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THE PEW CHARITABLE TRUSTS | MacArthur Foundation

The Children's Health Insurance Program

A 50-state examination of CHIP spending and enrollment

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much money states spend on health care, how and why that amount has changed over time, and which policies are containing costs while maintaining or improving health outcomes. For additional information, visit www.pewtrusts.org/healthcarespending.

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Overview

Millions of children in the United States lack health insurance.[1] Research shows that these uninsured children are far less likely to receive medical care than are their peers with health insurance. They have more avoidable hospitalizations and worse asthma outcomes, and they are at higher risk of having truancy problems.[2]

The Children's Health Insurance Program (CHIP) was created in 1997 as a federal-state partnership administered by every state to provide health insurance to those children who neither qualify for Medicaid nor have access to other forms of insurance.

In fiscal year 2013, CHIP covered 8.1 million children at a total cost of more than $13 billion.[3] And since its inception, the program has been instrumental in reducing the number of uninsured children nationally from 10.7 million (15 percent of all children) in 1997 to 6.6 million (9 percent) in 2012.[4]

To provide policymakers and other stakeholders with a better understanding of CHIP's impact in the states, researchers from the State Health Care Spending Project—a collaborative effort of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation—examined key facets of the program and how it is administered, analyzing data on CHIP spending and enrollment for the 50 states and the District of Columbia. To place such data in context, this report also examined data on other insurance coverage and spending, state revenue, and overall national health expenditures.*

By design, CHIP gives states flexibility in how they structure their programs and spend their designated dollars to extend health insurance to uninsured children. As a result, the implementation of the program varies widely among the states. The data on CHIP that are examined in this report show:

- Differences persist among states in spending, percentage of children enrolled, and enrollment trends over time.
- Nationwide, program spending grew by 5.5 percent from 2005 to 2012—more than double the rate of overall national health expenditures (2.7 percent).†
- During the same period, enrollment grew by 2 million, or 32 percent.
- Growth in CHIP spending ranged across states from a 27.2 percent annual decrease to a 27.2 percent increase between 2005 and 2012.
- CHIP spending is low compared with other types of insurance, costing approximately 40 percent less per child than employer-sponsored insurance and Medicaid in 2010, the last year for which data were available across all insurance types.

The landscape of children's health insurance and the role of CHIP will change because of the ongoing implementation of the Affordable Care Act, which provides other methods for children to receive health insurance and thus could reduce the number of CHIP enrollees. In addition, the act only funds CHIP through Oct. 1, 2015; if Congress continues the program beyond that date, funding will shift, with contributions from states reduced and the contribution from the federal government increased. Eligibility levels would remain the same for at least four years, because the act requires states to cover children at current income eligibility standards until 2019.

* Overall national health expenditures include spending on public and private health insurance, as well as individuals' out-of-pocket costs.

† These numbers represent the compound annual growth rate and are adjusted for inflation.

The State Health Care Spending 50-State Study Report Series

The State Health Care Spending Project, a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, is examining seven major areas of state health care spending—Medicaid, the Children's Health Insurance Program, substance abuse services, mental health care, prison health, active state government employee health insurance, and retired state government employee health insurance. The project is providing a comprehensive examination of each of these health programs that states fund. The programs vary by state in many ways, so the research highlights those variations and some of the principal factors driving them. The project has also released state-by-state data on 20 key health indicators to complement the programmatic spending analysis. For more information, see http://www.pewtrusts.org/healthcarespending.

Background

CHIP covers 8.1 million children plus 200,000 adults such as parents of enrollees and pregnant women.[5] The program has been instrumental in reducing the number of uninsured children nationally by 4.1 million, from 15 percent of all children in 1997 to 9 percent in 2012.[6]

CHIP is jointly paid for by state and federal funds—similar to Medicaid. The portion of each state's CHIP expenditures that are borne by the federal government is based on a formula that builds on the Federal Medical Assistance Percentage (FMAP) used for calculating the federal share of Medicaid funding. The formula used for CHIP, referred to as "enhanced FMAP," reflects a state's average per-capita income of residents relative to the national average, and it takes into consideration previous program spending, per-capita national health expenditures, and growth in the state's population of children.[7]

As an incentive for states to expand health insurance coverage for children, Congress set an enhanced FMAP for CHIP expenditures.* In fiscal 2013, it ranged from a minimum of 65 percent to a maximum of 81 percent. Federal match rates for CHIP are typically 15 percentage points higher than those for Medicaid in each state.[8]

Unlike Medicaid, federal contributions toward CHIP in each state are capped. Furthermore, states must spend the funds allotted to them within two years or else the funds may be distributed to other states.[9] (See Table 1.)

Table 1

A Comparison of CHIP and Medicaid for Financing, Enrollment, and Program Characteristics

	CHIP	Medicaid
Enrollment	8.1 million children in FY 2013*	32.0 million children in FY 2011*
	8.3 million people total in FY 2013	67.6 million people total in FY 2011
Total spending	$13.0 billion in FY 2013*	$431.1 billion in FY 2013*
Federal funding structure	States receive a 2-year federal allotment.†	No spending limit.†
Federal share toward cost of health services	65 to 81 percent*	50 to 73 percent*
Eligibility	Income eligibility levels vary by state. States can cap their CHIP enrollment depending on program type.‡	Income eligibility levels vary by state but must meet a federally defined minimum. Enrollment cannot be capped.‡
Benefits	States can offer a more limited set of benefits than Medicaid, but they must be above a federally defined minimum.‡	States can offer the broad set of federally defined minimum benefits or more expansive benefits.‡
Cost sharing	States have greater flexibility than they do under Medicaid to impose cost sharing.§	When permitted, cost sharing is generally limited to nominal amounts.§

* Project's analysis of Medicaid and CHIP Payment and Access Commission, Report to the Congress on Medicaid and CHIP (March 2014), Tables 2, 3, 7, 8, and 14, accessed March 28, 2014, http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0&d=1.

† Project's analysis of Sheila Hoag et al., *Children's Health Insurance Program: An Evaluation (1997-2010)*, Interim Report to Congress, Mathematica Policy Research (2011), 1 and 8, accessed Feb. 18, 2014, http://aspe.hhs.gov/health/reports/2012/CHIPRA-IRTC/index.pdf.

‡ Project's analysis of Kaiser Commission on Medicaid and the Uninsured, "Health Coverage of Children: The Role of Medicaid and CHIP," Kaiser Family Foundation (2012), accessed April 14, 2014, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7698-06.pdf.

§ Project's analysis of Elicia J. Herz, "Medicaid Cost-sharing Under the Deficit Reduction Act of 2005 (DRA)," Congressional Research Service (2007), http://assets.opencrs.com/rpts/RS22578_20070125.pdf.

* The enhanced FMAP was set by Congress so that the federal share of CHIP funding for each state is 30 percent more than that of Medicaid.

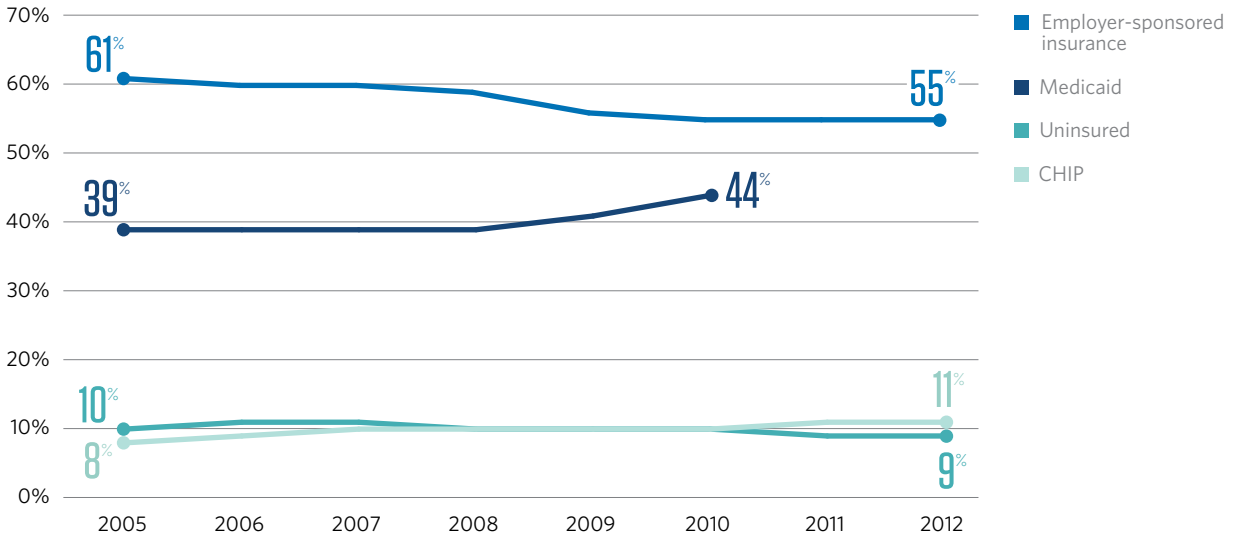
Sources of health insurance coverage for children

The majority of children in the United States receive health care coverage through employer-sponsored insurance (ESI), Medicaid, or CHIP. Enrollment trends in these programs are related. For example, Medicaid and CHIP partially fill the gap when rates of employer-sponsored insurance decline. (See Figure 1.) Depending on changes in family income as well as the availability and affordability of a parent's employer-sponsored insurance, children may frequently move among the three sources of insurance. Such fluctuations in coverage often result in varying levels of cost sharing, differing benefits, and perhaps changing health care providers.

Figure 1

Medicaid and CHIP Help Fill the Coverage Gap for Children

Percentage of U.S. children enrolled at any point in the year, 2005-12



Note: The total does not add up to 100 percent because some children have multiple sources of health insurance over the course of a year, and the figure does not include those covered under TRICARE, the Indian Health Service, or nongroup insurance. Data for children's Medicaid enrollment were not available from the Kaiser Family Foundation after 2010.

Sources: Project's analysis of U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplements, Health Insurance Historical Tables," Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State—Children Under 18: 1999 to 2012, accessed Jan. 9, 2013, http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html; Kaiser Family Foundation's State Health Facts, "Distribution of Medicaid Enrollees by Enrollment Group, FY 2010"; data source: Medicaid Statistical Information System, FY 2010, accessed Jan. 29, 2014, http://kff.org/medicaid/state-indicator/distribution-by-enrollment-group/; and Kaiser Family Foundation's State Health Facts, "Number of Children Ever Enrolled in the Children's Health Insurance Program (CHIP), FY 2011-2012"; data sources: Statistical Enrollment Data System data from forms CMS-21E, CMS-64.21E, and CMS-64.EC as of April 9, 2013, reported by the Department of Health and Human Services, accessed May 15, 2014, http://kff.org/other/state-indicator/annual-chip-enrollment/.

The proportion of children covered by each major type of insurance and the total percentage of uninsured children varies widely by state and over time. For example, Nevada and Oregon's rates of employer-sponsored insurance were similar in 2012 (54 and 55 percent, respectively). However, Nevada's Medicaid and CHIP programs covered a total of 35 percent of children, while 18 percent were uninsured. These same public programs insured 52 percent of Oregon's children, and the state had an uninsured rate of 6 percent. (See Table B.1 in Appendix B for state-level data.)

Flexibility and variation in CHIP programs across the states

States have significant flexibility in how they can administer and implement their CHIP programs. This characteristic is one of the factors that drive variation in program enrollment and spending.

Program implementation and structure

A state can choose to structure its CHIP program as one of three types: an extension of its Medicaid program (Medicaid expansion CHIP*), a stand-alone program (separate CHIP), or a combination in which the state runs both Medicaid expansion CHIP and separate CHIP programs that are geared toward different populations (combination CHIP). Each program type comes with unique options and requirements for eligibility and benefits. To meet the needs of their citizens, states have discretion in how to operate their CHIP programs within their funding levels. (See Table 2.)

Table 2

State Options for Administering CHIP Services Varies by Program Type

Selected options and requirements for eligibility and benefits

Program type	Eligibility	Benefits†
Medicaid expansion CHIP (8 states)‡	Same as Medicaid; cannot freeze enrollment or use wait lists†	• Mandatory Medicaid services (e.g., inpatient and outpatient hospital services; Early and Periodic Screening, Diagnostic, and Treatment services; physician services; laboratory and X-ray services; and transportation services). • Can offer additional benefits above the state's Medicaid program. • Premiums or other cost-sharing mechanisms must follow Medicaid rules.
Separate CHIP program (14 states)‡	Set own income eligibility levels, which are currently 205% (AZ, UT, and WY) to 319% (PA) of federal poverty levels‡; can freeze enrollment and use wait lists†	• State must choose a benefits package that is: 1) Based on federal or state employee benefits or the HMO plan with the highest commercial enrollment in the state ("benchmark"). 2) Actuarially equivalent to the benchmark plan. 3) Approved by the secretary of health and human services and covers specific services (e.g., inpatient and outpatient services, physician services, laboratory and X-ray services, well-baby and well-child care, and dental care). • Can offer additional benefits above federally defined minimums. • Can use premiums and cost-sharing options.
Combination CHIP (29 states)‡	Medicaid expansion and separate CHIP programs cover different populations with separate eligibility criteria; income eligibility levels range† from 175% (ND) to 405% (NY) of federal poverty levels‡	• Can offer different benefits for the 2 populations based on the descriptions above.

† Project's analysis of Sheila Hoag et al., *Children's Health Insurance Program: An Evaluation (1997-2010),* Interim Report to Congress, Mathematica Policy Research (2011), accessed Feb. 18, 2014, http://aspe.hhs.gov/health/reports/2012/CHIPRA-IRTC/index.pdf.

‡ Project's analysis of Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (March 2014), Tables 3 and 9, accessed March 28, 2014, http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0&d=1.

* Medicaid expansion CHIP programs operate as an extension of the state's Medicaid program. They are separate from the expansion of states' Medicaid programs occurring under the Affordable Care Act.

The structure of a CHIP program greatly influences its breadth and scope. Separate CHIP programs allow states the greatest opportunity to tailor their programs to their needs. For example, states can choose to implement cost-sharing strategies such as premium payments, copays, or coinsurance dependent on income.

All states, regardless of the program structure they select, have the option to cover specific low-income populations other than children.*,[10]

CHIP enrollment

CHIP enrollment increased nationally by almost 2 million children from 2005 to 2012, with wide variation among the states. Because CHIP is not an entitlement program—states are not required to cover all individuals who meet eligibility criteria—some states adopted policies to intentionally keep their CHIP enrollment flat. Arizona, for example, froze its enrollment beginning Jan. 1, 2010. Two percent of Arizona children were enrolled in CHIP in 2012. (See Table B.1 in Appendix B for state-level data.)

In contrast, other states have tried to maximize enrollment through broader eligibility criteria or enhanced outreach efforts. California, for example, had the highest CHIP enrollment rate in the country at 19.3 percent, covering children whose family income is up to 321 percent of the federal poverty level.†,[11] California has also leveraged electronic outreach strategies as well as partnerships with community-based organizations and schools to promote program enrollment and retention.[12] In an effort to reduce the burden on applicants, some states are also simplifying procedures for enrollment and reenrollment by, for example, allowing continuous eligibility and automatic renewals.[13]

State spending

Although CHIP has helped decrease uninsured rates among children, it is a relatively small program in terms of state dollars. Nationally, state-funded CHIP spending was just 0.3 percent of revenue from states' own sources in 2012, amounting to $3.7 billion.‡ (See Table B.3 in Appendix B for state-level data.) By comparison, Medicaid was, on average, 16 percent of states' own-source revenue.

Total CHIP spending, including federal and state dollars, increased from $8.4 billion in 2005 to $12.2 billion in 2012,§ equating to an inflation-adjusted compound annual growth rate||¶of 5.5 percent, which was more than double that of overall national health expenditures.#**This figure amounts to a cumulative growth of 45 percent. During the same time period, CHIP enrollment grew by a factor of 32 percent.

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* Adults who are potentially able to receive CHIP coverage include parents of CHIP-eligible children and pregnant women who have incomes above Medicaid eligibility thresholds or are legal immigrants who have been in the United States less than five years. States had the option of covering parents through Dec. 31, 2009. However, some states requested that the U.S. Department of Health and Human Services allow them to offer CHIP benefits to nonpregnant childless adults through Sept. 30, 2013.

† California's separate CHIP program covers children whose family income up to 321 percent of the federal poverty level in three counties. In another county, the program covers those with family income of up to 416 percent.

‡ State spending is inflation-adjusted and expressed in 2013 dollars.

§ Total CHIP spending is inflation-adjusted and expressed in 2013 dollars.

|| The compound annual growth rate shows the smoothed year-over-year growth in spending over time. (Source: Investopedia, "Compound Annual Growth Rate—CAGR," accessed April 7, 2014, http://www.investopedia.com/terms/c/cagr.asp.)

National health expenditures grew at an annual average rate of 2.7 percent from 2005 to 2012 after adjusting for inflation. (Source: Project's analysis of Centers for Medicare & Medicaid Services, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2012," National Health Expenditure Accounts, accessed Jan. 7, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.)

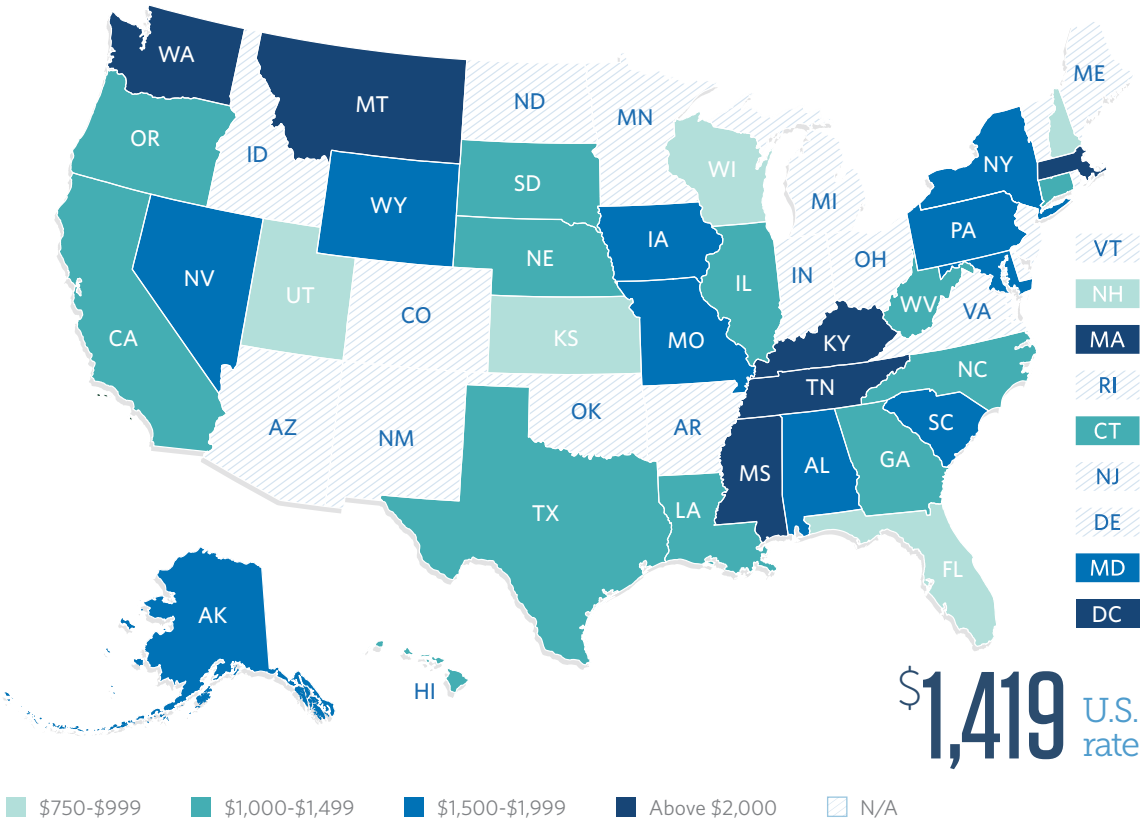
Growth in CHIP spending varied widely across the states, decreasing by 27.2 percent in Arizona and increasing by 27.2 percent in New Mexico from 2005 to 2012. (See Table B.2 in Appendix B for state-level data.) State policies drove some spending trends, such as Arizona's decision to freeze CHIP enrollment, which resulted in a spending drop from $272.4 million in fiscal 2009 to $45.7 million in fiscal 2011. Other potential reasons for variation include changes to the breadth of program eligibility and benefits, health status and income of residents, the strength of the state's economy (particularly its rates of employer-sponsored insurance coverage and unemployment), and regional differences in the cost of providing health care services.

Although CHIP spending is tied to program enrollment, the wide variability in spending persisted when examining spending per child. In 2013, national CHIP spending per child enrolled at any point during the year was $1,419. Most states spent between $1,000 and $3,000 per child. (See Figure 2.) This range is not surprising given the diversity of CHIP programs—both with respect to eligibility and benefits—and is likely to directly reflect state policies.

Figure 2

CHIP Spending per Child Varies Widely

Total CHIP spending per child enrolled at any point during the year, FY 2013



Note: N/A = Data are excluded because the state either covers some adults in CHIP or has a large variation between the percentage of children enrolled in the CHIP program at any given time compared with the average monthly enrollment. See Appendix A for details.

Source: Project's analysis of Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (March 2014), Tables 3 and 8, accessed March 28, 2014, http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0&d=1.

These figures probably underestimate spending per child because they are based on the number of children enrolled at any point in the year—a week, a month, or the entire year. Because CHIP enrollees often move in and out of eligibility, or "churn," over the course of the year, average monthly enrollment may be more reflective of the overall CHIP population, especially in states with a high degree of churn. However, these data are not available at the state level.

CHIP spending is low compared with other types of insurance, costing approximately 40 percent less per child than employer-sponsored insurance and Medicaid in 2010.* However, children's health care needs can vary among the insurance programs. For example, in some states, Medicaid enrolls most seriously disabled children regardless of parental income, making it the primary insurer for these high-cost enrollees, which in turn drives up spending per child enrolled.[14] CHIP and Medicaid must provide comprehensive children's health insurance benefits, including screening services; vision, hearing, and dental services; and medically necessary services to treat or ameliorate any illness.[15] On the other hand, public insurance programs such as Medicaid and CHIP generally pay providers less for health care services than employer-sponsored insurance does.

Looking ahead: Impacts of the Affordable Care Act

The Affordable Care Act of 2010 funds CHIP through 2015 and will also increase the federal match rate by up to 23 percentage points in October 2015. This means the federal share of CHIP funding will average 93 percent. As a result, state spending on the program will be dramatically reduced or even eliminated in some states.

The law requires states that operate separate CHIP programs to shift coverage of children with a family income of up to 138 percent of the poverty level to Medicaid while continuing to receive the higher match from federal CHIP funds.[16] States also must maintain or enhance their current CHIP eligibility levels as well as enrollment and renewal policies, or risk losing federal Medicaid funds. This mandate applies through Sept. 30, 2019, assuming that Congress renews funding for CHIP beyond 2015.

The Affordable Care Act streamlines eligibility determinations by calling for Medicaid, CHIP, and the new health exchanges to use modified adjusted gross income as a standard for counting family income.† In addition, states that meet eligibility criteria‡ can cover children of low-income state employees in the CHIP program. As of April 2014, 10 states had adopted this provision.§,[17] Two states, Mississippi and North Carolina, allowed qualified children of state employees to enroll in CHIP before enactment of the Affordable Care Act since those states do not contribute toward the premium for their employees' dependent coverage.[18]

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* Project's analysis of Medicaid and the Health Care Cost Institute estimates of spending per ever-enrolled child. (Sources: Health Care Cost Institute, email communication to Pew, "National and Select State per Capita Expenditures for Children and Adults Covered by ESI, 2007-2012" (unpublished), accessed March 7, 2014; Kaiser Family Foundation's State Health Facts, "Distribution of Medicaid Payments by Enrollment Group, FY 2010"; data source: Medicaid Statistical Information Systems and CMS-64 Quarterly Expense Reports, FY 2010, accessed Jan. 29, 2014, http://kff.org/medicaid/state-indicator/payments-by-enrollment-group/.)

† The eligibility of some groups is not based on modified adjusted gross income, such as those who are eligible as medically needy or have long-term care needs.

‡ States can extend CHIP to children of public employees if (1) the state's annual increase in per-employee expenditures for dependent health coverage is not less than the annual increase in medical inflation since 1997, or (2) the state demonstrates that the employee share of premiums and cost sharing for all state health plans would exceed 5 percent of the family's income. These children must still meet the state's CHIP eligibility requirements.

§ States whose employees' children may be covered by CHIP under the Affordable Care Act include Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Montana, Pennsylvania, Texas, and Vermont.

Conclusion

Although CHIP programs account for a relatively small portion of states' revenue, they have helped states close the health insurance gap for low-income children—particularly those who do not qualify for Medicaid. Designed to provide states with flexibility in covering children, CHIP programs vary widely in terms of how much states spend and also who is eligible and what benefits are covered. The Affordable Care Act will have a significant impact on CHIP by reducing the states' share of program costs, as well as by shifting many children to Medicaid or the health exchanges and by simplifying eligibility determinations.

Appendix A: Methodology

Project researchers analyzed CHIP spending and enrollment data for the 50 states and the District of Columbia. U.S. territories were excluded from this analysis owing to the different financing structures of federal funding for their CHIP programs.[19] To place the spending and enrollment in context, data were analyzed on other insurance coverage and spending as well as on state revenue and overall national health expenditures. Any reference to fiscal year refers to the period of Oct. 1 of the prior year through Sept. 30.

Children's health insurance coverage, 2005-12

CHIP coverage: The calculations for the percent of children enrolled in CHIP for fiscal 2005-12 were based on CHIP enrollment data from the Statistical Enrollment Data System (SEDS) reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute (KCMU/UI) as well as population estimates from the U.S. Census Bureau's Current Population Survey Annual Social and Economic Supplement (CPS ASEC) for calendar years 2005-12.[*, 20] CHIP enrollment represents individuals who are in CHIP at any point for any amount of time in the fiscal year, regardless of whether they use services.[21]

Medicaid coverage: The calculations for the percent of nondisabled children enrolled in Medicaid for fiscal 2005-10 were based on Medicaid enrollment data from the Medicaid Statistical Information System (MSIS) reported by KCMU/UI and population estimates from the U.S. Census Bureau's CPS ASEC for calendar years 2005-10.[†, 22] Because of lags in reporting, Medicaid enrollment data are not available from KCMU/UI to calculate the number of children enrolled in Medicaid for fiscal 2011 and 2012. Enrollment data represent the number of children in Medicaid at any point for any amount of time over the course of the fiscal year, not at a particular point in time. Enrollees are presumed to be unduplicated.[23] The enrollment estimates differ slightly from similar estimates posted by the Centers for Medicare & Medicaid Services (CMS) because KCMU/UI adjusted the data for several states in which some individuals appeared to be categorized incorrectly.[24]

Employer-sponsored insurance coverage and the uninsured: Data from the U.S. Census Bureau's CPS ASEC on population estimates and health insurance enrollment for calendar years 2005-12 were analyzed to calculate the percentage of children enrolled in employer-sponsored insurance and the percent of children without insurance in each year.[25] The number of children with employer-sponsored insurance coverage and the number of uninsured children are calendar year estimates.[26]

Data notes

Percentages by coverage type do not add up to 100 percent because some children have multiple sources of health insurance coverage in a year.[27] Furthermore, the analysis does not include children covered under TRICARE, the Indian Health Service, or nongroup insurance. These figures represent actual Medicaid and CHIP enrollment data from MSIS and SEDS, respectively, as reported by KCMU/UI. These data were used as opposed to survey data from the U.S. Census Bureau's CPS ASEC because it combines Medicaid and CHIP enrollees when

* The SEDS data are reported by states and represent the number of children enrolled in CHIP at any point in the year as of the date of collection. States may subsequently revise their current and/or historical data.

† While data on the number of children enrolled in Medicaid do not include disabled children, data on CHIP child enrollment, ESI child enrollment, and the numbers of uninsured children do include children with disabilities. (Sources: Kaiser Family Foundation's State Health Facts, "Distribution of Medicaid Payments by Enrollment Group, FY 2010"; data source: Medicaid Statistical Information Systems and CMS-64 Quarterly Expense Reports, FY 2010, accessed Jan. 29, 2014, http://kff.org/medicaid/state-indicator/payments-by-enrollment-group/; Kaiser Family Foundation, email communication to Pew, "2001-2009 Enrollment, Payments, and PPE" (unpublished), accessed Feb. 26, 2014; and Amy Steinweg, telephone interview with U.S. Census Bureau employee, "CPS ASEC Methodology" (unpublished), accessed Feb. 25, 2014).

reporting enrollment and the data are prone to undercounting all insurance sources.[28]

- Tennessee phased out its Medicaid expansion CHIP program in September 2002 and began a new program in 2007, so data are not available for CHIP enrollees in fiscal 2005 and 2006. [29]
- Because 2009 Medicaid enrollment data were unavailable for Pennsylvania, Utah, and Wisconsin, KCMU/UI used 2008 MSIS data.[30]
- Because 2010 Medicaid enrollment data were unavailable for Colorado, Idaho, Missouri, North Carolina, and West Virginia, KCMU/UI used 2009 MSIS data.[31]
- For 2010, 2011, and 2012, the U.S. Census Bureau amended the methods used to calculate estimates of the population, estimates of the number of uninsured, and estimates of the number of employer-sponsored insurance enrollees to include population controls based on the 2010 census.[32]

Compound annual growth rate of total CHIP spending and overall national health expenditures, inflation-adjusted

Fiscal 2005-12 total computable total net expenditures for the CHIP stand-alone and CHIP expansion program components of the CMS-64 data were used to calculate the compound annual growth rate of total CHIP spending for fiscal 2005-12.[33]

CMS' National Health Expenditure Accounts data were used to calculate the compound annual growth rate of overall national health expenditures for calendar years 2005-12.[*, 34] CHIP spending data and national health expenditures are adjusted for inflation to 2013 dollars using the Bureau of Economic Analysis' 2013 implicit price deflator for gross domestic product.[35]

State-funded CHIP and Medicaid expenditures as a percent of state own-source revenue

Fiscal 2012 CMS-64 data and state fiscal year 2012 data from the U.S. Census Bureau's Annual Survey of State Government Finances were analyzed to calculate the state share of CHIP spending as a percent of state own-source revenue and the state share of Medicaid spending as a percent of state own-source revenue for the aggregate of the U.S. states.[†, 36] State own-source revenue was calculated as state general revenue data less federal intergovernmental transfer data.[‡]

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* National health expenditures from CMS' National Health Expenditure Accounts include annual U.S. expenditures for health care goods and services, public health activities, government administration, investment related to health care, and the net cost of health insurance. This includes private health insurance, Medicare, Medicaid, CHIP, the departments of Defense and Veterans Affairs' expenditures, and Indian Health Service, as well as individuals' out-of-pocket costs. (Source: Centers for Medicare & Medicaid Services, *National Health Expenditures Accounts: Methodology Paper, 2012* (2012), accessed March 4, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf.)

† The state fiscal year runs from July 1 of the prior year through June 30. States with different fiscal years are Alabama and Michigan (Oct. 1 through Sept. 30), New York (April 1 through March 31), and Texas (Sept. 1 through Aug. 31). (Source: National Conference of State Legislatures, "Quick Reference Fiscal Table" (July 13, 2012), accessed Jan. 28, 2014, http://www.ncsl.org/research/fiscal-policy/basic-information-about-which-states-have-major-ta.aspx#fyrs.)

‡ Because some states use local revenue to fund the state share of Medicaid and/or CHIP spending, we included local revenue when comparing the state share of Medicaid spending to total state own-source revenue. (Sources: Centers for Medicare & Medicaid Services, "Program Financing for State Plan, Section IV," State CHIP Annual Reports, accessed July 15, 2014, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Annual-Reports.html; and Kathryn Murphy, "Counties and Medicaid: A Snap Shot," National Association of Counties (2010), accessed April 15, 2014, http://www.naco.org/newsroom/pubs/Documents/Health,%20Human%20Services%20and%20Justice/Counties%20and%20Medicaid.pdf.)

Per-child spending by state, inflation-adjusted

Fiscal 2010-13 SEDS and CMS-64 data reported by MACPAC were analyzed to develop CHIP spending per child enrollee nationally and for select states and the District of Columbia.[*, 37] Also included were fiscal 2010 CMS-64 and MSIS data reported by KCMU/UI to show Medicaid payments for services per child enrolled at any point during the year; and calendar year 2010-12 estimates from the Health Care Cost Institute (HCCI) for employer-sponsored insurance expenditures per child enrolled at any point in the years.[†, 38] HCCI used its database of ESI health care claims to estimate per-child ESI spending nationally and for the 20 states and the District of Columbia for which they held at least 24 percent of the ESI data in a given year.[‡, 39] CHIP, Medicaid, and ESI spending data are adjusted for inflation to 2013 dollars. Administrative expenses are not included in data for the Medicaid and ESI per-child spending estimates, and project researchers excluded administrative expenses from the CHIP per-child spending estimates.[40]

States that were excluded from this analysis: To ensure consistency when comparing per-child spending, states were excluded according to two criteria.

1. Because adult health care spending is much higher on average than that for children, states were excluded in the years for which adults were enrolled in the CHIP program.[§, 41]

2. CHIP enrollment data from MACPAC represent individuals who are enrolled at any point in time during the fiscal year, even for one month.[42] These enrollment numbers provide an inflated estimate of how many children are actually in the CHIP program at any given point in time because CHIP enrollees often "churn," or move in and out of eligibility for the program over the course of the year.[**, 43] To approximate the degree of churning in each fiscal 2013 state CHIP program, the Kaiser Family Foundation June 2013 CHIP enrollment estimates were divided by the MACPAC estimates of fiscal 2013 CHIP children ever enrolled during the year. Using this ratio, it was determined that states with values greater than one standard deviation below the mean of the 50 states and the District had an estimated high degree of churn, and, therefore, they were excluded from the analysis.[††] While average monthly enrollment would more accurately reflect the CHIP

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* The SEDS data are reported by individual states and are representative of children ever enrolled in CHIP as of the date of collection. States may subsequently revise their current and/or historical data.

† The HCCI estimates are based on claims data on payments to providers from insurers and cost-sharing payments from the insured and do not include administrative expenditures. The data behind these estimates came from a national, multipayer, commercial health care claims database created by HCCI containing information provided by three major insurers. An analytic subset of this database represents the health care activity of about 25 percent of all individuals younger than 65 with ESI coverage.

‡ The HCCI held claims data for at least 24 percent of ESI enrollees in the state for Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Kentucky, Louisiana, Maryland, Maine, Minnesota, Missouri, New Jersey, Ohio, Oklahoma, Rhode Island, Texas, Wisconsin, Vermont, and the District of Columbia. (Sources: Health Care Cost Institute, 2012 Health Care Cost and Utilization Report, Children's Health Spending: 2009-2012: Analytic Methodology V2.9 Abridged for The Pew Charitable Trust's State Health Care Spending Project (Health Care Cost Institute, 2014), accessed March 27, 2014; and Health Care Cost Institute, 2007-2011 Vermont Health Care Cost and Utilization Report: Analytic Methodology (2014), accessed May 13, 2014.)

§ Adults who were enrolled in the CHIP program included eligible pregnant women, parents of CHIP children, and childless adults. States with adult enrollees were removed from this analysis and include: Colorado, Idaho, Michigan, Nevada, New Jersey, New Mexico, Rhode Island, and Virginia for fiscal 2010; Arkansas, Colorado, Idaho, Nevada, New Jersey, New Mexico, Rhode Island, and Virginia for fiscal 2011; and Arkansas , Colorado, Idaho, New Jersey, New Mexico, Rhode Island, and Virginia for fiscal 2012 and 2013.

** In the event that individuals were in multiple categories during the year (for example, in Medicaid expansion CHIP for the first half of the year and then a separate CHIP program for the second half), the individual would only be counted in the most recent category.

†† States that were excluded from the analysis on the basis of an estimated high degree of churn include: Arizona, Delaware, Indiana, Maine, Michigan, Minnesota, North Dakota, Ohio, Oklahoma, and Vermont.

population and result in a higher estimate of per-child spending, these estimates are not reported in this brief due to state-level data limitations.

Data notes:

- Because fiscal 2012 CHIP enrollment data for Ohio were unavailable, MACPAC used data from fiscal 2011.[44]
- Montana, Nevada, and New York were combination programs in fiscal 2013 but did not report any Medicaid-expansion enrollees in the CHIP SEDS data.[45]
- Because 2010 Medicaid child spending and enrollment data were unavailable for Missouri, North Carolina, and West Virginia, KCMU/UI used 2009 MSIS data. KCMU/UI then adjusted 2009 spending data to 2010 CMS-64 spending levels.[46]
- Estimates of ESI spending per child were not available for Vermont in fiscal 2012.[47]

State-funded CHIP annual spending and spending growth, inflation-adjusted, 2010-13

Fiscal 2010-13 CMS Medicaid and CHIP Budget Expenditure System data reported by MACPAC were analyzed to show the state share of CHIP spending and the percent growth in the state share of CHIP spending from fiscal 2010-13. In its analysis of state CHIP spending, MACPAC subtracted 2015(g) funds, resulting in negative spending for some states; for the purposes of this project's analysis, we added these funds back.*, [48] CHIP spending data are adjusted for inflation to 2013 dollars using the Bureau of Economic Analysis' 2013 implicit price deflator for gross domestic product.[49]

* Section 2105(g) of the Social Security Act permits 11 qualifying states to 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 of the federal poverty level. Although these are CHIP funds, they effectively reduce state spending on children in Medicaid and do not require a state match within the CHIP program. In cases in which the sum of 2105(g) federal CHIP spending (for Medicaid enrollees) and regular federal CHIP spending (for CHIP enrollees) exceeds total spending for CHIP enrollees, MACPAC reports negative state CHIP spending (Connecticut, Minnesota, and Vermont in 2013; Connecticut, Minnesota, Vermont, and Washington in 2012; and Connecticut, Minnesota, and Vermont in 2011).

Appendix B: Data tables

Table B.1

Percentage of Children Enrolled in Health Insurance at Any Point in the Year, by Source

State	CHIP		Medicaid		ESI		Uninsured	
	2005	2012	2005	2010	2005	2012	2005	2012
United States	8%	11%	39%	44%	61%	55%	10%	9%
Alabama	8%	10%	42%	45%	63%	49%	5%	8%
Alaska	12%	7%	39%	40%	57%	50%	8%	16%
Arizona	5%	2%	41%	42%	54%	52%	16%	14%
Arkansas	0.2%	16%	60%	55%	56%	41%	11%	8%
California	13%	19%	45%	49%	53%	50%	13%	10%
Colorado	5%	10%	27%	30%	65%	65%	13%	6%
Connecticut	3%	3%	17%	38%	72%	70%	7%	4%
Delaware	5%	6%	39%	44%	67%	56%	11%	10%
District of Columbia	6%	6%	69%	80%	48%	49%	6%	2%
Florida	10%	10%	39%	48%	55%	48%	17%	13%
Georgia	13%	10%	46%	45%	55%	48%	10%	13%
Hawaii	7%	11%	31%	37%	68%	61%	5%	4%
Idaho	6%	11%	34%	33%	61%	56%	11%	9%
Illinois	9%	12%	37%	50%	67%	59%	10%	7%
Indiana	8%	10%	36%	42%	63%	56%	10%	10%
Iowa	7%	11%	30%	37%	72%	61%	5%	5%
Kansas	7%	9%	29%	31%	67%	53%	6%	6%
Kentucky	6%	8%	39%	44%	62%	52%	7%	9%
Louisiana	14%	13%	58%	56%	58%	52%	8%	8%
Maine	11%	14%	42%	47%	60%	60%	7%	4%
Maryland	9%	10%	28%	35%	68%	66%	8%	7%
Massachusetts	11%	10%	28%	36%	72%	66%	4%	4%
Michigan	3%	4%	37%	50%	70%	64%	4%	3%
Minnesota	0.4%	0.3%	31%	35%	74%	67%	6%	6%
Mississippi	11%	12%	53%	53%	49%	48%	11%	9%
Missouri	8%	7%	42%	42%	61%	58%	7%	11%
Montana	7%	13%	29%	34%	56%	53%	14%	12%

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State	CHIP		Medicaid		ESI		Uninsured	
	2005	2012	2005	2010	2005	2012	2005	2012
Nebraska	10%	12%	33%	35%	71%	57%	5%	10%
Nevada	6%	4%	22%	31%	70%	54%	13%	18%
New Hampshire	4%	4%	28%	35%	78%	66%	4%	6%
New Jersey	6%	10%	22%	28%	73%	68%	10%	6%
New Mexico	5%	2%	62%	68%	48%	41%	20%	15%
New York	14%	13%	46%	48%	62%	57%	7%	6%
North Carolina	9%	11%	38%	41%	58%	52%	11%	8%
North Dakota	4%	5%	26%	29%	68%	66%	9%	6%
Ohio	8%	11%	38%	43%	68%	60%	7%	7%
Oklahoma	12%	13%	48%	51%	54%	44%	11%	10%
Oregon	6%	14%	31%	38%	59%	55%	10%	6%
Pennsylvania	6%	10%	34%	39%	68%	61%	7%	8%
Rhode Island	11%	12%	36%	44%	66%	62%	7%	7%
South Carolina	8%	7%	44%	45%	59%	57%	9%	10%
South Dakota	7%	9%	38%	41%	62%	59%	8%	8%
Tennessee	N/A	7%	48%	53%	62%	51%	9%	7%
Texas	8%	14%	40%	45%	51%	47%	18%	16%
Utah	6%	7%	23%	24%	65%	68%	12%	9%
Vermont	5%	6%	52%	55%	59%	54%	5%	5%
Virginia	7%	10%	25%	31%	69%	63%	8%	6%
Washington	1%	3%	41%	48%	63%	60%	8%	5%
West Virginia	10%	10%	49%	50%	62%	58%	6%	8%
Wisconsin	4%	13%	32%	38%	70%	65%	6%	5%
Wyoming	5%	6%	44%	41%	61%	65%	10%	10%

Note: N/A = Data are not available for Tennessee in 2005.

Sources: Project's analysis of U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplements, Health Insurance Historical Tables," Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State—Children Under 18: 1999 to 2012, accessed Jan. 9, 2013, http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html; Kaiser Family Foundation's State Health Facts, "Distribution of Medicaid Payments by Enrollment Group, FY 2010"; data source: Medicaid Statistical Information Systems and CMS-64 Quarterly Expense Reports, FY 2010, accessed Jan. 29, 2014, http://kff.org/medicaid/state-indicator/payments-by-enrollment-group/; and Kaiser Family Foundation's State Health Facts, "Number of Children Ever Enrolled in the Children's Health Insurance Program (CHIP), FY 2011-2012," Data sources: Statistical Enrollment Data System data from forms CMS-21E, CMS-64.21E, and CMS-64.EC as of April 9, 2013, reported by the Department of Health and Human Services, accessed May 15, 2014, http://kff.org/other/state-indicator/annual-chip-enrollment/.

Table B.2

Compound Annual Growth Rate of Total CHIP Spending, Inflation-adjusted, 2005-12

State	Compound annual growth rate	State	Compound annual growth rate
United States	5.5%	Missouri	22.6%
Alabama	-3.7%	Montana	1.1%
Alaska	-27.2%	Nebraska	0.0%
Arizona	5.2%	Nevada	8.7%
Arkansas	4.9%	New Hampshire	14.8%
California	16.2%	New Jersey	27.2%
Colorado	-4.9%	New Mexico	4.4%
Connecticut	10.3%	New York	2.6%
Delaware	7.3%	North Carolina	10.2%
District of Columbia	3.5%	North Dakota	6.7%
Florida	1.6%	Ohio	7.0%
Georgia	9.1%	Oklahoma	17.5%
Hawaii	9.0%	Oregon	8.8%
Idaho	-4.4%	Pennsylvania	-6.8%
Illinois	6.4%	Rhode Island	5.3%
Indiana	10.1%	South Carolina	5.7%
Iowa	1.8%	South Dakota	N/A
Kansas	8.2%	Tennessee	15.0%
Kentucky	5.4%	Texas	5.5%
Louisiana	3.9%	Utah	9.1%
Maine	1.4%	Vermont	6.7%
Maryland	13.2%	Virginia	10.2%
Massachusetts	-18.7%	Washington	3.0%
Michigan	-23.3%	West Virginia	3.2%
Minnesota	4.5%	Wisconsin	-0.8%
Mississippi	1.9%	Wyoming	8.0%

Notes: Data represent the compound annual growth rate. N/A = Data are not available for Tennessee in 2005.

Source: Project's analysis of CMS-64 data

Table B.3

State-funded CHIP Spending in Millions, Inflation-adjusted, 2010-13

State	2010	2011	2012	2013	Percent change, 2010-13
U.S. total	$3,566.7	$3,667.8	$3,669.2	$3,974.5	11.4%
Alabama	$39.0	$42.1	$44.8	$42.6	9.3%
Alaska	$10.1	$11.2	$10.8	$11.5	13.7%
Arizona	$19.2	$10.8	$7.3	$17.7	-7.7%
Arkansas	$21.3	$23.5	$26.0	$27.4	28.8%
California	$672.9	$766.0	$681.6	$744.4	10.6%
Colorado	$65.5	$59.6	$69.0	$79.5	21.4%
Connecticut	$13.1	$12.4	$8.8	$9.8	-25.0%
District of Columbia	$3.2	$7.1	$7.2	$7.6	140.5%
Delaware	$7.3	$3.4	$3.8	$3.9	-46.3%
Florida	$149.4	$156.9	$156.0	$153.2	2.5%
Georgia	$76.6	$81.6	$85.5	$99.7	30.2%
Hawaii	$15.6	$15.6	$14.0	$13.7	-12.1%
Idaho	$9.8	$11.1	$9.2	$12.4	26.6%
Illinois	$147.9	$130.0	$144.6	$181.3	22.6%
Indiana	$29.5	$28.5	$42.5	$36.2	22.8%
Iowa	$25.8	$29.6	$34.3	$38.0	47.3%
Kansas	$21.9	$22.7	$23.3	$23.0	5.0%
Kentucky	$33.1	$34.9	$36.4	$38.1	15.2%
Louisiana	$54.2	$57.8	$62.7	$55.2	1.8%
Maine	$11.5	$10.8	$10.6	$9.7	-15.5%
Maryland	$90.9	$79.0	$84.3	$90.4	-0.5%
Massachusetts	$171.0	$193.1	$174.0	$200.8	17.4%
Michigan	$42.7	$25.1	$13.7	$34.7	-18.6%
Minnesota	$8.8	$6.9	$7.0	$6.7	-24.3%
Mississippi	$33.0	$35.6	$38.0	$38.6	17.1%
Missouri	$37.3	$38.6	$41.3	$45.8	22.8%
Montana	$11.4	$14.8	$18.1	$21.8	91.7%
Nebraska	$14.7	$17.2	$18.1	$21.9	48.5%
Nevada	$12.7	$12.7	$13.8	$10.5	-17.6%

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State	2010	2011	2012	2013	Percent change, 2010-13
New Hampshire	$6.4	$7.1	$7.1	$5.9	-8.2%
New Jersey	$318.5	$344.7	$336.3	$371.5	16.7%
New Mexico	$61.0	$40.9	$33.0	$35.0	-42.6%
New York	$283.2	$296.5	$304.7	$335.9	18.6%
North Carolina	$123.2	$97.3	$95.1	$96.1	-22.0%
North Dakota	$5.3	$6.3	$7.6	$8.9	69.0%
Ohio	$95.8	$92.7	$110.0	$97.2	1.4%
Oklahoma	$39.5	$31.8	$37.5	$43.5	10.1%
Oregon	$31.9	$42.8	$49.2	$55.0	72.4%
Pennsylvania	$147.9	$131.7	$136.9	$136.9	-7.4%
Rhode Island	$15.1	$11.5	$19.4	$27.4	81.9%
South Carolina	$25.6	$26.2	$25.2	$27.4	7.1%
South Dakota	$7.1	$6.8	$7.6	$7.6	7.7%
Tennessee	$41.2	$52.3	$60.2	$61.6	49.6%
Texas	$332.2	$336.1	$356.9	$366.2	10.2%
Utah	$15.5	$13.3	$15.4	$14.6	-5.7%
Vermont	$2.1	$2.3	$2.7	$2.8	32.9%
Virginia	$93.8	$96.4	$98.1	$105.4	12.3%
Washington	$18.5	$35.2	$25.5	$42.9	131.4%
West Virginia	$9.2	$9.9	$11.2	$11.3	23.3%
Wisconsin	$39.7	$41.4	$37.0	$39.6	-0.3%
Wyoming	$5.3	$5.7	$5.6	$5.7	8.2%

Note: State spending is inflation-adjusted and reported in 2013 dollars.

Source: Project's analysis of MACPAC data from the Medicaid and CHIP Budget Expenditure Systems

Endnotes

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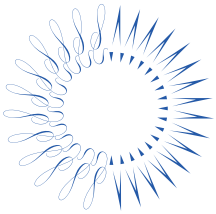

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