Next Steps for the Children's Health Insurance Program

by Joan Alker and Anne Dwyer

Eleventh in a series of papers from the Georgetown University Center for Children and Families on the future of children's health coverage.

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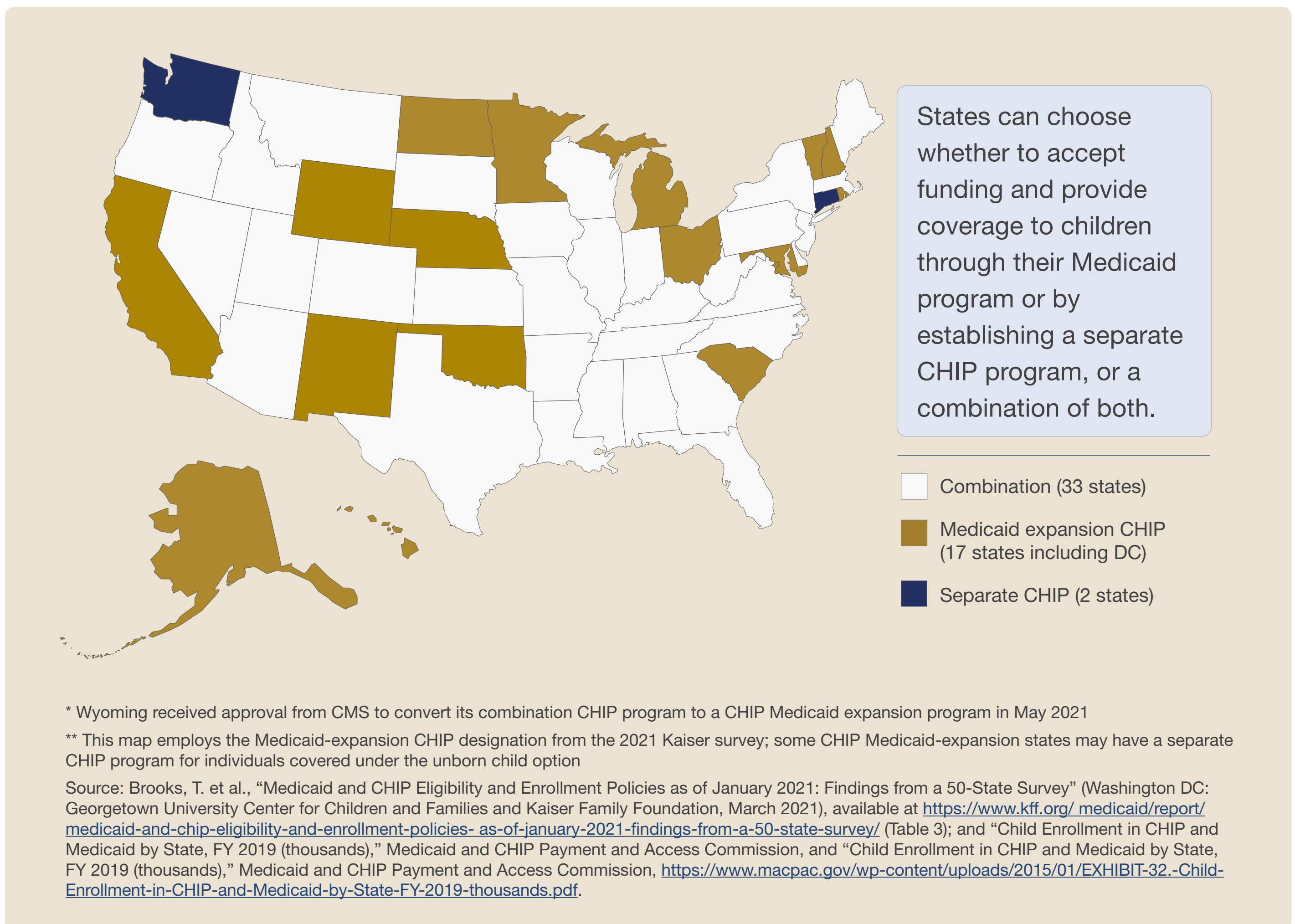
Introduction and Background

The Children's Health Insurance Program (CHIP) serves a vital role in America's health care system. First enacted in 1997, today CHIP provides health coverage to 6.8 million people each month—mostly children.[1] Under the program, states are provided funding through a complex formula to cover children and pregnant individuals whose family incomes are over eligibility levels for Medicaid but may otherwise be uninsured.[2] At present, the median income eligibility level for CHIP is 255 percent of the federal poverty line.[3]

Under the program, states can choose whether to accept funding and provide coverage to children through their Medicaid program or by establishing a separate CHIP program, or a combination of both. Most states operate combination programs with some individuals enrolled through the state's Medicaid program and some enrolled in a separate CHIP program, or full Medicaid expansion CHIP programs (see map).[4] As a result, the majority of children are now enrolled in CHIP-funded Medicaid programs. Only two states operate fully separate CHIP programs. In all states, CHIP sits on the shoulders of Medicaid—which covers a much larger number of children, nearly 32 million.[5] Over the past several decades, Medicaid and CHIP together have contributed to a dramatic decline in the share of uninsured children of more than 60 percent[6]—though the number of uninsured children began to increase from 2017 onward.[7]

As part of its financing structure, CHIP provides enhanced federal funding under which states receive federal matching funds for all children eligible for CHIP (even if they are covered through their Medicaid program) based on Medicaid's formula, but with a higher level of federal participation than for Medicaid.[8] Federal matching funds for CHIP were also further temporarily increased in response to the COVID-19 public health emergency as a result of the increase to the base Medicaid matching rate.[9] See Appendix 1. However, unlike Medicaid, federal CHIP funding is capped and not permanent. As a consequence, Congress has had to act to reappropriate funds periodically.

Currently, CHIP funding is available until September 30, 2027 (i.e., through federal fiscal year 2027), and states are also required to keep current income eligibility levels for children in place up to 300 percent of the federal poverty line through fiscal year 2027. While there is considerable bipartisan support for CHIP, its extension has not always been a smooth process in Congress. Most recently Congress let annual funding for CHIP lapse from September 30, 2017 until January 22, 2018—forcing states to rely on carryover funding and, in some cases, to notify families that they were planning to close enrollment.[10] This financial uncertainty does not work well for states or families, and deters states from making program improvements when they are uncertain about future federal funding.



* Wyoming received approval from CMS to convert its combination CHIP program to a CHIP Medicaid expansion program in May 2021

** This map employs the Medicaid-expansion CHIP designation from the 2021 Kaiser survey; some CHIP Medicaid-expansion states may have a separate CHIP program for individuals covered under the unborn child option

Source: Brooks, T. et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey" (Washington DC: Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2021), available at https://www.kff.org/ medicaid/report/ medicaid-and-chip-eligibility-and-enrollment-policies- as-of-january-2021-findings-from-a-50-state-survey/ (Table 3); and "Child Enrollment in CHIP and Medicaid by State, FY 2019 (thousands)," Medicaid and CHIP Payment and Access Commission, and "Child Enrollment in CHIP and Medicaid by State, FY 2019 (thousands)," Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-32.-Child-Enrollment-in-CHIP-and-Medicaid-by-State-FY-2019-thousands.pdf.

As Congress considers major health legislation, what should become of CHIP?

CHIP funding should be made permanent

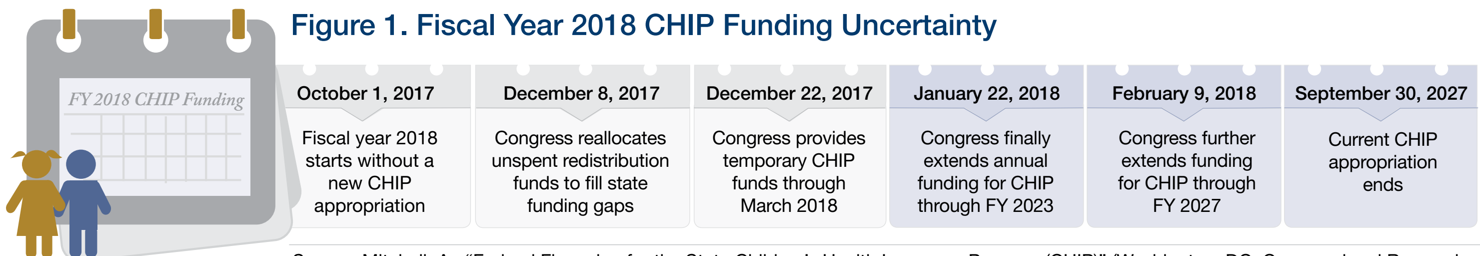
CHIP has established itself as a critical piece of the federal/state response to children's health care needs. In addition to covering over 6 million children directly, CHIP has spurred outreach and enrollment simplification efforts that have resulted in more eligible children receiving Medicaid. Though children enrolled in separate CHIP programs do not have a coverage guarantee such as children in Medicaid, the coverage provided to children under CHIP is more comprehensive and responsive to their needs than benefits provided through federal and state marketplaces.[11] Accordingly, CHIP should be made permanent to ensure that children and families do not have to withstand future lapses in Congressional commitment, and states have the certainty from the federal government to maintain and improve their programs.

Prior to 2009, Congress had to take action on a number of occasions to avert funding shortfalls under the program.[12] The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 made a number of critical improvements to CHIP's underlying financing structure to help ensure that states did not face such shortfalls, however, annual CHIP funding remained temporary in nature. As a result, Congress has had to act multiple times since CHIPRA to appropriate funding for the program. During the most recent funding extension negotiations, Congress missed its deadline altogether and failed to appropriate new funding for CHIP at the beginning of federal fiscal year 2018 (see Figure 1). While Congress ultimately acted to extend funding, in the intervening weeks and months of uncertainty, a number of states posted announcements on their websites or sent notices to families alerting them that their CHIP coverage could end—with Connecticut even going as far as to implement an enrollment freeze on new applications during the Christmas and New Year holidays in 2017.[13]

Such lapses are unacceptable for children, particularly in a post Affordable Care Act (ACA) world, where everyone should have a path to affordable coverage. This long-standing bipartisan program has demonstrated time and time again that it works to provide comprehensive, affordable health coverage to millions of children across the nation. As policymakers consider what is next for America's health care system and contemplate improvements to the existing system, making funding for CHIP and its supporting financing structures permanent (including the redistribution fund, the Child Enrollment Contingency Fund and qualifying state option) should be included in any major health legislation.

Various bills have been introduced in Congress to make CHIP funding permanent. The Patient Protection and Affordable Care Enhancement Act, which was passed by the House of Representatives in July of 2020, included permanent funding for CHIP. Earlier this year, the CARING for Kids Act (H.R. 66) and the CHIPP Act (H.R. 1791) were introduced in the House—both bills would permanently fund CHIP and extend other CHIP financing structures such as the Child Enrollment Contingency Fund.[14]

Figure 1. Fiscal Year 2018 CHIP Funding Uncertainty



Source: Mitchell, A., "Federal Financing for the State Children's Health Insurance Program (CHIP)" (Washington, DC: Congressional Research Service, May 2018), available at https://fas.org/crs/misc/R43949.pdf.

Maintain children's income eligibility standards and protections

In addition to guaranteeing funding for CHIP, permanently extending the children's "maintenance of effort" (MOE) requirements will be critical to ensuring stability of coverage for children in Medicaid and CHIP.

Originally included in the ACA and subsequently extended, the MOE ensures that children maintain stable health coverage by requiring states to maintain Medicaid and CHIP income eligibility standards and preventing them from adding new barriers to enrollment such as increased premiums. This requirement remains in place through fiscal year 2027 though it was modified under the HEALTHY KIDS Act in 2018 to apply only to families with incomes less than 300 percent of the federal poverty level.[15]

As discussed in our 2017 brief, this requirement—along with coverage expansions for parents and other adults in Medicaid and the state and federal marketplaces—helped bring the uninsured rate for children down to historic lows.[16] While this positive trend reversed over the past few years, the MOE has undoubtedly prevented even more children from losing coverage. In fact, the recent increases in the rate of uninsured children make the continuation of the MOE more important than ever. It is clear that CHIP funding and the MOE go hand in hand to ensure children in Medicaid and CHIP can depend on stable health coverage. Accordingly, permanent continuation of the MOE must be part of any future CHIP legislation.

CHIP Enrollment Caps and Freezes

Over the 24-year history of CHIP, 12 states have put an enrollment cap or freeze in place. While most lasted for less than a year,[17] the longest and most significant freeze was initiated in 2010, when the state of Arizona froze enrollment in response to state budget cuts just before the ACA's MOE went into effect leading to waiting list for Arizona's KidsCare program of more than 100,000 children.[18] While Arizona later lifted the enrollment freeze,[19] such state actions demonstrate the need to ensure children are fully protected from harmful freezes or caps. Accordingly, any extension of the CHIP MOE should include a statutory change to ensure that states cannot restrict enrollment through freezes or caps so that children living in states like Arizona are protected.

Increase and permanently extend outreach and enrollment funding

In 2009, CHIPRA established grants to eligible entities such as community-based organizations to conduct outreach and enrollment efforts to reduce the number of children eligible but not enrolled in Medicaid and CHIP. Funding for these grants was extended as part of subsequent CHIP extensions including most recently under the HEALTHY KIDS Act and the ACCESS Act in 2018.[20] Unfortunately, the ACCESS Act, which extended funding for CHIP for fiscal years 2024 through 2027, reduced outreach and enrollment funding during this timeframe relative to previous funding levels.[21]

Outreach and enrollment grants serve an important role in helping to ensure children can access and maintain Medicaid and CHIP coverage.

Outreach and enrollment grants serve an important role in helping to ensure otherwise eligible children can access and maintain Medicaid and CHIP coverage and have been targeted to organizations working with children that are more likely to be uninsured—such as American Indian and Alaska Native children, adolescents, and children living in rural areas.[22] Nearly 6 in 10 uninsured children are eligible for Medicaid and CHIP but are not currently enrolled.[23] Outreach and enrollment assistance with trusted messengers is important especially for communities where there has been a chilling effect as a consequence of anti-immigrant policies.[24]

Accordingly, funding for outreach and enrollment should be part of any CHIP legislation. In addition, outreach and enrollment funding for fiscal years 2024 and onward should be provided at least at the HEALTHY KIDS Act levels to support these essential activities.

What other improvements can be made to CHIP?

There are a number of other policy changes that could be made to modernize and strengthen CHIP.

1. Eliminate the option for states to have "waiting periods"

Originally conceived of as a measure to prevent dropping of employer-sponsored coverage, states are currently permitted to establish waiting periods of up to 90 days before children can be enrolled in CHIP coverage.[25] Many states have dropped their waiting periods over the years, but 12 states still have waiting periods—10 of which are for the maximum permissible length of 90 days.[26] This provision amounts to a forced period of uninsurance for children during which they may miss needed preventive or acute care and families may incur large medical bills.[27] There is no evidence that these policies are preventing dropping of employer-sponsored coverage and they should be prohibited.

2. Allow states to increase children's income eligibility through a state plan amendment rather than through a waiver

As a result of changes made by the ACA, states can no longer expand income eligibility for children above a certain threshold via a state plan amendment. Therefore, most states must seek permission to expand eligibility through Section 1115 demonstration authority. This creates a complicated path for a state that wishes to cover more children. A simple technical fix would clarify that states have the flexibility to raise their income eligibility threshold for children in CHIP.

3. End "lockouts" and better align CHIP premium and cost-sharing rules with Medicaid

States that operate separate state CHIP program are permitted to charge premiums, deny coverage to those families who cannot pay them, and even "lockout" children for a period of up to 90 days for nonpayment—even after a family resumes paying the premiums. For low- and moderate-income families, premiums and lockouts pose a barrier to coverage and contribute to periods of uninsurance for children.[28] Twenty-six states charge premiums; with five states charging premiums to children in families with incomes below 150 percent of the federal poverty line (AZ, FL, GA, NV, UT).[29] In addition, states that operate separate CHIP programs may also impose higher cost-sharing requirements including co-insurance and deductibles (i.e., UT) that could diminish access to care.[30]

In recognition of the challenges premiums and cost-sharing pose, many states waived or lowered premiums and cost-sharing, eliminated premium lockouts, and/or waived outstanding premiums for the period of the public health emergency as part of temporary disaster relief state plan amendments.[31] Such actions demonstrate that states recognize that premiums and cost-sharing present burdensome barriers to necessary coverage. Moreover, such premium and cost-sharing policies should be revisited at the federal level in light of the Affordable Care Act and subsequent changes focused on improving access to and affordability of coverage such as the increase to premium subsidies included under the American Rescue Plan.[32]

Federal policymakers should take a number of steps to ease the burdens of premiums, cost-sharing and lockouts on families and better align CHIP policies with that of Medicaid:

- States should not be permitted to impose lockouts on families for nonpayment of premiums or enrollment fees.
- States should not be permitted to charge premiums to children in families with incomes below 150 percent of the federal poverty line (FPL). This would bring CHIP premium rules in line with Medicaid policies.[33] It would also align with current eligibility for Advance Premium Tax Credits (APTCs) allowing for coverage with zero premiums for people with incomes below 150 percent of FPL in the ACA marketplace.[34]
- States should be required to align CHIP cost-sharing protections with those in Medicaid.[35]
- States should be encouraged to maintain the policies that were adopted during the public health emergency to minimize the burden of premiums and cost-sharing on families.

4. **Create a permanent Pediatric Quality Measures Program**

CHIPRA launched the Child Core Set of Health Care Quality Measures in Medicaid and CHIP, which states must report beginning in 2024. To support pediatric quality measurement, CHIPRA initiated the development of the Pediatric Quality Measures Program (PQMP), which funds Centers of Excellence intended to improve and strengthen the initial core set of child health quality measures and to increase the portfolio of evidence-based, consensus-driven pediatric quality measures available to both public and private payers. In the annual review of the child core set, quality experts have continued to point out gaps in quality measures in key areas including adverse childhood experiences, the social determinants of health, and continuity of coverage. Federal policymakers should continue to fund and support the development and testing of new measures through the PQMP and to incentivize states to demonstrate improvement in the quality of care children receive in Medicaid and CHIP.

5. **Make Express Lane Eligibility a permanent state option and extend it to adults**

Express Lane Eligibility (ELE) is a state option that allows states to use the eligibility findings from other public programs to streamline enrollment and renewal for children in Medicaid and CHIP. States like Alabama and Louisiana have successfully used Supplemental Nutrition Assistance Program (SNAP) enrollment data to ensure that children receiving SNAP benefits are also enrolled in Medicaid, an effort that also helps address the social determinants of health and is administratively efficient. However, the fact that prior CHIP funding extensions have always established a sunset date for the policy discourages states from implementing it as it requires an upfront investment of time and technology to maximize its efficiency and effectiveness. Congress should make ELE a permanent state option and extend the policy to adults so that states can enroll all eligible members of a family.

6. **Ensure that children in separate CHIP programs are eligible for the Vaccines for Children program**

As the COVID-19 pandemic has made painfully clear, vaccinations are a critical part of children's preventive care. The Vaccines for Children (VFC) program provides vaccines at no or de minimus charge to children who would otherwise not have access due to cost. However, Congress has not acted to update the VFC program for decades and it does not reflect the existence of CHIP or advancements in vaccine science.[36] As a consequence, children enrolled in CHIP through a state's Medicaid program are eligible for VFC vaccines, but children enrolled in a state's separate CHIP program are not—unless they are American Indian or Alaska Native children. To simplify vaccine administration, the VFC program should be expanded to include all CHIP enrollees.

7. **Extend Medicaid rebates to separate state CHIP programs**

As we recommended in our 2019 report on how to strengthen the Medicaid Drug Rebate Program (MDRP) and address rising Medicaid prescription drug costs, Medicaid rebates should be extended to separate CHIP programs.[37] Under current law, the MDPR does not apply to separate CHIP programs. As a result, separate state CHIP programs are not benefiting from rebates available under the MDRP that would help lower CHIP prescription drug costs. Moreover, it is very likely that separate state CHIP programs, and the managed care plans that contract with them, are obtaining considerably smaller rebates than what is now required under Medicaid. Extending Medicaid rebates to separate state CHIP programs would provide additional financial assistance to states and also help to better ensure children in separate CHIP programs receive access to needed prescription drugs.

Conclusion

The nation has made enormous progress in reducing the number of uninsured children thanks to Medicaid and CHIP; however recent trends have moved the number in the wrong direction. Having access to public coverage provides children and society with long-term benefits as health and educational gains provide a strong return on investment.[38] Children who face additional barriers to good health as a consequence of income, geography, race, or all of the above, must have continuous affordable coverage at a minimum—so that other challenges they face can be addressed. CHIP plays a critical role in providing such coverage and improving the health of the nation's children. Therefore, CHIP funding should be made permanent alongside other improvements as described above to better support this vital program and the children and families that rely on it to meet their health care needs.

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Appendix Table 1. State E-FMAPs

State	FY 2021	FY 2021 (with Families First Coronavirus Response Act FMAP increase)
Alabama	80.81%	85.15%
Alaska	65.00%	69.34%
Arizona	79.01%	83.35%
Arkansas	79.86%	84.20%
California	65.00%	69.34%
Colorado	65.00%	69.34%
Connecticut	65.00%	69.34%
Delaware	70.42%	74.76%
District of Columbia	79.00%	83.34%
Florida	73.37%	77.71%
Georgia	76.92%	81.26%
Hawaii	67.11%	71.45%
Idaho	79.29%	83.63%
Illinois	65.67%	70.01%
Indiana	76.08%	80.42%
Iowa	73.23%	77.57%
Kansas	71.78%	76.12%
Kentucky	80.44%	84.78%
Louisiana	77.19%	81.53%
Maine	74.58%	78.92%
Maryland	65.00%	69.34%
Massachusetts	65.00%	69.34%
Michigan	74.86%	79.20%
Minnesota	65.00%	69.34%
Mississippi	84.43%	88.77%
Missouri	75.47%	79.81%
Montana	75.92%	80.26%
Nebraska	69.53%	73.87%
Nevada	74.31%	78.65%
New Hampshire	65.00%	69.34%
New Jersey	65.00%	69.34%
New Mexico	81.42%	85.76%
New York	65.00%	69.34%
North Carolina	77.18%	81.52%
North Dakota	66.68%	71.02%
Ohio	74.54%	78.88%
Oklahoma	77.59%	81.93%
Oregon	72.59%	76.93%
Pennsylvania	66.54%	70.88%
Rhode Island	67.86%	72.20%
South Carolina	79.44%	83.78%
South Dakota	70.80%	75.14%
Tennessee	76.27%	80.61%
Texas	73.27%	77.61%
Utah	77.26%	81.60%
Vermont	68.20%	72.54%
Virginia	65.00%	69.34%
Washington	65.00%	69.34%
West Virginia	82.49%	86.83%
Wisconsin	71.56%	75.90%
Wyoming	65.00%	69.34%

Source: Medicaid and CHIP Payment and Access Commission analysis of U.S. Department of Health and Human Services, Federal Register notices for FYs 2019–2022, available at https://www.macpac.gov/wp-content/uploads/2018/04/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-and-Enhanced-FMAPs-by-State-FYs-2019%E2%80%932022.pdf.

About this Series

This issue brief is eleventh in a series of papers from Georgetown University Center for Children and Families on the future of children's health coverage. Other briefs in the series include:

Continuous Eligibility in Medicaid and CHIP. *An update on the current policy landscape and the benefits of continuous eligibility.* (July 2021)

Covering All Kids. *Focuses on the remaining 4 million uninsured children and makes recommendations for policy changes to reach them as well as to simplify and improve children's coverage overall.* (February 2020)

Promoting Health Coverage of American Indian and Alaska Native Children. *Focuses on improving access to health care for American Indian and Alaska Native children.* (September 2019)

How Medicaid and CHIP Can Support Student Success through Schools. *Examines how Medicaid can help schools better serve children and families and how schools can help students get the health care they need.* (April 2019)

The Questions to Ask When Assessing the Impact of Coverage Expansion Proposals on Children. *Focuses on a number of key questions to help assess the relative merits of coverage expansion proposals from the perspective of children.* (February 2019)

How to Strengthen the Medicaid Drug Rebate Program to Address Rising Medicaid Prescription Drug Costs. *Focuses on the effectiveness of the Medicaid Drug Rebate program and how to improve it.* (January 2019)

Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP). *Focuses on ways that state and federal policymakers can use Medicaid and CHIP to more effectively put young children on the best path for success in school and in life*. (October 2018)

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The Future of Children's Coverage: Children in the Marketplace. *Focuses on ways to improve marketplace coverage and the associated financial assistance for children.* (June 2016)

Endnotes

[1] "March 2021 Medicaid & CHIP Enrollment Data Highlights," Centers for Medicare & Medicaid Services, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[2] There are a few exceptions to this like the unborn child option.

[3] Brooks, T. et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey" (Washington DC: Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2021), available at https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey/.

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[15] See Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (referred to as the HEALTHY KIDS Act), Pub.L. 115-120, section 3001 et seq. and the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act), Pub.L. 115-123, section 50100 et seq; Whitener, K. op. cit.; and Brooks, T., Roygardner, L., and Artiga, S., "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey" (Washington DC: Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2019), available at https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey-tables/.

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[17] Georgetown University Center for Children and Families analysis of the annual 50-state survey on eligibility and enrollment procedures published by the Kaiser Commission on Medicaid and the Uninsured and other reports on CHIP enrollment freezes and caps. North Carolina had a freeze in place from January to July 2001. Between 2001 until 2007, Utah processed CHIP enrollment only during specific open enrollment periods. During the 2003-2004 recession, 7 states (AL, CO, GA, FL, ID MD, MT) implemented caps or freezes for less than one year. California implemented a freeze from July until September 2009. Tennessee has two CHIP-funded programs, both of which have been closed and re-opened at various times; both are currently open. Note: Maryland had a separate CHIP program during its enrollment freeze but merged the program into Medicaid in 2007.

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[20] See endnote 15.

[21] HEALTHY KIDS Act and ACCESS Act, op. cit. Outreach and enrollment grants have been funded at approximately $20 million per year from fiscal year 2009 through 2023 including under the HEALTHY KIDS Act. However, the ACCESS Act reduced total funding for outreach and enrollment to $48 million over the 2024 through 2027 fiscal year period bringing funding levels down to $12 million a year.

[22] See, e.g., "Outreach & Enrollment Grants," InsureKidsNow.gov, https://www.insurekidsnow.gov/campaign-information/outreach-enrollment-grants/index.html.

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