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CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief

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Summary

The State Children’s Health Insurance Program (CHIP) is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but do not have health insurance. CHIP is jointly financed by the federal government and the states and administered by the states. The federal government sets basic requirements for CHIP, but states have the flexibility to design their own version of CHIP within the federal government’s basic framework. States may design their CHIP programs in three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach in which the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. As a result, there is significant variation across CHIP programs. In FY2015, CHIP enrollment totaled 5.9 million and federal and state CHIP expenditures totaled \$13.7 billion.

Under the CHIP statute, FY2017 is the last year federal CHIP funding is provided, even though the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) child maintenance of effort (MOE) requirement is in place through FY2019. The MOE provision requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving federal Medicaid payments (notwithstanding the lack of corresponding federal CHIP appropriations for FY2018 and FY2019). The MOE requirement impacts CHIP Medicaid expansion programs and separate CHIP programs differently.

- *For CHIP Medicaid expansion programs*, when federal CHIP funding is exhausted, the CHIP-eligible children in these programs will continue to be enrolled in Medicaid but financing will switch from CHIP to Medicaid.
- *For separate CHIP programs*, states are provided a couple of exceptions to the MOE requirement: (1) states may impose waiting lists or enrollment caps to limit CHIP expenditures, and (2) after September 1, 2015, states may enroll CHIP-eligible children in qualified health plans in the health insurance exchanges. In addition, in the event that a state’s CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen children for Medicaid eligibility and enroll those who are Medicaid eligible. For children not eligible for Medicaid, the state must establish procedures to enroll CHIP children in qualified health plans in the health insurance exchanges that have been certified by the Secretary of Health and Human Services to be “at least comparable” to CHIP in terms of benefits and cost sharing.

This report discusses the ACA MOE requirement for children if federal CHIP funding expires. It begins with a brief background about CHIP, including information regarding program design and financing. The report then describes the ACA child MOE requirements for CHIP Medicaid expansion programs and for separate CHIP programs and discusses potential coverage implications.

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Introduction

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

This report discusses the ACA MOE requirement for children if federal CHIP funding expires. It begins with a brief background of CHIP, including information regarding program design and financing. The report then describes the ACA child MOE requirements for CHIP Medicaid expansion programs and for separate CHIP programs and discusses potential coverage implications.

CHIP Background

CHIP is a federal-state program that provides health coverage to certain uninsured, low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but do not have health insurance.¹ CHIP is jointly financed by the federal government and the states and is administered by the states. Participation in CHIP is voluntary, and all states and the District of Columbia participate. The federal government sets basic requirements for CHIP, but states have the flexibility to design their own version of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs. In FY2015, CHIP enrollment totaled 5.9 million and federal and state CHIP expenditures totaled \$13.7 billion.²

CHIP was established as part of the Balanced Budget Act of 1997 (P.L. 105-33) under a new Title XXI of the Social Security Act. Since that time, other federal laws have provided additional funding and made significant changes to CHIP. Most notably, the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) increased appropriation levels for CHIP, changed the formula for distributing CHIP funding among states, and altered the eligibility and benefit requirements.³ The ACA largely maintains the current CHIP structure through FY2019 and requires states to maintain their Medicaid and CHIP child eligibility levels through FY2019 as a condition for receiving federal Medicaid matching funds. The ACA provided federal CHIP funding for FY2014 and FY2015, then the Medicare Access and CHIP Reauthorization Act of

¹ For more information about the State Children's Health Insurance Program (CHIP), see CRS Report R43627, *State Children's Health Insurance Program: An Overview*, by Evelyne P. Baumrucker and Alison Mitchell.

² This CHIP enrollment figure is measured according to the average monthly enrollment, which differs from ever-enrolled counts, which measure the number of people covered by Medicaid for any period of time during the year. (The CHIP Statistical Enrollment Dataset.) The Centers for Medicare & Medicaid Services (CMS), the Medicaid Financial Management Reports.

³ For more information on the changes enacted under the Children's Health Insurance Program Reauthorization Act of 2009, see CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker, Elicia J. Herz, and Jane G. Gravelle.

2015 (MACRA; P.L. 114-10) extended federal CHIP funding for another two years (i.e., through FY2017).⁴

Program Design

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

CHIP benefit coverage and cost-sharing rules depend on program design. CHIP Medicaid expansions must follow the federal Medicaid rules for benefits and cost sharing, which entitle CHIP enrollees to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage (effectively eliminating any state-defined limits on the amount, duration, and scope of any benefit listed in Medicaid statute) and exempt the majority of children from any cost sharing. For separate CHIP programs, states can design benefits that look more like private health insurance and may impose cost sharing, such as premiums or co-payments, with a maximum allowable amount that is tied to annual family income. Aggregate cost sharing under CHIP may not exceed 5% of annual family income.

Regardless of the choice of program design, all states must cover emergency services; well-baby and well-child care, including age-appropriate immunizations; and dental services. If offered, mental health services must meet federal mental health parity requirements. States that want to make changes to their programs beyond what Medicaid or CHIP laws allow may seek approval from the Centers for Medicare & Medicaid Services (CMS) through the use of the Section 1115 waiver authority.⁵

Eight states, the District of Columbia, and the territories had CHIP Medicaid expansions as of May 1, 2015, whereas 13 states had separate CHIP programs and 29 states used a combination approach.⁶ According to preliminary CHIP enrollment data for FY2015, almost 60% of CHIP enrollees are in CHIP Medicaid expansion programs and 40% are in separate CHIP programs.⁷

⁴ For more information about the changes enacted under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*, coordinated by Jim Hahn.

⁵ Under §1115 of the Social Security Act, the Secretary of Health and Human Services (HHS) may waive CHIP program requirements so states can test new program design options that further the goals of the CHIP program. CHIP §1115 waivers are time limited (up to five years) and must be allotment neutral to the federal government. In other words, they cannot cost the federal government more than what is available under the state's annual allotment(s) (i.e., federal funds allocated to each state for the federal share of its CHIP expenditures) applicable to the fiscal years for which the demonstration is operational.

⁶ As of May 1, 2015, two states (Washington and Connecticut) had separate CHIP programs with no Medicaid expansions. The remaining 11 states (Alabama, Arizona, Georgia, Kansas, Oregon, Mississippi, Pennsylvania, Texas, Utah, West Virginia, and Wyoming) are considered to have separate CHIP programs, but technically these programs are part of combination CHIP programs due to the ACA requirement to transition CHIP children aged 6 through 18 in families with annual income less than 133% of the federal poverty level (based on modified adjusted gross income, or MAGI) to Medicaid, beginning January 1, 2014. CMS, *Children's Health Insurance Program Plan Activity*, as of May 1, 2015.

⁷ CMS, CHIP Statistical Enrollment Dataset.

CHIP Financing

CHIP is jointly financed by the federal government and the states.⁸ The federal government reimburses states for a portion of every dollar they spend on CHIP (including both CHIP Medicaid expansions and separate CHIP programs) up to state-specific annual limits called allotments. The federal government's share of CHIP expenditures (including both services and administration) is determined by the enhanced federal medical assistance percentage (E-FMAP) rate that varies by state. The E-FMAP rate is calculated by reducing the state share under the federal medical assistance percentage (FMAP) rate (i.e., the federal matching rate for most Medicaid expenditures) by 30%, which increases the federal share of expenditures.⁹ For FY2016 through FY2019, the E-FMAP rate increases by 23 percentage points for most CHIP expenditures. With this increase, the E-FMAP ranges from 88% to 100%.

Although FY2017 is the last year states are to receive CHIP allotments, federal CHIP outlays are expected in FY2018. States have two years to spend their CHIP allotment funds, so states could have access to unspent funds from their FY2017 allotments and unspent FY2016 allotments redistributed to shortfall states (if any).¹⁰

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, certain states significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997.¹¹ These states are allowed to use their CHIP allotment funds to finance the difference between the Medicaid and CHIP matching rates (i.e., the FMAP and E-FMAP rates, respectively) to cover the cost of children in Medicaid above 133% of the federal poverty level (FPL).¹² In addition, states may use CHIP allotment funds and receive the higher CHIP matching rate (i.e., E-FMAP rate) for expenditures for children who had been enrolled in separate CHIP programs and were transitioned to Medicaid due to the ACA provision expanding mandatory Medicaid eligibility for children aged 6 to 18 with incomes up to 133% of FPL.¹³

States that design their CHIP programs as a CHIP Medicaid expansion or a combination program and face a shortfall after receiving Child Enrollment Contingency Fund payments and redistribution funds may receive federal Medicaid matching funds to fund the shortfall in the CHIP Medicaid expansion portion of their CHIP programs.¹⁴ When Medicaid funds are used to fund CHIP, the state receives the lower regular FMAP rate (i.e., the federal Medicaid matching rate) rather than the higher E-FMAP rate provided for other CHIP expenditures. However,

⁸ For more information about federal CHIP financing, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by Alison Mitchell.

⁹ For more information about the federal medical assistance percentage (FMAP) rate and how it is calculated, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell.

¹⁰ If a state's CHIP allotment for the current year, in addition to any allotment funds carried over from the prior year, is insufficient to cover the projected CHIP expenditures for the current year, a few different shortfall funding sources are available. These include Child Enrollment Contingency Funds, redistribution funds, and Medicaid funds.

¹¹ The following 11 states meet this definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.

¹² §2015(g) of the Social Security Act.

¹³ The E-FMAP rate is *not* available for children aged 6 to 18 who have access to private health insurance.

¹⁴ If a state's CHIP allotment for the current year, in addition to any allotment funds carried over from the prior year, is insufficient to cover the state's projected CHIP expenditures for the current year, a few different shortfall funding sources are available. Child Enrollment Contingency Fund payments and redistribution funds are two sources of CHIP shortfall funding. For more information about CHIP shortfall funding, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by Alison Mitchell.

although federal CHIP funding is capped, federal Medicaid funding is open-ended, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

MOE Requirement

The ACA extended and expanded the MOE provisions in the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5).¹⁵ The ACA MOE provisions contain separate requirements for Medicaid and CHIP and were designed to ensure that individuals eligible for these programs did not lose coverage between the date of enactment of the ACA (March 23, 2010) and the implementation of the health insurance exchanges (for adults) and September 30, 2019 (for children).

Under the ACA MOE provisions, states are required to maintain their Medicaid programs with the same eligibility standards, methodologies, and procedures in place on the date of enactment of the ACA until January 1, 2014, for adults and through September 30, 2019, for children up to the age of 19. The ACA also requires states to maintain income eligibility levels for CHIP children through September 30, 2019, as a condition for receiving payments under Medicaid.¹⁶ The penalty to states for not complying with either the Medicaid or the CHIP MOE requirements would be the loss of all federal Medicaid matching funds.¹⁷

Together, these MOE requirements for Medicaid and CHIP impact CHIP Medicaid expansion programs and separate CHIP programs differently.¹⁸

CHIP Medicaid Expansion Programs

For CHIP Medicaid expansion programs, the Medicaid and CHIP MOE provisions apply concurrently. For states to continue to receive federal Medicaid funds, the ACA child MOE provisions require that CHIP-eligible children in CHIP Medicaid expansion programs must continue to be eligible for Medicaid through September 30, 2019.¹⁹ When a state's federal CHIP funding is exhausted, the state's financing for these children switches from CHIP to Medicaid. This switch would cause the state share of covering these children to increase because the federal matching rate for Medicaid is less than the E-FMAP rate.

As discussed above, states may have some Medicaid expenditures financed with federal CHIP funds. In any of these situations, when federal CHIP funding is exhausted, states would be responsible for continuing to provide Medicaid coverage to these children through September 30, 2019. However, as is the case with the CHIP Medicaid expansion programs, the financing would switch from CHIP to Medicaid, resulting in an increase in the state share of these expenditures because the federal matching rate would be lowered from the E-FMAP rate to the FMAP rate.

¹⁵ The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5; extended in P.L. 111-226) included a temporary increase in the FMAP. To receive the FMAP increase under ARRA, states were required to maintain the same Medicaid eligibility standards, methodologies, and procedures in effect on July 1, 2008, through June 30, 2011.

¹⁶ §2105(d)(3) of the Social Security Act.

¹⁷ §1902(gg)(2) of the Social Security Act.

¹⁸ The Secretary of HHS has not issued guidance regarding the impact of the maintenance of effort (MOE) requirements if federal CHIP funding expires.

¹⁹ CHIP children covered under CHIP Medicaid expansion programs are an optional eligibility group under Medicaid. However, because the Medicaid MOE for children extends through FY2019, states are not permitted to roll back Medicaid eligibility for these children without the loss of all Medicaid federal matching funds.

Separate CHIP Programs

For separate CHIP programs, only the CHIP-specific provisions of the ACA MOE requirements are applicable. These provisions contain a couple of exceptions:

- states may impose waiting lists or enrollment caps to limit CHIP expenditures, or
- after September 1, 2015, states may enroll CHIP-eligible children in qualified health plans in the health insurance exchanges that have been certified by the Secretary of Health and Human Services (HHS) to be “at least comparable” to CHIP in terms of benefits and cost sharing.

In addition, in the event that a state’s CHIP allotment is insufficient to fund CHIP coverage for all eligible children, a state must establish procedures to screen CHIP-eligible children for Medicaid eligibility and to enroll those who are eligible in Medicaid.²⁰

For children not eligible for Medicaid, the state must establish procedures to enroll CHIP-eligible children in qualified health plans offered in the health insurance exchanges that have been certified by the Secretary of HHS to be “at least comparable” to CHIP in terms of benefits and cost sharing.

The Secretary of HHS was required by statute to review the benefits and cost sharing for children under the qualified health plans in the exchanges and certify those plans that offer benefits and cost sharing at least comparable to CHIP coverage.²¹ In the review released November 25, 2015, the Secretary of HHS was not able to certify any qualified health plans as comparable to CHIP coverage because out-of-pocket costs were higher under the qualified health plans and the CHIP benefits were generally more comprehensive for child-specific services (e.g., dental, vision, and habilitation services).²²

Under these ACA MOE requirements, states are required only to establish procedures to enroll children in qualified health plans certified by the Secretary. If there are no certified plans, the MOE requirement does not obligate states to provide coverage to these children. Even when there are certified plans, not all CHIP children may be eligible for subsidized exchange coverage due to the *family glitch*,²³ among other reasons.

²⁰ States must conduct eligibility redeterminations for Medicaid and CHIP at least annually. Due to fluctuations in income among the CHIP target population, it is possible that a formerly CHIP-eligible child may meet the state’s Medicaid eligibility standard due to a change in annual income that may not have been taken into consideration until the enrollee’s next regularly scheduled eligibility redetermination.

²¹ §2105(d)(3)(C) of the Social Security Act.

²² The Department of Health and Human Services reviewed the second-lowest-cost silver plan in the largest rating area in each state to compare it to CHIP in that state. (CMS, *Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans*, November 25, 2015.)

²³ Subsidized coverage in the health insurance exchanges is not available to individuals with access to affordable health insurance. The *family glitch* results from the definition of affordable coverage. Under the ACA, employer-sponsored insurance is considered affordable if an employee’s premium contributions for self-only coverage (not family coverage) comprise less than 9.5% of household income. However, there is no affordability limit on the employee’s share of the premium for family coverage. Due to the family glitch, some current CHIP enrollees would *not* be eligible for subsidized coverage in the health insurance exchanges based on a parent’s access to affordable employer-sponsored insurance. For more information about subsidized coverage in the health insurance exchanges, see CRS Report R44425, *Eligibility and Determination of Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*, by Bernadette Fernandez.

Conclusion

FY2017 is the last year in which federal CHIP funding is provided in the CHIP statute. If no additional federal funding is provided for the program, once federal CHIP funding is exhausted, CHIP children in CHIP Medicaid expansion programs would continue to receive coverage under Medicaid through at least FY2019, due to the ACA MOE requirement. However, when CHIP funding is exhausted, CHIP children in separate CHIP programs could obtain coverage through the exchanges or employer-sponsored insurance, but some of the children likely would become uninsured. According to a Medicaid and CHIP Payment and Access Commission estimate of what would happen if separate CHIP coverage ended in FY2018 (which is when federal CHIP funding is expected to be exhausted under current law), 36% of the children with separate CHIP coverage would become uninsured.²⁴

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²⁴ Medicaid and CHIP Payment and Access Commission, *Consideration of Criteria and Options for Children's Coverage*, Presentation, March 31, 2016.