

CHAPTER 1

Sources of Coverage for Children If CHIP Funding Is Exhausted

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Key Points

- MACPAC projects that if federal funding for the State Children’s Health Insurance Program (CHIP) is not extended this year, then 3.7 million children would lose separate CHIP coverage in fiscal year (FY) 2016. Approximately half of these children would be eligible for subsidized exchange coverage and the other half for employer-sponsored insurance, according to an analysis by the Urban Institute for MACPAC.
- Of the children projected to lose separate CHIP coverage, 1.1 million children would become uninsured, bringing the number of uninsured children in the United States to 4 million. This would be a nearly 40 percent increase in the projected number of uninsured children nationally.
- Children covered in Medicaid-expansion CHIP programs are not at risk of becoming uninsured. This is because a maintenance of effort provision enacted in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires states to continue such coverage at least through FY 2019. Federal funding in Medicaid-expansion CHIP would revert from the CHIP enhanced matching rate to the lower Medicaid matching rate, making states liable for additional spending.
- More than two-thirds of children covered under separate CHIP programs are projected to obtain coverage from other payers—1.4 million (36.5 percent) through subsidized exchange coverage and 1.2 million (32.6 percent) through a parent’s job-based coverage.
- The out-of-pocket premiums for adding children to employer-sponsored coverage could be substantial. On average, these projected premiums would average \$3,751 per year, or 9.1 percent of family income. The impact on individual families will depend upon various factors, including whether other family members are already enrolled. The increase ranges from \$125 per year on average among the 25 percent of families facing the lowest additional premiums to \$8,814 for the 25 percent of families facing the highest premiums.
- These findings reinforce the Commission’s recommendation that CHIP be extended for two years while safeguards are developed to address concerns about affordability and adequacy, with the ultimate goal being the integration of CHIP-enrolled children into other sources of coverage, including Medicaid, exchange plans, or employer-sponsored insurance. The Commission will weigh such alternatives carefully, based on their costs and impact on families, states, and the federal government.

CHAPTER 1: Sources of Coverage for Children If CHIP Funding Is Exhausted

Under current law, federal funding for the State Children’s Health Insurance Program (CHIP) will be exhausted in fiscal year (FY) 2016. A new analysis for MACPAC by the Urban Institute projects that this will result in 3.7 million children needing to find another source of health insurance coverage.¹ More than two-thirds would enroll in subsidized exchange coverage or employer-sponsored insurance, but nearly one-third, 1.1 million children, would become uninsured.² This number would rise further if the U.S. Supreme Court were to rule in *King v. Burwell* that subsidies are not permitted in the federally facilitated exchanges.

In this chapter we describe the sources of health insurance coverage available to children who would lose access to CHIP if no additional federal CHIP funding is provided and states exhaust their remaining balances in FY 2016. Projections are then provided of how many of these children would be eligible for other sources of coverage in the absence of CHIP, how much it would cost them, and whether or not families would enroll. These projections are based on the Urban Institute’s Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS).

In considering the future of children’s coverage, the Commission has noted that the long-term goal should be to ensure that low- and moderate-income children have affordable coverage that offers access to high-quality care and services critical to children’s healthy development. These children should also have a smooth transition to other sources of coverage, including Medicaid, exchange plans, and employer-sponsored insurance. For this reason, the Commission has

recommended that CHIP be extended in the short term while safeguards are developed to address concerns about affordability and adequacy and until enrollees can be integrated into other coverage. The Commission will carefully weigh such alternatives based on their cost and impact on families, states, and the federal government.

Overview of Coverage Alternatives If CHIP Funding Is Exhausted

The type of coverage children will be eligible for if CHIP funding is exhausted depends on several factors, the first being whether they are enrolled in a Medicaid-expansion CHIP program or a separate CHIP program. States with Medicaid-expansion CHIP programs must maintain those eligibility levels through at least FY 2019, while separate CHIP programs can be shut down, with those enrollees left to find other coverage or become uninsured. Forty-one states would face both of these effects because, as combination states, they have some children in Medicaid-expansion CHIP and others in separate CHIP programs (HHS 2015). For example, in 2014 the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required many states that had previously run separate CHIP programs exclusively to move 6- to 18-year-olds between 100 and 138 percent of the federal poverty level (FPL) from separate CHIP coverage into new Medicaid-expansion CHIP coverage. (For a family of three in the contiguous 48 states and the District of Columbia, 100 percent FPL is approximately \$20,000 per year.)

In the absence of CHIP funding, states’ budget obligations will increase for children enrolled in Medicaid-expansion CHIP due to the maintenance of effort requirement included in the ACA. This maintenance of effort requires states to continue Medicaid coverage at current eligibility levels for children in Medicaid and Medicaid-expansion CHIP

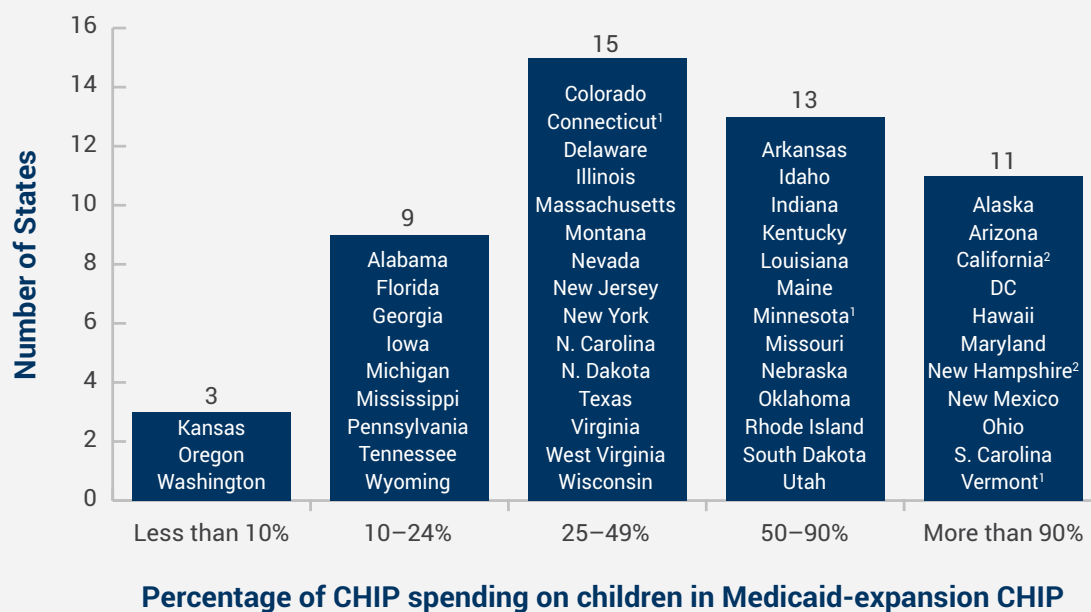
at least through FY 2019 even if CHIP funding runs out (HHS 2015).³

However, when CHIP funding is exhausted, federal matching will decrease from CHIP rates to Medicaid rates, and states will have to make up the difference, resulting in a 43 percent larger state contribution than currently required under CHIP.⁴

The extent to which states will be affected by the maintenance of effort requirement as CHIP funding

is exhausted varies substantially.⁵ Overall, states project that half of their CHIP spending in FY 2016 will be for children in Medicaid-expansion CHIP; but in 11 states, Medicaid-enrolled children account for more than 90 percent of projected federal CHIP spending (Figure 1-1). So these 11 states must continue coverage at increased state cost for nearly all of their current CHIP-financed population, with relatively few of their children projected to become uninsured. In contrast, three states are projected to have less than 10 percent of CHIP

FIGURE 1-1. Projected Share of Federal CHIP Funds to Be Spent on Children in Medicaid-Expansion CHIP, Fiscal Year 2016



Notes:

¹ In this figure, spending under §2105(g) of the Social Security Act is treated as spending for children in Medicaid-expansion CHIP. Section 2105(g) permits 11 qualifying states to use federal CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level. State projections for fiscal year (FY) 2016 indicate that §2105(g) spending would account for 44 percent of federal CHIP spending in Connecticut, 55 percent in Minnesota, 15 percent in New Hampshire, and 57 percent in Vermont. Section 2105(g) spending in these four states places them in a higher category.

² Maintenance of effort is tied to eligibility policies in place on March 23, 2010, the date the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) was enacted. California and New Hampshire converted much of their separate CHIP population to Medicaid-expansion coverage after that date, and it is not clear whether these states will be permitted to remove these children from Medicaid as CHIP funding is exhausted.

Source: MACPAC analysis of projections of FY 2016 federal CHIP spending provided by states in the Medicaid and CHIP Budget and Expenditure System as of January 2015.

spending attributable to Medicaid-enrolled children and thus would face little increased state Medicaid spending for enrollees whose coverage must continue under the regular Medicaid match.

The experience of two states illustrates how the exhaustion of federal CHIP funds affects states differently depending on their share of enrollees with either Medicaid-expansion or separate CHIP coverage. Maryland is one of eight states considered to run a Medicaid-expansion CHIP program exclusively. In Maryland, CHIP pays for children's Medicaid coverage that is above the pre-CHIP Medicaid eligibility levels, up to 322 percent FPL. Maryland must maintain these eligibility levels up to 322 percent FPL through FY 2019. The state would face increased state spending as the federal matching rate falls from that of CHIP to Medicaid. In 2015, the federal CHIP matching rate for Maryland is 65 percent, compared to 50 percent for Medicaid.⁶ On the other hand, all of these children would remain insured, at least through FY 2019, even if CHIP funding were exhausted.

In contrast, Iowa has both Medicaid-expansion CHIP and separate CHIP. Its Medicaid-expansion CHIP covers 1- to 18-year-olds above pre-CHIP Medicaid eligibility levels, up to 172 percent FPL.⁷ Its separate CHIP covers 1- to 18-year-olds between 173 and 307 percent FPL. If CHIP funding ends, Iowa must maintain its Medicaid-expansion CHIP eligibility levels through FY 2019 but can end its separate CHIP coverage.

When the maintenance of effort requirement expires after FY 2019, some states will likely roll back their eligibility levels for children's Medicaid and Medicaid-expansion CHIP to the federal Medicaid minimums—nationally at 138 percent FPL.⁸ The additional number of children becoming uninsured without CHIP as the maintenance of effort expires after FY 2019 will depend not only on whether states decide to reduce eligibility levels, but also on what alternatives are available to children then.⁹

Projected Coverage among Children Losing Separate CHIP in 2016

As indicated above, approximately 3.7 million children age 0–18 are projected to be enrolled in separate CHIP in 2016. Because the maintenance of effort requirement does not apply to these separate CHIP programs in the absence of federal funding, states may close them down after their CHIP funds are exhausted. The remainder of this chapter provides projections of the coverage in which separate-CHIP-enrolled children would enroll in 2016 in the absence of CHIP, based on an Urban Institute analysis (Box 1-1). To produce these projections, the Urban Institute considered a number of factors, including the following:

- out-of-pocket premium costs, accounting for the extent to which the whole family must be enrolled in coverage in order to cover children, whether for employer-sponsored insurance or subsidized exchange coverage;
- family members' expected health care costs;
- historical data on individual coverage decisions that weigh costs and health risks;
- the impact of the individual mandate penalty being fully in effect;¹⁰ and
- other demographic, socioeconomic, and health characteristics.¹¹

Projected eligibility versus projected enrollment

Eligibility. If all separate CHIP programs are discontinued in 2016, then an estimated 1.9 million of the projected 3.7 million separate-CHIP-enrolled children will be eligible for subsidized exchange coverage.¹² This group comprises 1.6 million children whose parents do not have an offer of employer-sponsored insurance, 0.1 million children whose

BOX 1-1. Modeling Approach Used to Project Coverage among Children Losing Separate CHIP Coverage in 2016

In this chapter, projections of children's eligibility, enrollment, and premiums were provided by Urban Institute researchers using their Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS). The core data in the model are from the Census Bureau's American Community Survey, which is an annual survey of 3 million U.S. residents, representative at the state and national level. To follow the data trends forward to 2013, Census Bureau estimates of individual state population growth from 2010 to 2013 are used. Census Bureau population projections are used to produce estimates through 2016. Additional information, such as detailed firm size and unemployment compensation, is incorporated into the model from the Census Bureau's Current Population Survey (CPS). Health care use and spending are estimated for each individual for all of the possible insurance types based on data from the Household Component of the Medical Expenditure Panel Survey (MEPS) and benchmarked to relevant standards for each type of insurance.

To support analyses of children's coverage absent CHIP, HIPSM-ACS was enhanced with data provided by the Agency for Healthcare Research and Quality (AHRQ) from the Insurance Component (IC) of MEPS. The MEPS-IC obtains detailed information about employers, the extent to which they offer health insurance, the cost of that coverage, and the firms' and employees' characteristics associated with those offers. In particular, HIPSM-ACS was enhanced to allow for the modeling of offers and costs of employee-plus-one coverage and of the joint distribution of the employee and employer costs of self-only, employee-plus-one, and family coverage. This enhancement allowed for more precise modeling of the cost of self-only coverage and circumstances in which the cost of such coverage for the employee would be low but the cost for family coverage would be high. These data were critical in projecting the offers and family out-of-pocket costs for job-based coverage if an employee's child's separate CHIP coverage were to end.

National and state rules and costs for Medicaid, CHIP, and exchange coverage were used to simulate eligibility for these programs. The costs and eligibility for employer-sponsored coverage were also included. With this information, each individual in the model can be assessed in order to project the following as of 2016:

- Who is eligible for coverage?
- How much would it cost?
- Who would enroll or be uninsured?
- How would coverage change under different scenarios?

There are a number of caveats that need to be considered in any simulation model regarding assumptions, forecasting, and measurement error. First, there is uncertainty in the model's assumptions about the rate of participation in subsidized exchange coverage at different income levels and in participation among those who were previously eligible for Medicaid and CHIP. These assumptions affect the coverage projected in 2016 as well as the effects for the scenario in which separate CHIP coverage ends. To address this uncertainty, estimates were also produced that

BOX 1-1 (continued)

assumed lower take-up rates than the standard model. Even with rates that led to a difference of several million in the overall number of uninsured people, the number of newly uninsured children as a result of the discontinuation of CHIP increased only modestly, from 1.1 to 1.2 million. Second, in forecasting to 2016, the analysis assumes that the economic picture and the structure of employer-sponsored coverage remains constant. However, improvements in the economy could result in fewer children being eligible and enrolled in separate CHIP coverage, potentially leading to an overestimation of the number of children who would become uninsured if separate CHIP programs were discontinued. On the other hand, trends in employer-sponsored insurance, such as increasing family premiums and deductibles, may encourage more families to enroll their children in separate CHIP coverage, potentially leading to an underestimation of the number of children who would become uninsured if separate CHIP programs were discontinued. Third, income, insurance coverage, and premiums faced by CHIP-eligible families are subject to measurement and reporting errors.

Detailed documentation for the analyses in this chapter and of the HIPSM-ACS as enhanced with the MEPS-IC can be found in Dubay et al. 2015.

parents have an offer of employer-sponsored coverage that is not available to dependents, and 0.2 million children whose parents have an offer of employer-sponsored insurance that is not considered affordable according to the ACA (Figure 1-2).

The remaining 1.8 million children projected to lose separate CHIP coverage in 2016 would be ineligible for exchange subsidies because they have a parent or parents with an offer of employer-sponsored insurance that is available to dependents and that is defined by the ACA as affordable. In the majority of these families, a parent is already enrolled in job-based coverage (Figure 1-2).

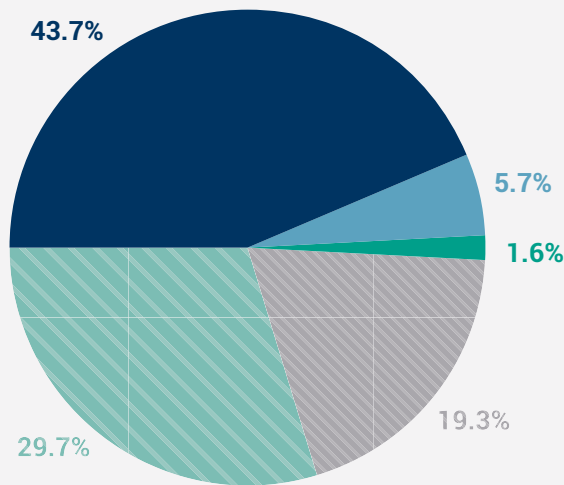
Affordable coverage. The ACA defines employer-sponsored coverage as affordable if an employee's out-of-pocket premiums for self-only coverage would account for no more than 9.5 percent of family income. This affordability test is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered. In 2013, employee contributions for employer-sponsored, self-only coverage averaged \$1,170, which amounts to 3.7 percent of income for a family of three at






160 percent FPL and 2.9 percent of income at 210 percent FPL (AHRQ 2013a). For family coverage, the out-of-pocket premiums averaged \$4,421, which amounts to 14.1 percent of income for a family of three at 160 percent FPL and 10.8 percent of income at 210 percent FPL (AHRQ 2013b).

Using the current affordability test, 5.7 percent of children projected to lose separate CHIP would be eligible for exchange subsidies because the self-only premium for employer-sponsored coverage exceeds 9.5 percent of income (Figure 1-2). Note, however, that even families made eligible for exchange subsidies under the current affordability test may choose not to enroll for a variety of reasons, including costs, as discussed in greater detail below.

Enrollment. The Urban Institute projects that of the 3.7 million children who will lose separate CHIP coverage in 2016, an estimated 1.4 million will enroll in subsidized exchange coverage, 1.2 million will enroll in employer-sponsored coverage, and 1.1 million will become uninsured (Figure 1-3).¹³

FIGURE 1-2. Eligibility among the Projected 3.7 Million Separate-CHIP-Enrolled Children Who Will Lose That Coverage in 2016

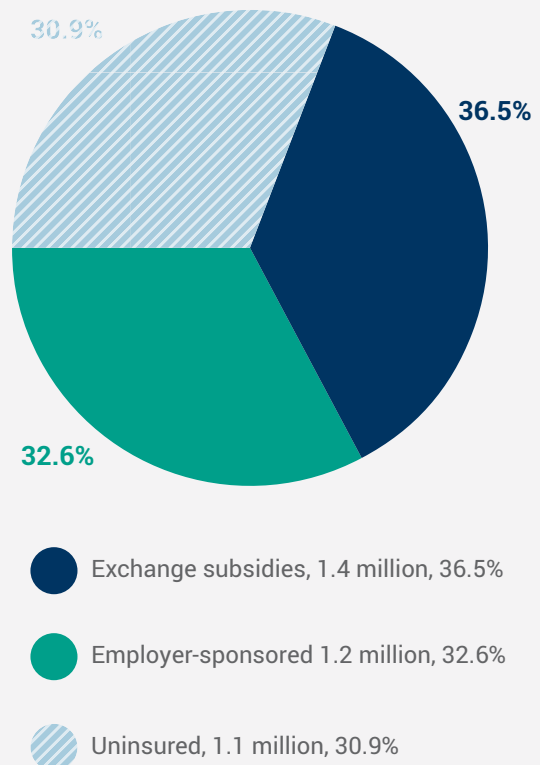





-  Eligible for exchange subsidies: No ESI offer, 1.6 million, 43.7%
-  Eligible for exchange subsidies: ESI not affordable, 0.2 million, 5.7%
-  Eligible for exchange subsidies: ESI excludes dependents, 0.1 million, 1.6%
-  Ineligible for exchange subsidies: Parent offered but not enrolled in ESI, 0.7 million, 19.3%
-  Ineligible for exchange subsidies: Parent enrolled in ESI, 1.1 million, 29.7%

Notes: ESI is employer-sponsored insurance. The number 3.7 million is the number of children projected to be enrolled in separate CHIP at a point in time in 2016 assuming the continuation of CHIP into that year. Excludes unborn children and children enrolled in Medicaid-expansion CHIP. Affordable is defined as ESI with self-only premium less than 9.5 percent of family income per the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

FIGURE 1-3. Projected Subsequent Enrollment in Health Insurance Coverage and Uninsurance among the Projected 3.7 Million Separate-CHIP-Enrolled Children Who Will Lose That Coverage in 2016



-  Exchange subsidies, 1.4 million, 36.5%
-  Employer-sponsored 1.2 million, 32.6%
-  Uninsured, 1.1 million, 30.9%

Notes: The number 3.7 million is the number of children projected to be enrolled in separate CHIP at a point in time in 2016 assuming the continuation of CHIP into that year. Excludes unborn children and children enrolled in Medicaid-expansion CHIP.

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

Children losing CHIP who are eligible for employer-sponsored coverage

Approximately 1.8 million children projected to lose separate CHIP coverage will be eligible for employer-sponsored coverage (Figure 1-2), in which an estimated 1.2 million will enroll (Figure 1-3). If CHIP ends, nearly all children who have a parent in employer-sponsored coverage are projected to join that coverage. This is based on historical experience that parents rarely let their children go uninsured if they have employer-sponsored coverage for themselves.

On the other hand, among the 0.7 million children in separate CHIP coverage whose parents are not enrolled in the employer-sponsored coverage for which they are eligible, 87 percent are projected to become uninsured if CHIP ends. For the parents

of these children to obtain employer-sponsored coverage for their children, they must also obtain coverage for themselves, and the total out-of-pocket premiums may be substantial.

For example, for families whose children lose separate CHIP and are eligible for employer-sponsored coverage, the average additional premiums to obtain family coverage would be approximately \$3,751, or 9.1 percent of family income (Table 1-1).¹⁴ In comparison, the average annual premium for an individual child enrolled in CHIP is \$92 at 160 percent FPL (0.3 percent of family income) and \$319 at 210 percent FPL (0.8 percent of family income) (Bly et al. 2014, Cardwell et al. 2014). Chapter 2 discusses out-of-pocket costs in more detail.

TABLE 1-1. Estimates of Out-of-Pocket Premiums for the 1.8 Million Separate-CHIP-Enrolled Children Who Will Lose That Coverage and Be Eligible for Employer-Sponsored Insurance in 2016

	Additional premium contribution to add child to employer-sponsored insurance ¹		Total premium contribution for family coverage in employer-sponsored insurance	
	Increase in out-of-pocket premium ¹	Percent of income	Total out-of-pocket premium	Percent of income
Average	\$3,751	9.1%	\$5,163	12.2%
Median (50 th percentile)	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

Notes: The number 1.8 million is the number of children projected to lose separate CHIP and be eligible for employer-sponsored insurance at a point in time in 2016. Excludes unborn children, children enrolled in Medicaid-expansion CHIP, and children losing separate CHIP coverage who qualify for exchange subsidies.

¹ This captures the range of possibilities for families to enroll their children, taking into account family structure and the availability and enrollment in employer-sponsored coverage by other family members. For example, in families where one parent is already enrolled, the cost to add a child will be the additional premium for employee-plus-one coverage (if available) or family coverage. On the other hand, if no one is enrolled, then the additional cost to enroll the child is, in fact, the out-of-pocket premium to enroll the entire family.

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSIM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

The additional contributions for employer-sponsored coverage will vary by a number of factors, including whether or not the employee and other dependents are already enrolled. For example, if the employee is already enrolled, then the additional premium to move from self-only to family coverage will be less than if the employee is not enrolled and is moving from no coverage to family coverage. As a result of this and other family and employer characteristics, the average out-of-pocket premiums incurred for adding dependent coverage range widely, from 0.3 percent of income (\$125) in the lowest quartile to 21.1 percent of income (\$8,814) in the highest quartile (Table 1-1).

The total out-of-pocket premiums—that is, employee premium contributions for the entire family—for families with children losing separate CHIP but qualifying for employer-sponsored coverage would average \$5,163, or 12.2 percent of family income (Table 1-1). In light of these substantial costs, many families will decide not to enroll, leading to the projection that approximately 37 percent of children eligible for employer-sponsored insurance will become uninsured without CHIP.

Cost-sharing expenses, such as deductibles and copayments, may also be quite high and influence family decisions about insurance coverage. In 2013, the deductible for those enrolled in employer-sponsored family coverage averaged \$2,491, which amounts to 7.9 percent of income for a family of three at 160 percent FPL and 6.0 percent of income at 210 percent FPL (AHRQ 2013c). As described in Chapter 2 of this report, separate CHIP programs generally do not have deductibles and have substantially less cost sharing (or none at all) compared to employer-sponsored or subsidized exchange coverage.

Children losing separate CHIP who are eligible for subsidized exchange coverage

Among the 1.9 million children losing separate CHIP coverage who would be eligible for exchange

subsidies, 67 percent are projected to enroll in exchange plans and 8 percent in available employer-sponsored coverage, while 25 percent would become uninsured.

Of this group of subsidy-eligible children, 63 percent are expected to face no additional premium to obtain exchange coverage. This is because one or more family members will have already obtained premium tax credits for an exchange plan and, in doing so, will already have paid the maximum family contribution.¹⁵ Thus, the cost of adding the child would be borne not by the family but by the federal government in the form of an increase in the family's tax credit. Nearly all of these children are expected to enroll in subsidized exchange coverage. Despite the fact that the additional premium costs would be fully covered, these children will likely face higher cost-sharing amounts in the form of deductibles and copayments than they would under CHIP.

The remaining 37 percent of subsidy-eligible children will face some premiums, varying according to family income. The required contribution for a family's subsidized exchange coverage in the CHIP income range varies from 3 percent to 9.5 percent of family income, excluding any additional premiums for a standalone dental plan, as described in Chapter 2. While these premiums are generally lower than for employer-sponsored coverage, they would typically be higher than for CHIP. CHIP premiums across all incomes are relatively modest, and they are lower than those in private coverage, particularly for lower-income families.

Children losing CHIP who become uninsured

Of the 1.1 million children projected to become uninsured if CHIP funding is exhausted, 59.1 percent will be eligible for a parent's employer-sponsored coverage and therefore ineligible for exchange subsidies (Figure 1-4). In nearly all of these cases, the parent is not enrolled in that

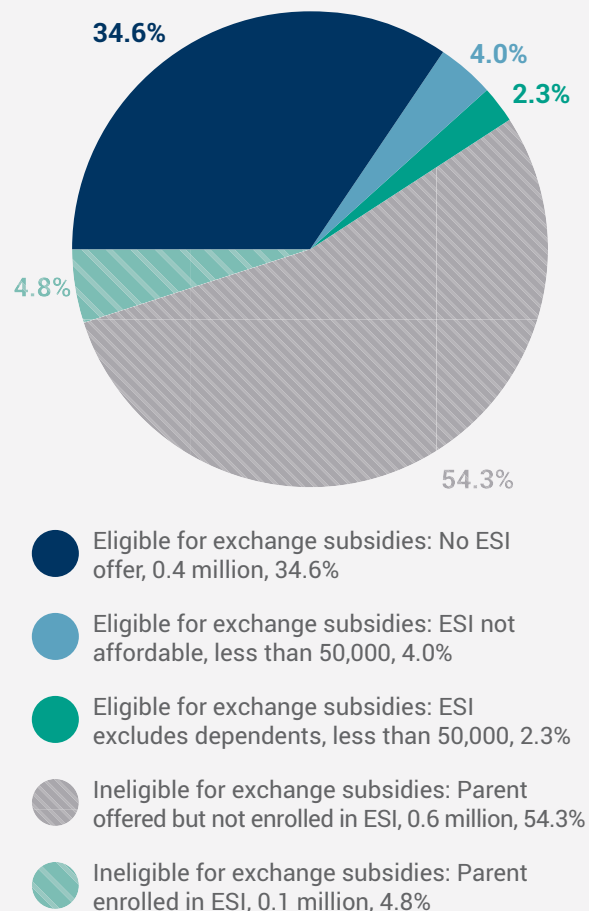
employer-sponsored coverage. The remaining 40.9 percent of children becoming uninsured after CHIP funding runs out would be eligible for subsidized exchange coverage, including 34.6 percent with parents with no offer of employer-sponsored insurance, as well as 2.3 percent whose parents have an offer of employer-sponsored coverage that is not available to dependents, and 4.0 percent whose parents have an offer of employer-sponsored insurance that is not considered affordable according to the ACA (Figure 1-4).

The 1.1 million separate-CHIP-enrolled children who will become uninsured if CHIP funding is exhausted have varying characteristics. The majority are below 200 percent FPL (61.3 percent) and are non-white (53.9 percent). Close to 90 percent have a full-time worker in the family (Table 1-2).

Policy Implications

While the number of uninsured children has been halved since CHIP’s creation 18 years ago, the exhaustion of federal CHIP funds under current law is projected to erode some of those coverage gains. Under current law, states will exhaust their federal CHIP funds in FY 2016, and this is projected to increase the number of uninsured children in 2016 by nearly 40 percent, from 2.9 to 4 million.¹⁶ To prevent this in the short term, the Commission recommended in 2014 that CHIP be extended by two years. For the long term, the Commission is exploring policy options that could reduce the number of children projected to become uninsured without CHIP. These potential options include expanding access to and subsidies for exchange-based coverage, employer-sponsored coverage, and Medicaid. For each option, the Commission is considering the impact on government spending and the effects on families, states, the federal government, plans, and providers, as well as enrollment in privately funded versus publicly funded sources of coverage.

FIGURE 1-4. Eligibility among 1.1 Million Children Projected to Become Uninsured If Their Separate CHIP Coverage Ends in 2016



Notes: ESI is employer-sponsored insurance. The number 1.1 million is the number of separate-CHIP-enrolled children projected to become uninsured at a point in time in 2016 if CHIP funding is not extended. Excludes unborn children and children enrolled in Medicaid-expansion CHIP. Affordable is defined as ESI with self-only premium less than 9.5% of family income per the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

TABLE 1-2. Characteristics of Children Age 0–18 Projected to Have Separate CHIP Coverage and Those Projected to Become Uninsured if CHIP Ends in 2016

Characteristics	Separate CHIP enrollees		Percent projected to become uninsured	Separate CHIP enrollees projected to become uninsured	
Total	3,715,000	100.0%	30.9%	1,148,000	100.0%
Income					
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
201–300% FPL	1,360,000	36.6	29.3	399,000	34.8
301–405% FPL	152,000	4.1	29.9	45,000	4.0
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
Census Division					
New England ¹	157,000	4.2	41.4	65,000	5.6
Middle Atlantic ²	889,000	23.9	30.1	267,000	23.3
East North Central ³	565,000	15.2	40.8	231,000	20.1
West North Central ⁴	223,000	6.0	25.5	57,000	4.9
South Atlantic ⁵	702,000	18.9	28.0	197,000	17.1
East South Central ⁶	331,000	8.9	28.4	94,000	8.2
West South Central ⁷	453,000	12.2	28.2	128,000	11.1
Mountain ⁸	218,000	5.9	29.8	65,000	5.7
Pacific ⁹	177,000	4.8	25.4	45,000	3.9
Age					
0	91,000	2.5	35.7	33,000	2.8
1–5	977,000	26.3	33.1	324,000	28.2
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
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
Any small firm worker in family	1,254,000	33.8	35.7	447,000	39.0
Any self-employed worker in family	741,000	19.9	22.0	163,000	14.2
Child's health status					
Fair or Poor	266,000	7.2	29.6	79,000	6.8
Excellent, Very Good, or Good	3,449,000	92.8	31.0	1,069,000	93.2

Notes: FPL is federal poverty level. Numbers projected at a point in time in 2016.

¹ New England is Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

² Middle Atlantic is New Jersey, New York, and Pennsylvania.

³ East North Central is Illinois, Indiana, Michigan, Ohio, and Wisconsin.

⁴ West North Central is Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota.

⁵ South Atlantic is Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, Washington D.C., and West Virginia.

⁶ East South Central is Alabama, Kentucky, Mississippi, and Tennessee.

⁷ West South Central is Arkansas, Louisiana, Oklahoma, and Texas.

⁸ Mountain is Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming.

⁹ Pacific is Alaska, California, Hawaii, Oregon, and Washington.

Source: Urban Institute analysis for MACPAC of Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) enhanced with Medical Expenditure Panel Survey Insurance Component (MEPS-IC) data from the Agency for Healthcare Research and Quality (see also Dubay et al. 2015).

Endnotes

¹ This projection of children enrolled in separate CHIP programs in 2016 (3.7 million) is lower than MACPAC's previously published historical numbers. This is primarily because the projections in this chapter are of the number of children enrolled in separate CHIP at a point in time, while MACPAC's CHIP enrollment is generally of children ever enrolled during the year, even if for one month. The number ever enrolled during the year will be higher than the number at a point in time. For example, in its June 2014 report to Congress, MACPAC reported that there were 5.3 million children age 0–18 ever enrolled in separate CHIP during fiscal year (FY) 2013, while average monthly enrollment (which is generally comparable to a point-in-time estimate) among these children was 3.4 million. Beginning in 2014, the implementation of modified adjusted gross income as well as the required transition of 6- to 18-year-olds between 100 and 138 percent of the federal poverty level (FPL) from separate CHIP into Medicaid-expansion CHIP have decreased the number of separate CHIP enrollees projected in the model. On the other hand, projected enrollment in separate CHIP is increased because of other factors, such as the effect of the individual mandate penalty being fully in effect.

² An analysis by the Urban Institute from 2011 found that as many as 2 million children could become uninsured if CHIP funding were exhausted (Kenney et al. 2011). That estimate differs from the current one for several reasons. For example, it was modeled using data from several years ago and does not take into account that some states, most notably California, have transitioned the vast majority of their enrollees from separate CHIP to Medicaid-expansion CHIP.

³ Because the maintenance of effort requirement is tied to eligibility policies in place on March 23, 2010, it is not clear whether states that elected to convert much of their population from separate CHIP to Medicaid-expansion after that date, such as California and New Hampshire, will be permitted to remove those children from Medicaid as CHIP funding is exhausted. In addition, if a state covers children enrolled in Medicaid-expansion CHIP under a §1115 waiver that expires prior to FY 2020, the maintenance of effort does not require a state to request an extension (CMS 2011).

⁴ Historically, the federal matching rate has averaged 70 percent for CHIP spending, versus 57 percent for Medicaid. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) increases the federal CHIP matching rate for FYs 2016–2019 by 23 percentage points. As a result, moving from CHIP to Medicaid funding will result in an even larger increase in state spending than the 43 percent difference that has been in place since the creation of CHIP.

⁵ Additional budget effects will be unique to five states with projected CHIP spending under §2105(g) of the Social Security Act. Section 2105(g) spending is projected to total 1 percent of federal CHIP spending nationally in FY 2016. Under §2105(g), 11 qualifying states that expanded Medicaid to higher-income children prior to CHIP's enactment may use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent FPL. Thus, when considering the post-CHIP implications on state budgets, CHIP funding under §2105(g) is similar to funding for children enrolled in Medicaid-expansion CHIP—that is, in both cases, these are children who are enrolled in Medicaid with additional funding provided from CHIP and for whom, in the absence of CHIP funding, states must continue providing coverage through at least FY 2019 with Medicaid funds at Medicaid's federal matching rate. In FY 2016, §2105(g) spending is projected to account for 44 percent of the federal CHIP spending in Connecticut, 55 percent in Minnesota, 15 percent in New Hampshire, 57 percent in Vermont, and 8 percent in Washington.

⁶ Under the ACA, the FY 2016 CHIP matching rate in Maryland will increase by 23 percentage points, to 88 percent.

⁷ Iowa's Medicaid-expansion CHIP also covers infants (under age 1) at 241–380 percent FPL.

⁸ When the maintenance of effort requirement for children expires after FY 2019, states with Medicaid eligibility levels above 138 percent FPL could roll back to the minimum levels. The following 19 states must also maintain Medicaid eligibility levels for infants above 133 percent FPL to at least the levels that were in place on December 19, 1989 (§1902(l)(2)(A)(iv) of the Social Security Act): California, Connecticut, Florida, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, New York, North Carolina, Rhode Island, South Carolina, Vermont, Washington, and West Virginia. The highest level permitted at that time was 185 percent FPL, which was used by all of these states except Florida, Kansas, North Carolina, and West Virginia, which used 150 percent FPL (NGA 1990).

⁹ Even after the maintenance of effort requirement expires, 43 states and the District of Columbia will continue covering at least some children below 138 percent FPL who are mandatory under Medicaid but were previously funded by CHIP. The other seven states (Connecticut, Minnesota, New Hampshire, New Mexico, Oregon, Vermont, and Washington) expanded children's Medicaid eligibility to some level at or above 138 percent FPL prior to the enactment of CHIP and therefore do not qualify for any CHIP-funded coverage of Medicaid-enrolled children below 138 percent FPL.

¹⁰ In the typical CHIP income range in 2016, this penalty will be \$695 for each adult who is uninsured for the entire year and \$347.50 per child, up to a family maximum of \$2,085—or 2.5 percent of countable income, if higher (subject to other limitations). There are several statutory and regulatory exemptions to this penalty (§5000A(d)-(e) of the Internal Revenue Code, 26 CFR 1.5000A-3). While these exemptions would not necessarily apply to all children who lose CHIP, the Secretary of the U.S. Department of Health and Human Services (the Secretary) has the flexibility to exempt any individual found to have suffered a hardship (§5000A(e) (5) of the Internal Revenue Code, 26 CFR 1.5000A-3(h)(3) (iii)). Thus, the Secretary could waive these penalties for all families losing CHIP. However, doing so would further increase the number of children projected to become uninsured without CHIP.

¹¹ The HIPSM-ACS relies on a microsimulation approach based on the relative desirability of health insurance options. This approach, known as a utility-based framework, allows new coverage options to be assessed beyond simply extrapolating from historical data. As mentioned, the decisions of individuals and families in the model take into account factors including 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. Affordability of coverage is built into the model and decisions can be greatly affected by the individual mandate for those who do not qualify for an exemption. The utility model takes into account an individual's choices as reported in the survey data. For example, if a child is currently eligible for Medicaid or CHIP but not enrolled, then the child's parents have shown a preference against such coverage. Such preferences are used to customize individual utility functions so that an individual's current choices score the highest, and this affects that individual's behavior if separate CHIP coverage ends. 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 (Dubay et al. 2015).

¹² These projections are of separate-CHIP-enrolled children age 0–18. They exclude children enrolled in Medicaid-expansion CHIP, adult pregnant women covered by CHIP, and unborn children. In the absence of CHIP funding, unborn children would not be eligible in their own right for Medicaid or exchange coverage.

¹³ These projections do not take into account the possibility that in the absence of CHIP, states could take other actions to cover children in the income range for separate CHIP, such as expanding Medicaid or funding affected children's coverage at 100 percent state expense.

¹⁴ This estimate includes the cost of enrolling the parents who are offered that coverage but are not already enrolled. The estimate is higher among the subset of children projected to become uninsured if CHIP funding ends: It is approximately \$5,500 per year on average, or 13.2 percent of family income, for children projected to become uninsured who are eligible for job-based coverage rather than subsidized exchange coverage.

¹⁵ This assumes families enroll in the second-lowest-cost silver exchange plan, on which premium tax credits are based. If families choose a plan with a different premium, their out-of-pocket payments will vary accordingly.

¹⁶ The projected 2.9 million is the number of uninsured children at a point in time in 2016 assuming the continuation of CHIP in that year.

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