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"CHIP: An Overview"

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee thank you for this opportunity to appear before you on behalf of the Congressional Research Service. My name is Evelyne Baumrucker and I am here to provide an overview of the State Children's Health Insurance Program (CHIP). My colleague, Alison Mitchell, will address CHIP financing and the Patient Protection and Affordable Care Act (ACA) maintenance of effort (MOE) for children.

CHIP is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but have no health insurance. CHIP is jointly financed by the federal government and states, and is administered by the states. In FY2013, CHIP enrollment totaled 8.4 million and federal and state expenditures totaled $13.2 billion.

CHIP was established as part of the Balanced Budget Act of 1997 under a new Title XXI of the Social Security Act. Since that time, other federal laws have provided additional funding, and made significant changes to CHIP. Most notably, the Children's Health Insurance Program Reauthorization Act of 2009 increased appropriation levels, and changed the federal allotment formula, eligibility, and benefit requirements. The ACA largely maintains the current CHIP structure through FY2019 and requires states to maintain their Medicaid and CHIP child eligibility levels through this period as a condition for receiving Medicaid federal matching funds. However, the ACA does not provide federal CHIP appropriations beyond FY2015.

State participation in CHIP is voluntary. However, all states, the District of Columbia, and the territories participate. The federal government sets basic requirements for CHIP, but states have the flexibility to design their own version within the federal government's basic framework. As a result, there is significant variation across CHIP programs. Currently, state upper-income eligibility limits for children range from a low of 175% of the federal poverty level to a high of 405% of FPL (in FY2013, the federal poverty level for a family of four was equal to $23,550). Despite the fact that 27 states extend CHIP coverage to children in families with annual income greater than 250% FPL, FY2013 administrative data show that CHIP enrollment is concentrated among families with annual income at lower levels. Almost 90% of CHIP child enrollees were in families with annual income at or below 200% FPL.

States may design their CHIP programs in three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. As of May 2014, the territories, the District of Columbia, and seven states were using CHIP Medicaid expansions; 14 states operated separate CHIP programs; and 29 states used a combination approach. In FY2013, approximately 70% of CHIP program enrollees received coverage through separate CHIP programs and the remainder received coverage through a CHIP Medicaid expansion.

CHIP benefit coverage and cost-sharing rules depend on program design. CHIP Medicaid expansions must follow the federal Medicaid rules for benefits and cost sharing, which entitles CHIP enrollees to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage effectively eliminating any state-defined limits on the amount, duration, and scope of any benefit listed in Medicaid statute, and exempts the majority of children from any cost sharing. For separate CHIP programs, the benefits are permitted to look more like private health insurance, and states may impose cost sharing, such as premiums or enrollment fees, with a maximum allowable amount that is tied to annual family income. Aggregate cost-sharing under CHIP may not exceed 5% of annual family income. Regardless of the choice of program design, all states must cover emergency services, well baby and well child care including age-appropriate immunizations, and dental services. If offered, mental health services must meet federal mental health parity requirements.

As we begin the final year of federal CHIP funding under the CHIP statute, Congress has begun considering the future of the program and exploring alternative policy options. The health insurance market is far different today than when CHIP was established. CHIP was designed to work in coordination with Medicaid to provide health coverage to low-income children. Before CHIP was established, no federal program provided health coverage to children with family annual incomes above Medicaid eligibility levels. The ACA further expanded the options for some children in low-income families with incomes at or above CHIP eligibility levels by offering subsidized coverage for insurance purchased through health insurance exchanges. Congress' action or inaction on the CHIP program may affect health insurance options and resulting coverage for targeted low-income children that are eligible for the current CHIP program.

This concludes my statement. CRS is happy to answer your questions at the appropriate time.