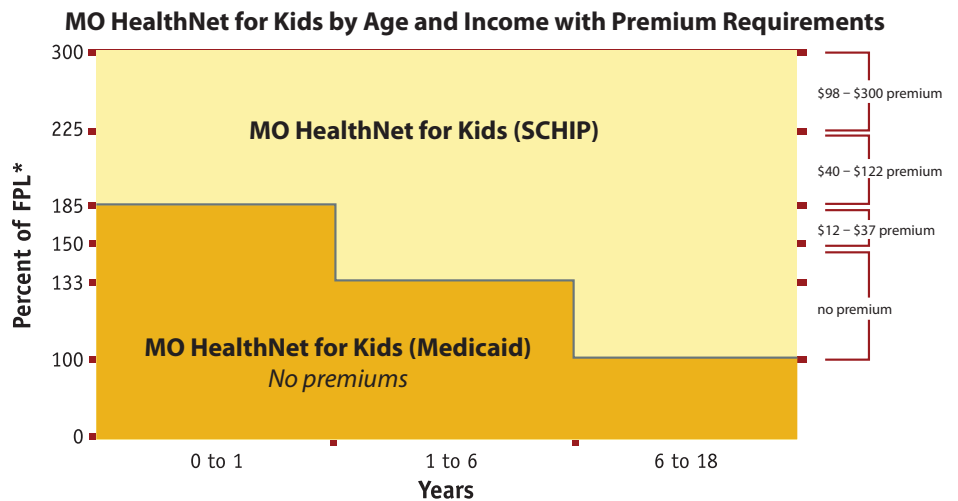


SCHIP Reauthorization 2009

The State Children’s Health Insurance Program (SCHIP) provides affordable health coverage to more than 7 million children nationally, including 66,000 in Missouri. In February 2009, the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was passed by Congress and signed into law by President Obama. The new law went into effect April 1, 2009, and extends the program until September 2013. This issue brief provides an overview of CHIPRA and highlights the policy implications for Missouri.

Background

SCHIP was created as part of the federal Balanced Budget Act of 1997. In each state, SCHIP provides health insurance for uninsured children whose family incomes are too high to qualify for Medicaid but too low to afford private insurance. The federal government matches SCHIP spending at a higher rate than for Medicaid. In Missouri, the federal FY 2009 match for Medicaid is 63 percent, but the federal match for Missouri’s SCHIP program is 74 percent.



Using its allocated SCHIP funds, Missouri extended health coverage to low-income children with family income up to 300 percent of the federal poverty level (FPL). In Missouri, SCHIP is known as MO HealthNet for Kids. Based on an income scale, some individuals covered under MO HealthNet for Kids must pay premiums. Premiums paid per family per month range from \$12 to \$300 (see chart). Approximately 66,000 children currently have coverage under the MO HealthNet for Kids program in Missouri.

SCHIP was slated for federal reauthorization due to a March 31, 2009, expiration date. On February 4, 2009, President Obama signed CHIPRA into law. CHIPRA extends the program for four and a half years and provides states with additional funding, incentives, and mechanisms to increase enrollment and improve benefit packages. The following provides an overview of the federal law and highlights implications for Missouri state policy.

Summary of CHIPRA Legislation

Federal Funding

CHIPRA extends the SCHIP program from April 1, 2009, until the end of fiscal year 2013 and provides an additional \$32.8 billion above current federal SCHIP spending. The additional spending is funded primarily from a 62-cent increase in the federal tobacco tax.

Coverage Expansion

CHIPRA ensures that the 7 million children currently covered under SCHIP continue to be covered and

intends to cover approximately 4 million more children who would otherwise be uninsured. It is estimated that 83 percent of these uninsured children are already eligible for SCHIP or Medicaid but are not enrolled.¹

State Allocations

CHIPRA applies a new formula to state allotments, which target dollars to states that spend the most. CHIPRA bases allotments on each state's previous and projected expenditures, per capita health expenditures, and child population growth. These allotments are re-calculated every two years and states will have two years to spend their annual allotments. This new state allocation formula makes Missouri's budget decisions in the next two years especially important, as spending will determine future allotments. Failure to claim SCHIP funds could lead to funds being sent to other states. The table below shows Missouri's 2009 projected allotment under CHIPRA, compared to Missouri's allotment under the previous law.

Missouri Allotment under Previous Law FY2009	Missouri Projected Allotment under CHIPRA 2009	Percentage Difference of CHIPRA 2009 Allotments over Previous Law
\$81.9 million	\$129.3 million	58% larger

Source: <http://www.statehealthfacts.org/comparetable.jsp?ind=660&cat=4>

To avoid shortfalls in SCHIP funding (which has happened to some states in the past), CHIPRA sets up a federal contingency fund (capped at 20 percent of the national allotment). States will be eligible to receive this assistance if they exceed their SCHIP enrollment targets and have a funding shortfall. However, the new distribution formula of CHIPRA should help prevent states from experiencing any shortfalls.

Eligibility

States provide coverage for a variety of populations under their SCHIP and Medicaid programs. CHIPRA clarifies which groups can be covered under which programs.

CHIPRA continues to allow states to cover children up to 300 percent FPL at the enhanced SCHIP match rate. However, states that propose to cover children in families with incomes greater than 300 percent FPL will only receive the lower Medicaid match rate for these children. States can continue to cover pregnant women using SCHIP funds and can now use state plan amendments instead of waivers to declare eligibility for this population (this reduces administrative hassle). Missouri does not currently have a waiver to cover pregnant women using SCHIP funds.

In the past, some states have been granted waivers to cover both parents and childless adults through SCHIP. CHIPRA will gradually shift these eligibility groups out of SCHIP (this does not affect Missouri because parents and childless adults are not currently covered through the state's SCHIP program).

Finally, the new law allows states the option of eliminating the five-year waiting period for lawfully residing immigrant children and pregnant women in Medicaid and SCHIP. All states, including the 22 states that covered this group through state-only funds, will now be allowed to use federal funds.² Missouri does not currently cover legal immigrant children and pregnant women during their first five years in the country.

Outreach and Enrollment

CHIPRA allocates \$100 million for fiscal years 2009 through 2013 to fund outreach and enrollment activities. Of this funding, \$10 million will be directed to a national campaign to improve enrollment while \$90 million will fund enrollment efforts of state and local groups (i.e., federally qualified health centers, disproportionate share hospitals, community groups, and schools). The funding directed to state and local groups includes \$10 million dedicated to outreach and enrollment of Native American children. To receive funding, a state must maintain the funding level it spent for outreach and enrollment activities in the previous fiscal year. The state of Missouri did not spend a significant amount of funding on outreach and enrollment in fiscal year 2008. While some state funds may have

been used at the community level for planning of outreach activities, no state-wide enrollment and outreach efforts were funded by Missouri in 2008.

Bonus Payments: To encourage states to enroll more children, CHIPRA provides a variety of tools and incentives, including a performance bonus system. To qualify for this bonus, states must: 1) increase their enrollment of already-eligible uninsured children in Medicaid above a target level and 2) adopt at least five out of eight enrollment policies. Enrollment targets will be calculated based on the number of children enrolled in Medicaid in the state in fiscal year 2007 inflated by the increase in the number of children living in the state in 2008 and 2009. For children enrolled above this baseline, the state will receive a bonus based on the Medicaid cost per child.

The eight enrollment policies, or performance measures, are outlined in the following table. For 2010 and beyond, five of the eight policies must be in place for the full federal fiscal year for a state to qualify for a bonus. An initial review indicates that Missouri has already adopted two of these policies fully. Three policies have been partially implemented and may only require small changes to meet the criteria. Instruction from the Centers for Medicare and Medicaid Services (CMS) will be needed to inform states on the specific definitions of these performance measures.

Performance Measure	Missouri Status
Implementation of 12-month continuous eligibility for all children	Not implemented
Elimination of asset tests, or allow verification of assets by means that do not require provision of unnecessary documentation	Partially implemented. Children in families with income above 150% of FPL are subject to a "net worth" test of \$250,000. However, Missouri only requires self-attestation, not extensive documentation. This may meet the asset test measure, or may only require slight modification to qualify.
Elimination of face-to-face interview	Implemented
Use of joint Medicaid-SCHIP application/same application and renewal verification process	Implemented
Implementation of administrative or paperless verification at renewal through the use of completed forms or ex parte determinations	Not implemented
Use of Presumptive Eligibility	Partially implemented. Presumptive eligibility is used for certain groups.
Use of the option in the new law for Express Lane Eligibility	Not implemented
Use of the option in the new law for Premium Assistance	Partially implemented. The current Health Insurance Premium Payment (HIPP) program may only require small changes to qualify as premium assistance.

Further information on performance measures can be found at <http://www.kff.org/medicaid/upload/7885.pdf>.

Express Lane Eligibility and Auto-Enrollment: Another way CHIPRA encourages states to enroll more eligible children is through "Express Lane Eligibility." Through this new option, states can accept income determinations from state agencies that administer other means-tested programs (such as free and reduced-price school lunches; the Women, Infants and Children (WIC) program; and food stamps). This alleviates the need for families to prove income separately for eligibility or renewal of Medicaid or SCHIP. Children can then be enrolled into SCHIP or Medicaid without an application once they are determined to fit the income eligibility requirements. As long as the parent consents, the child/children can be "auto-enrolled," eliminating a separate application process.

Citizenship Documentation and Translation Services: CHIPRA requires Medicaid citizenship documentation for both SCHIP and Medicaid and clarifies that no federal funding will be available to immigrants who are not in the country legally. The burdensome documentation process for families is lessened by allowing states to accept Social Security numbers and use the Social Security

Administration database to verify identification and citizenship. The law clarifies that children born to a mother on Medicaid are exempt from this requirement. CHIPRA also provides an enhanced match rate for translation and interpretation services for SCHIP and Medicaid families who do not speak English as their primary language (this applies to enrollment, renewal, and services).

Benefits, Access and Quality

Dental: Starting October 1, 2009, CHIPRA requires SCHIP plans to include dental services. Although most states' SCHIP programs currently include dental services (including Missouri), they have not been required to do so in the past. CHIPRA also allows states to offer dental coverage to children who are eligible for SCHIP but enrolled in private coverage that does not offer dental benefits.

Mental Health Parity: If a state provides mental health services through SCHIP, the limitations on mental health benefits must not be greater than the limitations on medical benefits (this does not mean that mental health services are required in SCHIP). If a SCHIP plan includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, this satisfies the mental health parity requirement.

Premium Assistance: CHIPRA includes new rules and options for states implementing premium assistance programs. It reduces barriers for states to provide subsidies for the purchase of employer-sponsored insurance. Coverage may be subsidized if the employer contributes at least 40 percent of the cost and the benefit package is actuarially equivalent to the SCHIP benefit package. The law also amends the federal Employee Retirement Income Security Act (ERISA) law to encourage coordination between public and private coverage. This amendment makes losing or gaining Medicaid or SCHIP a qualifying event for enrolling in employer-based coverage.

Quality: CHIPRA includes a quality health initiative, providing \$225 million over fiscal years 2009 to 2013 for child health quality measurement and data reporting. Demonstration grants focused on the use of health information technology are included in this funding. A separate allocation of \$25 million is dedicated to demonstration funding to address childhood obesity.

Conclusion

Through the reauthorization of SCHIP, states have been given significant funding support and new policy options for full implementation of children's coverage programs. In recent years, the number of uninsured children in Missouri has increased to 150,000. CHIPRA allows Missouri the opportunity to reduce this number by easing the fiscal and administrative burden placed on parents. It offers incentives for effective outreach and enrollment of uninsured children who are already eligible for the program. By taking advantage of the CHIPRA legislation, Missouri can leverage millions of additional federal stimulus dollars that, if not used, will be distributed to other states. Through CHIPRA, Missouri policymakers have the opportunity to significantly reduce the number of uninsured children, ultimately improving their health status.

End Notes

- 1 Center for Children and Families, The Children's Health Insurance Program Reauthorization Act of 2009 (Washington, DC: Georgetown University, February 2009).
- 2 Center on Budget and Policy Priorities and National Immigration Law Center. Information available at <http://www.cbpp.org/4-20-07health2.htm>.