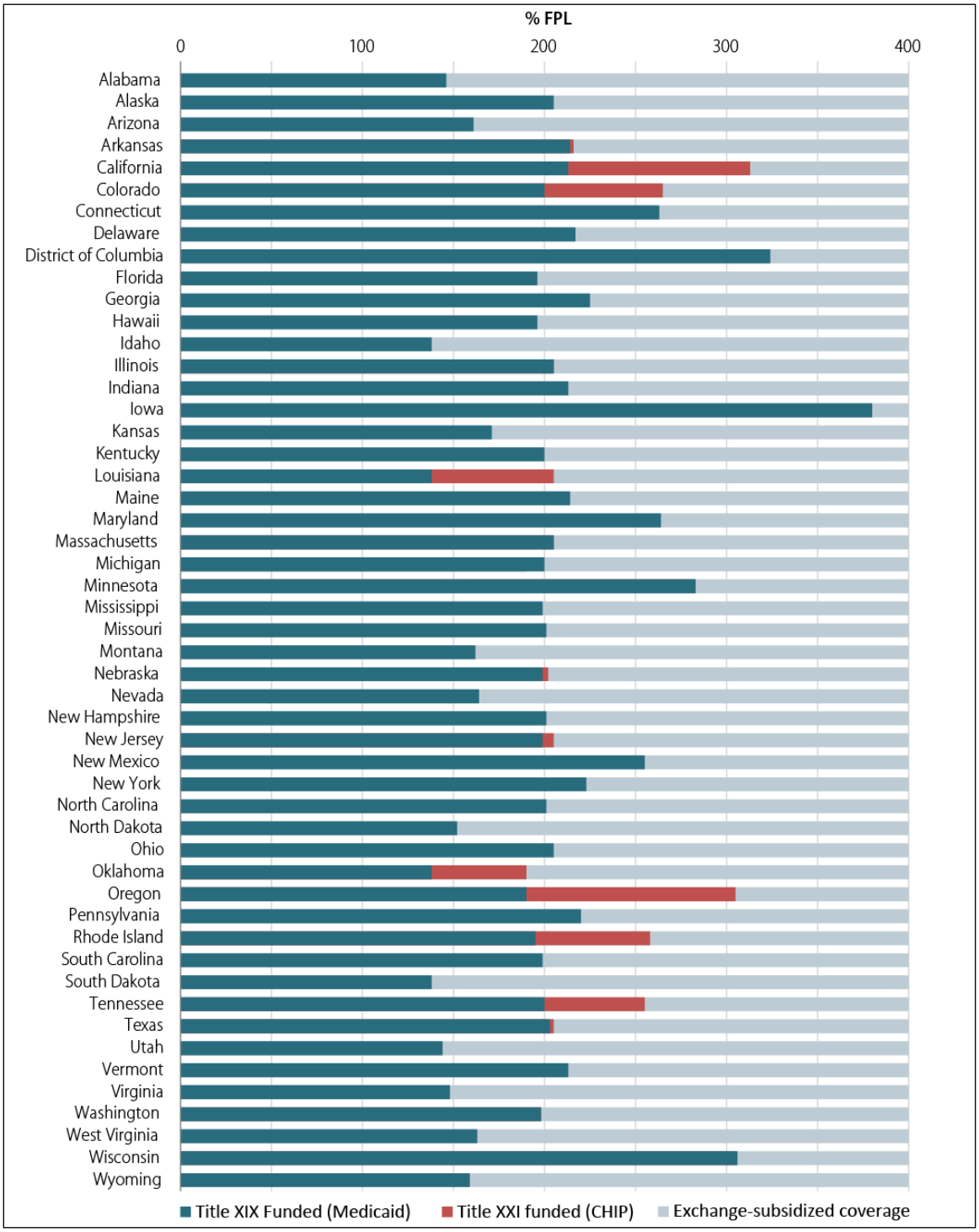
It is important to note that CHIP coverage is limited to uninsured children, so children who have health insurance coverage and fall in the income eligibility range shown for CHIP are nonetheless not CHIP eligible because of their insurance status.

In one county in California and New York, CHIP coverage for CHIP children extends to a higher income eligibility threshold than subsidized exchange coverage (i.e., 416% FPL in one county and 405% FPL, respectively). Email correspondence with CMS from March 9, 2015, indicates that California's CHIP expansion to 416% FPL was approved by CMS but never implemented by the state.

FPL: Federal poverty level.

Figure B-4. Upper Income Eligibility Levels for Pregnant Women and Unborn Children, as a Percentage of the FPL in Medicaid, CHIP, and Subsidized Exchange Coverage by State

(as of January 1, 2014)



Source: MACPAC, *Report to Congress on Medicaid and CHIP,* March 2014, MACStats, Table 9.

Notes: Upper income levels (% FPL) represent the highest income eligibility threshold available in the state, and include the 5% disregard (which the law provides as a standard disregard).

As of January 2014, 15 states extended CHIP coverage to unborn children in Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Washington and Wisconsin. State income eligibility boundaries associated with the unborn child pathway are not shown here.

FPL: Federal poverty level.

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