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Federal Financing for the State Children's Health Insurance Program (CHIP)

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Summary

The State Children's Health Insurance Program (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 the states, and the states are responsible for administering CHIP.

The federal government pays about 70% of CHIP expenditures, and the federal government's share of CHIP expenditures (including both services and administration) is determined by the enhanced federal medical assistance percentage (E-FMAP) rate. In FY2015, the E-FMAP rate ranges from 65% (13 states) to 82% (Mississippi). The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included a provision to increase the E-FMAP rate by 23 percentage points for most CHIP expenditures from FY2016 through FY2019.

The federal appropriation for CHIP is provided in statute. From this federal appropriation, states receive CHIP allotments, which are the federal funds allocated to each state and the territories for the federal share of their CHIP expenditures. In addition, if a state has a shortfall in federal CHIP funding, there are a few sources of shortfall funding, such as the Child Enrollment Contingency Fund, redistribution funds, and Medicaid funds.

FY2015 was the final year for which federal CHIP funding was provided in statute, but the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) extended federal CHIP funding, among other provisions. Specifically, P.L. 114-10 extended CHIP funding for two additional years (i.e., through FY2017) and maintained the current allotment formula with the 23 percentage point increase to the E-FMAP. The bill also extended the qualifying state option, the Child Enrollment Contingency Fund, and outreach and enrollment grants.

With FY2017 now being the final year for which federal CHIP funding is provided in statute, Congress's action or inaction over the next couple of years will determine the future of CHIP and of health coverage for CHIP children. In considering the future of CHIP, Congress has a number of policy options, including extending federal CHIP funding and continuing the program or letting CHIP funding expire.

Even though federal CHIP funding is set to expire after FY2017, under current law the ACA maintenance of effort (MOE) requirement for children is in place through FY2019. The MOE provision requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving federal Medicaid payments (notwithstanding the lack of corresponding federal CHIP appropriations for FY2018 and FY2019). If federal CHIP funding expires, the MOE requirement would impact CHIP Medicaid expansion programs and separate CHIP programs differently. States with CHIP Medicaid expansion programs must continue to cover their CHIP children once federal funding is no longer available. However, states with separate CHIP programs would not be required to continue coverage.

This report provides an overview of CHIP financing, beginning with an explanation of the federal matching rate. It describes various aspects of federal CHIP funding, such as the federal appropriation, state allotments, the Child Enrollment Contingency Fund, redistribution funds, outreach and enrollment grants, and performance bonus payments. The report ends with a section about the future of CHIP funding, including the options for extending CHIP funding and what could happen if federal funding expires.

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Introduction

The State Children's Health Insurance Program (CHIP) is a federal-state program that provides health coverage to certain uninsured, low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but do not have health insurance.[1] CHIP is jointly financed by the federal government and the states and is administered by the states. Participation in CHIP is voluntary, and all states and the District of Columbia participate. The federal government sets basic requirements for CHIP, but states have the flexibility to design their own version of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs.

States may design their CHIP programs in one of three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach in which the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. 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. 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.

FY2017 is the last year federal CHIP funding has been appropriated in statute even though the Patient Protection and Affordable Care Act's (ACA; P.L. 111-148, as amended) maintenance of effort (MOE) requirement is in place through FY2019.[2] The ACA MOE provision requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving federal Medicaid payments (notwithstanding the lack of corresponding federal CHIP appropriations for FY2018 and FY2019).

This report provides an overview of CHIP financing, beginning with an explanation of the federal matching rate. It describes various aspects of federal CHIP funding, such as the federal appropriation, state allotments, the Child Enrollment Contingency Fund, redistribution funds, outreach and enrollment grants, and performance bonus payments. The report ends with a section about the future of CHIP funding, including the options for extending CHIP funding and what could happen if federal funding expires.

Federal Matching Rate

The federal government pays about 70% of CHIP expenditures, and the federal government's share of CHIP expenditures (including both services and administration) is determined by the enhanced federal medical assistance percentage (E-FMAP) rate.

[1] For more information about the State Children's Health Insurance Program (CHIP), see CRS Report R43627, *State Children's Health Insurance Program: An Overview*, by (name redacted) and (name redacted).

[2] For more information about the impact of the Patient Protection and Affordable Care Act's (ACA's) child maintenance of effort (MOE) provision on CHIP, see CRS Report R43909, *CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief*, by (name redacted) and (name redacted).

The E-FMAP rate is based on the FMAP rate, which is the federal matching rate for the Medicaid program. The FMAP formula compares each state's average per capita income with average U.S. per capita income. The formula provides higher reimbursement to states with lower incomes (with a statutory maximum of 83%) and lower reimbursement to states with higher incomes (with a statutory minimum of 50%).

The E-FMAP rate is calculated by reducing the state share under the regular FMAP rate by 30.0%.[3] Statutorily, the E-FMAP (or federal matching rate) can range from 65.0% to 85.0%.[4] In FY2015, the E-FMAP ranges from 65.0% (13 states) to 81.5% (Mississippi).

For some CHIP expenditures, the federal matching rate is different than the E-FMAP rate. For instance, the matching rate for translation and interpretation services is the higher of 75% or states' E-FMAP rate plus 5 percentage points. Also, the Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3) included a provision that reduced the matching rate to the regular FMAP rate for children with family incomes exceeding 300% of the federal poverty level (FPL) with an exception for certain states.[5]

The ACA included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019. The 23 percentage point increase will not apply to certain expenditures, such as translation services, CHIP children above 300% of FPL (with an exception for certain states), expenditures for administration of citizenship documentation requirements, expenditures for administration of payment error rate measurement (PERM), and Medicaid coverage of certain breast or cervical cancer patients.

This provision will increase the statutory range of the E-FMAP rate to between 88% and 100%. In FY2016, 12 states are expected to have E-FMAP rates of 100%. **Figure 1** shows the state distribution of E-FMAP rates for FY2016 with the 23 percentage point increase. Because the federal share of CHIP will be significantly higher with this increase, states are expected to spend through the federal CHIP funding allocated to them (i.e., state CHIP allotments) faster when the enhanced rate takes effect.

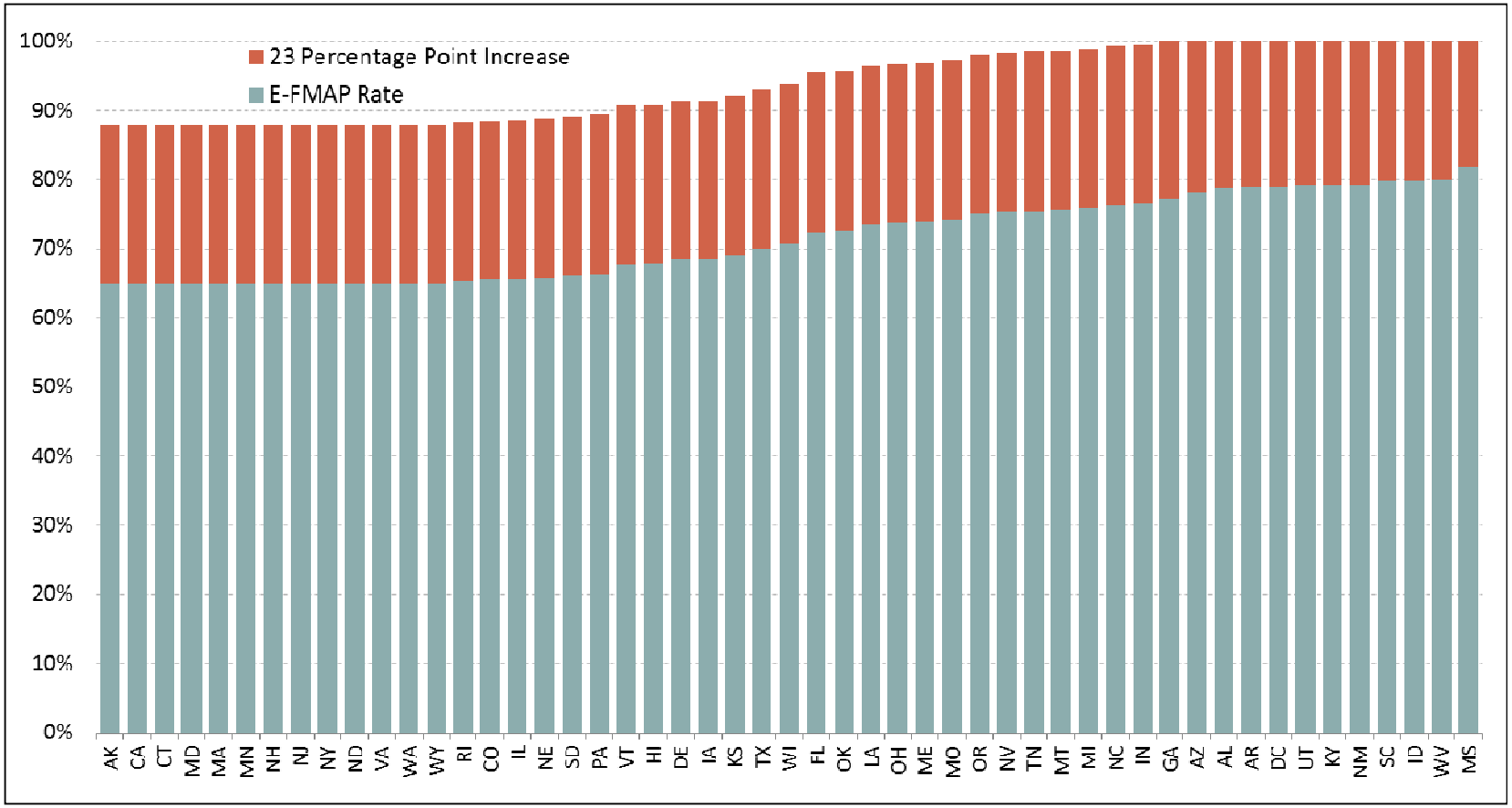
[3] For example, assume a state has a federal medical assistance percentage (FMAP) rate of 60%, which means the state share is 40%. To figure out the enhanced federal medical assistance percentage (E-FMAP) rate for this state, first figure out 30% of the state share (i.e., 40%), which is 12%, then subtract 12 percentage points from the state share under Medicaid to get the state share under CHIP, which is 28%. To get the E-FMAP rate, take 100% minus the state share under CHIP to get an E-FMAP rate of 72%.

[4] §2105(b) of the Social Security Act.

[5] States that already had a federal approval plan or that had enacted a state law to submit a plan for federal approval on the date of enactment for the Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3). Two states (New Jersey and New York) plus one county in California fall into these exceptions and receive the E-FMAP rate for CHIP enrollees above 300% of the federal poverty level (FPL). No other state provides CHIP coverage to children over 300% of FPL.

Figure 1. State Distribution of E-FMAP Rate with the 23 Percentage Point Increase

(FY2016)



Source: Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2015 Through September 30, 2016," 79 *Federal Register* 71426, December 2, 2014.

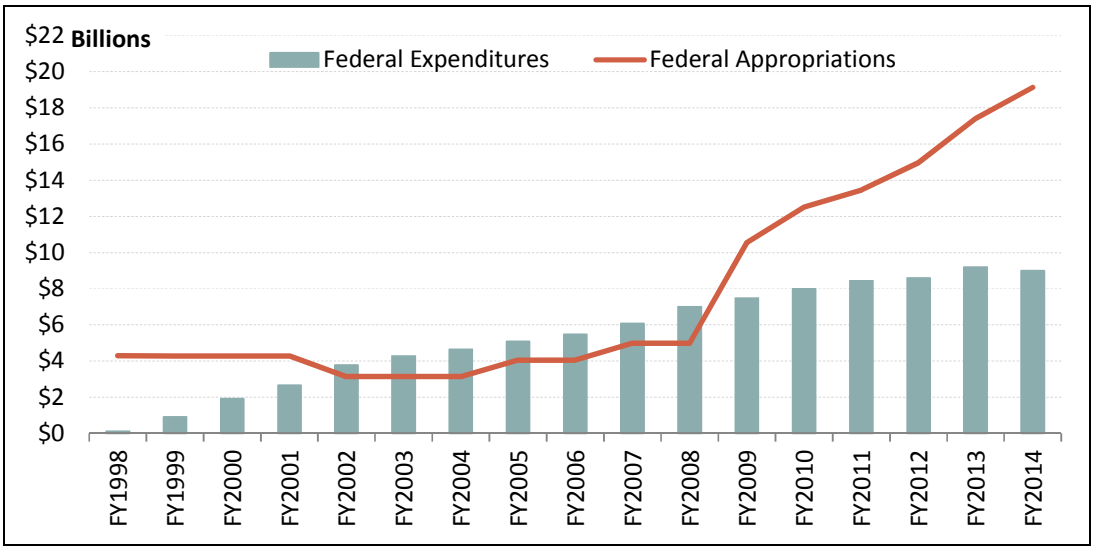
Note: E-FMAP = Enhanced federal medical assistance percentage.

Federal CHIP Funding

Federal CHIP funding is mandatory spending (i.e., funding controlled outside of the annual appropriations process through authorizing laws), and this funding is an entitlement to states that adhere to the federal CHIP rules. The funding for this program is provided through a mandatory appropriation set in statute.

Figure 2 shows the federal appropriation amounts and federal expenditures for CHIP from FY1998 through FY2014. The national appropriation amount is the maximum amount of federal funding for CHIP. Most of the federal CHIP expenditures are from state CHIP allotments, which are the federal funds allocated to each state to finance its CHIP program. In addition to allotments, states could receive shortfall funding, such as Child Enrollment Contingency Fund payments, redistribution funds, or Medicaid funds. Some CHIP funding is used to finance some Medicaid expenses. Also, states can receive outreach and enrollment grants, and states were eligible for performance bonus payments from FY2009 through FY2013.

Figure 2. CHIP Federal Expenditures and Federal Appropriations
(FY1998 through FY2014)



Sources: Appropriated amounts are from §2104 and §2105 of the Social Security Act and §108 of the Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) as amended by §10203(d)(2)(F) of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended); and Medicaid Financial Management Reports.

Federal Appropriation

The federal appropriation for CHIP is provided in Section 2104(a) of the Social Security Act. This amount is the overall annual ceiling on federal CHIP spending to the states, the District of Columbia, and the territories.[6] CHIPRA increased the annual appropriation amounts substantially

[6] The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

beginning in FY2009 and provided funding through FY2013. The ACA provided funding for an additional two years (i.e., through FY2015), and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) added appropriations for FY2016 and FY2017 at $19.3 billion and $20.4 billion,[7] respectively.[8]

If the federal appropriations were not large enough to cover state allotments in any given year, the state allotments would be reduced proportionally. However, **Figure 2** shows the national appropriation has been more than sufficient to fund federal CHIP expenditures since FY2009.[9] In fact, from FY2011 through FY2015, multiple appropriations laws have rescinded a total of $24.3 billion in funding from CHIP (see text box entitled "CHIP Changes in Mandatory Programs" for more detail about these rescissions).

CHIP Changes in Mandatory Programs

Changes in mandatory programs (CHIMPs) are provisions in appropriations acts that reduce or constrain mandatory spending. From FY2011 through FY2015, multiple appropriations laws have rescinded a total of $24.3 billion in funding from CHIP through CHIMPs directed at the performance bonus payments fund.

CHIPRA established performance bonus payments for states that increase their Medicaid (not CHIP) enrollment among low-income children above a defined baseline (see the "Performance Bonus Payments" section). Funding for the performance bonus payments was provided through an initial, one-time appropriation of $3.2 billion in FY2009. In addition, funding for the bonus payments was transferred annually from unobligated federal appropriations for FY2009 through FY2013, excess funding in the Child Enrollment Contingency Fund for FY2009 through FY2013, and unexpended state allotments not used for redistribution for FY2009 through FY2013.

The fund balance for the performance bonus payments increased significantly every year because the transfers into the fund were substantially higher than the actual performance bonus payments to states. From FY2009 through FY2013, 27 states received CHIPRA performance bonus payments totaling $1.1 billion over the 5 years. **Table 1** shows the annual aggregate performance bonus payment amounts and the annual rescission amounts.

Table 1. Performance Bonus Fund Payments to States and Rescission Amounts

($ in billions)

	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	Total
Payments to States	$0.0	-$0.2	-$0.3	-$0.3	-$0.3	—	—	**-$1.1**
Rescission Amounts	—	—	-$3.5	-$6.4	-$6.4	-$6.3	-$1.7	**-$24.3**

Sources: Centers for Medicare & Medicaid Services, *CHIPRA Performance Bonuses: A History,* December 2013; Defense and Full-Year Appropriations, 2011 (P.L. 112-10); Consolidated Appropriations Act, 2012 (P.L. 112-74); Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6); Consolidated Appropriations Act, 2014 (P.L. 113-76); and Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235).

Note: Performance bonus payments were $37 million in FY2009.

[7] The FY2017 appropriation is the combination of two half-year appropriations of $2.85 billion from §2104(a) of the Social Security Act plus a one-time appropriation in the amount of $14.70 billion from §301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10).

[8] For more information about the changes enacted under MACRA, see CRS Report R43962, *H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015*, coordinated by (name redacted) and Kirstin B. Blom.

[9] From FY2002 through FY2008, the national appropriation amounts were insufficient to cover the full cost of some states' CHIP programs. For FY2002 through FY2005, the amount of redistribution funds from other states was enough to make up the difference. For FY2006 through FY2008, however, additional CHIP appropriations were provided to cover the cost of the federal share of CHIP expenditures.

State Allotments

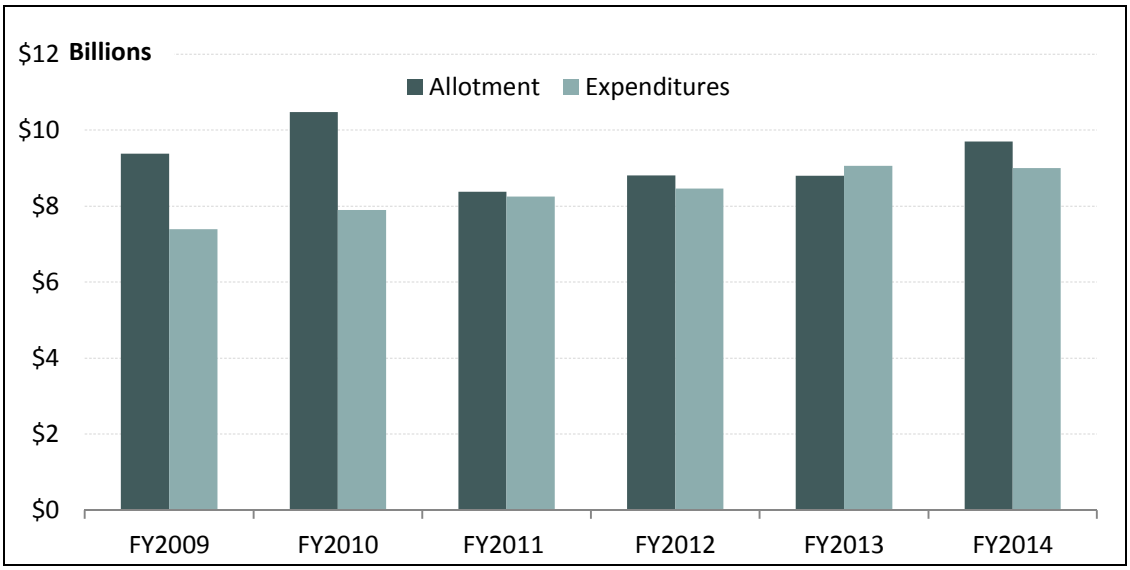
State allotments are the federal funds allocated to each state and territory for the federal share of its CHIP expenditures. CHIPRA established a new allocation of federal CHIP funds among the states based largely on states' actual use of and projected need for CHIP funds.[10] There are two formulas for determining state allotments: an even-year formula and an odd-year formula.[11]

In even years, such as FY2014, state CHIP allotments are each state's *allotment* for the prior year plus any Child Enrollment Contingency Fund (described below) payments from the previous year adjusted for growth in per capita National Health Expenditures and child population in the state. For even years, the formula for CHIP allotments can be increased to reflect CHIP eligibility or benefit expansions.

In odd years, state CHIP allotments are each state's *spending* for the prior year (including federal CHIP payments from the state CHIP allotment, payments from the Child Enrollment Contingency Fund, and redistribution funds) adjusted using the same growth factor as the even-year formula (i.e., per capita National Health Expenditures growth and child population growth in the state). Since the odd-year formula is based on states' actual use of CHIP funds, it is called the *re-basing year* because a state's CHIP allotment can either increase or decrease depending on that state's CHIP expenditures in the previous year. **Figure 3** shows how the re-basing for FY2011 significantly decreased the aggregate amount for state allotments from FY2010 to FY2011.

Figure 3. CHIP Allotments and Federal Expenditures

(FY2009 through FY2014)



Sources: Various *Federal Register* notices; Chris Peterson and Ben Finder, *Extending CHIP: Short-Term Issues*, Medicaid and CHIP Payment and Access Commission, February 26, 2015.

Note: This figure does not show the availability of unspent allotments from the prior year and redistribution funds.

[10] Prior to CHIPRA, the territories received 0.25% of the national appropriation amount and the remainder was divided, or allotted, among the states based on a formula using survey estimates of the number of low-income children in each state and the number of those children who were uninsured.

[11] §2104(m) of the Social Security Act.

State CHIP allotment funds are available to states for two years, which explains why federal expenditures are sometimes higher than the state allotments in some years. The federal CHIP expenditures can include federal funding from states' allotments for the specified year and the prior year.

The allotment is available to states to cover the federal share of both CHIP benefit and administrative expenditures.[12] However, no more than 10% of the federal CHIP funds that a state draws down from its CHIP allotment can be spent on non-benefit expenditures, including expenditures for administration, translation services, and outreach efforts.

MACRA added a couple of special rules to the state allotments for FY2016 and FY2018. The special rule for FY2016 establishes the states' allotments by taking into account the 23 percentage point increase in the E-FMAP that begins in that year. Specifically, the FY2016 allotments will be each state's FY2015 allotment (including Child Enrollment Contingency Fund payments and redistribution funds), but it will be determined as if the 23 percentage point increase in the E-FMAP were in place for FY2015. Then, that amount will be adjusted using the same growth factor as the even- and odd-year formulas (i.e., growth in per capita National Health Expenditures and child population in the state).

For FY2018, MACRA included a provision that will reduce the amount of states' unspent funds from their FY2017 allotments available for expenditures in FY2018 by one-third. Although FY2017 is the last year for which federal CHIP funding is provided under current law, states could have federal CHIP spending in FY2018 because states could have access to unspent funds from their FY2017 allotments and unspent FY2016 allotments redistributed to shortfall states.

Shortfall Funding

If a state's CHIP allotment for the current year, in addition to any allotment funds carried over from the prior year, is insufficient to cover the state's projected CHIP expenditures for the current year, a few different shortfall funding sources are available. These sources include the Child Enrollment Contingency Fund, redistribution funds, and Medicaid funds. Since FY2009, one state and one territory have received shortfall funding.

Child Enrollment Contingency Fund

CHIPRA established the Child Enrollment Contingency Fund and made its funds available to states for FY2009 through FY2015, and MACRA extended the availability of the Child Enrollment Contingency Fund and of payments from the fund through FY2017.[13] A state is eligible for Child Enrollment Contingency Fund payments if it has both a funding shortfall[14] and

[12] CHIP Medicaid expansion states may use federal Medicaid funds to pay for CHIP administrative expenditures.

[13] §2104(n) of the Social Security Act.

[14] For Child Enrollment Contingency Fund payments, a state has a funding shortfall if a state's current-year CHIP allotment plus any unused CHIP allotment funds from the previous year are insufficient to cover the federal share of the state's CHIP program. The definition of shortfall funding for Child Enrollment Contingency Fund payments does not factor in redistribution funds.

CHIP enrollment (for children) that exceeds a target level.[15] As a result, not all states with funding shortfalls are eligible for Child Enrollment Contingency Fund payments.

The Child Enrollment Contingency Fund was funded with an initial deposit equal to 20% of the appropriated amount for FY2009 (i.e., $2.1 billion). In addition, for FY2010 through FY2017, such sums as are necessary for making Child Enrollment Contingency Fund payments to eligible states are to be deposited into the fund, but these transfers cannot exceed 20% of the federal appropriation for the fiscal year.

The Child Enrollment Contingency Fund payment formula is based on a state's growth in CHIP enrollment and per capita spending, which means a state may receive a payment from the fund that does not equal its actual shortfall. Iowa is the only state that has received payments from the Child Enrollment Contingency Fund since FY2009, when funds were first available.[16]

Redistribution Funds

After two years, any unused state CHIP allotment funds are redistributed to shortfall states.[17] For redistribution funds, a shortfall state is defined as a state that will not have enough money to meet projected costs in the current year after counting (1) the current year's state allotment, (2) unspent funds from the prior year's state allotment, and (3) available Child Enrollment Contingency Fund payments. If redistributed funds are insufficient to meet the needs of all shortfall states, each shortfall state receives a proportionate share of the available funds based on the shortfall in each state. Since FY2009, only Puerto Rico has received redistribution funds.[18]

Medicaid Funds

States that design their CHIP program as a CHIP Medicaid expansion or a combination program and face a shortfall after receiving Child Enrollment Contingency Fund payments and redistribution funds may receive federal Medicaid matching funds to fund the shortfall in the CHIP Medicaid expansion portion of their CHIP program.[19] When Medicaid funds are used to fund CHIP, the state receives the lower regular FMAP rate (i.e., the federal Medicaid matching rate) rather than the higher E-FMAP rate provided for other CHIP expenditures. However, although federal CHIP funding is capped, federal Medicaid funding is open-ended, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

[15] The target enrollment level for Child Enrollment Contingency Fund payments is the target enrollment level for the previous year increased by the child population growth factor used to calculate the allotment growth factor.

[16] In FY2011, Iowa had a projected shortfall in federal CHIP funding of $3.8 million. Because Iowa's CHIP enrollment exceeded the target level, Iowa was eligible for Child Enrollment Contingency Fund payments and received $28.9 million. (Medicaid and CHIP Payment and Access Commission, *MAC Basics: Federal CHIP Financing*, September 2011; Communication with the Centers for Medicare & Medicaid Services in November 2014.)

[17] §2104(f) of the Social Security Act.

[18] In FY2012 and FY2013, Puerto Rico received $23.7 million and $0.8 million, respectively, in CHIP redistribution funds. (Communication with the Centers for Medicare & Medicaid Services in November 2014.)

[19] Prior to CHIPRA, children in a CHIP Medicaid expansion program were to be paid for out of CHIP funds at the E-FMAP rate and Medicaid funding for these children could not be used until a state's available CHIP funding was exhausted. CHIPRA gave states the option to draw Medicaid funds at the regular FMAP rate for CHIP Medicaid expansion children prior to exhausting federal CHIP funding.

Federal CHIP Funds Finance Some Medicaid Expenditures

In a few situations, federal CHIP funding is used to finance Medicaid expenditures, such as the *qualifying state* option, the stairstep children, and the transition to the modified adjusted gross income (MAGI) counting rules.

Qualifying State Option

Certain states had significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997, and these states are allowed to use their CHIP allotment funds to fund the difference between the Medicaid and CHIP matching rates (i.e., FMAP and E-FMAP rates, respectively) to finance the cost for children in Medicaid above 133% of FPL. This provision is referred to as the *qualifying state* option. FY2015 was the last year for which the qualifying state option was authorized, but MACRA extended the qualifying state option through FY2017.

The following 11 states meet the definition of a qualifying state: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. Although 11 states are eligible for this option, only 6 states (Connecticut, Minnesota, New Hampshire, Vermont, Washington, and Wisconsin) had CHIP expenditures under the qualifying state option in FY2013.

Stairstep Children

The ACA required states to transition CHIP children aged 6 through 18 in families with annual income less than 133% of FPL to Medicaid, beginning January 1, 2014.[20] Coverage for such children continues to be financed with states' CHIP annual allotment funding at the E-FMAP rate as long as their income eligibility is greater than the state's March 31, 1997, Medicaid income standard for children.[21] However, the E-FMAP rate is not available for children between the ages of 6 and 18 who have access to private health insurance.

Transition to Modified Adjusted Gross Income

Beginning January 1, 2014, the ACA required the federal government and states to rely on MAGI[22] income counting rules when determining eligibility for most CHIP enrollees. Under the MAGI rules, a state looks at each individual's MAGI, deducts 5% (which the law provides as a standard disregard), and compares that income with the new income standards set by each state.[23]

[20] The Centers for Medicare & Medicaid Services granted approval for Pennsylvania to delay the transition of CHIP children aged 6 to 18 in families with income less than 133% of FPL until CY2015.

[21] Centers for Medicare & Medicaid Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 77 *Federal Register* 17144, March 23, 2012; Centers for Medicare & Medicaid Services, *Medicaid and CHIP FAQs: Funding for New Adult Group, Coverage of Former Foster Care Children and CHIP Financing*, December 2013.

[22] MAGI is defined as the Internal Revenue Code's (IRC's) adjusted gross income (AGI) plus certain foreign-earned income and tax-exempt interest. AGI reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments, increased by tax-exempt interest and income earned by U.S. citizens or residents living abroad.

[23] For more information about MAGI, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, coordinated by (name redacted).

Children moving from CHIP to Medicaid due to the application of the 5% income disregard may be funded with states' annual CHIP allotment funding at the E-FMAP rate.[24]

Outreach and Enrollment Grants

CHIPRA established outreach and enrollment grants aimed at reducing the number of children eligible for but not enrolled in Medicaid and CHIP and improving retention so that eligible children stay covered for as long as they are eligible for the programs. CHIPRA provided $100 million to fund the outreach and enrollment grants for FY2009 through FY2013. The ACA extended the outreach and enrollment grants through FY2015 and provided an additional $40 million in funding. MACRA extended the outreach and enrollment grants through FY2017 and authorized another $40 million in funding.

Ten percent of the allocation was to be directed to a national enrollment campaign, and 10% was to be targeted to outreach for American Indian and Alaska Native children. The remaining 80% was to 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 also were targeted at proposals that address cultural and linguistic barriers to enrollment.

Performance Bonus Payments

CHIPRA established performance bonus payments for states that increased their Medicaid (not CHIP) enrollment among low-income children above a defined baseline. CHIPRA performance bonus payments began in FY2009, and FY2013 was the final year in which a state could earn a bonus payment. To qualify for these bonus payments, states had to (1) implement strategies to simplify the application and enrollment process and (2) achieve state-specific targets for increasing Medicaid enrollment among children.

There were two tiers of bonus payments depending on how much the state's enrollment exceeded the baseline. Tier 1 bonus payments were available to states with enrollment exceeding the baseline by less than 10%, and tier 1 bonus payments were calculated by multiplying the amount the enrollment exceeded the baseline by 15% of the state-specific per capita Medicaid expenditures. States with enrollment exceeding the baseline enrollment level by more than 10% also received additional tier 2 bonus payments for the enrollment in excess of 10% above baseline, and Tier 2 bonus payments were calculated by multiplying the amount the enrollment exceeded the baseline plus 10% by 62.5% of the state-specific per capita Medicaid expenditures.

From FY2009 through FY2013, 27 states received CHIPRA performance bonus payments totaling $1.1 billion over the five years. Some states received payments in more than one year.[25]

[24] Coverage for this population will be paid for out of the state's CHIP allotment at the E-FMAP rate and will cease when the last child has been afforded 12 months of coverage (expected to be no later than April 1, 2016). (Centers for Medicare & Medicaid Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 77 *Federal Register* 17144, March 23, 2012; Centers for Medicare & Medicaid Services, *Medicaid and CHIP FAQs: Funding for New Adult Group, Coverage of Former Foster Care Children and CHIP Financing*, December 2013.)

[25] Insure Kids Now, *CHIPRA Performance Bonuses: A History*, December 2013.

Funding for the performance bonus payments was provided through an initial one-time appropriation of $3.2 billion in FY2009. In addition, funding for these payments was transferred from unobligated national allotments for FY2009 through FY2013, excess funding in the Child Enrollment Contingency Fund for FY2010 through FY2013, and unexpended allotments not used for redistribution for FY2010 through FY2013.

Future of CHIP Funding

With federal funding for CHIP set to end after FY2017, Congress will need to decide whether to continue the program. In considering the future of CHIP, it is helpful to recall why the program was created in 1997: to provide affordable health coverage at a time when there were few other insurance coverage options for low-income children outside of Medicaid. The health insurance market is far different today, with the enactment of the ACA. Now, if CHIP funding is exhausted, current CHIP-eligible children could be eligible for Medicaid or potentially for subsidized coverage in the health insurance exchanges. However, not all CHIP-eligible children would be eligible for these programs, and some could end up being uninsured if CHIP is no longer available.

Some argue that it is important to continue providing CHIP children with child-specific safety net coverage because each of the low-income subsidy programs (e.g., CHIP, Medicaid, and subsidized exchange coverage) plays a unique role in the health care delivery system.[26] For instance, greater cost-sharing protections exist for the programs that target families at the lower ends of the income eligibility spectrum.[27] In addition, some are wary of providing coverage for children in the health insurance exchanges because the exchanges are new and there is little evidence about how coverage in the exchanges compares to CHIP coverage.[28]

With FY2017 being the final year for which federal CHIP funding is provided in statute, Congress's action or inaction will determine the future of CHIP and of health coverage for CHIP children. In considering the future of CHIP, Congress has a number of policy options, including extending federal CHIP funding and continuing the program or letting CHIP funding expire.

Extending Federal CHIP Funding

If Congress decides to extend federal CHIP funding after FY2017, there are a number of policy options regarding how long to extend funding and whether to make programmatic changes.

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[26] See Tricia Brooks, Martha Heberlein, and Joseph Fu, Georgetown University Health Policy Institute, Center for Children and Families, *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs,* May 2014; and Anita Cardwell, et al., National Academy for State Health Policy and Georgetown University Health Policy Institute, Center for Children and Families; *Benefits and Cost Sharing in Separate CHIP Programs*, May 2014.

[27] Under CHIP and Medicaid, out-of-pocket spending (including both premiums and cost sharing) is exempt for many children and pregnant women and, when premiums and cost sharing apply, they cannot exceed 5% of the family's income. For the health insurance exchanges, in 2014, out-of-pocket spending cannot exceed $6,350 for self-only coverage and $12,700 for coverage other than self-only.

[28] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to Congress on Medicaid and CHIP*, June 2014; Tricia Brooks, "MACPAC Considers Future of CHIP," *Say Ahhh!: A Children's Health Policy* Blog, Georgetown University Health Policy Institute's Center for Children and Families, November 22, 2013, at http://ccf.georgetown.edu/all/macpac-considers-future-of-chip/.

Funding could be extended for just a few years (e.g., two or four years) or indefinitely, and the extension could maintain, phase down, or eliminate the 23 percentage point increase to the E-FMAP rate (i.e., the federal matching rate for CHIP). (See the textbox "Federal Cost of Extending CHIP Funding" for more information about extending CHIP funding.)

Federal Cost of Extending CHIP Funding

The Congressional Budget Office (CBO) is required to assume that mandatory spending programs in existence on or before the enactment of the Balanced Budget Act of 1997 (P.L. 105-33), which would include CHIP, that lack future appropriations and have current-year outlays of at least $50 million will continue operating as they had been immediately prior to their expiration. This requirement is in the Balanced Budget and Emergency Deficit Control Act of 1985, Section 257(b)(2).

Under current law, as shown in **Figure 4**, funding for CHIP in FY2017 consists of two semiannual appropriations of $2.85 billion—amounts that are much smaller than the appropriations in other years. The first semiannual appropriation in FY2017 will be supplemented by a one-time appropriation in the amount of $14.70 billion provided in the first six months of FY2017 that will remain available until expended. To calculate the CHIP program levels that will continue in the baseline pursuant to these scorekeeping rules, CBO annualizes the $2.85 billion provided for the allotment for the last six months of its authorization for the remainder of the baseline period. CBO does not include the other amounts provided to CHIP for the earlier part of FY2017 because these are not available immediately before the program expires at the end of the fiscal year. For this reason, CBO's baseline for CHIP includes $5.7 billion in federal CHIP funding for each year after FY2017.

Figure 4. Federal CHIP Funding for FY2017 and CBO's Baseline for FY2018 and Subsequent Years

($ in billions)

FY2017 Funding	
First Six Months	
Semiannual Appropriation	$2.85
One-Time Appropriation	14.70
Second Six Months	
Semiannual Appropriation	$2.85
One-Time Appropriation	+0.0
TOTAL	**$21.06**

CBO Baseline for FY2018 and Subsequent Years	
FY2017 Funding for the Second Six Months	$2.85
Annualized	x2
TOTAL	**$5.70**

Source: Congressional Research Service.

CHIP: State Children's Health Insurance Program.

CBO: Congressional Budget Office.

Because the baseline projections assume $5.7 billion in federal CHIP spending for FY2018 and subsequent years within the budget window, CBO's estimated cost of extending federal CHIP funding is lower than it would have been without this assumption. In addition, the federal costs of extending CHIP funding would be offset by reductions in federal spending for Medicaid and subsidized exchange coverage because some CHIP children would receive Medicaid coverage or subsidized exchange coverage if CHIP were to expire.

According to CBO and the Joint Committee on Taxation, the extension of CHIP included in P.L. 114-10 would increase outlays by a net of $5.6 billion over the next 10 years, even with the 23 percentage point increase in the E-FMAP rate.[29]

If Federal CHIP Funding Expires

Although FY2017 is the last year for which federal CHIP funding is provided under current law, states are expected to have federal CHIP spending in FY2018 because states will have access to unspent funds from their FY2017 allotments and to unspent FY2016 allotments redistributed to shortfall states (if any).

If federal CHIP funding expires after FY2017, the loss of funding and the ACA MOE requirements would impact states' CHIP programs differently depending on whether the program is a CHIP Medicaid expansion or a separate CHIP program.

The CHIP enrollees in CHIP Medicaid expansion programs (roughly half of CHIP enrollees)[30] likely would continue to receive coverage through their state's Medicaid program due to the ACA MOE requirement, which requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving any Medicaid funding (notwithstanding the lack of corresponding federal CHIP appropriations for FY2018 and FY2019).[31] This switch would cause the federal share of expenditures to decrease from the E-FMAP rate to the regular FMAP rate, which means the cost of covering these children would increase for states.

For the roughly half of CHIP enrollees in separate CHIP programs,[32] if CHIP funding expires, states would have to enroll these children in Medicaid or certified qualified health plans in the health insurance exchanges.[33] However, if no certified qualified health plans exist, states are relieved from the MOE requirement to provide coverage for the CHIP enrollees in separate CHIP programs when the federal CHIP funding expires.

[29] Congressional Budget Office, Letter to the Honorable John A. Boehner, Re: Cost Estimate and Supplemental Analyses for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, March 25, 2015, at https://www.cbo.gov/sites/default/files/cbofiles/attachments/hr2.pdf.

[30] Preliminary FY2014 CHIP enrollment data show about half of CHIP enrollees are in CHIP Medicaid expansion programs and about half are in separate CHIP programs. See MACPAC, *Report to Congress on Medicaid and CHIP*, March 2015.

[31] For more information about the ACA MOE requirement, see CRS Report R43909, *CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief*, by (name redacted) and (name redacted).

[32] See footnote 30.

[33] A certified qualified health plan is a qualified health plan that has been certified by the Secretary of Health and Human Services to be "at least comparable" to CHIP in terms of benefits and cost sharing.

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