The New Children's Health Insurance Program

Targeted at uninsured, low-income individuals through age 18, the federally mandated State Children's Health Insurance Program (CHIP) will be structured and administered largely by the states. Depending on the eligibility and program design decisions states make, as well as on the extent and quality of their outreach efforts, CHIP could serve as an important source of financial support for family planning and maternity services for the over one million currently uninsured female adolescents in the United States.

By Rachel Benson Gold

As part of last year's balanced budget legislation, Congress established the State Children's Health Insurance Program (CHIP) in order to expand health insurance coverage to many of the over 10 million uninsured children in the United States. According to Alan Guttmacher Institute (AGI) estimates, this includes 1.3 million female adolescents between the ages of 13 and 18. With $20 billion in federal matching funds distributed over five years, the effort is aimed at uninsured children through age 18 in families with incomes at or below 200% of poverty. Responding to concerns about runaway spending under other federal entitlement programs such as Medicaid and Medicare, however, Congress created CHIP as an entitlement to states, not to individual recipients.

In order for states to receive their first-year allotments, they must have a plan approved by the Health Care Financing Administration (HCFA)—the federal agency that currently administers Medicaid and will administer the new program—by September 30, the end of FY 1998. According to HCFA, this deadline means that state plans need to be submitted by July 1. So far, 22 states have submitted plans, and four—Alabama, Colorado, Florida and South Carolina—have already been approved (see table). According to the National Governors' Association (NGA), an additional 14 states have basically outlined their programs but not yet submitted formal plans for review.

Eligibility Issues

The federal CHIP statute gives states broad authority to set age and income eligibility standards as long as they meet the stated goal of covering uninsured children in families with incomes above state-set Medicaid income ceilings but without access to private insurance coverage. [Medicaid law requires states to cover children up to age 14 whose family incomes are below poverty—currently $16,450 for a family of four—although several states have already extended Medicaid coverage beyond that point, by altering either income or age eligibility.] Virtually all the states that have announced their program intentions have indicated that they will cover children through age 17 or 18. With only a few exceptions, all expect to expand eligibility to at least 150% of the federal poverty level (see table).

In addition to using their new authority under CHIP to expand coverage for children and adolescents, at least nine states have indicated that they intend to use their existing authority under Medicaid to expand coverage for adult pregnant women at the same time. This continues a long-standing tradition of simultaneously expanding Medicaid coverage for pregnant women and for children, based on the assumption that adequate prenatal care is integral to improved birth outcomes and child health.

Program Type

Beyond setting age and income eligibility levels, states have enormous latitude in structuring their CHIP program. A state may choose to expand its existing Medicaid program or set up a completely separate effort instead. Alternatively, a state may do both by creating a hybrid, built partially on Medicaid and partly on a state-designed program. Some states have indicated that they may initially opt for a Medicaid expansion but move to a separate program over time.

If a state expands its Medicaid program, the newly covered children will become regular Medicaid recipients, eligible for Medicaid benefits under the same conditions as are other Medicaid recipients. As under Medicaid, states would be able to claim federal reimbursement for a share of the costs of serving CHIP enrollees. However, under a complex formula, states are able to claim federal reimbursement for these children at a greatly enhanced rate, compared to the one available under the regular Medicaid program. The new rate effectively reduces the state share of the cost by 30%, so that a state paying 50% of the costs for services to regular Medicaid beneficiaries would pay only 35% of the costs of care for CHIP enrollees.

Alternatively, a state may create an entirely new program. This option gives the state much greater flexibility to structure its program and design a benefit package. A state could choose to model its program after one of three so-called benchmarks—the Blue Cross/Blue Shield plan offered to federal employees in that area, the coverage available to state employees or the coverage available through the health maintenance organization (HMO) with the largest enrollment in the state. Or, it could develop its own benefit package so long as that package covers certain "basic" services including hospital, physician, laboratory and well-baby/child care, and is "actuarially equivalent" to one of the benchmark plans. Beyond the basic services requirement, according to NGA's Joan Henneberry, "as long as what a state designs costs the same as the benchmark, it can modify the benchmark plan or just use it as is."

Of the 35 states and the District of Columbia that have either submitted plans to HCFA or made public the outlines of the plan they intend to submit, 15 plus the District of Columbia have said that they expect to develop a Medicaid expansion, while 10 anticipate using a benchmark-based model. The remaining 10 states expect to develop a mixed program, establishing a Medicaid-based program for some enrollees and a benchmark-based program for others; some states could take different approaches based on income, and others could make distinctions based on the age of the child.

Covered Services

The choices a state makes about program structure will be crucial in determining coverage of such key reproductive health services as family planning and maternity care. (The federal statute prohibits CHIP from covering abortions except in cases of life endangerment, rape and incest.) States are just now beginning to grapple with these issues. According to Shelly Gehshan of the National Conference of State Legislatures, "People have moved from the broad brush strokes of whether to expand Medicaid or set up a new program to the fine print. Part of that is figuring out what these choices mean in terms of the specific services adolescents need, such as family planning, mental health and dental care."

Family Planning Services

If a state chooses the Medicaid route, adolescents meeting the state-set age and income requirements will be eligible for all Medicaid-covered services, including family planning services and supplies. Medicaid rules prohibiting the imposition of client cost-sharing for family planning also will apply, as will the so-called freedom-of-choice provisions allowing an enrollee in a managed care plan, if she so desires, to obtain family planning services from a provider who is not affiliated with her plan.

On the other hand, though the federal CHIP statute explicitly includes "pre-pregnancy family planning services" as services that states *may* include in their plans, coverage will not be automatic in states choosing the benchmark approach for two reasons. First, it is far from certain that the benchmark plan will itself cover the full range of family planning services and supplies. Data from a 1994 study by AGI show that family planning is not uniformly covered under private-sector insurance plans. That study found that half of all traditional fee-for-service plans covered *no* reversible contraceptive methods. Some managed care plans—notably HMOs—provided significantly more extensive coverage. Nonetheless, while only 7% of HMOs covered no contraceptive methods, only four in 10 gave enrollees a choice among all five of the leading reversible methods. Newer types of managed care organizations provided less complete coverage, with preferred provider organizations closest to fee-for-service plans in their coverage patterns.

Second, even if the selected benchmark *does* include family planning, states have the latitude to change the coverage provided in the benchmark, so long as the final package is actuarially equivalent. In short, whether a non-Medicaid plan covers family planning services is largely left to the state's discretion.

Maternity Care

Since maternity care coverage is almost universal in both Medicaid and private-sector insurance—and it is extremely unlikely that states would move to take this crucial service out of a benchmark plan, even though they theoretically have the latitude to do so—coverage for pregnant adolescents is a virtual certainty under CHIP. In light of the fact that, according to AGI estimates, there are 14,000 births a year to uninsured mothers between the ages of 13 and 18, the impact could be significant.

For maternity care, however, the open question is one of eligibility. Under Medicaid, states have the option to permit pregnant teenagers living at home with their parents to qualify for coverage based on their own income, rather than their family's income. While most observers predict that states using a Medicaid approach for their CHIP programs are likely to follow the same procedures for pregnant teenagers as they do under their regular Medicaid programs, they question how states will deal with this politically charged issue if they are developing a separate, non-Medicaid based CHIP program.

Critical Role of Outreach

Whatever decisions states make about eligibility and program design, they will need to grapple with a range of issues related to outreach and education if they are

Initial Implementation of the Children's Health Insurance Program State Plans

State	Status*	Eligibility		Program Type	Simultaneous Expansion for Pregnant Women†
		Ages	Income Ceiling (% of Federal Poverty Level)		
Alabama	approved	birth–18	100%	Medicaid	
Alaska			200%	mixed	
Arizona		birth–18	150%	benchmark	
Arkansas					
California	submitted	1–18	200%	mixed	yes[1]
Colorado	approved	birth–17[2]	185%[3]	benchmark	
Connecticut	submitted	birth–18	300%[3]	mixed	
District of Columbia		birth–18	200%	Medicaid	
Delaware		birth–18	200%	benchmark	
Florida	approved	5–18[4]	185%[3]	mixed	
Georgia		birth–18	200%	mixed	yes
Hawaii					
Idaho	submitted	birth–18	160%	Medicaid	
Illinois	submitted	birth–18	133%	Medicaid	yes[1]
Indiana					
Iowa					
Kansas					
Kentucky		birth–18	200%	mixed	
Louisiana		birth–17	200%	mixed	
Maine					
Maryland		birth–17	200%	Medicaid	yes
Massachusetts	submitted	birth–18	200%	mixed	yes
Michigan	submitted	birth–18	200%	benchmark	
Minnesota					
Mississippi					
Missouri	submitted	birth–18	300%	Medicaid	yes[5]
Montana					
Nebraska		birth–17	185%	Medicaid	yes
Nevada	submitted	birth–18		benchmark	
New Hampshire					
New Jersey	submitted	birth–18	200%	mixed	
New Mexico			235%	Medicaid	
New York	submitted	birth–18	222%	benchmark	
North Carolina		birth–18	200%	benchmark	
North Dakota					
Ohio	submitted	birth–18	150%	Medicaid	
Oklahoma	submitted	birth–17	185%	Medicaid	yes
Oregon	submitted	birth–18	170%	Medicaid	
Pennsylvania	submitted	birth–16	185%[6]	benchmark	
Rhode Island	submitted	birth–18	250%	Medicaid	
South Carolina	approved	birth–18	150%	Medicaid	
South Dakota		6–18	133%	Medicaid	
Tennessee	submitted	birth–17	200%	Medicaid	
Texas					
Utah		birth–18	200%	benchmark	
Vermont	submitted		300%	Medicaid	
Virginia			175%	benchmark	
Washington					
West Virginia					
Wisconsin	submitted	birth–18	185%	mixed	yes
Wyoming					

*States submit plans to HCFA for approval. †Under existing Medicaid authority. 1. For pregnant women and infants, the income eligibility ceiling is 250% of poverty in CA and 200% of poverty in IL. 2. Pending state legislation extends eligibility through age 18. 3. Families with incomes above the eligibility ceiling may buy in without the state subsidy. 4. Local program sites may extend enrollment to younger children. 5. Women who lose Medicaid eligibility 60 days after the birth of a child will be eligible for women's health services for two years. 6. For infants and children ages 0-5, the income eligibility ceiling is 235% of poverty. *Source:* The National Governors' Association, Center for Best Practices, *State Implementation Plans of Title XXI*, March 12, 1998; *Matrix of State Plans for the State Children's Health Insurance Program*, Feb. 21, 1998, <http://www.nga.org>, accessed March 20, 1998.

to fulfill their goal of insuring large numbers of uninsured children. Traditionally, the most common avenue to Medicaid coverage has been through eligibility for welfare. However, beginning with a series of Medicaid expansions in the 1980s for pregnant women and young children—through which large groups of women and children were brought onto Medicaid on the basis of income alone—a series of policy initiatives has chipped away at the welfare-Medicaid link. CHIP is the latest move in this ongoing effort to disentangle eligibility for Medicaid from eligibility for other assistance programs.

This poses a two-part challenge for states. First, they must locate eligible children without being able to rely on an easy link to welfare to bring these families into the program. Rather than essentially sit back and wait for these families to enter the system on their own—as states traditionally have been able to do with Medicaid—states will need to take the initiative to find eligible children through aggressive efforts to locate uninsured families and educate them about taking advantage of the new program.

But locating eligible families is only the first challenge for a state. Once these families are located, the state must establish a simple, user-friendly system that encourages enrollment, rather than discourages it—as traditional welfare apparatuses are often thought to do. Indeed, according to a statement recently released by NGA, "Successful outreach programs have found that health insurance programs are more attractive to low-income working families if they are not associated with welfare programs."

One means of achieving this broad enrollment goal, and of hastening access to needed health care, is the so-called presumptive eligibility process. Developed for the 1980s Medicaid expansions for pregnant women and young children and specifically authorized under CHIP, presumptive eligibility allows health care providers, on site, to grant temporary program eligibility coverage and to provide care for 45 days while a CHIP enrollment application is being processed.

In recognition of the pivotal role outreach efforts will play in CHIP's ultimate success, HCFA is requiring that each state's plan include a description of the expected approach for locating and enrolling eligible children. Moreover, the Clinton administration in its FY 1999 budget is proposing that nearly $200 million be allocated under CHIP for additional state outreach efforts.

Looking to Past State Expansions

The experiences of states in implementing the 1980s Medicaid expansions—a process that posed similar challenges—are instructive. A 1993 study by AGI found that while the proportion of births across the nation that were subsidized by Medicaid more than doubled between 1985 and 1991, the increase varied widely from state to state. The study also found that there were tremendous state-to-state differences in outreach efforts. For example, although all states established toll-free hotlines, the information provided through this mechanism differed greatly. Nearly all states provided the location of prenatal care providers; 30 went on to give providers' hours of operation. Eighteen states utilized bilingual or multilingual hotline operators, while 11 states allowed hotline operators to schedule prenatal care appointments for callers.

Along the same lines, the study also found that the implementation of enrollment strategies such as presumptive eligibility was uneven. By 1991, half the states offered presumptive eligibility in an attempt to ease the enrollment process; qualified sites were available in one-third of U.S. counties. In five of the states that offered some presumptive eligibility, however, qualified sites were available in fewer than one in four counties. Nationwide, fewer than half the women of reproductive age below 185% of poverty lived in a county with at least one provider that could certify presumptive eligibility.

Clearly, the CHIP expansion will be no more self-executing than this earlier effort. States seeking to truly make coverage available to large numbers of uninsured children not only will need to make wise policy decisions about program design and eligibility, but also will need to take additional steps to ensure that eligible children are located and enrolled. In this, a state's own past experience may prove to be its best teacher.

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