

Guide to Equity in the Children’s Health Insurance Program

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ABOUT THIS GUIDE

This guide equips advocates and other changemakers with key information about the Children’s Health Insurance Program, including an overview of [the system’s inequities](#), and highlights the policy and accountability levers that can [advance equity](#).

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit urbn.is/4054rNQ.

The other topics [covered include the following](#):

- behavioral health care system
- health care for the uninsured
- Indian Health Service
- Marketplace insurance
- Medicaid
- Medicare
- Medicaid-Medicare (dual eligible)
- pharmacy services
- Veterans’ Affairs

OVERVIEW

The Children’s Health Insurance Program (CHIP) was created in 1997 to offer affordable coverage for uninsured children under 19 years of age whose family incomes are too high to qualify for Medicaid but who do not have access to affordable private coverage. CHIP, like Medicaid, is administered by states and funded jointly by the state and federal governments. Though CHIP is an optional program, all states currently participate. The median US income eligibility level for CHIP is 255 percent of the federal poverty level, which translates to an annual income of \$76,500 for a family of four in 2023. The implementation of CHIP prompted greater efforts to reach and enroll eligible children and led to efforts to simplify enrollment in both Medicaid and CHIP. Besides reductions in children’s uninsurance, children’s coverage by CHIP and Medicaid has been associated with improved access to health care, reductions in family financial burdens, and improved health and well-being for children and their families.

States can offer CHIP coverage as part of their Medicaid programs, under separate CHIP programs, or a combination of both. Currently, 34 states have separate CHIP programs for children. CHIP-eligible children in the remaining 16 states are enrolled in Medicaid. Fourteen states impose a 90-day waiting period during which a child must be uninsured to qualify for CHIP. While CHIP benefits vary by state, all states cover comprehensive services such as routine well-baby and well-child visits, immunizations, dental and vision care, prescriptions, and hospital and emergency department services.

For More Information

- **About CHIP:** “[The Children’s Health Insurance Program](#),” Washington, DC: Georgetown Center for Children and Families, February 6, 2017; and Cathy Hope, “[CHIP: Serving America’s Children for 25 Years](#),” Washington, DC: Georgetown Center for Children and Families, July 15, 2022.
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- **Managed care:** Andy Schneider, Hannah Klukoff, and Maclaine Lehan, 2023, “[An Introduction to Managed Care in CHIP](#),” Washington, DC: Georgetown Center for Children and Families.
 - **Waiting periods:** “[Waiting Periods in CHIP](#),” Medicaid.gov, accessed December 12, 2023.
 - **Benefits:** “[Benefits](#),” Medicaid.gov, accessed December 12, 2023.
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POPULATION

As of July 2023, over 7 million individuals were enrolled in CHIP nationwide. This may include some adults in 20 states that offer CHIP coverage to pregnant women who otherwise may not be eligible for pregnancy-related Medicaid coverage. In May 2023, 22 states offered CHIP coverage to lawfully residing immigrant children and six additional states covered both lawfully residing immigrant children and pregnant women without the federally required five-year waiting period.

Little information is available on the demographic and socioeconomic characteristics specifically for CHIP enrollees because states often report combined data on child enrollees across both Medicaid and CHIP programs. According to data from fiscal year 2020, over 44 million children (more than half of the nation’s children) were enrolled in Medicaid and CHIP, with the majority covered by Medicaid. Combined, Medicaid and CHIP disproportionately serve children of color. In 2022, nearly two-thirds of Medicaid/CHIP enrollees between the ages of 0 to 18 identified as nonwhite. About one in four (38.5 percent) children enrolled in Medicaid or CHIP identified as Hispanic, 19 percent identified as Black, 3.1 percent identified as Asian, and 5.6 percent identified as other single or multiple races. Almost half of all US children with special health care needs are covered by Medicaid/CHIP.

For More Information

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 - **Coverage for pregnant women:** Maggie Clark, 2020, “[Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options](#),” Washington, DC: Georgetown Center for Children and Families.
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 - **Demographic data:** “[MACStats: Medicaid and CHIP Data Book](#),” MACPAC, December 2022.
 - **Children with special health care needs:** Elizabeth Williams and MaryBeth Musumeci, 2021, “[Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access](#),” San Fransisco: KFF
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PROVIDERS AND SERVICE DELIVERY

Similar to Medicaid, CHIP programs can contract with providers directly on a fee-for-service basis or contract with managed care plans responsible for assembling provider networks to deliver services to CHIP enrollees. Some states have separate CHIP-managed care plans, while others may combine Medicaid and CHIP contracts. Many of the same providers who care for Medicaid patients care for CHIP beneficiaries, including community health centers, pediatric primary care and specialist practices, and children’s hospitals.

For More Information

- **Managed care:** Andy Schneider, Hannah Klukoff, and Maclaine Lehan, 2023, “[An Introduction to Managed Care in CHIP](#),” Washington, DC: Georgetown Center for Children and Families.

FINANCING

Unlike Medicaid funding, which has no limits on federal matching funds, CHIP is funded as a block grant, meaning that federal funding is capped at a certain amount. Federal CHIP allotments are provided to states annually on a matching basis, but CHIP matching rates are higher than matching rates states receive for Medicaid. Also, unlike Medicaid, CHIP funding has to be periodically reauthorized by Congress. The current funding period was approved through September 30, 2029.

Some states require CHIP enrollees to pay monthly premiums or cost sharing, such as paying deductibles or copays. But some services, such as immunizations or well-child visits, are exempted from cost-sharing requirements, and overall premium or cost-sharing requirements cannot exceed 5 percent of annual family income.

How CHIP Coverage Helps Families

A family is forced to live on one income because one of the parents has to provide full-time care for a two-year-old with complex medical needs that require expensive medical equipment, medications, and physical therapy. Thanks to a state CHIP program, the family pays as little as \$50 a month to access all the services and medications their toddler needs. Without this option, the family would likely pay hundreds of dollars more for private health insurance premiums, deductibles, and copays.

— From Dylan Scott, “[Why CHIP Is So Essential for American Kids, Explained by One Family’s Story](#),” Vox, January 12, 2018.

For More Information

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- **Key issues in children’s health coverage:** Samantha Artiga and Petry Ubri, 2017, “[Key Issues in Children’s Health Coverage](#),” San Francisco: KFF.
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- **Medicaid and CHIP reauthorization:** Edwin Park, Anne Dwyer, Tricia Brooks, Maggie Clark, and Joan Alker, 2023, “[Consolidated Appropriations Act, 2023: Medicaid and CHIP Provision Explained](#),” Washington, DC: Georgetown Center for Children and Families.

BARRIERS TO ACCESSING AND MAINTAINING CHIP COVERAGE

Families can encounter many barriers to enrolling and maintaining uninterrupted CHIP coverage for their eligible children, including the following:

Administrative Challenges

Difficulties with filling out complicated application forms, providing required documentation, responding to requests to verify information, or obtaining program information in languages other than English may contribute to many children not accessing CHIP or losing coverage during the periodic eligibility renewals.

Changes in Family Circumstances

Life transitions such as income fluctuations because of unstable or seasonal parental employment or divorce, birth of a new child, or moving to a different county or state contribute to challenges maintaining CHIP enrollment and often result in children going on and off CHIP and experiencing temporary uninsurance.

State Income Limits

Qualification criteria for CHIP vary by state and by age, contributing to complexity for families and inequities in access to CHIP. Furthermore, Medicaid income limits for parents and caregivers are generally much lower than for children, particularly in states that have not expanded Medicaid. Children are more likely to enroll and maintain coverage if their parents or caregivers also have health insurance.

Immigration Requirements

Twenty-two states currently impose a 5-year waiting period for lawfully residing immigrant children to qualify for CHIP, leaving thousands of immigrant children without access to health insurance. Furthermore, mixed-status immigrant families experience challenges maintaining coverage for their children even if they are eligible for public benefits because of fear of immigration enforcement.

Monthly Premium Requirements

While CHIP premiums are typically small, a requirement to pay a monthly premium can pose a barrier for many families to obtain and maintain CHIP coverage.

Temporary and Capped Federal Funding

Because CHIP has to be periodically reauthorized by Congress, there is uncertainty for states and families on whether the program will continue. Additionally, once the state reaches its annual capped funding allotment, eligible children may be denied CHIP coverage.

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BARRIERS TO ACCESSING HEALTH CARE SERVICES IN CHIP

Enrollment in CHIP does not necessarily mean children can easily access health care services. Key access barriers include:

Waiting Periods

To qualify for CHIP in some states, children must be uninsured for some time, which can cause disruptions in access to health care.

Cost-Sharing Requirements

Requiring families to pay for health care, such as deductibles and copays, even in small amounts, can cause some families to delay or avoid accessing care.

Limited Covered Benefits

Covered benefits vary by state, and some services children need may be unavailable or limited. An important distinction between Medicaid and CHIP benefits is that separate CHIP programs are not required to include the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which is designed to ensure that children receive developmentally appropriate prevention and treatment for all medically necessary physical, behavioral, and dental needs.

Difficult Access to Specialty Care

While children covered by Medicaid and CHIP have about the same access to routine primary care as children covered by private insurance, they may experience difficulties accessing some care, particularly specialty services, including mental health, substance use, and home and community-based services.

For More Information

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 - **CHIP eligibility and covered benefits by state:** [“Find Coverage for Your Family,”](#) InsureKidsNow.gov, accessed December 26, 2023.
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DISPARITIES

Racism negatively affects the health and well-being of children and youth, including by reducing access to health care and other resources that affect living conditions and are critical for healthy physical and emotional childhood development. While public health insurance programs such as Medicaid and CHIP reduced uninsurance and improved access to basic health care services for children overall, there are ongoing and persistent racial and ethnic inequities in health care access, quality, and health outcomes of children and youth in the US. Some examples of these disparities include:

- Hispanic/Latinx and American Indian/Alaska Native children are two to three times more likely to be uninsured than white children.
- Babies born to African American/Black mothers are more than twice as likely to die within the first year of life than babies born to white mothers.
- African American/Black and Hispanic/Latinx children are less likely to have a usual source of health care when sick or receive recommended immunizations than white children and more likely to report food insecurity and adverse childhood experiences than white children.
- African American/Black and Hispanic/Latinx children are more likely to develop asthma and more likely to experience poorer care and worse health outcomes, including death, related to asthma than white children.
- African American/Black and American Indian/Alaska Native children are disproportionately affected by separation from family and foster care placement, where they experience barriers in accessing comprehensive health care services.
- Children and youth of color and LGBTQIA children and youth have higher rates of mental health and substance use problems and worse access to behavioral health services than white and straight youth. Youth of color are also more likely than white youth to face harsh school discipline, suspension, and even jail time related to behavioral health issues.

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OVERSIGHT AND ACCOUNTABILITY

The federal and state governments are responsible for CHIP.

Federal

- **US Congress** oversees the CHIP program and can use legislation to alter the program and regulate funding levels.
- **Centers for Medicaid and CHIP Services (CMCS):** CMCS sits within the Centers for Medicare and Medicaid Services under the US Department of Health and Human Services (HHS). CMCS oversees CHIP policy development and operations, ensuring states comply with federal laws and regulations pertaining to CHIP.
- **Government Accountability Office (GAO):** Dubbed “the investigative arm of Congress” and “the congressional watchdog,” GAO aids Congress in improving the performance of federal programs, including CHIP, by conducting independent research and providing recommendations.
- **The Medicaid and CHIP Payment and Access Commission (MACPAC):** MACPAC is a nonpartisan federal partner that analyzes Medicaid and CHIP policies and data, providing updates and recommendations to the federal government on improving the programs.

State

- State governments administer CHIP and can decide many aspects of the program, including eligibility requirements (e.g., waiting periods, income limits), covered benefits, cost-sharing requirements, delivery models (e.g., managed care), and provider reimbursement rates.

Individuals

- **Appeals:** Similar to Medicaid, states must allow CHIP enrollees to appeal enrollment and coverage decisions. Appeals procedures vary by state and can be confusing and complex. State and local legal aid organizations offer free or low-cost assistance for health insurance appeals.
- **Advocacy:** Many national and state organizations advocate for policies and resources to support healthy children and youth, including the American Academy of Pediatrics, Annie E. Casey Foundation, Children's Defense Fund, Families USA, Voices for America's Children, Youth Law Center, and many others.

For More Information

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POLICIES AND ACTIONS THAT COULD LESSEN BARRIERS AND DISPARITIES

Unimpeded and consistent access to high-quality, culturally and developmentally effective comprehensive health care services in childhood and adolescence forms a foundation for good health and improves individuals' and society's educational, social, and economic outcomes. CHIP and Medicaid programs play a critical role in children's

health and could be strengthened by eliminating barriers and reducing inequities, including the following federal and state actions:

Permanently funding and increasing investments in CHIP by:

- making CHIP a permanent entitlement program similar to Medicaid (this could include permanently adopting key provisions related to outreach and enrollment of eligible children and prohibiting states from capping enrollment and imposing premiums or cost-sharing requirements); and
- increasing federal matching rates for both CHIP and Medicaid child enrollees to ensure equitable access to care regardless of family income or geography.

Expanding eligibility and simplifying enrollment by:

- developing and requiring a federal minimum income eligibility standard for all children at 400 percent of the federal poverty level;
- expanding eligibility for all immigrant children regardless of immigrant status and authorizing the use of federal funds to cover immigrant children who are not lawfully present;
- expanding Medicaid/CHIP continuous coverage requirement for children from currently required 12-month continuous coverage to a minimum of six years of children between 0 to 6 (this will provide children with consistent coverage in early childhood and could also help reduce administrative costs for the state from not having to process periodic renewals); and
- enhancing enrollment outreach and assistance by funding culturally and linguistically effective communication strategies and highly trained enrollment navigators to help families with children obtain and maintain health insurance coverage.

Enhancing benefits and ensuring equitable access to care by:

- developing national standards for a universal children’s benefits package that is aligned across states and Medicaid and CHIP, including prescription medications and therapies, and requiring EPSDT as a standard benefit in CHIP;
- ensuring provider payment rates are adequately reimbursing the cost of care and supporting robust, diverse, culturally and linguistically effective provider networks to meet the physical, behavioral, and dental health care needs of all enrolled children (this could be achieved by setting minimum federal rate schedule for comprehensive pediatric health care services that is at least equal to Medicare rates and requiring that states periodically update Medicaid/CHIP payment rates for community health centers);
- increasing access to racially, ethnically, and culturally diverse pediatric health care workforce;
- ensuring that states are held accountable for collecting, reporting, addressing underperformance on pediatric health care quality measures and ensuring that states report on pediatric measures by race, ethnicity, and other characteristics and are required to address identified inequities; and
- requiring that CHIP enrollees and/or their parents/caregivers are represented on Medical Care Advisory Committees and Beneficiary Advisory Groups and encourage states to meaningfully engage beneficiaries in policymaking.

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GLOSSARY

Accountability is an assurance that an individual or organization is evaluated on its performance or behavior related to something for which it is responsible.

Adverse Childhood Experiences are traumatic events that children experience that can have long-lasting effects on their healthy development and well-being, including neglect, abuse, or parental substance use problems and incarceration.

The **Affordable Care Act** (sometimes known as ACA, PPACA, or “Obamacare”) is a comprehensive health care reform law enacted in March 2010. The primary goals of the ACA are to make health insurance more affordable by providing financial assistance (also known as subsidies) to people to purchase health insurance and expand the Medicaid program to cover more people with low incomes.

An **appeal** is a request to a health insurer to review a decision that denies a benefit or payment for health care services or medications.

The **federal poverty level** is a measure of income issued every year by HHS. Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance and Medicaid and CHIP coverage.

Federal subsidies are cash assistance available to purchase health coverage at reduced or no cost for people with incomes below certain levels. Marketplace insurance plans with premium tax credits are sometimes known as subsidized coverage.

Health disparities are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

LGBTQIA+ is an abbreviation for lesbian, gay, bisexual, transgender, questioning, intersex, asexual, and others. These terms are used to describe an individual’s sexual orientation or gender identity.

Marketplace is a shopping and enrollment service for medical insurance created by the ACA in 2010. In some states, the federal government runs the Marketplace (sometimes called the "exchange") for individuals and families.

Quality measures are tools that help assess or quantify health care processes, outcomes, patient experiences, and organizational structures and/or systems associated with providing high-quality health care.

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