Implementation of the

Children's Health Insurance Program

National Economic Council / Domestic Policy Council

The White House

SIX-MONTH PROGRESS REPORT ON THE

CHILDREN'S HEALTH INSURANCE PROGRAM: OVERVIEW

SUCCESSFUL SIX-MONTH ANNIVERSARY.

April 1, 1998 marks the six-month anniversary of the start of the Children's Health Insurance Program (CHIP). The Administration, Congress, State Governors and State Legislatures have been working aggressively to set up rules for the program, target uninsured children, develop plans for covering those children, and approve and implement those plans. After only six months:

- **8 States have approved plans to cover over 1 million children**

. With the approval of New York and Illinois today, 8 States have approved plan which combined, according to their estimates, will cover over 1 million children. For several states (e.g., Alabama and Illinois), this is the first phase of their expansion, so that they will cover even more children in the future.

- **Another 15 States have submitted their Child Health Plans for approval.**

- **Almost all other States have processes in place to develop and submit their plans**

, including pending legislation, task forces and public processes to determine the best way to cover uninsured children through CHIP.

UNIQUE APPROACHES.

States have taken advantage of the flexibility of CHIP to design programs to suit their own children's needs. Of the States who have submitted plans:

- 12 States plan to expand through Medicaid,

- 6 States plan to expand through a State grant program, and

- 5 States plan to expand through a combination of a Medicaid and grant program.

Some States, like Florida, New York and (to some extent) Colorado, are building on existing State programs. Others, like Massachusetts, New Jersey and Connecticut, have designed new programs that, for example, subsidize employer-based coverage, create seamless Medicaid and grant programs through joint applications, and design a special benefits package for children with special needs.

IMPORTANCE OF OUTREACH

. Aggressive implementation of CHIP will help many, but not all, of America's low-income, uninsured children. A recent study found that over 4 million uninsured children could be covered today through Medicaid. States must include in their Child Health Plan descriptions of their plans for outreach (increasing education about health insurance programs and simplifying the application and enrollment process). The President has also advocated for a public-private effort to increase enrollment in Medicaid and called for legislation that provides States additional funding and flexibility to conduct aggressive, effective outreach.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

PROGRESS REPORT AS OF APRIL 1, 1998

STATE	STATE PLAN		TYPE OF EXPANSION			UPPER ELIG-	STATE EST ENROLL-
	Submitted	Approved	Medicaid	Grant	Combined	IBILITY*	MENT
U.S.	**23**	**8**	**21**	**14**	**10**	**1,893,400**	
STATES WITH APPROVED PLANS			**4**	**2**	**2**		**1,271,400**
Alabama **	11/03/97	01/30/98	X			100%	20,000
Colorado	10/14/97	02/18/98		X		185%	23,000
South Carolina* *	12/08/97	02/18/98	X			150%	75,000
Florida	12/03/97	03/05/98			X	185%	120,000
Ohio **	12/23/97	03/23/98	X			150%	133,000
California	11/19/97	03/24/98			X	200%	500,000
Illinois **	01/05/98	04/01/98	X			133%	40,400
New York	11/05/97	04/01/98		X		185%	360,000
STATES WITH SUBMITTED			**8**	**4**	**3**		

PLANS					
Missouri	09/29/97	X			300%
Pennsylvania	11/03/97		X		185%
Michigan	12/29/97		X		200%
Tennessee	01/02/98	X			200%
Rhode Island	01/05/98	X			250%
Massachusetts	01/15/98			X	200%
Connecticut	01/21/98			X	300%
Oklahoma	01/23/98	X			185%
New Jersey	02/06/98			X	200%
Idaho	02/13/98	X			160%
Oregon	03/02/98		X		170%
Nevada	03/11/98		X		200%
Wisconsin **	03/12/98	X			100%
Vermont	03/16/98	X			300%
Puerto Rico	03/30/98	X			200%
STATES IN THE PLANNING PHASE		**9**	**8**	**5**	
Alaska		X			200%
Arizona			X		150%
Arkansas		X			
Delaware			X		200%
District of Columbia		X			200%
Georgia				X	200%
Hawaii					
Indiana					
Iowa				X	185%
Kansas				X	200%
Kentucky			X		200%
Louisiana				X	200%
Maine				X	185%
Maryland		X			200%
Minnesota		X			

Mississippi			
Montana		X	150%
Nebraska	X		185%
New Hampshire			
New Mexico	X		235%
North Carolina		X	200%
North Dakota			
South Dakota	X		133%
Texas			
Utah		X	200%
Virginia		X	175%
Washington		X	
West Virginia	X		150%
Wyoming			

NOTES:

Estimated enrollment are States' unreviewed estimates of enrollment for when the program is fully implemented.

* Upper eligibility is defined as a percent of the Federal poverty standard. In 1998, this is $16,450 for a family of 4.

** States that have indicated that the plan submitted is only the first step in a broader expansion.

SOURCES:

HHS tracking documents and State plans

National Governors' Association Center for Best Practices. "State Implementation Plans of Title XXI: The State Children's Health Insurance Program as of March 12, 1998".

Children's Defense Fund. "Progress Report: Implementing the State Children's Health Insurance Program (CHIP)".

PROGRESS REPORT ON THE IMPLEMENTATION OF THE

CHILDREN'S HEALTH INSURANCE PROGRAM

The Children's Health Insurance Program (CHIP) was created in the bi-partisan Balanced Budget Act on August 5, 1997. Less than two months later, on October 1, 1997, CHIP began. Today, April 1, 1998, marks the six-month anniversary of CHIP. This report reviews Federal and State progress toward achieving the goal of covering up to 5 million uninsured children.

CHILDREN'S HEALTH INSURANCE PROGRAM: ITS CREATION AND IMPLEMENTATION

Expanding health insurance to vulnerable Americans has been a long-standing goal of the President as well as many Republicans and Democrats in Congress. In his 1997 State of the Union, the President announced his support for covering up to 5 million uninsured children by both working to enroll eligible but uninsured children in Medicaid and expanding the funding for new, more flexible State-administered programs designed to cover millions of uninsured children. This funding — about $24 billion in Federal funds over 5 years — was delivered in the Balanced Budget Act of 1997 that created the Children's Health Insurance Program (CHIP).

CHIP provides about $4.3 billion in Federal funds annually for 1998 through 2001 for use in providing health insurance to "targeted low-income children." A targeted low-income child is, in general, an uninsured child whose family income is higher than Medicaid eligibility but lower than 200 percent of poverty (about $32,000 for a family of 4). States may use the Federal funds to provide coverage through Medicaid, a State grant program, or a combination of the two. States that opt for a Medicaid expansion provide Medicaid's comprehensive benefits. State that choose to expand through a State grant program have flexibility in designing covered services and cost sharing within Federal guidelines. All States must include procedures to prevent the substitution of Federal funds for current State or private spending on health insurance.

To receive Federal funds, States must have an approved Child Health Plan. The content of these plans is mostly defined in the law, and includes items like the State's budget, proposed benefits, performance measures, and plans for outreach. States with approved plans receive Federal "allotments" or shares of the Federal funds, based on their proportion of low-income and uninsured children and an adjustment for geographic costs. These Federal funds require a State contribution as well. States contribute to CHIP at a matching rate that is 30 percent lower than its matching rate in Medicaid.

Since last August, the Department of Health and Human Services has worked with States, Congress, health care providers, children's advocates and other interested groups to

develop guidelines for this program and to ensure that it is implemented expeditiously and well. As part of the process, the Department has sent letters to State officials, distributed answers to key questions, and held regional conferences to assure rapid, effective implementation of CHIP.

STATES' PROGRESS IN SUBMITTING PLANS

As of April 1, 1998, nearly half the States (23) have submitted Child Health Plans and 8 States have had their plans approved, including New York and Illinois today. Virtually all other States are planning to submit plans before the end of fiscal year 1998 (to receive a 1998 Federal allotment, State must have their plans approved in fiscal year 1998).

SUMMARY OF STATES WITH APPROVED PLANS

Eligibility and Estimated Enrollment.

The eligibility for children for CHIP varies in the States with approved plans from 100 percent of poverty (Alabama) to 200 percent of poverty (California). In part, this wide range reflects the fact that 4 of the 8 States with approved plans (Alabama, Illinois, Ohio and South Carolina) are expanding in stages, meaning that they are planning modest expansions now, with plans for a second expansion later.

In total, States estimate that 1,271,400 children will be covered under their newly approved plans when fully implemented. This amount ranges from a high of about 500,000 in California — the State with the highest number of uninsured, low-income children — to 20,000 in Alabama. Since half of these States have indicated that their expansions are the first of two stages, even more children will be covered in these States in the future.

Type of Expansion.

States have taken advantage of the choice that CHIP offers of expanding health insurance coverage for children through Medicaid, a State grant program, or a combination of the two. Of States with approved plans, 4 States will expand through Medicaid, 2 States through a State grant approach, and 2 States through a combination of the two. The 2 States that have expanded through State grant programs, New York and Colorado, are building upon existing programs. These States are using the extra funding to improve benefits, make the program accessible to all eligible children, and raise income eligibility.

Interestingly, all 4 of the States expanding through Medicaid have indicated that these expansions are first steps, with a second expansion in the works. At least 2 of these States (Alabama and South Carolina) have said that this second expansion will be through a State grant program.

The 2 States with combination programs, California and Florida, have accelerated the current-law phased-in coverage of all poor children by covering 15 to 18 year olds in

Medicaid with family income up to 100 percent of poverty. They also will offer eligibility to children in families with income above Medicaid eligibility through a grant program. California is operating its grant program by allowing families access to a purchasing pool for coverage for children. Florida is expanding its Healthy Kids program State-wide. This program, which has been considered a model program nationwide, was developed at the local level and is school-based; enrollment is linked to the free and reduced-price lunch program.

Benefits.

States that expand through Medicaid give children Medicaid benefits with no cost sharing. California's benefits are based on the State employee health benefits and families pay up to $27 per month. Colorado's benefits are equivalent to the benchmarks in legislation, and premiums range from $9 and $30 per month. Florida and New York (along with Pennsylvania) had their State program's benefits grandfathered into law because of these program's success; premiums are up to $15 per month in Florida and up to $36 per month in New York.

Targeting Uninsured Children

. States have taken several different approaches to assuring that Federal dollars are not substituted for private dollars already being spent on children's coverage. California has waiting period (a child must be uninsured for 3 months) for eligibility to prevent families from dropping private coverage to enroll in CHIP. Colorado prohibits children from being eligible if they have coverage in an employer-sponsored plan with at least a 50 percent employer contribution in the last 3 months. Florida will use an open enrollment period with a "fallback": if, after six month, there appears to be a problem with crowd out, the State will limit eligibility to children who have been uninsured for at least 3 months or who do not have access to employer-based coverage.

Outreach.

States have proposed innovative ways of simplifying the application and enrollment process and educating families about their eligibility. California will launch a media and outreach initiative, involving community based organizations, schools, day care centers, and health providers. It will also pay a $25 application assistance fee for each beneficiary that is enrolled in a program. South Carolina has focused on simplifying the application process for Medicaid and CHIP to make the programs more accessible. Most States intend on educating families about their eligibility through a non-health network that includes schools, churches, day care facilities, Child Care Resource and Referral Centers, homeless shelters, and through WIC and other public programs.

SUMMARY OF STATES WITH SUBMITTED PLANS

Although State plans usually change (sometime significantly) during the review process, the following is a brief overview of the types of plans in States that are currently under consideration.

Eligibility

. Compared to States with approved plans, States with submitted plans cover children in higher income families. This is mostly because a number of these States (e.g., Rhode Island, Vermont, and Connecticut) had already expanded coverage through Medicaid to children just above the Medicaid mandatory eligibility levels. Wisconsin, which is expanding Medicaid to all poverty-level children, is the only one of these States that appears to be applying for a first stage of a larger expansion.

Type of Expansion

. Eight of the States with submitted plans will expand through Medicaid, 4 through State grant programs, and 3 through a combination of the two. As in States with approved plans, the States with submitted combination plans are using Medicaid to cover lower income children and grant programs to cover higher income children. The major difference is that the new States are expanding Medicaid to children above poverty: to 133 percent of poverty in New Jersey, to 150 percent of poverty in Massachusetts, and to 185 percent of poverty in Connecticut.

Benefits

. There is wide range of benefits standards proposed in the submitted but not yet approved State plans. Two States are using the Federal Employees' Blue Cross Blue Shield option, another 2 are using their State employee benefits plan, and other States are using the most popular HMO in the State, the State Medicaid benefits, and a grandfathered plan (Pennsylvania).

Targeting Uninsured Children

. In addition to the strategies used by States with approved plans, States with submitted plans propose to prevent substitution of private spending by: ending eligibility for children who gain access to creditable health coverage (Oregon); maintaining a data base of employer coverage to assess whether families applying are eligible (Massachusetts); and include longer waiting periods for coverage (12 months in New Jersey).

Outreach

. A wide range of ideas have been proposed by States with submitted plans, including: working with organizations like AARP, PTAs, and the School Nurse Association (Tennessee); using a single application for all children's health programs (Connecticut); giving grants to community-based organizations to help enroll hard-to-reach children (Massachusetts); and use of multi-cultural educational materials (most States).

STATES IN THE PLANNING PROCESS

Virtually all other States have task forces at work, bills being considered by their State legislatures, and tentative plans for expanding coverage to children through CHIP.

IMPORTANCE OF OUTREACH

In March, the Agency for Health Care Research and Policy released a new report that found that over 4 million uninsured children are eligible for Medicaid. There has been no conclusive study about why these uninsured children do not get enrolled in Medicaid, but several likely reasons include the difficulty of the application process, the "stigma" associated with Medicaid, and the lack of knowledge about the program.

Because of the importance of outreach, States must include a detailed description in their Child Health Plans about how they intend to educate families about CHIP and coordinate with Medicaid.

CONCLUSION

As study after study shows, a healthy childhood is essential to both the physical and intellectual development of children. Health insurance can play a key role in that development. The Children's Health Insurance Program represents the single largest expansion of insurance for children since Medicaid was created over 30 years ago. It targets the fastest growing group of uninsured children: those in working families that cannot afford health insurance.

This progress report shows that Governors, State legislators, health care providers, children's advocates and all other participants have made great strides in the six months since CHIP was implemented. Eight States have approved plans, another 15 have submitted plans, and virtually all other States are planning their children's health insurance expansions.

However, implementing CHIP alone will not significantly reduce the number of uninsured children. Medicaid outreach efforts are needed to ensure that all uninsured children who are eligible for Medicaid get enrolled. The President has made Medicaid outreach a priority. In February, the President directed all Federal agencies with programs that serve low-income families to come up with a plan by mid-May to use their workers to help find and educate families about health insurance. This Federal effort is being complemented by private sector activities. These include a campaign to educate families by creating a toll-free number that links families to their State's eligibility offices and promoting that toll-free number on grocery bags, labels on children's drugs, diaper boxes and other products that low-income families use.

In addition, the President has proposed policies in his FY 1999 budget to increase funding and flexibility for States to conduct innovative and effective outreach. One policy expands the Balanced Budget Act's "presumptive eligibility" option to allow

workers at sites like schools and child care resource and referral centers to assist families in enrolling their children in Medicaid. Additionally, the President proposes broadening the use a special fund created for outreach for people moving from welfare to work. These policies, and others like them, provide needed support for States as we work together to ensure that all children who are eligible for health insurance get that coverage.

APPENDIX: SUMMARY OF ACTIVITIES IN STATES WITH SUBMITTED PLANS

STATES WITH APPROVED CHILD HEALTH PLANS

ALABAMA

On January 31, 1998, Alabama's plan to expand Medicaid to children 15 to 18 years old up to 100 percent of poverty was approved. The State considers this the first step in expanding coverage, and is planning to create a State grant program for children in families up to 200 percent of poverty this year.

CALIFORNIA

On March 24, 1998, California's "Healthy Families" plan was approved. California plans a combination of a Medicaid and State grant program expansion. It will: (1) expand Medi-Cal (its Medicaid program) to cover all poor children; (2) expand Access for Infants and Mothers (AIM) to cover infants up to 250 percent of poverty, and (3) create Healthy Families to cover children above Medi-Cal but below 200 percent of poverty. In the Healthy Families program, families can pay a premium to purchase coverage that is equivalent to the State employees plan plus dental and vision coverage. California will offer premium assistance through a purchasing pool. The State began its Medicaid expansion on March 1, 1998 and plans to begin the State grant program by July 1, 1998.

COLORADO

On February 18, 1998, "Colorado Child Health Plan Plus" was approved. Beginning on April 1, families with incomes above Medicaid eligibility and below 185 percent of poverty can pay premiums between $9 and 30 per month to receive coverage equivalent to a benchmark plan. This builds on an existing State program called the Colorado Child Health Plan, which covered only outpatient services.

FLORIDA

On March 5, 1998, Florida's "Healthy Kids" expansion was approved. This combined plan makes poor children 15 to 18 years old eligible for Medicaid, and children between Medicaid and 185 percent of poverty eligible for the State grant program called Healthy Kids. Healthy Kids, which has been operational in several counties for the past few years, has its benefits grandfathered into CHIP by law, and charges families a premium up to

$15 per month for their children. Healthy Kids is a model build around school-based enrollment.

ILLINOIS

On April 1, 1998, Illinois's plan to expand Medicaid to children with family income up to 133 percent of poverty was approved. The State considers this the first step in expanding coverage, and is planning to submit a plan later in 1998 to cover children in families up to 200 percent of poverty.

NEW YORK

On April 1, 1998, New York's "Child Health Plus" plan was approved. It allows families with income up to 185 percent of poverty to pay a premium to purchase the Child Health Plus benefits which, like Florida and Pennsylvania's State programs, were grandfathered into law. This builds on the existing Child Health Plus program that has been operational for several years and was the largest State program in the nation prior to CHIP.

OHIO

On March 23, 1998, Ohio's plan to expand Medicaid to children up to 150 percent of poverty was approved. The State has indicated that it may consider this the first step in expanding coverage, and may expand more in the future.

SOUTH CAROLINA

On February 18, 1998, South Carolina's "Partners for Healthy Children" was approved. As of October 1, 1997, children in families with income up to 150 percent of poverty can enroll in Medicaid. South Carolina will also use the new Balanced Budget Act option to provide all Medicaid children with 12-month continuous coverage. The State is considering a second, grant program expansion to cover children between 150 and 200 percent of poverty.

STATES WITH SUBMITTED CHILD HEALTH PLANS

Note: The following descriptions are based on the first plan submissions. Any changes that occur informally or formally in the review process are not reflected in this document.

CONNECTICUT

On January 21, 1998, Connecticut submitted its "Husky" plan. This plans is a combined Medicaid and State grant program. It would expand Medicaid for children in families up to 185 percent of poverty, and would create a State grant program for children in families with income between 185 and 300 percent of poverty. The benefits in the State grant program would be equivalent to those of State employees. The plan also includes programs for children with special needs.

IDAHO

On February 13, 1998, Idaho submitted its plan to expand Medicaid up to 160 percent of poverty. The State has convened a task force to examine options for a second, State grant program expansion to cover children above 160 percent of poverty.

MASSACHUSETTS

On January 15, 1998, Massachusetts submitted its "MassHealth" plan, which is a combination of a Medicaid and State grant program expansion. Children in families with income up to 150 percent of poverty would be eligible for Medicaid, and children in families between 150 and 200 percent of poverty would be eligible for the State grant program. Families without access to employer-based insurance can pay for coverage through MassHealth Family Assistance, whose benefits are equivalent to the Federal Employees Health Benefits plan. Families with access to employer-based insurance would receive premium assistance to purchase that coverage. Massachusetts also proposes to have a program for children with disabilities with family income between 150 and 200 percent of poverty.

MICHIGAN

On December 29, 1997, Michigan submitted its "MIChild" plan. This State grant program would allow families with income up to 200 percent of poverty to pay a premium for coverage equivalent to that of State employees.

MISSOURI

On September 29, 1997, Missouri submitted an 1115 waiver, and on February 13, 1998, it submitted a Child Health Plan. The State plans to expand its Medicaid program up to 300 percent of poverty. Its waiver includes coverage for adults and a small change in the Medicaid benefits package (does not cover non-emergency medical transportation).

NEVADA

On March 11, 1998, Nevada submitted its "Nevada ü Check Up" plan. This State grant program will allow families with income up to 200 percent of poverty to pay premiums for coverage available in the largest HMO in the State.

NEW JERSEY

On February 6, 1998, New Jersey submitted its "NJ KidCare" proposal for a combined Medicaid and State grant program. Medicaid would be expanded to cover all children with family income up to 133 percent of poverty. Families with income between 133 and 200 percent of poverty can pay different levels of premiums to buy coverage equivalent to the Federal employees' Blue Cross Blue Shield benefit. The State implemented these expansions in February and March.

OKLAHOMA

On January 23, 1998, Oklahoma submitted its "SoonerCare" plan to expand Medicaid to children in families with income up to 185 percent of poverty. This coverage expansion will be phased in over a three-year period.

OREGON

On March 2, 1998, Oregon submitted a plan to expand coverage through a State grant program to children with family income up to 170 percent of poverty. Children would receive coverage that is the same as what children receive under Oregon's Medicaid waiver.

PENNSYLVANIA

On November 3, 1997, Pennsylvania submitted its Children's Health Insurance Program (CHIP) plan. Like Florida and New York, Pennsylvania's State program has been running for years and thus its benefits were grandfathered in the law creating CHIP. It plans to expand CHIP to children in families with income up to 185 percent of poverty.

PUERTO RICO

On March 30, 1998, Puerto Rico submitted its plan to expand Medicaid to 200 percent of poverty.

RHODE ISLAND

On January 5, 1998, Rhode Island submitted its "Rite Care" Medicaid expansion to cover children in families with income up to 250 percent of poverty. The State expanded coverage to these children before October 1 but after the statutory deadline, so its expansion may qualify for CHIP funding retrospectively.

TENNESSEE

On January 2, 1998, Tennessee submitted its plan to extend its existing Medicaid waiver program to children in families with income up to 200 percent of poverty. TennCare, which has been running since 1994, allows low-income families to buy into a modified Medicaid benefit. Because of budget constraints, it closed enrollment in 1995. TennCare opened enrollment for children in 1997 and expanded coverage for children again in January, 1998.

VERMONT

On March 16, 1998, Vermont submitted a combined CHIP and Medicaid 1115 waiver to expand Medicaid. The State now operates a waiver program called Dr. Dinosaur that covers children with family income up to 225 percent of poverty. Vermont is requesting

to expand eligibility to children with family income up to 300 percent of poverty as well as uninsured parents with family income from 150 to 185 percent of poverty.

WISCONSIN

On March 12, 1998, Wisconsin submitted the CHIP portion of a more general Medicaid 1115 waiver called "BadgerCare." The plan would cover children 15 through 18 with incomes up to 100 percent of poverty through Medicaid. This is the first phase of a broader expansion to families with income up to 185 percent of poverty. Wisconsin is seeking to use CHIP funds to cover low-income adults and to subsidize dependent coverage in employer-based family plans in this broader expansion.

SOURCES

HHS tracking documents and State plans

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