MACPAC

Advising Congress on
Medicaid and CHIP Policy

Statement of
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Medicaid and CHIP
Payment and Access Commission

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Summary

Since its enactment with strong bipartisan support in 1997, CHIP has played an important role in providing insurance coverage and access to health care for tens of millions of low- and moderate-income children with incomes just above Medicaid eligibility levels. Under current law, CHIP is funded through fiscal year (FY) 2017. The Commission urges Congress to act as soon as possible to avoid disruption for families, plans, providers, and states, and to ensure that children continue to have access to needed health care services. Without congressional action, states will not receive new federal funds for CHIP beyond the end of this month, and states will rapidly deplete available funding. MACPAC projects that four states will exhaust available federal funds in the first quarter of FY 2018; another 27 will do so in the second quarter.

In January 2017, MACPAC recommended that Congress extend federal CHIP funding for a transition period of five years, as well as extend the CHIP maintenance of effort requirement and 23 percentage point increase in the CHIP matching rate though FY 2022. The Commission's priority in making these recommendations was to ensure the stability of children's health coverage during a period of uncertainty as Congress debates the future of Medicaid and subsidized exchange markets.

In coming to these recommendations, the Commission considered what would happen if no CHIP allotments were available to states after FY 2017. Our most recent estimates are that, if CHIP funding is not renewed, 1.2 million children covered under separate CHIP will become uninsured. While others may transition to employer-sponsored or exchange coverage, it would cost considerably more, potentially creating barriers to obtaining needed health and developmental services. In addition they could lose access to needed services that these sources are less likely to cover, such as dental care or audiology services.

When the Commission made these recommendations, it noted that coverage under separate CHIP authority should not be maintained indefinitely but that more time is needed to address concerns related to the affordability and comprehensiveness of other sources of children's coverage. Health insurance markets may face substantial changes over the next few years; unless renewed, federal funding for CHIP will be exhausted long before any such changes can be fully realized.

Although states can continue to use FY 2017 funds into FY 2018, they cannot do so indefinitely. Moreover, they have legal obligations to notify families, plans, and providers about future plans, which may include freezing enrollment, transitioning children to other sources of coverage, and making eligibility and enrollment systems changes. In some states (e.g., Arizona and West Virginia), state law requires termination of CHIP if federal funding is not available.

In the long term, a more seamless system of children's coverage needs to be developed. That is why the Commission made a number of recommendations for a more seamless system of children's coverage to accompany its recommendations for federal CHIP funding. Such a system would provide comprehensive and affordable coverage to low- and moderate-income children and remove the potential gaps in coverage children may experience as they transition between publicly and privately financed health insurance.

Statement of Anne L. Schwartz, PhD, Executive Director Medicaid and CHIP Payment and Access Commission

Good morning Chairman Hatch, Ranking Member Wyden, and members of the Committee. I am Anne Schwartz, executive director of the Medicaid and CHIP Payment and Access Commission (MACPAC). As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on issues affecting these programs. Its 17 members, including Chair Penny Thompson and Vice Chair Marsha Gold, are appointed by the U.S. Government Accountability Office (GAO). While the insights and information I will share this morning build on the analyses conducted by MACPAC's staff, they are in fact the views of the Commission itself. We appreciate the opportunity to share MACPAC's recommendations and work as this Committee considers the future of the State Children's Health Insurance Program (CHIP).

Overview of CHIP

Since its enactment with strong bipartisan support in 1997, CHIP, a joint federal-state program, has played an important role in providing insurance coverage and access to health care for millions of low-income children with incomes just above Medicaid eligibility levels. Over this period, the share of uninsured children in the typical CHIP income range (those with family income above 100 percent but below 200 percent of the federal poverty level (FPL)) has fallen dramatically—from 22.8 percent in 1997 to 6.7 percent in 2015 (MACPAC 2017a). In contrast, during the same period, which included two recessions, private coverage for children in this income range declined substantially—from 55 percent in 1997 to 29.8 percent in 2015 (Martinez et al. 2017).

In fiscal year 2016, 8.9 million children were enrolled in CHIP-funded coverage (CMS 2017a). States have flexibility in designing CHIP. States can operate these programs either as an expansion of Medicaid, an entirely separate program, or a combination of both approaches. States with Medicaid-expansion CHIP must provide the full Medicaid benefit package, including early and periodic screening, diagnostic, and treatment services, and must follow Medicaid cost-sharing rules. States with separate CHIP provide comprehensive health care services subject to the approval of the Secretary of the U.S. Department of Health and Human Services (the Secretary) or based on a benchmark benefit package. In separate CHIP, states may require premiums and cost sharing, such as

copayments and deductibles (although not for preventive services), with a combined limit of 5 percent of income. States receive an enhanced federal match for CHIP, subject to the cap on their allotments, and must contribute a state share to receive their federal funding allotments.

Basis for MACPAC recommendations

Under current law, CHIP is funded through FY 2017, and without congressional action, states will not receive any new federal funds for CHIP beyond September 30, 2017. Mindful of this date, the Commission devoted considerable attention over the past several years to CHIP's role in our health care system and policy approaches for the future. We reviewed available evidence about the quality and affordability of CHIP compared to other alternatives, and focused attention on the implications of various policy approaches for children and their families, states, providers, health plans, and the federal government.

Based on this review, the Commission issued a report this past January recommending that federal funding for CHIP be extended for five years. If CHIP funding is not renewed, many of the children covered under separate CHIP will lose their health coverage. While some of these children may be eligible for private coverage, their families would have to pay considerably more than under CHIP, potentially creating barriers to needed health and developmental services. In addition, they would lose access to services covered by CHIP that are not typically covered by other payers. Those covered by Medicaid-expansion CHIP would not lose coverage but there would be a significant shift in the funding obligation for their coverage to the states.

MACPAC has always looked at CHIP in its context, a relatively small public health coverage program in an evolving array of sources of coverage for children that includes Medicaid, publicly subsidized exchange coverage established by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), and employer-sponsored coverage. In the long term, the development of a more seamless system of children's coverage is needed. Such a system would provide comprehensive and affordable coverage to low- and moderate-income children, removing the potential gaps in coverage and care that can affect children as they transition among different sources of publicly and privately financed health insurance.

Moreover, the future of publicly financed health coverage markets currently is uncertain. Over the past few months, Congress has been debating reforms to both Medicaid and federally subsidized exchange coverage that would affect the available alternatives for children in the absence of CHIP. This uncertainty heightens the need for congressional action to extend CHIP.

In my testimony today, I will present the rationale behind the Commission's recommendations on the future of CHIP funding and children's coverage, as well as the evidence it considered in making its recommendations. I also will address CHIP financing; in particular, how states will be affected if federal CHIP funding ends. MACPAC's most recent analyses focus on when states are projected to run out of CHIP funds and how the requirement that states maintain coverage for children through fiscal year (FY) 2019 will affect states differentially based on their decisions to run CHIP as a Medicaid expansion or a separate program.

MACPAC's Recommendations on the Future of CHIP and Children's Coverage

In a January 2017 special report (made available in print in our March 2017 *Report to Congress on Medicaid and CHIP*, MACPAC made nine recommendations to Congress to fund and stabilize CHIP, and to move toward a more seamless system of affordable and comprehensive children coverage (Box 1).

Stabilizing children's health coverage

In making its recommendations for CHIP funding, a key priority for the Commission was to ensure the stability of children's health coverage during this period of uncertainty about other sources of coverage. The Commission recommends that Congress extend federal CHIP funding for a transitional period of five years through FY 2022. It also recommends extension of the current CHIP maintenance of effort (MOE) requirement and the 23 percentage point increase in the federal CHIP matching rate through FY 2022.

Rationale. Extending CHIP for a transition period would ensure that low- and moderate-income children would retain access to affordable insurance coverage during a time of uncertainty for coverage markets. The transition period of five years would also provide time to address concerns with affordability and benefits of other coverage sources, which are described in greater detail below. In addition, this period would provide federal and state policymakers time to plan and implement comprehensive children's coverage demonstrations, which the Commission also is recommending.

BOX 1. MACPAC Recommendations for the Future of CHIP and Children's Coverage

Recommendation 1.1

Congress should extend federal CHIP funding for a transition period that would maintain a stable source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.

Recommendation 1.2

Congress should extend federal CHIP funding for five years, through fiscal year 2022, to give federal and state policymakers time to develop policies for, and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.

Recommendation 1.3

In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP matching rate, currently in effect through FY 2019, for three additional years, through fiscal year 2022.

Recommendation 1.4

To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP.

Recommendation 1.5

In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums.

Recommendation 1.6

Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support state efforts to develop, test, and implement approaches to providing, for CHIP-eligible children, seamless health coverage that is as comprehensive and affordable as CHIP.

Recommendation 1.7

Congress should permanently extend the authority for states to use Express Lane Eligibility for children in Medicaid and CHIP.

Recommendation 1.8

The Secretary of Health and Human Services, in consultation with the Secretaries of Agriculture and Education, should not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.

Recommendation 1.9

Congress should extend funding for five years for grants to support outreach and enrollment of Medicaid- and CHIP-eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures program, through fiscal year 2022.

To further stabilize children's coverage and prevent states from rolling back eligibility, the Commission recommends extending the CHIP MOE through FY 2022. The current MOE, which requires states to maintain the CHIP eligibility levels in place on March 23, 2010 through FY 2019, was established by the ACA (Appendix A). The MOE also prohibits states from adopting eligibility and enrollment standards or methodologies that are more restrictive than those in place prior to the enactment of the ACA (§ 2105(d)(3) of the Act).

MACPAC also recommends extending the 23 percentage point increase to the CHIP enhanced matching rate through FY 2022. This increase was enacted in the ACA for FYs 2016—2019. In the current fiscal year, 11 states and the District of Columbia have a CHIP matching rate of 100 percent meaning that the federal government pays for 100 percent of the cost of providing CHIP coverage to children (Appendix B). An additional 22 states have CHIP matching rates ranging from 90 percent to 99 percent (MACPAC 2017a).

The Commission's recommendation reflects the view that an extension to the MOE, which it judged important to retaining gains in coverage, should be accompanied by an extension of enhanced funding. The increase to the CHIP matching rate is also thought to have influenced decisions in 2016 in some states to expand children's coverage, within permissible limits.[1] For example, Florida and Utah expanded Medicaid and CHIP coverage to lawfully residing immigrant children. In July 2016, Arizona reinstated CHIP, which it had previously closed.

The Commission has long held that coverage under separate CHIP authority should not be maintained indefinitely (MACPAC 2014a). The Commission also has stated that children's coverage should be affordable and comprehensive, and state flexibility in program design must be maintained. In the Commission's view, other current sources of coverage do not meet these standards. In addition, over the course of the Commission's deliberation, two additional facts became clear. First, more time is needed for assessing, planning, and implementing changes to address concerns of other coverage sources for children. Second, given the expectation that health insurance markets may face substantial changes over the next few years, federal funding for CHIP would be exhausted before these changes would be fully realized.

Implications if federal CHIP funding is not renewed

If CHIP funding ends and states exhaust available federal funds, the implications for states depend on whether they operate CHIP as a Medicaid expansion or a separate program. As of January 1, 2016, 10 states (including the District of Columbia) ran CHIP as a Medicaid expansion, 2 states had separate CHIP, and 39 operated combination

programs (MACPAC 2017a). In the absence of CHIP, children leaving separate CHIP and gaining other coverage likely would face higher cost sharing, different benefits, and enrollment in plans with different provider networks.

Increase in uninsurance. Although the MOE generally requires states to maintain their children's coverage eligibility levels in place when the ACA was enacted, states face different scenarios for separate CHIP and Medicaid-expansion if federal CHIP funds run out. States with Medicaid-expansion CHIP must continue that coverage for children, but instead of receiving the enhanced CHIP match, states will receive the lower Medicaid matching rate. Of the 8.4 million children enrolled in CHIP-funded coverage in 2015, 4.7 million were in Medicaid-expansion CHIP (MACPAC 2017a).

States with separate CHIP are permitted to terminate that coverage if federal CHIP funds run out. In this case, the ACA requires states to develop procedures to automatically transition children from separate CHIP to exchange coverage that has been certified as "at least comparable to" CHIP programs with respect to benefits and cost sharing (§2105(d)(3)(B) of the Social Security Act (the Act)). If the Secretary finds that no exchange plans are comparable to CHIP, states are not required facilitate the transition to exchange coverage, although families may obtain subsidized exchange coverage on their own. In November 2015, the Secretary of the U.S. Department of Health and Human Services (the Secretary) did not certify any exchange plan as comparable to CHIP coverage (CMS 2015).

We recently updated our analysis of how an end to separate CHIP would affect children's coverage, finding that in the absence of CHIP, 1.2 million children enrolled in separate CHIP would become uninsured because the cost of other sources of coverage would be unaffordable.[2] We estimate that 1.1 million would enroll in employer-sponsored coverage, and almost 700,000 would enroll in subsidized exchange coverage.

This analysis also found that of the children losing separate CHIP and who would become uninsured:

- 44 percent will be eligible for exchange subsidies;
- 40 percent are eligible for exchange subsidies because their parents do not have an offer of employer coverage or the available employer-sponsored coverage excludes dependent coverage; and
- 56 percent will have an offer of employer-sponsored coverage in the household.

However, the average additional premium to obtain family coverage would be 8 percent of income, making the total cost of family coverage equal to 11 percent of family income.

We also previously noted that the majority of separate-CHIP-enrolled children who would become uninsured if CHIP funding is exhausted have family income below 200 percent FPL (61.3 percent) and are non-white (53.9 percent). In addition, 89.6 percent have a full-time worker in the family (MACPAC 2015).

Affordability of coverage. For children in the CHIP income-eligibility range, CHIP coverage is considerably less costly to families with respect to both premiums and out-of-pocket cost sharing than exchange or employer-sponsored coverage (MACPAC 2016, 2015).[3] In 2015, the combined premiums and cost sharing of separate CHIP in 36 states averaged $158 per year per child, $127 for premium and $31 for cost sharing. On average in these 36 states, the effective actuarial value of CHIP coverage was 98 percent. In other words, the plans covered 98 percent of the cost of covered medical benefits and enrollees 2 percent.

If these same children were enrolled in employer-sponsored insurance, they would have faced an estimated $891 per year per child in average annual out-of-pocket spending ($603 for premiums and $288 in cost sharing), and if enrolled in the second lowest cost silver exchange plan, they would have faced an estimated $1,073 per year per child ($806 for premiums and $266 in cost sharing). The effective actuarial value averaged 81 percent in employer sponsored insurance plans and 82 percent in second lowest cost silver exchange plans, with families responsible for the remaining 18 percent to 19 percent through cost sharing (MACPAC 2016).

Adequacy of benefits. MACPAC's comparison of benefits in separate CHIP, Medicaid (including Medicaid-expansion CHIP), exchange plans, and employer-sponsored insurance found that covered benefits vary within each source—between states for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans (MACPAC 2015). Most separate CHIP, Medicaid, exchange, and employer-sponsored insurance plans cover major medical benefits, such as inpatient and outpatient care, physician services, and prescription drugs. Children enrolled in Medicaid-expansion CHIP are entitled to all Medicaid services, including early and periodic screening, diagnostic, and treatment (EPSDT) services that exchange and employer-sponsored plans often do not cover.

Differences are pronounced for dental care, an EPSDT service. Like Medicaid, separate CHIP covers pediatric dental services. However in most exchanges and employer-sponsored coverage, dental benefits are offered as a separate, stand-alone insurance product for which families pay separate premiums and cover cost sharing expenses. More than half of all employer-sponsored plans (54 percent) do not include pediatric dental coverage. Of the employers that offer separate dental coverage, many require an additional premium.

CHIP also covers many services important to children's healthy development that are not always available in exchange plans. For example, all separate CHIP and Medicaid programs cover audiology exams, and 95 percent of separate CHIP programs cover hearing aids. However, only 37 percent of exchange plan essential health benefit benchmarks cover audiology exams, and only 54 percent cover hearing aids (MACPAC 2015). Among employer-sponsored health plans, 34 percent cover pediatric audiology exams and 43 percent cover hearing aids (MACPAC 2015).

Provider networks. The Commission also looked at how CHIP provider networks compare to those of other sources of coverage. Under federal law, CHIP managed care is subject to the same federal provisions that establish standards for Medicaid managed care (§ 2103(f)(3) of the Act). These provisions require states to establish "standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity" (§ 1932(c)(1)(A)(i) of the Act). CHIP regulations also specify that a state must ensure "access to out-of-network providers when the network is not adequate for the enrollee's medical condition" (42 CFR 457.495).

Advocates have suggested that separate CHIP networks are better than Medicaid or exchange plan networks because they are similar to private plan networks or because they are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, we found little empirical evidence to either support or refute this assertion.

Implications for states

MACPAC has also considered the financial and operational implications for states if CHIP funding were to end, which are described below. Unless funding for CHIP is renewed, states will begin running out of available federal funds during the first quarter of FY 2018, which begins in just a few weeks. All states will exhaust their funds before the end of fiscal year 2018.

Exhaustion of federal funds. Federal funding for CHIP is capped and allotted to states annually. States have two years to spend their allotments, and unspent allotments are available for redistribution to other states experiencing CHIP funding shortfalls.[4] Under current law, new CHIP allotments are not available after FY 2017 and unspent FY 2017 CHIP allotments that remain available for expenditures in FY 2018 are reduced by one-third (§ 2104(m)(2)(B)(iv) of the Act).[5]

Under current law, in FY 2018, states may continue to spend unspent FY 2017 allotments and redistribution funds from prior years (an estimated $4.2 billion in total), however these funds are expected to be insufficient to cover expected state CHIP expenses in FY 2018 (an estimated $17.4 billion).[6] Based on state spending estimates submitted to CMS, MACPAC projects that three states and the District of Columbia will exhaust available federal CHIP funds sometime in the first quarter of the fiscal year, and 27 states will do so in the second quarter (Table 1 and Appendix C).

TABLE 1. Projected Exhaustion of Federal CHIP Funds in Fiscal Year 2018

Quarter of fiscal year	Number of states	States
First quarter (October–December 2017)	4	Arizona, District of Columbia, Minnesota, and North Carolina
Second quarter (January–March 2018)	27	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nevada, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, and Washington
Third quarter (April–June 2018)	19	Alabama, Georgia, Illinois, Indiana, Iowa, Maine, Maryland, Michigan, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, West Virginia, and Wisconsin
Fourth quarter (July–September 2018)	1	Wyoming

Note: CHIP is the State Children's Health Insurance Program.
Source: MACPAC 2017 analysis using June 2017 Medicaid and CHIP Budget and Expenditure System data from the Centers for Medicare & Medicaid Services, including quarterly projections provided by states in May 2017.

State policies may also affect when states exhaust their federal CHIP funding. For example, while the ACA's maintenance of effort (MOE) requirement generally prohibits reducing children's eligibility for CHIP, states are permitted to impose enrollment limits "in order to limit expenditures . . . to those for which Federal financial participation is available" (§2105(d)(3)(A)(iii) of the Act). States may also take other actions to reduce CHIP spending such as allowing CHIP waivers to expire and cutting payments to plans and providers.

State budgets. Most states have fiscal years that begin July 1; thus they have already set their budgets for the state fiscal year 2018. Despite the uncertainty of federal CHIP funding, 33 out of 40 states responding to a survey about the future of CHIP funding indicated that their state budget assumed that CHIP funding would continue; 21

states have assumed that the 23 percentage point increase in the CHIP match continues as well (NASHP 2017). Absent congressional action, these states will likely experience shortfalls and may have to close their separate CHIP programs or provide coverage to children enrolled in Medicaid-expansion CHIP with substantially fewer federal funds than anticipated.

Operational considerations and timelines. Although states can continue to use FY 2017 funds into FY 2018, they cannot do so indefinitely. Moreover, they have legal obligations to notify families, plans, and providers about future plans, which may include freezing enrollment, transitioning children to other sources of coverage, and making eligibility and enrollment systems changes (NASHP 2017). In some states (e.g., Arizona and West Virginia), state law requires termination of CHIP if federal funding is not available.

Although we are hearing from state officials that they do not wish to unnecessarily alarm beneficiaries and other stakeholders, others are planning to send notices this month with freezes beginning in October and November.

Companion Recommendations to Promote Seamless Children's Coverage

In addition to the recommendations pertaining to federal CHIP funding, the Commission made a number of companion recommendations for moving toward a more seamless system of children's coverage. These recommendations include:

- creating and funding a children's coverage demonstration grant program to support state efforts to develop, test, and implement approaches to providing CHIP-eligible children with seamless health coverage that is as comprehensive and affordable as CHIP;
- eliminating waiting periods in CHIP, aligning separate CHIP premium policies with those of Medicaid, and permanently extending authority for states to use Express Lane Eligibility; and
- extending funding to support outreach and enrollment of Medicaid- and CHIP-eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program.

Demonstration grants. State innovation will be a key driver in improving the system of coverage for low- and moderate-income children; federal support of such efforts would ease financial barriers to states that aspire to transform their children's coverage systems.

To encourage and support child-focused efforts, the Commission recommends providing planning and implementation demonstration grants to develop and test models for transforming coverage systems for children. Such models could be developed using existing state plan and waiver authorities, such as those available under Sections 1115 and 1332 of the Act. Developing options for a seamless system of affordable and comprehensive coverage for children across available coverage sources will require resources for research and analysis of markets, needs assessments, stakeholder and expert engagement, as well as legal, regulatory, policy, and cost analyses. These activities are typically not eligible for federal match under state plan authority, and in past efforts to develop and implement health delivery system changes, states have used waiver authority or other grant funding such as the Real Choice Systems Change grant program to finance these planning activities. Historically, state demonstrations have been an effective way to gain experience from which learning and strategies can be gleaned for broader take up by states.

Eliminate CHIP waiting periods and premiums for children under 150 percent FPL. While CHIP has been an enormously successful in reducing uninsurance, steps can be taken to promote greater continuity and seamlessness of coverage within the existing program. MACPAC initially recommended such steps relating to CHIP waiting periods and premiums in order to achieve these goals in March 2014, and continues to recommend them in 2017. There is little evidence showing that waiting periods have deterred crowd-out of private coverage; eliminating them would promote more stable coverage for children, simplify and make CHIP policy more consistent with Medicaid and other publicly finance coverage programs, and reduce administrative complexity and burden for families, states, health plans, and providers (MACPAC 2014b). Eliminating CHIP premiums for families with incomes under 150 percent FPL would reduce uninsurance and align CHIP premium policies with Medicaid policies for lower-income children. Compared to higher-income enrollees, families with incomes below 150 percent FPL are more price sensitive and less likely to take up CHIP coverage for their children when a premium is required (MACPAC 2017).

Express Lane Eligibility. The Commission recommends that Congress permanently extend Express Lane Eligibility (ELE) authority as an option states can adopt to simplify enrollment processes and promote continuity of coverage. ELE, currently authorized through September 30, 2017, permits states to rely on findings from another program designated as an Express Lane agency (e.g., Supplemental Nutrition Assistance Program, the National School Lunch Program, and Head Start) when making Medicaid and CHIP eligibility determinations (including renewals of eligibility).

ELE processes are associated with positive enrollment gains (both new enrollment and renewals), and administrative savings in some states (OIG 2016, Hoag et al. 2013). A federal evaluation indicated that, as of December 2013, nearly 1.4 million children enrolled in Medicaid or CHIP and retained coverage through ELE processes. Federal evaluations have found that some states reported that implementing ELE resulted in administrative savings. For example, one state reportedly saved $7.3 million between 2011 and 2014, and another state reported that the Medicaid agency saved $25.77 per initial enrollment and $5.15 per renewal (OIG 2016).[7] Without an extension, states that have implemented this option would be likely to incur additional costs in reverting to legacy eligibility processes. Should authority for the ELE option expire, the states that have implemented this option could only continue to do so under a Section 1115 waiver.[8]

The Commission also recommends that the HHS Secretary, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of Education, assess and report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families. Given the efficiencies and favorable enrollment gains associated with ELE as currently implemented, the Commission seeks information on changes necessary to modify ELE authority so that designated programs can use Medicaid or CHIP eligibility determination information, and the potential for reducing administrative burden for families and states.[9]

Renewal of other programs. The Commission recommends extending funding for three programs that focus on improving aspects of coverage or care for children enrolled in Medicaid or CHIP for five years through FY 2022: Medicaid and CHIP outreach and enrollment grants, the Childhood Obesity Research Demonstration (CORD) projects, and the Pediatric Quality Measures Program. In past years, funding for these programs has been renewed alongside CHIP funding.

- Outreach and enrollment grants created in 2009 have helped to support states, tribes, and community-based organizations in a variety of proactive outreach and enrollment activities. Funds have also supported a national outreach and enrollment campaign (CMS 2016). These grants are needed to maintain the historic successes in finding and enrolling eligible children and in helping them retain coverage at renewal. Absent such grants, state spending on outreach and enrollment would be limited by federal law to the 10 percent cap on CHIP administrative spending. CHIPRA established this program, appropriating $100 million for FYs 2009–2013. Funding was most recently renewed under the Medicare Access and CHIP Reauthorization Act (MACRA, P.L. 114-10) at $40 million for FYs 2016–2017.
- CHIPRA also established the Childhood Obesity Research Demonstration (CORD) to identify and evaluate health care and community strategies to combat childhood obesity in children age 2–12 enrolled in or eligible

for Medicaid or CHIP (Dooyema et al. 2013). CORD project grantees are evaluating whether multi-level, multi-setting approaches that integrate primary care with public health strategies can improve health behaviors and reduce childhood obesity. The second phase of CORD grants focuses on preventive services to individual children and families in Arizona and Massachusetts. Evaluation results which became available in July 2017 from some of the Phase I demonstrations, show a statistically significant reduction in child body mass index and increase in parent satisfaction with obesity related care. Providers who participated in one demonstration showed improved confidence in determining child overweight or obesity status, providing counseling, and setting behavioral goals with families. Most recently, MACRA extended funding for this effort, at $10 million for FYs 2016–2017. Continued federal funding is important to efforts to develop and test strategies to reduce childhood obesity, as well as disseminating results.

- In 2009, the Centers for Medicare & Medicaid Services (CMS) developed a core set of children's health care quality measures for children in Medicaid and CHIP, the first focused effort to measure the quality of publicly funded children's health care in a consistent way on a national level. Since 2010, state participation in reporting the voluntary core set of child health measures has increased; by FY 2014, all 50 states and the District of Columbia reported at least one measure (CMS 2016b, CMS 2011). In its initial phase, the Pediatric Quality Measures Program (PQMP) worked to improve and strengthen the initial child core set by bringing together experts, to develop and improve pediatric quality measures (AHRQ 2016, Sebelius 2014). Current PQMP grantees are assessing the feasibility and usability of the measures at the state, health plan, and provider levels (AHRQ 2016). MACRA extended funding of $20 million over FYs 2016 and 2017.

  An extension of PQMP funding will allow the Secretary to continue to develop, test, validate, and disseminate new child health quality measures, and to continue revising existing measures for children enrolled in Medicaid and CHIP. In a November 2014 letter to Congress, MACPAC stated that the needed investments in quality measurement are relatively small, but that they are important, not only for those whose care is financed by Medicaid and CHIP but also for taxpayers (MACPAC 2014b). In the letter, MACPAC noted several key areas in which ongoing work can build on progress to date, including strengthening CMS's capacity to calculate quality measures for states, improving quality measures for individuals with disabilities, and expanding the use of core quality measures in state quality improvement efforts. Continuation of the PQMP could also support efforts to measure and improve care provided to children with special health care needs enrolled in Medicaid and CHIP coverage.

Federal Budget Implications

The Congressional Budget Office (CBO) estimates that these recommendations would increase net federal spending by about $18.7 billion above the agency's current law baseline over a ten-year period of FYs 2017—2026. CBO's estimate also reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2015 at $5.7 billion each year.[10]

Conclusion

CHIP has clearly played an important role in providing access to health care coverage to low- to moderate-income children who otherwise would have been uninsured. In addition, CHIP has provided a platform for state innovations to improve take-up of public coverage among eligible but uninsured children, remove enrollment barriers, and focus on the quality of children's care. For example, outreach and enrollment techniques that often began as experiments in CHIP in individual states were subsequently identified as best practices and, in some cases, are now required in all states for both CHIP and Medicaid.

Congress now faces an important decision regarding the future of CHIP and its approach to providing a stable, affordable, and adequate source of coverage to millions of low- and moderate income children. MACPAC's recommendations provide advice on how to ensure a stable source of affordable and comprehensive coverage for low- and moderate-income children during a period of uncertainty affecting other health care markets.

When the Commission made its recommendations in January, it noted the urgent need for congressional action. With the end of the fiscal year in sight, the Commission must underscore the need for Congress to act as soon as possible to extend CHIP so that states do not respond to uncertainty around CHIP's future by implementing policies that reduce children's access to needed health care services.

The Commission's longer-term vision looks to state innovations that would create a more seamless system of children's coverage, provide comprehensive and affordable coverage for low- and moderate-income children, and remove the potential for gaps in coverage and care as children transition between different sources of publicly and privately financed health insurance. Such a system would promote greater alignment between Medicaid, CHIP, and other insurance sources and would smooth out transitions between them. The recommendations of the Commission reflect these goals and take steps to provide states and their federal partners the tools to transform children's coverage.

Thank you, members of the Committee. I would be happy to answer any questions you may have.

Endnotes

[1] The definition of targeted low-income child at section 2110(b) created a CHIP upper income-eligibility limit of no greater than 50 points above the state pre-CHIP Medicaid income levels.

[2] Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS), August 2017.

[3] Premiums and cost sharing are permitted for children in separate CHIP (capped at 5 percent of family income), but they generally are prohibited for children in Medicaid.

[4] MACPAC projects that the federal CHIP funding that states have received through their FY 2017 allotments and the redistribution funding that is available from prior year allotments will be adequate to cover projected state spending in FY 2017 (MACPAC 2017b). Four states and the District of Columbia are projected to have CHIP spending that exceeds their FY 2017 allotment, but these states are expected to receive redistribution funds in FY 2017 sufficient to cover their projected CHIP funding shortfall. Approximately $3 billion in redistribution funding is available in FY 2017 (MACPAC 2017b).

[5] States experiencing CHIP funding shortfalls can also receive contingency fund payments if their CHIP enrollment exceeds target levels specified in Section 2105(n) of the Act. However, contingency fund payments are not available for FY 2018 and subsequent years.

[6] The projected FY 2018 federal CHIP spending of $17.4 billion includes states and territories.

[7] Savings were the result of reduced staff time to complete eligibility determinations due to simplified enrollment processes, according to state reports (OIG 2016).

[8] As of January 1, 2016, eight states use ELE for children at Medicaid enrollment, five states use ELE for CHIP enrollment, seven states use ELE for children at Medicaid renewal, and three states use ELE for CHIP renewal (KFF 2016).

[9] Specifically, the report should describe the legislative and regulatory changes necessary to allow designated programs to use publicly subsidized health program findings to determine eligibility for other programs. The report should also assess the operational challenges and technical feasibility of this policy, and evaluate the implications of broadening ELE authority.

[10] The Congressional Budget Office (CBO) makes unique assumptions regarding the future of CHIP, which will affect the projected federal cost of legislative proposals it examines. CBO is required to assume that CHIP and certain other expiring programs continue in perpetuity at the last appropriated level (2 USC 907(b)(2)(A)(i)). However, in order to reduce the long-term federal spending projected by CBO under these assumptions, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was worded so that the last appropriated level for CBO's purposes was $5.7 billion in FY 2013 rather than the $17.4 billion actually appropriated for FY 2013. In extending federal CHIP funding by two years, the ACA continued the use of this language so that the last appropriated level for CBO's purposes for CHIP past FY 2015 is $5.7 billion rather than $21.1 billion.

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Appendix A:

Eligibility and Enrollment

Appendix A: CHIP Eligibility and Enrollment

TABLE A-1. CHIP Eligibility Levels (2016) and Enrollment (FY 2015) by State

State	Program type[1] (as of July 1, 2016)	Children in Medicaid-Expansion CHIP[1]				Children in separate CHIP							Total CHIP-funded child enrollment[4]
						Separate CHIP: Age 0–18[2]				Separate CHIP: Unborn		Total separate CHIP enrollment	
		Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Eligibility[3]	Enrollment		
Total	–	–	–	–	**4,702,185**	–	–	–	**3,362,642**	–	**327,175**	**3,689,817**	**8,397,651**
Alabama	Combination	–	–	107–141	45,697	142–312	142–312	142–312	87,346	–	–	87,346	**133,043**
Alaska	Medicaid expansion	159–203	159–203	124–203	10,182	–	–	–	–	–	–	–	**10,182**
Arizona[5]	Combination	–	–	104–133	37,412	148–200	142–200	134–200	1,399	–	–	1,399	**38,811**
Arkansas	Combination	–	–	107–142	108,706	143–211	143–211	143–211	–[6]	209	3,365	3,365	**112,071**
California[7,8]	Combination	208–261	142–261	108–261	1,787,470	262–317	262–317	262–317	2,461	317	122,197	124,658	**1,912,128**
Colorado	Combination	–	–	108–142	23,687	143–260	143–260	143–260	62,446	–	–	62,446	**86,133**
Connecticut	Separate	–	–	–	–	197–318	197–318	197–318	24,884	–	–	24,884	**24,884**
Delaware	Combination	194–212	–	110–133	238	–[9]	143–212[9]	134–212[9]	16,141	–	–	16,141	**16,379**
District of Columbia	Medicaid expansion	206–319	146–319	112–319	10,676	–	–	–	–	–	–	–	**10,676**
Florida	Combination	192–206	–	112–133	134,708	–[9]	141–210[9]	134–210[9]	293,386	–	–	293,386	**428,094**
Georgia	Combination	–	–	113–133	53,906	206–247	150–247	134–247	176,909	–	–	176,909	**230,815**
Hawaii	Medicaid expansion	191–308	139–308	105–308	27,239	–	–	–	–	–	–	–	**27,239**
Idaho	Combination	–	–	107–133	8,937	143–185	143–185	134–185	25,576	–	–	25,576	**34,513**
Illinois	Combination	–	–	108–142	113,105	143–313	143–313	143–313	191,328	208	26,138	217,466	**330,571**
Indiana	Combination	157–208	141–158	106–158	69,462	209–250	159–250	159–250	31,098	–	–	31,098	**100,560**
Iowa	Combination	240–375	–	122–167	21,777	–[9]	168–302[9]	168–302[9]	60,880	–	–	60,880	**82,657**
Kansas	Combination	–	–	113–133	54	167–238	150–238	134–238	77,085	–	–	77,085	**77,139**
Kentucky	Combination	–	142–159	109–159	50,926	196–213	160–213	160–213	36,050	–	–	36,050	**86,976**
Louisiana	Combination	142–212	142–212	108–212	122,878	213–250	213–250	213–250	3,498	209	9,238	12,736	**135,614**
Maine	Combination	–	140–157	132–157	13,440	192–208	158–208	158–208	8,870	–	–	8,870	**22,310**
Maryland	Medicaid expansion	194–317	138–317	109–317	142,327	–	–	–	–	–	–	–	**142,327**
Massachusetts[10]	Combination	185–200	133–150	114–150	79,299	201–300	151–300	151–300	76,519	200	13,123	89,642	**168,941**
Michigan[11]	Combination	195–212	143–212	109–212	29,226	–	–	–	85,302	195	5,171	90,473	**119,699**
Minnesota	Combination	275–283[12]	–	–	474	–	–	–	–	278	3,361	3,361	**3,835**
Mississippi	Combination	–	–	107–133	30,819	205–209	144–209	134–209	56,286	–	–	56,286	**87,105**
Missouri	Combination	–	148–150	110–150	38,600	197–300	151–300	151–300	39,744	300	–[13]	39,744	**78,344**
Montana	Combination	–	–	109–143	16,008	144–261	144–261	144–261	29,253	–	–	29,253	**45,261**
Nebraska	Combination	162–213	145–213	109–213	55,515	–	–	–	4,613[14]	197	2,090	6,703	**62,218**

TABLE A-1. (continued)

State	Program type[1] (as of July 1, 2016)	Children in Medicaid-Expansion CHIP[1]				Children in separate CHIP							Total CHIP-funded child enrollment[4]
						Separate CHIP: Age 0–18[2]				Separate CHIP: Unborn		Total separate CHIP enrollment	
		Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Infants <1 (% FPL)	Age 1–5 (% FPL)	Age 6–18 (% FPL)	Enrollment	Eligibility[3]	Enrollment		
Nevada	Combination	–	–	122–133	17,763	161–200	161–200	134–200	44,145	–	–	44,145	**61,908**
New Hampshire	Medicaid expansion	196–318	196–318	196–318	16,651	–	–	–	–	–	–	–	**16,651**
New Jersey	Combination	–	–	107–142	100,826	195–350	143–350	143–350	114,365	–	–	114,365	**215,191**
New Mexico	Medicaid expansion	200–300	200–300	138–240	17,155	–	–	–	40[14]	–	–	40	**17,195**
New York	Combination	–	–	110–149	235,945	219–400	150–400	150–400	394,787	–	–	394,787	**630,732**
North Carolina	Combination	194–210	141–210	107–133	134,413	–	–	138–211	100,237	–	4[15]	100,241	**234,654**
North Dakota	Combination	–	–	111–133	–	148–170	148–170	134–170	4,955	–	–	4,955	**4,955**
Ohio	Medicaid expansion	141–206	141–206	107–206	181,100	–	–	–	–	–	–	–	**181,100**
Oklahoma	Combination	169–205	151–205	115–205	174,167	–	–	–	208[16]	205	16,483	16,691	**190,858**
Oregon[17]	Combination	133–185	–	100–133	–	186–300	134–300	134–300	115,726	185	6,143	121,869	**121,869**
Pennsylvania	Combination	–	–	119–133	64,638	216–314	158–314	134–314	229,704	–	–	229,704	**294,342**
Rhode Island	Combination	190–261	142–261	109–261	29,948	–	–	–	1376[14]	253	–[18]	1,376	**31,324**
South Carolina	Medicaid expansion	194–208	143–208	107–208	98,336	–	–	–	–	–	–	–	**98,336**
South Dakota	Combination	177–182	177–182	124–182	12,441	183–204	183–204	183–204	3,775	–	–	3,775	**16,216**
Tennessee[19]	Combination	–	–	109–133	17,971	196–250	143–250	134–250	78,731	250	9,513	88,244	**106,215**
Texas	Combination	–	–	109–133	336,769	199–201	145–201	133–201	614,417	202	98,437	712,854	**1,049,623**
Utah	Combination	–	–	105–133	27,762	145–200	145–200	139–200	27,523	–	–	27,523	**55,285**
Vermont	Medicaid expansion	237–312	237–312	237–312	4,766	–	–	–	–	–	–	–	**4,766**
Virginia	Combination	–	–	109–143	86,551	144–200	144–200	144–200	102,815	–	–	102,815	**189,366**
Washington	Separate	–	–	–	–	211–312	211–312	211–312	37,883	193	8,154	46,037	**46,037**
West Virginia[20]	Combination	–	–	108–133	15,242	159–300	142–300	134–300	33,036	–	–	33,036	**48,278**
Wisconsin	Combination	–	–	101–151	96,973	– [9]	187–301[9]	152–301[9]	67,845	301	3,758	71,603	**168,576**
Wyoming[21]	Combination	–	–	119–133	–[22]	155–200	155–200	134–200	–[22]	–	–	–[22]	**5,649**

Notes: FY is fiscal year. FPL is federal poverty level. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but separate CHIP for the second half), the individual would only be counted in the most recent category. Enrollment data shown in the table are as of July 2016, the most current enrollment data available; states may subsequently revise their current or historical data.

– Dash indicates that state does not use this eligibility pathway.

[1] Under CHIP, states have the option to use an expansion of Medicaid, separate CHIP, or a combination of both approaches. Ten states (including the District of Columbia) are Medicaid expansions and two states are separate CHIP only (Connecticut and Washington). There are combination programs in 39 states; among those, 11 consider themselves to have separate programs but are technically combinations due to the transition of children below 133 percent FPL from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, Wyoming). Medicaid-expansion CHIP eligibility ranges of 5 percentage points attributable to the mandatory 5 percent disregard are not shown. For states that have different CHIP-funded eligibility levels for children age 6–13 and age 14–18, this table shows only the levels for children age 6–13. For example, Oklahoma offers CHIP-funded Medicaid coverage to children age 6–14 with family income 115–205 percent FPL, and to 14- to 18-year-olds with family income 65–205 percent FPL. Tennessee offers CHIP-funded Medicaid coverage to children age 6–14 with family income from 109–133 percent FPL and 14–19 year olds with family income 29–133 percent FPL.

[2] CHIP eligibility levels as of July 2016.

[3] Separate CHIP eligibility for children birth through age 18 generally begins where Medicaid coverage ends (as shown in the previous columns). For unborn children, there is no lower bound for income eligibility if the mother is not eligible for Medicaid.

[4] Total exceeds the sum of Medicaid expansion and separate CHIP columns due to only total CHIP enrollment being reported for Wyoming.

[5] Arizona closed separate CHIP (KidsCare) to new enrollment in January 2010. The state reinstated the program on September 1, 2016.

[6] Although Arkansas transitioned its Medicaid-expansion CHIP to separate CHIP effective January 1, 2015, the state continued to report enrollment for children age 0–18 years under Medicaid-expansion CHIP.

[7] California has separate CHIP in three counties only that covers children up to 317 percent FPL.

[8] Due to reporting system updates, California CHIP enrollment totals are estimates as a result of the exclusion of certain unborn CHIP enrollees in reporting.

[9] Separate CHIP in Delaware, Florida, Iowa, and Wisconsin covers children age 1–18.

[10] Certain enrollees who should have been assigned to CHIP were assigned to Medicaid beginning in the second quarter of 2014, making FY 2015 totals artificially low.

[11] CHIP-funded Medicaid Michigan enrollees are included in Medicaid enrollment counts rather than in CHIP for FY 2015. Therefore, the CHIP enrollment totals are artificially low and the Medicaid enrollment totals are artificially high. Michigan transitioned its separate CHIP into Medicaid-expansion CHIP effective January 1, 2016.

[12] In Minnesota, only infants (defined by the state as being under age two) are eligible for Medicaid-expansion CHIP up to 283 percent FPL.

[13] Missouri began covering unborn children effective January 1, 2016, however the state has not reported enrollment for this coverage group.

[14] Separate CHIP enrollment figures in Nebraska, New Mexico, and Rhode Island are for the states' §2101(f) coverage group under the Patient Protection and Affordable Care Act. Section 2101(f) required that states provide separate CHIP coverage to children to who lost Medicaid eligibility (including through Medicaid-expansion CHIP) due to the elimination of income disregards under the modified adjusted gross income (MAGI) based methodologies. Children covered under §2101(f) remained eligible for such coverage until their next scheduled renewal or their 19th birthday, or until they moved out of state, requested removal from the program, or were deceased. Coverage under §2101(f) has now been phased out.

[15] North Carolina does not provide unborn children separate CHIP coverage. Errors in enrollment data reported are likely due to data quality issues.

[16] Separate CHIP enrollment in Oklahoma is for children enrolled in the state's premium assistance program.

[17] Certain Oregon enrollees who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FY 2014 and FY 2015.

[18] Lack of enrollment for separate CHIP unborn coverage in Rhode Island is likely due to data quality issues.

[19] While Tennessee covers children with CHIP-funded Medicaid, enrollment is currently capped, except for children who roll over from traditional Medicaid.

[20] West Virginia's enrollment totals are artificially high because children who transitioned between CHIP and Medicaid are reported in both programs, rather than the program they were last enrolled.

[21] CMS's FY 2015 children's enrollment report considers these values to be estimates.

[22] Due to inconsistencies between the Statistical Enrollment Data System data and the Centers for Medicare & Medicaid Services' FY 2015 children's enrollment report, we do not report enrollment for Medicaid expansion and separate CHIP. We only report total CHIP enrollment as provided in CMS's FY 2015 children's enrollment report.

Sources: Personal communication with CMS staff on December 2, 2016 and December 9, 2016. For numbers of children: MACPAC, 2016, analysis of CHIP Statistical Enrollment Data System from Centers for Medicare & Medicaid Service as of July 1, 2016; MACPAC, 2016, *MACStats: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, https://www.macpac.gov/publication/child-enrollment-in-chip-and-medicaid-by-state/. For eligibility levels: MACPAC, 2016, *MACStats: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, https://www.macpac.gov/publication/medicaid-and-chip-income-eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-children-and-pregnant-women-by-state/.

Appendix B:

CHIP Enhanced Federal Medical Assistance Percentages

Appendix B: CHIP Enhanced Federal Medical Assistance Percentages

TABLE B-1. CHIP Enhanced Federal Medical Assistance Percentages by State, FYs 2013–2017

State	E-FMAPs for CHIP		
	FY 2015[1]	FY 2016[2]	FY 2017[2]
All states (median)	**70.8%**	**93.8%**	**94.0%**
Alabama	78.3	100.0	100.0
Alaska	65.0	88.0	88.0
Arizona	77.9	100.0	100.0
Arkansas	79.6	100.0	100.0
California	65.0	88.0	88.0
Colorado	65.7	88.5	88.0
Connecticut	65.0	88.0	88.0
Delaware	67.5	91.4	90.9
District of Columbia	79.0	100.0	100.0
Florida	71.8	95.5	95.8
Georgia	76.9	100.0	100.0
Hawaii	66.6	90.8	91.5
Idaho	80.2	100.0	100.0
Illinois	65.5	88.6	88.9
Indiana	76.6	99.6	99.7
Iowa	68.9	91.4	92.7
Kansas	69.6	92.2	92.4
Kentucky	79.0	100.0	100.0
Louisiana	73.4	96.6	96.6
Maine	73.3	96.9	98.1
Maryland	65.0	88.0	88.0
Massachusetts	65.0	88.0	88.0
Michigan	75.9	98.9	98.6
Minnesota	65.0	88.0	88.0
Mississippi	81.5	100.0	100.0
Missouri	74.4	97.3	97.3
Montana	76.1	98.7	98.9

TABLE D-1. (continued)

State	E-FMAPs for CHIP		
	FY 2015[1]	FY 2016[2]	FY 2017[2]
Nebraska	67.3%	88.8%	89.3%
Nevada	75.1	98.5	98.3
New Hampshire	65.0	88.0	88.0
New Jersey	65.0	88.0	88.0
New Mexico	78.8	100.0	100.0
New York	65.0	88.0	88.0
North Carolina	76.1	99.4	99.8
North Dakota	65.0	88.0	88.0
Ohio	73.9	96.7	96.6
Oklahoma	73.6	95.7	95.0
Oregon	74.8	98.1	98.1
Pennsylvania	66.3	89.4	89.3
Rhode Island	65.0	88.3	88.7
South Carolina	79.5	100.0	100.0
South Dakota	66.2	89.1	91.5
Tennessee	75.5	98.5	98.5
Texas	70.6	93.0	92.3
Utah	79.4	100.0	100.0
Vermont	67.8	90.7	91.1
Virginia	65.0	88.0	88.0
Washington	65.0	88.0	88.0
West Virginia	80.0	100.0	100.0
Wisconsin	70.8	93.8	94.0
Wyoming	65.0	88.0	88.0

Notes: FY is fiscal year. FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). The E-FMAP determines the federal share of both service and administrative costs for CHIP, subject to the availability of funds from a state's federal allotments for CHIP.

Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent. In FYs 2016 through 2019, the E-FMAPs are increased by 23 percentage points. For additional information on Medicaid FMAPs, see https://www.macpac.gov/subtopic/matching-rates/.

E-FMAPs for the territories are not included. In FY 2015, all territories had an E-FMAP of 68.5 percent, and in FY 2016 and 2017, 91.5 percent.

[1] In FY 2015, states received the traditional CHIP E-FMAP.

[2] Under the ACA, beginning on October 1, 2015, and ending on September 30, 2019, the enhanced FMAPs are increased by 23 percentage points, not to exceed 100 percent, for all states.

Sources: Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, ASPE FMAP reports for 2015, 2016, and 2017, https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages (for FY 2017), http://aspe.hhs.gov/health/reports/2015/FMAP2016/fmap16.cfm (for FY 2016), http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.pdf (for FY 2015).

Appendix C:

Federal CHIP Funding: When Will States Exhaust Allotments?

Federal CHIP Funding: When Will States Exhaust Allotments?

Under current law, federal funds for the State Children's Health Insurance Program (CHIP) are only provided through fiscal year (FY) 2017. Unless CHIP funding is extended, all states are expected to exhaust their federal CHIP funds during FY 2018; this includes unspent CHIP funding from prior years. Three states and the District of Columbia are projected to exhaust their funds by December 2017. Most states (31 states and the District of Columbia) are projected to exhaust federal CHIP funds by March 2018. These estimates are based on states' projections of their CHIP spending for FYs 2017 and 2018.[1] How quickly states deplete CHIP funds could change if actual CHIP spending is above or below projections.

This issue brief updates data on the exhaustion of CHIP funds presented in a March 2017 issue brief and with MACPAC's January 2017 *Recommendations for the Future of CHIP and Children's Coverage*. With the end of FY 2017 approaching, congressional action to renew CHIP funding is urgent to ensure the stability of children's coverage during a time in which health insurance markets are expected to face substantial changes, and to provide budgetary certainty for states. If CHIP funding is not renewed, states will need to make decisions including whether to end separate CHIP, how to finance Medicaid-expansion CHIP with reduced federal spending, and how to provide information to families, providers, and plans (Hensley-Quinn and King 2016).

Federal CHIP Funding and Its Exhaustion under Current Law

Federal CHIP funds are allotted to states annually based on each state's recent CHIP spending, increased by a growth factor. States have two years to spend their allotments, and unspent allotments are available for redistribution to other states experiencing CHIP funding shortfalls. Under current law, new CHIP allotments are not available after FY 2017 and unspent FY 2017 CHIP allotments that remain available for expenditures in FY 2018 are reduced by one-third (§ 2104(m)(2)(B)(iv) of the Social Security Act (the Act)).

States experiencing CHIP funding shortfalls can also receive contingency fund payments if their CHIP enrollment exceeds target levels specified in Section 2105(n) of the Act. However, contingency fund payments are not available for FY 2018 and subsequent years.

CHIP funding in FY 2017

The federal CHIP funding that states have received for FY 2017 and the redistribution funding that is available from prior year allotments is projected to be adequate to cover projected spending in FY 2017. Two states (Arizona and Minnesota) are projected to have CHIP spending that exceeds their FY 2017 allotment, but these states are expected to receive redistribution funds in FY 2017 sufficient to cover their

projected CHIP funding shortfall. Approximately $3 billion in redistribution funding is available in FY 2017 (CMS 2017).

CHIP funding in FY 2018

Under current law, in FY 2018, states may continue to spend unspent FY 2017 allotments and redistribution funds from prior years. These funds will cover some but not all expected state CHIP expenses in FY 2018. By the second quarter of FY 2018, more than half of states are projected to exhaust all available federal CHIP funding, including redistribution funds (Table 1).

TABLE 1. Projected Exhaustion of Federal CHIP Funds in Fiscal Year 2018

Quarter of fiscal year	Number of states	States
First quarter (October–December 2017)	4	Arizona, District of Columbia, Minnesota, and North Carolina
Second quarter (January–March 2018)	27	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nevada, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, and Washington
Third quarter (April–June 2018)	19	Alabama, Georgia, Illinois, Indiana, Iowa, Maine, Michigan, Maryland, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, West Virginia, and Wisconsin
Fourth quarter (July–September 2018)	1	Wyoming

Note: CHIP is the State Children's Health Insurance Program.
Source: MACPAC 2017 analysis using June 2017 Medicaid and CHIP Budget and Expenditure System data from the Centers for Medicare & Medicaid Services, including quarterly projections provided by states in May 2017.

An estimated $4.2 billion in unspent FY 2017 allotments will be available for spending in FY 2018. Total projected FY 2018 federal CHIP spending for states and territories is $17.4 billion. States will exhaust their federal CHIP funds at different points during FY 2018 depending on their rollover balances from prior year allotments and projected spending (Table 2).

TABLE 2. Projected Federal CHIP Funding and Spending in FY 2018, by State (millions)

State	Estimated unspent FY 2017 allotments	Unspent FY 2017 allotments available in FY 2018	FY 2018 projected redistribution funding from prior year allotments	Total FY 2018 projected CHIP funding	FY 2018 projected federal CHIP spending	Month projected to exhaust CHIP funding
	A	B = A × .67	C	D = B + C	E	F
Total	**$6,346.2**	**$4,230.8**	**$2,949.4**	**$7,180.2**	**$17,372.4**	**N/A**
Alabama	176.9	118.0	37.4	155.3	284.4	April 2018
Alaska	17.8	11.8	5.4	17.2	35.7	March 2018
Arizona	0.0	0.0	60.1	60.1	267.9	December 2017
Arkansas	96.3	64.2	28.7	92.9	191.9	March 2018
California	192.2	128.1	710.0	838.1	3291.4	January 2018
Colorado	87.5	58.3	55.1	113.4	303.7	February 2018
Connecticut	24.3	16.2	14.3	30.5	79.9	February 2018
Delaware	10.6	7.1	6.3	13.4	35.2	February 2018
District of Columbia	1.6	1.1	10.9	11.9	49.4	December 2017
Florida	135.7	90.5	204.6	295.1	1002.2	January 2018
Georgia	220.6	147.1	56.6	203.6	399.1	April 2018
Hawaii	17.4	11.6	8.2	19.8	48.1	February 2018
Idaho	22.2	14.8	15.4	30.2	83.4	February 2018
Illinois	349.1	232.7	36.6	269.3	395.7	June 2018
Indiana	144.8	96.5	19.9	116.4	185.2	May 2018
Iowa	75.8	50.6	19.4	70.0	137.2	April 2018
Kansas	47.7	31.8	15.9	47.7	102.8	March 2018
Kentucky	87.7	58.4	40.7	99.2	240.0	February 2018
Louisiana	134.1	89.4	58.5	147.9	350.0	March 2018
Maine	29.3	19.5	3.3	22.8	34.1	June 2018
Maryland	187.6	125.1	35.0	160.1	281.0	April 2018
Massachusetts	168.4	112.3	117.0	229.3	633.7	February 2018
Michigan	264.8	176.5	31.3	207.9	316.2	May 2018
Minnesota	0.0	0.0	38.8	38.8	172.9	December 2017
Mississippi	147.7	98.5	41.3	139.8	282.5	March 2018
Missouri	118.6	79.1	32.8	111.8	225.0	March 2018
Montana	31.8	21.2	18.4	39.6	103.2	February 2018
Nebraska	61.1	40.7	6.8	47.5	70.9	June 2018
Nevada	16.5	11.0	15.2	26.2	78.6	January 2018
New Hampshire	19.9	13.3	4.5	17.8	33.4	April 2018
New Jersey	337.1	224.7	59.7	284.4	490.7	April 2018
New Mexico	95.7	63.8	10.8	74.6	112.0	May 2018
New York	527.3	351.6	197.1	548.6	1229.8	March 2018
North Carolina	12.2	8.2	182.9	191.1	823.2	December 2017

TABLE 2. (continued)

State	Estimated unspent FY 2017 allotments	Unspent FY 2017 allotments available in FY 2018	FY 2018 projected redistribution funding from prior year allotments	Total FY 2018 projected CHIP funding	FY 2018 projected federal CHIP spending	Month projected to exhaust CHIP funding
	A	B = A × .67	C	D = B + C	E	F
North Dakota	$16.6	$11.1	$2.3	$13.3	$21.2	May 2018
Ohio	200.1	133.4	70.1	203.5	445.6	March 2018
Oklahoma	127.5	85.0	30.4	115.4	220.6	April 2018
Oregon	48.6	32.4	52.5	84.9	266.3	January 2018
Pennsylvania	193.6	129.1	114.1	243.2	637.6	February 2018
Rhode Island	11.1	7.4	15.4	22.8	76.1	January 2018
South Carolina	127.5	85.0	15.5	100.5	154.2	May 2018
South Dakota	16.2	10.8	4.5	15.3	30.9	March 2018
Tennessee	202.2	134.8	30.1	164.9	268.8	May 2018
Texas	1074.5	716.4	204.6	921.0	1628.0	April 2018
Utah	30.0	20.0	28.2	48.2	145.6	January 2018
Vermont	5.6	3.7	5.5	9.2	28.1	January 2018
Virginia	127.5	85.0	51.0	136.0	312.3	March 2018
Washington	42.1	28.0	49.0	77.1	246.6	January 2018
West Virginia	43.8	29.2	8.9	38.0	68.6	April 2018
Wisconsin	127.3	84.9	31.8	116.7	226.7	April 2018
Wyoming	12.2	8.1	0.8	8.9	11.5	July 2018

Notes: FY is fiscal year. CHIP is the State Children's Health Insurance Program. Total dollars include territories. Under current law, available unspent FY 2017 CHIP allotments are reduced by one-third in FY 2018. Projected redistribution funding is distributed proportionally among states based on their projected CHIP funding shortfalls for FY 2018 and the amount of unspent CHIP funding available from prior years.
Source: MACPAC 2017 analysis as of June 2017 of Medicaid and CHIP Budget Expenditure System data from the Centers for Medicare & Medicaid Services, including quarterly projections provided by states in May 2017.

Implications

The exhaustion of CHIP funding in FY 2018 will affect state budgets and will require states to make decisions about children's coverage depending on the type of CHIP program states had in place in March 2010.[2] Under the maintenance of effort requirement in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), states must maintain 2010 Medicaid and CHIP eligibility levels for children through FY 2019.

States with separate CHIP are permitted to terminate that coverage if federal CHIP funding runs out; states with Medicaid-expansion CHIP must continue that coverage for children at the lower federal Medicaid matching rate. As of January 2016, 10 states (including the District of Columbia) ran CHIP as a Medicaid expansion, 2 states had separate CHIP, and 39 states operated a combination of both approaches (Table 3, MACPAC 2017).

Separate CHIP

Of the 8.4 million children enrolled in CHIP-funded coverage during FY 2015, 43.9 percent (3.7 million) were enrolled in separate CHIP. Once federal CHIP funding is exhausted, states are not obligated to continue covering these children. In the absence of separate CHIP coverage, some of these children would be eligible for employer-sponsored insurance or subsidized exchange coverage. MACPAC's prior estimates indicated that 1.1 million children would become uninsured (MACPAC 2015).[3] States that elect to shut down CHIP in the absence of federal funding will bear little direct cost for children they formerly covered whether they move to employer-sponsored or subsidized exchange coverage, or become uninsured.

Medicaid-expansion CHIP

In FY 2015, 4.7 million children were enrolled in Medicaid-expansion CHIP. If CHIP funding is exhausted, the federal matching rate for these children falls back from the CHIP enhanced match to the regular Medicaid matching rate.[4] Although states are generally prohibited from reducing eligibility levels in Medicaid-expansion CHIP through at least FY 2019, the budget consequences resulting from the higher state share of spending for those children could lead states to take other steps affecting access, such as lowering provider payment rates or increasing requirements for prior authorization.

TABLE 3. State CHIP Program Type and Enrollment

State	Program type[1]	CHIP-funded enrollment (FY 2015)					Month and year of projected CHIP funding exhaustion (as of June 2017)
		Medicaid-expansion CHIP	Separate CHIP			Total[2]	
			Birth–18	Unborn	Total		
Total		**4,702,185**	**3,362,642**	**327,175**	**3,689,817**	**8,397,651**	
Alabama	Combination	45,697	87,346	–	87,346	133,043	April 2018
Alaska	Medicaid Expansion	10,182	–	–	–	10,182	March 2018
Arizona[3]	Combination	37,412	1,399	–	1,399	38,811	December 2017
Arkansas	Combination	108,706	– [4]	3,365	3,365	112,071	March 2018
California[5,6]	Combination	1,787,470	2,461	122,197	124,658	1,912,128	January 2018
Colorado	Combination	23,687	62,446	–	62,446	86,133	February 2018
Connecticut	Separate	–	24,884	–	24,884	24,884	January 2018

TABLE 3. (continued)

State	Program type[1]	CHIP-funded enrollment (FY 2015)					Month and year of projected CHIP funding exhaustion (as of June 2017)
		Medicaid-expansion CHIP	Separate CHIP			Total[2]	
			Birth–18	Unborn	Total		
Delaware	Combination	238	16,141	–	16,141	16,379	February 2018
District of Columbia	Medicaid Expansion	10,676	–	–	–	10,676	December 2017
Florida	Combination	134,708	293,386	–	293,386	428,094	January 2018
Georgia	Combination	53,906	176,909	–	176,909	230,815	April 2018
Hawaii	Medicaid Expansion	27,239	–	–	–	27,239	March 2018
Idaho	Combination	8,937	25,576	–	25,576	34,513	February 2018
Illinois	Combination	113,105	191,328	26,138	217,466	330,571	May 2018
Indiana	Combination	69,462	31,098	–	31,098	100,560	May 2018
Iowa	Combination	21,777	60,880	–	60,880	82,657	April 2018
Kansas	Combination	54	77,085	–	77,085	77,139	March 2018
Kentucky	Combination	50,926	36,050	–	36,050	86,976	February 2018
Louisiana	Combination	122,878	3,498	9,238	12,736	135,614	March 2018
Maine	Combination	13,440	8,870	–	8,870	22,310	June 2018
Maryland	Medicaid Expansion	142,327	–	–	–	142,327	April 2018
Massachusetts[7]	Combination	79,299	76,519	13,123	89,642	168,941	February 2018
Michigan[8]	Combination	29,226	85,302	5,171	90,473	119,699	June 2018
Minnesota	Combination	474	–	3,361	3,361	3,835	December 2017
Mississippi	Combination	30,819	56,286	–	56,286	87,105	March 2018

TABLE 3. (continued)

State	Program type[1]	CHIP-funded enrollment (FY 2015)					Month and year of projected CHIP funding exhaustion (as of June 2017)
		Medicaid-expansion CHIP	Separate CHIP			Total[2]	
			Birth–18	Unborn	Total		
Missouri	Combination	38,600	39,744	– [9]	39,744	78,344	March 2018
Montana	Combination	16,008	29,253	–	29,253	45,261	February 2018
Nebraska	Combination	55,515	4,613 [10]	2,090	6,703	62,218	May 2018
Nevada	Combination	17,763	44,145	–	44,145	61,908	January 2018
New Hampshire	Medicaid Expansion	16,651	–	–	–	16,651	April 2018
New Jersey	Combination	100,826	114,365	–	114,365	215,191	April 2018
New Mexico	Medicaid Expansion	17,155	40 [10]	–	40	17,195	May 2018
New York	Combination	235,945	394,787	–	394,787	630,732	March 2018
North Carolina	Combination	134,413	100,237	4 [11]	100,241	234,654	December 2017
North Dakota	Combination	–	4,955	–	4,955	4,955	May 2018
Ohio	Medicaid Expansion	181,100	–	–	–	181,100	March 2018
Oklahoma	Combination	174,167	208 [12]	16,483	16,691	190,858	April 2018
Oregon[13]	Combination	–	115,726	6,143	121,869	121,869	February 2018
Pennsylvania	Combination	64,638	229,704	–	229,704	294,342	February 2018
Rhode Island	Combination	29,948	1376 [10]	– [14]	1,376	31,324	February 2018
South Carolina	Medicaid Expansion	98,336	–	–	–	98,336	June 2018
South Dakota	Combination	12,441	3,775	–	3,775	16,216	March 2018
Tennessee[15]	Combination	17,971	78,731	9,513	88,244	106,215	May 2018

TABLE 3. (continued)

State	Program type[1]	CHIP-funded enrollment (FY 2015)					Month and year of projected CHIP funding exhaustion (as of June 2017)
		Medicaid-expansion CHIP	Separate CHIP			Total[2]	
			Birth–18	Unborn	Total		
Texas	Combination	336,769	614,417	98,437	712,854	1,049,623	April 2018
Utah	Combination	27,762	27,523	–	27,523	55,285	January 2018
Vermont	Medicaid Expansion	4,766	–	–	–	4,766	January 2018
Virginia	Combination	86,551	102,815	–	102,815	189,366	February 2018
Washington	Separate	–	37,883	8,154	46,037	46,037	January 2018
West Virginia[16]	Combination	15,242	33,036	–	33,036	48,278	April 2018
Wisconsin	Combination	96,973	67,845	3,758	71,603	168,576	April 2018
Wyoming[17]	Combination	[18]	[18]	–	[18]	5,649	July 2018

Notes: FPL is federal poverty level. FY is fiscal year. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but a separate CHIP program for the second half) the individual would only be counted in the most recent category. Enrollment data shown in the table are as of July 2016, the most current enrollment data available; states may subsequently revise their current or historical data.

– Dash indicates zero. State does not use eligibility pathway.

[1] Under CHIP, states have the option to use an expansion of Medicaid, separate CHIP, or a combination of both approaches. Eleven states consider their programs to be separate but technically have combination programs due to the transition of children below 133 percent FPL from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, and Wyoming).

[2] Total exceeds the sum of Medicaid expansion and separate CHIP columns due to Wyoming reporting total CHIP enrollment only.

[3] Arizona closed its separate CHIP (KidsCare) to new enrollment in January 2010. The state reinstated the program on September 1, 2016.

[4] Although Arkansas transitioned its Medicaid-expansion CHIP to separate CHIP effective January 1, 2015, the state continued to report enrollment for children age 0–18 years under Medicaid-expansion CHIP.

[5] California has separate CHIP in three counties only that covers children up to 317 percent FPL.

[6] Due to reporting system updates, California CHIP enrollment totals are estimates as a result of the exclusion of certain unborn CHIP enrollees in reporting.

TABLE 3. (continued)

[7] Certain enrollees who should have been assigned to CHIP were assigned to Medicaid beginning in the second quarter of 2014, making FY 2015 totals artificially low.

[8] In Michigan, CHIP-funded Medicaid enrollees are included in Medicaid enrollment counts, rather than in CHIP for FY 2015. Therefore, the CHIP enrollment totals are artificially low. Michigan transitioned from separate CHIP to Medicaid-expansion CHIP effective January 1, 2016.

[9] Missouri began covering unborn children effective January 1, 2016. However, the state has not reported enrollment for this coverage group.

[10] Separate CHIP enrollment in Nebraska, New Mexico, and Rhode Island are for the states' section 2101(f) coverage group under the Patient Protection and Affordable Care Act. Section 2101(f) required that states provide separate CHIP coverage to children to who lost Medicaid eligibility (including through Medicaid-expansion CHIP) due to the elimination of income disregards under the modified adjusted gross income-based methodologies. Children covered under section 2101(f) remained eligible for such coverage until their next scheduled renewal, their 19th birthday, they moved out of state, they requested removal from the program, or were deceased. Coverage under section 2101(f) has now been phased out.

[11] North Carolina does not provide unborn children with separate CHIP coverage. Errors in enrollment data reported are likely due to data quality issues.

[12] Separate CHIP enrollment in Oklahoma is for children enrolled in the state's premium assistance program.
[13] Certain Oregon enrollees who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FYs 2014 and 2015.

[14] Lack of enrollment for separate CHIP unborn children coverage in Rhode Island is likely due to data quality issues.

[15] While Tennessee covers children with CHIP-funded Medicaid, enrollment is currently capped, except for children who roll over from traditional Medicaid.

[16] West Virginia's enrollment totals are artificially high because children who transitioned between CHIP and Medicaid are reported in both programs, rather than the program they were last enrolled.

[17] The Centers for Medicare & Medicaid Services (CMS) FY 2015 children's enrollment report considers these values to be estimates.

[18] Due to inconsistencies between the Statistical Enrollment Data System (SEDS) data and CMS's FY 2015 children's enrollment report, we do not report enrollment for Medicaid expansion and separate CHIP. We only report total CHIP enrollment as provided in CMS's FY 2015 children's enrollment report.

Sources: For numbers of children: MACPAC analysis of CMS SEDS data from as of July 1, 2016; *MACStats: Medicaid and CHIP Data Book, December 2016*; personal communication with CMS staff on December 2, 2016; and December 9, 2016. For projected exhaustion of CHIP funds: MACPAC 2017 analysis using March June 2017 Medicaid and CHIP Budget and Expenditure System data from CMS, including quarterly projections provided by states in February May 2017.

Endnotes

[1] States report their anticipated expenditures for both Medicaid and CHIP to the Centers for Medicare & Medicaid Services on a quarterly basis. The data used for this issue brief reflect quarterly projections provided by states in May 2017. MACPAC previously issued this data in March 2017 using states' budget projections submitted in February 2017.

[2] States have the flexibility to structure CHIP as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches.

[3] If CHIP funding were exhausted, unborn children enrolled through separate CHIP in 15 states could not be moved into Medicaid under current law and regulations.

[4] In FY 2017, the median CHIP matching rate is 94.0 percent and the median Medicaid matching rate is 58.5 percent (MACPAC 2016).

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