

## Major CHIPRA Provisions – Comments, Questions and Tentative Recommendations Relating to Wisconsin Implementation

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Wisconsin has made tremendous strides in improving access to health insurance for children and parents, thanks to the enactment of BadgerCare Plus. In addition, the state recently began covering low-income childless adults.

The recession makes the improved health care safety net all the more important, but it also strains the state's ability to sustain those gains. Fortunately, the federal Recovery Act and the law reauthorizing the Children's Health Insurance Program (CHIP) give states increased funding and other tools that should enable Wisconsin to protect BadgerCare Plus and move even closer to the goal of making health insurance accessible to all children in the state.

The following table summarizes and comments on options for states in the Children's Health Insurance Program Reauthorization Act (CHIPRA), and reports on their status in Wisconsin. It also identifies some of the questions that need to be answered as state policymakers consider these options. (This document draws upon a March 2009 publication by the Center for Children and Families, [The Children's Health Insurance Program Reauthorization Act of 2009: Overview and Summary](#), and the page numbers in the left column are references to that publication.)

The Wisconsin Council on Children and Families (WCCF) has been working with the Covering Kids and Families (CKF) Policy Committee to explore the CHIPRA options and to solicit input about which items should be priorities for implementation in Wisconsin. We continue to be interested in your comments and suggestions.

Key CHIPRA Provisions	WI Status	Comments, questions and recommendations
<b>State Options</b>		
Eliminate <b>5-year waiting period</b> for lawfully residing children. States will get the enhanced CHIP match for these kids. <i>Effective date: April 1, 2009</i> <i>Summary: Pg. 14</i>	DHS issued an Operations Memo to implement the change, beginning 10/1/2009. (Because the BC+ statute is tied to federal law, no statutory change was needed.) DHS made minor changes in late January 2010 after fed. officials clarified that the law applied to additional categories of lawfully residing immigrants.	The Governor has always said that BC+ covers <u>all</u> kids, to the extent allowed by federal law. Taking advantage of the new federal option removes one of the last remaining barriers to reaching the goal of covering all kids. DHS and advocates need to do more outreach to help make immigrants and safety net providers aware of the changes. Further tweaks may be needed in state policies to make them consistent with the July 1, 2010 CMS guidance.

<p>Document citizenship and identity using a <b>Social Security (SS) Number match</b>  <i>Effective date: Jan. 1, 2010</i>  <i>Summary: Pg. 12</i></p>	<p>DHS is aiming to implement this change in Oct. 2010. The change wasn't made more quickly because DHS was focusing on other systems changes relating to the new BC+ Basic Plan for childless adults.</p>	<p>This option will simplify and speed up the enrollment process for many families and reduce administrative costs. About 10 states began using the option in January 2010, and the initial data showed a SS match was found in at least 94% of the cases. Care needs to be taken to be sure that parents applying only for their children aren't led to believe that the people filing the applications need to have SS numbers.</p>
<p>Provide <b>wrap-around dental coverage</b> for kids with employer sponsored health insurance.  <i>Effective date: Apr. 1, 2009</i>  <i>Summary: Pg. 17</i></p>	<p>This is only an option in states that have separate CHIP programs. Iowa recently began to use this option. States like WI with combined programs could accomplish much the same thing through a wraparound Medicaid benefit.</p>	<p>The initial sentiment in WI is that using the option (as an MA wrap-around benefit) wouldn't be useful, because of the shortage of dentists who take BC+ enrollees.  <i>Question:</i> Is there a way to use it to help uninsured kids in areas served by community clinics?</p>
<p><b>Express lane eligibility</b>  States may determine kids' eligibility by using info from other means-tested programs.  <i>Effective date: Feb. 4, 2009</i>  <i>Summary: Pg. 11</i></p>	<p>This can take lots of forms. Options include using info from school lunch programs, Food Share, WIC, the unemployment insurance system &amp; tax forms.</p>	<p>This option is very problematic in states with family-based coverage, since express lane enrollment can only be used for children. The state should monitor initiatives in other states to see what is &amp; isn't working, particularly in states with family based coverage.</p>
<p><b>Gain or loss of Medicaid or CHIP are "qualifying events"</b> for ERISA-regulated private coverage.  <i>Effective date: Apr. 1, 2009.</i>  <i>Summary: Pg. 16</i></p>	<p>DHS notifies people who lose BC+ eligibility that this gives them a new opportunity to enroll in their employer's plan.</p>	<p>This can be very helpful for people exiting BC+ who have access to employer-sponsored insurance. We need to work with the Insurance Commissioner's Office to ensure that they are educating companies about the law.</p>
<p><b>Buy-in option</b> – States may establish a purchasing pool for "small" employers (with less than 250 employees), with CHIP-funded subsidies for CHIP-eligible kids.</p>	<p>We aren't aware of any state that has begun making plans to use this option. It has been eclipsed by federal health care reform.</p>	<p><i>Recommendation:</i> Assess the relevance of this option after we study the federal health care reform act.</p>
<p><b>Automatic deeming of eligibility of newborns</b> – States may automatically enroll newborns whose births were covered by MA or CHIP funding. Those newborns will get 12 months continuous eligibility.</p>	<p>A Bush Administration policy, which has now been changed, limited this policy to kids whose births were covered by MA funds, which excluded the newborns of immigrant women in BC+ Prenatal. In order to deem eligibility for all newborns, DHS shifted those birth costs to Emergency MA.</p>	<p>WI would get a higher federal match rate if DHS shifted the BC+ Prenatal births back to CHIP funding. The revised CMS policies seem to allow that, but there is still some confusion.  <i>Recommendation:</i> Discuss the issue with DHS once we get clarification of the current policy from CMS.</p>

<b>Requirements</b>		
<p><b>Mental health parity</b> – If a state provides mental health or substance abuse services, the financial requirements and treatment limits can't be more restrictive than those for medical &amp; surgical benefits. <i>Effective with first plan year that takes effect on or after Oct. 4, 2009.</i></p>	<p>Wisconsin finally adopted a mental health parity bill in April 2010. It appears to meet and complement the federal requirements.</p>	<p>We need to continue to monitor the issue to ensure that EPSDT services in the BC+ Benchmark Plan meet the parity requirement in CHIPRA. In addition, work is needed to ensure that access to insurance coverage translates into access to mental health and substance abuse treatment services.</p>
<b>Financial Assistance</b>		
<p>States may use CHIP funds to <b>extend coverage to pregnant immigrant women</b>, if they aren't already eligible for MA coverage. <i>Effective date: Apr. 1, 2009 Summary: Pg. 14</i></p>	<p>An Oct. 5, 2009 Operations Memo removes the 5-year bar for lawfully residing pregnant immigrants in WI. Other pregnant immigrants can continue to be covered through the fetus option (BC+ Prenatal).</p>	<p>The DHS policy change that serves more pregnant women through BC+ (rather than BC+ Prenatal) offers a number of advantages. The BC+ coverage isn't limited to pregnancy-related services, it doesn't preclude covering women who have access to employer insurance they can't afford, and it includes express enrollment and continuous eligibility.</p>
<p><b>Outreach and enrollment grants</b> available to states, local governments, and community-based organizations <i>Funding available 2009 – 2013; Summary: Pg. 10</i></p>	<p>HHS released an RFP in July 2009, for the first half of the funding. A grant proposal developed by DHS and some state and local organizations was approved last fall. The timing on the 2<sup>nd</sup> half is unclear</p>	<p><i>Recommendations:</i> Monitor and support implementation of the DHS grant. Consider improvements or gaps that we might want to address in a subsequent proposal (once there's a 2<sup>nd</sup> RFP).</p>
<p>Increases match (to 75% for MA and a minimum of 75% for CHIP) for <b>translation and interpretation service</b>. <i>Effective date: Apr. 1, 2009 Summary: Pg. 11</i></p>	<p>This may be a little more difficult to take advantage of in states like WI that rely heavily on managed care. (A WCCF blog post summarizes some of the potential uses.)</p>	<p><i>Questions:</i> What policy changes, if any, are needed to take advantage of the increased fed. match rate? Can this help clinics hire more multilingual workers? How can we use this to better serve women in BC+ prenatal?</p>
<p><b>Performance bonus funding:</b> (<i>Funding available 2009 – 2013; Summary: Pg. 10</i>) States are eligible if they significantly increase enrollment <u>and</u> meet 5 of the following 8 standards:</p>	<p>WI has had a very large increase in BC+ enrollment of MA-funded kids. We think WI could potentially get several million dollars in 2009-11. DHS believes a few changes made in the fall of 2009 and March 2010 qualify our state for bonus funding in FFY 2010.</p>	<p>Continue to monitor this and urge DHS to expand presumptive eligibility in order to give the state a margin for error, in case CMS decides at some point that WI doesn't meet one of the other standards.</p> <p><i>Technical question:</i> How does CMS measure the MA increase if WI shifts kids from the old Healthy Start category from MA funding to CHIP?</p>

<ul style="list-style-type: none"> <li>• <b>12-month continuous coverage</b></li> </ul>	<p>WI still only has it for infants. Expanding it would require a statutory change. DHS has not been very receptive to the idea, in part because they think it's a less attractive option in a state that has family-based coverage.</p> <p>(There are at least 30 states that have 12-months continuous eligibility for kids, regardless of age, including 12 that provide it for kids in separate CHIP programs but not in Medicaid.)</p>	<p>This could be one of the most effective changes. Continuity of coverage is important to reduce admin. costs and for HMOS to provide good preventive care. Consideration of this option might be part of the RWJ-funded review of options to reduce churning among enrollees. <i>Questions:</i> How much would it cost? Has BC+ reduced churning and the need for continuous eligibility? What other factors contribute to churning?</p>
<ul style="list-style-type: none"> <li>• <b>Administrative or <i>ex parte</i> renewals</b> – Establish procedures for renewing participants administratively using information already available to the state (by, for example, using pre-populated forms).</li> </ul>	<p>In January 2010, DHS began allowing online renewal, including use of “pre-populated” forms for people coming up for their annual review. A March 29, 2010 Operations Memo (#10-25) initiates the use of prepopulated forms for people who request mail-in renewal forms, and that appears to be sufficient for WI to meet this standard.</p>	<p>Louisiana has used this for a couple of years and serves as a model for how it can be used to reduce churning. Meeting this standard is just one step in improving the renewal process, which is one of the weak points in the states efforts to insure all eligible children. The state needs to continue working to better coordinate its various databases to help expedite renewals.</p>
<ul style="list-style-type: none"> <li>• <b>Presumptive eligibility</b> – Allow children who appear to be eligible to be presumed eligible &amp; get coverage for up to 60 days, while a formal determination is being made.</li> </ul>	<p>Known in our state as “express enrollment” (EE) – this now applies only to MA-funded kids (and not the higher income CHIP funded children). Expanding it would require a statutory change.</p>	<p>EE has many advantages and expanding it to all children merits consideration. However, the state should also look at how the current process is working, because many kids lose eligibility after the EE period. The state should carefully review that data and ensure that providers doing EE are adequately assisting families with the regular enrollment process.</p>
<ul style="list-style-type: none"> <li>• Eliminate or simplify the <b>asset test</b> for children.</li> </ul>	<p>Until fall 2009, WI still had an asset test in a few circumstances relating to children with disabilities or in institutions. DHS has now changed that, effective 10/1/09.</p>	<p>Eliminating the asset test for all children has little cost and should yield savings by simplifying administration (and by helping the state qualify for bonus funding).</p>
<ul style="list-style-type: none"> <li>• Use <b>joint applications</b> and supplemental forms and the same application and renewal verification process for MA &amp; CHIP</li> </ul>	<p>WI meets this test.</p>	<p>Maintain current law</p>

<ul style="list-style-type: none"> <li>• Eliminate in-person <b>interview requirements</b> at application &amp; renewal</li> </ul>	<p>WI meets this test.</p>	<p>Maintain current law</p>
<ul style="list-style-type: none"> <li>• <b>Express lane eligibility</b> – Use info from other means-tested programs to determine eligibility for MA and CHIP subsidized coverage.</li> </ul>	<p>We hoped that WI might meet this standard because of the capacity of the ACCESS system to use Food Share and child care subsidy application info for BC+ purposes. However, CMS has said that a process of combining applications is not sufficient to meet this standard. That decision makes it a more cumbersome option, especially for states with family-based coverage.</p>	<p>Very few states have been able to meet this standard, and it is particularly problematic in states that have family based coverage, because only the kids are eligible for the express lane process. We should monitor initiatives in other states to see what is and isn't working, particularly in states with family based coverage. DHS should explore the possibility of getting a federal waiver to allow use of express lane for family applications. .</p>
<ul style="list-style-type: none"> <li>• Exercise the new options in the law for <b>premium assistance</b> (such as including the cost of covering parents in assessing the cost-effectiveness of providing premium subsidies).</li> </ul>	<p>DHS got approval that it meets this standard in March 2010, thanks in part to making premium assistance optional for families, effective on 10/1/09. (It had previously been required under certain circumstances, if it was found to be cost-effective.) WI was only the second state to be approved for this standard.</p>	<p>Premium assistance hasn't proven to be a very effective coverage strategy in WI or in most other states that have tried it. Our preliminary assessment is that the CHIPRA changes will have little effect in WI, because our state already goes further than most in promoting its use, and it rarely meets the federal standard for cost effectiveness. However, giving families the option of whether they want to opt out of premium assistance seems to be a positive change.</p>

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