



Summary of the Children's Health Insurance Program Reauthorization Act of 2009

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which reauthorizes the Children's Health Insurance Program (CHIP) and extends funding through Fiscal Year 2013. The law provides significant new funding for states to enroll additional children in CHIP.

According to the Congressional Budget Office, CHIPRA includes funding and enrollment policies that will result in the enrollment of 4.1 million additional children who are not currently covered by Medicaid or CHIP. The law provides \$32 billion in new funding for CHIP and Medicaid over the next 4.5 years. The funding will be paid for by an increase in the federal tax on tobacco products. CHIPRA also includes most of the provisions of the Children's Health Care Quality Act of 2007, which has been championed by N.A.C.H., and for the first time makes a significant federal investment in pediatric quality measurement and improvement.

The following is a summary of the main provisions in CHIPRA of interest to children's hospitals.

Overall Funding

The legislation provides \$32.8 billion above the current baseline of \$25 billion. The following are the national CHIP allotment levels:

- FY 2009 - \$10,562,000,000
- FY 2010 - \$12,520,000,000
- FY 2011 - \$13,459,000,000
- FY 2012 - \$14,982,000,000
- FY 2013 - \$17,406,000,000

While the national allotments include additional funding for CHIP, if there is not enough CHIP funding to give each state the allotment it is calculated to receive, the law requires for a proportional reduction in each state's allotment to stay within the national cap.

Financing

The \$32.8 billion in additional funding will be paid for by raising the federal tax on tobacco products. Each pack of cigarettes will be subject to a \$.62 tax, with proportional tax increases on all other tobacco products.

State Allotments

CHIPRA increases CHIP funding for all states. Previously, CHIP allotments were based primarily on the number of uninsured and uninsured low-income children in the state. The state allotments under the new law are calculated as follows:

- FY 2009 - State allotments will be calculated as 110 percent of the greatest of the three following amounts:
 1. Total federal CHIP funding for the state in FY 2008, multiplied by the annual adjustment based on health care inflation and child population growth;
 2. The state's FY 2008 CHIP allotment, multiplied by the annual adjustment based on health care inflation and child population growth; or
 3. Projected FY 2009 federal CHIP spending for the state as of March 2009.

- FY 2010 and 2012 – State allotments will equal its previous fiscal year allotment adjusted for health care inflation and child population growth. This will also take into account any funds the state receives from the child enrollment contingency fund.
- FY 2011 and 2013 – State allotments will be rebased in FY 2011 to reflect its actual use of CHIP funds in the previous fiscal year.

The law changes current policy by allowing states two years to spend their CHIP allotments rather than three years. Unused funds will be redistributed to states facing CHIP funding shortfalls. The Georgetown Center for Children and Families has developed a table of estimated state CHIP allotments.

Child Enrollment Contingency Fund: CHIPRA creates a child enrollment contingency fund to provide states with additional funding if they face a CHIP funding shortfall and their enrollment of children exceeds a certain target level. As stated above, any funding provided to states from the fund will be included in the state's allotment calculation.

States with Significant Medicaid expansions Pre-CHIP: States that had expanded Medicaid prior to the original enactment of CHIP in 1997 are given more flexibility to access the enhanced CHIP match rate. The law allows these states to use CHIP funds to draw down the difference between the Medicaid and CHIP match rate for children on Medicaid in families with incomes above 133 percent of the federal poverty level.

Enhanced Match Rate for Translation and Interpreter Services: The law provides an enhanced matching rate in CHIP and Medicaid for translation and interpretation services for children in families with limited English proficiency. For CHIP the matching rate is the highest of 75 percent or the state's current enhanced match rate plus 5 percentage points. For Medicaid, the matching rate will be 75 percent. The enhanced match is available to states providing translation and interpretation services when an individual enrolls in coverage, renews coverage or utilizes coverage.

Performance Bonuses

In an effort to encourage states to enroll as many eligible children as possible, CHIPRA provides incentive bonuses to states that are successful at reducing the number of children who are eligible for Medicaid or CHIP, but not enrolled. To receive bonuses, states would have to implement five of eight specific enrollment and retention practices:

- Adopt 12-month continuous eligible for children
- Liberalize asset requirements
- Eliminate in person interview requirements
- Use joint application for Medicaid and CHIP
- Institute automatic enrollment renewal
- Implement presumptive eligibility for children
- Use express lane eligibility
- Provide premium assistance subsidies

Eligibility Changes

CHIPRA retains much of the flexibility states currently have to set eligibility levels for children under CHIP; however, the law changes the matching rate available to states to cover children from moderate income families. The law also provides the states a new option to cover pregnant women and legal immigrant children.

Children: The law limits the enhanced CHIP federal matching rate to coverage of children in families with incomes less than 300 percent of the federal poverty level. Two states that currently cover children at higher incomes levels – NY and NJ-- are grandfathered in.

Legal Immigrants: CHIPRA allows states the option to cover eligible legal immigrant children and pregnant women in CHIP and Medicaid without a five-year waiting period.

Low-Income Pregnant Women: CHIPRA allows states to provide coverage under CHIP to pregnant women through a state plan amendment, with no waiver approval required. States can use this option up to, but no higher than the state's income eligibility level for children. States that want to use this option also must:

- Cover children up to at least 200 percent of the federal poverty level and cannot limit enrollment or institute a waiting list for children;
- Cover pregnant women in Medicaid up to at least 185 percent of the federal poverty level and the state cannot reduce its Medicaid eligibility level for pregnant women less than was in effect on July 1, 2008;
- Not cover higher income pregnant women without covering lower income women and cannot impose pre-existing conditions or have waiting periods before a pregnant women can get coverage.

Parents: CHIPRA prohibits the Centers for Medicare and Medicaid Services (CMS) from approving waivers that allow states to use CHIP funds to provide coverage to parents. States with existing waivers may continue to cover this population through FY 2012 at the enhanced CHIP match rate. After FY 2012, states can continue to cover parents but it would receive a reduced federal matching rate:

1. If the state were to reach a number of benchmarks for enrolling eligible children, the state would receive a reduced federal matching rate, equal to half-way between the enhanced CHIP match rate and the regular Medicaid match rate; or
2. If the state did not meet the benchmarks, the state would receive the regular Medicaid match rate.

Childless Adults: CHIPRA prohibits CMS from approving any new waivers or renewing existing waivers that allow federal CHIP funds to be used to provide health coverage to childless adults. States that have existing waivers may continue to use federal funds to cover this population only through FY 2009.

Outreach and Enrollment

CHIPRA establishes a new grant program to finance outreach and enrollment efforts that increase participation of eligible children in both Medicaid and CHIP, funded at \$100 million for FY 2009-2013. In each year, 10 percent of the funds (\$2 million annually) are to fund a national enrollment campaign. An additional 10 percent of the funds will be used to award grants to Indian Health Service providers and Urban Indian Organizations to enroll Native American children.

The remaining \$80 million (\$16 million annually) are dedicated to provide grants to states, local governments, schools and certain other non-profit organizations, including providers that seek to implement plans to enroll eligible children.

CHIPRA also includes new provisions to allow states additional options to enroll and retain eligible children on Medicaid and CHIP. For example, the law allows states to use relevant funds from other public programs, like food stamps, school lunch and WIC, when determining a child's eligibility for Medicaid or CHIP.

Removal of Barriers to Enrollment

The Deficit Reduction Act (DRA) of 2005 included strict new citizenship documentation requirements for people seeking to enroll or remain enrolled in Medicaid. These new requirements have had a negative impact on children's enrollment in many states. CHIPRA includes provisions that while adding the citizenship documentation requirements to the CHIP program also provide an alternative method of proving citizenship status.

Beginning January 1, 2010, states are allowed to document citizenship by submitting the names and social security numbers (SSNs) or individuals declaring they are citizens or nationals to the Social Security Administration (SSA). If SSA finds that the name, SSN, or the applicant's declaration of citizenship is inconsistent with its records, the state must make a reasonable effort to address the inconsistency while providing coverage to the otherwise eligible individual. If the state cannot resolve the issue, the individual would have 90 days to provide citizenship documentation to fix the problem with SSA. If the individual is not able to resolve the inconsistency, then their eligibility will be terminated within 30 days following the 90-day period.

CHIPRA also sets some new requirements related to citizenship documentation:

1. Individuals who are otherwise eligible must be provided benefits while they are proving their citizenship.
2. Newborns who currently automatically receive Medicaid coverage based on their mother's eligibility at the time of birth no longer have to document their citizenship after that year of eligibility ends.
3. Native Americans are allowed new ways to meet the requirements.

Premium Assistance

CHIPRA provides new rules and options for states implementing premium assistance programs. The law reduced barriers for states to provide subsidies for the purchase of employer-sponsored insurance (ESI) by allowing states to include the cost of covering parents in assessing the cost-effectiveness of providing premium assistance for children on CHIP. Under CHIPRA, states must also include the administrative costs of subsidizing ESI versus direct coverage in the cost-effectiveness calculation. The ESI coverage must meet three main requirements:

- The employer must contribute at least 40 percent of the cost of the premium;
- The benefit package must be actuarially equivalent to CHIP coverage or supplemental benefits and cost sharing protections must be provided; and
- Coverage must not include high deductible plans and/or benefits provided under flexible spending accounts.

CHIPRA requires group health plans to permit eligible but unenrolled employees or dependents to enroll in the plan if the employee or dependent loses eligible for Medicaid/CHIP, or if the employee becomes eligible for premium assistance through Medicaid/CHIP. Employers with group health plans in a state that provides premium assistance are required to provide employees with written notice of the potential opportunities for premium assistance.

The law includes additional provisions designed to coordinate premium assistance with private coverage.

Strengthening the Quality of Care for Children

CHIPRA includes a significant quality improvement section, based on legislation championed by N.A.C.H. The law appropriates \$45 million over five years, FY 2009 – 2013, for the purpose of carrying out provisions of the quality improvement section.

Development of Child Health Quality Measures for Children in Medicaid and CHIP: The U.S. Secretary of Health and Human Services is required to develop and provide for public comment an initial "core set" of child health care quality measures for use by states. These measures are designed to be systemic and state-level. Before 2010, the Secretary is required to report to Congress on the status of efforts to improve child health quality.

Advancing and Improving Pediatric Quality Measures: The Secretary is required to establish a pediatric quality measures program before 2010. The program's purpose is to:

- Improve and strengthen the core set developed by the Secretary
- Expand on existing pediatric quality measures used by public and private purchasers
- Increase the portfolio of pediatric quality measures available to purchasers, providers, and consumers
- The Secretary is required "to award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services..."

Annual State Reports Regarding State-Specific Quality of Care Measures Applied Under Medicaid or CHIP: Each state is required to report annually to the Secretary a set of state-specific child health quality measures. The Secretary is required to report on the collected information.

Demonstration Projects for Improving the Quality of Children's Health Care and Use of Health Information Technology: The Secretary is required to award grants to state and child health providers to "conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care furnished under Medicaid and CHIP."

Development of Model Electronic Health Record Format for Children Enrolled in Medicaid or CHIP: The Secretary is required to "establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled...in Medicaid or CHIP."

Study of Pediatric Health and Health Care Quality Measures: The Institute of Medicine is required to "study and report to Congress on the extent and quality of efforts to measure child health statutes and the quality of health care for children..."

Benefits

CHIPRA makes changes to CHIP coverage of dental and mental health services.

Dental Benefits: Beginning October 1, 2009, CHIPRA requires state CHIP plans to include coverage of dental services. Currently, states cannot use CHIP funds to provide coverage or cost sharing assistance to children who have other insurance. The new law makes an exception with respect to dental coverage. The law allows states to provide dental-only supplemental coverage or cost sharing protections for dental coverage to otherwise eligible children.

Mental Health Parity: The new law requires that if states provide coverage of mental health or substance abuse services in their CHIP plans than the financial requirements and treatment limitations for these benefits cannot be any more restrictive than those for medical and surgical benefits. CHIPRA does not require states to cover mental health services under CHIP.

EPSDT Services in Medicaid: CHIPRA makes a technical fix to the DRA of 2005 to clarify that EPSDT services must be provided as part of benchmark benefit packages for children on Medicaid.

Additional Provisions

Access Commission: The law establishes a Medicaid and CHIP Payment and Access Commission (MACPAC), similar to Medicare's MedPAC, to evaluate children's access to care in addition to payment policies in Medicaid and CHIP. The commission will make annual recommendations to Congress, with the first set due by March 1, 2010. The commission will be composed of 17 members appointed by the Comptroller General of the United States. Physicians and health care professionals would be included in this commission, along with consumers, states, third party payers and experts in the health care field.

Childhood Obesity Demonstration Project: CHIPRA provides \$25 million for FY 2009-2013 for a childhood obesity demonstration project. The law directs the Secretary of Health and Human Services, in consultation with the Administrator of CMS, to conduct a demonstration project to “develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities...” Health care providers are included in the list of eligible entities.

Managed Care Standards Apply to CHIP: CHIPRA applies Medicaid managed care standards, such as beneficiary protections and quality assurance requirements, to CHIP.

Health Opportunity Accounts: The law prohibits the Secretary of Health and Human Services from approving any new Health Opportunity Account demonstrations, which were provided for in the DRA of 2005.

Disproportionate Share Hospital (DSH) Allotments for Tennessee and Hawaii: CHIPRA extends state DSH allotments for Tennessee and Hawaii through the first quarter of fiscal year 2012. (These states do not receive DSH allotments as other states do because they operate their Medicaid programs under Section 1115 waivers that waived the requirement to make DSH payments).