From SCHIP to CHIPRA
by Robin Lane

The launching of the State Children’s Health Insurance Program (SCHIP) just over a decade ago marked the beginning of a tangible commitment to improve access to high quality, affordable health care for America’s youngest citizens. The product of compromise and bipartisan cooperation, SCHIP gave states an opportunity to use federal financing aid to provide health insurance to children.

When the program began, nearly 22 percent of poor children in the U.S. were uninsured. During the ensuing years, SCHIP provided insurance coverage and new prospects for healthy futures to many millions of children. In 2007, with the original ceiling on financing due to expire, an estimated 8.9 million children still did not have coverage, and advocates mobilized to reauthorize the program.

Reauthorization Basics
President Obama signed The Children’s Health Insurance Reauthorization Act (CHIPRA) into law in February 2009. Reauthorization of SCHIP, known more simply in the new bill as “CHIP,” is projected to extend coverage to 4.1 million children, who otherwise would have been uninsured by 2013, accomplishing an almost 50 percent reduction in their numbers.

Who Is Covered by CHIP?
CHIP targets children and teens whose families are caught in the gap between having too much income to qualify for Medicaid but not enough to afford private insurance. More than two-thirds of such families have a parent or guardian who is working full time. In original CHIP legislation, eligibility was set at or less than 200 percent of the Federal Poverty Level (FPL), or what is now (in 2009) roughly $44,000 for a family of four. Waivers allowed states to extend coverage to families at more than 200 percent of the FPL, and eligibility levels now vary from state to state. For specific information about your state, see http://www.insurekidsnow.gov.

How Does CHIP Differ from Medicaid?
Although about half of Medicaid enrollees are children, Medicaid also covers low income parents, seniors and persons with disabilities. CHIP is a program for children and pregnant women (previous waivers that allowed states to cover parents and low income childless adults are phased out under CHIPRA). Medicaid is an entitlement program, meaning that states must enroll every person who meets established criteria. CHIP has no individual entitlement. Under CHIP, when state or federal funds are exhausted, enrollment stops.

How Is CHIP Structured?
When states first established their programs, they were offered three options. Using allotments of federal dollars to match state expenditures, they could:
- expand their existing Medicaid program,
- establish a new child health assistance program, or
- combine Medicaid and CHIP into a single program with both components.
States were given the option of providing the insurance themselves, with the state agency acting as the insurer, or they could elect to purchase coverage through an entity (a managed care organization, for example) that met certain federal conditions. CHIPRA maintains these options.
How Is It Funded?
Both Medicaid and CHIP are federal-state matching programs with match amounts determined through a complicated set of formulas unique to each state. One formula, the Federal Medical Assistance Percentage (FMAP), is based on the state’s average wages compared to the national average (states with lower per capita income receive matches at a higher rate). An Enhanced FMAP, which reimburses CHIP expenditures at an average rate of 70 percent compared to the standard FMAP Medicaid rate of 57 percent, is available in order to encourage participation in CHIP. Matches for CHIP state expenditures are a good deal for states: for every $1.00 of expense the state pays, it is matched with $2.57 of federal dollars.

How Does State Funding Change with Reauthorization?
Experience in the first ten years of the program demonstrated that states did not always spend enough state dollars to use their full federal match. New CHIPRA provisions encourage states to actually spend their allotments: they must be used in two years instead of three, and unused money must be returned for other states to use. New formulas for the allotments, implemented in stages starting in 2009, help states receive allotments that are more in line with actual expenditures. States that unexpectedly exceed enrollment targets and experience funding shortfalls may apply for help from a new Child Enrollment Contingency Fund. In addition, states will be rewarded for enrolling the lowest income children in their state (those eligible for Medicaid) by exceeding set target numbers and by implementing at least five of eight proven enrollment and retention strategies (elimination of face-to-face interview requirements).

What Else Is New?
Flexibility in program design and implementation was a key feature of the first CHIP legislation. CHIPRA preserves this flexibility, while encouraging states to advance their program:
• With federal approval, states may elect to cover children up to and over 300 percent of FPL, but if implemented after July 1, 2008, expenditures over 300 percent will be matched at the lower Medicaid rate.
• For the first time, states have an option to cover legal immigrant children and pregnant women during their first five years in the United States (the original legislation denied this eligibility).
• Pregnant women may be covered with an amendment to a state plan (previously required a waiver, which is harder to achieve).
• State plans must include dental benefits, but have an option to provide “dental-only” supplemental coverage to children who have other insurance without dental benefits.
• Mental health parity is required in CHIP plans for states that elect to cover mental health.

Impact on Reform: The Politics of CHIP
While there is broad support for insuring children, ideological divides over the role of government in reforming health care translated into two years of defeat before final passage of CHIPRA. Proponents of the bill, which infuses $44 billion in new spending between 2009 and 2013 on top of the baseline funding of $5 billion per year, celebrate the legislation as an important incremental step towards solving the problem of America’s uninsured.
Opponents cite the risks of offering public benefits to families they see as able to afford private coverage. Some opponents take issue with fact that new funding comes largely from a $0.62 increase in the federal cigarette tax as well as increases in other tobacco product taxes.\(^5\)\(^6\) Whichever view is held by legislators and private citizens, however, it is clear that without CHIPRA, many states would have faced serious budget shortfalls just to maintain original CHIP programs.

**What’s Left to Do?**

While CHIP demonstrated the benefits of adequate health insurance to children and their families, it also generated a list of “lessons learned,” among them: the need to continue vigorous outreach, and to simplify application and enrollment/reenrollment policies and procedures. Application of these lessons will be important in future reform debates.

**Endnotes**

2. [http://www.kff.org/medicaid/kcnu031709oth.cfm](http://www.kff.org/medicaid/kcnu031709oth.cfm)
5. [http://www.familiesusa.org/issues/childrens-health/reauthorization](http://www.familiesusa.org/issues/childrens-health/reauthorization)
6. [http://www.familiesusa.org/assets/pdfs/chipra-3-senate-2-02-09.pdf](http://www.familiesusa.org/assets/pdfs/chipra-3-senate-2-02-09.pdf)

**For additional information:**

5. Families USA. (2009). *Yes We Can...Cover More than 4 Million Uninsured Children.* Washington, DC.

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