Children’s Coverage: Medicaid and CHIP

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CHILDREN’S COVERAGE
The Children’s Uninsured Rate has Declined to an Historic Low

* Change is significant at the 90% confidence level. 2013 was the only year that did not show a significant one-year decline in the national rate of uninsured children. The Census began collecting data for the health insurance series in 2008, therefore there is no significance available for 2008

The Public is not Aware of this Success

In the Last 5 Years, Do You Think the Number of Uninsured Children Has Increased, Decreased, or Stayed the Same?

- Increased: 49%
- Decreased: 28%
- Don't Know/Refused: 1%
- Stayed the Same: 22%

How Children are Covered

Figure 3. Sources of Children’s Coverage, 2013-2015

- Employer-sponsored: 46.5% in 2013, 46.5% in 2015
- Medicaid/CHIP: 34.2% in 2013, 35.7% in 2015
- Other*: 7.2% in 2013, 7.4% in 2015
- Direct-purchase*: 5.0% in 2013, 5.5% in 2015
- Uninsured: 7.1% in 2013, 4.8% in 2015

*Change is significant at the 90% confidence level.

Other includes Medicare, TRICARE, VA, and two or more types of coverage.

Direct-purchase includes coverage through the marketplace. See methodology section for more information.

Medicaid and CHIP cover 44% of Children under age 6

Medicaid plays a major role in Covering Low-Income Children

Figure 2. Health Coverage for Low-Income Children Under the Age of Six

- Medicaid/CHIP: 80% for Family Income ≤138% FPL ($27,821 annually for a family of 3, 2016)
- Medicaid/CHIP: 72% for Family Income ≤200% FPL ($40,320 annually for a family of 3, 2016)
- Private Coverage: 18%, 6%
- Uninsured: 6%, 7%

Note: Individuals can report more than one source of coverage and totals may add to more than 100 percent.
Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) file.

Children’s Coverage Sources and Eligibility

Source: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families. January 2017.
Public Coverage for Children

Medicaid
37.1 million

CHIP
8.9 million

Marketplace
1.1 million

Sources: SEDS FY 2016 Ever-Enrolled in Medicaid/CHIP
Rate of Children’s Uninsurance by State, 2015

Long-Term Effects of Childhood Medicaid Coverage

Healthier Adults

Greater Academic Achievement

Greater Economic Success

Government Savings (ROI)

CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)
**CHIP: Federal-State Partnership**

<table>
<thead>
<tr>
<th></th>
<th>Federal Government</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administration</strong></td>
<td>Oversight</td>
<td>Direct administration</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Cover 65% to 85% of costs; ACA/MACRA increased by 23 percentage points (bump) through 2017 to maximum of 100%</td>
<td>Pay a share of cost (if under 100% federal matching rate)</td>
</tr>
<tr>
<td><strong>Program Rules</strong></td>
<td>Minimum standards; more flexibility relative to Medicaid</td>
<td>Determines eligibility levels, benefits, and cost sharing within guidelines; sets provider payments</td>
</tr>
<tr>
<td><strong>Coverage Guarantee</strong></td>
<td>None required</td>
<td>Can freeze or cap enrollment (ACA changed this until 2019 with some exceptions!)</td>
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Children’s Upper Income Eligibility

<table>
<thead>
<tr>
<th>Breakdown of State Eligibility</th>
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<tbody>
<tr>
<td>FPL</td>
</tr>
<tr>
<td>&lt; 200%</td>
</tr>
<tr>
<td>200% – 250%</td>
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<tr>
<td>250% - 300%</td>
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<tr>
<td>&gt; 300%</td>
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</table>

Income Eligibility Levels for Children in Medicaid/CHIP, January 2017

CHIP Program Design Options

Medicaid Expansion
• All Medicaid rules apply except children must be uninsured
• States can use Medicaid funds to cover children with other coverage

Separate CHIP
• Choice of Benchmark Plan or
• Secretary approved

Combination
• Medicaid expansion for certain children based on age or income
• Separate CHIP program for other children
38 States provide Medicaid or Medicaid-based benefits for CHIP-financed kids

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

• Comprehensive array of preventive and ameliorative care for children
• Covers all appropriate and medically necessary services needed to correct and ameliorate health conditions, *even if such services are not included in the Medicaid state plan*
• States are required to inform all Medicaid-eligible individuals under age 21 that EPSDT services are available and of the need for age-appropriate immunizations
### Separate CHIP Benefits

**Actuarially equivalent to benchmark plan**

1. HMO with state’s largest enrollment
2. State Employee Plan
3. Federal Employee Plan, or
4. Secretary Approved

**Services must include:**

- Well child; preventive care
- Immunizations
- Emergency care
- Inpatient and outpatient hospital services
- Physician services
- Lab and x-ray
- Dental services
- Mental health parity
## Premiums and Cost-Sharing in CHIP

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Cost-Sharing</th>
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<tbody>
<tr>
<td>• State flexibility subject to 5% aggregate cap</td>
<td>• None for preventive care</td>
</tr>
<tr>
<td></td>
<td>• Children with income between 133-150% FPL: Limited cost-sharing*</td>
</tr>
<tr>
<td></td>
<td>• Children with income &gt; 150% FPL: State flexibility on all other services subject to 5% aggregate cap</td>
</tr>
</tbody>
</table>

* Cost-sharing limits in CHIP for children with income equal to or below 150% FPL vary based on type of service and the cost the state pays for the service as described in 42 CFR § 457.555.
KEY ISSUES FOR CHIP TODAY

- MOE: Waiting periods
- Bump: Premiums
- Long-term: Immigrant kids
- Comparability

21
Funding

CHIP Timeline

1997

S-CHIP

2007 2009

Gap

Funding

CHIPRA

2013 2015 2017

ACA

MACRA

MACRA?
# Maintenance of Effort (MOE)

<table>
<thead>
<tr>
<th>Maintenance of Effort Requirement: What States Can and Cannot Do</th>
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<tr>
<td><strong>States can:</strong></td>
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<tr>
<td>• Adopt or continue enrollment simplification initiatives</td>
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<tr>
<td>• Maintain caps or freezes that existed prior to the MOE (March 23, 2010)</td>
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<tr>
<td>• Choose not to renew waiver programs once they expire</td>
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<tr>
<td><strong>States cannot:</strong></td>
</tr>
<tr>
<td>• Eliminate CHIP or scale back eligibility for children in CHIP or Medicaid below levels in place as of March 23, 2010;</td>
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<tr>
<td>• Raise premiums for CHIP or Medicaid children;</td>
</tr>
<tr>
<td>• Impose or increase waiting periods, or the time that children must remain without group coverage before becoming eligible to enroll in CHIP. Current federal rules do not allow states to impose waiting periods longer than 90 days.6</td>
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Uninsured rate rose with CHIP freezes

SHADAC analysis of Current Population Survey (CPS) and American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Data reported from 1987 through 2012 are from SHADAC analysis of the Current Population Survey’s Annual Social and Economic Su
The Bump

• A 23-percentage point increase to the federal CHIP match rate
• Authorized for 4 years 2016-2019
• Has been used to:
  - Expand coverage to lawfully residing immigrant children
  - Avoid provider payment cuts and other program cutbacks
  - Launch health services initiatives
MACPAC Recommendation

- 5-year funding extension
- MOE through 2022
- Bump through 2022
- Grants
  - Outreach
  - Child Obesity Demonstration Projects
  - Pediatric Quality Measures Program
- Eliminate CHIP waiting periods
- Make Express Lane Eligibility permanent
- Eliminate premiums under 150% FPL
10 States estimate exhausting carry-over allotments before end of 2017

<table>
<thead>
<tr>
<th>Quarter of Fiscal Year</th>
<th>Number of States</th>
<th>States</th>
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<tbody>
<tr>
<td>Third Quarter FFY 2018 (April - June 2018)</td>
<td>7</td>
<td>Arkansas, Indiana, Iowa, Nebraska, North Dakota, Oklahoma, Wyoming</td>
</tr>
<tr>
<td>Fourth Quarter FFY 2018 (July - September 2018)</td>
<td>3</td>
<td>New Jersey, New Mexico, South Carolina</td>
</tr>
<tr>
<td>Not Reported</td>
<td>9</td>
<td>Alaska, Illinois, Kansas, Maine, Maryland, Minnesota, New Hampshire, Tennessee, Texas</td>
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Implications of Funding Delay

- Freeze/phase down costs are not accounted for in projections of when states run out of funds
- Advance notice
  - Families
  - Managed care entities and providers
  - Community partners and other stakeholders
- System changes
- Screening and referrals to other programs
- Caseworker training
- Administrative paperwork (contracts, manuals, SPAs)
State Budget Impact

- No advance warning to states
- State budgets are final and assume CHIP continues
- Most with “bump”
- Several states have laws that end program participation without federal match (AZ, CO, WV)
- States will be forced to make difficult decisions regarding eligibility, benefits, cost-sharing, and more
Harm to Nation’s Success in Covering Kids

- Consumer confusion stemming in politicized debate on health policy
- Lack of oversight of ACA enrollment and retention simplifications
- Cuts to ACA marketing, outreach and consumer assistance
- Impact of immigration policy
Gavin’s Story

After three years of consistent hearing aid use and regular habilitation treatment services, Gavin entered preschool with normal receptive and expressive language, on par with his peers.

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