State Children's Health Insurance Program (CHIP): A Brief Overview

Elicia J. Herz
Specialist in Health Care Financing

Chris L. Peterson
Specialist in Health Care Financing

Evelyne P. Baumrucker
Analyst in Health Care Financing

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Summary

The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the State Children's Health Insurance Program (CHIP) under a new Title XXI of the Social Security Act and provided annual appropriations for CHIP through FY2007. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, H.R. 2, P.L. 111-3), which was signed into law on February 4, 2009, provided CHIP appropriations through FY2013 and made other changes.

In general, CHIP allows states to cover targeted low-income children with no health insurance in families with income above Medicaid eligibility levels. States may also extend CHIP coverage to pregnant women when certain conditions are met. The highest state-reported upper income eligibility limit for children in CHIP is 350% of the federal poverty level, in New Jersey.

Under CHIP, states may enroll targeted low-income children in a CHIP-financed expansion of Medicaid, create a new separate state CHIP program, or devise a combination of both approaches. States choosing the Medicaid option must provide all Medicaid mandatory benefits and all optional services covered under the state plan. In addition, they must follow the nominal Medicaid cost-sharing rules or apply the new state plan option for premiums and service-related cost-sharing as allowed under the Deficit Reduction Act of 2005 (DRA). In general, separate state programs must follow certain coverage and benefit options outlined in CHIP law. While some cost-sharing provisions vary by family income, the total annual aggregate cost-sharing (including premiums, copayments, and other similar charges) for a family may not exceed 5% of total income in a year. Preventive services are exempt from cost-sharing.

All states, the District of Columbia, and the five territories have CHIP programs. The territories, the District of Columbia, and six states use Medicaid expansions; 18 states use separate state programs; and 26 states use a combination approach. At the national level, nearly 7.4 million children were enrolled in CHIP during FY2008. In addition, 12 states reported enrolling about 335,000 adults in CHIP through program waivers in FY2008.

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The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the State Children's Health Insurance Program (CHIP)[1] under a new Title XXI of the Social Security Act and provided annual appropriations for CHIP through FY2007. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, H.R. 2, P.L. 111-3), which was signed into law on February 4, 2009, provided CHIP appropriations through FY2013 and made other changes. CHIP offers federal matching funds to states and territories to provide health insurance to certain uninsured low-income children and pregnant women. Although specific requirements apply to eligibility, benefits, and beneficiary cost-sharing, as described below, these rules can be modified via waiver authority provided in Section 1115 of the Social Security Act.[2]

Eligibility

Eligibility for health benefits under CHIP is available to different groups via different federal authority and mechanisms. These groups have included children, pregnant women, parents and childless adults. Groups may be covered under the CHIP state plan or via special waiver authority.

Children

In general, Title XXI defines a targeted low-income child as one who is under age 19 with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. States can set the upper income level for targeted low-income children up to 200% of the federal poverty level (FPL),[3] or 50 percentage points above the applicable pre-CHIP Medicaid income level. However, "(u)nder current statutory and regulatory authority, States are able to effectively expand eligibility of all children under 19 years of age to whatever level they choose."[4] For states seeking CMS approval to expand eligibility, CHIPRA reduces federal CHIP payments for certain higher-income CHIP children. Specifically, the regular Medicaid federal matching rate (FMAP), which is lower than the CHIP enhanced matching rate, will be used for CHIP enrollees whose effective family income exceeds 300% of poverty using the state's policy of excluding "a block of income that is not determined by type of expense or type of income," with an exception for states that already had a federal approval plan (i.e., New Jersey) or that had enacted a state law to submit a plan for federal approval (i.e., New York).

Within these general rules, states may provide assistance to qualifying children in two basic ways. They may cover such children under their Medicaid programs and/or they may create a separate CHIP program for this purpose. (More details on available benefits under each approach are described in the next section.) When states provide Medicaid coverage to targeted low-income children, Medicaid rules typically apply. When states provide coverage to targeted low-income

[1] One of the provisions of CHIPRA permits using CHIP as the program's acronym, instead of SCHIP. This report reflects this change, using CHIP instead of SCHIP.

[2] See CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*.

[3] In 2009, the poverty guideline in the 48 contiguous states and the District of Columbia is $22,050 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 74 *Federal Register* 4199, January 23, 2009).

[4] 66 *Federal Register* 2320, January 11, 2001. For additional information on states' flexibility in counting income for purposes of determining CHIP eligibility, see CRS Congressional Distribution Memorandum, *Overview of Medicaid and Medicaid-Expansion SCHIP Eligibility for Children and Rules for Counting Income*, by April Grady, November 29, 2007, available upon request.

children through separate CHIP programs, Title XXI rules typically apply. In both cases, the federal share of program costs comes from federal CHIP funds (also described in further detail below).

Title XXI does not establish an individual entitlement to benefits. Instead, Title XXI entitles states with approved state CHIP plans to pre-determined federal allotments based on a distribution formula set in the law (explained further below). Targeted low-income children covered under a CHIP-financed expansion of Medicaid are, however, entitled to the benefits offered under that program as dictated by Medicaid law. No such individual entitlement exists for targeted low-income children covered in separate CHIP programs.

States may cover targeted low-income children by expanding their Medicaid programs in the following ways: (1) by establishing a new optional eligibility group for such children as authorized in Title XXI, and/or (2) by liberalizing the financial rules[5] for any of several existing Medicaid eligibility categories. Many states with Medicaid-expansion CHIP programs chose the latter, opting to cover targeted low-income children under existing Medicaid eligibility pathways, especially Medicaid's poverty-related child groups, rather than by establishing the Title XXI optional coverage group.[6] Such a strategy reduces the administrative burden of creating and implementing a new coverage group.[7]

States may also provide coverage to targeted low-income children by creating a separate CHIP program. States define the group of targeted low-income children who may enroll in separate CHIP programs. Title XXI allows states to use the following factors in determining eligibility: geography (e.g., sub-state areas or statewide), age (e.g., subgroups under 19), income, resources (assets), residency, disability status (so long as any standard relating to that status does not restrict eligibility), access to or coverage under other health insurance (to establish whether such access/coverage precludes CHIP eligibility), and duration of CHIP eligibility.

Pregnant Women

Prior to CHIPRA, states were able to cover adult pregnant women (ages 19 and older) in one of three ways: (1) states could apply for Section 1115 waivers to extend coverage to such pregnant women; (2) states could provide health benefits coverage, including prenatal care and delivery services, to unborn children of adult pregnant women through a CHIP state plan amendment

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[5] Under Medicaid law, Section 1902(r)(2) authority may be used to liberalize income and resource methodologies for a number of groups, including, for example, poverty-related children (i.e., those under age 6 in families with income up to 133% FPL and those between ages 6 and 18 in families with income up to 100% FPL). That same authority can be used to liberalize financial rules for CHIP purposes. Family coverage is provided under Section 1931. This section has its own provisions for liberalizing income and resource standards.

[6] Personal communication with Judy Rhoades, Centers for Medicare and Medicaid Services, June 5, 2003.

[7] Because individuals can have other health insurance and still be covered by Medicaid, this approach also allows states to bring into Medicaid otherwise ineligible higher-income children *regardless* of their other health insurance status. Under this strategy, for example, states can provide Medicaid benefits to additional children whose existing health insurance is limited (sometimes referred to as under-insured). When states liberalize the financial rules for existing Medicaid eligibility groups, the federal share of the costs for services provided to the subset *without* other health insurance—the targeted low-income children—is paid for out of CHIP funds (described in further detail below). The federal share of the costs for services delivered to the remaining children *with* other health insurance is paid for by Medicaid.

(SPA) as permitted through regulation;[8] or (3) states could offer a "family coverage option" through a group health plan that may include maternity care to adult females in eligible families.

As of October 2007, 17 states offered pregnancy-related services to adults using CHIP funds. Of those, 6 states used the §1115 waiver authority, and 12 states extended coverage to unborn children of adult pregnant women through unborn child SPAs (Rhode Island extends coverage to adult pregnant women through both authorities).[9] Of the 12 states that offered pregnancy-related services to unborn children under the CHIP SPAs,[10] all but Tennessee extended coverage to the unborn children of undocumented aliens who otherwise would not have access to federally funded pregnancy-related services, except through emergency Medicaid.[11]

In FY2008, there were 364,161 unborn children enrolled in CHIP, nearly half of whom (176,822, 48.6%) were in California.[12]

CHIPRA added a new state option to cover pregnant women under CHIP through a state plan amendment. To implement this option, states must meet certain conditions (e.g., the Medicaid income standard for pregnant women must be at least 185% FPL but in no case lower than the percentage level in effect on July 1, 2008; no pre-existing conditions or waiting periods may be imposed; CHIP cost-sharing protections described below must apply). The upper income level for pregnant women may be as high as the standard applicable to CHIP children in the state. Other eligibility restrictions applicable to CHIP children (e.g., must be uninsured, ineligible for state employee health coverage) also apply. The period of coverage is during pregnancy through the postpartum period (through roughly 60 days after delivery). States are allowed to temporarily enroll pregnant women for up to two months until a formal determination of eligibility is made (referred to as presumptive eligibility). Benefits include all services available to CHIP children in the state as well as prenatal, delivery and postpartum care. Infants born to these pregnant women are deemed eligible for Medicaid or CHIP, as appropriate, and are covered up to age one year, at which point eligibility could be redetermined. States may continue to cover pregnant women through waivers and the unborn child regulation described above. For the latter case, CHIPRA clarified that states are allowed to offer postpartum services.

Legal Immigrants

Prior to CHIPRA, legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years here. Coverage of such persons after the five-year bar was permitted at state option if they met other eligibility requirements for

[8] Although the Bush Administration required the care to be directed at the unborn child, the CHIP unborn child SPA option effectively enables states to provide prenatal care to adult pregnant women including those with incomes at or above the Medicaid income eligibility thresholds and for individuals who do not qualify for Medicaid (or CHIP) for other reasons, such as immigration status or incarceration.

[9] For more information, see CRS Report RS22785, *SCHIP Coverage for Pregnant Women and Unborn Children*.

[10] Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Rhode Island, Tennessee, Texas, Washington and Wisconsin.

[11] Illegal immigrants are barred from Medicaid and CHIP eligibility. Such women who otherwise qualify but for their documentation status have access to emergency care under Medicaid, which includes labor and delivery costs (Section 1903(v)(2) of the Social Security Act).

[12] Centers for Medicare and Medicaid Services (CMS) analysis of SEDS FY2008, "Unborn Children Chart FY 2008.xls," January 20, 2009.

that program. For legal immigrants (but not refugees and asylees), the law requires that their sponsor's income and resources for those who have signed a legally binding affidavit of support would be taken into account in determining eligibility. Generally speaking, for federally means-tested programs (e.g., Medicaid, TANF), the affidavit of support required the sponsor to ensure that the new immigrant will not become a public charge and makes the sponsor financially responsible for the individual.

CHIPRA permitted states to waive the five-year bar for Medicaid or CHIP coverage to pregnant women and children who are (1) lawfully residing in the United States and (2) are otherwise eligible for such coverage. The CHIP state plan option made available under this provision is available only to states that (1) elect this state plan option under Medicaid and (2) in the case of pregnant women coverage, elect the CHIP state plan option (described above) to provide assistance for pregnant women. For states that elect to extend such coverage, the provision assured that the cost of care will not be deemed under an affidavit of support against an individual's sponsor. In addition, as a part of states' redetermination processes (i.e., to redetermine eligibility at least every 12 months with respect to circumstances that may change and affect eligibility), individuals made eligible under this provision whose initial documentation showing legal residence is no longer valid will be required to show "further documentation or other evidence" that the individual continues to lawfully reside.

Adult Coverage

Under current law, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) broad authority to modify many aspects of the CHIP programs including expanding eligibility to populations who are not otherwise eligible for CHIP (e.g., childless adults, [13] and parents of Medicaid and CHIP-eligible children). Certain states that have covered adults with CHIP funds were permitted to do so almost entirely through the use of these waivers.[14] Adult coverage waivers, which initially are effective for five years, are subject to renewal at least every three years. Prior to 2007, waiver renewals for states with adult coverage waivers were approved, even for those states that were projected to face federal CHIP shortfalls (e.g., New Jersey, Rhode Island). Beginning in 2007, however, such waiver renewals have not been approved (e.g., Illinois, Oregon) or states have begun to transition adult populations out of CHIP coverage (e.g., Wisconsin, [15] Minnesota). As of January 7, 2009, 4 states[16] have CMS

[13] The Deficit Reduction Act of 2005 (P.L. 109-171) prohibits the use of CHIP funds for coverage of non-pregnant childless adults in any new waivers approved after February 8, 2006.

[14] On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. Using Section 1115 waiver authority, this initiative was designed to encourage states to extend Medicaid and CHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with income below 200% FPL. In other words, states were permitted and encouraged to direct their unspent CHIP funds towards coverage expansions under the HIFA initiative. Source: *Medicine and Health*, "CMS Administrator: McClellan on Value Purchasing, SCHIP, DSH, and Specialty Hospitals," March 22, 2004.

[15] Under its prior waiver, parents of Medicaid- or CHIP-enrolled children from 100% to 185% FPL were eligible for CHIP; under the renewal, parents from 100% up to 130% FPL are in Medicaid, with parents from 130% to 185% FPL in CHIP. Although family income cannot exceed 185% FPL for initial eligibility, parents may continue enrollment as long as family income does not exceed 200% FPL.

[16] States with CMS authority to extend CHIP coverage to non-pregnant childless adults as of (1/14/09) include Arizona, Idaho, Michigan, and New Mexico. FY2008 CHIP Annual enrollment reports did not show enrollment associated with Arizona's childless adult demonstration population despite the fact that the state has CMS authority to provide coverage to such individuals.

authority to use CHIP funds to extend coverage to certain childless adult populations, and 7 states[17] have such authority to cover parent populations (see **Table 1**).

CHIPRA terminates CHIP coverage of nonpregnant childless adults by the end of calendar year 2009. States with existing childless adult waivers that were in effect during FY2009 are permitted to apply for Medicaid waivers to continue coverage for these individuals subject to a specified budget neutrality standard, but in FY2010 childless adult spending under the waiver will be tied to the state's 2009 waiver spending on this population. CHIPRA requires budget neutrality standards for succeeding fiscal years to be tied to waiver spending in the preceding fiscal year.

Under CHIPRA, coverage of parents is permitted for states with CHIP parent coverage waivers that were in effect during FY2009, but beginning in FY2012, allowable spending under the waivers will be subject to a set-aside amount from a separate allotment and will be matched at the state's regular Medicaid FMAP unless the state is able to prove it meets certain coverage benchmarks (related to performance in providing coverage to children). In FY2013, even states meeting the coverage benchmarks will not get the enhanced FMAP for parents but an amount between the regular and enhanced FMAPs. Finally, CHIPRA prohibits waiver spending under the set-aside for parents whose family income exceeds the income eligibility thresholds that were in effect under the existing waivers as of February 4, 2009.

Enrollment and Access

Outreach and Enrollment

CHIPRA included provisions to facilitate access and enrollment in Medicaid and CHIP. Besides the bonus payments described below, CHIPRA authorizes $100 million in outreach and enrollment grants above and beyond the regular CHIP allotments for fiscal years 2009 through 2013. Ten percent of the allocation will be directed to a national enrollment campaign, and 10% will be targeted to outreach for Native American children. The remaining 80% will be distributed among state and local governments and to community-based organizations for purposes of conducting outreach campaigns with a particular focus on rural areas and underserved populations. Grant funds will also be targeted at proposals that address cultural and linguistic barriers to enrollment. Also as a part of the outreach-related provisions, CHIPRA requires the state plan to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the state determines is appropriate to reduce newly identified barriers to enrollment.

Express Lane Eligibility

In terms of enrollment facilitation, CHIPRA creates a state option to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) to determine whether a child under age 19 (or an age specified by the state not to exceed 21 years of age) has met one or more

[17] States with CMS authority to extend CHIP coverage to parents of Medicaid and/or CHIP eligible children (as of 1/14/09) include Arizona, Arkansas, Idaho, Nevada, New Jersey, New Mexico, and Wisconsin.

of the eligibility requirements (e.g., income, assets, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid or CHIP. States will have the option to institute automatic enrollment through an Express Lane eligibility determination contingent on a family's consent. The provision gives states the option to rely on an applicant's reported income as shown by state income tax records or returns. Under CHIPRA, states are required to inform families that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated by the state Medicaid agency. CHIPRA also drops the requirement for signatures on a Medicaid or CHIP application form under penalty of perjury.

Citizenship Documentation

The Deficit Reduction Act of 2005 (DRA) required citizens and nationals applying for Medicaid who claim to be citizens to provide both proof of citizenship and identity. Before DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence. CHIPRA provided a specific alternative, which allows a state to use the Social Security Number (SSN) provided by individuals and verified by the Social Security Administration (SSA), and provides an enhanced match for certain administrative costs. (SSNs by themselves do not denote citizenship, because certain noncitizens are eligible for them.) CHIPRA also adds a requirement for citizenship documentation in CHIP.

Enrollment

Table 1 shows every state's CHIP program type as well as upper-income eligibility and enrollment data by population group. The highest state-reported upper income eligibility limit for children in CHIP is 350% of the FPL, in New Jersey.[18] Eleven states and the District of Columbia (plus four counties and certain children up to age two in California) have CHIP coverage above 250% FPL. An additional 11 states (including California) have income thresholds greater than 200% FPL but less than or equal to 250% FPL. Twenty-two states have upper income limits at 200% FPL. Six states set maximum income levels below 200% FPL.[19]

The latest official numbers show that CHIP enrollment reached nearly 7.4 million children in FY2008. Of this total, about 5.3 million were covered in separate state programs, and 2.1 million were targeted low-income children under Medicaid.

One of the primary uses of waiver authority under CHIP has been to expand coverage for adult populations, which has proven controversial.[20] (See above for further discussion of adult coverage

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[18] For determining financial eligibility for CHIP and Medicaid, certain types and/or amounts of income are not counted. These are called "income disregards." For example, specified dollar amounts may be subtracted from gross income to calculate net income, which is then compared to the applicable income criterion.

[19] States may apply resource, or asset, tests in determining financial eligibility, but are not required to do so. In states with a resource test, individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, tax credits, etc. Nearly all states have done away with asset tests for CHIP.

[20] For example, see the hearing webcast and written testimony for *Covering Uninsured Kids: Missed Opportunities for Moving Forward*, held by the Subcommittee on Health, House Energy and Commerce Committee, January 29, 2008, at (continued...)

under CHIP and changes to CHIP adult coverage made by CHIPRA.) Twelve states reported enrollment of about 335,000 adults in CHIP in FY2008 (see **Table 1**). Most of these adults (65%, or 216,000) were parents. Roughly 111,000 were childless adults, and the remainder (7,829) were pregnant women. The number of CHIP-enrolled adults in FY2008 is lower than in FY2006 (701,000) and in FY2007 (587,000). This was because several adult-coverage waivers were not renewed or were scaled back in the latter half of the administration of George W. Bush (see discussion above).

In FY2008, Michigan, New Mexico, and Minnesota reported more adult CHIP enrollees than children.

Benefits

As noted above, when designing their CHIP programs, states may cover targeted low-income children under their Medicaid program, create a new separate CHIP program, or devise a combination of both approaches.

States that use Medicaid-expansion CHIP programs must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (P.L. 109-171; DRA) gave states the option to enroll state-specified groups, including children in CHIP-financed Medicaid expansions, in new benchmark and benchmark-equivalent benefit plans. These plans are nearly identical to the benefit packages offered through separate CHIP programs (described below). For any child under age 21 in one of the major mandatory and optional Medicaid eligibility groups, including targeted low-income children, the benefits available through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program must be provided, whether through a benchmark plan or otherwise (per CHIPRA). Under EPSDT, children receive well-child care, immunizations, and other screening services, as well as medical care necessary to correct or ameliorate identified defects, illnesses, or conditions, including optional services states may not otherwise cover in their Medicaid programs.

States that choose to create separate CHIP programs may elect any of three benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary of Health and Human Services determines will provide appropriate coverage to the targeted population of uninsured children.[21]

A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the state involved, and (3) the health coverage that is offered by a health

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(...continued)

[http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.012908.CoveringUninsured.shtml].

[21] When the law establishing CHIP was enacted, existing programs financed entirely by the state in Florida, New York, and Pennsylvania were designated as meeting the minimum benefit requirements under CHIP (i.e., these programs were grandfathered into CHIP).

maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Benchmark-equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services[22] include prescription drugs, vision services, and hearing services. States are encouraged to cover other categories of service not listed above. Abortions may not be covered, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life.

All 50 states, the District of Columbia, and five territories have CHIP programs. The territories, the District of Columbia, and 6 states use Medicaid expansions; 18 states use separate state programs; and 26 states use a combination approach. Among other types of separate CHIP programs, data from 2005[23] indicate that most of the benchmark and benchmark-equivalent plans are based on a state employees' health plan, and most secretary-approved plans are modeled after Medicaid.

Recent Changes to Mental Health and Dental Benefits

CHIPRA made some changes to coverage of mental health and substance abuse services under CHIP. The new law ensures that, in the case of a state CHIP plan that provides both medical and surgical benefits and mental health or substance abuse disorder benefits, the predominant financial requirements (e.g., deductibles, copayments) and treatment limitations (e.g., number of visits, days of coverage) applicable to such mental health or substance abuse disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered under the state CHIP plan. In addition, there can be no separate cost-sharing requirements or treatment limitations applicable only to mental health or substance abuse disorder benefits. State CHIP plans that include coverage of EPSDT services (as defined in Medicaid statute) are deemed to satisfy these mental health parity requirements.

CHIPRA also made modifications to dental care under CHIP. Dental services are now a required benefit under separate CHIP programs and include services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. (Dental benefits have always been required for CHIP Medicaid expansion children via EPSDT.) States have the option to provide dental services through "benchmark dental benefit packages" modeled after the benchmark plans for medical services described above (e.g., dental benefit plans under FEHBP, state employee programs and commercial HMO options). The new law also

[22] Prior to CHIPRA, these additional services included mental health services. CHIPRA deleted this reference and added an assurance of mental health parity applicable to separate CHIP programs, described below.

[23] CRS analysis of unpublished data from a 2005 survey of state CHIP programs conducted by the National Academy for State Health Policy (NASHP). For more information about this survey, see [http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf].

includes provisions for dental education for parents of newborns and dental services through federally qualified health centers. States must report detailed information in their annual reports and for EPSDT reporting purposes on, for example, the number of children by age group receiving various types of dental care. Information on dental providers and covered dental services will be available to the public via the federal *Insure Kids Now* website and hotline. GAO is to conduct a study on children's access to dental care under Medicaid and CHIP. The report on this study is to include recommendations for federal and state actions to address barriers to dental care, and the feasibility and appropriateness of using qualified mid-level providers to improve access.

Prior to CHIPRA, CHIP funds could never be used to pay for any services of children enrolled in employer-sponsored coverage. (CHIPRA provided authority for premium assistance programs described in the next section.) CHIPRA provided a state option under separate CHIP programs, subject to certain conditions, to provide dental-only supplemental coverage to children enrolled in group or employer coverage who otherwise meet CHIP eligibility criteria. The provision allows states to provide dental coverage consistent with the new dental benchmark benefits plans or cost-sharing protections for dental coverage applicable under CHIP. States may set the upper income level for this new benefit up to the level otherwise applicable under their separate CHIP programs. States are not allowed to offer dental-only supplemental coverage unless (1) the state has implemented the highest income eligibility permitted in federal CHIP statute (or a waiver) as of January 1, 2009; (2) the state does not limit acceptance of applications for children or impose any enrollment caps, waiting lists, or similar eligibility limitations under CHIP; and (3) the state provides benefits to all children in the state who apply for and meet the eligibility standards. In addition, states may not provide more favorable dental coverage or related cost-sharing protections for children provided dental-only supplemental coverage than the dental coverage or related cost-sharing protections for CHIP children eligible for the full range of CHIP benefits. States would have the option to not apply an eligibility waiting period for children provided dental-only supplemental coverage.

Premium Assistance

Under prior law, states were permitted to pay a beneficiary's share of costs for group (employer based) health insurance in CHIP if the employer plan was cost effective relative to the amount paid to cover only the targeted low-income children, and did not substitute for coverage under group health plans otherwise being provided to the children. In addition, states using CHIP funds for employer-based plan premiums were required to ensure that CHIP minimum benefits were provided, CHIP cost-sharing ceilings were met, and the children to be enrolled have not had group coverage for a specified period of time (typically four to six months).[24] Under Medicaid, including a Medicaid expansion CHIP program, states may implement a premium assistance program if the employer plan is comprehensive and cost-effective for the state. Under Medicaid, an individual's enrollment in an employer plan is considered cost-effective if paying the premiums, deductible, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing Medicaid-covered services. To meet the comprehensiveness test under Medicaid, states are required to provide coverage for those Medicaid-covered services that are not included in the private plans. In other words, they must

[24] CHIP premium assistance programs approved under state plan authority are referred to as family coverage variance programs. As of June 7, 2007, there were two states—New Jersey and Massachusetts—with operational family coverage variance programs under CHIP.

provide "wrap-around" benefit coverage. It has proved prohibitive for many employer plans and states to meet all of these requirements. To circumvent these restrictions, most states operating CHIP or Medicaid premium assistance programs do so under waivers.[25]

CHIPRA created a new state plan option for providing premium assistance and required states to include a description of the procedures to provide outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under CHIP. States have the option to offer premium assistance for Medicaid and CHIP-eligible children and/or parents of Medicaid and/or CHIP-eligible children where the family has access to employer-sponsored insurance (ESI) coverage, if the employer pays at least 40% of the total premium, the employer's group health plan qualifies as "creditable coverage"[26] (as defined by the Public Health Service Act), and the coverage is offered to all individuals in a nondiscriminatory way (as defined by the Internal Revenue Code of 1986). Under CHIPRA, a state offering premium assistance may not require CHIP eligible individuals to enroll in an employer's plan; individuals eligible for CHIP and for employment-based coverage may choose to enroll in regular CHIP rather than the premium assistance program. The premium assistance subsidy will generally be the difference between the worker's out-of-pocket premium that included the child(ren) versus only covering the employee. For employer plans that do not meet CHIP benefit requirements, a wrap-around is required.

For the child's coverage using premium assistance, no cost-effectiveness test is required regarding the cost of the private coverage (plus any necessary wrap-around) relative to regular CHIP coverage. CHIPRA establishes a separate test for family coverage. If the CHIP cost of covering the entire family in the employer-sponsored plan is less than regular CHIP coverage for the eligible individual(s) alone, then the premium assistance subsidy may be used to pay the entire family's share of the premium. In states that offered premium assistance, CHIPRA requires states and participating employers to do outreach. Under CHIPRA, states are permitted to establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least one employee who is a CHIP-eligible pregnant woman or at least one member of the family is a CHIP-eligible child. The law stipulates that the new premium assistance provisions under Medicaid, not CHIP, will apply to children enrolled in a Medicaid-expansion CHIP program. Finally, CHIPRA amends applicable Federal laws to streamline coordination between public and private coverage, including making the loss of Medicaid/CHIP eligibility a "qualifying event" for the purpose of purchasing employer-sponsored coverage. The provision also requires health plan administrators to disclose to the state, upon request, information about their benefit packages so states can evaluate the need to provide wraparound coverage.

Cost-Sharing

Cost-sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan. Cost-sharing may include monthly premiums, enrollment fees, deductibles, copayments, coinsurance and other similar charges.

[25] As of September 21, 2007, 10 states reported operating a premium assistance program under CHIP or Medicaid through waiver authority. (Other states may also be providing premium assistance through state plan amendments.)

[26] Benefits provided under a health flexible spending arrangement or a high deductible health plan are specifically excluded as credible health coverage under CHIPRA.

Federal law permits states to impose cost-sharing for some beneficiaries and some services under CHIP. States that cover targeted low-income children under Medicaid must follow the nominal cost-sharing rules of the Medicaid program. Under these rules, the majority of such children are exempt. Children who are 18 years of age and enrolled in Medicaid expansions under CHIP may be subject to service-related cost-sharing (e.g., copayments) at state option.

DRA[27] provided states with a new option for premiums and service-related cost-sharing that may be applied to targeted low-income children under CHIP Medicaid-expansion programs. For children in families with income under 100% FPL, no premiums are allowed and service-related cost-sharing is limited to nominal amounts. For children in families with income between 100%-150% FPL, no premiums may be imposed; however, service-related cost-sharing may be applied up to 10% of the cost of the item or service rendered. For children in families with income above 150% FPL, premiums are allowed (no limit is specified), and service-related cost-sharing may be applied up to 20% of the cost of the item or service rendered. For all individuals, the total aggregate amount of all cost-sharing cannot exceed 5% of family income (on a quarterly or monthly basis as specified by the state). Preventive services for children are exempt from DRA cost-sharing. The nominal Medicaid cost-sharing amounts in regulation will be indexed by medical care inflation. Special rules apply to cost-sharing for prescription drugs, and for emergency room copayments for non-emergency care. DRA also allows states to condition continuing Medicaid eligibility on the payment of premiums. Providers may also be allowed to deny care for failure to pay service-related cost-sharing.

If a state implements CHIP through a separate state program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. For all families with incomes under 150% FPL and enrolled in separate state programs, premiums may not exceed the amounts set forth in federal Medicaid regulations. Additionally, these families may be charged service-related cost-sharing, but such cost-sharing is limited to (1) nominal amounts defined in federal Medicaid regulations for the subgroup with income below 100% FPL, and (2) slightly higher amounts defined in CHIP regulations for families with income between 100%-150% FPL. For a family with income above 150% FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-income children and subject to the out-of-pocket limit of 5% of family income. In addition, states are required to inform families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

Preventive services are exempt from cost-sharing for all CHIP families regardless of income. The Centers for Medicare and Medicaid Services (CMS) defines such preventive services to include, at a minimum, the following: all healthy newborn physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests associated with such routine physical examinations; immunizations and related office visits; and routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).

[27] P.L. 109-432 modified DRA by specifying cost-sharing rules for individuals in families with income under 100% FPL. For additional information, see CRS Report RS22578, *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*.

New Data Collection and Reporting Requirements Under CHIP

CHIPRA 2009 contained several provisions to expand and improve data collection and reporting by both the states and the federal government with respect to CHIP and, for some initiatives, also for Medicaid. For example, the new law directs the Secretary of HHS to develop child health quality measures, a standardized format for reporting such information, and procedures to encourage states to voluntarily report on the quality of pediatric care under both CHIP and Medicaid. In addition, several reporting requirements were added to states' annual CHIP reports including, for example, data on eligibility criteria, access to primary and specialty care, and data on premium assistance for employer-sponsored coverage. GAO is to conduct a study of children's access to primary and specialty care under Medicaid and CHIP.

CHIPRA also established a new federal commission, called the Medicaid and CHIP Payment and Access Commission, or MACPAC. This commission will review policies under both programs affecting children's access to benefits including, for example, payment policies and their impact on access and quality of care. Regular, on-going reports to Congress are to detail these findings and are to include recommendations for improving access and quality of care for children under Medicaid and CHIP.

CHIPRA also required the Secretary of HHS to conduct a new, independent federal evaluation of 10 states with approved CHIP plans that meet certain criteria (e.g., represent different geographic regions, utilize diverse approaches to CHIP coverage, and have significant portions of uninsured children). This evaluation will be modeled after the first such federal evaluation undertaken in the early 2000s. As with the first federal evaluation, the new evaluation will examine, for example, effectiveness of outreach and enrollment strategies, the effects of cost-sharing on utilization, and factors related to disenrollment and retention of children.

Financing and Expenditures

Federal financing of CHIP includes three major components: (1) total federal appropriations for states' annual CHIP allotments of federal funds among the states and territories, (2) reallocation of unspent federal funds and appropriations for eliminating states' shortfalls, and (3) other factors affecting federal financing including the federal matching rate and caps on administrative expenses.

Federal Appropriations and Allotments Among the States and Territories

BBA 97 appropriated a total of approximately $40 billion for CHIP allotments for FY1998 to FY2007. The funding level by fiscal year varied across time. The total annual appropriation for each of FY1998-FY2001 was a little more than $4.2 billion. This annual total dropped to under $3.2 billion in FY2002-FY2004. Then the appropriation rose to about $4.1 billion for FY2005 and FY2006, with a further increase to roughly $5.0 billion in FY2007. The drop in funding for FY2002-FY2004, sometimes referred to as the "CHIP dip," was written into CHIP's authorizing legislation due to budgetary constraints applicable at the time the legislation was drafted.

The 110th Congress passed two bills to "reauthorize" CHIP—providing CHIP funding for FY2008 through FY2012 and making other changes to both CHIP and Medicaid. Both H.R. 976 and H.R. 3963 were vetoed by President George W. Bush, with the Congress unable to override these vetoes. In lieu of reauthorization, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) appropriated funds to provide CHIP allotments for FY2008 and FY2009, but only to be available through March 31, 2009. Because shortfalls of federal CHIP funds were still projected to occur in certain states, additional funds besides the allotments were also appropriated, as discussed in the next section.

CHIPRA provided a national appropriation for CHIP allotments totaling $68.9 billion from FY2009 to FY2013.[28] The national appropriation available for CHIP allotments under CHIPRA are $10.562 billion in FY2009; $12.52 billion in FY2010; $13.459 billion in FY2011; $14.982 billion in FY2012; and $17.406 billion in FY2013.

The allotment of the annual federal CHIP appropriation among the states is determined by a formula set in law. Prior to CHIPRA, of the national appropriation ($5 billion for each of FY2007, FY2008 and FY2009, for example), the territories received 0.25%. The remainder ($4.9875 billion for each of FY2007, FY2008 and FY2009) was divided, or allotted, among the states based on a formula using survey estimates of the number of low-income children in the state and the number of those children who were uninsured. These amounts were adjusted by a geographic adjustment factor and were limited by various floors and ceilings to ensure that a state's allotment did not vary substantially from certain past allotments.

Rather than dividing a fixed national appropriation on the basis of state survey estimates, a state's allotment is now calculated as described below and if the total of all the states' and territories' allotments does not exceed the national appropriation, that will be the state's allotment.

CHIP allotments are basically separate, sequential funding accounts. For each state and territory, the account for a given fiscal year is made available at the beginning of that year and remains available for a certain period of time. Prior to CHIPRA, allotments were available for three years. However, the CHIP allotments for FY2009 and after will only be available for two years. Typically, CHIP payments are taken out of the earliest active account. Once that fiscal year allotment is fully expended, the state can begin drawing from the next available allotment.

FY2009 Allotment

FY2009 federal CHIP allotments for states[29] are the largest of three state-specific amounts:

- the state's FY2008 federal CHIP spending, multiplied by a growth factor;
- the state's FY2008 federal CHIP allotment, multiplied by a growth factor; and
- the state's own projections of federal CHIP spending for FY2009, submitted by states to the Secretary of Health and Human Services (HHS) as of February 2009.

[28] Cost estimates from the Congressional Budget Office (CBO) indicated that CHIPRA would increase overall outlays (across all provisions of the bill) by $32.8 billion over five years (FY2009-13), which would be offset primarily by increases in federal tobacco taxes, estimated to increase on-budget revenue by $32.8 billion over five years.

[29] The territories' FY2009 federal CHIP allotments are calculated as the largest of their federal CHIP expenditures from FY1999 to FY2008, increased by the allotment increase factor calculated nationally.

The largest of these three amounts will be increased by 10% and will serve as the state's FY2009 federal CHIP allotment, as long as the national appropriation is adequate to cover all the states' and territories' FY2009 allotments.[30] If not, allotments will be reduced proportionally.

FY2010 Allotment

For FY2010, the allotment for a state (or territory) will be calculated as the sum of the following four amounts, if applicable, multiplied by the applicable growth factor for the year:

- the FY2009 CHIP allotment;
- FY2006 unspent allotments redistributed to and spent by shortfall states in FY2009;
- spending of funds provided to shortfall states in the first half of FY2009; and
- spending of Contingency Fund payments (discussed below) in FY2009, although there may be none.

FY2011 and FY2013 Allotments

For FY2011 and FY2013, the allotment for a state (or territory) will be "rebased," based on prior year spending. This will be done by multiplying the state's growth factor for the year by the new base, which will be the prior year's federal CHIP spending.

FY2012 Allotment

For FY2012, the allotment for a state (or territory) will be calculated as the FY2011 allotment and any FY2011 Contingency Fund spending, multiplied by the state's growth factor for the year.

Redistribution of Unspent Federal Funds and Appropriations to Address Shortfalls

At the end of the applicable period of availability, unspent allotments are redistributed to other states. The rules vary by fiscal year. BBA 97 stipulated that only states that exhausted the relevant allotment within three years were eligible to receive unspent funds from other states. However, the Secretary determined how the funds would be redistributed to states that qualified.

For FY2006, the amount available for redistribution was inadequate for covering projected federal CHIP shortfalls in 12 states. In DRA, Congress appropriated an additional $283 million to cover the projected shortfalls. Two states (Illinois and Massachusetts) ultimately had higher FY2006 CHIP spending than anticipated, so they experienced shortfalls totaling approximately $100 million, almost all of that from Illinois.

In FY2007, $147 million in unspent FY2004 original allotments was available for redistribution. In the closing hours of the 109th Congress, a bill was passed to specify how those funds would be

[30] For more information, see CRS Report R40129, *Projections of FY2009 Federal CHIP Allotments Under CHIPRA (P.L. 111-3)*.

redistributed. The National Institutes of Health (NIH) Reform Act of 2006 (H.R. 6164, P.L. 109-482, NIHRA) required that the funds go to states "in the order in which such [shortfall] States realize monthly funding shortfalls ... for fiscal year 2007." The purpose was to delay any state facing a shortfall as far into the year as possible with the available funds. CRS projections indicated that this particular provision would delay shortfalls until the end of March 2007. To delay shortfalls even further, the CHIP provisions of NIHRA called for an initial redistribution of up to half of unspent FY2005 original allotments as of March 31, 2007 (capped at $20 million per state)—after 2½ years of availability. For a state to forgo unspent FY2005 funds on that date, NIHRA required not only that the state have unspent FY2005 balances but that the state's total CHIP balances (from the FY2005-FY2007 original allotments) as of March 31, 2007, were at least double what the state projected to spend in federal CHIP funds in FY2007. This was projected to provide an additional $138 million for shortfall states, delaying any state facing a shortfall of federal CHIP funds until May 2007. The shortfalls remaining for the rest of the fiscal year were projected at just over $600 million in 12 states.

On May 25, 2007, P.L. 110-28 (the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007; UTRA) was enacted. In it, Congress appropriated up to $650 million to cover shortfalls of federal CHIP funds in 10 states[31] for the remainder of FY2007. **Table 2** shows cumulative federal CHIP financing from the BBA 97 era of CHIP—from1998 through FY2007.

For FY2008, MMSEA required that unspent FY2005 allotments be redistributed to shortfall states on a monthly basis in the order in which these states experience shortfalls. In addition to this redistribution, MMSEA appropriated up to $1.6 billion for states' remaining shortfalls in FY2008. Actual shortfall funding provided in FY2008 totaled just under $1 billion, as shown in Column E of **Table 3**.

For FY2009, MMSEA also required that unspent FY2006 allotments be redistributed to states projected to face shortfalls in FY2009 before March 31, 2009, on a monthly basis in the order in which these states experience shortfalls. In addition to this redistribution, MMSEA appropriated up to $275 million for states' remaining shortfalls through March 31, 2009.

The increased FY2009 allotments provided by CHIPRA should prevent any federal CHIP funding shortfalls for the second half of FY2009. Under CHIPRA, any unspent funds available for redistribution would first be provided to shortfall states and then, if any redistribution funds still remain, toward bonus payments, which are discussed in the next section.

The creation of a Child Enrollment Contingency Fund was an additional CHIPRA measure to prevent states from experiencing shortfalls of federal CHIP funds. This fund receives an appropriation separate from the national CHIP allotment amounts. Direct payments from the Contingency Fund can be made to shortfall states for the federal share of expenditures for CHIP children above a target enrollment level.[32] Payments from the Contingency Fund cannot exceed 20% of that year's national allotment amount and are to be reduced proportionally if necessary.

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[31] Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New Jersey, and Rhode Island.

[32] The structure of CHIPRA financing is such that funding through the regular allotments should be adequate for children under a state's target enrollment level.

Other Factors Affecting Federal Financing

Like Medicaid, CHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from CHIP accounts. A state's share of program spending for Medicaid is equal to 100% minus the federal medical assistance percentage (FMAP). The enhanced FMAP (E-FMAP) for CHIP means a state's share of expenditures is 30% lower than under the regular FMAP. One new exception is that the temporary Medicaid FMAP increases specified in the American Recovery and Reinvestment Act of 2009 (ARRA, H.R. 1, P.L. 111-5) are not considered in calculating the E-FMAP.[33]

Compared with the Medicaid FMAP, which ranged from 50% to 75.84% in FY2009 prior to ARRA, the enhanced FMAP for CHIP ranges from 65% to 83.09%. All CHIP assistance for targeted low-income children, including coverage provided under Medicaid, is eligible for the enhanced FMAP. The Medicaid FMAP and the enhanced CHIP FMAP are subject to a ceiling of 83% and 85%, respectively, and a floor of 50% and 65%.

There is a limit on federal spending for CHIP administrative expenses, which include activities such as data collection and reporting, outreach and education, and other activities. For federal matching purposes, a 10% cap applies to state non-benefit expenses. This cap is tied to the dollar amount that a state draws down from its annual allotment to cover benefits and these non-benefit costs under CHIP, as opposed to 10% of a state's total annual allotment. In other words, no more than 10% of the federal funds that a state draws down for CHIP benefit and non-benefit expenditures combined can be used for non-benefit costs including administrative expenses.

Under CHIPRA, federal CHIP bonus payments are available to states that (1) increase Medicaid (not CHIP) child enrollment by certain amounts,[34] and (2) implement five out of eight specific outreach and enrollment activities.[35] The source of funding for these payments would be an initial $3.225 billion appropriation in FY2009 as well as unspent national allotment and redistribution amounts.

[33] For more information, see CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA): Title V, Medicaid Provisions*.

[34] Qualifying children must have been able to meet the state's Medicaid eligibility criteria in place on July 1, 2008.

[35] For addition detail, see Sec. 104 of CHIPRA as described in CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*.

Table 1. CHIP Enrollment and Eligibility Information for the States and the District of Columbia

State and Program Type as of January 2009	Reported Upper Income Level for Children (% FPL) as of January 2009	Number of Children Ever Enrolled in FY2008			Number of Adults Ever Enrolled in CHIP Waivers in FY2008 (and Income Level by Group)			
		Medicaid Expansions	Separate CHIP Programs	Total Children	Pregnant Women	Parents of Medicaid and/or CHIP Children	Childless Adults	Total Adults
Alabama (S)	200%		110,821	110,821				
Alaska (M)	175%	18,707		18,707				
Arizona (S)	200%		112,072	112,072		24,000 (100-200%)[a]	(0-100%)[b]	24,000
Arkansas (C)	200%	89,646	3,800	93,446		2,317 (0-200%)[c]		2,317
California (C)	250%[d]	304,918	1,387,169	1,692,087				
Colorado (S)	200%		99,555	99,555	3,868 (185-200%)[e]			3,868
Connecticut (S)	300%		22,270	22,270				
Delaware (C)	200%	81	11,111	11,192				
DC (M)	300%	8,746		8,746				
Florida (C)	200%	1,250	353,135	354,385				
Georgia (S)	235%		311,234	311,234				
Hawaii (M)	300%	28,803		28,803				
Idaho (C)	185%	19,772	23,754	43,526	(133-185%)[f]	371 (above §1931 levels-185%)[g]	121 (0-185%)[g]	492
Illinois (C)	200%	164,482	191,978	356,460				
Indiana (C)	250%	92,488	32,466	124,954				
Iowa (C)	200%	17,709	32,681	50,390				
Kansas (S)	200%		51,162	51,162				

State and Program Type as of January 2009	Reported Upper Income Level for Children (% FPL) as of January 2009	Number of Children Ever Enrolled in FY2008			Number of Adults Ever Enrolled in CHIP Waivers in FY2008 (and Income Level by Group)			
		Medicaid Expansions	Separate CHIP Programs	Total Children	Pregnant Women	Parents of Medicaid and/or CHIP Children	Childless Adults	Total Adults
Kentucky (C)	200%	43,073	24,644	67,717				
Louisiana (C)	250%	142,691	5,172	147,863				
Maine (C)	200%	21,660	9,287	30,947				
Maryland (M)	300%	132,864		132,864				
Massachusetts (C)	300%	100,097	100,853	200,950				
Michigan (C)	200%	14,885	52,878	67,763			87,313 (0-35%)[h]	87,313
Minnesota (C)	280%	78	5,543	5,621		26,852 (100-200%)[h]		26,852
Mississippi (S)	200%		84,370	84,370				
Missouri (C)	300%	52,920	83,215	136,135				
Montana (S)	175%		22,679	22,679				
Nebraska (M)	185%	48,827		48,827				
Nevada (S)	200%		38,592	38,592	174 (133-185%)[j]	3 (0-200%)[j]		177
New Hampshire (C)	300%	712	11,524	12,236				
New Jersey (C)	350%	56,652	95,153	151,805	323 (185-200%)[k]	125,060 (above Medicaid-200%)[k]		125,383
New Mexico (M)	235%	14,944		14,944		11,193 (37-200%)[l]	23,469 (0-200%)[l]	34,662
New York (S)	250%		517,256	517,256				
North Carolina (C)	200%	70,787	180,866	251,653				
North Dakota (C)	150%	1,672	5,945	7,617				

State and Program Type as of January 2009	Reported Upper Income Level for Children (% FPL) as of January 2009	Number of Children Ever Enrolled in FY2008			Number of Adults Ever Enrolled in CHIP Waivers in FY2008 (and Income Level by Group)			
		Medicaid Expansions	Separate CHIP Programs	Total Children	Pregnant Women	Parents of Medicaid and/or CHIP Children	Childless Adults	Total Adults
Ohio (M)	300%	251,278		251,278				
Oklahoma (C)	200%	114,208	3,299	117,507				
Oregon (S)	185%		73,686	73,686		5,939 (100-185%)[m]		5,939
Pennsylvania (S)	300%		256,627	256,627				
Rhode Island (C)	250%	24,038	1,993	26,031	357 (185-250%)[n]	20,149 (100-185%)[n]		20,506
South Carolina (C)	200%	67,799	5,821	73,620				
South Dakota (C)	200%	11,713	3,564	15,277				
Tennessee (C)	250%	32,751	30,868	63,619				
Texas (S)	200%		731,916	731,916				
Utah (S)	200%		51,092	51,092				
Vermont (S)	300%		6,496	6,496				
Virginia (C)	200%	70,715	84,574	155,289	3,107 (133-185%)[o]			3,107
Washington (S)	250%		16,831	16,831				
West Virginia (S)	250%		37,645	37,645				
Wisconsin (C)	250%	48,846	4,094	52,940				
Wyoming (S)	200%		8,976	8,976		(130-185%)[p]		
State Total		**2,069,812**	**5,298,667**	**7,368,479**	**7,829**	**215,884**	**110,903**	**334,616**

Source: Congressional Research Service (CRS) analysis of information from the Centers for Medicare and Medicaid Services (CMS)

Note: (M) is a Medicaid-expansion CHIP program; (S) is separate from Medicaid; (C) is a combination, having both a Medicaid-expansion portion and a separate portion. FPL is "federal poverty level."

a. Arizona adult CHIP expiration date: 9/30/11.

b. Arizona has CMS authority to extend CHIP coverage to childless adult populations, but the state has claimed Title XIX matching funds for this population since 2006.

c. Arkansas adult CHIP expiration date:9/30/11.

d. California also provides coverage up to 300% in four select counties and for infants covered under the Access for Infants and Mother's (AIM) Program.

e. Colorado adult CHIP expiration date: 9/30/09.

f. FY2008 CHIP annual enrollment reports did not show enrollment estimates associated with Idaho's pregnant women coverage group despite the fact that the state added this population in FY2008.

g. Idaho's CHIP adult coverage waiver is doe employees of small businesses (and their families) with access to job-based health insurance. Idaho adult CHIP expiration date: 11/3/09.

h. E-mail correspondence with CMS/OL (from 1/7/09) confirms that Michigan submitted a letter to CMS expressing interest in continuing their Title XXI SCHIP adult coverage waiver, but the state failed to submit a renewal application and supporting documents within the statutory deadlines required under the Section 1115 waiver authority (i.e., Requests for an extension must be submitted 120 days prior to the expiration of the current period of the waiver in accordance with Section 1115 (f)(1) of the Social Security Act). Michigan adult CHIP waiver expiration date: 3/31/09.

i. Minnesota adult CHIP waiver expiration date: 6/12/09. The state is transitioning its CHIP adults to Title XIX funding through their Medicaid Comprehensive Demonstration waiver.

j. Nevada's adult CHIP waiver provides coverage through job-based insurance. Nevada adult CHIP waiver expiration date: 11/30/11.

k. E-mail correspondence with CMS/OL (from 1/7/09) confirms that New Jersey submitted a letter to CMS expressing interest in continuing their Title XXI SCHIP adult coverage waiver, but the state failed to submit a renewal application and supporting documents within the statutory deadlines required under the Section 1115 waiver authority (i.e., Requests for an extension must be submitted 120 days prior to the expiration of the current period of the waiver in accordance with Section 1115 (f)(1) of the Social Security Act). New Jersey adult CHIP waiver expiration date: 3/31/09.

l. New Mexico adult CHIP waiver expiration: 12/31/10.

m. Oregon adult CHIP waiver expired: 10/31/07.

n. Rhode Island adult CHIP waiver expired: 7/31/08.

o. Virginia adult CHIP waiver expiration date: 6/30/10.

p. As of 10/1/07, parents in Wisconsin's CHIP adult coverage waiver are eligible for CHIP between 130% and 185% FPL. Although family income cannot exceed 185% FPL for initial eligibility, parents may continue enrollment as long as family income does not exceed 200% FPL. Wisconsin adult CHIP waiver expiration date: 3/31/10.

Table 2. Cumulative FY1998-FY2007 Federal CHIP Financing, by State and Territory

(millions of dollars)

State and territory	FY1998-FY2007 original CHIP allotments	Net funds gained (forfeited) through redistributions	FY2006 and FY2007 shortfall allotments[a]	FY1998-FY2007 Federal CHIP expenditures	Amount of expired FY1998-FY2002 reallocated CHIP funds
A	B	C	D	E	F
Alabama	$680	($73)		$561	
Alaska	$82	$98		$170	$9
Arizona	$1,091	$25		$1,083	
Arkansas	$451	($134)		$249	$11
California	$6,892	($1,455)		$5,141	
Colorado	$479	($55)		$319	
Connecticut	$338	($89)		$160	
Delaware	$90	($29)		$39	
DC	$100	($24)		$53	
Florida	$2,326	$50		$1,902	
Georgia	$1,248	($37)	$109	$1,356	
Hawaii	$108	($24)		$71	
Idaho	$186	($20)		$129	
Illinois	$1,466	($167)	$237	$1,591	
Indiana	$659	$67		$610	
Iowa	$285	($11)	$16	$290	
Kansas	$283	$32		$295	
Kentucky	$509	$240		$588	$99
Louisiana	$804	($127)		$640	
Maine	$121	$50	$7	$172	$6
Maryland	$499	$390	$54	$961	$8

State and territory	FY1998-FY2007 original CHIP allotments	Net funds gained (forfeited) through redistributions	FY2006 and FY2007 shortfall allotments[a]	FY1998-FY2007 Federal CHIP expenditures	Amount of expired FY1998-FY2002 reallocated CHIP funds
A	B	C	D	E	F
Massachusetts	$519	$217	$98	$865	$31
Michigan	$1,065	($153)		$868	
Minnesota	$343	$52	$9	$404	
Mississippi	$497	$81	$84	$662	
Missouri	$540	$41	$8	$573	
Montana	$125	($5)		$106	
Nebraska	$165	$0	$16	$180	
Nevada	$346	($63)		$175	
New Hampshire	$100	($34)		$50	
New Jersey	$855	$586	$144	$1,663	
New Mexico	$468	($177)		$170	$33
New York	$2,680	$1,788		$3,070	$951
North Carolina	$957	$165	$3	$1,109	
North Dakota	$59	($8)		$50	
Ohio	$1,238	($14)		$1,161	
Oklahoma	$637	($171)		$433	
Oregon	$439	($116)		$260	
Pennsylvania	$1,242	($33)		$1,060	
Rhode Island	$95	$157	$24	$303	
South Carolina	$577	$144		$440	$152
South Dakota	$77	($1)	$1	$71	
Tennessee	$728	($247)		$72	$97

State and territory	FY1998-FY2007 original CHIP allotments	Net funds gained (forfeited) through redistributions	FY2006 and FY2007 shortfall allotments[a]	FY1998-FY2007 Federal CHIP expenditures	Amount of expired FY1998-FY2002 reallocated CHIP funds
A	**B**	**C**	**D**	**E**	**F**
Texas	$4,482	($832)		$2,512	
Utah	$282	($11)		$230	
Vermont	$42	($6)		$28	
Virginia	$692	($134)		$493	
Washington	$559	($178)		$183	$12
West Virginia	$219	$25		$220	
Wisconsin	$480	$142		$610	
Wyoming	$65	($19)		$36	
Puerto Rico	$348	$93	$3	$442	
Guam	$13	$4	$0	$19	
Virgin Islands	$10	$3	$0	$12	
American Samoa	$5	$1	$0	$8	
N. Mariana Islands	$4	$1	$0	$9	
Total	**$39,651**	**$0**	**$811**	**$34,925**	**$1,409**

Source: Congressional Research Service (CRS) analysis of information from the Centers for Medicare and Medicaid Services (CMS)

a. This column shows the amount of funds provided to states to eliminate their FY2006 and FY2007 federal CHIP shortfalls as appropriated, respectively, in the Deficit Reduction Act of 2005 (P.L. 109-171, enacted February 8, 2006) and the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28, enacted May 25, 2007).

Table 3. FY2008 Federal CHIP Financing

(millions of dollars)

State	Available unspent FY2006 and FY2007 balances	Redistribution from other states' unspent FY2005 allotments	States' FY2008 federal CHIP allotments	Additional allotments for FY2008 to eliminate shortfalls[a]	States' FY2008 federal CHIP balances	States' projected FY2008 federal CHIP spending
A	B	C	D	E	F = B + C + D + E	G
Alabama	$45.8		$72.3		**$118.1**	**$108.8**
Alaska	$0.6		$11.2	$2.6	**$14.4**	**$14.4**
Arizona	$33.1		$143.0		**$176.0**	**$119.4**
Arkansas	$56.5		$47.5	$9.2	**$113.2**	**$113.2**
California	$296.1		$789.2	$174.1	**$1,259.3**	**$1,259.3**
Colorado	$99.7		$71.5		**$171.2**	**$82.5**
Connecticut	$68.8		$38.8		**$107.6**	**$26.3**
Delaware	$17.9		$12.8		**$30.7**	**$9.7**
DC	$20.4		$12.1		**$32.5**	**$10.1**
Florida	$453.1		$301.7		**$754.8**	**$272.3**
Georgia			$167.9	$57.1	**$225.0**	**$225.0**
Hawaii	$14.0		$15.2		**$29.2**	**$17.6**
Idaho	$36.7		$23.8		**$60.5**	**$35.4**
Illinois			$208.3	$84.5	**$292.9**	**$292.9**
Indiana	$115.2		$97.4		**$212.6**	**$102.4**
Iowa			$33.2	$22.1	**$55.3**	**$55.3**
Kansas	$19.4		$36.6		**$56.1**	**$47.9**
Kentucky	$62.9		$68.2		**$131.1**	**$90.3**
Louisiana	$37.0		$84.1	$38.2	**$159.2**	**$159.2**
Maine		$0.3	$15.4	$17.6	**$33.4**	**$33.4**
Maryland		$3.3	$72.4	$80.6	**$156.2**	**$156.2**

State	Available unspent FY2006 and FY2007 balances	Redistribution from other states' unspent FY2005 allotments	States' FY2008 federal CHIP allotments	Additional allotments for FY2008 to eliminate shortfalls[a]	States' FY2008 federal CHIP balances	States' projected FY2008 federal CHIP spending
A	B	C	D	E	F = B + C + D + E	G
Massachusetts		$46.9	$73.3	$139.1	**$259.3**	**$259.3**
Michigan	$43.7		$147.1		**$190.8**	**$172.9**
Minnesota			$48.6	$22.8	**$71.4**	**$71.4**
Mississippi		$0.7	$61.0	$81.2	**$142.9**	**$142.9**
Missouri	$16.0		$77.6		**$93.6**	**$79.6**
Montana	$14.0		$15.9		**$29.9**	**$24.9**
Nebraska	$0.4		$21.4	$13.7	**$35.6**	**$35.6**
Nevada	$90.4		$51.1		**$141.5**	**$28.8**
New Hampshire	$14.7		$10.7		**$25.4**	**$11.2**
New Jersey		$42.8	$105.5	$174.7	**$323.1**	**$323.1**
New Mexico	$74.6		$52.0		**$126.6**	**$124.3**
New York	$447.0		$328.7		**$775.6**	**$326.9**
North Carolina	$15.7		$136.1	$41.8	**$193.7**	**$193.7**
North Dakota	$1.9		$7.9	$3.7	**$13.5**	**$13.5**
Ohio	$62.4		$157.9	[b]	**$227.5**	**$227.5**
Oklahoma	$33.8		$70.8		**$104.6**	**$99.4**
Oregon	$63.9		$60.1		**$124.1**	**$66.3**
Pennsylvania	$149.2		$168.8		**$318.0**	**$204.5**
Rhode Island		$13.0	$14.0	$32.2	**$59.1**	**$59.1**
South Carolina	$122.4		$71.0		**$193.5**	**$57.8**
South Dakota	$5.8		$10.5		**$16.3**	**$15.6**
Tennessee	$177.9		$99.8		**$277.7**	**$77.5**

State	Available unspent FY2006 and FY2007 balances	Redistribution from other states' unspent FY2005 allotments	States' FY2008 federal CHIP allotments	Additional allotments for FY2008 to eliminate shortfalls[a]	States' FY2008 federal CHIP balances	States' projected FY2008 federal CHIP spending
A	**B**	**C**	**D**	**E**	**F = B + C + D + E**	**G**
Texas	$1,012.7		$556.2		**$1,568.9**	**$698.0**
Utah	$40.4		$41.3		**$81.7**	**$50.3**
Vermont	$7.5		$5.6		**$13.1**	**$5.7**
Virginia	$65.4		$90.3		**$155.7**	**$131.3**
Washington	$144.6		$79.9		**$224.5**	**$43.4**
West Virginia	$23.3		$25.7		**$49.0**	**$36.8**
Wisconsin	$11.7		$69.6		**$81.3**	**$75.3**
Wyoming	$9.7		$6.4		**$16.1**	**$8.7**
State Total	**$4,026.4**	**$107.0**	**$4,987.5**	**$995.2**	**$10,123.2**	**$6,896.6**

Source: Congressional Research Service (CRS) analysis of information from the Centers for Medicare and Medicaid Services (CMS)

a. Up to $1.6 billion provided The Medicare, Medicaid, and CHIP Extension Act of 2007 (MMSEA, P.L. 110-173, enacted December 29, 2007).

b. Ohio experienced an FY2008 federal CHIP shortfall of $7.2 million. Because its CHIP program is a Medicaid expansion, the state could claim those shortfall expenditures under Medicaid, for which it received $6.0 million in federal Medicaid funding.

Author Contact Information

Elicia J. Herz
Specialist in Health Care Financing
eherz@crs.loc.gov, 7-1377

Chris L. Peterson
Specialist in Health Care Financing
cpeterson@crs.loc.gov, 7-4681

Evelyne P. Baumrucker
Analyst in Health Care Financing
ebaumrucker@crs.loc.gov, 7-8913