Renewing The Children’s Health Insurance Program: Understanding State Concerns, Updates from Washington, and Strategies for Advocacy

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Snapshot of CHIP and its current funding

Children’s Dental Health Project Webinar
September 7, 2017
Maureen Hensley-Quinn, NASHP
About NASHP

• The National Academy for State Health Policy (NASHP) is an independent academy of, by, and for state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and non-partisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues.

• To accomplish our mission we:
  ▫ Convene state leaders to solve problems and share solutions
  ▫ Conduct policy analyses and research
  ▫ Disseminate information on state policies and programs
  ▫ Provide technical assistance to states
What is CHIP?

- Bi-partisan program established in 1997 to provide health coverage for children of low-income working families
- Financed with federal dollars and states provide matching funds
  - Federal CHIP matching rate higher than Medicaid FMAP
- States implemented and operate different types of CHIP programs
  - Separate, Medicaid-expansion/look alike, combination
- Comprehensive benefits
- Low cost-sharing (no more than 5% of income)
Current authorizing legislation

- Passed in April 2015 after some uncertainty...
  - H. R. 2: Medicare Access and CHIP Reauthorization Bill of 2015 (MACRA)
MACRA’s CHIP Funding Extension

- Maintains CHIP’s financing structure, including fully funded allotments through FFY 2017
- Extends Express Lane Eligibility (ELE) authorization through FFY 2017
- Appropriated funds for 23 percentage-point increase to the federal CHIP match, which began October 1, 2015
- Maintains MOE for children’s coverage in Medicaid and CHIP through 2019
- Extends CHIPRA outreach and enrollment grants ($40M)
- CHIPRA quality provisions ($10M for childhood obesity demonstrations and $20M for pediatric quality measures).
Impact of CHIP on State Children’s Health Coverage Activity
Reaching, Enrolling and Retaining Kids

• States have achieved great successes in enrollment for children and families pre and post ACA
  ▫ Targeted Enrollment Strategies
    • Facilitating enrollment through administrative data transfer
    • Enrolling parents based on children’s eligibility
  ▫ Focus on Retention
    • Electronic data matches
    • Administratively renew certain populations
  ▫ Updated and enhanced systems
    • Allow for better data feedback loop – informed decision-making
  ▫ Increased partnerships – across agencies and with stakeholders
Strengthening Care and Access for Kids

• Strong focus across states = improving care and access to providers for children
  ▫ Quality initiatives
  ▫ Expanding benefits – dental, behavioral and mental health, Applied Behavioral Analysis (ABA)
  ▫ Engaging providers – targeted outreach to dentists, improve telehealth (dental and mental health)
  ▫ Improving delivery system and engaging managed care organizations (MCOs)

• Renewed interest in Health Services Initiatives (HSIs)
  ▫ Use of CHIP administrative funds for children’s health beyond direct medical services
    • Ex. engaging schools; child and adolescent health campaigns
Children’s Coverage Now

- 8.9 million enrolled in CHIP in 2016 (Increase of approx. 500K from 2015)

- Eligibility Levels as percent of federal poverty levels (FPL)
  - 28 states cover children with family income = or + 250% of FPL
  - 20 states cover children with family income 200% - 250% of FPL
  - 3 states cover children with family income below 200% of FPL

- Participation rate = the % of those eligible and enrolled
  - In 2014 participation rate for children = 91% nationwide
  - In 2014, 33 states (including DC) achieved participation rate 90%+
  - According to American Community Survey (ACS) data – 2.8 million children who are eligible are uninsured

(Source: G. Kenney, May 2016
Clock is ticking for states as federal CHIP funding set to end without Congressional action
### Projected Exhaustion of Federal CHIP Funds

<table>
<thead>
<tr>
<th>Quarter of fiscal year</th>
<th>Number of states</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>First quarter (October–December 2017)</td>
<td>4</td>
<td>Arizona, District of Columbia, Minnesota, and North Carolina</td>
</tr>
<tr>
<td>Third quarter (April–June 2018)</td>
<td>19</td>
<td>Alabama, Georgia, Illinois, Indiana, Iowa, Maine, Michigan, Maryland, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, West Virginia, and Wisconsin</td>
</tr>
<tr>
<td>Fourth quarter (July–September 2018)</td>
<td>1</td>
<td>Wyoming</td>
</tr>
</tbody>
</table>

**Note:** CHIP is the State Children’s Health Insurance Program.  
**Source:** MACPAC 2017 analysis using June 2017 Medicaid and CHIP Budget and Expenditure System data from the Centers for Medicare & Medicaid Services, including quarterly projections provided by states in May 2017.
Explanation of MACPAC Projections

• Projections = estimates that are subject to change
  ▫ Affected by:
    • Increases in enrollment
    • Increased utilization of services
    • Increases in program costs

• Calculations assume all funds will be spent on services for enrollees, but states will need money to make programmatic changes
CMS Contingency Guidance to States

Three options for states to transition children…

• Phase out separate CHIP coverage and coordinate with other insurance affordability programs to transition children to either Medicaid or exchange coverage;

• Move children covered under separate CHIP programs to a Medicaid expansion CHIP program; or

• Establish a combination of these approaches based on income level

**All of these are financially and administratively burdensome for states**
State considerations to end CHIP

- State budgets – under pressure and already set
  - M-CHIP states must maintain coverage at lower FMAP

- Policy and operational considerations and action steps
  - Develop communication plans for: families, providers, stakeholders
  - Evaluate and change contracts – MCOs, vendors (i.e. call centers), third party administrators
  - Review and modify state policy, laws, regulations
  - Address changes to federal waivers and state plan amendments
  - Make systems changes – eligibility, claims
  - Transition children to other potential available sources of coverage

- Continuity of care issues for children
State budget assumptions

Does your state budget assume the 23% bump in federal matching funds for CHIP will continue?

- Yes: 36
- No: 3

N=39

Source: NASHP July 2017 Survey of CHIP Directors
State budget assumptions

Does your state have contingency funds if the 23% bump does not continue?

- Yes
- No

N=39

Source: NASHP July 2017 Survey of CHIP Directors
NASHP CHIP Resources

• Regularly updated webpage: http://nashp.org/childrens-health-insurance-resources-962/
• State survey
• Timeline for wrapping up state CHIP programs
• State CHIP fact sheets
• Policy briefs
• Blogs

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CHIP and Children’s Dental Health

September 2017
Deborah Vishnevsky, Policy Analyst, CDHP

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CHIP dental was a late addition, but it works

- When CHIP was introduced in 1997 it did not require a dental benefit
  - Federal requirement of a dental benefit only added in Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009
    - requires that “child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions”
- Details of benefit depend on the type of program a child is in
  - Medicaid expansion programs are provided with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
  - Stand alone CHIP programs may develop their own periodicity schedule and coverage package or they may use a benchmark as defined in CHIPRA
- We know that these dental benefits have a positive impact
  - Utilization of these benefits is on par with privately insured children and associated with regular dental providers and fewer unmet needs

1Sources: MACPAC, Medicaid Access in Brief: Children’s Dental Services, June 2016 and MACPAC, Report to Congress on the Medicaid and CHIP, March 2017
CHIP dental coverage has direct and indirect benefits for children and families

• **CHIP dental coverage eliminates barriers to care.**
  – While dental coverage for children is required to be offered in marketplaces, not all medical plans include dental insurance.
  – Even with private coverage, the high premiums and cost-sharing of dental plans can present obstacles to care, especially for lower income families.\(^1\)

• **CHIP coverage protects families from medical debt.**
  – CHIP programs include some cost-sharing (or out-of-pocket fees for care) but with strict protective limits. This enables families to focus on getting children necessary care, rather than trying to cut or delay costs.
  – Research shows that families with children with chronic conditions were confronted with significantly higher OOP costs when switching from CHIP to private insurance.\(^12\)

• **CHIP has impact outside of health like school performance and long-term earning potential**
CHIP Dental benefits are generous among coverage options for low income children, also makes them a target

- CHIP Dental benefits are unique for low-income children

<table>
<thead>
<tr>
<th>Benefit category</th>
<th>Separate CHIP</th>
<th>Medicaid</th>
<th>Exchange plans</th>
<th>Employer-sponsored insurance plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of states with some coverage in this benefit category</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%*</td>
</tr>
<tr>
<td>Percent of states with some coverage in this benefit category</td>
<td>94%</td>
<td>40%</td>
<td>46%</td>
<td>46%+</td>
</tr>
</tbody>
</table>

- Market place and employer-sponsored insurance programs are not required to provide children’s dental (although some states have since added this requirement)

- In January 2017, MACPAC stated that based on it’s own research, and reporting out of HHS, CHIP is more comprehensive and affordable than market place coverage

- Pediatric dental benefits are often an easy target for cuts
  - While not in CHIP, during ACA repeal process CBO pointed out that pediatric dental services would likely be a target for states waiving EHB’s

Sources:
1 March 2015 MACPAC report to Congress on Medicaid and CHIP
2 CBO Cost Estimate for HR 1628 from May 4, 2017
CHIP vs. the Exchanges

In their March 2017 report on the future of the Medicaid and CHIP MACPAC points out:

“uncertainty about the stability of the exchange market, further heightened by potential action by the 115th Congress on proposals to repeal the law underpinning the workings of this market and to change the structure and financing of the Medicaid program, have led the Commission to once again recommend extending CHIP … Commission recommends that funding be extended for a period of five years, through FY 2022. Such an extension would ensure the stability of children’s coverage during a time in which the coverage environment could change significantly, and would also be responsive to the pressing concerns of states as they begin budget and policy planning for the next fiscal year and beyond.”
Thank you!

For more information:

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The Future of the CHIP Program: an Update from Washington and How You Can Speak Up

September 2017

Libby Mullin, Principal, Mullin Strategies

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CHIP Funding and Tight Deadlines

• Federal funding for CHIP expires September 30
  – Without action from Congress, states will have to make alternate plans
  – States need assurance of stability for budget planning - state budgets have already been decided and likely run tight

• National Academy for State Health Policy (NASHP) did a blog post on the issue of timing
  – “States have their own budgetary restraints as well as statutory and regulatory requirements that must be considered as they develop contingency plans for their CHIP programs”
  – At least 21 states have public noticing requirements that apply to CHIP with time frames of 30 to 100 days prior to changing the program

• Colorado has already posted a banner on their website about the future of their CHIP program
Future of Child Health Plan Plus (CHP+)

- Current law allows states to continue to spend unspent federal fund allotments collected before October 1, 2017.
  - Because of this, there will be no immediate changes to CHP+ eligibility, enrollment, renewals, or benefits on October 1, 2017, even if Congress has not taken action by that time
  - CHP+ benefits will not end until the federal fund allotment Colorado already possesses as of September 30, 2017, runs out
    - We estimate this would happen sometime in the first quarter of calendar year 2018
    - We do not know the exact date
    - This would occur only if Congress does not authorize any new federal funding after September 30, 2017

- If Congress does not act, and after the federal fund allotment Colorado already possesses is spent, the CHP+ program will end.
  - If the program ends, the system will automatically check to see if the children and pregnant women who were covered by CHP+ qualify for Health First Colorado (Colorado’s Medicaid Program) or a subsidy to purchase private insurance through Connect for Health Colorado
Obstacles and Support for CHIP renewal

• Congress returned from recess this week and the schedule is hectic, along with CHIP other timely work includes:
  – Houston Emergency Funding
  – Debt ceiling
  – Tax reform
  – Omnibus appropriations
  – More

• Historically bipartisan support for the program
  – All sides want CHIP to pass, disagreement is in how to accomplish that
  – Could renewal of CHIP be treated as Hatch’s legacy program?
CHIP is a better option than the Exchanges

- CHIP provides comprehensive medical and dental coverage for low income children - but limits out of pocket costs (including premiums) to 5% of family income
  - In most states there are no cost sharing requirements
- Private coverage is more expensive for families than CHIP – for monthly premiums and out-of-pocket burden for care
  - Most marketplaces do not require that parents purchase children’s dental coverage
    - Lacking dental coverage is associated with having more unmet dental needs
- Current uncertainty/instability in marketplace coverage and costs underscores need to maintain CHIP

1Peltz, A; Davidoff, A; Gross, C and Rosenthal, M. “Low-Income Children With Chronic Conditions Face Increased Costs If Shifted From CHIP To Marketplace Plans.” Health Aff, April 2017, 36:4616-625; doi:10.1377/hlthaff.2016.1280
Goal: Long term renewal of current CHIP policy

- Long term funding is crucial
  - NGA, Children’s groups, etc. – all call for 5 years of funding
  - 5 years is more cost effective (than 2 years)
    - Also allows states to build infrastructure and innovate programs
    - CHIP extension could be complicated by traditionally 2-year riders
- Maintenance of Effort (MOE) requirements (or similar) should be preserved to ensure that CHIP continues to benefit all who need it
- Any Congressional action should be sensitive of the 23% federal match rate increase – too late to cancel it for 2018
  - States receive federal funding at a predetermined match rate of 65-80% - under 2015’s MACRA that rate was increased by 23%
  - State legislatures have recessed for the year - already determined budgets for 2018 (and 2019) - their calculations included the 23% “bump”
  - To protect state CHIP programs legislation should extend the bump
Messaging: CHIP needs immediate action, it works, and it is a good source of coverage for children

- **CHIP is expiring and needs action NOW**
  - States will soon have to make and implement disenrollment plans

- **CHIP works**
  - Provides comprehensive medical and dental coverage
  - Associated with regular medical and dental providers, fewer unmet needs
  - Associated with indirect benefits too – school attendance and completion, long term employability, etc.

- **CHIP is a stable, affordable source of coverage**
  - CHIP limits OOP costs (including premiums) to 5% of family income and in most states there are no cost sharing requirements
  - Private coverage options are far more costly, no guarantee kids will have dental coverage
  - Uncertainty in marketplace coverage underscores need to maintain CHIP

- **Personal stories are so important!**
Key Targets

• **Governors**

• Senate and House leadership and Committee members, particularly:
  – Republican members on [Senate Finance Committee](#)
  – Republican members on [House Energy and Commerce Committee](#)
  – Democratic leadership:
    • [Representative Nancy Pelosi](#) – California’s 12th district (House Democratic Leader)
    • [Representative Steny Hoyer](#) – Maryland’s 5th district (House Democratic Whip)
    • [Senator Charles Schumer](#) – New York State (Senate Minority Leader)

See the CDHP Toolkit for a draft message and call script - [www.cdhp.org/toolkit](http://www.cdhp.org/toolkit)
Thank you!

For more information:

Libby Mullin, Mullin Strategies

Check out our “Why Dental Coverage Matters” toolkit at: cdhp.org/toolkit

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