RESEARCH REPORT

# Estimates of Coverage Changes for Children Enrolled in Separate Children's Health Insurance Programs in the Absence of Additional Federal CHIP Funding—Key Findings and Methodology

## Report to the Medicaid and CHIP Payment and Access Commission

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The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

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# Introduction

Federal funding for the Children's Health Insurance Program (CHIP) extends through September 30, 2015. Under current law, even without additional federal funds for CHIP, states would be required to cover children enrolled in Medicaid expansion CHIP programs until 2019 because of maintenance of effort provisions of the Affordable Care Act (ACA). States would receive their regular Medicaid match rate rather than the enhanced CHIP match rate for these children. In contrast, with no additional federal funding for CHIP, states would not be required to continue their separate CHIP programs. Children losing eligibility for separate CHIP programs would no longer have access to public coverage and would have to seek health insurance coverage through other mechanisms—either through marketplace tax credits or through their parent's employer. Although some children currently enrolled in separate CHIP programs would be eligible to for tax credits in the marketplace, others would be barred from this type of coverage because of the firewall that limits eligibility for marketplace tax credits to families where the cost of a single policy is less than 9.5 percent of family income even in circumstances where the cost of family coverage is much higher (i.e., the "family affordability glitch") (Selden et al. forthcoming). Currently, the CHIP program protects many children from this problem, but in its absence some children will be left with no affordable options for coverage.

The Medicaid and CHIP Payment and Access Commission (MACPAC) commissioned the Urban Institute to update its model to consider the alternative health insurance options that would be available to children enrolled in separate CHIP programs were separate CHIP coverage to be discontinued. The analysis prepared for MACPAC was based on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) that relies on the American Community Survey (ACS). The HIPSM-ACS was updated for this analysis using new estimates from the Medical Expenditure Survey–Insurance Component (MEPS-IC). Chapter 1, "Sources of Coverage for Children if CHIP Funding Is Exhausted," of the March 2015 MACPAC report to Congress presents key findings from our simulation modeling (MACPAC 2015). This report provides additional detail on the methodology used to develop the estimates and includes supplemental tables that support the estimates included in chapter 1 of the March 2015 MACPAC report.

# Methodology

We use the HIPSM-ACS to model what health insurance options would be available to children enrolled in separate CHIP programs and what would happen to coverage for these children were separate CHIP coverage to be discontinued. The HIPSM-ACS builds on the original version of the HIPSM that used the Current Population Survey (CPS).[1] In addition to ACS data, the HIPSM-ACS incorporates information from the Medical Expenditure Panel Survey (MEPS), its Household Component (MEPS-HC) and Insurance Component (MEPS-IC), and data from the CPS. We apply the microsimulation approach developed in the HIPSM-CPS to model decisions of individuals and firms in response to policy changes, such as Medicaid expansions, new health insurance options, premium tax credits for the purchase of health insurance, and insurance market reforms, with data from the ACS.[2]

To conduct policy simulations using the HIPSIM, we established a baseline scenario through the following steps:

- We use multiple years of the ACS and the MEPS-HC.
- We estimate health care expenditures for each individual in the data set in each possible coverage status, including out-of-pocket spending, spending covered by insurance, Medicaid/CHIP spending, and uncompensated care for the uninsured.
- We impute offers of employer-sponsored insurance, immigration status, and eligibility for Medicaid, CHIP, and marketplace tax credits.
- We group together workers with the same employment characteristics, such as firm size and industry, into simulated firms.

The general flow of a HIPSM simulation is as follows:

- The model constructs available insurance packages and computes premiums based on current enrollment.
- Simulated employers choose whether or not to offer coverage and whether to offer coverage inside or outside the marketplaces (if applicable).
- Individuals and families choose from among the coverage options available to them: employer-sponsored insurance, non-group insurance, health insurance marketplaces (if applicable), Medicaid/CHIP, or uninsured.

- Employer, individual, and family decisions are calibrated so that overall behavior is consistent with a number of results from the health economics literature.
- Premiums are updated based on the new enrollment decisions. The cycle is repeated until equilibrium—in other words, until there is little change between successive iterations of the model.

The following sections describe the imputation of dependent-coverage options and contribution rates, the data underlying the HIPSM, how eligibility under the ACA is modeled, how projections of health insurance coverage under the ACA are developed, the policy simulations conducted for this project, and the limitations to our approach.

# Imputation of Dependent-Coverage Options and Contribution Rates

As part of our work for MACPAC, the HIPSM-ACS was enhanced to better model issues around the "family affordability glitch." Employer coverage is the leading source of coverage for children, and the availability and affordability of employer-sponsored dependent coverage is crucial to many policy questions related to children's coverage. We collaborated with the Agency for Healthcare Research and Quality (AHRQ) to obtain details on dependent coverage and premiums for different types of firms from the 2013 MEPS-IC that were not previously available. This led to two main advances over our previous modeling. First, we were able to impute the types of dependent coverage offered by firms: none, single plus one, family, or both single plus one and family. Second, we were able to use information about the joint distribution of required worker contributions for single, employee-plus-one, and family coverage. Previously published results showed only the single distributions of these contributions. This information allowed us to model, for example, the extent to which firms require small contributions to single coverage but large contributions to dependent coverage, which is critical for modeling the cost of alternative coverage options that would be available for children in the absence of CHIP.

We used the coefficients from a set of regression models developed by AHRQ on MEPS-IC data to assign dependent-coverage options and worker contribution rates to our synthetic firms.[3]

**Dependent–coverage options.** Three regression models were used for imputing the availability of dependent coverage in a synthetic firm. "Single to family" gave the probability that a firm offered family coverage. "Single to plus one" gave the probability that a firm offered employee-plus-one coverage.

"Plus one to family" gave the probability that firms offering plus-one also offered family coverage. We used these models to compute the probabilities that a firm offering single coverage offered one of four dependent-coverage options:

- No dependent coverage
- Plus-one and family coverage
- Family but not plus-one coverage
- Plus-one but not family coverage

An option was assigned to each firm using a Monte Carlo model.

**Zero worker contributions for all options**. In the next step, we imputed the probability that a firm did not require worker premium contributions for either single or dependent coverage using regression models developed by AHRQ.

**Joint distribution of single and dependent contributions**. For firms that required nonzero contributions for some coverage options, we assigned each firm to a cell in the following matrix (table 1). The quartiles were computed over all firms with nonzero contributions. This was done for both employee-plus-one policies and family policies.

TABLE 1

**Matrix of Contribution Categories**

| Dependent coverage (family or plus one) | Single coverage | | | | |
|---|---|---|---|---|---|
| | Zero contribution | 1st quartile | 2nd quartile | 3rd quartile | 4th quartile |
| 1st quartile | | | | | |
| 2nd quartile | | | | | |
| 3rd quartile | (Collapsed) | | | | |
| 4th quartile | | | | | |

Because of sample size, two cells with zero single contribution had to be collapsed. The first set of models computed the probability that a firm was in the collapsed cell. For all other cells, the imputation was done using a two-stage process. First, we used regression models of the probability of being in each single worker contribution group (columns in table 1: zero contribution and contribution quartiles). By design, the probabilities for the five single-coverage options summed to 100 percent, so we assigned a single-coverage option to each firm by a Monte Carlo model.

In the next stage, we used regression models of the probability of being in each of the four dependent-coverage contribution groups (rows in table 1). In addition to firm characteristics, these regressions take into account the single-coverage contribution group to which the firm is imputed. Based on the resulting probabilities, we imputed a dependent-coverage group for each firm.

**Contribution rates.** For each type of coverage (single, employee plus one, and family), we computed the average contribution rate in each quartile among firms with nonzero worker contributions from MEPS-IC survey data. Employee contributions to premiums for single and employee plus one were assigned to each firm offering that option based on the average rate for the imputed quartile.

# Data Underlying the HIPSM

The core data from the HIPSM-ACS currently rely on three years (2009–11) of pooled data from the ACS. The ACS is an annual survey fielded by the US Census Bureau. We use an augmented version of the ACS prepared by the University of Minnesota Population Center, known as the Integrated Public Use Microdata Sample, which uses the public use sample of the ACS and contains edits for family relationships and other variables. The 2009 ACS has a reported household response rate of 98.0 percent, which ranges from 94.9 percent in the District of Columbia to 99.4 percent in Wisconsin (US Census Bureau 2009). It is a mixed-mode survey that starts with a mail-back questionnaire—52.7 percent of the civilian noninstitutionalized sample was completed by mail in 2009—and is followed by telephone interviews for initial non-responders, and further followed by in-person interviews for a subsample of remaining non-responders.

The three years of pooled ACS data are reweighted to 2011 characteristics, particularly the distribution of insurance coverage. This step is important because the uninsured rate had increased during the recessionary years of 2008–2009. We then produced weights for 2016, using Census Bureau population projections for age, gender, and race/ethnicity. The Census Bureau does not release projections of state populations beyond 2013, so we projected the population of the 15 largest states for 2016 based on census estimates of state populations from 2010 to 2013.

The ACS is enhanced in a number of ways through data edits and imputations of necessary variables. The Urban Institute has developed a set of health coverage edits to the ACS. These edits result in health coverage that closely aligns with the National Health Insurance Survey and the National Associations of Insurance Commissioners data, which are generally considered the best measures of health coverage nationally.

We impute detailed firm size, insurance policyholder status, unemployment compensation, offers of employer-based coverage (employer-sponsored insurance, or ESI) among those not actually covered by employer plans, and immigration status to individuals on the ACS. We impute firm size on the ACS because offers are highly dependent on firm size, and we need to be able to match individuals on the ACS to our synthetic firms based on firm size. Similarly, we impute policyholder status to people in families with ESI because the ACS does not ask whose job offered the ESI present in the family, and we need to be able to match workers who take up coverage to synthetic firms that offer such coverage. We impute unemployment compensation because it is absent on the ACS but is used in computing modified adjusted gross income under the ACA. These three imputations build on analyses conducted with the Annual Supplement on Economic Conditions to the CPS. We use individual-level data from the ACS and similar data from the Annual Supplement on Economic Conditions to the CPS to impute these missing data elements to the ACS.

To impute employer offer status, we begin by using regression models estimated from the Contingent Worker Supplement to the February CPS collected in 2005, the last year available from the CPS that includes information on ESI offers in this supplement. This allows us to compute a probability of offer based on detailed firm characteristics. We then adjust the model so that the probabilities of offer by firm size match the most recent published MEPS-IC data (2013).

Eligibility for Medicaid, CHIP, and marketplace tax credits depends on immigration status and requires that enrollees be citizens or authorized immigrants. Moreover, in some states, immigrant eligibility depends on how long an immigrant has been in the country. The ACS does not contain sufficient information to determine whether noncitizens are authorized immigrants. Therefore, we impute documentation status for noncitizens in each year of survey data separately, based on a year-specific model. Documentation status is imputed to immigrants in two stages, using individual and family characteristics. The imputation methodology we use is based on the methodology originally developed by Passel (Passel and Cohen 2009). The approach is designed to produce imputations that match, in the aggregate, published summary estimates of the US undocumented population, nationally and in California, Florida, Illinois, New Jersey, New York, and Texas. To determine whether certain immigrants are eligible for public programs, we use state eligibility rules and ACS information about citizenship, imputed documentation status, and date of immigration.

# Eligibility under the ACA

Under the ACA, income eligibility is based on the Internal Revenue Service tax definition of modified adjusted gross income and includes the following types of income for everyone who is not a tax-dependent child: wages, net business income, retirement income, Social Security, investment income, alimony, unemployment compensation, and financial and educational assistance.

To compute family income as a ratio of the federal poverty level (FPL), we sum the person-level modified adjusted gross income across the tax unit (Kenney et al. 2013). In situations where a dependent child is away at school, the ACS does not contain data on the family income and other family information on the child's record or the presence of the dependent child on the records of family members, so we assign some college students to families before beginning the simulation. In addition, we take into account immigration status in determining eligibility for Medicaid, CHIP, and marketplace tax credits, using the documentation status imputations previously described.

We simulate ACA eligibility for adults and children for the eligibility pathways that correspond roughly to the order in which we expect eligibility to be determined. For children, we check for disability (Supplemental Security Income or blind and disabled eligibility under current rules); Medicaid eligibility (family income up to 138 percent of FPL or higher, depending on the state, and meets immigration requirements); and CHIP eligibility, distinguishing between eligibility for Medicaid expansion and separate CHIP programs, and other eligibility under current rules.[4]

We model marketplace tax credit eligibility, which depends on family income and whether the family was offered affordable health insurance benefits, based on imputations of the presence of an insurance offer in the family and the value of the employee's contribution toward the cost of the insurance premium among those with ESI.

# Projections of Health Insurance Coverage under the ACA

Once we have modeled eligibility status for Medicaid, CHIP and subsidized coverage in the exchanges, we use the HIPSM to simulate the decisions of employers, families, and individuals to offer and enroll in health insurance coverage. To calculate the impacts of reform options, the HIPSM uses a microsimulation approach based on the relative desirability of the health insurance options available to each individual and family under reform. The approach (known as a utility-based framework) allows new coverage options to be assessed without simply extrapolating from historical data, as in previous

models. The health insurance coverage decisions of individuals and families in the model take into account a number of factors, such as premiums and out-of-pocket health care costs for available insurance products, health care risk, whether or not the individual mandate would apply to them and the size of the applicable penalties, and family disposable income. Our utility model takes into account people's current choices as reported on the survey data. We use such preferences to customize individual utility functions so their current choices score the highest, and this in turn affects behavior under the ACA. The resulting health insurance decisions made by individuals, families, and employers are calibrated to findings in the empirical economics literature, such as price elasticities for employer-sponsored and non-group coverage.

The first stage in the simulation process is to estimate additional enrollment in Medicaid and CHIP, by both those gaining eligibility under the ACA and those who are currently eligible, but not enrolled. Many characteristics are used to determine take-up, but the two most important are newly eligible status and current insurance coverage, if any. The ACA includes a number of policies aimed at promoting enrollment, including a "no wrong door" enrollment policy whereby children and families will be screened and evaluated for Medicaid, CHIP, and subsidy eligibility no matter where they apply for coverage (through Medicaid, CHIP, or an exchange); new outreach funding; and procedures that minimize application and enrollment barriers. As a consequence, the model projects that Medicaid/CHIP participation rates will rise under the ACA for children and nonelderly adults who are eligible for Medicaid under current rules (see Holahan et al. 2012 for more on this issue.) Although the HIPSM projects that participation among children and nonelderly adults will increase with full implementation of the ACA, it also projects that some individuals will remain uninsured despite being eligible for Medicaid/CHIP coverage. In subsequent stages, we model the following sequentially: enrollment in the non-group exchange, additional enrollment of the uninsured in employer-sponsored coverage, additional enrollment of the uninsured in non-group coverage outside of the exchange, transition from single to family ESI, and transition from non-group coverage to ESI.

# Policy Simulation

We simulate the main coverage provisions of the ACA as if they were fully implemented and the impacts were fully realized in 2016. These estimates assume that state Medicaid expansions will continue as implemented in 2014. The HIPSM models use a microsimulation approach based on the relative desirability of the health insurance options available to each individual and family under reform, taking into account a number of factors such as premiums and out-of-pocket health care costs for

available insurance products, health care risk, whether or not the individual mandate would apply to them, and family disposable income.

Two policy simulations are developed to model what would happen to children's coverage were the CHIP program not to be extended. First, we simulate children's coverage under full implementation of the ACA in 2016. We then simulate health insurance for children under full implementation of the ACA without separate CHIP programs. Under this simulation, children who were previously eligible for separate CHIP programs are no longer eligible for this type of coverage and are tested for marketplace tax credit eligibility based on their family income and whether an affordable offer of health insurance coverage exists in their family. We compare the two simulations to assess what coverage changes would occur for children who were simulated to enroll in separate CHIP programs in the first scenario; whether they are eligible for marketplace premium tax credits; and for those not eligible for premium tax credits, what would be the cost of employer-sponsored coverage.

We identified states with separate CHIP programs based on data published by the Center for Medicaid and Medicare Services (CMS) on income eligibility levels for 2014 (table 2). Importantly, states could make a number of choices in response to the discontinuation of additional federal funding for CHIP. With no additional federal funding for separate CHIP coverage, states could move children covered by separate CHIP programs into the Medicaid program and continue to cover them with the lower Medicaid match rate. Alternatively, states could eliminate their separate CHIP program, which would reduce eligibility for children. Still other states, such as California and New Hampshire, who have recently moved children from their separate CHIP program into the Medicaid program, could move them back into a separate CHIP program and then eliminate coverage. In this analysis, we do not predict which states would choose which option. Rather, we estimate the effects of all states eliminating coverage for children in separate CHIP programs. We model California and New Hampshire as Medicaid expansion CHIP coverage that would continue in 2016 under current law given the maintenance of effort provision under the ACA, which extends through 2019.

TABLE 2

**States with Separate CHIP Programs**

| | | | |
|---|---|---|---|
| Alabama | Iowa | Montana | Tennessee |
| Colorado | Kansas | Nevada | Texas |
| Connecticut | Kentucky | New Jersey | Utah |
| Delaware | Louisiana | New York | Virginia |
| Florida | Maine | North Carolina | Vermont |
| Georgia | Massachusetts | North Dakota | Washington |
| Idaho | Michigan | Oregon | West Virginia |
| Illinois | Mississippi | Pennsylvania | Wisconsin |
| Indiana | Missouri | South Dakota | Wyoming |

**Source**: Centers for Medicare and Medicaid Services 2014.

# Limitations

The policy simulations presented here have a number of limitations. First, the rate of participation in the health insurance marketplaces is an important source of uncertainty in these estimates. Marketplace enrollment in federally facilitated marketplace states among those eligible for tax credits increased 43 percent between the 2014 and 2015 open-enrollment periods based on enrollment data available as of February 15, 2015. Most analysts expect that a further increase in enrollment will occur during the remainder of 2015 and in the 2016 open-enrollment period, which is built into our 2016 enrollment projections. Marketplace participation is also important in estimating the impact of restricting CHIP or Medicaid eligibility.

Second, there is additional uncertainty in any projection of ACA coverage impacts related to predicting take-up of different types of coverage under the ACA. A host of implementation issues associated with state and federal actions and guidance could not only encourage or discourage participation among those previously and newly eligible for programs under the ACA but affect renewals among those already enrolled as well.

Third, this analysis assumes that the economic picture and the structure of employer-sponsored health coverage remain constant in forecasting data to 2016. Improvements in the economy could result in fewer children being eligible and enrolled in Medicaid and CHIP, thus reducing the impact of cuts in eligibility. In contrast, trends in employer-sponsored insurance, such as increasing premiums and deductibles, may make Medicaid and CHIP coverage more attractive to families with eligible children, potentially understating the number of children who would become uninsured if eligibility were to be

restricted. Also, insurance coverage and premiums faced by families are subject to measurement and reporting errors.

Fourth, Medicaid, CHIP, and marketplace tax credit eligibility is measured with error. Efforts to simulate eligibility for public coverage based on survey data are inherently challenging because of misreporting of income, insurance coverage, or other information used to model eligibility and lack of specific information needed to simulate all the pathways to eligibility. The ACS, like many other surveys, does not contain information on such factors as pregnancy status, legal disability status, child support amounts, whether custodial parents meet child support cooperation requirements, medical spending (which would be used to calculate spend-down for medically needy eligibility), and duration of Medicaid enrollment or income history to determine Transitional Medical Assistance and related eligibility (Kenney et al. 2009). Unlike other information, such as firm size and immigration status, these factors could not readily be imputed.

Fifth, measurement error is also inherent in our estimates of the number of children with Medicaid and CHIP coverage. About 2.1 million children report being enrolled in Medicaid or CHIP but are not found eligible by our model. We could observe these ineligible reporters for a number of reasons. There are Medicaid eligibility pathways which are difficult to model completely from ACS data and for which we likely understate eligibility. In addition, the ACS reflects coverage at the point in time of the survey whereas income is measured for the past year. It may be the case that some ineligible reporters were eligible for Medicaid at some point in the year, just not based on their annual income. We believe these seemingly ineligible children were at some point covered by Medicaid or CHIP, but we cannot determine the specific program in which they were enrolled. Consequently, we do not consider them in counts of people affected by changes in policy. This means, however, that our estimates may understate the number of children losing coverage if separate CHIP programs are discontinued.

# Supplemental Tables for Chapter 1 of March 2015 MACPAC Report

This section includes the six tables that were derived from our simulation modeling to produce the findings contained in the chapter 1 of the March 2015 MACPAC report to Congress (MACPAC 2015).

In table 3, we show the types of coverage that would be available to the children who are projected be enrolled in separate CHIP programs in 2016 and provide estimates of the number projected to become uninsured if CHIP funding were not extended. We also show the number of children whose families face employee contributions of less than 9.5 percent of family income for single coverage but whose total out-of-pocket premium for family coverage is greater than 9.5 percent of family income.[5] In addition, we show the share of children who are eligible for marketplace tax credits and who could be added to their parent's marketplace policy at no additional cost and the rate at which children losing CHIP eligibility would become uninsured based on what they would be eligible for if separate CHIP coverage were discontinued.

Highlights from this table include the following:

- We project that 3.7 million children would lose their coverage under separate CHIP programs in 2016 if separate CHIP programs were discontinued.
- Of the 3.7 million who would lose separate CHIP coverage if separate CHIP programs were discontinued, 51 percent would be eligible for marketplace tax credits and 49 percent would have an offer of employer-sponsored coverage that is deemed affordable under the current interpretation of the firewall for determining eligibility for marketplace tax credits.
- If separate CHIP coverage were discontinued, 1.1 million children would become uninsured.
- Among the children in families with access to employer-sponsored coverage that would be deemed affordable under the current interpretation of the firewall for determining eligibility for marketplace tax credits, 51 percent face out-of-pocket premiums for family coverage that exceed 9.5 percent of family income.

TABLE 3

**Eligibility and Employer Coverage Options of Children Losing Eligibility for Separate CHIP Coverage, 2016**

| | Total and Composition of Each Subgroup Enrolled in Separate CHIP | | Percentage Projected to Become Uninsured | Number and Percentage Becoming Uninsured if CHIP Ends | |
|---|---|---|---|---|---|
| | Number | Share of subgroup (%) | | Number | Share of subgroup (%) |
| **Total** | 3,715,000 | 100.0 | 31 | 1,148,000 | 100.0 |
| **Eligibility if CHIP ends** | | | | | |
| **Eligible for ESI instead of exchange premium tax credits** | 1,820,000 | 49.0 | 37 | 678,000 | 59.1 |
| *Parent enrolled in ESI* | 1,103,000 | 60.6 | 5 | 55,000 | 8.1 |
| *Parent not enrolled in ESI* | 717,000 | 39.4 | 87 | 623,000 | 91.9 |
| **Parent(s) enrolled in ESI with no additional out-of-pocket premium to enroll child** | 397,000 | 21.8 | 1 | 5,000 | 0.7 |
| **Total family out-of-pocket premium exceeds 9.5 percent of income** | 935,000 | 51.4 | 41 | 381,000 | 56.1 |
| **Eligible for exchange premium tax credits** | 1,894,000 | 51.0 | 25 | 469,000 | 40.9 |
| *No ESI offer* | 1,624,000 | 85.7 | 24 | 397,000 | 84.6 |
| *ESI not affordable* | 210,000 | 11.1 | 22 | 46,000 | 9.7 |
| *ESI excludes dependents* | 60,000 | 3.1 | 44 | 26,000 | 5.6 |
| *State relies on federal exchange* | 1,419,000 | 74.9 | 26 | 368,000 | 78.5 |
| *Parent(s) enrolled in exchange premium tax credits with no additional out-of-pocket premium to enroll child* | 1,198,000 | 63.2 | 0 | 2,000 | 0.3 |

**Source:** Urban Institute analysis for MACPAC of HIPSM-ACS enhanced with MEPS-IC data from the AHRQ.
**Note:** Coverage under the ACA projected for 2016 with CHIP funding continued. Estimates rounded to nearest 1,000s.

Tables 4 and 5 focus on the additional premium costs for employer coverage that would be faced by families with children currently enrolled in separate CHIP programs and who would be deemed to have "affordable" offers of coverage were CHIP coverage discontinued. Table 4 shows the average additional amount that a family would have to pay in premiums to cover their children under an employer plan (i.e. the marginal cost to the family) and the total amount that the family would spend for employer coverage (i.e. the total cost). The marginal cost is generally lower than the total cost because most CHIP children not eligible for marketplace tax credits have a parent already enrolled in an employer plan. Table 5 provides additional information on the distribution of marginal and total costs, including the median and the values for the first, second, third, and fourth quartiles.

Highlights from these tables include the following:

- Families with access to employer-sponsored coverage deemed affordable would face average premium contributions of $3,751, or 9.1 percent of family income, to enroll their children in such coverage, bringing average total family contributions to $5,163, or 12.2 percent of family income.
- Families in the third and fourth quartiles of employee premiums would face, on average, premiums of $3,999 and $8,814, respectively, to cover their children, bringing average total family costs to $4,380 and $9,153 for families in these quartiles, respectively.

TABLE 4

**Average Out-of-Pocket Premiums for Children Losing Separate CHIP if CHIP Ends in 2016**

| | Premiums Facing Children Losing Eligibility for Separate CHIP | | | | | Children Enrolled in Separate CHIP Becoming Uninsured | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Average Out-of-Pocket Premium to Add Child(ren) to Coverage | % Income | Average Out-of-Pocket Premium to Cover Entire Family | % Income | Number | Average Out-of-Pocket Premium to Add Child(ren) to Coverage | % Income | Average Out-of-Pocket Premium to Cover Entire Family | % Income |
| **Total** | 3,715,000 | | | | | 1,148,000 | | | | |
| **Eligible for ESI instead of exchange premium tax credits** | 1,820,000 | $3,751 | 9.1 | $5,163 | 12.2 | 678,000 | $5,509 | 13.2 | $5,605 | 13.5% |
| *Parent enrolled in ESI* | 1,103,000 | $2,730 | 6.9 | $5,031 | 11.9 | 55,000 | $7,148 | 19.0 | $8,090 | 21.6% |
| *Parent not enrolled in ESI* | 717,000 | $5,322 | 12.5 | $5,367 | 12.6 | 623,000 | $5,364 | 12.7 | $5,385 | 12.8% |
| **Total family out-of-pocket premium exceeds 9.5 percent of income** | 935,000 | $5,495 | 14.0 | $7,193 | 18.0 | 381,000 | $7,486 | 18.9 | $7,615 | 19.3% |
| **Eligible for exchange premium tax credits** | 1,894,000 | | | | | 469,000 | | | | |
| *No ESI offer* | 1,624,000 | | | | | 397,000 | | | | |
| *ESI not affordable* | 210,000 | | | | | 46,000 | | | | |
| *ESI excludes dependents* | 60,000 | | | | | 26,000 | | | | |

**Source:** Urban Institute analysis for MACPAC of HIPSM-ACS enhanced with MEPS-IC data from the AHRQ.
**Note:** Coverage under the ACA projected for 2016 with CHIP funding continued. Estimates rounded to nearest 1,000s.

TABLE 5

**Out-of-Pocket Premiums for Children Losing Separate CHIP if CHIP Ends in 2016**

| | Average Out-of-Pocket Premium to Add Child(ren) to Coverage | % Income | Average Out-of-Pocket Premium to Cover Entire Family | % Income |
|---|---|---|---|---|
| Eligible for ESI Instead of Exchange Premium Tax Credits | | | | |
| *Number* | 1,820,000 | | 1,820,000 | |
| *Mean* | $3,751 | 9.1 | $5,163 | 12.2 |
| *Median* | $2,969 | 6.9 | $4,169 | 9.7 |
| *First quartile average* | $125 | 0.3 | $4,413 | 9.1 |
| *Second quartile average* | $2,067 | 5.3 | $2,691 | 6.9 |
| *Third quartile average* | $3,999 | 9.7 | $4,389 | 10.6 |
| *Fourth quartile average* | $8,814 | 21.1 | $9,163 | 22.0 |
| Eligible for ESI Instead of Exchange Premium Tax Credits and Projected to Become Uninsured | | | | |
| *Number* | 678,000 | | 678,000 | |
| *Mean* | $5,509 | 13.2 | $5,605 | 13.5 |
| *Median* | $4,499 | 10.4 | $4,499 | 10.5 |
| *First quartile average* | $2,002 | 5.1 | $2,176 | 5.5 |
| *Second quartile average* | $3,769 | 9.1 | $3,807 | 9.2 |
| *Third quartile average* | $5,596 | 13.3 | $5,652 | 13.4 |
| *Fourth quartile average* | $10,763 | 25.8 | $10,878 | 26.1 |
| Eligible for Exchange Premium Tax Credits | | | | |
| *Number* | 1,894,000 | | 1,894,000 | |
| *Number projected to become uninsured* | 469,000 | | 469,000 | |

**Source:** Urban Institute analysis for MACPAC of HIPSM-ACS enhanced with MEPS-IC data from the AHRQ.
**Note:** Coverage under the ACA projected for 2016 with CHIP funding continued. Estimates rounded to nearest 1,000s.

In table 6 and 7 we show the projected national distribution of children's health insurance coverage in 2016 both with and without an extension of federal funding for CHIP. Table 6 includes all children, and table 7 includes children with family incomes up to 405 percent of FPL, which is the highest level of current CHIP eligibility in any state (New York). The MACPAC report focused on what would happen to children enrolled in separate CHIP programs. In this table, we put them in the broader context of the changes in health insurance coverage for all children.

Highlights from this table include the following:

- If separate CHIP coverage were discontinued, it is projected that among the 3.7 million children enrolled in CHIP in 2016, 1.2 million would obtain coverage through a parent's employer, 1.4 would obtain premium tax credits and purchase coverage in the marketplace, and 1.1 million would become uninsured.
- Overall, the number of uninsured children would increase by 40 percent, rising from 2.9 million to 4.0 million, were separate CHIP coverage to be discontinued.

TABLE 6

**Distribution of Children's Coverage, All States**

*All Incomes*

| | ACA with Separate CHIP | | ACA without Separate CHIP | | |
|---|---|---|---|---|---|
| | Number | Share (%) | Number | Share (%) | Change |
| **Insured** | 76,392,000 | 96.4 | 75,244,000 | 94.9 | −1,148,000 |
| **Employer** | 38,713,000 | 48.8 | 39,920,000 | 50.4 | 1,207,000 |
| **Non-group (non-exchange)** | 710,000 | 0.9 | 750,000 | 1.0 | 40,000 |
| **Non-group (exchange)** | 1,323,000 | 1.7 | 2,644,000 | 3.3 | 1,321,000 |
| **Medicaid** | 26,128,000 | 33.0 | 26,128,000 | 33.0 | 0 |
| **Medicaid CHIP** | 4,407,000 | 5.6 | 4,407,000 | 5.6 | 0 |
| **Separate CHIP** | 3,715,000 | 4.7 | 0 | 0.0 | −3,715,000 |
| **Other (including Medicare)** | 1,397,000 | 1.8 | 1,396,000 | 1.8 | −1,000 |
| **Uninsured** | 2,876,000 | 3.6 | 4,024,000 | 5.1 | 1,148,000 |
| **Eligible for Medicaid** | 1,111,000 | 1.4 | 1,111,000 | 1.4 | 0 |
| **Eligible for separate CHIP** | 452,000 | 0.6 | 0 | 0.0 | −452,000 |
| **Eligible for premium tax credits** | 135,000 | 0.2 | 735,000 | 0.9 | 600,000 |
| **Other** | 1,179,000 | 1.5 | 2,179,000 | 2.7 | 1,000,000 |
| **Total** | 79,268,000 | 100.0 | 79,268,000 | 100.0 | 0 |

**Source:** Urban Institute analysis for MACPAC of HIPSM-ACS enhanced with MEPS-IC data from the AHRQ.
**Note:** Coverage under the ACA projected for 2016 with CHIP funding continued. Estimates rounded to nearest 1,000s.

TABLE 7

**Distribution of Children's Coverage, All States**

*< 405% FPL*

| | ACA with CHIP funding | | ACA without CHIP funding | | |
|---|---|---|---|---|---|
| | Number | Share (%) | Number | Share (%) | Change |
| **Insured** | 58,269,000 | 96.6 | 57,121,000 | 94.7 | −1,148,000 |
| **Employer** | 22,663,000 | 37.6 | 23,870,000 | 39.6 | 1,207,000 |
| **Non-group (non-exchange)** | 299,000 | 0.5 | 338,000 | 0.6 | 40,000 |
| **Non-group (exchange)** | 780,819 | 1.3 | 2,102,000 | 3.5 | 1,321,000 |
| **Medicaid** | 25,343,000 | 42.0 | 25,343,000 | 42.0 | 0 |
| **Medicaid CHIP** | 4,407,000 | 7.3 | 4,407,000 | 7.3 | 0 |
| **Separate CHIP** | 3,715,000 | 6.2 | 0 | 0.0 | −3,715,000 |
| **Other (including Medicare)** | 1,063,000 | 1.8 | 1,062,000 | 1.8 | −1,000 |
| **Uninsured** | 2,053,000 | 3.4 | 3,201,000 | 5.3 | 1,148,000 |
| **Eligible for Medicaid** | 1,104,000 | 1.9 | 1,104,000 | 1.9 | 0 |
| **Eligible for separate CHIP** | 452,000 | 0.7 | 0 | 0.0 | −452,000 |
| **Eligible for premium tax credits** | 135,000 | 0.2 | 735,000 | 1.2 | 600,000 |
| **Other** | 362,000 | 0.6 | 1,362,000 | 2.2 | 1,000,000 |
| **Total** | 60,322,000 | 100.0 | 60,322,000 | 100.0 | 0 |

**Source:** Urban Institute analysis for MACPAC of HIPSM-ACS enhanced with MEPS-IC data from the AHRQ.
**Note:** Coverage under the ACA projected for 2016 with CHIP funding continued. Estimates rounded to nearest 1,000s.

Table 8 shows selected demographic and economic characteristics of the children projected to be enrolled in separate CHIP coverage in 2016 and of the children who are projected to become uninsured without separate CHIP coverage. We include estimates by income, race/ethnicity, census division, age of the child, parental employment status and firm size, and child's health status. Table 8 expands on table 2 in the MACPAC report, adding detail on income, age, and health status.

Highlights from this table include the following:

- Among the 1.1 million children projected to become uninsured if separate CHIP coverage is discontinued, 54 percent have family incomes that are between 151 and 200 percent of FPL.
- Among the 1.1 million children projected to become uninsured if separate CHIP coverage is discontinued, 90 percent have a full-time worker in the family.

TABLE 8

**Characteristics of Children Losing Eligibility for Separate CHIP Coverage, 2016**

| | Separate CHIP Program Enrollees | | Projected to Become Uninsured without CHIP Funding | | |
|---|---|---|---|---|---|
| **Characteristics** | **Number** | **%** | **Rate (%)** | **Number** | **%** |
| **Total** | 3,715,000 | 100.0 | 30.9 | 1,148,000 | 100.0 |
| **Income** | | | | | |
| *139–200% FPL* | 2,203,000 | 59.3 | 31.9 | 703,000 | 61.3 |
| *139–150% FPL* | 277,000 | 7.5 | 31.5 | 87,000 | 7.6 |
| *151–200% FPL* | 1,926,000 | 51.8 | 32.0 | 616,000 | 53.7 |
| *201–405% FPL* | 1,512,000 | 40.7 | 29.4 | 444,000 | 38.8 |
| **Age (years)** | | | | | |
| *< 1* | 91,000 | 2.5 | 35.7 | 33,000 | 2.8 |
| *1–5* | 977,000 | 26.3 | 33.1 | 324,000 | 28.2 |
| *6–18* | 2,647,000 | 71.2 | 29.9 | 792,000 | 69.0 |
| *6–12* | 1,481,000 | 39.9 | 31.2 | 461,000 | 40.2 |
| *13–18* | 1,166,000 | 31.4 | 28.3 | 330,000 | 28.8 |
| **Race/Ethnicity** | | | | | |
| *White, non-Hispanic* | 1,940,000 | 52.2 | 27.3 | 529,000 | 46.1 |
| *Black, non-Hispanic* | 574,000 | 15.5 | 32.2 | 185,000 | 16.1 |
| *Hispanic* | 902,000 | 24.3 | 37.8 | 341,000 | 29.7 |
| *Other* | 299,000 | 8.0 | 30.9 | 92,000 | 8.0 |

| | Separate CHIP Program Enrollees | | Projected to Become Uninsured without CHIP Funding | | |
|---|---|---|---|---|---|
| **Characteristics** | **Number** | **%** | **Rate (%)** | **Number** | **%** |
| **Census division** | | | | | |
| *New England* | 157,000 | 4.2 | 41.4 | 65,000 | 5.6 |
| *Middle Atlantic* | 889,000 | 23.9 | 30.1 | 267,000 | 23.3 |
| *East North Central* | 565,000 | 15.2 | 40.8 | 231,000 | 20.1 |
| *West North Central* | 223,000 | 6.0 | 25.5 | 57,000 | 4.9 |
| *South Atlantic* | 702,000 | 18.9 | 28.0 | 197,000 | 17.1 |
| *East South Central* | 331,000 | 8.9 | 28.4 | 94,000 | 8.2 |
| *West South Central* | 453,000 | 12.2 | 28.2 | 128,000 | 11.1 |
| *Mountain* | 218,000 | 5.9 | 29.8 | 65,000 | 5.7 |
| *Pacific* | 177,000 | 4.8 | 25.4 | 45,000 | 3.9 |
| **Child's Health Status** | | | | | |
| *Fair/Poor* | 266,000 | 7.2 | 29.6 | 79,000 | 6.8 |
| *Better than Fair/Poor* | 3,449,000 | 92.8 | 31.0 | 1,069,000 | 93.2 |
| *Poor* | 97,000 | 2.6 | 29.5 | 28,000 | 2.5 |
| *Fair* | 169,000 | 4.6 | 29.6 | 50,000 | 4.4 |
| *Good* | 1,120,000 | 30.1 | 31.1 | 348,000 | 30.3 |
| *Very Good* | 1,141,000 | 30.7 | 30.8 | 352,000 | 30.6 |
| *Excellent* | 1,188,000 | 32.0 | 31.1 | 369,000 | 32.2 |
| **Parent Employment** | | | | | |
| *Full-time worker in family* | 3,387,000 | 91.2 | 30.4 | 1,028,000 | 89.6 |
| *Only part-time workers in family* | 263,000 | 7.1 | 32.5 | 86,000 | 7.5 |
| *No workers in family* | 64,000 | 1.7 | 53.1 | 34,000 | 3.0 |

**Source:** Urban Institute analysis for MACPAC of HIPSM-ACS enhanced with MEPS-IC data from the AHRQ.
**Note:** Coverage under the ACA projected for 2016 with CHIP funding continued. Estimates rounded to nearest 1,000s.

# Conclusion

The CHIP program provides an important safety net for children. In the absence of CHIP funding, an estimated 3.7 million children enrolled in separate CHIP programs in 36 states would need to obtain coverage elsewhere in 2016. We find that about half these children would be eligible for subsidized coverage in the marketplace. In general, families would face much higher out-of-pocket costs and less-comprehensive benefits when they use services in marketplace plans than they would under CHIP (Bly, Lerche, and Rustagi 2014). For 63 percent of children in this situation, their parents would already be enrolled in subsidized marketplace coverage, and the family would face no additional premiums to cover them. For other families, the whole family would need to enroll in marketplace coverage to cover the children, making the incremental costs much higher than covering the child under CHIP. The other half of the children projected to have separate CHIP coverage in 2016 would have employer offers of coverage that are deemed affordable under the current interpretation of the firewall for determining eligibility for marketplace tax credits because the employee costs for a single policy are less than 9.5 percent of their family income. Half the children deemed to have "affordable" offers of employer-sponsored coverage are in families where the cost of family coverage exceeds 9.5 percent of their income. In other words, they are caught in the family affordability glitch and would face high costs as a share of their income to cover their children. Unlike children eligible for marketplace tax credits, only 22 percent of children in families with "affordable" employer offers would face no incremental premium costs to cover the children.

The analysis presented here estimates that an additional 1.1 million children would become uninsured if separate CHIP coverage were eliminated. This would constitute a 40 percent increase in the number of uninsured children in the United States relative to the number projected under the ACA with the continuation of CHIP. The discontinuation of federal CHIP funding is not the only potential policy change on the horizon for children's health insurance coverage. A current case before the Supreme Court puts tax credits in doubt for families in states that do not have a state-based marketplace. In addition, one current proposal includes rolling back the Medicaid and CHIP maintenance of effort requirement for children (House Energy and Commerce Committee 2015). Both of these changes would cause more children to join the ranks of the uninsured (Buettgens et al. 2015).

# Notes

1. More detailed documentation on the HIPSM-CPS is available at http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf.
2. More detailed documentation on previous versions of the Urban Institute's HIPSM-ACS is available here: http://www.urban.org/health_policy/url.cfm?ID=412841.
3. Detailed documentation of these regressions is forthcoming as a Center for Economic Studies Working Paper (http://www.census.gov/ces/).
4. The eligibility model also distinguishes between CHIP-eligible children who are served by the Medicaid program but for whom the state receives the CHIP matching rate.
5. In 2015 the threshold for affordability is 9.56 percent of family income, increasing from the 9.5 percent threshold for 2014. This threshold will be higher in 2016. We modeled the threshold at 9.5 percent of family income, but the higher threshold would not make an appreciable difference.

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