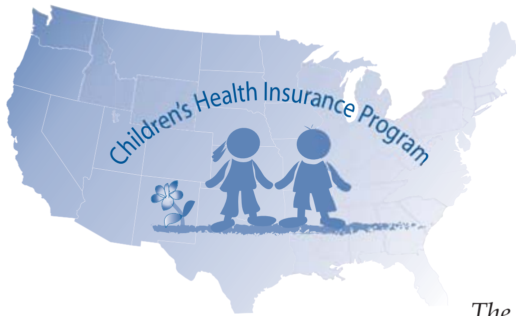

CHIPRA 101: Overview of the CHIP Reauthorization Legislation

The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health coverage to low-income children in working families who make too much money to be eligible for Medicaid but not enough to afford private coverage. The program currently covers more than 7 million children. In February 2009, after a protracted political fight, Congress enacted, and President Obama signed, legislation that renewed CHIP through the end of 2013 and expanded its scope. This series of issue briefs examines the new provisions that were included in the reauthorization and how they will affect implementation in the coming months.

When CHIP was created, it represented a new federal commitment to ensuring that children in working families would have access to high-quality, affordable health coverage. CHIP enjoyed broad, bipartisan support, and it played an integral role in reducing the percentage of children who are uninsured by nearly a third, even as the percentage of adults who were uninsured increased markedly. The new legislation (H.R. 2; the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA) signals that the federal government intends to stand behind and build upon its commitment to improve access to health care for children in working families.

Eleven years of experience with CHIP have provided Congress with a wealth of information about how to improve upon an already successful program. As a result, the CHIPRA legislation includes significant changes to the existing CHIP program that are designed to increase participation among eligible uninsured children. In particular, the legislation provides states with additional funding, new tools and incentives to make it easier to enroll eligible children, and a better benefits package to ensure that children who are enrolled get access to the full range of health care services that they need.

The Basics

CHIP was originally authorized for 10 years, from 1997-2007. In order for the program to continue beyond its original authorization, federal action had to be taken before the end of September 2007. On two occasions in 2007, Congress passed legislation to reauthorize CHIP, but President Bush vetoed that legislation each time it was placed on his desk. In response, Congress passed stopgap legislation to continue the program for 18 months, extending it through the end of March 2009.

In early January 2009, the 111th Congress passed legislation (CHIPRA) that formally reauthorized the program. President Obama, who has been a longtime supporter of the program, signed CHIPRA into law on February 4, 2009, and it will take effect on April 1, 2009. This reauthorization lasts through the end of September 2013 (when CHIP will need to be reauthorized again). The Congressional Budget Office anticipates that CHIPRA will allow states to continue covering all of the children who are currently enrolled and to enroll an additional 4.1 million uninsured children in CHIP and Medicaid by the end of September 2013.[1]

The overall goal of CHIPRA is to induce states to enroll more uninsured children. To achieve that end, it not only increases the amount of money that is available to states for children's health coverage, it also makes significant changes to how money flows through CHIP. These changes reward states for enrolling more children and for making it easier for families to learn about CHIP and Medicaid, to enroll in these programs, and to keep their coverage for as long as they are eligible. The law also makes a landmark policy change by allowing states to provide coverage to legal immigrant children and pregnant women who have been in the country for fewer than five years.

While CHIPRA will make it easier for states to cover more children, it also includes provisions that may reduce the likelihood that states will expand coverage to children in families with incomes above 300 percent of the federal poverty level ($54,930 for a family of three in 2009). It also phases out CHIP-funded coverage for adults. We discuss these and other changes in more detail below.

Significant New Funding

One of the issues that was of paramount importance in the CHIP reauthorization process was ensuring that the program was granted sufficient funding both to maintain coverage for current enrollees and to make significant progress in covering more of the 8.6 million remaining uninsured children.[2] The law achieves this by adding $44 billion in new federal funding between 2009 and 2013 on top of the so-called "baseline" of $5 billion per year, bringing the total amount available for CHIP to $69 billion.[3] This increase was largely funded by raising the federal tobacco tax by 62 cents. (Note: Although in the legislative fight to pass CHIPRA, the amount of funding that Congress had to "pay for" for budgetary purposes was $32.8 billion, this amount does not correspond directly to the total amount that will be available for CHIP allotments.)

The total amount of funding that will be available for state CHIP allotments in fiscal year (FY) 2009 under CHIPRA is nearly twice as much as the amount that was available in FY 2008 ($10.6 billion in FY 2009, compared to $6.2 billion in FY 2008). And according to the Congressional Research Service, which has estimated each state's CHIP allotment for FY 2009 under the new law, on average, state allotments will be 96 percent higher under the new law than they would have been under the old law.[4]

With one exception that is described below (see "Interpretation and Translation Services" on page 7), the law does not change the state-federal match structure of CHIP funding: Each state will continue to pay a share of all of its CHIP expenditures, and that state funding will be matched by federal CHIP dollars. States will continue to receive an "enhanced" federal matching rate that is higher than the matching rate for their Medicaid program. The average CHIP matching rate for FY 2009 is 72 percent, which means that, on average, for every $1.00 a state spends on CHIP, the federal government contributes a matching amount of $2.57.

Funding: Use It or Lose It

In addition to increasing the amount of money that is available for children's health coverage, CHIPRA also establishes a new way to better target the money to those states that are covering more children. Under the old law, each state had three years to spend its annual CHIP allotment. Under CHIPRA, states will instead have only two years to spend the money. Any amounts that are not used by the end of the second year will revert back to the "pot" and will be redistributed to other states that demonstrate a need for more CHIP funds.

Just as before, a specific amount of federal CHIP funding will be available for each state for each fiscal year. However, these annual allotments will be distributed to states according to a new formula that takes into account how much each state actually spends on CHIP, as follows:

- Each state's FY 2009 CHIP allotment will be based on the highest of the following: its FY 2008 CHIP spending (plus an inflation factor), its FY 2008 allotment (plus an inflation factor), or its projected CHIP spending in FY 2009. As noted above, each state's FY 2009 allotment will be significantly higher than it has ever been.
- In FY 2010 and FY 2012, each state's allotment will automatically be increased over the previous year's allotment according to an inflation factor (to account for medical inflation and for the growth in the number of children in the state).
- In FY 2011 and FY 2013, allotments will be "rebased" (basically, recalibrated) according to how much each state actually *spent* the previous year (rather than how much it *received* in its allotment), as well as increased to account for medical inflation and the growth in the number of children in the state. This rebasing process will ensure that states that are not spending their allotments cannot withhold that unused funding from the states that *are*.
- States that want to expand CHIP and that therefore need more funding than their "rebased" allotments for FY 2011 or FY 2013 can request additional funding from CMS.

Preventing Shortfalls

Historically, some states have experienced CHIP funding shortfalls. The new distribution formula will help prevent this from happening in the future, but CHIPRA also creates a Contingency Fund of readily available federal dollars to help fill any shortfalls that states may encounter. States that have a funding shortfall *and* that are exceeding their CHIP enrollment targets (as defined in the statute) will automatically be eligible to receive assistance from the Contingency Fund.

Rewarding Success

Another new feature that CHIPRA creates is a system of annual performance bonuses that are designed to reward states that are effectively covering the lowest-income children in their state—those children who are eligible for Medicaid. The bonuses will be awarded on a per-child basis to states that exceed their enrollment targets for children in Medicaid.[5] States must do two things to qualify for these bonuses: (1) exceed their enrollment target for children in Medicaid; and (2) implement at least five of the following eight outreach/enrollment/retention best practices:

- 12-month continuous eligibility,
- elimination of asset tests/administrative verification of assets,
- elimination of a face-to-face interview requirement,
- joint Medicaid/CHIP application,
- automatic/administrative renewal,
- presumptive eligibility,
- express lane eligibility, or
- premium assistance.

Who Is Eligible for CHIP?

CHIPRA makes some changes and clarifications about who is eligible for CHIP-funded health coverage.

Children

States will no longer be permitted to receive the full CHIP matching rate for covering children in families with incomes greater than three times the federal poverty level ($54,930 for a family of three in 2009). They will still be allowed to cover these children (as long as they have received federal approval to do so), but they will receive the lower Medicaid matching rate instead. New York and New Jersey, which already had federal approval or had enacted legislation to expand CHIP eligibility to these children before CHIPRA was signed into law, are exempt from this restriction.

Beginning in January 1, 2010, states will need to apply the Medicaid citizenship documentation requirement to children who apply for CHIP coverage as well. (To learn more, see one of Families USA's many publications on the citizenship documentation requirement online at http://www.familiesusa.org/issues/medicaid/citizenship-documentation.) However, the new law eases this burden on families by allowing states to verify citizenship status using Social Security Administration databases when possible, rather than requiring families to comply with cumbersome documentation requirements.

CHIPRA also makes changes to existing law with respect to CHIP and premium assistance. States will now have the option to use CHIP funding to subsidize qualified job-based coverage for children who are eligible for CHIP. Families that have an offer of job-based coverage must be given a choice between the state's CHIP plan and premium assistance; they cannot be forced to participate in premium assistance if they would prefer to enroll in CHIP instead. For families that do enroll their children in CHIP-funded premium assistance, states must provide any benefits that are included in the CHIP plan that the job-based plan does not cover (known as wrap-around coverage), and states must provide the same cost-sharing protections that apply to children who are enrolled in the CHIP plan.

Pregnant Women

States are already permitted to use CHIP funds to cover pregnant women using waivers. Under the new CHIP law, they will be able to do so through state plan amendments, which are less onerous administratively and which do not require periodic renewal as waivers do. As of 2007, six states had waivers to cover pregnant women using CHIP funding: Colorado, Idaho, Nevada, New Jersey, Rhode Island, and Virginia.[6]

Legal Immigrant Children and Pregnant Women

CHIPRA eliminates the five-year waiting period for legal immigrant children and pregnant women who are eligible for Medicaid or CHIP. Nineteen states currently offer state-funded coverage for these individuals and will now be able to cover them using federal funding.[7] Other states are now allowed to expand federally funded coverage to this group of legal immigrants as well. Legal immigrant children and pregnant women will be required to verify their citizenship status every time they renew their coverage. The law reiterates the existing bar on federally funded coverage for illegal immigrants.

Parents and Other Adults

Although in the past states have been granted waivers to offer CHIP-funded coverage to parents and other adults without dependent children, the new CHIP law will gradually shift these individuals out of CHIP. It also prohibits any new CHIP waivers for adult coverage. Currently, 11 states provide CHIP coverage to parents and/or adults without dependent children: Arizona, Arkansas, Idaho, Illinois, Michigan, Minnesota, Nevada, New Mexico, Oregon, Rhode Island, and Wisconsin.

States that use CHIP funds to cover parents can continue doing so and continue receiving the CHIP matching rate through the end of FY 2011. Beginning in FY 2012, states that still cover parents with CHIP funding and that elect to continue doing so will need to cover these parents through a separate block grant that will be deducted from their CHIP allotment. They will also need to meet child enrollment targets (as defined in the statute) in order to continue getting the CHIP matching rate for these adults. Otherwise, the state will get only the Medicaid match for them. In FY 2013, states that are meeting their child enrollment targets will get a matching rate that is lower than the CHIP matching rate but still higher than the Medicaid matching rate (the "reduced enhanced medical assistance percentage" or REMAP); otherwise, they will get the Medicaid matching rate for parent coverage.

States that use CHIP funds to cover adults without dependent children can continue to cover these individuals and receive the enhanced CHIP matching rate through the end of December 2009. These states can apply for a Medicaid waiver to transition these individuals to Medicaid coverage, but they will not be allowed to cover them using CHIP funds after December 31, 2009.

Getting More Children Enrolled

Congress intended to cover more than 4 million uninsured children through the new CHIP law. An estimated two-thirds of these uninsured children are eligible for CHIP, and the remaining third are eligible for Medicaid.[8] In order to help states reach out to these uninsured, eligible children, CHIPRA gives states a variety of incentives and tools to make outreach and enrollment in both CHIP and Medicaid easier and more effective. As described above, performance bonuses will provide states with a direct financial incentive to find and enroll the lowest-income uninsured children in Medicaid. States will have to implement outreach, enrollment, and retention best practices in order to receive this bonus. Research and state experience have shown that these practices are the most effective ways to increase enrollment of uninsured children; without these practices in place, a state would be unlikely to exceed its Medicaid enrollment target.

Express Lane Eligibility/Auto-Enrollment

States were given a new option to find and enroll children who are already participating in other means-tested programs, such as the free and reduced-price school lunch program and food stamps. This new option is called "Express Lane Eligibility." Express Lane Eligibility allows state CHIP and Medicaid agencies to accept income determinations from state agencies that administer other means-tested programs instead of requiring families to prove their income separately for CHIP or Medicaid eligibility or renewal.

CHIPRA also allows states to use this information to "auto-enroll" children into CHIP and Medicaid. Under this option, a family that is applying for a means-tested program other than CHIP or Medicaid can consent to have their child auto-enrolled in CHIP or Medicaid if he or she is determined to be eligible. If the child meets the income requirements for either

program, he or she can be automatically enrolled in the program without the parents having to complete a separate application. This will allow states to enroll uninsured children who are eligible for coverage but whose parents might not otherwise have known about CHIP or Medicaid, or whose parents would have had to complete a separate application process to get their child enrolled.

Outreach Grants

The new CHIP law includes $100 million in funding that is to be used specifically for grants to organizations that promote CHIP and Medicaid outreach and enrollment. Of this, $10 million will be used for a nationwide outreach campaign, $10 million will be for grants specifically to reach out to Native American children, and the remaining $80 million will be for grants to state and local organizations (including government agencies). The Secretary of Health and Human Services (HHS) will award these grants, with a preference given to organizations that serve areas with a high percentage of uninsured children and to organizations that specifically serve racial and ethnic minorities.

Interpretation and Translation Services

CHIPRA allows states to receive a significantly higher matching rate (at least 75 percent, higher depending on the state) for providing translation and interpretation services for children in their CHIP and Medicaid programs. This will be an incentive for states to provide better, more culturally appropriate outreach to children in racial and ethnic minority groups who may benefit from translation of outreach and enrollment documents, or from an interpreter to facilitate the enrollment process. It will also allow these children to receive more appropriate health care services once they are enrolled, since the higher matching rate is also available for translation and interpretation services in health care delivery settings.

Improving Children's Health

Finally, there are several significant changes in the new law that are designed to improve the health care that children receive in CHIP and Medicaid.

Dental Benefits

There are two provisions in the legislation that are designed to improve access to dental care for children. First, CHIPRA requires states to include dental coverage in their CHIP benefit packages. Although most states currently provide dental coverage through CHIP, they are not required to do so, and in the past, states could cut these services if they chose to. Now, states must offer a dental benefit that is equivalent to one of the following: the children's coverage that is provided in the Federal Employees Health Benefits Program (FEHBP), state employee dependent dental coverage, or dental coverage that is offered through the commercial dental plan in the state with the highest non-Medicaid enrollment. Dental care is an essential health care benefit, especially for children, and now, children enrolled in CHIP will be assured of having adequate dental coverage.

Second, it allows states for the first time to offer dental coverage to children who are enrolled in private or job-based plans that do not include dental coverage. As long as these children are otherwise eligible for CHIP, states can enroll them in CHIP exclusively for dental coverage. This new provision is a significant change in the program, because previously, children could get coverage in CHIP only if they were uninsured. This provision for the first time allows children who have other health coverage to benefit from CHIP. It is an especially important provision because dental coverage is frequently sold separately from other health coverage, and many children who are otherwise insured lack access to dental care.

Mental Health Parity

The new CHIP law also guarantees mental health parity in CHIP. This means that, as with job-based coverage, states must provide the same level of services for mental health benefits in CHIP as they provide for physical health benefits. States that operate CHIP as a Medicaid expansion and hence offer early and periodic screening, diagnosis and treatment (EPSDT, which essentially guarantees all medically necessary health services for children) are considered to be in compliance with the mental health parity requirement. In the past, states could charge different cost-sharing amounts or impose separate spending caps on mental health services than they did for other health benefits. They could also meet the CHIP benefit requirements by providing only 75 percent of the actuarial value of mental health benefits in one of the benchmark benefit plans. Now, states must offer the full actuarial equivalent for mental health services.

Quality Improvements

CHIPRA includes several measures that are designed to improve other aspects of medical care that is provided to children through CHIP and Medicaid, including the following:

- the creation of new quality measures for children's coverage,
- a $20 million demonstration project to study quality measures and health information technology (HIT) for children,
- a $25 million demonstration project to prevent child obesity,
- $5 million for the development of children's electronic medical records, and
- development of a Medicaid and CHIP Payment Advisory Committee (MACPAC, similar to Medicare's "MEDPAC") to review and make recommendations about payment rates for children's coverage in Medicaid and CHIP.

Conclusion

Together, the increased funding that is available for children's coverage, the new tools that are designed to enhance outreach and enrollment, and the significant improvements to CHIP benefits and children's health care delivery will make it possible for states to make great progress in covering many of the approximately 8.6 million uninsured children in the country. However, states will be successful in reaching these children only if they take advantage of the many new opportunities—progress is possible only if states take action.

Subsequent briefs in this series will examine in much greater depth specific aspects of CHIPRA and how states can implement them effectively.

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[1] Congressional Budget Office, *H.R. 2 Children's Health Insurance Program Reauthorization Act of 2009* (Washington: Congressional Budget Office, February 11, 2009), available online at: http://www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf.

[2] Jennifer Sullivan and Rachel Klein, *Left Behind: America's Uninsured Children* (Washington: Families USA, November 2008).

[3] CHIP has been operating under a temporary extension since October 2007, when its original 10-year authorization period expired. Because President Bush vetoed the reauthorization legislation that Congress presented to him on two occasions, the program was temporarily extended through the end of March 2009.

[4] Families USA calculations based on Chris L. Peterson, *Projections of FY2009 Federal SCHIP Allotments under CHIPRA 2009* (Washington: Congressional Research Service, January 22, 2009).

[5] This Medicaid enrollment baseline is initially calculated based on the number of children who are enrolled in Medicaid in FY 2007, increased by the growth rate in the state's child population plus 4 percentage points, for both FY 2008 and FY 2009. For FY 2010-2012, the baseline is the previous year's baseline increased by the growth rate in the state's child population plus 3.5 percentage points. For FY 2013-2015, the baseline is the previous year's baseline increased by the growth rate in the state's child population plus 3 percentage points.

[6] Kathryn Allen, Testimony before the U.S. Senate Committee on Finance, *State Experiences in Implementing SCHIP and Considerations for Reauthorization* (Washington: Government Accountability Office, February 1, 2007).

[7] National Immigration Law Center, *Talking Points: SCHIP Reauthorization Legislation Can Help Ensure that Children Receive Timely Health Care Coverage* (Washington: National Immigration Law Center, January 13, 2009), available online at http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA_Talking_Points_Final_1-8-09.pdf.

[8] Congressional Budget Office, op. cit.

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