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Assessing the New House Republican CHIP Bill

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On October 4, the House Energy and Commerce Committee passed on a party-line vote the HEALTHY KIDS Act, which would extend funding for the Children's Health Insurance Program (CHIP) and temporarily increase federal Medicaid funding for Puerto Rico and the U.S. Virgin Islands. The bill includes sound CHIP funding provisions nearly identical to the bipartisan legislation crafted by Senate Finance Committee Chair Orrin Hatch and Ranking Member Ron Wyden, which the Finance Committee approved by voice vote on October 4. However, the Puerto Rico and U.S. Virgin Islands provisions fall well short of the assistance needed and the provisions to offset the cost of the bill raise substantial concerns.

Extension of CHIP Funding

With no additional federal CHIP funding, states will start exhausting their remaining CHIP funds. Utah, for example, which expects to run out of federal CHIP funds at the end of December, is preparing notices to send to families beginning November 1 that the program is at risk of closure.[1]

Altogether, a Kaiser Family Foundation survey finds that 11 states expect to run out of their federal funds by the end of 2017, with the remaining states expected to exhaust their CHIP funds sometime in 2018.[2] As a result, states with separate CHIP programs — in which about 44 percent of children with CHIP coverage nationwide are enrolled — may be forced to cap or freeze enrollment or shut down their programs entirely. States with CHIP-funded Medicaid expansions must continue coverage for their CHIP-eligible children but at the state's regular Medicaid matching rate, which is well below the CHIP matching rate.

The HEALTHY KIDS Act largely mirrors the bipartisan CHIP provisions in the Hatch-Wyden bill, which the Senate Finance Committee approved on October 4. The House bill would give states budget certainty about the future availability of federal CHIP funding by providing sufficient funding for states to sustain (and expand) their existing CHIP programs for five years, through fiscal

[1] Kaiser Family Foundation, "Current Status of State Planning for the Future of CHIP," updated October 4, 2017, https://www.kff.org/medicaid/fact-sheet/current-status-of-state-planning-for-the-future-of-chip/.

[2] Kaiser Family Foundation, *op. cit.*

year 2022. That's in line with the recommendations of a bipartisan group of governors[3] and the nonpartisan Medicaid and CHIP Payment and Access Commission.[4]

The House bill would also retain the Affordable Care Act's (ACA) temporary, 23-percentage-point increase in the federal CHIP matching rate through fiscal year 2019, as scheduled under current law. This would protect state budgets, as nearly all states responding to a recent National Academy for State Health Policy survey said that their budgets assume the enhanced matching rate will be in effect as scheduled for fiscal year 2018.[5] Without it, states would face a roughly *$3.5 billion* cut in federal support for CHIP next federal fiscal year. The House bill would then give states a one-year transition by providing an 11.5-percentage-point increase in the matching rate in 2020, before returning the matching rate to its regular level (70 percent, on average) in 2021.

The bill would also continue through 2019 the ACA's maintenance-of-eligibility requirement, which prohibits states from cutting children's eligibility for Medicaid and CHIP or making it harder for eligible children to enroll. It would then extend that requirement through 2022 for all children in families with incomes below 300 percent of the federal poverty line. That would protect nearly all Medicaid- and CHIP-covered children from eligibility cuts or restrictive enrollment and renewal procedures.

Finally, the HEALTHY KIDS Act would extend for five years the Express Lane Eligibility (ELE) option, which makes it easier for eligible children to enroll in (and renew) Medicaid and CHIP coverage. ELE allows a state to use information for Medicaid and CHIP that it has already obtained and verified when determining the family's eligibility for another program, like SNAP (formerly food stamps). As a result, these families no longer have to submit the same information twice and state workers do not have to duplicate their effort, which reduces states' administrative costs. Nine states use ELE in their Medicaid and/or CHIP programs: Alabama, Colorado, Iowa, Louisiana, Massachusetts, New York, Pennsylvania, South Carolina, and South Dakota.

Aid to Puerto Rico and U.S. Virgin Islands

The HEALTHY KIDS Act includes up to $1 billion in additional Medicaid funding for Puerto Rico and roughly $30 million for the U.S. Virgin Islands.[6] While this is a welcome move, it falls well short of what those U.S. territories need in enhanced federal financial support for their Medicaid programs after Hurricanes Maria and Irma.

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[3] National Governors Association, May 11, 2017, https://www.nga.org/cms/nga-letters/chip-reauthorization.

[4] "Recommendations for the Future of CHIP and Children's Coverage," Medicaid and CHIP Payment and Access Commission, January 2017, https://www.macpac.gov/wp-content/uploads/2017/01/Recommendations-for-the-Future-of-CHIP-and-Childrens-Coverage.pdf.

[5] Maureen Hensley-Quinn and Anita Cardwell, "State CHIP Changes Are Coming Soon," National Academy for State Health Policy, August 1, 2017, http://nashp.org/state-chip-changes-are-coming-soon/.

[6] During the October 5 markup, the committee adopted an amendment to the HEALTHY KIDS Act introduced by Rep. Gus Bilirakis, which would provide a modest amount of federal Medicaid funding to the U.S. Virgin Islands as well. http://docs.house.gov/meetings/IF/IF14/20171004/106486/BILLS-115-3921-B001257-Amdt-123.pdf.

Under Medicaid today, the federal government picks up a fixed share of Medicaid costs for states, but Puerto Rico, the U.S. Virgin Islands, and the other territories receive only a highly inadequate block grant — a fixed *amount* of federal funding that's well below their actual Medicaid costs. Moreover, while states' federal matching rates are based on their per capita income relative to the nation, territories receive a set match rate of 55 percent. This financing structure means that once a territory's Medicaid expenditures exceed its federal block grant amount, it is responsible for 100 percent of Medicaid costs going forward. Prior to the ACA, the federal government effectively picked up only 15-20 percent of Puerto Rico's Medicaid costs.[7] If Puerto Rico's funding were not capped and were based on the same formula as used for the states, it would receive a matching rate of 83 percent. Other territories' matching rates would also be much higher than the current 55 percent.

The ACA provided an additional $7.3 billion in federal Medicaid funding to the territories, available through 2019. Puerto Rico has nearly exhausted its share of those funds, so Congress provided an additional $295 million in May. But according to estimates from the Medicaid and CHIP Payment and Access Commission, these supplemental funds would have maintained Puerto Rico's existing Medicaid program only until April 2018, resulting in a fiscal cliff, even without the hurricane.[8] Without additional funding, Puerto Rico would likely have to cut up to 900,000 people off Medicaid — more than half of total enrollment.

An additional $1 billion would have only allowed Puerto Rico to sustain its pre-hurricane Medicaid program for *less* than a year.[9] But due to the hurricane, many more residents will likely need Medicaid and their average medical needs will likely be greater. Moreover, the hurricane likely has drastically reduced the Commonwealth's fiscal capacity to maintain its current Medicaid contribution. As a result, the bill's Puerto Rico Medicaid provision falls well short of the funding needed. Moreover, the additional $30 million the U.S. Virgin Islands would receive would provide no immediate benefit if it can't raise its own spending to address its greater Medicaid needs post-Hurricanes Irma and Maria.

Instead, for the short term, the block grants for Puerto Rico and the U.S. Virgin Islands need temporary increases sufficient to both sustain the underlying Medicaid program *and* address the higher demands resulting from the hurricanes. That should also include a temporary increase in the federal matching rate, as neither Puerto Rico nor the U.S Virgin Islands will be able to finance their current share of Medicaid costs anytime soon. For example, the federal government picked up 100 percent of states' Medicaid costs related to survivors of Hurricane Katrina.[10]

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[7] See Edwin Park, "Addressing Puerto Rico's Medicaid Funding Shortfalls Would Help Ensure Fiscal Stability and Growth," Center on Budget and Policy Priorities, September 16, 2017, https://www.cbpp.org/research/health/addressing-puerto-ricos-medicaid-funding-shortfalls-would-help-ensure-fiscal.

[8] Medicaid and CHIP Payment and Access Commission, "Medicaid Financing and Spending in Puerto Rico," September 2017, https://www.macpac.gov/wp-content/uploads/2017/09/Medicaid-Financing-and-Spending-in-Puerto-Rico.pdf.

[9] A separate provision in the HEALTHY KIDS Act would also modestly increase Puerto Rico's underlying block grant amounts for two years.

[10] See also Edwin Park, "Why House Bill's Medicaid Funding for Puerto Rico, Virgin Islands Falls Way Short," Center on Budget and Policy Priorities, October 5, 2017, https://www.cbpp.org/blog/why-house-bills-medicaid-funding-for-puerto-rico-virgin-islands-falls-way-short. The Centers for Medicare & Medicaid Services, working with the Medicaid

To ensure fiscal stability over the long run, federal policymakers should eventually eliminate the cap on federal funding for Puerto Rico, the U.S. Virgin Islands, and the territories. Over time, Puerto Rico's (as well as the other territories') federal Medicaid matching rates should also be set in the same manner as the matching rates are set for the states. This would also help Puerto Rico and the U.S. Virgin Islands cope with future natural disasters.

Offsets

Several provisions of the House bill are intended to produce Medicaid and Medicare savings to offset the cost of the rest of the bill. These provisions, however, raise some substantial concerns.

Medicaid Third-Party Liability

When Medicaid beneficiaries have other insurance that may be liable to pay for their health care, states generally must ensure that the other insurer is billed before Medicaid.[11] In this way Medicaid avoids paying for services that are the responsibility of another payor. However, special rules apply to prenatal and pediatric care and situations where a child support order requires a parent to maintain health coverage for a child. States must pay claims for furnishing prenatal or pediatric care when a third party such as a private insurer is responsible, then recover the amount from the liable third party. For child support situations, states must pay claims if no payment is made under the parent's health insurance within 30 days. These special rules help ensure that children and pregnant women receive care without delay and that sufficient pediatric and obstetric providers participate in Medicaid.

Budget legislation enacted in 2013 modified the special rules for pediatric and prenatal care and child support orders, but those changes were delayed until October 2017.[12] In the case of prenatal and pediatric care, the changes allow states to withhold payment for up to 90 days if doing so is cost-effective and wouldn't "adversely affect access to care." For child support situations, states can wait 90 days to pay claims except when necessary to ensure access to care.

The HEALTHY KIDS Act would go further than the 2013 changes and fully repeal the special treatment for prenatal and pediatric care and child support orders. This could make it harder for children and pregnant women to get care. If pediatric and obstetric providers must wait for payment and bill other insurers — particularly insurers in other states, which is often the case in child support situations — some providers would likely be less willing to participate in the program. Moreover, in some situations, needed care could be delayed while providers sort out the responsibility of the different insurers.

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agencies of Puerto Rico and the U.S. Virgin Islands, could take additional steps administratively to make it easier for Medicaid beneficiaries to enroll or renew coverage in the aftermath of the hurricanes.

[11] These rules are in section 1902(a)(25) of the Social Security Act.

[12] Section 202 of the Bipartisan Budget Act of 2013 (Public Law 113-67).

Treatment of Lump-Sum Income Under Medicaid

The House bill would also change the treatment of lottery winnings and other lump sums, including gambling winnings and proceeds from some lawsuits and estates, in determining Medicaid eligibility. People who received lottery winnings or lump sums of $80,000 or more would lose Medicaid eligibility for a period of time based on the size of the lump sum. For example, a person who received $95,000 would be ineligible for three months.

The bill would have a significant impact on the streamlined enrollment process designed to simplify the process of determining Medicaid eligibility and coordinating eligibility for Medicaid with eligibility for marketplace subsidies. States would have to add new questions to the Medicaid application and track lottery winnings and other lump sums for what would likely be a limited return. For example, Michigan's Medicaid expansion waiver allows the state to garnish state tax refunds and lottery winnings to recoup unpaid premiums and cost-sharing from participants; yet the state collected just $3,622 in 2015 and 2016 combined from 36 lottery winners, suggesting that most lottery winnings are too small to trigger a change in eligibility. States would likely spend more to collect these funds than they would save from making people ineligible for Medicaid.

Full-Cost Premiums for High-Income Medicare Beneficiaries

Finally, the House bill would further increase Medicare premiums on very high-income beneficiaries, potentially undermining the program's universal nature. Most beneficiaries' monthly premiums cover 25 percent of the cost of coverage for Medicare Parts B and D. Higher-income beneficiaries pay more. In 2018, single beneficiaries with incomes over $85,000 and couples with incomes over $170,000 will pay premiums that cover 35 percent to 80 percent of the cost on a sliding scale. These income-related premiums were last increased as part of the Medicare Access and CHIP Reauthorization Act of 2015.

The House bill would require single individuals with incomes of $500,000 or more and couples with incomes of $875,000 or more to pay premiums for Parts B and D that cover *100 percent* of the cost. Although individuals at these income levels could doubtless afford higher premiums, requiring them to pay premiums that cover the full cost of Parts B and D could cause some high-income individuals to drop coverage altogether. This would worsen the Medicare risk pool and weaken support for Medicare as a universal social insurance program.