



Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), H.R. 2

AMA Summary of Key Provisions

On February 4, 2009, President Obama signed into law H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA reauthorizes the State Children's Health Insurance Program (SCHIP) for four and a half years through Fiscal Year 2013, and expands coverage to approximately 4 million children beyond the 7 million children currently covered under the program. The \$32.8 billion cost (\$40 billion over 5 years) is completely offset, primarily through increasing tobacco taxes, including a \$.62 rise in the cigarette tax to \$1.01 per pack. Restrictions on physician-owned hospitals, which were included in the House-passed version of the reauthorization legislation, are not included in the final enacted bill.

Key provision of interest to the AMA are as follows:

Allotments. States will receive increased SCHIP allotments, through an updated formula that reflects actual projected spending and state demographic and national spending trends. Under the formula, state allotments will be rebased every few years to ensure that funding is targeted to states that are using them for coverage of children. States that face a funding shortfall and meet enrollment goals will receive adjustment payments. The formula also sets in place new overall caps on federal funding to ensure the program's expenditures do not exceed the authorized amounts.

Initiatives to Enroll the Lowest-Income Uninsured Children. New tools are included to simplify and streamline enrollment, such as Express Lane eligibility, to encourage the enrollment of already-eligible uninsured children in coverage, as well as increased funding for outreach activities to states, local governments, schools, community-based organizations, safety-net providers, and others. Bonus payments are available to states when they significantly increase their enrollment of the lowest-income uninsured children in Medicaid and adopt specified measures to streamline enrollment and retention in both Medicaid and SCHIP.

Changes in Eligibility Rules. Several changes in eligibility are made:

- Although state flexibility is preserved to determine the income eligibility level for children and the methodologies used to determine income or assets under the program, new limits are imposed on expansions to children in families with income above 300% of the federal poverty level (FPL). States may continue to use specific disregards, such as work expenses, when setting their income rules. However, states are specifically barred from using "block of income" disregards (e.g., disregarding all income between 300% and 400% of FPL) to effectively expand coverage to children above 300% FPL. States providing coverage to children above 300% FPL will receive the Medicaid matching rate rather than the enhanced SCHIP matching rate; states (e.g., New York and New Jersey) that have an approved state plan amendment or waiver, or state law to provide coverage above 300% FPL are grandfathered.
- States are provided with a new option to cover pregnant women under their state plan, but can continue to cover pregnant women under existing options (waiver or regulation).
- No new waivers will be allowed to cover parents under SCHIP. States that have received waivers to cover low-income parents will be allowed to extend such waivers through fiscal year 2011; in subsequent years, states will be allowed to transition parents into a separate block grant.

- The current law prohibiting new waivers for coverage of childless adults is retained. Childless adults currently covered through a waiver will be transitioned out; for states that have received waivers, those waivers will be terminated after one year. These states will be allowed to apply for a Medicaid waiver for any further coverage for such adults.
- States have a new option to cover children and pregnant women lawfully residing in the U.S. who otherwise meet Medicaid or SCHIP eligibility requirements, without a five-year waiting period. Federal payments for individuals who are not legal residents are specifically prohibited.

Citizenship/Nationality Verification. States are allowed to use an alternative to a controversial proof-of-citizenship requirement that has been found to have denied Medicaid coverage for many eligible children. Instead of requiring documentation proving identity and citizenship, as required under the Deficit Reduction Act of 2005, states would be allowed to submit the name and social security numbers of applicants to the Social Security Administration (SSA) for verification. If the SSA determines that the applicant is not a citizen, states have up to 90 days in which to determine an applicant's legal status. This verification process would also be applied to SCHIP. States would also be required to annually certify the legal status of beneficiaries.

Premium Assistance. The legislation expands current premium assistance options for states and streamlines coordination between public and private coverage by allowing states to offer a premium assistance subsidy for qualified cost-effective employer-sponsored coverage to children and parents eligible for SCHIP. A demonstration program would be created under which states could allow employers with less than 250 employees and at least one employee with a SCHIP-eligible child or SCHIP-eligible pregnant woman to buy into a purchasing pool that offers SCHIP benchmark benefits. Federal ERISA law is amended to promote coordination between public and private coverage by establishing that both the loss of or gaining of Medicaid/SCHIP coverage counts as a “qualifying event” for the purposes of being eligible for employer-sponsored coverage. There are several provisions to encourage outreach on premium assistance, and a GAO study on state programs is mandated.

Improving Quality. A new quality child health initiative is created to develop and implement evidence-based quality measures for children enrolled in SCHIP and Medicaid and improve state reporting of quality data. The Secretary of HHS would develop an initial core set of measures, based on consultations with states, pediatricians and other primary and specialized pediatric health care professionals, national organizations and individuals with expertise in pediatric health quality measurement, and voluntary consensus standards setting organizations, and would award grants and contracts to develop, test and update such measures. The Secretary is also required to establish a program to encourage the creation and dissemination of model electronic health record format for children, and to create a demonstration program to reduce childhood obesity.

Improving Benefits. Dental benefits will be provided to all children enrolled in SCHIP. States will also be allowed to use SCHIP funds to provide dental benefits for children who are otherwise insured but lack dental coverage. Mental health benefits are to be provided on par with medical and surgical benefits. In addition, a commission will be created to study and report on SCHIP and Medicaid access to care and provider payments.