

BACKGROUND

No. 3263 | NOVEMBER 1, 2017

The State Children's Health Insurance Program at 20: A Reform Agenda for Congress

Meridian Paulton, Robert E. Moffit, PhD, and Marie Fishpaw

Abstract

Funding recently expired for the states' Children's Health Insurance Program (CHIP), and states will soon run out of funds for their programs. Congress must decide how it will respond. While the debate is focused more on funding, it is even more important to resolve the policy problems that beset the program. Congress created this program in 1997 to address the problem of children lacking health insurance. American taxpayers have invested billions of dollars, with mixed results. Millions of children have received coverage. However, CHIP expansion has also contributed to the "crowding out" of private health insurance coverage for children, as coverage expansion has occurred by adding children to the government health care program. As a result, access to coverage itself does not automatically translate into access to appropriate health care options that fit a particular family's needs, since public programs leave government officials—not parents—in charge of many decisions. CHIP-enrolled children often do not have the same level of access to medical specialists as privately insured children, and they are more likely than privately insured children to resort to costly hospital emergency room services. Congress should make structural policy changes, particularly in the program's financing.

Congress is now overdue to reauthorize funding for the State Children's Health Insurance Program (CHIP). The funding provided in the last reauthorization expired on September 30 and by the end of this year, states will begin to run out of money to fund their programs. While the current congressional debate is focused primarily on funding,¹ it is even more important to resolve the policy problems that beset the program.

KEY POINTS

- Starting this fall, the Children's Health Insurance Program (CHIP) begins to run out of money and faces a multi-billion-dollar funding gap created by Obamacare.
- CHIP contributes to "crowding out" private health insurance for children by providing government insurance for millions of children. A smaller percentage of children are privately insured today than they were 20 years ago.
- Private coverage for children is preferable. Public programs place government officials—not parents—in charge of plan selection. CHIP-enrolled children often lack the level of access to medical specialists that privately insured children have, and they are more likely to use costly hospital emergency room services.
- Congress should adopt significant structural reforms to the 20-year-old CHIP—restructuring the program so parents are in charge of selecting their children's plan, giving families the flexibility to choose from new and innovative private health plans, and focusing federal funding on those who need it most.

This paper, in its entirety, can be found at <http://report.heritage.org/bg3263>

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

Twenty years ago in 1997, Congress created CHIP to address the problem of uninsured American children.² Since that time, American taxpayers have invested billions of dollars,³ with mixed results. Millions of children have received access to coverage. However, CHIP expansion also has contributed to the “crowding out” of private health insurance coverage for children. Moreover, states offer a limited set of coverage options, so access to coverage itself does not automatically translate into access to a variety of quality health care options for all children. CHIP-enrolled children often do not have the same level of access to medical specialists as privately insured children, and they are more likely than privately insured children to resort to hospital emergency room services, which are generally costlier than services delivered in conventional outpatient settings.

New CHIP Policies

Congress should make structural policy changes to CHIP, particularly in the program’s financing. To ensure that CHIP better meets its coverage goals, improves children’s health options, and yields a better return on the taxpayers’ investment, Congress should make three major policy changes.

1. Establish a Defined Contribution Payment System. Congress should convert CHIP into a per capita allotment program for eligible children. That way, parents can secure CHIP funds for the kind of health coverage they choose for their children, whether public or private—including employer-sponsored plans. Currently, states hold the power to decide whether parents will have these options. Letting parents decide where their money goes would enable a

greater number of low-income children and their parents to choose private health insurance plans just like others do. It would allow parents to use CHIP funds to help finance family coverage if the parents wished to include their children in their own health plans. Families would be able to consider family health care options holistically. In at least some cases, families would be able to receive care that would be harder to obtain through conventional CHIP coverage.

2. Empower Parents and Encourage States to Create New Coverage Options for CHIP Recipients. Congress should ensure that enrollees have access to the full range of private insurance options, including employer-provided health care, health-savings-accounts-linked plans, or plans with a direct primary care component.⁴ Today, most states set up their programs as an extension of Medicaid or a similar state-defined approach. The health care system is undergoing rapid transition, and enrollees in government programs, such as CHIP, ought to be able to access new health care options, instead of being trapped in bureaucratic boxes. Moreover, Congress should return to its efforts to address Obamacare’s damage and give states the authority to make regulatory changes in their insurance markets: Under Obamacare, the private market consists of limited options primarily regulated by federal mandates that have driven up the cost of care and reduced plan choices.

3. Focus Federal Funds on the Most Vulnerable. When CHIP was enacted in 1997, it was supposed to be a federal–state partnership. Now, it has largely become another Washington-financed program, as federal payments have become a progressively larger part of the program (due in part to Obamacare).⁵ Congress should

1. Meridian M. Paulton, “Congressional CHIP Bills Fall Short of Needed Reforms,” Heritage Foundation *Issue Brief* No. 4776, October 19, 2017, <http://www.heritage.org/sites/default/files/2017-10/IB4776.pdf>.

2. CHIP was enacted as part of the Balanced Budget Amendment of 1997 and was authorized under Title 21 of the Social Security Act. Increased tobacco taxes provide funding for block grants to each of the states and five U.S. territories—American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands. See 42 U.S. Code § 1397dd(c)(3) (2017). States are ineligible to receive federal funding under this subtitle if they fail to administer a CHIP program according to the federally prescribed program parameters. 42 U.S. Code § 1397aa(b) (2017).

3. Centers for Medicare and Medicaid Services, “CMS-21 Annual CHIP Expenditures Reports,” <https://www.medicare.gov/medicaid/data-and-systems/macbis/mbes/cms-21/cms-21-chip/index.html> (accessed August 25, 2017).

4. Conservatives have suggested for some time that, if the government spends money to enroll a person in a public plan, it “ought to be willing to spend an identical sum on private insurance instead.” See John C. Goodman, “Applying the ‘Do No Harm’ Principle to Health Policy,” *The Journal of Legal Medicine*, Vol. 28, (2007), pp. 37–52.

5. CHIP has, in effect, become an almost entirely federally funded program. However, when Congress created the program in 1997, it was named the State Children’s Health Insurance Program (SCHIP). Gradually, as the program evolved, it has become known as CHIP—dropping the use of the word “State.” This reflects the substantive changes to the program’s nature. Given the dominant role of the federal government in the program’s funding, the state role is becoming subordinate in the “partnership.” The policy changes in this proposal are, in part, intended to encourage states to take greater ownership of their own programs, and return the main program, over time, to its original design.

start to gradually roll back the current level of federal funding for the program over a multi-year period. Federal payment should go to low-income persons and families who need federal assistance the most. So, while federal funds today match coverage for families as high as 405 percent of the federal poverty level (FPL), Congress should gradually reduce the federal share of payment to 250 percent of the FPL, and allow states to fund higher eligibility levels if they wish to do so.

How CHIP Works Today

Americans normally get their health insurance coverage in one of three ways: (1) from their employers in group health insurance, where they enjoy federal tax relief for their coverage; (2) in the individual market, where many middle-income persons must pay for health insurance coverage with after-tax dollars;⁶ or (3) through a government health program, such as Medicaid, Medicare, or CHIP.

CHIP is structured as a program run by the states and funded in large part by the federal government. Funding is allocated in two-year cycles,⁷ and states are expected to operate their programs within provided amounts. Limited options are available to states that may run short of funds over the allocation period.⁸

To receive federal funds for the program, states must follow federal requirements for eligibility and types of medical services provided. In practice, states

largely focus eligibility on lower-income families, but they can receive federal matching funds for expanding eligibility to much higher income levels. Twenty-nine states extend eligibility to children who live in households earning over 250 percent of the FPL.

The vast majority (nearly 89 percent) of families on the program are at or below 200 percent of the FPL. For a family of four, that equates to \$49,200 in annual household income. Over 97 percent of children who are on CHIP are in families with incomes at or below 250 percent of the FPL, or \$61,500 for a family of four.⁹ The remaining 2.6 percent of children enrolled in the program are in households earning above 250 percent of the FPL. The highest eligibility level is in New York, where a family of four with an annual income of over \$99,000 could still qualify for CHIP if the children were uninsured.

To implement their programs, states may adopt one of three federally sanctioned approaches. States may (1) expand Medicaid to cover the additional population (and thus follow Medicaid rules); (2) create a new “stand-alone” program to cover the eligible individuals (and thus enjoy more independence from the federal requirements for eligibility and benefit design than with the Medicaid option); or (3) adopt a bifurcated approach that covers some children through Medicaid and others through a stand-alone program.¹⁰ If states choose the bifurcated approach, those on the low end of the income eligibility scale are covered through

-
6. Lower-income persons enrolled in the health insurance exchanges receive tax subsidies via Obamacare. See Kaiser Family Foundation, “Explaining Health Care Reform: Questions About Health,” November 1, 2016, <http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/> (accessed August 25, 2017).
 7. The formula that determines the amount of funding is called the Enhanced Federal Medical Assistance Program (E-FMAP). It allocates grants to the states based on a combination of average incomes in the state and certain floors and ceilings imposed by the governing statute. States receive federal funding based on the state’s previous spending on the program, increased by a growth variable. The exact calculation per state for the federal reimbursement of state spending is determined by average income in the state, compared against the national average. (This calculation constitutes the E-FMAP.) Obamacare requires that the E-FMAP be provided at a rate of 88 percent to 100 percent through fiscal year (FY) 2019. Allotments are given in two-year increments. See Medicaid and CHIP Payment and Access Commission, “CHIP Financing,” <https://www.macpac.gov/subtopic/financing/> (accessed August 25, 2017).
 8. For states that may run short of funds before any given two-year allocation period ends, emergency funding is available in three forms: (1) The Child Enrollment Contingency Fund (CECF) provides funds in states that are short of funds with enrollment above a target level; (2) any funds that are unused after the two-year allocation period are put in a fund for redistribution to states with shortfalls; however, only one state, Iowa, has received redistribution funds, according to the Congressional Research Service; and (3) Medicaid itself may help to fill in the funding gaps. See Alison Mitchell, “Federal Financing for the State Children’s Health Insurance Program,” Congressional Research Service, September 19, 2016, <https://fas.org/sgp/crs/misc/R43949.pdf> (accessed August 25, 2017).
 9. Medicaid and CHIP Payment and Access Commission, “CHIP Eligibility,” <https://www.macpac.gov/subtopic/eligibility-2/> (accessed September 14, 2017). Calculations based on Healthcare.gov, “Federal Poverty Level,” <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/> (accessed September 14, 2017).
 10. For example, in Colorado, children are eligible for Medicaid-funded CHIP if their family’s income is up to 147 percent of the FPL. Past 147 percent of the FPL, children can enroll in a separate CHIP program when their family income is up to 265 percent of the FPL. See Kaiser Family Foundation, “Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults,” March 15, 2017, <http://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/> (accessed August 25, 2017).
-

Medicaid expansion packs, while those with higher incomes are placed in the separate CHIP program.

Today, 13 states have a stand-alone CHIP program and nine states designed their CHIP program as a Medicaid expansion.¹¹ The remaining 29 states opt to follow the bifurcated approach.¹²

Obamacare's Impact on CHIP

Obamacare changed CHIP program funding in two primary ways. First, Obamacare increased the federal share of CHIP funding. It did so by increasing the CHIP matching rate by up to 23 percentage points.¹³ For example, a state that previously received federal funds at a match rate of 77 percent would henceforth be able to get those funds at a match rate of 100 percent.

The result: The vast majority of CHIP spending today comes from the federal government.¹⁴ In fiscal year (FY) 2016, of the \$15.6 billion spent on CHIP, less than \$2 billion came from state contributions.¹⁵

Second, Obamacare made it more difficult for states to manage their programs. It did so by extending CHIP eligibility levels past the expiration of funding in 2017, by imposing a “maintenance of effort” (MOE) requirement that states maintain pre-Obamacare eligibility

levels for their CHIP programs through September 30, 2019.¹⁶ If they do not, under Obamacare, they lose federal matching funds for Medicaid. Obamacare also provided that in the event that a state discontinues its CHIP program, the Medicaid-eligible CHIP enrollees in the state must be maintained in Medicaid. This action is taken regardless of the preferences of the parents of these children. This requirement constrains the states' ability to adjust their enrolled population, or to end their programs.¹⁷

The MOE has the additional effect of preventing states from shifting children with family incomes above the Medicaid eligibility level into federally subsidized exchange coverage. Absent the MOE, it is possible that more children now on CHIP would move into private plans that cover the whole family. For example, this could occur in California. There, if a CHIP family had an income in the range of 108 percent of the FPL to 142 percent of the FPL, children under age six would receive Medicaid coverage, and children ages six and above would receive separate CHIP funding. This further contributes to the balkanization of the family in health coverage.¹⁸

11. Ibid.

12. U.S. Census Bureau, “The 15 Most Populous Cities: July 1, 2016,” <https://www.census.gov/content/dam/Census/newsroom/releases/2017/cb17-81-table3-most-populous.pdf> (accessed September 13, 2017).

13. The Federal Medical Assistance Percentage (FMAP) provides federal money to the states for their health care programs. The FMAP is the means by which states receive their funding for CHIP. For every dollar that a state spends, the federal government reimburses that state a certain percentage. Prior to Obamacare, the FMAP that CHIP programs received fell between 65 percent and 81 percent, depending on the state. That figure is now between 88 percent and 100 percent. (CHIP E-FMAPs are calculated based on Medicaid FMAPs, which change based on per capita income in a state relative to the national average.) See Kaiser Family Foundation, “Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP,” set to FY 2018, <http://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed August 25, 2017).

14. 42 U.S. Code § 1397dd (2017). FMAP multipliers available at Kaiser Family Foundation, “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier,” <http://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed August 25, 2017). Previously, the variable rate was 23 points lower, but this adjustment came with the ACA adjustments to the E-FMAP. For previous rates, see Kaiser Family Foundation, “Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP,” set to FY 2015, <http://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed August 25, 2017).

15. Medicaid and CHIP Payment and Access Commission, “Exhibit 32. CHIP Spending by State, FY 2016 (millions),” <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-32.-CHIP-Spending-by-State-FY-2016-millions.pdf> (accessed August 25, 2017).

16. Alison Mitchell and Evelyne P. Baumrucker, “CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief,” Congressional Research Service, September 19, 2016, <https://fas.org/sgp/crs/misc/R43909.pdf> (accessed September 5, 2017).

17. For context: As of FY 2016, about 8.9 million children were enrolled in CHIP at some point during the year. See Centers for Medicare and Medicaid Services, “Unduplicated Number of Children Ever Enrolled,” Medicaid.gov, <https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf> (accessed August 25, 2017).

18. Based on eligibility levels listed at: Kaiser Family Foundation, “Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level (FPL),” as of January 1, 2017, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed October 30, 2017).

CHIP's Performance: A Mixed Record

CHIP has a mixed record. This points to the need for structural reforms that would improve access to quality health care options for eligible children and their families. While children's insurance rates have fallen, public coverage has also expanded.

Increased Number of Insured Children at the Cost of Private Crowd-Out. Millions of children have received coverage.¹⁹ However, CHIP expansion has occurred simultaneously with a decrease in private health insurance coverage for children.

Expansions of public health programs have occurred at the same time as a decrease in private health insurance coverage, such as employer-sponsored coverage. Since the creation of CHIP, the percentage of children who are enrolled in any kind of public health plan coverage (including Medicaid, CHIP, and other forms of public coverage) has increased from 21.4 percent in 1997 to 43 percent in 2016.²⁰ At the same time, the percentage of children who are covered by some form of private insurance has fallen from 66.2 percent in 1997 to 53.8 percent in 2016.²¹ In March 2017, the total number of children enrolled in Medicaid or CHIP was about 36 million²²—more than the total population of America's 15 largest cities combined.²³

Less Access to Care. Children enrolled in public plans sometimes have less access to medical care and services, particularly specialist care, than those enrolled in private insurance. Data from the Kaiser Family Foundation shows that children on CHIP are:²⁴

- Three times more likely than privately insured children to have difficulty getting a referral to a specialist, and they are more likely to have their coverage rejected by a specialist;
- More likely than privately insured children to use the emergency department (even though many primary care physicians do offer services to CHIP children); and
- Less likely to visit a dentist.

Data from the Government Accountability Office also demonstrate this concern with CHIP:

- Among children under age six, only about one-third had preventive health services.
- Children on CHIP are half as likely as privately insured children to see an orthodontist.
- Less than half of CHIP-ensured children received preventive dental services, and only a quarter received dental treatment services.²⁵

Moreover, original Heritage Foundation data analysis confirms the differences in comparative performance between public and private insurance. For example, there is a projected 7 percentage point difference in specialist access between the two groups, where access is defined by "usually or always easy for the child to see a necessary specialist."²⁶

19. Since 1997, the rate of children who are uninsured has fallen about 8.8 percentage points total. See National Center for Health Statistics, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016," Table III, p. A6, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf> (accessed August 25, 2017).

20. National Center for Health Statistics, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016," Table III, p. A6.

21. Ibid.

22. Medicaid.gov, "June 2017 Medicaid and CHIP Enrollment Data Highlights," <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html> (accessed September 13, 2017).

23. U.S. Census Bureau, "The 15 Most Populous Cities: July 1, 2016."

24. Julia Paradise, "The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us?" Kaiser Family Foundation, July 17, 2014, <http://www.kff.org/report-section/the-impact-of-the-childrens-health-insurance-program-chip-issue-brief/> (accessed August 25, 2017). Some factors, such as likelihood to receive a well-child check-up, can be explained by socioeconomic differences, according to the Kaiser study. The actual receipt of specialist care can also be explained in this way. However, the factors listed here remain after socioeconomic differences are accounted for, or, in the case of specialist care, is a reference specifically to the difficulty of getting referrals, not to the receipt of visits.

25. Government Accountability Office, "Children's Health Insurance Program: Effects on Coverage and Access, and Considerations for Extending Funding," February 2015, <http://www.gao.gov/assets/670/668768.pdf> 9 (accessed August 25, 2017).

26. Estimate generated from Heritage Health Insurance Microsimulation Model (HHIMM). This model is a large model that draws data from the various public datasets, including, in particular, the Medical Expenditure Panel Survey (MEPS).

As noted, in many states, CHIP is simply an extension of the state's Medicaid program. But the Medicaid program itself has been rightly criticized for providing substandard access to care with a lower performance on medical outcomes.²⁷

Artificially Separating Parents' and Children's Coverage

In private health insurance, it is routine for private plans to offer family coverage as well as single coverage, and offer premium rates reflecting those coverage arrangements.²⁸

Sound policy would enable parents to pick the coverage that is best for them and their children, and enable them to keep the whole family on one plan. Under CHIP, children are on one plan; the parents may be on another; and as noted, in some states, a family could have a young child on Medicaid and an older child on CHIP. Parents with insurance ought to be able to include their children in their family's coverage. Today, however, power to put CHIP dollars toward a single family plan is in the hands of the state, not individual parents: This lends itself to artificial separation of children and parents. The artificial separation can discourage the best and most efficient use of health insurance dollars, and inhibit the development of the best health care options for families and children.

In short, Congress should encourage improvement in children's coverage by allowing parents to make the choice about whole-family participation in a single health plan. The arrangement would encourage greater overall coverage. Research shows that children are more likely to be insured if their parents are insured.²⁹ It may be true that CHIP has improved children's coverage; but children could be helped even more if parents and children were supported in obtaining health insurance as a family.

How to Reform the CHIP Program

Congress should take this opportunity to learn from the program's mixed track record, and address its structural issues with three key reforms:

1. Restructure Federal CHIP Payment as a Defined Contribution System. Congress should enable parents to use CHIP funds to buy the coverage they want for their children. This requires converting the program into a defined contribution, or per capita allotment. This policy would build on the success of other defined contribution health programs, such as Medicare Advantage, a system of private competitive plans within Medicare, and Medicare Part D, the prescription drug program. Congress also uses this approach for the federal workforce through the Federal Employees Health Benefits Program (FEHBP). In each case, Congress makes a per capita payment, based on a formula, to the plan of the enrollees' choice. Plans compete directly for the consumers' dollars. The result has been high patient satisfaction, benefit innovations, and greater competition that has controlled program and beneficiary costs.

2. Provide Families Flexibility to Choose from New and Innovative Private Health Plan Options. Congress should give parents the choice to enroll in a wide variety of private health plans, including employer-sponsored plans and new and innovative health plans. This may include health savings accounts, plans with a heavy emphasis on primary care or pediatric care, or plans with a direct primary care component.

This policy would empower parents to choose the best plan that meets the particular health care needs of their children. Parents may determine that a child should have access to certain types of specialists, or parents could choose to use their dollars toward an employer-based insurance, if available. When combined with a defined contribution financing mechanism, parents may be able to use CHIP dollars to add their children to their own health plan, rather than keeping their child in an entirely separate plan with different

27. Kevin D. Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation *Backgrounder* No. 2740, November 7, 2012, <http://www.heritage.org/health-care-reform/report/studies-show-medicaid-patients-have-worse-access-and-outcomes-the>.

28. Even Obamacare—despite its many shortcomings—recognized this fact as the standard approach. Premiums and tax credits under Obamacare automatically adjust for family size and composition.

29. Georgetown University Health Policy Institute: Center for Children and Families, "Health Coverage for Parents and Caregivers Helps Children," <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf> (accessed August 25, 2017).

access and benefit packages. This reform could provide incentives and the ability to help families think holistically about health care.

Such a reform would also help to reverse the phenomenon of crowd-out. As noted, public coverage expansions often crowd out private insurance. By providing low-income persons with the means to engage in the private market, it can expand private options and reduce the progressively heavier reliance on public coverage that had been characteristic of health policy for decades. By giving parents the flexibility to provide the kind of coverage they want for their children, and encouraging states to provide access to a full range of private insurance options, Congress would encourage more robust private and employer-based markets.

3. Focus Federal Funding on Those Who Need it Most. Congress should address the policy problem with the program's funding mechanism. Today, the bulk of CHIP funding comes from the federal taxpayers, with the federal match rate as high as 100 percent in some states. While most enrollees are in households with incomes of 250 percent of the FPL or lower, states may expand their programs to higher-income persons and receive federal matching funds.³⁰ As noted, federal CHIP funds are available, as in the case of New York, to families with incomes at 405 percent of the FPL—in other words, a family with an annual income of over \$99,000.³¹

Over a period of years, Congress could gradually focus federal spending on individuals who are most in need. A gradual reduction would prevent any abrupt loss in coverage during the transition by allowing states to make up any difference in the shortfall, or even increase funding.

A reasonable target for federal payment is to ensure federal funds are targeted to the population of up to 250 percent of the FPL. The overwhelming majority (over 97 percent) of children on the program come from families with incomes of 250 percent of the FPL or lower. So, setting such a target would not drastically affect children or state funding levels. However, it would encourage states to take more direct ownership of the program if they want to maintain—or increase—eligibility levels. This change would entail a repeal of Obamacare's mandate to maintain today's high eligibility levels.

Conclusion

Congress designed CHIP to help low-income children obtain health care coverage, and has spent tens of billions of dollars over the past 20 years to achieve that goal. In 2017, Congress again faces a debate over the program's funding. It is critical to resolve the policy problems facing the program rather than simply financing the status quo.

—*Meridian Paulton is a Research Assistant in, Robert E. Moffit, PhD, is Senior Fellow in, and Marie Fishpaw is Director of, Domestic Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*

30. While at 300 percent of the FPL the match rate drops significantly, these high eligibility levels are still federally subsidized. See Medicaid and CHIP Payment and Access Commission, "The Future of CHIP and Children's Coverage," March 2017, <https://www.macpac.gov/wp-content/uploads/2017/03/The-Future-of-CHIP-and-Childrens-Coverage.pdf> (accessed August 25, 2017).

31. While the congressional bills currently under consideration take steps in the right direction by rolling back eligibility levels to 300 percent of the FPL, 250 percent of the FPL is a more appropriate level given these facts. For details, see Paulton, "Congressional CHIP Bills Fall Short of Needed Reforms."