Health Program
Health Project

The Role and Future of the Children's Health Insurance Program

March 2015

BIPARTISAN POLICY CENTER

Health Program
Health Project

ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

STAFF

Katherine Hayes
Director, Health Policy

G. William Hoagland
Senior Vice President

Nancy Lopez
Associate Director, Health Policy

Katherine Taylor
Project Assistant, Health Project

Marisa Workman
Policy Analyst, Health Project

REPORT

This report was produced by BPC staff, under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, in collaboration with a distinguished group of senior advisors and experts. BPC would like to thank Sheila Burke, Stuart Butler, Chris Jennings, and Timothy Westmoreland who shaped and strengthened the content of this paper by providing substantial feedback, support, and direction. BPC thanks our leaders on this report, Senate Majority Leaders Tom Daschle and Bill Frist, for their guidance and feedback.

ACKNOWLEDGEMENTS

BPC would like to thank the Robert Wood Johnson Foundation for their generous support in producing this report.

Table of Contents

Executive Summary

The Future of CHIP Funding

The Patient Protection and Affordable Care Act (ACA) reauthorized the Children's Health Insurance Program (CHIP) through FY 2019, but it did not provide new funding beyond FY 2015. Congressional leaders on both sides of the aisle and the administration have indicated a desire to extend CHIP funding. In addressing the lack of funding, policymakers face numerous considerations, including whether to extend funding for the remaining four years of the program's authorization, whether to extend funding for a shorter period of time, and whether to make other changes to the program as part of the funding extension. Enacted with bipartisan support as part of the Balanced Budget Act of 1997, CHIP is a capped entitlement to states. The program was designed to provide maximum flexibility to states that choose to provide health insurance coverage to low-income, uninsured children whose family incomes exceed Medicaid eligibility levels. Approximately 8.13 million children received health insurance coverage through CHIP, at an authorized spending level of $21.1 billion in FY 2015. States have two years to spend their allocations. As policymakers consider an extension of CHIP funding, a number of other issues around timing and policy can affect coverage for low-income children.

Short-term Considerations

State Budgets: Governors and state legislatures need certainty as they work to enact state budgets for FY 2016, most of which begin July 1, 2015.

"Family Glitch": Under the ACA, workers who have access to employer-sponsored health insurance coverage are not eligible for federal-premium and cost-sharing assistance to purchase health insurance coverage through a state or federal insurance exchange. An exception applies if the employer's coverage is not "affordable," meaning that the premium exceeds 9.5 percent of family income. However, the affordability test is based on the cost of the premium for individual coverage, not for the cost of family coverage. As a result, no family member, including children, qualifies for premium or cost-sharing assistance through an exchange, even if the cost of family coverage well exceeds 9.5 percent of the family's income. Lower income, uninsured children could potentially be ineligible for assistance through state and federal insurance exchanges.

***King v. Burwell*:** In June 2015, the Supreme Court will issue a decision in a case challenging the authority of the secretary of Health and Human Services (HHS) to make federal-premium and cost-sharing assistance available through the federal

health insurance exchange. Should the Court rule against the secretary, lower income, uninsured children eligible for coverage through the federal exchange would lose any assistance, barring congressional or agency intervention.

Comparable Benefits: If a child loses coverage through CHIP, many private plans do not offer the same benefits, such as pediatric dental benefits, or lower cost-sharing. As a result, if a former CHIP-eligible child is enrolled in private coverage, the child could face barriers to care due to differences in benefits, higher cost-sharing, or both.

Long-term Considerations

Beyond the near-term problems identified above, there is inherent programmatic confusion in CHIP as implemented today. Families and taxpayers are not well served by multiple federal and state programs that impose different eligibility requirements, enrollment processes and enrollment periods, different premium and cost-sharing requirements, and potentially different provider networks for parents and their children. The current patchwork of coverage for parents and children (often different programs for children in the same family, depending on their ages) is confusing, administratively burdensome for families, and an inefficient use of taxpayer dollars. In the coming years, coverage gaps can and should be addressed, ending the need for CHIP.

Recommendations

As Bipartisan Policy Center (BPC) health project leaders, we propose the following recommendations:

1. Extend CHIP for a minimum of two years, while recognizing that two years does not provide sufficient time for state and federal elected officials and agencies to address major programmatic changes sought by policymakers on both sides of the aisle and at both levels of government.

2. Extend CHIP funding at the current authorized 2015 level of $21.1 billion per year. Any increase in authorized spending over the current congressionally assumed baseline spending of $5.7 billion per year, must be offset so that program extension costs do not increase the federal debt. This would mean identifying spending reductions or revenue increases (or a combination of the two). Final estimates will be made by the Congressional Budget Office (CBO) at the time of the program's extension, but based on previous CBO scoring projections and underlying assumptions about interactions with Medicaid and the exchanges should the CHIP extension not occur, the two-year cost of extending this program is likely to be approximately $5 billion.

3. Eliminate gaps in coverage by resolving issues related to the ACA, such as the so-called "family glitch," or other gaps created by changes in eligibility premium tax-credits and costsharing subsidies.

4. Over the long term, modify eligibility for public and private coverage (Medicaid, employer-sponsored coverage, exchange-based insurance) to allow children and parents to be enrolled in the same insurance plan, eliminating the need for CHIP.

5. Also over the long term, ensure that differences in benefits and out-of-pocket costs in current employer-sponsored or exchange plans do not result in the loss of important benefits, such as dental services, or in high cost-sharing for lower income children.

Section I. Introduction and Overview

Although the Patient Protection and Affordable Care Act (ACA) reauthorized the State Children's Health Insurance Program (CHIP) through FY 2019, the law did not provide new funding beyond FY 2015.[1] The administration and congressional leaders in the House and Senate on both sides of the political aisle support an extension of CHIP funding. In addressing the lack of funding, however, a number of policymakers, including advocates and those charged with implementing the program, face numerous decision points. They include whether it is prudent to extend funding for the remaining four years of the program's authorization, whether to extend funding for a shorter period of time, and whether to make other changes in the program as part of the funding extension.

This paper is designed to provide robust analysis to assist policymakers as they consider options to extend CHIP funding. It explores the implications of changes in federal funding, as well as other factors that may affect coverage for low-income children, including interactions with the ACA, challenges facing states in enacting budgets for FY 2016, and administrative challenges faced by families enrolling in and navigating the health care system. Finally, based on this analysis, this paper makes a series of recommendations on both the short-term and long-term future of CHIP. These recommendations seek to ensure that children have access to quality and affordable health insurance coverage in the near-term and well into the future.

Section II. Snapshot of CHIP

Since its creation in 1997, CHIP has provided health coverage to uninsured children in families with lower incomes who do not qualify for the basic Medicaid program in their home states. CHIP is administered by states according to federal requirements and funded jointly by states and the federal government. CHIP is not an individual entitlement, but rather, an entitlement to states with annual state allotments. According to its August 2014 program evaluation, in federal FY 2013:

- **8.13 million children** were enrolled in CHIP at some point during the year.
- **219,473 adults** were enrolled in CHIP, primarily through special waiver programs for low-income parents and pregnant women in some states.
- **Federal CHIP spending totaled $9.2 billion**, 70 percent of total spending on the program, which was $13.2 billion for FY 2013.
- **State spending on CHIP totaled $4 billion**, 30 percent of total spending.
- Between 1997, the year of CHIP's enactment, and 2012, the **percentage of all uninsured children dropped from 15 percent to 9 percent**.
- Low-income, uninsured children dropped from **25 percent to 13 percent** (family incomes below 200 percent of the federal poverty level (FPL), or $46,100 for a family of four in 2012 dollars).[2]

While governors differ in their preferences for funding, time frames, and programmatic changes, they overwhelmingly support extension of CHIP funding.[3] In response to last year's request for input from chairmen of the Senate Finance Committee and House Energy and Commerce Committee, 39 governors urged that action be taken early in 2015, in time to account for states' budgetary cycles. Almost all state fiscal years begin on July 1, 2015. Similarly, Democrats and Republicans have expressed support for a funding extension, but they may differ over the length of the extension and certainly differ on underlying changes in the program.

Section III. Legislative History and Structure of CHIP

Legislative History

Following the failed health-reform debates of 1993 through 1994 and the enactment of private health insurance market reforms included in the Health Insurance Portability and Accountability Act (HIPAA) of 1996,[4] children's advocates and other policymakers advocated for the expansion of health insurance for uninsured low-income children. At the time, there were more than ten million uninsured children in the United States.[5] In March 1997, Senator Orrin Hatch (R-UT) shifted the legislative landscape in favor of expansion by announcing that he would join with Senator Ted Kennedy (D-MA) to support financing health insurance for uninsured low-income children.[6]

Shortly after the senator's announcement, and following months of difficult negotiations, the Republican-controlled Congress and the Clinton administration reached an agreement on FY 1998 budget resolution.[7] The resolution outlined the compromise to reduce federal spending and to cut taxes. It also included an agreement to establish a new program to finance health insurance coverage for low-income, uninsured children.[8]

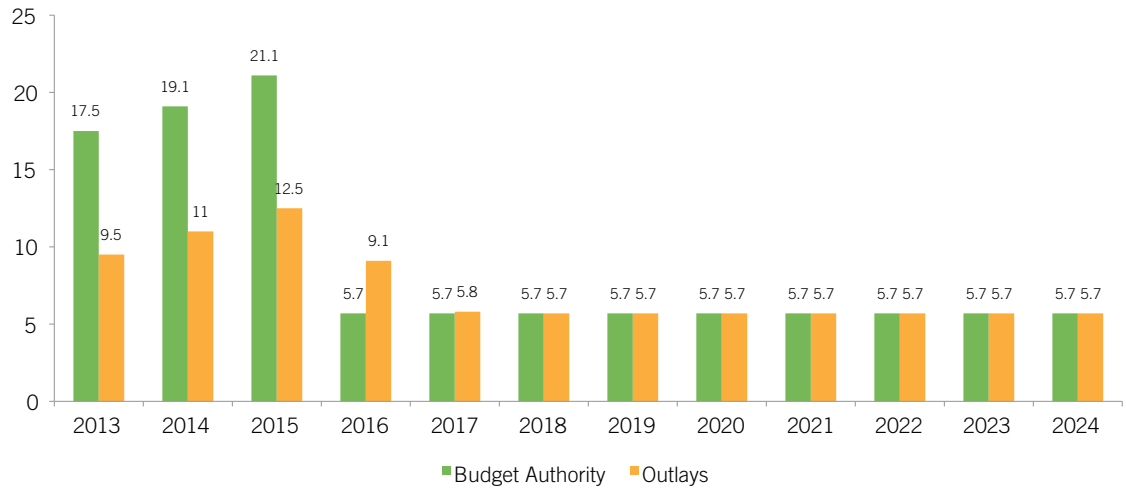
Legislation introduced by Senators Hatch and Kennedy raised tobacco taxes and designated half of the revenue to deficit reduction and half to funding a new children's health insurance program.[9] Although the legislation did not specify the structure of the new children's health insurance program, some congressional leaders proposed using Medicaid to expand health insurance coverage for low-income children,[10] while others supported providing coverage through private insurance plans.[11] Ultimately, the program was designed to leave that decision to the states, and CHIP was enacted as part of the Balanced Budget Act of 1997.[12]

The program was originally authorized and funded for ten years, but Congress provided additional funding in FY 2006 and FY 2007 to avoid shortfalls in funding to states.[13,14] In 2007, Congress passed two CHIP reauthorization bills, with strong bipartisan support.[15,16] President George W. Bush vetoed both bills over issues

relating to eligibility levels and concerns that federal-and state-financed health insurance coverage was supplanting or "crowding out" private insurance coverage.[17]

After two unsuccessful attempts to override the president's veto in the House of Representatives, a temporary reauthorization passed in late December 2007 providing CHIP funding through March 2009.[18] In 2009, the Children's Health Insurance Reauthorization Act (CHIPRA) was passed by a Democrat-controlled Congress and was signed by President Obama.[19] CHIPRA set mandatory spending levels through 2013.[20] As previously noted, the ACA reauthorized CHIP through FY 2019, but it did not provide new funding beyond FY 2015.[21] The Congressional Budget Office assumes in its baseline spending projection for CHIP that funding will continue at $5.7 billion annually for FY 2016 through FY 2025. (See Figure 1.)

Figure 1. Budget authority for CHIP will be held at $5.7 billion after FY 2015.



Source: Congressional Budget Office, Detail of Spending and Enrollment for the Children's Health Insurance Program for CBO's April 2014 Baseline

Program Structure

CHIP is authorized under Title XXI of the Social Security Act. Unlike Medicaid, the program is an entitlement to states rather than to individuals.[22] States have the option of expanding coverage to children through the state's Medicaid program, through a separate state program, or through a combination of Medicaid and one or more separate state programs.[23] In 2014, seven states and the District of Columbia operated CHIP through Medicaid expansion, 14 states through a separate CHIP program, and 29 states used a combination of the two approaches.[24] The federal government matches state spending on CHIP-eligible individuals; however, the match rate is at a higher or "enhanced" level (enhanced FMAP) and funds are available only up to the state's annual allotment.[25] Federal matching dollars available under CHIP average about 15 percentage points higher than Medicaid and may not exceed 85 percent.[26] The average enhanced CHIP match rate is 71 percent.[27] In FY 2015, 13 states received the enhanced FMAP rate of 65 percent.[28] Mississippi received the highest enhanced FMAP at 81.51 percent.[29] Beginning October 1, 2015, the CHIP federal match rate will increase by 23 percentage points, but no state match rate will exceed 100 percent.[30,i]

Eligibility

CHIP was originally intended to help states finance health insurance coverage for low-income children without access to health insurance coverage (Medicaid or private coverage). Low-income children were defined as those whose family incomes were at or below 200 percent of the federal poverty level, which in 1997 was $16,050 for a family of four.[31] Under the law, states are permitted to decide whether to cover all or part of the uninsured population.

States have the flexibility to limit coverage to certain geographic areas and by children's age. States have used this flexibility in a wide variety of ways, some quite complicated. In California, although most eligible children were transitioned from the separate CHIP program to Medicaid-expansion CHIP in 2013, three counties remain participants in the separate CHIP program up to 316 percent FPL and one county covers children up to 415 percent FPL, while other eligibility levels vary by age in the Medicaid-expansion program for the rest of the state.[32]

In the early years of CHIP implementation, states expanded coverage to include children in families with incomes over 200 percent of FPL, pregnant women, parents, and/or childless adults; states did so by disregarding income as permitted under

[i] For a current snapshot of how states have structured their CHIP programs, see "Medicaid income eligibility limits for children as a percentage of the Federal Poverty Level," Kaiser Family Foundation State Health Facts. Available online at http://kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/

Medicaid,[33] through Section 1115 waivers or a combination of the two options.[ii] Both of the bills vetoed by President Bush in 2007 included language to limit states' ability to cover adults and higher-income children. Under the vetoed 2007 reauthorization, states that expanded coverage above 300 percent of FPL would have received the state's regular match rate, instead of the CHIP enhanced match.[34]

At the time of the 2007 authorization, only two states, New York and New Jersey, had expanded coverage to children with family incomes over 300 percent of poverty. The 2007 reauthorization gave states choosing to cover children with incomes over 300 percent of poverty until 2010 to demonstrate that they were using "best practices," to limit crowd-out and were required to meet "ambitious standards" for the coverage of lower-income children.[35] In addition, the 2007 reauthorization bills prohibited the U.S. Department of Health and Human Services (HHS) from approving any new waivers to cover parents with CHIP funds. Finally, the legislation ended coverage of childless adults using CHIP funds, beginning in FY 2008.

2009 Reauthorization

As previously noted, in 2009, Congress enacted CHIPRA. CHIPRA included many of the provisions in the vetoed 2007 reauthorization bills that were designed to refocus the program on low-income children.[36] CHIPRA limited enhanced FMAP to those children living in families with incomes up to 300 percent of FPL. States expanding coverage beyond 300 percent receive their traditional Medicaid match rate, rather than the enhanced FMAP.[37] In addition, the law limited the use of funds to children and pregnant women, and it eliminated coverage of non-pregnant adults. The law also expanded significantly the amount of funds available to states, allocating $68.9 billion in funding over five years. In 2010, the ACA eliminated the ability of states to modify income and resource standards under Medicaid for individuals under age 65, including children, requiring eligibility determinations to be based on modified adjusted gross income (MAGI) beginning in FY 2014.[iii] As a result, states may no longer use different income and resource standards in determining CHIP eligibility.

[ii] According to a 2007 Government Accountability Office Report, five states (Michigan, Indiana, Illinois, New Mexico, and Oregon) used CHIP funding to cover childless adults. For more information see "State Children's Health Insurance Program, Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States That Cover Adults.", November 2007. Available online at: http://www.gao.gov/new.items/d0850.pdf.

[iii] "The term 'modified adjusted gross income' means adjusted gross income increased by:

(i) any amount excluded from gross income under section 911;

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax; and

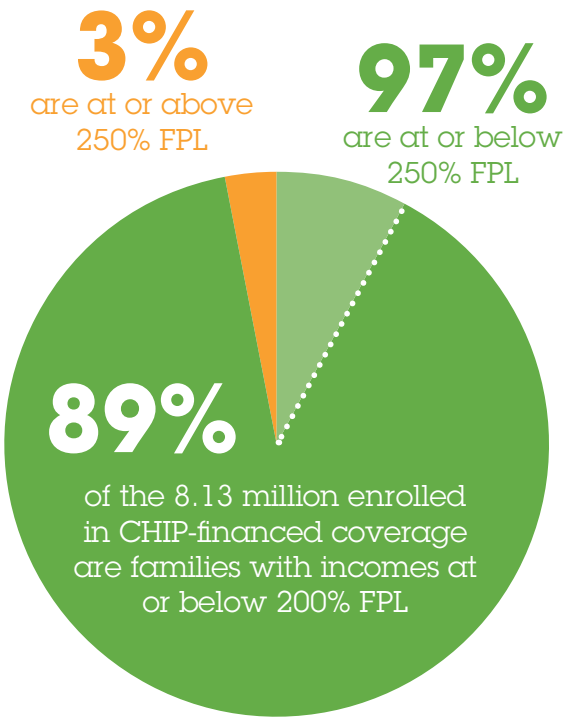
(iii) any amount equal to the portion of the taxpayer's Social Security benefits (as defined in section 86 [(d)]), which is not included in gross income under section 86 for the taxable year."

United States. Patient Protection Affordable Care Act. §1401, adding §36B to the Internal Revenue Code of 1986 [26 USC 36 (B)]. Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

In setting eligibility standards, states may not cover children with higher-income levels without first making children at lower-income limits eligible, may not deny eligibility based on pre-existing conditions, and may not apply waiting periods for pregnant women. States do have the ability to apply waiting periods to children. This waiting period was designed to discourage parents from dropping private coverage and enrolling children in CHIP, in an effort to prevent crowd-out of private coverage. In addition, a state must demonstrate that it targets low-income children and screens to assure that Medicaid-eligible children are enrolled in Medicaid.[38]

Today, states maintain myriad levels of eligibility for Medicaid and CHIP. Upper income limits for CHIP eligibility range from 175 percent to 405 percent of FPL. Twenty-four states and the District of Columbia permit coverage through CHIP to children in families with incomes of 255 percent of FPL or higher, although the numbers of children at higher-income levels are very low (See Figure 2.).[39] In FY 2013, 89 percent of children enrolled in CHIP had incomes at or below 200 percent of FPL, and 97 percent were at or below 250 percent FPL.[40] For 2015, FPL is $11,670 for an individual and $47,700 for a family of four.

Figure 2.



Source: Medicaid and CHIP Payment and Access Commission (MACPAC) Report to the Congress on Medicaid and CHIP June 2014

Benefits

States that expand CHIP coverage through a Medicaid expansion must offer the full range of Medicaid benefits.[41] By contrast, those children in separate CHIP programs have coverage linked to a commercial "benchmark." This means that the health benefits package and aggregate actuarial value of CHIP coverage must approximate what a child might receive under an employer-sponsored commercial insurance plan (i.e., the "benchmark" plan).[42] The health benefits package in separate CHIP programs must meet the threshold of coverage based on one of the following:

- The standard Blue Cross/Blue Shield preferred-provider option service-benefit plan offered to federal employees;
- The state employees' coverage plan; or
- The HMO plan that has the largest commercial, non-Medicaid enrollment within the state. [43]

The value of the benefits in separate CHIP programs must be actuarially equivalent and include:

- Inpatient and outpatient hospital services;
- Physicians' services;
- Surgical and medical services;
- Laboratory and X-ray services; and
- Well-baby and well-child care, including immunizations. [44]

For separate CHIP programs, a children's dental benefit was required through CHIPRA in 2009.[45] Similar to the health benefit requirements, CHIPRA linked dental coverage to commercial dental benchmark packages, which must be based on one of the following:

- The most popular federal employee dental plan for dependents;
- The most popular plan selected for dependents in the state's employee dental plan; or
- Dental coverage offered through the most popular commercial insurer in the state. [46]

Cost-sharing

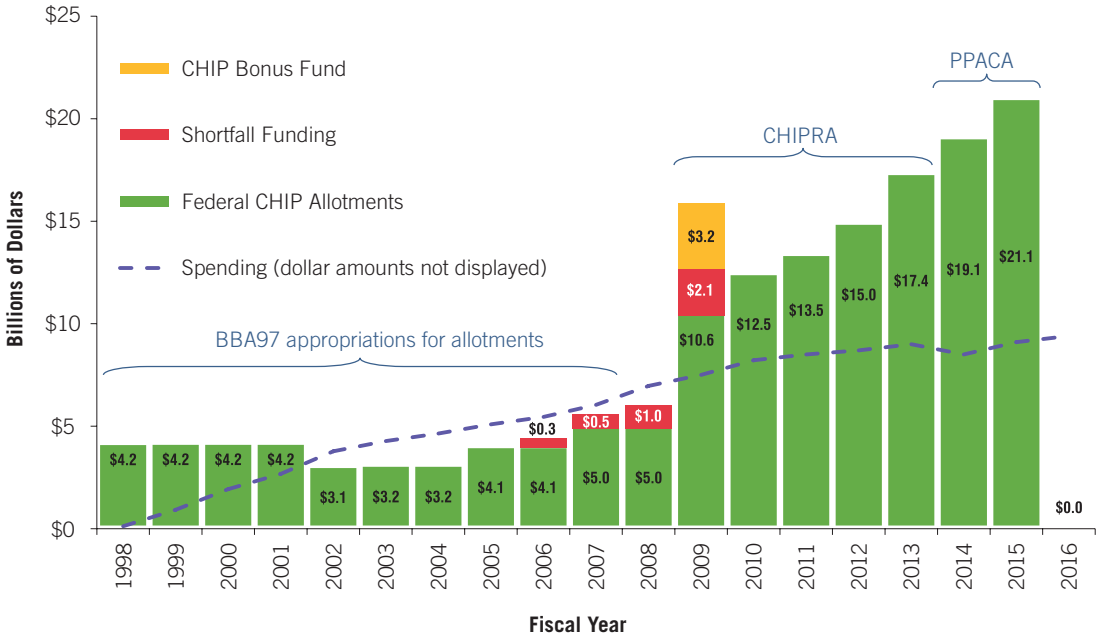
Cost-sharing in separate CHIP programs varies by state; currently, 28 states require cost-sharing for a variety of services, most commonly: inpatient hospital visits, non-preventive physician visits, emergency-room visits, and prescription drugs.[47] Under

current law, cost-sharing expenses cannot exceed five percent of a family's income,[48] though 20 states operate at a lower cap.[49] In a recent Government Accountability Office (GAO) analysis including cost-sharing information for separate CHIPs in five states—Colorado, Illinois, Kansas, New York, and Utah—two of the five states (Kansas and New York) charged no cost-sharing for any children, though they did charge higher premiums to those enrollees with higher incomes.[50]

Program Financing

As noted above, CHIP is a capped entitlement to states. Congress authorizes a maximum appropriation level for each year, from which states may draw enhanced federal matching funds up to the state's allotment. States have up to two years to draw down their annual allotment. Over the history of the CHIP program, funding has increased from an initial level of $4.2 billion in FY 1998 to $21.1 billion in FY 2015. Due to delays in drawing down federal matching dollars and differences in states in using their allotments, actual spending does not track mandatory appropriation levels. From FY 2006 to FY 2009, Congress provided additional funding for shortfalls in federal funds, and in 2009, an additional $3.2 billion was appropriated for a bonus fund. This funding was made available to states that implemented outreach and enrollment activities that resulted in significant increases in enrollment. (See Figure 3.)

Figure 3. Federal CHIP Appropriations, FY 1998-2016



Source: Chart reproduced courtesy of Medicaid and CHIP Payment and Access Commission (MACPAC).

Notes: The figure shows amounts explicitly appropriated in statute. Redistributed amounts are not shown as separate appropriations because they come from allotments (shown in the figure) that were appropriated but unspent. Federal CHIP spending is from all sources (allotments, redistributed funds, shortfall funding, bonus payments). For FY 2002-5, the line in the figure shows spending nationally exceeding the annual allotment appropriations but no shortfall funding; shortfall appropriations were not needed during this time because states also drew from their unspent prior-year balances and redistribution funds. For FY 2006-8, shortfall funding represents the amounts appropriated in separate bills to eliminate projected shortfalls in those years; for FY 2009, shortfall funding is the initial appropriated amount for the CHIP contingency fund created by CHIPRA.

BBA 97=Balanced Budget Act of 1997 (P.L. 105-33); CHIPRA=Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3); PPACA=Patient Protection and Affordable Care Act (P.L. 111-148).

Source: Appropriated amounts are from MACPAC analyses of §§2104 and 2105 of the Social Security Act and §108 of CHIPRA, as amended by §10203(d)(2)(F) of PPACA. Actual federal CHIP spending (FY 1998-2010) is from Centers for Medicare & Medicaid Services (CMS) expenditure reports; projected federal CHIP spending (FY 2011-2016) is from Congressional Budget Office (CBO), "Spending and Enrollment Detail for CBO's March 2011 Baseline: Children's Health Insurance Program (CHIP)," March 18, 2011, http://www.cbo.gov/budget/factsheets/2011b/Chip.pdf.

Program Evaluations

Since the enactment of CHIP, the share of uninsured children has fallen by half, from 13.9 percent to 7.1 percent.[51] Federal and state efforts to cover eligible but unenrolled children through CHIP led to increased coverage of children under CHIP as well as under traditional Medicaid, resulting in the overall reduction of uninsured children. A recent report from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) concluded that CHIP contributed to the decline of uninsured

rates among low-income children, falling from 25 percent in 1997 to 13 percent in 2012.[52] According to the report, coverage rates improved for all ethnic and income groups; enrollees in Medicaid and CHIP had better access to care, fewer unmet needs, and greater financial protection than those children who were uninsured.[53] Prior to the enactment of CHIP, three states covered children with family incomes up to 200 percent of FPL, and today 48 states provide such coverage. (Indiana and North Dakota limit children's eligibility to below 200 percent FPL.)[54,55]

While evaluations have documented the success of CHIP in improving health insurance coverage rates, they have also noted areas for improvement. For example, according to the ASPE survey, 25 percent of the children in CHIP had some type of unmet need: "Most CHIP enrollees received annual well-child checkups, [but] fewer than half received key preventive services such as immunizations and health screenings during those visits."[56] Though most CHIP enrollees received annual dental checkups, a significant share of them did not get recommended follow-up dental treatment.[57] There is also room for improvement in reducing the percentage of children who cycle off and back on to Medicaid and CHIP, and reducing gaps in coverage associated with moving between Medicaid and separate CHIP programs.[58] Finally, evaluations have indicated that, while participation rates have grown to high levels in most states, greater efforts could be made to target the 3.7 million children who are eligible for Medicaid or CHIP but remain uninsured.[59]

Section IV. Considering the Future of CHIP

Congressional leaders on both sides of the aisle and the administration have indicated a desire to extend CHIP funding.[60,61,62] As policymakers consider the future of CHIP funding, a number of other issues around timing and policy can affect coverage for low-income children.

State Budget Cycles

Although CHIP funding is authorized through the end of the current federal fiscal year—September 30, 2015—most states begin their fiscal years on July 1, 2015.[63] Forty-six states have a July 1 fiscal year start date. Of the remaining four states, New York has the earliest fiscal year, with a start date of April 1, Texas begins on September 1, and Alabama and Michigan begin on October 1. In addition, while 27 states, like the federal government, have an annual budget cycle, 21 states set state spending for two-year cycles or on a biennial basis, and two (Kansas and Missouri) use both.[64] As of mid-February, 39 state governors had submitted their budgets to state legislatures. As noted in the governors' letters to the U.S. Senate and House of Representatives committees, it is critical for states to know whether they will have access to federal funding under CHIP as early as possible, since uncertainty complicates establishing their FY 2016 budgets.[65]

State expenditures are matched at a level higher than Medicaid, up to the state's annual allotments, and are available to states for two years. FY 2015, which began on October 1, 2014, is the last year that new federal funds are made available. Thus, states will have until September 30, 2016, to expend any remaining federal allotments. There are several factors that will influence the rate of state spending. Perhaps most importantly, beginning in FY 2016 through FY 2019, the enhanced FMAP will be increased by 23 percentage points (not to exceed 100 percent).[66] Consequently, whatever remaining federal funds states have in FY 2016 will have to be drawn down at a faster rate.

Medicaid CHIP Expansions

Another factor is the maintenance of effort (MOE) requirement that states maintain 2010 eligibility levels for those children in Medicaid and CHIP through FY 2019.[67] The effect of this MOE requirement is different depending on how the state created its CHIP program. For those 2.5 million children enrolled in Medicaid-expansion CHIP (32 states and D.C.), the loss of CHIP funding would result in the state's continuing coverage under Medicaid at the its usual federal match rate.[68] Under this scenario, states will have unlimited funding through Medicaid, but the federal matching rate will decrease and the state's contribution will increase.

Separate CHIP Programs

States that provide coverage to children through a separate CHIP program may freeze new enrollment if they are at risk of running out of their CHIP allotment and may terminate coverage once that allotment is exhausted.[69] In these states, children may be enrolled in employer-sponsored coverage, if a parent has an employer that offers health insurance coverage to employees and their families. If a child does not have access to employer-sponsored coverage, the child can be enrolled in a qualified health plan offered through either a state or a federal health insurance exchange.[70]

Combination Programs

Twenty-eight states chose to expand coverage to children through a combination of a Medicaid expansion and a separate state program. In those states, children would be treated differently based on whether they were enrolled through the Medicaid expansion or through the separate state program. Furthermore, states that used waivers to expand coverage may discontinue that coverage once a waiver expires.[71] As noted earlier, states have up to two years to spend their allocations, so states that have not exhausted their allotments will be able to continue to draw down federal matching dollars until their allotments are exhausted.

Children's Health Benefits

Under the ACA, children enrolled in separate CHIP programs (approximately 5.3 million) may be transitioned to exchange coverage if the HHS secretary certifies by April 1, 2015, that plans in the exchange (known as qualified health plans) are "at least comparable" to the CHIP program benefits and cost-sharing.[72] These criteria will be hard to achieve, according to the June 2014 Medicaid and CHIP Payment and Access Commission report, which highlights that the exchange cost-sharing levels are not comparable to those in CHIP, meaning that states would not be permitted to transition these children to qualified health plans through the exchange.

A study of KidsCare (Arizona's CHIP program) and the Arizona exchange plans found that families would pay more to get a qualified health plan in the exchange compared with KidsCare.[73] Arizona's KidsCare benefits were also found to be more comprehensive than available exchange plans.[74] Another state analysis conducted by Wakely Consulting Group found that exchange plans had ten times more costly cost-sharing than CHIP.[75]

If a child loses coverage through CHIP, many private plans do not offer the same benefits available through CHIP, such as pediatric dental benefits or lower cost-sharing. As a result, if a former CHIP-eligible child is enrolled in private coverage, the child could face barriers to care because of differences in benefits, higher cost-sharing, or both.

Administrative Complexities

While one of the characteristics of CHIP is the flexibility provided to states, CHIP's flexibility also may result in a confusing array of requirements within a single state. Children in the same family may be eligible for different programs with different requirements, benefits, premiums, or cost-sharing. For example, in some states, a child under one year of age may be eligible for CHIP through Medicaid, the child's six-year-old sibling may be eligible for CHIP through a separate state program, and another 14-year-old sibling may be eligible for a second separate CHIP program in the same state, with different premiums and cost-sharing, while some older children may be ineligible for CHIP.[76,77]

Beyond the near-term problems identified above, there is a need to address the inherent programmatic confusion in CHIP as implemented today. Families and taxpayers are not well served by multiple federal and state programs that impose different eligibility requirements, enrollment processes and enrollment periods, different premium and cost-sharing requirements, and potentially different provider networks for parents and their children. The current patchwork of coverage for parents and children (often different programs for children in the same family, depending on their age) is confusing, administratively burdensome for families, and an inefficient use of taxpayer dollars. In the coming years, coverage gaps can and should be addressed, eventually ending the need for CHIP.

"Family Glitch"

Another issue that would affect the exchange coverage option for children if CHIP expires is the possibility that these children may not be able to access the subsidies offered through the exchanges because their parents are eligible for affordable employer-sponsored coverage. According to an analysis by the Agency for Healthcare Research and Quality, 56 percent of children in separate CHIP programs have a parent with employer-sponsored insurance; a vast majority of these parents have

access to coverage that is deemed to be "affordable" (meaning that the employee's contribution to self-only coverage is less than 9.5 percent of the employee's family income).[78]

Under the ACA, workers who have access to employer-sponsored health insurance coverage are not eligible for federal premium and cost-sharing assistance to purchase health insurance coverage through a state or federal insurance exchange. An exception applies if the employer's coverage is not "affordable," meaning that the premium exceeds 9.5 percent of family income. However, the affordability test is based on the cost of the premium for *individual* coverage, not the cost of *family* coverage. As a result, no family member, including children, qualifies for premium or cost-sharing assistance through an exchange, even if the cost of family coverage well exceeds 9.5 percent of the family's income. Low-income, uninsured children could potentially be ineligible for assistance through state and federal insurance exchanges. This helps explain why the GAO estimated that if CHIP funding expires, about 1.9 million children would lose access to affordable coverage due to this "family glitch."[79]

King v. Burwell Supreme Court Ruling

As previously mentioned, if funding for CHIP expires, children in a separate CHIP program may be transitioned into the exchanges to enroll in subsidized coverage; aside from the "family glitch," the majority of CHIP enrollees have family income that falls within the range of subsidy-eligibility levels. If no plans are comparable, then the state is *not required* to transition these children. If the state does not make this transition, families could enroll in subsidized coverage through a state or federal exchange. In the U.S. Supreme Court case *King v. Burwell*,[80] the Court is asked to determine whether the ACA allows subsidies to be available to eligible individuals enrolled in federally facilitated exchanges. If the Court, whose decision is expected at the end of June 2015, determines that subsidies are not available in federally facilitated exchanges, millions of children in states that have federally facilitated exchanges would have limited or no ability to find affordable insurance.

Section V. BPC Recommendations

As Bipartisan Policy Center (BPC) Health Project leaders, we propose the following recommendations:

1. Extend CHIP for a minimum of two years, while recognizing that two years does not provide sufficient time for state and federal elected officials and agencies to address major programmatic changes sought by policymakers on both sides of the aisle and at both levels of government.
2. Extend CHIP funding at the current authorized 2015 level of $21.1 billion per year. Any increase in authorized spending over the current Congressional Budget Office (CBO) baseline projection of $5.7 billion per year must be offset so that the program extension costs do not increase the federal debt. This would mean identifying spending reductions or revenue increases (or a combination of the two). Final estimates will be made by the CBO at the time of the program's extension, but based on previous CBO scoring projections and underlying assumptions about interactions with Medicaid and the exchanges should the CHIP extension not occur, the two-year cost of extending this program is likely to be approximately $5 billion.
3. Eliminate gaps in coverage by resolving issues related to the ACA, such as the so-called "family glitch," or other gaps created by changes in eligibility, premium tax-credits, and cost-sharing subsidies.
4. Over the long-term, modify eligibility for public and private coverage (Medicaid, employer-sponsored coverage, exchange-based insurance) to allow children and parents to be enrolled in the same insurance plan, eliminating the need for CHIP.
5. Also over the long-term, ensure that differences in benefits and out-of-pocket costs in current employer-sponsored or exchange plans do not result in the loss of important benefits or in high cost-sharing for low-income children.

There is agreement among policymakers on both sides of the aisle that CHIP funding should be extended, yet there are considerable differences as to the scope of the funding extension. Democratic congressional leaders have recommended four years;[81,82,83] Republican congressional leaders have released draft legislation seeking feedback on the length of the funding extension,[84] with both parties seeking material changes in the authorization. The Medicaid and CHIP Payment and Access

Commission, a legislative-branch agency charged with providing advice to Congress on Medicaid and CHIP, has recommended that the program be extended two years to provide time to better understand potential coverage gaps and to assess the affordability and adequacy of children's coverage offered through health insurance exchanges.[85] Suggested changes to the CHIP authorization include alternatively extending or eliminating CHIP performance bonuses, and eliminating the 23 percent increase in FMAP effective October 1, 2015. Some policy experts have suggested that of the nine million children enrolled in CHIP, as many as 6.4 million should have access to other affordable coverage and that the CHIP program should focus on low-income, uninsured children who are not eligible for Medicaid and those who are ineligible for coverage through exchanges because of the "family glitch."[86]

Based on the review and analysis as described in this report, BPC leaders recommend extending CHIP for a minimum of two years. At the same time the leaders acknowledge that four years may be needed to resolve the uncertainties surrounding the transition of CHIP-eligible children into private health insurance coverage. Regardless of the length of the extension, BPC's Health Project leaders believe that a separate program to cover children should not be maintained indefinitely. Our ultimate goal is to unify families and prevent churning in eligibility between programs and policies.

Whenever possible, parents and children should be enrolled in the same insurance policies. Under current law, low-income parents and children may be enrolled in different health insurance policies, with different benefits, different provider networks, different premiums, and different cost-sharing. Negotiating eligibility and enrollment in some states can be a significant barrier to coverage and care. For example, under the current structure, in some states one parent could be enrolled in employer-sponsored coverage, the other parent enrolled in private coverage through an exchange, a young child enrolled in Medicaid, and older siblings enrolled in one or more separate state CHIP programs.[iv]

Children who are eligible for coverage through a parent's employer or through an exchange should be enrolled in insurance policies with their parents and other family members. Whether policymakers extend the program for two years or four years, policymakers should utilize that time to review benefits and cost-sharing to assure

[iv] Due to historical coverage requirements in Medicaid and the CHIP option to cover children in a separate state program, many states have younger children eligible for Medicaid or CHIP at a higher level of family income than older children in the same family, making one or more children eligible for Medicaid, while older children are eligible for CHIP or not eligible at all. "Florida operates three separate CHIP-funded programs. Healthy Kids covers children ages 5 through 19, as well as younger siblings in some locations; MediKids covers children ages 1 through 4; and the Children's Medical Service Network serves children with special health care needs from birth through age 18." See: "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level." State Health Facts, Henry J. Kaiser Family Foundation FN 6. Available online at: http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/. Accessed February 18, 2015.

that high out-of-pocket costs or coverage limitations in employer-sponsored and exchange plans do not result in barriers in access to care for children.

Timing of Extension

Regardless of time lines or changes, policymakers should take action to extend funding early in the year to avoid disruptions in coverage for children, given the lack of alignment between the beginnings of state and federal fiscal years and state legislative adjournment schedules.

Conclusion

The State Children's Health Insurance Program has historically enjoyed broad bipartisan support. Extending CHIP funding in the short-term will give states time to make adjustments in their budgets and will allow policymakers to discuss differences and resolve disagreements over the long-term structure of the U.S. health care system, reducing fragmentation, administrative burden, and churning between programs and policies.

Endnotes

[1] United States. H.R. 3590 — 111th Congress: Patient Protection and Affordable Care Act. 42 U.S.C. §10203(d) (1), amending CHIPRA §2104(a) (42 U.S.C. 1397dd [(a])) Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Accessed on February 18, 2015.

[2] Harrington and Kenney, et al. 2014. "CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings." Report submitted to the Office of the Assistant Secretary for Planning and Evaluation. Ann Arbor, MI: Mathematica Policy Research. August 2014. Available online at: http://www.medicaid.gov/chip/downloads/chip_report_congress-2014.pdf.

[3] House Energy and Commerce Committee. "Responses to Bipartisan, Bicameral Letters to Governors Regarding CHIP." House Energy and Commerce Committee, December 3, 2014. Available online at: http://energycommerce.house.gov/letter/responses-bipartisan-bicameral-letters-governors-regarding-chip. Accessed on February 26, 2015.

[4] United States. H.R. 3103 — 104th Congress. Health Insurance Portability and Accountability Act of 1996. August 21, 1996. Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/html/PLAW-104publ191.htm. Accessed on March 2, 2015.

[5] United States. Statement by Senator John D. (Jay) Rockefeller, Ranking Member., Senate Health Care Subcommittee, "CHIP at 10: A Decade of Covering Children" (as prepared). July 25, 2006. Available online at: http://www.finance.senate.gov/imo/media/doc/072506jr1.pdf. Accessed on February 19, 2015.

[6] Pear, Robert. "Hatch Joins Kennedy to Back a Health Program." *The New York Times*, March 14, 1997. Available online at: http://www.nytimes.com/1997/03/14/us/hatch-joins-kennedy-to-back-a-health-program.html. Accessed February 6, 2015.

[7] "Reconciliation Package: Spending Cuts." *An article from CQ Almanac, 1997*. Available online at: http://library.cqpress.com/cqalmanac/document.php?id=cqal97-0000181054. Accessed on February 26, 2015.

[8] United States. H. Con. Res. 84—105th Congress. June 5, 1997. Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-105hconres84enr/html/BILLS-105hconres84enr.htm. Accessed on February 26, 2015.

[9] United States. S. 526 — 105th Congress. "To amend the Internal Revenue Code of 1986 to increase the excise taxes on tobacco products for the purpose of offsetting the Federal budgetary costs associated with the Child Health Insurance and Lower Deficit Act." Introduced on April 8, 1997. Available online at: http://www.gpo.gov/fdsys/search/pagedetails.action?packageId=BILLS-105s526is. Accessed February 6, 2015.

[10] United States. S.674 — 105th Congress. Children's Health Insurance Provides Security (CHIPS) Act of 1997. Introduced April 30, 1997. Available online at: https://www.congress.gov/105/bills/s674/BILLS-105s674is.pdf. Accessed on March 2, 2015.

[11] United States. S.13 — 105th Congress. The Children's Health Coverage Act. January 21, 1997. Available online at: https://www.congress.gov/105/bills/s13/BILLS-105s13is.pdf. Accessed on March 2, 2015.

[12] United States. H.R. 2015 — 105th Congress. Balanced Budget Act of 1997. §4901, amending the Social Security Act §2101. [42 U.S.C. 1397aa]. Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-105hr2015enr/pdf/BILLS-105hr2015enr.pdf. Accessed on March 2, 2015.

[13] United States. S. 1932— 109th Congress. Deficit Reduction Act of 2005, §6101, amending §2104 of the Social Security Act (42 U.S.C. 1397dd). Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-109s1932enr/pdf/BILLS-109s1932enr.pdf. Accessed on March 2, 2015.

[14] United States. H.R.6164 — 109th Congress. National Institutes of Health Reform Act of 2006. , §201, amending §2104 of the SSA (42 U.S.C. 1397dd). Available online at: https://www.congress.gov/109/bills/hr6164/BILLS-109hr6164enr.pdf . Accessed on March 2, 2015.

[15] United States H.R. 976 — 110th Congress. Final Vote Results for Roll Call 102 H.R. 976. Available online at: http://clerk.house.gov/evs/2007/roll1009.xml. Accessed February 6, 2014.

U.S. Senate Roll Call Votes 110th Congress— - 1st Session H.R.976. Available online at: http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=110&session=1&vote=00307. Accessed on March 2, 2015.

[16] United States. H.R.3963— 110th Congress. Final Vote Results for Roll Call 1009 H.R. 3963. Available online at: http://clerk.house.gov/evs/2007/roll1009.xml . Accessed on March 2, 2015.

U.S. Senate Roll Call Votes 110th Congress— - 1st Session H.R. 3963. Available online at: http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=110&session=1&vote=00403. Accessed on March 2, 2015.

[17] United States. "Message from the President of the United States transmitting his veto of H.R. 976, the Children's Health Insurance Program Reauthorization Act of 2007.," House Document 110-62., October 3, 2007. Available for download online at: https://vf-manprod.klnpa.org/vufind/Record/cup.513131/UserComments. Accessed February 6, 2015.

[18] United States. S.2499 — 110th Congress. Medicare, Medicaid, and SCHIP Extension Act of 2007. §201, amending §2104 of the Social Security Act (42 U.S.C. 1397dd). Available online at: https://www.congress.gov/110/plaws/publ173/PLAW-110publ173.htm. Accessed on March 2, 2015.

[19] United States. H.R. 2 — 111th Congress: Children's Health Insurance Program Reauthorization Act of 2009. Available online at: https://www.congress.gov/111/bills/hr2/BILLS-111hr2enr.pdf.

[20] United States. H.R. 2 — 111th Congress: Children's Health Insurance Program Reauthorization Act of 2009. Available online at: https://www.congress.gov/111/bills/hr2/BILLS-111hr2enr.pdf. Accessed on February 18, 2015.

[21] United States. §10203 Patient Protection Affordable Care Act. Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Accessed on February 18, 2015.

[22] United States. H.R. 2015 — 105th Congress. Balanced Budget Act of 1997. §4901, amending the Social Security Act Sec. 2101. [42 U.S.C. 1397aa(c)]. Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-105hr2015enr/pdf/BILLS-105hr2015enr.pdf. Accessed on March 2, 2015.

[23] United States. H.R. 2015 — 105th Congress. Balanced Budget Act of 1997 §2101. Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-105hr2015enr/pdf/BILLS-105hr2015enr.pdf. Accessed February 4, 2015.

[24] Baumrucker, Evelyne P., and Mitchell, Alison. "State Children's Health Insurance Program: An Overview." Congressional Research Service. CRS Report R43627. December 8, 2014. Available for purchase online at: http://biblio.pennyhill.com/state-childrens-health-insurance-program-an-overview-r43627/ . Accessed on February 26, 2015.

[25] United States Social Security Act, §2105(b), [42 USC 1397ee(b)]. Available online at: http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXXI-sec1397ee.htm. Accessed on February 26, 2015.

[26] United States Social Security Act, §2105(b), [42 USC 1397ee(b)]. Available online at: http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXXI-sec1397ee.htm. Accessed on February 26, 2015.

[27] United States. Centers for Medicare and Medicaid Services. Children's Health Insurance Program Financing. Available online at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Childrens-Health-Insurance-Program-Financing.html. Accessed on March 2, 2015.

[28] Henry J. Kaiser Foundation. *Enhanced Federal Medical Assistance Percentage for CHIP, State Health Facts*. Available online at: http://kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/. Accessed January 31, 2015.

[29] Henry J. Kaiser Foundation. *Enhanced Federal Medical Assistance Percentage for CHIP, State Health Facts.* Available online at: http://kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/. Accessed January 31, 2015.

[30] United States. Patient Protection Affordable Care Act. §2101(b), adding SSA §2105(d)(3). Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

Accessed on February 18, 2015.

[31] United States. H.R. 2015 — 105th Congress. Balanced Budget Act of 1997. §2101(c)(4). Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-105hr2015enr/pdf/BILLS-105hr2015enr.pdf. Accessed February 4, 2015.

[32] Medicaid and CHIP Payment Access Commission (MACPAC). 2014b. *Report to the Congress on Medicaid and CHIP.* Appendix Table 1-A-3. June 2014. Available online at: MACPAC June 2014. Accessed on February 18, 2015.

[33] United States. Social Security Act. §1902(r)(2). Available online at: http://www.ssa.gov/OP_Home/ssact/title19/1902.htm. Accessed on March 2, 2015.

[34] United States. H.R.3963 — 110th Congress. Children's Health Insurance Reauthorization Act of 2007. Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-110hr3963enr/html/BILLS-110hr3963enr.htm. Accessed on March 2, 2015.

[35] Georgetown University Health Policy Institute, Center for Children and Families. "Summary of the Children's Health Insurance Program Reauthorization Act of 2007." Available online at: http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20schip%20policy_summary%20of%20the%20chipra.pdf. Accessed on March 2, 2015.

[36] United States. H.R. 2 — 111th Congress: Children's Health Insurance Program Reauthorization Act of 2009. Available online at: https://www.congress.gov/111/bills/hr2/BILLS-111hr2enr.pdf. Accessed on February 18, 2015.

[37] United States. H.R. 2 — 111th Congress: Children's Health Insurance Program Reauthorization Act of 2009. Sec. 114(a)(8). Available online at: https://www.congress.gov/111/bills/hr2/BILLS-111hr2enr.pdf. Accessed on February 18, 2015.

[38] United States. Social Security Act. 42 U.S.C. 1397bb(b)(3).

[39] Medicaid and CHIP Payment Access Commission (MACPAC). 2014b. *Report to the Congress on Medicaid and CHIP.* June 2014. Available online at: MACPAC June 2014. Accessed on February 18, 2015.

[40] Baumrucker, Evelyne P., Mitchell, Alison. "State Children's Health Insurance Program: An Overview.," *Congressional Research Service*., July 3, 2014.

[41] United States. United States. H.R. 2015 — 105th Congress. Balanced Budget Act of 1997. §2101. Available online at: http://www.gpo.gov/fdsys/pkg/BILLS-105hr2015enr/pdf/BILLS-105hr2015enr.pdf. Accessed February 4, 2015.

[42] United States. Social Security Act. 42 U.S.C. Sect. 1397cc(a).

[43] *Ibid.*

[44] *Ibid.*

[45] United States. H.R. 2 — 111th Congress: Children's Health Insurance Reauthorization Act. §501, amending §2103 SSA (42 U.S.C. 1397cc). Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ3/html/PLAW-111publ3.htm. Accessed on February 26, 2015.

[46] *Ibid.*

[47] Cardwell, A.J. Jee, C. Hess, et al. 2014. *Benefits and cost sharing in separate CHIP programs.* Washington, D.C.: Georgetown University Center for Children and Families and National Academy for State Health Policy. Available online Accessed on January 28, 2015 at: http://ccf.georgetown.edu/wp-content/uploads/2014/05/Benefits-and-Cost-Sharing-in-Separate-CHIP-Programs.pdf. Accessed on January 28, 2015.

[48] United States. Social Security Act Sect. §2103(e)(3)(B).

[49] Cardwell, A.J. Jee, C. Hess, et al. *Benefits and cost sharing in separate CHIP programs.* Washington, D.C.: Georgetown University Center for Children and Families and National Academy for State Health Policy. Available online at: http://ccf.georgetown.edu/wp-content/uploads/2014/05/Benefits-and-Cost-Sharing-in-Separate-CHIP-Programs.pdf. Accessed on January 28, 2015.Cardwell, A.J. Jee, C. Hess, et al.

[50] United States Government Accountability Office. 2013. *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance.* Report no. GAO-14-40. Available online at: http://www.gao.gov/assets/660/659180.pdf. Accessed on March 2, 2015.

[51] Medicaid and CHIP Payment Access Commission (MACPAC). 2014b. *Report to the Congress on Medicaid and CHIP.* June 2014. Available online at: https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/reports/2014-06-13_MACPAC_Report.pdf?attachauth=ANoY7coT8G9bwkI4S27ZpTxWZJHRGpx0FHkXS8cjT9ORf9J5wrVsdNYv6gWSfmj5TT1HFZhr8h_NHZJYl5BsqePiKRI9KRmD7g78nLxJkDTl4yEzNTphAgCkUztbe8O6o2xLiBY3xFrSqZccLuUeu3R7LfJ16HSVH5zI4OUUclj8Ge4u1RLHkRaMH5KsE9DZvYNFh0pI6ivGLVtBBX9z_gWLrEtR8SiCv-oJm7HywRQbVRVFLSeC89I%3D&attredirects=1. Accessed on February 18, 2015.

[52] Harrington and Kenney, et al. 2014. "CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings." Report submitted to the Office of the Assistant Secretary for Planning and Evaluation. Ann Arbor, MI: Mathematica Policy Research. , August 2014. Available online Accessed on January 29, 2015 at: http://aspe.hhs.gov/health/reports/2014/CHIPevaluation/rpt_CHIPevaluation.pdf. Accessed on March 2, 2015.

[53] *Ibid.*

[54] Kaiser Family Foundation. . "Children's Health Insurance Timeline," 2013. Available online at: https://kaiserfamilyfoundation.files.wordpress.com/2007/02/5-09-13-childrens-health-insurance-timeline.pdf. Accessed on February 19, 2015.

[55] Kaiser Family Foundation. "Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women as of January 2015." February 2, 2015. Available online at: http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/. Accessed on February 26, 2015.

[56] Harrington and Kenney, et al. "CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings." Report submitted to the Office of the Assistant Secretary for Planning and Evaluation. Ann Arbor, MI: Mathematica Policy Research. August 2014. Available online at: http://aspe.hhs.gov/health/reports/2014/CHIPevaluation/rpt_CHIPevaluation.pdf. Accessed on March 2, 2015.Harrington and Kenney, et al. 2014.

[57] *Ibid.*

[58] *Ibid.*

[59] *Ibid.*

[60] United States. H.R.919 — 114th Congress. CHIP Extension and Improvement Act of 2015. Introduced February 2, 2015. Available online at: https://www.congress.gov/114/bills/hr919/BILLS-114hr919ih.pdf. Accessed on March 2, 2015.

[61] United States. S. 522 — 114th Congress. Protecting and Retaining Our Children's Health Insurance Program Act of 2015. Introduced on February 12, 2015. Available online at: https://www.congress.gov/114/bills/s522/BILLS-114s522is.pdf. Accessed on March 2, 2015.

[62] United States. House Committee on Energy and Commerce. "Discussion Draft: Extending Funding for the State Children's Health Insurance Program.," February 24, 2015. Available online at: http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Analysis/SCHIPSectionbySection.pdf. . Accessed on March 2, 2015.

[63] National Association of State Budget Officers. "The State Budget Process.," Available online at: http://www.nasbo.org/state-budget-basics-videos. Accessed February 15, 2015.

[64] *Ibid*.

[65] House Energy & Commerce Committee. "Responses to Bipartisan, Bicameral Letters to Governors Regarding CHIP." House Energy & Commerce Committee. - See more at: Available online at: http://energycommerce.house.gov/letter/responses-bipartisan-bicameral-letters-governors-regarding-chip. Accessed February 15, 2015.

[66] United States. Patient Protection Affordable Care Act. §2101(b), adding SSA §2105(d)(3). Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

Accessed on February 18, 2015.

[67] *Ibid.*

[68] MACPAC. *Report to the Congress on Medicaid and CHIP.* June 2014. Available online at: https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/reports/2014-06-13_MACPAC_Report.pdf?attachauth=ANoY7crS8UHNDCD8BTsSicWib9GSglYfsq8sihokWhj7ibKkXVuneDwC23RlpEbkMAPRfClREHD_92S8U6bHbrsWk-ZrRgHavpT2hf_LqjS7MsnYUvRb7woiC4f69a3wOXFO2hV0KQH8bIkhWEcfNc9DCYo6-2gCKnQndj-dw9Z8fWdzExqXncaC_rokYaTzkVl8akBZSGYpa2c7uX16wuo5LjBUMRt17RAcLp3_GstzjpO2QxhngsI%3D&attredirects=1. Accessed on February 18, 2015.

[69] United States. Centers for Medicare and Medicaid Services. State Medicaid Director Letter., February 25, 2011. Available online at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11001.pdf. Accessed on February 26, 2015.

[70] United States. Centers for Medicare and Medicaid Services. State Medicaid Director Letter., February 25, 2011. Available online at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11001.pdf.

[71] *Ibid*.

[72] United States. Patient Protection Affordable Care Act, §2101(b), adding SSA §2105(d)(3). Available online at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

Accessed on February 18, 2015.

[73] Georgetown University Center for Children and Families and National Academy for State Health Policy. "Benefits and Cost Sharing in Separate CHIP Programs." (May 2014.), Available online at:

http://ccf.georgetown.edu/wp-content/uploads/2014/05/Benefits-and-Cost-Sharing-in-Separate-CHIP-Programs.pdf. Accessed on February 26, 2015.

[74] *Ibid.*

[75] Wakely Consulting Group., "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans.," July 2014. , Available online at: http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf. Accessed on February 26, 2015.

[76] The Kaiser Commission on Medicaid and the Uninsured. "Modern Era Medicaid: Findings from a 50-state Survey of Eligibility, Enrollment, Renewal, and Cost-sharing Policies in Medicaid and CHIP as of January 2015." January 2015. Available online at: http://files.kff.org/attachment/report-modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015. Accessed February 1, 2015.

[77] Kaiser Family Foundation. "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level." January 1, 2015. Available online at: http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/ . Accessed February 1, 2015.

[78] MACPAC Report of the Congress on Medicaid and CHIP. Chapter 1: CHIP and the New Coverage Landscape, p. 9. (June 2014.) Available online at: https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/reports/2014-06-13_MACPAC_Report.pdf?attachauth=ANoY7crNr4Qd4yVM_mmY1qH3_0jdGOyFogp7wfKeX9LxPfJ-ZXo86lAq4QB-LUWENanIz_MsWsHKBloqZciAdGZO5cAjSJU0xKsz6xz86TFPkVgFv30nIkJi1kDB937lv4PWg46b59a5Jo0AXTOMlFJ6d05rwOCIFcc1w78yGoXUE-ara4XDmOVEVqtOt6rA3Cls4UsP3TMHFfxErdoH1r_HdpmNtZc0qTgI1lbkQEUfxndxv0W-oNg%3D&attredirects=1. Accessed on February 18, 2015.

[79] Government Accountability Office. *Opportunities Exist for Improved Access to Affordable Insurance.* GAO-12-648 at p. 14: Published: Jun 22, 2012. Available online at: http://www.gao.gov/assets/600/591797.pdf. Accessed on February 26, 2015.

[80] *King v. Burwell.* No. 14-1158, U.S. Court of Appeals for the Fourth Circuit. (July 22, 2014).

[81] United States. H.R.919 — 114th Congress. CHIP Extension and Improvement Act of 2015. Introduced February 2, 2015. Available online at: https://www.congress.gov/114/bills/hr919/BILLS-114hr919ih.pdf. Accessed on March 2, 2015.

[82] United States. S. 522 — 114th Congress. Protecting and Retaining Our Children's Health Insurance Program Act of 2015. Introduced on February 12, 2015. Available online at: https://www.congress.gov/114/bills/s522/BILLS-114s522is.pdf. Accessed on March 2, 2015.

[83] President Obama's FY 2016 budget proposal to Congress also included a four- year extension. For more information, see: http://www.hhs.gov/budget/fy2016/fy-2016-budget-in-brief.pdf, at p. 97.

[84] United States. House Committee on Energy and Commerce. "Discussion Draft: Extending Funding for the State Children's Health Insurance Program.," February 24, 2015. Available online at: http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Analysis/SCHIPSectionbySection.pdf. Accessed on March 2, 2015.

[85] Medicaid and CHIP Payment and Assessment Commission. Report to Congress on Medicaid and CHIP. , Medicaid and CHIP Payment and Assessment Commission, June 2015. Available online at: https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/reports/2014-06-13_MACPAC_Report.pdf?attachauth=ANoY7cpH9Pq0www0KNKuWwNk09KI9z7Z3dRmeU5gFBW6d6F5aqLOLkMWxTX2XuIDW399LEr7nJg5tL38uXrXN54nMSLyG2EZFlTF5HmmKq-dw3_Z6TEnI9LdWQB1lovCeTsde3q-6Muj1nXz6zLw5q3haZXzeISa0_zNCaAfFoeFaEOqowXcmsQHS0maeUjN2Tpr-FpxEqtrOuimbyywoesAH9kHDjeoiF5jxXiuOysIhfpoTcKS4rk%3D&attredirects=0. Accessed February 18, 2015.

[86] Douglas Holz-Eakin, Douglas. American Action Forum. "The Children's Health Insurance Program: Protecting America's Children and Families." Testimony before the Senate Finance Subcommittee on Health. September 16, 2014. Available online at: http://www.finance.senate.gov/imo/media/doc/Testimony%20of%20Douglas%20Holtz-Eakin%20-%20Senate%20Finance%202014-09-16.pdf. Accessed February 18, 2015.

BIPARTISAN POLICY CENTER

1225 Eye Street NW, Suite 1000
Washington, DC 20005
(202) 204-2400

WWW.BIPARTISANPOLICY.ORG