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CHIP: A Look at Emerging State Programs

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In August 1997, Congress enacted the Children's Health Insurance Program (CHIP) to expand health insurance coverage for low-income children up to age 19. CHIP, established as Title XXI of the Social Security Act, is a voluntary program that entitles states to approximately $40 billion through 2007. States must supply matching funds, but the required matching rates are lower than Medicaid rates. As of August 1, 1999, all 50 states and the District of Columbia had developed plans for children's health insurance expansions under CHIP—and all but three had received federal approval.[1]

This brief provides a snapshot of the types—and scale—of expansions that states have adopted in the early implementation phase of CHIP and their efforts to equalize income eligibility for all children regardless of age. In addition, the brief examines how coverage expansions vary in relation to state characteristics.

Before CHIP, the average income threshold for children was 121 percent of the FPL. After CHIP, the average income eligibility threshold increased to 206 percent.

Three Approaches to CHIP Expansion

The Balanced Budget Act of 1997 provides states with three options for increasing coverage under CHIP: expand Medicaid, establish a new insurance program separate from Medicaid, or implement a combination of both. Although expanding Medicaid affords less programmatic flexibility—for example, benefit package design and cost-sharing are predetermined—it has a number of advantages.[2] First, administrative structures and benefit packages are already in place, an advantage for states that want to act quickly. Second, Health Care Financing Administration (HCFA) guidelines guarantee these states funds at regular Medicaid matching rates if they exceed CHIP allotments. Third, states may wish to use CHIP to equalize Medicaid income eligibility criteria for children of all ages.

However, creating a separate non-Medicaid program has advantages too.[3] First, separate programs provide states greater flexibility to design alternative benefit packages and impose more stringent cost-sharing requirements. Second, because separate programs are not considered entitlements, policymakers can cap enrollment and expenditures. Finally, separate programs can create a new image for publicly sponsored health insurance programs, thus avoiding the stigma that families and providers often associate with Medicaid.

Of the 51 CHIP plans set forth by each state and the District of Columbia, 18 expand Medicaid, 17 create programs separate from Medicaid, and 16 do both.[4] The number of states relying either entirely or partially on Medicaid is similar to the number of states that have introduced or expanded a non-Medicaid program. However, at least 10 of the states that have created "new" programs have actually developed Medicaid look-alikes, which are nonentitlement programs that resemble Medicaid but cap enrollment and/or impose cost-sharing requirements.

Covering Children of Different Ages

Table 1 shows how states have expanded coverage under CHIP. Forty-five states are expanding coverage for infants, 49 states are

Table 1
CHIP Eligibility Expansions as a Percentage of the Federal Poverty Level

	Infants		Ages 1 to 6		Ages 6 to 15		Older	
	Medicaid %	Non-Medicaid %	Medicaid %	Non-Medicaid %	Medicaid %	Non-Medicaid %	Medicaid %	Non-Medicaid %
Alabama		133 to 200		133 to 200		100 to 200	15 to 100	100 to 200
Alaska	133 to 200		133 to 200		100 to 200		76 to 200	
Arizona		140 to 200		133 to 200		100 to 200		32 to 200
Arkansas	133 to 200		133 to 200		100 to 200		19 to 200	
California		200 to 250		133 to 200 (250)		100 to 200 (250)	56 to 100	100 to 200 (250)
Colorado		133 to 185		133 to 185		100 to 185		39 to 185
Connecticut		185 to 300		185 to 300		185 to 300	81 to 185	185 to 300
Delaware		185 to 200		133 to 200		100 to 200		100 to 200
District of Columbia	185 to 200		133 to 200		100 to 200		37 to 200	
Florida		185 to 200		133 to 200		100 to 200	28 to 100	100 to 200
Georgia		185 to 200		133 to 200		100 to 200		100 to 200
Hawaii[a]			133 to 200		100 to 200		100 to 200	
Idaho	133 to 150		133 to 150		100 to 150		29 to 150	
Illinois	133 to 200			(133 to 185)	100 to 133	(133 to 185)	35 to 133	(133 to 185)
Indiana	(150 to 200)		133 to 150	(150 to 200)	100 to 150	(150 to 200)	100 to 150	(150 to 200)
Iowa				133 to 185	100 to 133	133 to 185	37 to 133	133 to 185
Kansas		150 to 200		133 to 200		100 to 200		100 to 200
Kentucky		185 to 200	133 to 150	150 to 200	100 to 150	150 to 200	49 to 150	150 to 200
Louisiana[b]	(133 to 150)		(133 to 150)		100 to 133 (150)		18 to 133 (150)	
Maine			133 to 150	150 to 185	125 to 150	150 to 185	125 to 150	150 to 185
Maryland	185 to 200		185 to 200		185 to 200		34 to 200	
Massachusetts	185 to 200		133 to 150	150 to 200	100 to 150	150 to 200	52 to 150	150 to 200
Michigan		185 to 200		150 to 200		150 to 200	45 to 150	150 to 200
Minnesota	275 to 280							
Mississippi		(185 to 200)		(185 to 200)		100 to 133 (200)	34 to 100	100 to 133 (200)
Missouri	185 to 300		133 to 300		100 to 300		100 to 300	
Montana		133 to 150		133 to 150		100 to 150		41 to 150
Nebraska	150 to 185		133 to 185		100 to 185		34 to 185	
Nevada		133 to 200		133 to 200		100 to 200		100 to 200
New Hampshire	185 to 300			185 to 300		185 to 300		185 to 300
New Jersey		185 to 350		133 to 350	100 to 133	133 to 350	45 to 133	133 to 350
New Mexico	185 to 235		185 to 235		185 to 235		185 to 235	
New York		185 to 230 (250)		133 to 230 (250)	(100 to 133)	100 to 230 (250)	61 to 100 (133)	100 to 230 (250)
North Carolina		185 to 200		133 to 200		100 to 200		100 to 200
North Dakota		(133 to 140)		(133 to 140)		(133 to 140)	40 to 100	(100 to 140)
Ohio[c]	133 to 150		133 to 150		100 to 150		32 to 150	
Oklahoma[d]	150 to 185		133 to 185		100 to 185		28 to 185	
Oregon		133 to 170		133 to 170		100 to 170		100 to 170
Pennsylvania		185 to 235		133 to 235		100 to 235		38 to 235
Rhode Island[e]	185 to 250 (300)		185 to 250 (300)		185 to 250 (300)		185 to 250 (300)	
South Carolina			133 to 150		100 to 150		18 to 150	
South Dakota	133 to 140		133 to 140		100 to 140		47 to 140	
Tennessee[f]	(185 to 200)		(133 to 200)		(100 to 200)		54 to 100 (200)	
Texas		(185 to 200)		(133 to 200)		(100 to 200)	17 to 100	(100 to 200)
Utah		133 to 200		133 to 200		100 to 200		100 to 200
Vermont		225 to 300		225 to 300		225 to 300		225 to 300
Virginia		133 to 185 (200)		133 to 185 (200)		100 to 185 (200)		100 to 185 (200)
Washington		(200 to 250)		(200 to 250)		(200 to 250)		(200 to 250)
West Virginia			133 to 150			100 to 150		100 to 150
Wisconsin					100 to 185		48 to 185	
Wyoming		(133 to 150)		(133 to 150)		(100 to 150)		(55 to 150)

Source: Urban Institute analysis of state CHIP plans and source data from the National Governors' Association.
Figures reported in table 1 depict CHIP eligibility expansions as of August 1, 1999. Regular typeface indicates federal approval; figures in parentheses represent state expansions that may not have been implemented but have received approval from state executive and legislative branches and either have yet to be submitted for federal approval or are awaiting federal approval. For 1999, the federal poverty level for a family of three is $13,880.
Notes:
a. Hawaii's coverage of children is through QUEST, the state's Section 1115 waiver program. Hawaii has received approval to expand coverage in three phases. Phase 1 will expand coverage to children ages 1 to 6 between 134 and 185 percent of the FPL; phase two will expand coverage in two-year increments to children ages 6 through 18 in families with income up to 185 percent of the FPL; phase 3 will expand coverage to all children between 185 and 200 percent of the FPL.
b. Louisiana implemented a Medicaid expansion to 150 percent of the FPL in July 1999. Enabling legislation provides the option of expanding coverage to 200 percent of the FPL after July 1, 2000.
c. Governor Taft's FY 2000–2001 budget authorizes the Department of Human Services to submit a state plan no sooner than January 1, 2000, to expand coverage for children in families with income between 150 and 200 percent of the FPL.
d. Oklahoma's coverage of older children will be effective October 1, 1999.
e. Rhode Island received federal approval to expand to 300 percent of FPL. State legislative authorization is currently at 250 percent of FPL.
f. Tennessee's coverage of children is through TennCare, a Section 1115 waiver program. In 1994, Tennessee expanded subsidized coverage to uninsured children up to 400 percent of the FPL, but enrollment caps forced the state to limit enrollment beginning in 1995. In April 1997, the state reopened enrollment for children. Tennessee's approved CHIP program expands coverage for older children up to 100 percent of the FPL. Further expansions are under review by HCFA.

expanding coverage for children ages 1 to 6, and 50 are expanding coverage for children ages 6 to 15. While states have long possessed the optional authority to expand coverage to older adolescents beyond federally mandated minimums, only about one-third had done so as of June 1997. Under CHIP, however, all of the 31 states that had previously covered older adolescents only up to the state's AFDC level are now choosing to expand eligibility for this group up to at least the federal poverty level (FPL).

Chart 1 illustrates how states have used CHIP flexibility to equalize eligibility coverage across age groups.[5] Prior to CHIP, the average state's income threshold for children decreased as children grew older. Infants were covered up to 168 percent of the FPL, but for children ages 1 through 5, 6 through 13, and 14 through 18, average income eligibility thresholds were 148 percent, 122 percent, and 84 percent of the FPL, respectively.

Because of CHIP, average income eligibility thresholds for all children have equalized and now hover slightly above 200 percent of the FPL. This equalization produced an increase in the average threshold for adolescents of 121 percentage points, over three times greater than the increase for infants of 40 percentage points. The states that establish the same upper income threshold for all ages may resolve a long-standing dilemma of the Medicaid program: the low enrollment rates among eligible children, thought to be caused in part by the confusion and frustration among families sorting out various income eligibility thresholds. Prior to CHIP, 45 states covered younger children at higher income levels than older children. With CHIP, this trend is sharply reversed—now, all states are evening out income eligibility thresholds of children ages 1 through 18.[6]

Expansions by State Characteristics

After examining children's income eligibility before CHIP and after CHIP, it became clear that coverage expansions varied in relation to several state characteristics, including income eligibility thresholds prior to CHIP, the proportion of uninsured youth, the degree of wealth in the state, the change in matching rates as a result of CHIP, and the region of the United States in which the state is located.

Previous Level of Coverage

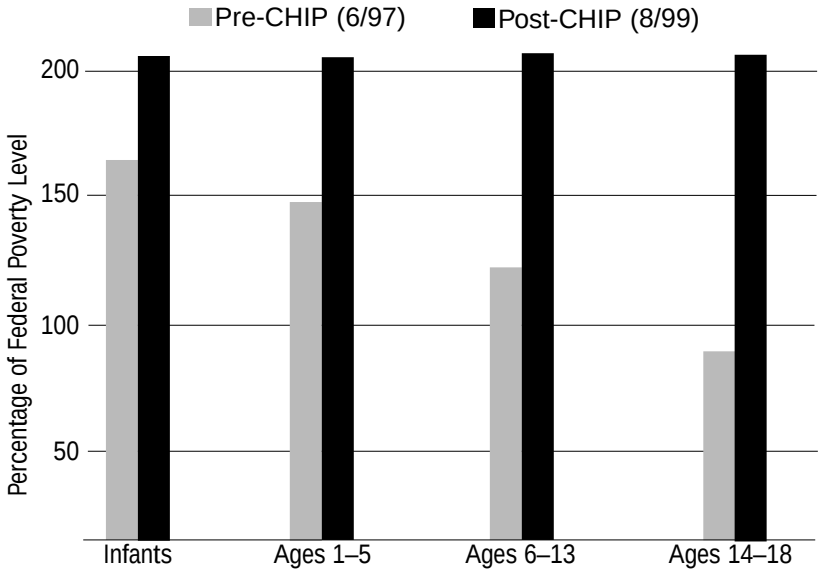
Before CHIP, the average income threshold for children was 121 percent of the FPL. After CHIP, the average income eligibility threshold increased to 206 percent. Increases in average income eligibility thresholds for children are displayed in table 2.

The analysis found that states with lower Medicaid thresholds prior to CHIP expanded income eligibility the most, while those with the highest pre-CHIP eligibility thresholds expanded eligibility the least. For example, states with the highest income thresholds before CHIP's passage expanded their eligibility for children from an average of 179 percent of the FPL to 247 percent—an increase of 68 percentage points (table 2). All other states with lower pre-CHIP eligibility thresholds increased their levels more dramatically, between 87 and 94 percentage points.

Uninsured Youth

Prior to CHIP, states with the highest proportions of low-income children without health insurance (uninsured children in families with income below 200 percent of the FPL) also had lower average Medicaid income eligibility criteria. For example, the average income threshold for states with the highest proportions of uninsured children was 103 percent of the FPL, compared with 135 percent of the FPL for states with the lowest proportions of uninsured children. With the help of CHIP, this discrepancy has been mitigated (table 2). The states with the lowest proportions of uninsured children increased their thresholds an average of 69 percentage points, to 205 percent of the FPL. In contrast, the states with the highest proportions of uninsured children nearly doubled their income thresholds for children, bringing their current average to 205 percent of the FPL. Despite this parity, states with lower-than-average proportions of uninsured children usually cover children at more generous levels than those with higher-than-average proportions. Still, this latter group may enroll greater numbers of children under CHIP because they draw from a larger pool of uninsured children.

Chart 1
Children's Eligibility Thresholds, by Age



State Per Capita Income

Before CHIP, the average income that qualified children residing in wealthier states for public insurance was 145 percent of the FPL. In poorer states, the average income eligibility threshold was 104 percent of the FPL, 41 percentage points lower than in wealthier states. In response to CHIP, it appears that the wealthier states (those with per capita personal income above the national average) are initiating the broadest expansions, as measured by income eligibility thresholds (table 2). For example, states with the highest per capita income (those in the highest quartile) expanded eligibility thresholds by an average of 94 percentage points, compared with 77 percentage points in the poorest states. Consequently, as of August 1999, the average eligibility threshold for children is 238 percent of the FPL in the wealthiest states and 181 percent in the poorest states.

This discrepancy between the wealthier states and the poorer states is understandable. It is relatively easier for wealthier states with smaller percentages of uninsured children to expand income eligibility thresholds than it is for poorer states with generally higher percentages of uninsured children. However, poorer states, even with smaller expansions, may end up extending coverage to many more children because they are drawing from a larger pool of uninsured children.

Federal Matching Rates

It appears that eligibility expansions are associated with the relative magnitude of change in federal matching rates after CHIP. Prior to passage of the Balanced Budget Act of 1997, Medicaid matching rates ranged from a low of 50 percent to over 70 percent, based on a formula driven by state per capita income, with higher matching rates extended to poorer states. Under CHIP, more generous federal matching rates were extended to all states, with their share of costs established at 70 percent of what they paid under Medicaid. Interestingly, this policy change has a greater effect among wealthier states with lower pre-CHIP matching rates than among poorer states with already high federal matching rates. For example, Connecticut's Medicaid matching rate is 50 percent, while its CHIP matching rate is 65 percent, an increase of 15 percentage points. In Mississippi, however, the Medicaid matching rate of 77 percent is only raised to 84 percent under CHIP, an increase of 7 percentage points.

Changes in state matching rates under CHIP, relative to Medicaid matching rates, relate to income eligibility expansions. States with matching rates that changed the most also expanded eligibility the most—by an average of 95 percentage points. This occurred even though these states, primarily wealthier, already had higher eligibility levels than their less-wealthy counterparts. In contrast, states whose matching rates changed the least expanded coverage the least—by an average of 74 percentage points. These findings suggest that federal matching rates, which are correlated to state per capita income, may also play a role in influencing eligibility expansion decisions.

Expansions by Region

Striking regional differences are apparent from the analysis conducted here. Before CHIP, the average income eligibility threshold for children was highest in the northeastern states and significantly lower in the rest of the country, with the lowest thresholds in the South (table 2). After CHIP, disparities in income eligibility thresholds between the northeastern states and the remainder of the country have increased. The average eligibility threshold for children in the northeastern states is 269 percent of the FPL, whereas average income eligibility thresholds in the remainder of the country are between 190 percent and 196 percent of the FPL. It has been well documented,

Table 2
Children's Eligibility Thresholds, by State Characteristics

	Percent of Federal Poverty Level		
	Pre-CHIP (6/97) %	Post-CHIP (8/99) %	Difference (Post-CHIP Minus Pre-CHIP) %
Average Threshold	**121**	**206**	**85**
Income eligibility threshold prior to CHIP			
Lowest quartile	92	179	87
2nd quartile	100	194	94
3rd quartile	112	202	89
Highest quartile	179	247	68
Percent of low-income uninsured children*			
Lowest quartile	135	205	69
2nd quartile	142	233	92
3rd quartile	106	180	74
Highest quartile	103	205	102
Per capita income			
Lowest quartile	104	181	77
2nd quartile	116	197	81
3rd quartile	119	205	87
Highest quartile	145	238	94
Change in matching rates			
Lowest quartile	106	180	74
2nd quartile	111	192	81
3rd quartile	127	215	88
Highest quartile	139	235	95
Region			
Northeast	164	269	105
Midwest	120	196	76
West	116	192	75
South	104	190	87

Sources: U.S. Bureau of the Census, three-year averages of the March 1996, 1997, and 1998 Current Population Surveys; U.S. Department of Commerce, Bureau of Economic Analysis News Release, "1998 State Per Capita Personal Income and State Personal Income (Preliminary)," April 27, 1999.

*Defined as children residing in families with income less than 200 percent of FPL.

however, that the northeastern states have fewer uninsured children than states in the South and West.[7] For example, based on Current Population Survey data, over two-thirds of CHIP-eligible uninsured children reside in southern and western states. Therefore, CHIP may enable states in these regions to provide new coverage to greater numbers of previously uninsured children, even with smaller income-threshold expansions, by virtue of the large base of uninsured children in these areas.

Conclusion

Since the enactment of CHIP, nearly every state has taken advantage of optional authority to provide expanded health care coverage to children in low-income families. CHIP provides states with significant flexibility in designing their programs; in fact, two-thirds of the states have used this flexibility to explore alternatives to Medicaid and have created or expanded non-Medicaid programs.

In examining changes in states' average income eligibility thresholds for children, pre- and post-CHIP, interesting relationships with state characteristics arise: states with the lowest level of coverage prior to CHIP have expanded income eligibility thresholds the most during the first two years of implementation; states with the largest percentages of low-income uninsured children have increased their income eligibility thresholds to a greater degree than states with smaller percentages of uninsured children; states with higher per capita personal income have raised eligibility thresholds more than states with lower per capita income; states that experienced the greatest increases in federal matching rates had the largest eligibility expansions; and states in the Northeast have increased thresholds to a greater extent than states in other regions of the country.

At this early phase of CHIP implementation, and with some states still expanding coverage, it is extremely difficult to predict how changes in income eligibility thresholds will affect insurance rates among children; this complex analysis will be the focus of future research.

Notes

1. Three states that are awaiting federal approval under CHIP are Tennessee, Washington, and Wyoming.

2. Weil, Alan. 1997. "The New Children's Health Insurance Program: Should States Expand Medicaid?" Washington, D.C.: Urban Institute. October.

3. Ibid.

4. The states using a Medicaid expansion are AK, AR, DC, HI, ID, LA, MD, MN, MO, NE, NM, OH, OK, RI, SC, SD, TN, and WI; the states with a separate program are AL, AZ, CO, DE, GA, KS, MT, NV, NH, NC, OR, PA, UT, VT, VA, WA, and WY; and the states using a combined approach are CA, CT, FL, IL, IN, IA, KY, ME, MA, MI, MS, NJ, NY, ND, TX, and WV.

5. Average income eligibility thresholds for children, per state, were generated by determining the income eligibility threshold for children up to age 19 and summing the income eligibility thresholds, then dividing by 19.

6. A separate problem surrounding children's eligibility persists, despite the evening out of upper income eligibility thresholds: it is still possible, in some states, for children of different ages in the same family to qualify for coverage under different programs.

7. Selden, Thomas, Jessica Banthin, and Joel Cohen. 1998. "Trends: Medicaid's Problem Children: Eligible but Not Enrolled." *Health Affairs* 17 (3, May/June): 192–200.

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