THE KAISER COMMISSION ON
Medicaid and the Uninsured

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CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007 (CHIPRA): THE REVISED CHIPRA BILL (H.R. 3963) COMPARED TO THE ORIGINAL BILL (H.R. 976)

The State Children's Health Insurance Program (SCHIP) was enacted with bi-partisan support a decade ago as part of the Balanced Budget Act of 1997 (BBA). Together with Medicaid, SCHIP has helped to reduce the number of low-income uninsured children by expanding eligibility levels and simplifying application procedures. While coverage gains helped to increase access to health services for millions of children, 9.4 million children remain uninsured. About two-thirds are eligible for Medicaid or SCHIP, but not enrolled.

H.R. 976, The Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA) to extend the SCHIP program was passed with bi-partisan support in Congress; however, the House was not able to override the President's veto. The House and Senate passed a revised version of CHIPRA (H.R. 3963) that was intended to address key concerns of opponents of the bill. The President has threatened to veto the bill and the House vote would not support an override. SCHIP is temporarily funded through December 14 at current levels that are not adequate to fund most states to maintain coverage of children currently enrolled.

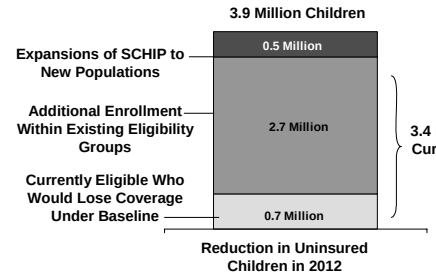
The first CHIPRA bill, in the view of opponents, did not adequately address the following issues: income eligibility for coverage of children, crowd-out, and the treatment of immigrants, parents and childless adults. In response, the revised bill would prohibit SCHIP matching funds for coverage of children beyond three times the poverty level, require additional verification of citizenship status, require all states to implement best practices to limit substitution of public coverage for private coverage, encourage premium assistance options, and speed up the transition of childless adults from SCHIP from two years to one year. The revised bill continues to rely on an increase in the tobacco tax to pay for a $35 billion increase for children's coverage. The bill also maintains key components of the original bill including fiscal incentives to encourage states to enroll low-income children, new outreach grants and initiatives to improve quality. This brief provides an overview of the key provisions in the original and revised version of CHIPRA.

Who Could Be Covered?

Children. CBO estimates that CHIPRA would provide coverage to 5.8 million children in SCHIP and Medicaid in 2012. More than two-thirds those enrolled (3.9 million children) would have otherwise been uninsured. (Figure 1) Nearly 90 percent or 3.4 million children are currently eligible for Medicaid or SCHIP. The remaining 0.5 million are expected enroll to as a result of state efforts to expand to new populations. HR 976 would have covered 3.8 million uninsured children (0.6 million enrolled through expansions).

Figure 1

Reduction in Uninsured Children in the Children's Health Insurance Program Reauthorization Act of 2007 (H.R. 3963)



SOURCE: CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under HR 976, CHIPRA. October 24, 2007

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Under the revised bill, states would be prohibited from covering children with family incomes above 300 percent of poverty under SCHIP, with an exception for New Jersey where eligibility for children is set at 350 percent of poverty, the only state that currently covers children above 300 percent of poverty. New Jersey would be subject to new participation requirements for lower-income children. New York's plan to expand to 400 percent of poverty would not be allowed. Under HR 976, states had flexibility to set eligibility levels, but the enhanced matching rate was restricted if states expanded beyond 300 percent of poverty in the future.

Pregnant Women and Adults. Like HR 976, the revised CHIPRA bill would establish new options to cover pregnant women, but would limit other coverage for adults while allowing for a transition for states that had such coverage in place. HR 3963 would prohibit new waivers for parent coverage. For the states covering parents as of October 1, 2007, the bill would limit funding by creating a set-aside separate from the SCHIP program for parent coverage that would be available to states at the Medicaid match (or a modified enhanced match subject to performance benchmarks on children's coverage) after two years. The bill would terminate coverage for childless adults and allow four states with such coverage to apply for a Medicaid waiver within one year to cover current enrollees, faster than the two year Medicaid transition included in HR 976.

Other Groups. Like HR 976, the revised bill would not allow states the option to expand coverage to legal immigrants, undocumented immigrants or children of state employees so these groups would continue to be ineligible for SCHIP.

Citizenship Documentation. Like HR 976, the DRA citizenship documentation requirements for Medicaid would now be required for children in SCHIP, but the bill would allow states new options to comply with these requirements by using data matching process with the Social Security Administration (SSA) to verify names and social security numbers. If the data match is not successful, applicants would need to provide original citizenship and identity documents as currently required for Medicaid under current law. The revised adds verification of citizenship status with the SSA database.

Efforts to Improve Coverage of Low-Income Children

The revised CHIPRA bill maintains fiscal incentives for states to enroll eligible low-income children but restricts the bonus payments to states that enroll children eligible but not enrolled in Medicaid. A bonus per child would be based on several factors including how far actual enrollment exceeds target levels. To be eligible for the bonus payments, states must implement five out of eight eligibility simplification efforts. Like HR 976, the revised bill provides $100 million in outreach grant funding and provides an enhanced match for translation and interpretation services.

Efforts to Limit Crowd-Out & Expand Private Coverage

Like HR 976, HR 3963 would continue the requirement that children must be uninsured to enroll in SCHIP. The bill would require GAO and IOM to produce studies to identify best-practices for states to use in addressing crowd-out. The revised bill requires all states to develop and implement best practices to limit crowd-out (HR 976 only required states covering higher income children to implement plans to address crowd-out). These provisions would replace current crowd-out requirements that were included in guidance released by CMS in August.

Like HR 976, the revised bill would establish a new cost effectiveness test, allow for premium assistance subsidies for qualifying employer plans, require employers to share information about benefit packages so states can more easily assess if plans are cost effective, and require states to provide outreach and education to families and employers that may qualify for premium assistance. In addition, HR 3963 adds premium assistance subsidies as one of the enrollment and retention options that states could adopt to qualify for performance bonuses.

Benefits, Data and Quality

The revised SCHIP bill does not change the benefit, data and quality provisions included in HR 976. The bill requires SCHIP plans to include dental coverage and would require mental health parity to medical and surgical benefits if a state offers mental health or substance abuse services. The bill applies the Medicaid payment rates for Federally Qualified Health Centers and Rural Health Clinics to SCHIP. The bill includes $225 million over the next five years for child health quality initiatives including the development of quality measures and demonstration programs to improve quality, combat obesity and develop electronic health records. The bill requires states to submit an annual report to HHS on eligibility, enrollment and retention, includes $20 million for the Census Bureau to improve state specific estimates of children and requires a federal evaluation of the program in 2010.

Financing and Allocation to States

The revised SCHIP bill does not change provisions related to financing included in HR 976. CHIP would continue as a capped program with enhanced matching rates. CHIPRA would increase funding for children's coverage by about $35 billion over baseline levels of $25 billion over the next five years using a 61-cent per-pack increase in cigarette taxes and other tobacco tax increases to finance the new spending. The bill would replace the current allocation formula with one that relies on state's actual and projected spending increased by factors for inflation and child population growth. CHIPRA would allow states 2 years (instead of 3) to spend their allotments. The bill creates a contingency fund (capped at 20 percent of the annual national allotment) available for states that face federal financing shortfalls for SCHIP due to increased enrollment of low-income children.

Outlook

The SCHIP reauthorization debate unfolds as new Census data shows a continued increase in the numbers of uninsured children driven by continued declines in employer sponsored coverage. Low and moderate income families are often not offered employer sponsored coverage and private coverage is increasingly not affordable.

Despite attempts to address opponent's concerns in the revised CHIPRA bill, the President has stated that he will veto the bill citing use of an increase in the tobacco tax as the revenue source. Temporary funding for SCHIP is set to expire on December 14 and under current funding levels, 21 states are expected to experience federal funding shortfalls in FY 2008 with 9 states facing shortfalls by March. While the outcome of the SCHIP reauthorization debate remains a question, states are struggling to administer their programs with unknown levels of federal support. Several states are already considering plans to cap eligibility or restrict their programs in anticipation of funding shortfalls. Without additional federal financing, it will be difficult for states to move forward to address the growing number of uninsured children and some of the 6 million children currently covered could be at risk of joining the ranks of the uninsured.

	HR 976	HR 3963
Enrollment Changes	5.8 million (3.8 million otherwise uninsured)	5.8 million (3.9 million otherwise uninsured)
Coverage for Children	States set eligibility (Medicaid match > 300% FPL, exceptions for NJ and NY)	No SCHIP coverage > 300% FPL (exception for NJ)
Pregnant Women	New State Option	No change
Parents	No new waivers. Move to capped funds for parents in states with parent waivers in 2007.	No new waivers. Move to capped funds for parents in states with parent waivers as of October 2007.
Childless Adults	Allows for transition of currently enrolled childless adults to Medicaid within 2 years.	Allows for transition of currently enrolled childless adults to Medicaid in 1 year
Immigrants	No new option to cover legal immigrants or undocumented immigrants.	No change
Citizenship Documentation	New requirements applied to SCHIP. New option for states to use Social Security Number to verify names with Social Security Administration (SSA).	Also requires states that use the new option to verify citizenship status with SSA.
Enrollment / Outreach Incentives	Performance bonuses for states that enroll more than the target for Medicaid and SCHIP. States must adopt 5 out of 8 eligibility simplification options. $100 million for outreach grants. Enhanced match for translation / interpretation services.	Performance bonuses limited to Medicaid enrollment.
Benefits	Dental services required. Mental health parity required if states offer mental health services.	No change
Quality	Development of measures and reporting standards. New demonstration programs.	No change
Crowd-Out	Requires GAO/IOM reports to develop best practices. Implementation of best practices for states covering children with incomes > 300% FPL.	All states must implement best practices on crowd-out.
Premium Assistance	Change cost effectiveness test, premium assistance subsidies, requires sharing of private benefit information, education on premium assistance options.	Premium assistance subsidies added as option to qualify for bonus payments
Allotments	Based primarily on actual and projected spending plus inflation for population growth and health care costs. Contingency fund for spending in excess of allotments. States allowed 2 years to spend allotments.	No change
Financing	61 cent increase in per pack cigarette tax. $35 billion over 5 years.	No change
Moratorium on Regulations	Imposes a moratorium on rehabilitation and school based services regulations through May 2008.	No change

Prepared by the Kaiser Commission on Medicaid and the Uninsured, November 2007.

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