CHIP and Medicaid: Evolving to Meet the Needs of Children

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ABSTRACT

OBJECTIVE: To examine the evolution of Children’s Health Insurance Program (CHIP) and Medicaid programs after passage of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), focusing on policies affecting eligibility, enrollment, renewal, benefits, access to care, cost sharing, and preparation for health care reform.

METHODS: Case studies were conducted in 10 states during 2012—which included key informant interviews and consumer focus groups—and a national survey of state CHIP program administrators was conducted in early 2013.

RESULTS: Despite the recession that persisted during much of the study period, many states expanded children’s coverage by raising upper income eligibility limits or by covering new groups made eligible by CHIPRA. Simplifying rules and procedures for enrollment and renewal continued to be a major priority for CHIP and Medicaid, and CHIPRA played a direct role in spurring innovation. CHIPRA’s outreach grants played an important role in supporting and supplementing state outreach efforts. Important legacies of CHIPRA are the law’s mandatory requirements for comprehensive dental benefits coverage and mental health parity for all types of CHIP programs. Although most states already offered generous coverage of these benefits, the mandate may have protected them from cuts during the economic downturn. Federal Maintenance of Effort rules were a crucial protection for CHIP, especially during the recession when state budget shortfalls could have led to program cuts.

CONCLUSIONS: Passage of the Affordable Care Act has raised questions surrounding the future role of CHIP in a reformed health care system. A growing number of stakeholders have recommended a 2-year extension of federal CHIP funding to allow complex transition issues to be resolved.

KEYWORDS: Affordable Care Act; CHIP; CHIPRA; Medicaid

WHAT’S NEW

The Children’s Health Insurance Program and Medicaid continue to play a critical role in extending affordable access to quality care for children. The Children’s Health Insurance Program Reauthorization Act of 2009 spurred states to expand eligibility, further streamline enrollment and renewal procedures, increase outreach, strengthen benefits, and improve quality assurance efforts.

The Children’s Health Insurance Program (CHIP), a landmark initiative to broaden health insurance coverage for low-income children, was created with bipartisan support as part of the Balanced Budget Act of 1997 and funded initially for a period of 10 years with an appropriation of approximately $40 billion. CHIP built upon Medicaid by allowing states to cover children in families with incomes up to 200% of the federal poverty level (FPL) and beyond. Unlike Medicaid, which is an entitlement program with no spending cap, CHIP is a block grant with federal allotments for each state based on the number of uninsured children residing there (among other factors), and is matched with federal dollars at an enhanced rate compared to Medicaid. Congress deliberately designed CHIP to give states more control over program design compared to Medicaid. States have 3 options for expanding coverage—through Medicaid, through the creation of new separate CHIP programs, or through a combination of the 2 approaches. Congress gave additional flexibility to states that enact separate programs. Within certain federal parameters, states can: 1) offer benefits that are less comprehensive than Medicaid’s, 2) impose cost sharing, 3) develop alternative service delivery systems, 4) adopt simpler eligibility rules and processes, and 5) administer the program outside of state Medicaid agencies. The law also explicitly allows states to use administrative funds to conduct outreach to uninsured children.

CHIP has not been a static program; states have modified their programs over the years in response to changing economic and political circumstances, and Congress has legislated changes, by far most significantly with the
passage of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). After 2 years of temporary extensions, Congress passed and President Barack Obama signed CHIPRA in early 2009, extending $44 billion in new funding through federal fiscal year 2013. CHIPRA also amended the formula for distributing federal monies to the states, basing state allotments on actual CHIP expenditures, and the law established a performance bonus fund to encourage states to adopt innovative simplification policies and reward improved enrollment and retention of children in the Medicaid program. CHIPRA also appropriated $100 million to support new outreach grants to promote public awareness and application assistance efforts in states, communities, and federally recognized American Indian tribes, and the law included a host of significant programmatic provisions to improve coverage, benefits, access, and quality of care (Table 1). The Affordable Care Act (ACA) further extended $40 billion of federal funds for CHIP for federal fiscal years 2014 and 2015, and authorized the program through fiscal year 2019.

Here we describe how CHIP programs and their Medicaid counterparts have evolved since their early years and in response to CHIPRA and the ACA. Findings are drawn from in-depth case studies of 10 states and a survey of state CHIP administrators in all 50 states. A synthesis and summary of key findings from these 2 data gathering efforts is presented, along with a discussion of the programs’ evolution in relation to the key policy areas of program design; eligibility, enrollment and retention; substitution of public for private coverage; outreach; benefits; service delivery, access to, and quality of care; cost sharing; financing; and preparation for health care reform.

METHODS

The CHIPRA-mandated evaluation of CHIP included a case study component to closely examine implementation in a sample of states, as well as a 50-state survey of CHIP program administrators that permitted nationwide tracking of CHIP program changes. The 10 states selected for this study represent diverse approaches to providing CHIP coverage, are geographically diverse, and contain 53% of the nation’s uninsured children and 57% of all children enrolled in CHIP. The case studies involved 4- to 5-day site visits to Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia, which were conducted between February and September 2012. Study teams, using standardized protocols, conducted key informant interviews with approximately 40 stakeholders in each state, including state CHIP and Medicaid officials, governors’ or state legislators’ health policy staff, pediatric and safety net providers, health plan administrators, child and family advocates, agencies involved with eligibility determination, and community-based organizations involved with outreach and application assistance. The evaluators also conducted 3 focus groups in each state with (primarily) parents of children enrolled in CHIP. Interview notes and focus group transcripts were coded using qualitative analysis software (NVivo) and analyzed according to a scheme that followed the areas of inquiry. Together, these inquiries elicited insights into: how CHIP has evolved and matured since the end of the previous congressionally mandated evaluation of CHIP in 2005; how states have grappled with implementation challenges involved with finding, enrolling, retaining, and delivering care to children; and what new issues may arise for CHIP as a result of passage of the ACA.

The evaluation’s national survey of CHIP program administrators was conducted by telephone in early 2013 and systematically gathered information about the implementation and influence of key CHIPRA provisions, how the ACA had affected CHIP programs, and how it was expected to influence programs in the future.

RESULTS

PROGRAM DESIGN

States have capitalized on the flexibility embedded in the CHIP statute to design programs that emulate private insurance coverage. From the outset, many states used the flexibility granted through CHIP to create separate programs designed to feel more like private insurance to consumers. By 2001, 35 states operated separate CHIP programs—either alone or in combination with (typically smaller) Medicaid expansions—under attractive names like Healthy Families (California) and Child Health Plus (New York). These programs have typically included cost sharing similar to (but much lower than) private insurance and service-delivery networks using mainstream managed care plans. At one point, the number of states with separate CHIP programs reached 43, but recently, partly in response to anticipated changes under the ACA, 6 states have eliminated their separate programs. As of January 2014, 37 states operated a separate CHIP (either alone or in combination with a Medicaid expansion CHIP), and 13 states and the District of Columbia operated only a Medicaid expansion CHIP.

ELIGIBILITY, ENROLLMENT, AND RETENTION

CHIP continues to extend broad coverage to children in working poor families. The financial stability and increased flexibility that CHIPRA provided led many states to further expand coverage for children and take advantage of newly available federal matching funds. For example, CHIPRA made it easier for states to cover children in families with incomes above 250% of the federal poverty level; as of January 2014, 25 states and the District of Columbia had done so. In addition, 24 states expanded CHIP to cover legally residing immigrant children or pregnant women, while 3 states used CHIPRA Section 111 rules to expand coverage for pregnant women. In response to the ACA, 16 states extended federally financed coverage to children of state employees.

Maintenance of Effort rules established by the American Recovery and Reinvestment Act of 2009 (and extended and broadened by the ACA) protected these and other expansions by prohibiting states from cutting eligibility and enrollment policies for Medicaid and CHIP to levels
Table 1. Key CHIPRA Provisions by Policy Area

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>• Creates an explicit new eligibility category for pregnant women in CHIP.</td>
</tr>
<tr>
<td></td>
<td>• Allows states to use federal funding to cover legally resident immigrant children and pregnant women in their first 5 years in the United States in Medicaid and CHIP.</td>
</tr>
<tr>
<td></td>
<td>• Reduces barriers to creating premium assistance programs for children and families, making it easier for states to use CHIP funds to subsidize families’ purchase of employer-sponsored insurance.</td>
</tr>
<tr>
<td></td>
<td>• Prohibits states from covering parents of children enrolled in CHIP.*</td>
</tr>
<tr>
<td></td>
<td>• Allows states to adopt ELE† for children in CHIP and Medicaid.</td>
</tr>
<tr>
<td></td>
<td>• Requires states to verify citizenship of children applying to CHIP‡ and allows them to do so electronically through data matches with the Social Security Administration.</td>
</tr>
<tr>
<td></td>
<td>• Requires states to provide a 30-day grace period before cancelling coverage due to nonpayment of premiums.</td>
</tr>
<tr>
<td>Benefits</td>
<td>• Requires states to cover dental services in CHIP benefit packages.§</td>
</tr>
<tr>
<td></td>
<td>• Allows states to provide dental-only supplemental coverage for children who would otherwise qualify for CHIP but have private health insurance without dental benefits.</td>
</tr>
<tr>
<td></td>
<td>• Requires mental health parity, such that mental health benefits offered by CHIP are covered at the same amount, duration, and scope as physical health benefits.</td>
</tr>
<tr>
<td>Quality measurements</td>
<td>• Establishes a new initiative to improve quality of care provided to children, including the development of new child-specific quality measures and new electronic medical record systems for children, and funding of demonstration projects for child health quality improvement.</td>
</tr>
</tbody>
</table>

CHIP indicates Children’s Health Insurance Program; and ELE, Express Lane Eligibility.

*States previously could cover parents of children enrolled in CHIP through waiver authority; the 8 states with waivers in place in 2009 were permitted to continue their programs through the end of fiscal year 2011 (Center for Children and Families. The Children’s Health Insurance Program Reauthorization Act of 2009: Overview and Summary. Washington, DC: Georgetown University Health Policy Institute. March 2009.).

†ELE allows states to use the findings of other need-based programs to establish eligibility for Medicaid or CHIP.

‡The Deficit Reduction Act of 2005, PL 109-171, had previously required citizenship documentation for Medicaid applicants.

§Previously a state option, though nearly every state already covered dental benefits.

||Given the early timing of the case studies, quality improvement efforts were not a focus of this component of the evaluation.

more restrictive than those in place in March 2010. In the survey of state CHIP administrators, officials from 30 states (of 46 responding to the question) reported that these rules were important in safeguarding CHIP and Medicaid from cuts, especially as state budgets came under pressure during the recession.

CHIPRA performance bonuses spurred states’ continued interest in pursuing enrollment and renewal simplification strategies. Since its inception, CHIP has been a fertile testing ground for state innovations related to eligibility, enrollment, and renewal simplification. States that adopted at least 5 of 8 approved simplification strategies (Table 2) in CHIP and/or Medicaid, and that met federally established, state-specific Medicaid enrollment growth targets qualified for performance bonuses that were quite substantial: over $1 billion was awarded to states between 2009 and 2013.12,13 Administrators from 29 states interviewed in the CHIP administrator survey—including states that did not receive a bonus—reported that the CHIPRA performance bonuses were an effective incentive spurring them to adopt additional simplification strategies to facilitate enrollment and renewal. Seven of the 10 case study states (Alabama, Louisiana, Michigan, New York, Ohio, Virginia, and Utah) qualified for CHIPRA performance bonuses between fiscal years 2009 and 2013, totaling over $243 million. Six of these states adopted at least one of the enrollment or renewal strategies after the passage of CHIPRA. However, states like California that have been leaders in simplifying enrollment and renewal did not achieve the Medicaid enrollment targets needed to qualify for the bonus because they had already captured a sizable proportion of those who might qualify.

The case studies identified numerous creative, multi-pronged strategies to streamline enrollment and renewal procedures and achieve high participation rates among eligible children (Table 3). All but one of the study states offered online applications for CHIP at the time of the site visits in 2012, and most had designed more integrated data systems capable of linking across public benefits programs and verifying applicants’ income, employment, health insurance status, and citizenship. Four of the case study states added Express Lane Eligibility to their toolbox of simplification strategies, a new option permitted by CHIPRA that allows states to use the findings of other need-based programs to establish or renew eligibility for children in Medicaid (eg, Alabama and Louisiana), CHIP (eg, Utah), or both (eg, New York).14 A majority of study states also used a variety of community-based application-assistance models that bolstered traditional outreach by enabling staff of local agencies, providers, and health plans to provide application assistance to families with uninsured children. Key informants described these staff assistants, who often reflect the ethnicities of the communities in which they worked, as “trusted” and “culturally competent” and therefore particularly successful in helping “hard-to-reach” populations to access coverage. Families participating in the study’s focus groups widely praised the ease with which they were able to apply for coverage for their children; they particularly noted how valuable the help of application assistants was in enrolling. States also focused considerable attention on simplifying renewal processes, recognizing that high
retention rates are crucial to reducing churn and maintaining gains in reducing the ranks of uninsured children. In the study’s focus groups, parents described how easy most CHIP renewal processes were for them.

**Substitution of CHIP for Private Coverage**

Administrators’ concerns about substitution of CHIP for private group coverage have diminished over time. During the initial development of CHIP, policymakers worried that the new program would encourage families to substitute government-sponsored health insurance for existing employer-sponsored coverage for their children. Many were also concerned that employers might stop offering dependent health coverage if their employees’ children became eligible for CHIP. In response to these concerns, the CHIP statute mandated that all states have “reasonable procedures” in place to protect against such substitution. Most states devised a range of strategies to prevent or discourage substitution, but they primarily relied on waiting periods during which children must be uninsured before they can enroll in CHIP.

During the study period, rates of employer-sponsored coverage of children continued to steadily decline, a trend attributed to the weakening economy. Still, officials in the 10 case study states did not express concerns that the substitution of CHIP for private coverage was a major concern or a problem contributing to this trend. Generally, they expressed the belief that provisions to prevent substitution had effectively deterred families from dropping private coverage. Nine of 10 study states imposed waiting periods (ranging from 3 to 12 months) and maintained a range of other provisions designed to discourage substitution. ACA regulations stipulate that states with separate CHIP programs cannot impose waiting periods longer than 3 months starting in 2014; this rule led numerous states to change their waiting period policies after the case studies were completed. All of the case study states have now done so, with Virginia eliminating its waiting period as of July 1, 2014. During the study period, only Louisiana and New York increased the length of waiting periods, doing so after they significantly expanded eligibility to higher-income families (with incomes up to 250% of FPL in Louisiana and 400% of FPL in New York). More often, states relaxed their antisubstitution provisions by either decreasing the length of a waiting period (as in Florida) or adding more exceptions to the waiting period for families in need of coverage for their children (as in New York, which permits an exception for children in households with incomes between 250% and 400% of the FPL when the cost of dependent coverage is more than 5% of household income).

**Outreach**

In recent years, states cut CHIP outreach budgets and relied more heavily on grassroots and community-based outreach efforts. Aggressive outreach was a hallmark of CHIP programs in the late 1990s and early 2000s, when states launched strategic efforts to market CHIP to eligible populations using both broad, statewide marketing
campaigns to create a strong brand identity for their programs, and more targeted community-based efforts to attract hard-to-reach families.\textsuperscript{4,16} However, between 2006 and 2012, the 10 study states modified their CHIP outreach efforts in response to state budget constraints and as the program became more publicly well known by cutting broad marketing campaigns and relying more on less expensive community-based efforts. For example, marketing budgets shrunk or were eliminated in 7 of 10 study states, while robust community-based outreach efforts persisted in 9 of the 10 states. Many key informants acknowledged that the shift to community-based outreach was appropriate given that states had succeeded in enrolling most eligible children; the remaining eligible but unenrolled children were likely members of harder-to-reach populations who were more apt to be identified by trusted community allies. In New York, health plans have also played a major role in CHIP outreach and marketing, filling some of the void left as the state reduced its outreach budget.

CHIPRA infused new federal funding to bolster outreach through the creation of new grants designed to fund activities that support raising public awareness and improving enrollment and renewal rates. Nationally, CHIPRA outreach grant funding amounts ranged from $70,000 to $2.5 million per awardee. Program administrators in 43 states (of 47 responding to the question in our survey) reported that organizations in their states—typically state and local governments and/or community-based and nonprofit organizations—received CHIPRA outreach grants. In the case study states, officials reported that CHIPRA outreach grants had been particularly helpful in bolstering otherwise underfunded outreach efforts and played a significant role in sustaining community-based groups involved in outreach.

Regardless of whether or not they received a grant, administrators from 30 states that participated in the survey of CHIP administrators thought that CHIPRA outreach grants should be continued past September 2013. Common reasons given by officials for continuing the grants included the lack of other sources for outreach funding and the ability to use grant money to fund grassroots campaigns and other efforts to target harder-to-reach populations within their states.\textsuperscript{17}

### Benefits

CHIPRA required states to cover comprehensive dental benefits and provide mental health parity under CHIP, and many states modified their programs as a result. Although the CHIP statute allows states with separate CHIP programs to cover fewer benefits than those required under Medicaid, it also required separate programs to meet certain minimum benchmark standards to ensure that children had access to adequate services. Since the early years of the program, however, most states with separate programs went beyond benchmark minimums to add broad coverage of services, including dental and mental health benefits, seeking to closely align coverage between separate CHIP programs and Medicaid.\textsuperscript{16,18} Key informants interviewed for this study and parents participating in the study’s focus groups consistently praised the generosity of the CHIP benefit packages, although a few deficiencies were noted, such as the lack of nonemergency transportation and Early Periodic Screening, Diagnosis, and Treatment protections.\textsuperscript{19}

CHIPRA introduced 2 new mandatory benefits: comprehensive dental services and mental health parity. In the survey of CHIP administrators, the majority of states did not report having to make any changes to dental benefits to comply with CHIPRA. Of the dozen states that did make changes, most reported that they removed limits on preexisting dental benefits or increased their coverage of particular dental benefits; the addition of medically necessary orthodontia was the most frequently reported benefit increase (by administrators from 7 states). Meanwhile, administrators from 28 states reported that they did not need to make any changes to conform to CHIPRA’s mental health parity provisions. Among the 19 states that made some changes in response to CHIPRA, 14 reduced or eliminated limits previously imposed on mental health and substance abuse services, and 2 implemented a limit on physical health services to comply with parity rules.

Notably, states continued to offer generous benefits in CHIP despite increased budget pressures during the recent

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**Table 3. CHIP Enrollment and Renewal Strategies by State, 2012**

<table>
<thead>
<tr>
<th>State</th>
<th>Mail-In Enrollment and Renewal</th>
<th>Online Enrollment and Renewal</th>
<th>Community-Based Application Assistance</th>
<th>Active or Administrative Renewal</th>
<th>Preprinted Renewal Form</th>
<th>Self-Declaration of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>California</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Florida</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Louisiana</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Administrative</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Michigan</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New York</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ohio</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Texas</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Utah</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Virginia</td>
<td>Enrollment Only</td>
<td>X</td>
<td>X</td>
<td>Active</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

CHIP indicates Children’s Health Insurance Program; and CHIPRA, Children’s Health Insurance Program Reauthorization Act of 2009.

Note: Active renewal means enrollees have to take steps to renew their coverage. Passive renewal means families may maintain their coverage without providing another form or more income documentation as long as no family member’s income has changed.

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.
recession. In light of Maintenance of Effort restrictions, benefits were one of the few program areas where policy makers had the ability to enact cuts. Thus, CHIPRA may have had a protective effect on these benefits because without the CHIPRA benefit mandates, dental and mental health might have been cut in response to state budget constraints.

**SERVICE DELIVERY**

CHIP programs continued to utilize managed care service delivery networks, viewing the model as one that offers good access to care. Earlier CHIP evaluations found mandatory enrollment in risk-based managed care plans to be the dominant form of service delivery for separate CHIP programs, more so than for Medicaid. This trend continued during the current study period (although Medicaid programs have also generally increased their reliance on risk-based managed care over the last decade). Among the 10 study states, 7 carved out both behavioral health and dental care from managed care programs and delivered these services through other arrangements, while 2 states carved out either behavioral health (Utah) or dental care (Ohio). Only one state (New York) required health plans to cover the full scope of care, including dental and behavioral services. CHIP program officials reported various reasons for choosing risk-based managed care, but primarily they viewed the delivery model as one that helps ensure good access to care through provider networks that resemble those of commercial insurance. Among the 10 study states, only Alabama used discounted fee-for-service reimbursement with a single insurer—Blue Cross/Blue Shield of Alabama—for its separate CHIP program. CHIPRA required that beneficiaries be offered a choice of at least 2 health plans when risk-based managed care is mandatory, a requirement that also exists for Medicaid. This requirement necessitated changes in Florida and New York, which had previously contracted with single plans in certain rural areas.

**ACCESS TO CARE**

Parents participating in our focus groups and key informants expressed broad satisfaction with access to care in separate CHIP programs. Access to primary care was viewed as particularly strong because of high levels of participation by pediatricians. These positive comments about access were less frequently made by key informants and parents in reference to Medicaid expansion programs, however. Provider reimbursement rates were reportedly lower in Medicaid expansions than in separate programs, and key informants suggested that as a consequence, provider participation and access to care were generally more limited, particularly in the case of dental care.

**COST SHARING**

Cost sharing remained a prominent feature of CHIP programs, in part because CHIP was intended to mirror private coverage. Federal law permits separate CHIP programs to impose cost sharing on families enrolled in CHIP—including premiums, copayments, deductibles, and coinsurance—as long as total out-of-pocket costs remain under 5% of a family’s income. A previous evaluation focused on CHIP’s early years found that separate CHIP programs established premiums and copayments at levels that both administrators and families viewed as fair and affordable; at that time, many key informants believed that cost sharing had a beneficial effect in making CHIP feel more like private insurance, instilling a sense of pride and responsibility in families that contributed, however nominally, to the cost of their children’s coverage. Most key informants interviewed for this evaluation continued to view cost sharing as a positive component of CHIP. Most parents participating in the study’s focus groups also spoke of CHIP cost sharing as both fair and affordable, and as much less expensive than private insurance. CHIPRA’s requirement that states allow a 30-day grace period before disenrolling children for nonpayment of premiums was cited as an important new protection for families.

When the case studies were conducted in 2012, all the study states had some form of cost sharing in their CHIP programs except Ohio (the sole study state to operate only a Medicaid expansion program). Cost sharing policies varied across the study states, and included annual enrollment fees (in 2 states), monthly or quarterly premiums (6 states), copayments (7 states), and deductibles and coinsurance (2 states). Given weak economies during the study period, states increasingly turned to cost sharing as a lever to address budget pressures by raising premiums (which can serve to discourage enrollment) as well as copayments (which can discourage inappropriate utilization). For example, 6 of 10 study states increased premiums between 2006 and 2010. Of the 9 states with cost sharing, 7 required copayments (Table 4), which varied by income and type of service. Copayments for medical office visits ranged from $2 in Virginia for families between 101% and 150% of FPL, to $25 in Utah and Texas for families with higher incomes. Prescription drug copays also varied; in Texas, families with incomes up to 150% of FPL receive free generic prescriptions, while families in California in the same income bracket pay $10 per generic prescription. Emergency department copayments were generally the most expensive across the states, particularly for nonemergency use: families between 151% and 200% of FPL pay between $25 in Virginia to $300 in Utah for a visit to the emergency room.

**DISCUSSION**

Case studies in 10 states and a national survey of CHIP program administrators revealed that CHIP and Medicaid programs continued to evolve, innovate, and adapt to changing circumstances while providing comprehensive health coverage to a growing share of the nation’s children. CHIPRA provided much-needed federal financial stability to the program, created incentives for states to simplify and streamline enrollment and renewal,
### Table 4. Copayment and Deductible Amounts for Selected Services, Case Study States, 2012

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>% FPL</th>
<th>Medical Office Visits Amount (Not Preventive)</th>
<th>Generic Prescription Drug</th>
<th>Brand Prescription Drug</th>
<th>ED</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>ALL Kids</td>
<td>101–150%</td>
<td>$3</td>
<td>$1</td>
<td>$5</td>
<td>$6</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>151–300%</td>
<td>$13</td>
<td>$5</td>
<td>$25</td>
<td>$60</td>
<td>NA</td>
</tr>
<tr>
<td>California</td>
<td>Healthy Families</td>
<td>All eligible</td>
<td>$10</td>
<td>$10</td>
<td>$15</td>
<td>$15</td>
<td>NA</td>
</tr>
<tr>
<td>Florida</td>
<td>Healthy Kids</td>
<td>All eligible</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
<td>$10 (if inappropriate)</td>
<td>NA</td>
</tr>
<tr>
<td>Louisiana</td>
<td>LaCHIP Affordable Plan</td>
<td>All eligible</td>
<td>Enrollees pay 10% of the fee-for-service rate in network and 30% out of network</td>
<td>Enrollees pay 50% of costs or a maximum of $50 for a 30 day supply</td>
<td>Enrollees pay 50% of costs or a maximum of $50 for a 30 day supply</td>
<td>$150 (waived if admitted)</td>
<td>$200 for mental health/ substance abuse services</td>
</tr>
<tr>
<td>Texas</td>
<td>CHIP</td>
<td>0–100%</td>
<td>$3</td>
<td>$0 generic</td>
<td>$3</td>
<td>$3 nonemergency</td>
<td>NA</td>
</tr>
<tr>
<td>Texas</td>
<td>CHIP</td>
<td>101–150%</td>
<td>$5</td>
<td>$0 generic</td>
<td>$5</td>
<td>$5 nonemergency</td>
<td>NA</td>
</tr>
<tr>
<td>Texas</td>
<td>CHIP</td>
<td>151–185%</td>
<td>$20</td>
<td>$10 generic</td>
<td>$35</td>
<td>$75 nonemergency</td>
<td>NA</td>
</tr>
<tr>
<td>Texas</td>
<td>CHIP</td>
<td>186–200%</td>
<td>$25</td>
<td>$10 generic</td>
<td>$35</td>
<td>$75 nonemergency</td>
<td>NA</td>
</tr>
<tr>
<td>Utah</td>
<td>CHIP Plan A</td>
<td>&lt;100%</td>
<td>$3</td>
<td>$1 generic</td>
<td>$1</td>
<td>$3</td>
<td>None</td>
</tr>
<tr>
<td>Utah</td>
<td>CHIP Plan B</td>
<td>101–150%</td>
<td>$5</td>
<td>$5 generic</td>
<td>5% of approved amount</td>
<td>$5 $10 nonemergency</td>
<td>$40/family</td>
</tr>
<tr>
<td>Utah</td>
<td>CHIP Plan C</td>
<td>151–200%</td>
<td>$25</td>
<td>$15 generic</td>
<td>25% of approved amount</td>
<td>$300 after deductible</td>
<td>$500/child; $1500/family max</td>
</tr>
<tr>
<td>Virginia</td>
<td>FAMIS</td>
<td>134–150%; ages 6–18</td>
<td>$2</td>
<td>$2</td>
<td>$2</td>
<td>$2 (10 nonemergency)</td>
<td>NA</td>
</tr>
<tr>
<td>Virginia</td>
<td>FAMIS</td>
<td>151–200%; ages 6–18</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
<td>$5 ($25 nonemergency)</td>
<td>NA</td>
</tr>
</tbody>
</table>

FPL indicates federal poverty level; ED, emergency department; NA, not applicable; CHIP, Children’s Health Insurance Program; CHIPRA, Children’s Health Insurance Program Reauthorization Act of 2009; and FAMIS, Virginia’s health insurance program for children.

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.
provided significant new support for outreach, broadened coverage of dental and mental health services, and promoted new child health quality improvement initiatives, among other provisions. In response, states expanded or maintained eligibility during the worst economic recession since the Great Depression, continued to make it easier for families to apply for and maintain coverage for their children, fine-tuned benefit packages, set cost sharing at levels that most deemed to be fair and affordable, delivered services through managed care provider networks that extended good access to care, and intensified efforts to measure and report on child health quality. (Of course, while reviewing these findings, readers should consider the limitations inherent in qualitative case study methods related to validity and generalizability.)

Passage of the ACA in 2010, just 1 year after CHIPRA, changed the contextual environment for CHIP programs significantly. Provisions in the law authorized CHIP through 2019 but extended funding only through 2015—leaving states once again in a position of uncertainty regarding future funding for CHIP. At the same time, however, the law raised the federal matching rate by 23% from 2016 through 2019, providing some hope that generous federal funding might remain available. Another ACA provision that required states to transition CHIP enrollees in families with income below 133% FPL into Medicaid has affected 21 states and resulted in an estimated 562,000 children being moved to Medicaid as of July 2014. Looking forward, many stakeholders have actively debated what role, if any, CHIP should play in a reformed, post-ACA health care system. As of May 2014, two states—California and New Hampshire—have merged their separate CHIP programs into Medicaid, while Arizona has dismantled its program entirely. But an emerging consensus from policy researchers, advocates, and policy makers suggests that while the ACA has the potential for establishing a system that can accommodate the needs of all children, there are many complex transitional issues—related to affordability of coverage through health insurance marketplaces, adequacy of benefits, and sufficiency of provider networks—that need to be addressed before eliminating CHIP. The Medicaid and CHIP Payment and Access Commission and others have recommended the reauthorization of CHIP for an additional 2 years while transition issues are addressed.11

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REFERENCES


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