CHAPTER 3

Overview of the State Children's Health Insurance Program

Section 1900(b) of the Social Security Act directs the Commission to review policies of the Medicaid program and the State Children's Health Insurance Program (CHIP) affecting access to covered items and services, including payment policies, eligibility policies, enrollment and retention processes, coverage policies, quality of care, the interaction of Medicaid and CHIP payment policies with health care delivery generally, interactions with Medicare and Medicaid, and other access policies.

Chapter Summary

CHIP is a joint federal-state program established to provide coverage to uninsured children in mostly working families whose incomes are too high to qualify for Medicaid. Enacted in 1997, CHIP has allowed states to provide health insurance benefits more similar to those offered in the commercial health insurance market.

CHIP is smaller than Medicaid both in terms of covered individuals (8 million vs. 68 million) and total spending ($11 billion vs. $400 billion). Like Medicaid, states administer their programs within federal rules and receive federal matching funds for program expenditures. CHIP, however, differs from Medicaid in a variety of ways. Under CHIP, federal funding is capped and there is no mandatory level of coverage. States can operate their CHIP programs as an expansion of Medicaid, a CHIP program separate from Medicaid, or a combination of both. In separate CHIP programs, there is no individual entitlement; states have additional flexibility to cap enrollment and implement waiting periods. In separate CHIP programs, states can also tailor benefit packages; charge premiums, deductibles, coinsurance and other cost-sharing; and generally exert greater control over their state spending and federal funds (allotments) than under Medicaid.

In its short existence, CHIP has undergone substantial legislative changes. For example, the formula for allotting federal CHIP funds to states was overhauled, due to misalignments between states' CHIP spending and their allotments of federal CHIP funds. Today, CHIP has a complex financing structure that includes rebasing state allotments every two years, redistributing unused federal allotment funds to states, a contingency fund for states that exhaust their federal CHIP funds, and bonus payments for state performance. Federal appropriations for CHIP allotments end after FY 2015. Although states have wide flexibility to expand children's CHIP eligibility, the federal CHIP statute was altered so that if a state covers children above 300 percent of the federal poverty level (FPL), the federal funding for those children will generally be at the regular Medicaid matching rate, rather than CHIP's enhanced rate. In FY 2010, 98 percent of children enrolled in CHIP had family income at or below 250 percent FPL, which is $46,325 for a family of three.

This chapter highlights CHIP eligibility, benefits and cost-sharing, state program flexibility, and the federal-state financing structure. In addition, the impacts of recent legislative changes on the current CHIP program are explained and future program issues are identified.

CHAPTER 3

Overview of the State Children's Health Insurance Program

In 1997, 10 million children were without health insurance (Martinez and Cohen 2010). Many of these children were in working families whose income was just above states' Medicaid eligibility levels. To extend coverage to these children, the Congress created the State Children's Health Insurance Program (CHIP) in the Balanced Budget Act of 1997 (P.L. 105-33) under a new Title XXI of the Social Security Act. In 2010, 6 million children were uninsured (Martinez and Cohen 2010).

Federal Legislative History of CHIP

In 1997, Congressional proposals to increase children's coverage ranged from the provision of tax credits to the expansion of Medicaid with uncapped federal financing at an enhanced federal matching rate (Smith and Moore 2010). The legislation that became CHIP gave states flexibility to use either an expansion of Medicaid, referred to as Medicaid-expansion CHIP programs, or to use additional flexibilities to create separate CHIP programs—or a combination of both approaches. Regardless of which approach states used, their CHIP expenditures were to be reimbursed by the federal government at a matching rate higher than Medicaid's—an enhanced Federal Medical Assistance Percentage (E-FMAP) that varies by state but, on average, pays for 70 percent of CHIP spending, compared to 57 percent historically under Medicaid. Unlike Medicaid, federal CHIP funding was capped.

CHIP was structured to differ from Medicaid in several ways. First, while eligible individuals are entitled to Medicaid coverage (including through Medicaid-expansion CHIP programs), there is no individual entitlement to coverage in separate CHIP programs. For example, states can institute enrollment caps and waiting periods in separate CHIP programs, policies that are not permitted in Medicaid without a waiver. In addition, while states with Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no minimum mandatory

income level up to which CHIP programs must extend coverage. Moreover, states with separate CHIP programs have greater flexibility around the design of their benefit packages and enrollee cost-sharing than is available for children in Medicaid. All of these additional flexibilities, particularly in separate CHIP programs, give states greater control, compared to Medicaid, over their CHIP spending. (There are several Medicaid requirements that apply to separate CHIP programs, as described in the Annex to this chapter.)

At the time of CHIP's creation, just how many states would respond to the new federal funding opportunity by extending eligibility to more children was uncertain. By FY 2000, however, every state, territory, and the District of Columbia had children enrolled in CHIP-financed coverage. Another uncertainty was how quickly and effectively states would be able to mount outreach efforts to identify and enroll the eligible population for this new program.

The Balanced Budget Act of 1997 (BBA 97) provided annual federal appropriations for CHIP allotments through FY 2007, totaling approximately $40 billion over the ten-year period from FY 1998 to FY 2007. For the first several years of the program, states' allotments tended to be much larger than their spending. However, as CHIP programs matured and national CHIP spending continued well in excess of the appropriations set in 1997, several states were slated to experience shortfalls of federal CHIP funding (GAO 2007). The Congress intervened to appropriate funding for FY 2006 ($283 million) and again for FY 2007 ($650 million) to prevent these shortfalls.

The original CHIP allotment formula was intended to approximate states' need for CHIP funds, based primarily on the number of low-income children in each state and the number of those children who were uninsured (Czajka and Jabine 2002). However, many states found that the formula did not accurately reflect their need for federal CHIP funding and created large and unexpected fluctuations in their annual CHIP allotments. So as the Congress began to examine how to extend federal CHIP funding past FY 2007, it also explored how to change the allotment formula to provide funding more in line with states' actual CHIP spending.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) extended CHIP appropriations through FY 2013, at much higher levels than under BBA 97.[1] The formula for allotting these funds to states was also overhauled to better target states' actual CHIP spending. CHIPRA made several other changes to the federal CHIP statute, such as requiring separate CHIP programs to cover dental benefits and to ensure any covered mental health benefits had parity with medical benefits.

[1] The 110th Congress passed two bills to "reauthorize" CHIP, which would have provided CHIP funding for FY 2008 through FY 2012 and would have made other changes to both CHIP and Medicaid. Both bills were vetoed. In lieu of being able to provide longer term CHIP funding, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) was enacted. MMSEA appropriated funds to provide CHIP allotments for FY 2008 and FY 2009 at FY 2007 levels, but only to be available through March 31, 2009. Because shortfalls of federal CHIP funds were still projected to occur in certain states, additional funds besides the allotments were also appropriated. CHIPRA then provided full-year FY 2009 federal CHIP allotments.

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) extended the program's federal funding by another two years, through FY 2015.

Impact of CHIP

Besides the overall increase in children's coverage, CHIP's impact may also be seen by comparing health insurance changes between 1997 and 2010 in low-income children's health insurance status to low-income adults, who generally did not see comparable eligibility expansions in public programs. Family income at or above 100 but below 200 percent of the federal poverty level (FPL) is the income range for which CHIP coverage is most likely—currently $18,530 to $37,060 for a family of three. Both children and non-elderly adults in this income range experienced declines in private coverage between 1997 and 2010 (Table 3-1). For these adults, the increase in public coverage between 1997 and 2010 did not offset declines in private coverage, and these adults' uninsurance levels *increased* by nine percentage points—from 34.9 percent in 1997 to 43.9 percent in 2010. For children in the same income range, the increase in public coverage between 1997 and 2010 more than offset the decline in private coverage, causing these children's uninsurance rate to *drop* by nine percentage points—from 22.8 percent in 1997 to 13.5 percent in 2010.

Eligibility for CHIP

This section describes eligibility for CHIP, which was designed for low-income children but has also extended coverage to pregnant women, and other adults on a limited basis, as described below.

TABLE 3-1. Sources of Coverage Among Children and Non-elderly Adults with Family Income from 100 through 199 Percent of the Federal Poverty Level (FPL), 1997 and 2010

	Private	Public	Uninsured
Children			
1997	55.0 percent	24.3 percent	22.8 percent
2010	30.8	57.6	13.5
Change	-24.2	+33.3	-9.3
Non-elderly Adults			
1997	52.6	14.6	34.9
2010	34.9	22.5	43.9
Change	-17.7	+7.9	+9.0

Source: National Health Interview Survey (NHIS), Martinez and Cohen 2010.

Note: For this table, the federal poverty level (FPL) is based on the U.S. Census Bureau's poverty thresholds. Children are between the ages of 0 and 17 years, and non-elderly adults are between the ages of 18 and 64. "Public" coverage includes CHIP, Medicaid, and Medicare. Federal surveys such as NHIS do not publish separate results for Medicaid and CHIP enrollment; child enrollment in Medicare is relatively small.

Children

Targeted low-income children eligible for CHIP are those under the age of 19 with no health insurance and who would not have been eligible for Medicaid under the state rules in effect on March 31, 1997.[2] The federal CHIP statute limits states' upper-income eligibility levels to 200 percent FPL or, if higher, 50 percentage points above states' pre-CHIP Medicaid levels. However, states have enough flexibility in how they count applicants' income so that they can effectively expand eligibility to any income level (HCFA 2001). CHIPRA altered the federal CHIP statute so that if a state covers children above 300 percent FPL, the federal funding for those children will be at the regular FMAP rather than the enhanced FMAP, with some exceptions.[3]

As shown for each state in Table 9 of MACStats, states' upper limits for income eligibility in CHIP funded coverage were as follows:

- Two states above 300 percent FPL: New York (400 percent FPL) and New Jersey (350 percent FPL);
- 16 states and the District of Columbia at 300 percent FPL;
- 11 states between 235 and 280 percent FPL;
- 18 states at 200 percent FPL; and
- three states below 200 percent FPL: Idaho (185 percent FPL), Alaska (175 percent FPL), and North Dakota (160 percent FPL).

As shown in Figure 3-1, 7.7 million children were enrolled in CHIP in FY 2010. More than 70 percent (5.5 million) of these children were in a separate program, and the remaining 2.2 million were in a Medicaid-expansion program.[4]

Children in CHIP-financed coverage, including those in Medicaid-expansion programs, are counted separately from children in regular Medicaid-financed coverage. As shown in Table 4 of MACStats, in FY 2010, 7.7 million children were enrolled in CHIP-financed coverage, while Medicaid paid for the coverage of four and a half times that many children (34.4 million).

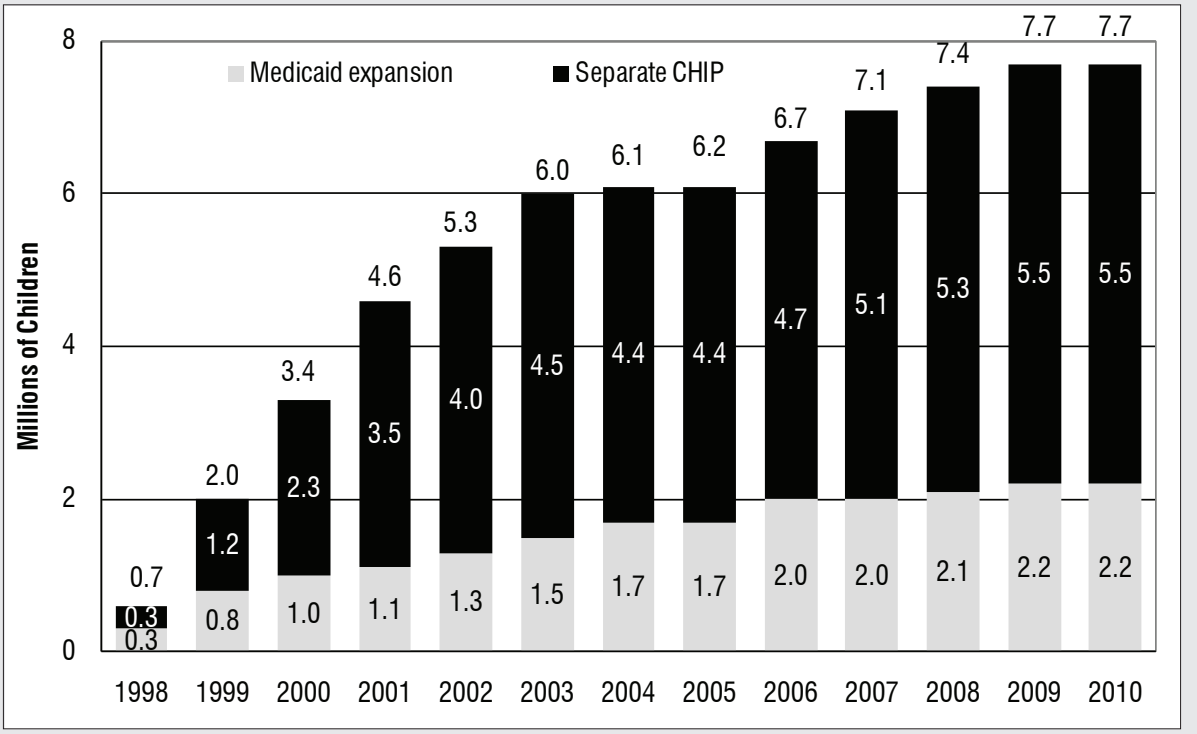
Based on Commission analyses of FY 2010 CHIP data, 90 percent of children enrolled in CHIP-financed coverage were at or below 200 percent FPL, and 98 percent were at or below 250 percent FPL (Table 3-2). Table 4 of MACStats displays these numbers by state. Even in New York, which extends CHIP eligibility to 400 percent FPL, three-quarters of CHIP child enrollees were at or below 200 percent FPL, and 91 percent were at or below 250 percent FPL. Although CHIP in some states may be extended to children in higher-income families, these children are still more likely to be enrolled in a parent's employer-sponsored health insurance, in which case they would be ineligible for CHIP.

[2] In addition, children who live in public institutions or are patients in an institution for mental diseases are ineligible for CHIP coverage. Children of state employees are also ineligible for CHIP, unless (1) annual agency expenditures for employees enrolled in a state employee health plan with dependent coverage (for the most recent state fiscal year) are at least the amount of such expenditures made for state fiscal year 1997 (adjusted for medical inflation) or (2) the state determines that the annual aggregate amount of the applicable premiums and cost-sharing in the state employee plan would exceed 5 percent of the family's annual income.

[3] Exceptions were provided for a state that, as of CHIPRA's enactment date (February 4, 2009), was already above 300 percent FPL (New Jersey) or had enacted a state law to submit a plan for federal approval to go above 300 percent FPL (New York).

[4] A child cannot technically enroll in a combination CHIP program; in a combination state, individual children are enrolled in either the state's separate CHIP program or its Medicaid-expansion CHIP program.

FIGURE 3-1. Child Enrollment in CHIP, FY 1998–2010



Note: Numbers are children ever enrolled during the year, even if only for a month. Components may not add to total due to rounding.
Source: CHIP Statistical Enrollment Data System (SEDS)

For at least some potential CHIP enrollees, most states require waiting periods—that is, minimum periods of uninsurance before individuals can enroll. For example, children must be uninsured for at least three months to enroll in New Jersey's separate CHIP program. States may exempt certain children, such as those with special health care needs or newborns, or those facing special family circumstances, such as a parent's recent job loss (NASHP 2011).

In a separate CHIP program, children have no entitlement to coverage; thus states may impose waiting periods or cap enrollment. For example, in December 2009, Arizona closed its CHIP program to new enrollees (HHS 2011). For Medicaid-expansion CHIP programs, the entitlement to

TABLE 3-2. Child Enrollment in CHIP by Family Income, FY 2010

Family Income as a Percent of Federal Poverty Level (FPL)	Percent of CHIP Child Enrollees
At or below 200 percent FPL	89.8
201–250 percent FPL	8.4
Above 250 percent FPL	1.8
Total	100.0

Note: 200 percent FPL in 2011 is $21,780 for an individual and $7,640 for each additional family member.
Source: MACPAC analysis (February 2011) of CHIP Statistical Enrollment Data System (SEDS), as reported by states.

Medicaid prohibits the use of waiting periods or enrollment caps. According to one analysis, however, 14 states and the District of Columbia had waiting periods for at least some of their Medicaid-expansion CHIP enrollees through the use of Section 1115 waivers (Ross et al. 2009). Section 1115 waivers generally apply to CHIP in the same way as in Medicaid, providing states with flexibility not otherwise permissible by federal law.[5] For additional background information, see the previous chapter's descriptions of 1115 waivers, which also apply to CHIP.

The maintenance of effort provision enacted in PPACA, discussed in Chapter 2, also applies to children in CHIP programs; states will lose all Medicaid funding if their CHIP programs implement eligibility standards or procedures for children that are more restrictive than those in place at PPACA's enactment (March 23, 2010). One of the exceptions to this provision is that a separate CHIP program can institute a waiting list or enrollment cap if otherwise it would exhaust all of its available federal CHIP funding.

Pregnant Women and Unborn Children

Prior to CHIPRA, adult pregnant women could receive CHIP-financed services primarily in one of two ways. First, states could apply for federal approval of a Section 1115 waiver of CHIP program rules in order to extend eligibility to adult pregnant women.[6] Second, CHIP regulations adopted in 2002 permit the coverage of unborn children (CMS 2002), which effectively provides CHIP coverage of pregnant women and is currently used by 13 states.[7]

CHIPRA created a new eligibility pathway for pregnant women, for whom the state can receive the enhanced FMAP from CHIP funds. To cover targeted low-income pregnant women, the state's *Medicaid* program must cover pregnant women up to 185 percent FPL (or, if higher, the level the state had in place on July 1, 2008). Another requirement is that the state's CHIP program cannot impose policies like enrollment caps on targeted low-income pregnant women *or children*. In addition, the upper limit of income eligibility for targeted low-income pregnant women cannot be higher than that of children. Two states have taken up this new option to cover targeted low-income pregnant women in CHIP; in FY 2010, New Jersey enrolled 295 targeted low-income pregnant women, and Rhode Island enrolled 151.

[5] §2107(e)(2)(A) of the Social Security Act, except that CHIP-related waivers cannot be used to waive current-law restrictions on CHIP coverage of childless adults and parents, per §2107(f).

[6] As shown in Table 3 of MACStats, there were 8,103 pregnant women enrolled in CHIP in FY 2010 under Section 1115 waivers, excluding New Jersey and Rhode Island, whose pregnant women were enrolled through the state plan option for targeted low-income pregnant women.

[7] Because the coverage is technically of the unborn child rather than the pregnant woman, the enrollment of these individuals appears in the number of children rather than the number of adults (CMS 2002). In FY 2010, there were 361,069 unborn children enrolled in CHIP, three-quarters of whom were either in California (147,965, 41 percent of national unborn child enrollment) or in Texas (126,772, 35 percent). The other 11 states that covered unborn children in FY 2010 were Arkansas, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Oklahoma, Oregon, Rhode Island, Washington and Wisconsin.

Other Adults

In CHIP's early years, many states were unable to use much of their federal CHIP allotments. This included states whose pre-CHIP Medicaid income-eligibility levels were quite high and that opted not to expand much further. For example, prior to CHIP, Minnesota's Medicaid program already covered children up to 275 percent FPL, currently $50,958 for a family of three; its original CHIP program covered only young children (under age 2) in a very narrow income range—between 275 percent and 280 percent FPL.[8] States received approval for waivers to use their unspent federal CHIP funds to cover adults, although adult coverage is now being phased out of CHIP.

In 2000, the U.S. Department of Health and Human Services (HHS) announced it would approve CHIP waivers to cover certain adults—pregnant women and parents—but not non-pregnant childless adults (HCFA 2000). In 2001, HHS announced greater waiver flexibility, including the use of CHIP funds to cover childless adults. In 2005, legislation prohibited any new states from having CHIP-funded childless adult coverage. CHIPRA terminated CHIP coverage of non-pregnant childless adults altogether after 2009. As shown in Table 3 of MACStats, non-pregnant CHIP enrollees in FY 2010 consisted of 114,095 childless adults in three states—Michigan, New Mexico and Idaho. These childless adults were covered by CHIP only in the first quarter of FY 2010—October through December 2009, after which childless adult CHIP coverage was prohibited. In these three states, childless adults are now covered through Medicaid at the regular FMAP.

CHIPRA also prohibited new states from covering parents with CHIP funds and phases out CHIP coverage of parents altogether by FY 2014. As shown in Table 3 of MACStats, CHIP enrolled 224,499 parents in four states in FY 2010. New Jersey accounted for more than 90 percent of these CHIP-funded parents.

Coverage and Payment of Benefits in CHIP

Depending on state decisions and policies, separate CHIP programs can have greater flexibility to tailor their benefit packages and cost-sharing arrangements to children enrolled in CHIP, who by definition have higher family incomes than children enrolled in Medicaid-financed coverage. This section describes the benefit options available for CHIP state plans under Medicaid-expansion versus separate CHIP programs. It also briefly examines the role of managed care in CHIP.

Children in Medicaid-expansion CHIP programs are protected by federal Medicaid benefits requirements and cost-sharing limitations. They are entitled to all of Medicaid's mandatory services, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, generally without any enrollee cost-sharing.[9]

[8] The state did ultimately obtain waivers to cover parents, although in FY 2010 Minnesota had no CHIP-financed coverage of adults per se; the state covered approximately 5,000 unborn children in FY 2010.

[9] EPSDT is described in Chapter 2. States may obtain Section 1115 waivers to charge premiums and service-related cost-sharing in Medicaid-expansion CHIP programs, which has been done in a handful of states. Sections 1916A and 1937 of the Social Security Act permit some additional flexibility, not described here.

For separate CHIP programs, the federal CHIP statute gives several options for how a state structures its benefit package, generally tied to specified benchmark benefit packages. The benchmark benefit packages for states to choose from are the Blue Cross and Blue Shield standard option available to federal employees, a plan available to state employees, and the HMO plan in the state with the largest commercial, non-Medicaid enrollment. In addition, states can seek approval for a benefit package not tied to these benchmarks; in this case, states design their own benefit package and obtain approval from the HHS Secretary. Many of these benefit packages are called Medicaid look-alikes. All separate CHIP benefit packages are required to cover inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care (including age-appropriate immunizations), and dental services. Separate CHIP programs are not required to cover EPSDT services, although they must cover similar preventive/screening services; differences between EPSDT services and separate CHIP benefit packages are more likely to be found in the treatment of serious and chronic conditions of children and adolescents than in preventive and screening services.

A separate CHIP program can charge premiums, deductibles, coinsurance, and other cost-sharing. However, out-of-pocket cost-sharing is always limited to 5 percent of family income. In addition, no cost-sharing can be charged for preventive or pregnancy-related services, and children with family income below 150 percent FPL are potentially subject to only very limited cost-sharing. One actuarial analysis found that while separate CHIP benefit packages may cover fewer services with higher cost-sharing than Medicaid, they generally cover more services, such as dental, with lower cost-sharing than typical commercial coverage (Watson Wyatt Worldwide 2009).

In FY 2010, three-quarters of all child CHIP enrollees were enrolled in a comprehensive managed care plan, although this varied depending on whether enrollees are in a Medicaid-expansion or separate CHIP program (Table 3-3). For a state-level breakdown in separate CHIP programs and a description of managed care, fee for service, and primary care case management (PCCM), refer to Table 5 of MACStats.

TABLE 3-3. Child CHIP Enrollment in Managed Care Plans, FY 2010

	Medicaid-expansion CHIP		Separate CHIP		Total	
Managed care plan	1,241,441	57%	4,503,711	81%	5,745,152	75%
Fee for service (FFS)	450,253	21	778,354	14	1,228,607	16
Primary care case management (PCCM)	474,256	22	257,708	5	731,964	9
Total	2,165,950	100%	5,539,773	–	7,705,723	100%

Note: For a description of managed care, fee for service, and primary care case management (PCCM), refer to Table 5 of MACStats.
Source: MACPAC analysis (February 2011) of CHIP Statistical Enrollment Data System (SEDS), as reported by states, based on their definitions

Federal Funding for CHIP

States' expenditures under CHIP generally are matched at an enhanced federal matching rate, which requires a state share 30 percent smaller than the regular Medicaid FMAP. For example, under Medicaid, the regular FMAP must be at least 50 percent; for these states, the enhanced FMAP under CHIP is 65 percent. Although it varies by state, the typical federal share of CHIP spending is 70 percent, compared to 57 percent historically for Medicaid.

Unlike Medicaid, however, federal CHIP funds are capped and allotted to states based on a formula, which has changed over the years. In past years, some states exhausted their available federal CHIP funds, for which additional funds generally were appropriated. From FY 1998 through FY 2007, the states, the District of Columbia, and the territories[10] were allotted approximately $40 billion; appropriations for shortfalls that occurred in FY 2006 to FY 2007 amounted to less than $1 billion.[11] CHIPRA changed many aspects of CHIP federal financing for FY 2009 onward. The descriptions that follow are generally based on the current CHIP program, as amended by CHIPRA and PPACA.

Actual federal and state CHIP spending (Figure 3-2) did not always align with federal CHIP appropriations or states' CHIP allotments. This misalignment was also affected by the multi-year availability of federal CHIP allotments. When CHIP began, for example, few states were able to spend their federal allotments, even over the three years for which they were available. While the CHIP allotments began at levels well in excess of CHIP spending, the situation reversed in the 2000s, when programs came to maturity and several states would have experienced shortfalls in the absence of additional Congressional appropriations. The remainder of this section describes CHIP's financing structure.

Federal CHIP Allotments

Prior to CHIPRA, the annual appropriations for federal CHIP allotments ranged from $3.1 billion to $5.0 billion. The following are the national appropriation amounts for CHIP allotments made available by CHIPRA (for FY 2009 to FY 2013) and PPACA (for FY 2014 and FY 2015):

- $10.562 billion in FY 2009;
- $12.520 billion in FY 2010;
- $13.459 billion in FY 2011;
- $14.982 billion in FY 2012;
- $17.406 billion in FY 2013;
- $19.147 billion in FY 2014; and
- $21.061 billion in FY 2015.

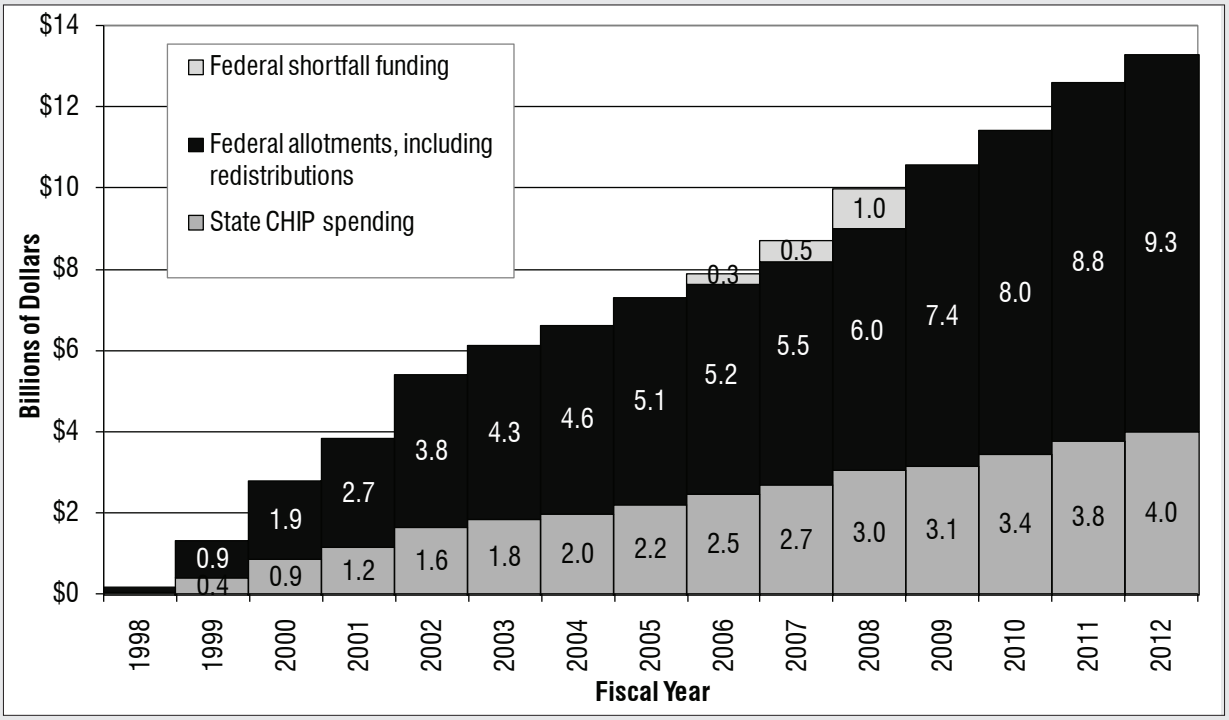
There are currently no appropriations for CHIP allotments beyond FY 2015.

CHIP allotment amounts are calculated for each state and territory. The states and territories will receive those amounts unless the national appropriation is inadequate. Going forward, for odd-numbered years (FY 2011, FY 2013 and FY 2015), the federal allotment for a state will be rebased—that is, it will be based on a new number, the state's prior-year CHIP *spending* plus a state

[10] The Commonwealth of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

[11] As described in footnote 1, MMSEA provided federal CHIP funding for a single year, FY 2008, including $1 billion for shortfalls.

FIGURE 3-2. Federal and State CHIP Spending, FY 1998 to FY 2012



Note: FY 2011 and FY 2012 are based on projections provided by states.
Source: CMS CHIP expenditure reports

growth factor. For even-numbered years (FY 2012 and FY 2014), the allotment will be calculated primarily as the prior-year *allotment* plus a state growth factor. Federal CHIP allotments are now available for two years.

Redistribution of CHIP Funds Among States

If a state does not exhaust its allotment within two years, any remaining balances are made available for redistribution to other states. In the years just prior to CHIPRA, redistribution funds went to states with shortfalls, eliminating or reducing the need for the Congress to appropriate funds to cover projected shortfalls. Since CHIPRA, however, a state is considered to be in shortfall *before* taking into account amounts that might be available to the state through redistribution, as described in greater detail in the next section. Redistribution funds are available for one year. Unexpended redistribution funds are transferred to the bonus fund, as described later.

The CHIPRA Contingency Fund

CHIPRA created a new Child Enrollment Contingency Fund that was appropriated $2.112 billion in FY 2009. Contingency funds are available *only* to states with shortfalls. As previously noted, a state is now considered to be in shortfall—and thus potentially eligible for federal contingency funds—*before* taking into account amounts that might already be available to the state through redistribution.

Prior to CHIPRA shortfall appropriations were based on a state's projected shortfalls for the year, which were reconciled with actual expenditures after the fiscal year ended. Like regular federal CHIP funding, shortfall appropriations had required a state share, based on the enhanced FMAP. Contingency funds, however, do not require state matching, and the amount of federal contingency funds a state receives is not based on the amount of its shortfall. Instead, once a state is determined to be in shortfall, the amount of contingency funds is determined by a complex formula that multiplies:

- growth in the state's CHIP child enrollment above its FY 2008 enrollment (as adjusted by the state's annual growth in child population plus 1 percentage point), by
- the state's per capita expenditures for the children enrolled in FY 2008, increased by annual growth factors, multiplied by the enhanced FMAP.[12]

No contingency funds were ultimately needed for FY 2009 or FY 2010. However, if a state *projects* a shortfall during the fiscal year, CMS and the affected state(s) will be required to calculate the components of the formula to provide the estimated federal contingency funds, even if the end-of-year determination would find the state did not actually experience a shortfall. This circumstance would require the state to return the federal contingency funds it received.

Bonus Payments for Performance

In FY 2009 the Congress appropriated $3.225 billion for CHIP bonus payments. Although these payments are from CHIP appropriations, they are only available to states that (1) increase Medicaid (not CHIP) child enrollment by significant amounts and (2) implement five out of eight specific outreach and retention efforts that are described in the Annex to this chapter. In addition to the initial FY 2009 appropriation, bonus payments may also be funded through unspent national allotment and redistribution amounts.

As shown in the chapter's Annex, in FY 2009, $75.4 million in bonus payments (2.3 percent of the appropriated amount), was awarded to ten states. Fifteen states received $206.2 million in bonus payments in FY 2010, out of $4.2 billion that were available (CMS 2011). Under current law, FY 2013 is the final year for bonus payments.

Looking Forward

CHIP has undergone substantial legislative change over the past few years. The preceding discussion described the impact of those changes on the current program. The remainder of this chapter highlights two future CHIP policy issues—one that is effective in 2014 (CHIP's interaction with exchange coverage) and one that concerns the period after FY 2015, when new federal CHIP funding will not be available under current law.

[12] The growth factor is based on per capita growth as published in the National Health Expenditures.

PPACA authorizes the development of health insurance exchanges, to be operated either by states or the federal government, in every state by 2014. The law defines exchanges as entities that will provide qualified individuals and small businesses with access to private insurers' plans in a comparable way and will identify individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits. Also beginning in 2014, PPACA requires that Medicaid and CHIP programs likewise be able to determine applicants' eligibility for subsidized exchange coverage.

Historically, with respect to CHIP the term "screen and enroll" has referred to the requirement that, if children are determined to be eligible for Medicaid, they cannot be enrolled in CHIP and must be enrolled in Medicaid. A comparable screen-and-enroll provision will apply to exchange coverage beginning in 2014. If a person applying for exchange coverage is found to be eligible for Medicaid or CHIP, the exchange is required to enroll them in that coverage; the person is prohibited from enrolling in subsidized exchange coverage.

The intent of this new screen-and-enroll provision with respect to exchanges is presumably the same as the original: to ensure that children are enrolled in a plan that offers benefits and cost-sharing protections better suited to their family income. However, this will result in cases where children who are eligible for CHIP (or Medicaid) will be prohibited from enrolling in their parents' federally subsidized family coverage through an exchange.[13]

Federal appropriations for CHIP allotments end after FY 2015.[14] If new federal CHIP funding is not made available after FY 2015 and states exhaust their balances, the statute permits CHIP children to enroll in subsidized exchange coverage; however, these children could only enroll in exchange plans with benefits and cost-sharing that the HHS Secretary determines are comparable to the state's CHIP plan. An actuarial analysis of 17 state CHIP benefit packages found that the levels specified for PPACA's subsidized exchange coverage would fall short of all those states' CHIP plans in terms of their benefits and cost-sharing (Watson Wyatt Worldwide 2009).

Although smaller and younger than Medicaid, CHIP provides essential coverage to nearly 8 million uninsured children in low-income, mostly working families. For their CHIP spending, states receive a federal matching rate that is enhanced, compared to Medicaid. While states can structure their CHIP programs to mirror Medicaid's benefits and cost-sharing, they can also tailor their benefit packages and cost-sharing to their enrollees by taking advantage of the CHIP statute's additional flexibility. The complex set of issues facing the CHIP program outlined in this chapter will continue to be part of the Commission's ongoing analyses.

[13] §§1311(d)(4)(f) and 1413(a) of PPACA, and §36B(c)(2)(B) of the Internal Revenue Code, as created by §1401(a) of PPACA. These provisions do not restrict families' ability to enroll their Medicaid- or CHIP-eligible children in their employer's coverage.

[14] For FY 2016 through FY 2019, current law would increase states' enhanced FMAPs by 23 percentage points—up to 100 percent federal match. If no CHIP appropriations are provided for FY 2016 onward, this increased matching rate will cause states to exhaust their remaining federal CHIP balances more quickly.

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Chapter 3 Annex

Federal Medicaid Provisions that Apply to Separate CHIP Programs

Chapter 3 describes how the Congress created CHIP in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) and gave states greater flexibility in the design of their separate CHIP programs, compared to Medicaid. However, some provisions in the federal Medicaid statute apply to separate CHIP programs as well. Some of these provisions give additional options to separate CHIP programs—for example, to cover legally residing pregnant women and children who have been in the country less than five years. Other provisions extend Medicaid requirements to separate CHIP programs, such as how to pay Federally Qualified Health Centers (FQHCs). This annex describes the Medicaid provisions that apply to separate CHIP programs, as listed in §2107(e)(1) of the Social Security Act.

At CHIP's enactment in BBA 97, the list of Medicaid provisions that applied to separate CHIP programs contained three items. Just before the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), it had four items. As of early 2011, the list contains 15 items. Most of these additions came from CHIPRA, but also from the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) and the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended).

The list below follows the order in the CHIP statute and does not reflect the order in which these provisions were added. The law that added the provision is noted in brackets.

1. **Conflict of interest standards.** Medicaid and CHIP programs must subject current and former state and local employees and contractors who are responsible for a substantial amount of Medicaid or CHIP spending to the same standards that apply to similarly situated individuals at the federal level. [BBA 97]
2. **FQHC flexibility in contracting for dental services.** State Medicaid and CHIP programs cannot prevent a Federally Qualified Health Center (FQHC) from contracting with private-practice dental providers. [CHIPRA]

3. **Advice from designees of Indian Health Programs and Urban Indian Organizations.** In a state where one or more Indian Health Programs or Urban Indian Organizations provide health care services, state Medicaid and CHIP programs must provide a process under which the state seeks advice from these programs and organizations. [ARRA]

4. **Provider and supplier screening, oversight and reporting.** Medicare, Medicaid and CHIP must ensure that health care providers and suppliers meet similar standards set by the HHS Secretary for all three programs. [PPACA]

5. **Express Lane Eligibility (ELE).** In determining whether a child meets one or more Medicaid or CHIP eligibility requirements (e.g., income, household composition, residency), state Medicaid and CHIP programs have the option to rely on findings from designated Express Lane agencies—for example, public agencies that administer Temporary Assistance for Needy Families (TANF), Medicaid, CHIP, Supplemental Nutrition Assistance Program (food stamps), and the National School Lunch Program. [CHIPRA]

6. **Modified Adjusted Gross Income (MAGI).** MAGI is a new federal income-counting methodology, described in Medicaid statute as taxpayers' adjusted gross income plus tax-exempt interest and foreign earned income. The Medicaid definitions and standards regarding MAGI also apply to CHIP, for state programs that use MAGI. [PPACA]

7. **Payments to FQHCs and RHCs.** State Medicaid and CHIP programs must pay for health care services rendered by FQHCs and Rural Health Clinics (RHCs) using a prospective payment system (PPS), generally based on each FQHC's and RHC's inflation-adjusted average Medicaid costs from 1999 and 2000. States may elect to develop a CHIP specific baseline PPS or use an alternate payment methodology, approved by each FQHC and RHC, to pay for services. [CHIPRA]

8. **Disregard of property when determining eligibility.** When state Medicaid and CHIP programs apply asset tests for eligibility, certain assets of Indians are to be excluded. [ARRA]

9. **Limitations on payments.** Conditions are specified under which Medicaid and CHIP cannot pay health care providers, such as when a provider is mandatorily excluded from Medicare or Medicaid because of patient abuse or a program-related crime. [BBA 97]

10. **Conditions for covering certain legally residing pregnant women and children.** Although Medicaid and CHIP coverage can only be provided to most legal non-citizens who have been in the country for five years (and meet all other eligibility criteria), states can choose to cover lawfully residing pregnant women and children without regard to this five-year waiting period. A state may only elect this option for individuals in its separate CHIP program if the state also elected the option for individuals in its Medicaid program. [CHIPRA]

11. **Limitations on provider taxes and donations.** Conditions are specified under which provider taxes and donations may be used to fund the non-federal share of states' Medicaid and CHIP spending. [BBA 97]

12. **Presumptive eligibility for children.** Entities are specified that can determine children's eligibility on a presumptive, or preliminary, basis until the state agency is able to do a full eligibility determination. [P.L. 106-554]

13. **Managed care requirements.** Conditions are specified under which Indians are exempt from mandatory enrollment in a managed care plan and under which other exemptions apply to Indian enrollees, providers and managed care plans. [ARRA] (CHIPRA added a host of other Medicaid managed care provisions unrelated to Indians that now apply to separate CHIP programs, as listed in §2103(f) of the Social Security Act. These provisions are broadly categorized as follows: process for enrollment, termination, and change of enrollment; provision of information to enrollees and potential enrollees; beneficiary protections; quality assurance standards; protections against fraud and abuse; and sanctions for noncompliance.)

14. **Authorization to receive data for eligibility determinations.** Conditions, as well as penalties for noncompliance, are specified under which Express Lane agencies and Medicaid and CHIP programs may exchange information used for eligibility determinations. [CHIPRA]

15. **Coordination with exchanges and Medicaid programs.** Beginning January 1, 2014, exchanges, Medicaid programs, and CHIP programs in each state must coordinate to ensure that individuals who apply through one of the other programs will be enrolled in the appropriate one. [PPACA]

CHIPRA Bonus Payments

In the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), the Congress appropriated more than $3 billion for CHIP bonus payments. Although these payments are described in the federal CHIP statute and are made from CHIP appropriations, they are only available to states that (1) increase Medicaid (not CHIP) child enrollment by significant amounts, and (2) implement five out of eight specific outreach and enrollment efforts described below. As shown in the table that follows, $75.4 million in bonus payments (2.25 percent of the available amount) was awarded to ten states in FY 2009 and $206.2 million to 15 states in FY 2010.

Eight Enrollment and Retention Efforts

Following is the list of eight enrollment and retention efforts, any five of which could qualify states with significant Medicaid child enrollment increases for CHIPRA bonus payments. To obtain CHIPRA bonus payments, the following efforts must apply to children, not adults, but must apply to children in both Medicaid and CHIP unless noted otherwise.[15]

1. **Twelve months of continuous eligibility.** States may choose to enroll children in Medicaid and CHIP for 12 months, regardless of changes in family income or family status that occur in the interim. There are certain conditions, however, that must still prompt a change in eligibility (e.g., death of the child, the child reaches the age limit).
2. **Liberalization of asset requirements.** States can meet this requirement in a couple of ways. First, they can eliminate altogether any asset test for determining children's eligibility for Medicaid and CHIP. (Only a few states still have asset tests for children.) Second, states with an asset test for children can use administrative verification of those assets. This is where the parent(s) can certify the amount of the family's assets by signature under penalty of perjury, or where the state can verify assets through means besides requiring documentation from the parent(s).
3. **Elimination of in-person interview requirement.** States' application or renewal process may not require a face-to-face interview, unless there are discrepancies or individual circumstances that merit it.
4. **Use of joint application for Medicaid and CHIP.** States may use a single application form and renewal forms that are used by both Medicaid and CHIP. Alternatively, the state Medicaid and CHIP programs may have separate application forms but are able to use either if submitted by an applicant.
5. **Automatic renewal (use of administrative renewal).** States can meet this requirement in a couple of ways. First, when a child's eligibility must be renewed, the state can provide the family with a pre-printed form completed by the state based on information it has on file. In this case, the state can continue the child's coverage, unless provided other information by the family or through the state's own verification efforts, or the state can require the family to confirm the information by returning a signed copy of the pre-populated form with any changes noted on the form. Another option does not involve a pre-printed form,

[15] These descriptions are based on §2105(a)(4) of the Social Security Act; CMS State Health Official (SHO) letter #09-015, CHIPRA Performance Bonus Payments, December 16, 2009, http://www.cms.gov/SMDL/downloads/SHO09015.pdf; and CMS SHO letter #10-008, CHIPRA Performance Bonus Payments, October 1, 2010, https://www.cms.gov/smdl/downloads/SHO10008.pdf.

but relies on *ex parte* redeterminations. This is where the state actually performs an eligibility redetermination based on information on file with the program or other agencies, notifying the family that coverage will continue, unless additional information is needed. To the extent information is not available to complete the redetermination, the family would be contacted only for submitting that additional information.

6. **Presumptive eligibility.** States may permit certain entities (e.g., medical providers, entities that determine eligibility for Head Start) to determine children's eligibility for Medicaid or CHIP on a presumptive, or preliminary, basis until the Medicaid or CHIP agency is able to do a full eligibility determination. Presumptively eligible children can be enrolled for up to two months without a full eligibility determination.
7. **Express Lane Eligibility (ELE).** In determining whether a child meets one or more Medicaid or CHIP eligibility requirements (e.g., income, household composition, residency), state Medicaid and CHIP programs have the option to rely on findings from designated Express Lane agencies—for example, public agencies that administer Temporary Assistance for Needy Families (TANF), Medicaid, CHIP, Supplemental Nutrition Assistance Program (food stamps), and the National School Lunch Program.
8. **Premium assistance.** States have the option to use premium assistance programs to help eligible individuals purchase private insurance through their employer. These programs must be cost-effective—that is, the cost of covering someone through his or her employer-sponsored insurance must not be greater than the cost of direct Medicaid or CHIP coverage. In the states that use premium assistance, most have implemented it through waivers. To qualify a state for CHIPRA bonus payments, however, the premium assistance program must *not* be through a waiver, but through particular Medicaid and CHIP state plan options—that is, those operating under §1906A *or* §2105(c)(10) of the Social Security Act.

TABLE 3A-1. FY 2009 and FY 2010 CHIPRA Bonus Payments

State	FY 2010 Outreach and Enrollment Efforts								FY 2009 CHIPRA Bonus Payments (millions of dollars)	FY 2010 CHIPRA Bonus Payments (millions of dollars)
	12 Months of Continuous Eligibility	Liberalization of Asset Requirements	Elimination of In-person Interview	Joint Application and Renewal Form	Automatic, Administrative Renewal	Presumptive Eligibility	Express Lane	Premium Assistance		
AL	✓	✓	✓	✓	✓	–	–	–	$39.8	$55.0
AK	✓	✓	✓	✓	✓	–	–	–	0.7	4.4
CO	–	✓	✓	✓	–	✓	–	✓	–	13.7
IL	✓	✓	✓	✓	✓	✓	–	–	9.5	15.0
IA	✓	✓	✓	✓	–	✓	–	–	–	6.8
KS	✓	✓	✓	✓	–	✓	–	–	1.2	2.6
LA	✓	✓	✓	✓	✓	–	–	–	1.5	3.6
MD	–	✓	✓	✓	✓	–	✓	–	–	10.5
MI	✓	✓	✓	✓	–	✓	–	–	4.7	9.3
NJ	–	✓	✓	✓	✓	✓	✓	–	3.1	8.8
NM	✓	✓	✓	✓	✓	✓	–	–	5.4	8.5
OH	✓	✓	✓	✓	–	✓	–	–	–	12.4
OR	✓	✓	✓	✓	✓	–	–	–	1.6	15.1
WA	✓	✓	✓	✓	–	–	–	✓	7.9	17.6
WI	–	✓	✓	✓	✓	–	–	✓	–	23.1
									$75.4	**$206.2**

Source: HHS 2011, *Connecting Kids to Coverage: Continuing the Progress—2010 CHIPRA Annual Report*, Appendix 3. http://www.insurekidsnow.gov/professionals/reports/chipra/2010_annual.pdf