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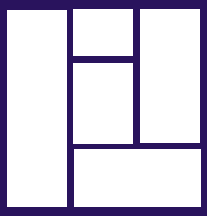

NEW FEDERALISM
ISSUES AND OPTIONS FOR STATES

A product of "Assessing the New Federalism," an Urban Institute Program to Assess Changing Social Policies

Children's Health Insurance Programs: Where States Are, Where They Are Headed

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The Balanced Budget Act of 1997 provides $24 billion in federal funds over the next five years for children's health.[1] The State Children's Health Insurance Program (CHIP) accounts for over $20 billion of these funds. Established as Title XXI of the Social Security Act, this program entitles states to grants to help create and expand insurance programs for low-income children. Funds are allocated to each state based on its share of the nation's uninsured children with family incomes below 200 percent of the federal poverty level, with adjustments for differences in health care costs across states. States must supply matching funds, but the required matching rates are lower than Medicaid matching rates.

States choosing to participate in CHIP may expand Medicaid, create or expand a non-Medicaid program, or use a combination of both approaches. While CHIP rules specify that states may only cover uninsured children in families with incomes up to 200 percent of poverty, there are important exceptions. In states that had expanded Medicaid eligibility for children beyond 150 percent of poverty prior to CHIP, CHIP eligibility limits can be raised up to 50 percentage points above their existing Medicaid eligibility thresholds.[2] States will receive the enhanced matching rate only for children above these existing eligibility thresholds. In addition, the Health Care Financing Administration (HCFA) will allow states to disregard income under the rules outlined in Section 1902(r)(2) of the Social Security Act. The 1902(r)(2) provision essentially allows states to cover uninsured children at any income level under CHIP.

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This brief first examines the variation in states' provision of health insurance coverage to children under both the Medicaid program and separate state initiatives prior to CHIP. The brief then summarizes states' CHIP plans, including those submitted to HCFA for approval and those proposed by governors, legislatures, or committees but still under consideration at the state level. We find that variety is, was, and will continue to be a dominant feature of children's health insurance programs.

Pre-CHIP Efforts to Cover Low-Income Children

During the early 1990s, the federal government granted states increasing flexibility to cover low-income children under Medicaid. Many states took advantage of this flexibility by extending Medicaid eligibility for children beyond the mandated age and income thresholds using Section 1115 waivers and Section 1902(r)(2) provisions. Some states also developed "state-only" initiatives to provide health insurance to low-income children outside of the Medicaid program in the past few years. State-only programs can cap program enrollment, impose cost-sharing requirements, and limit benefit packages—approaches that are limited or prohibited in the Medicaid program. As a result of states' varying commitments and approaches, publicly subsidized insurance coverage of children is markedly different among states in terms of the family income and age of children eligible for coverage, the benefits provided, the costs imposed on families, and the mechanisms through which coverage is provided (figure 1).

In general, states have taken three approaches to providing health insurance coverage to children. "Broad-coverage" states offer Medicaid coverage to children with family incomes well above federally mandated levels. With the exception of the state of Washington, states with the most liberal income and age limits for Medicaid established these limits through Medicaid research and demonstration waivers, also known as Section 1115 waivers. "Low-coverage" states offer sufficient coverage to meet federal Medicaid mandates, but little or no additional coverage. The remaining "middle-of-the-road" states either run relatively large state programs in addition to Medicaid or set Medicaid income and age limits somewhat above the federal mandates.[3]

Broad-Coverage States

Income and age limits for Medicaid eligibility in Minnesota, Rhode Island, Tennessee, Vermont, and Washington are significantly higher than mandated federal standards (figure 1). The first four states expanded Medicaid through research and demonstration waivers. In addition to having much higher income limits for children, these programs often rely on mandatory managed care enrollment to control costs. Washington used options available under Section 1902(r)(2) of the Social Security Act to raise age limits for children.

Although all five states offer coverage to children with incomes well above the mandated levels, these states impose premiums and other cost-sharing on certain families. For example, Rhode Island's RIte Care project requires that individuals with family incomes between 185 and 250 percent of poverty pay either fixed monthly premiums or copayments imposed at the point of service. Washington provides a comprehensive benefit package to children under age 19 with family incomes up to 200 percent of poverty through its Basic Health Plus program at no cost to the family. Basic Health Plus is a Medicaid program for children only that is coordinated with the state's Basic Health program, which provides partially subsidized coverage for adults and non-Medicaid-eligible children with family incomes up to 200 percent of poverty. Children (and adults) with family incomes over 200 percent of poverty may also participate in the regular Basic Health program, but the state does not subsidize this coverage and families must pay the entire premium. There is also a long waiting list because enrollment is capped.

Low-Coverage States

Several states provide Medicaid coverage for low-income children that complies with the standards mandated by the federal government but offer little or no coverage beyond that point. As of June 1, 1997, Medicaid income and age thresholds in 11 states were equal to the federal mandates: Alabama, Alaska, Arkansas, Colorado, Idaho, Illinois, Louisiana, Montana, Nevada, Ohio, and Wyoming. Colorado also funds a state health insurance program for low-income children, but this plan was not available statewide as of June 1, 1997, and it offered a limited benefit package. Another group of states provides coverage barely exceeding federally mandated levels. Arizona, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, Texas, and the District of Columbia had higher Medicaid income limits for pregnant women and infants, but income and age limits for children remained at or near the mandated levels.

Middle-of-the-Road States

Middle-of-the-road states provide coverage for low-income children with age and income limits above the federally mandated levels, but their income and/or age limits tend to be lower than those in broad-coverage states. Some states in this category have high income or age limits for Medicaid; others operate large state programs. A few states use both approaches. As a result, there are actually many different levels of coverage within this last category.

Florida, Massachusetts, New Jersey, New York, and Pennsylvania fund relatively large state-only programs that cover low-income children who are not eligible for Medicaid. Florida, New York, and Pennsylvania offer comprehensive benefit packages; Massachusetts and New Jersey provide more basic care. Regardless of the comprehensiveness of the benefit packages, these state initiatives provide care to children who might otherwise have no coverage at all. In addition, these states all offer Medicaid coverage to pregnant women and infants with family incomes up to at least 185 percent of poverty.

Other states in the middle-of-the-road group extend Medicaid to children whose ages or family incomes are somewhat higher than the federal mandates. Connecticut, Maryland, and Wisconsin raised their Medicaid income limits for children, but they only cover children born after September 30, 1983 (the federal mandate). Hawaii, North Dakota, Oregon, South Dakota, Utah, and Virginia cover older children, but they have not raised their income thresholds. As of June 1, 1997, Hawaii technically offered Medicaid coverage to children with family incomes as high as 300 percent of poverty; however, financial troubles prevented the state from subsidizing coverage above mandated income

Figure 1: State Initiatives to Expand Health Insurance for Children

	Medicaid Expansion (as of June 1, 1997)				
	Infants[a]	Ages 1 to 6[a]	Older Children	Age Limit[b]	Comments[c]
Federal Mandate	***133***	***133***	***100***	***13***	
Alabama	m	m	m	m	
Alaska	m	m	m	m	
Arizona	140	m	m	14	
Arkansas	m	m	m	m	Children through age 18 with family incomes less than 200% of poverty are now covered by ARKids First, a Section 1115 waiver program that started September 1, 1997. There are no premiums, but copayments are required for most services.
California	200	m	m	m	Access for Infants and Mothers (state-only) covers infants under age 2 between 200% and 300% of poverty. Cost-sharing is required, and enrollment can be capped.
Colorado	m	m	m	m	The Children's Health Plan (state-only) provides a limited benefit package to children through age 13 with family incomes up to 185% of poverty. Cost-sharing is required at higher incomes, and coverage is not available in all counties. Last year the state passed a law raising the age limit and expanding the benefit package. This expansion was incorporated into the state's submitted CHIP plan.
Connecticut	185	185	185	m	
Delaware	185	m	m	18	
District of Columbia	185	m	m	m	
Florida	185	m	m	m	Florida Healthy Kids (state-only) provides comprehensive coverage to students in grades K–12. There is no income limit, but premiums are much higher once family income exceeds 185% of poverty. The program is not statewide, and enrollment can be limited by available funds.
Georgia	185	m	m	18	
Hawaii	185 [300]	133 [300]	100 [300]	18	Hawaii covers children through QUEST, a Section 1115 waiver program. At first, children received subsidized coverage up to 300% of poverty. Since 1995, fiscal constraints have prevented the state from subsidizing coverage above the lower thresholds shown. Hawaii amended its plan in 1998, reducing eligibility to the mandated income limits.
Idaho	m	m	m	m	Idaho expanded Medicaid in October 1997 to cover children through age 18 with family incomes up to 160% of poverty.
Illinois	m	m	m	m	
Indiana	150	m	m	18	The age limit shown reflects an expansion that went into effect 5/1/97.
Iowa	185	m	m	m	
Kansas	150	m	m	17	
Kentucky	185	m	m	18	
Louisiana	m	m	m	m	
Maine	185	m	125	18	
Maryland	185	185	185	m	Maryland's Medicaid program provides a reduced benefit package to children ages 1 to 6 with family incomes from 133 to 185% of poverty, and older children with family incomes from 100 to 185% of poverty.
Massachusetts	185	m	m	m	In July 1997, the state implemented portions of MassHealth, its Section 1115 waiver program, expanding coverage to children through age 18 up to 133% of poverty. The waiver includes the Insurance Reimbursement Program, which provides subsidies to workers in small firms with family incomes up to 200% of poverty to purchase employer-sponsored group insurance. The existing Children's Medical Security Plan (state-only) will continue to provide basic coverage for children through age 18 who are not eligible for the Medicaid programs.
Michigan	185	150	150	15	
Minnesota	275	133 [275]	100/68 [275]	13/20	Minnesota's Section 1115 waiver program imposes premiums starting at 133% of poverty for children ages 1 to 6. Premiums start at 100% of poverty for children ages 6 to 13 (or born after 9/30/83), and at 68% of poverty for older children up to age 20. Subsidized premiums phase out at 275% of poverty. There are no premiums for infants.
Mississippi	185	m	m	m	
Missouri	185	m	m	18	
Montana	m	m	m	m	
Nebraska	150	m	m	m	
Nevada	m	m	m	m	
New Hampshire	185	185	185	18	

(continued)

Figure 1: State Initiatives to Expand Health Insurance for Children (continued)

	Medicaid Expansion (as of June 1, 1997)				
	Infants[a]	Ages 1 to 6[a]	Older Children	Age Limit[b]	Comments[c]
New Jersey	185	m	m	m	Health Access New Jersey (state-only) provides basic coverage to people ages 0 to 65 up to 250% of poverty, with cost-sharing. The program was closed to new enrollment in 1995.
New Mexico	185	185	185	18	
New York	185	m	m	m	Child Health Plus (state-only) provides comprehensive coverage to kids through age 18 up to 222% of poverty, with sliding-scale premiums. Enrollment is currently capped.
North Carolina	185	m	m	18	
North Dakota	m	m	m	17	
Ohio	m	m	m	m	A 1997 law required the state to expand Medicaid eligibility, not sooner than January 1, 1998, to children through age 18 with family incomes up to 150% of poverty. This expansion was submitted as a CHIP plan.
Oklahoma	150	m	m	m	A 1997 law specifies that Medicaid should cover children under age 6 with family incomes up to 185% of poverty and all older children born after 9/30/83 up to 185% of poverty. The state's submitted CHIP plan appears to be based on this law.
Oregon	m	m	m	m	A 1997 law established the Family Health Insurance Assistance Program (state-only), which provides vouchers to defray the cost of health insurance for families with incomes under 200% of poverty.
Pennsylvania	185	m	m	m	Children's Health Insurance Program (state-only) provides comprehensive benefits to children through age 16 up to 185% of poverty, with some cost-sharing. Private plans in two regions expand this program to additional children up to 235% of poverty. Enrollment is currently capped.
Rhode Island	185 [250]	185 [250]	185 [250]	18	RIte Care, a Section 1115 waiver program, covers children through age 17 (18 if still in school) up to 250% of poverty. Families with incomes over 185% of poverty pay either premiums or copayments.
South Carolina	185	m	m	m	
South Dakota	m	m	m	18	
Tennessee	185 [400]	133 [400]	100 [400]	18	TennCare, a Section 1115 waiver program, offers subsidized coverage to children up to 400% of poverty. Financial constraints forced the state to limit enrollment. As of April 1, 1997, the state reopened enrollment to all children under age 18 who did not have insurance. Premiums start at 185% of poverty for infants, 133% of poverty for ages 1 to 6, and 100% of poverty for older children.
Texas	185	m	m	m	
Utah	m	m	m	18	
Vermont	185 [225]	185 [225]	185 [225]	17	Premiums are required for children with family incomes above 185% of poverty. Subsidies phase out by 225% of poverty.
Virginia	m	m	m	18	
Washington	200	200	200	18	Children with family incomes over 200% of poverty may enroll in Basic Health (state-only), but they must pay the full premium. There are no age or income limits, but enrollment is currently capped.
West Virginia	150	m	m	18	
Wisconsin	185	185	m	m	
Wyoming	m	m	m	m	

Source: Urban Institute.
m = state provides the federal mandate.
a) An infant is a child who has not reached his/her first birthday. A child ages 1 to 6 is age 1 or older but has not reached his/her sixth birthday.
b) Federal law mandates that states cover all children born after September 30, 1983, with family incomes below 100 percent of poverty. Some states cover children born prior to this date and/or children with higher family incomes. States that have expanded coverage have done so primarily through Medicaid waivers or the 1902(r)(2) provision of the Social Security Act.
c) State-level programs mentioned here are those financed through public funds. Privately financed programs such as Blue Cross/Blue Shield Caring Programs for Children are not included.

levels. Consequently, children with family incomes above the mandated levels had to pay the full premium. Hawaii recently amended its Section 1115 waiver, lowering income eligibility to the mandated levels, although it continues to provide coverage to children through age 18. The 13 remaining middle-of-the-road states have higher income and age thresholds for children, but these expansions are modest compared to the thresholds in broad-coverage states.

A Sign of Things to Come

Several states were actively seeking to expand coverage for low-income children even before CHIP became a reality. According to the National Conference of State Legislatures, 38 states considered legislation to improve children's health care coverage during their 1997 legislative sessions; several initiatives passed (see comments, figure 1). Low-coverage states such as Arkansas, Indiana, Ohio, and Oklahoma passed legislation authorizing Medicaid expansions for children. Likewise, Colorado authorized expanded eligibility and a broader benefit package for its existing non-Medicaid plan. A number of middle-of-the-road states also considered new child health initiatives. California and Connecticut both authorized Medicaid expansions, while Massachusetts expanded eligibility in MassHealth, a Medicaid program. Several of these expansions were not implemented right away, and subsequently they have been submitted to HCFA under CHIP to take advantage of enhanced matching rates.

CHIP—The Next Wave of Expansion

Federal funds for CHIP became available October 1, 1997, sparking a flurry of activity devoted to children's health coverage. Most states are in the process of determining whom they can and will cover under CHIP and the mechanisms through which such coverage will be provided. States have raised questions regarding eligibility, funding, outreach, and other important aspects of the new program. Consequently, the development of CHIP plans has involved considerable interaction between the states and HCFA. Although there are no final regulations for CHIP, several states have already submitted plans for HCFA approval.

Submitted Plans

As of February 28, 1998, 18 states—Alabama, California, Colorado, Connecticut, Florida, Idaho, Illinois, Massachusetts, Michigan, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, and Tennessee—had submitted CHIP plans to HCFA. The plans in Alabama, Colorado, Florida, and South Carolina had received HCFA's approval at the time of this writing. All three approaches to coverage allowed under Title XXI are reflected in the submitted plans (see figure 2).

Several states were actively seeking to expand coverage for low-income children even before CHIP became a reality.

Fourteen of the 18 plans submitted to HCFA include Medicaid expansions. Of the 14 plans using Medicaid expansions, five plans—from California, Connecticut, Florida, Massachusetts, and New Jersey—are combination plans that include non-Medicaid programs. Few states have submitted plans for entirely new programs. Of the nine states that submitted plans to HCFA involving non-Medicaid programs (including the mixed plans), only California, Connecticut, Massachusetts, Michigan, and New Jersey want to create entirely new state-only programs. Colorado, Florida, New York, and Pennsylvania all plan to expand existing non-Medicaid programs.

Still in the Planning Stages

Preliminary indications from other states suggest that new children's health initiatives will continue to be diverse. According to information collected from several sources, six states—Alaska, Delaware, Indiana, Maryland, Nebraska, and New Mexico—and the District of Columbia are contemplating Medicaid expansions; five states—Arizona, Nevada, North Carolina, Utah, and Wisconsin—may create or expand non-Medicaid programs; and six states—Georgia, Iowa, Kentucky, Maine, Oregon, and West Virginia—are considering mixed approaches (see figure 2).[4]

Some states that have submitted plans are also considering additional expansions. For example, Alabama's CHIP planning commission voted to cover children up to 200 percent of poverty after the state submitted its approved plan. The state is still debating what form this additional expansion will take.[5] Illinois, Ohio, Oklahoma, and Rhode Island all submitted plans for modest Medicaid expansions, but additional expansions are under consideration in each of these states. Additional expansions to Florida's Healthy Kids program are also being discussed.

It should be noted that most of the plans still under discussion are proposals by governors, planning commissions, or legislatures. These plans may change before they are submitted to HCFA for approval. For example, some legislators in Maryland have expressed interest in a smaller Medicaid expansion than the governor has proposed, preferring a non-Medicaid plan for children from families with higher incomes. Some states may also add to their proposals before submitting them to HCFA. Idaho and Indiana appear to be leaning toward small Medicaid expansions, but they are still examining other options. In addition, some of the programs under consideration use unique administrative, benefit, and/or funding approaches that may require special waivers from HCFA. For example, Wisconsin's planned BadgerCare program would subsidize coverage for families, which is not allowed without a waiver.

Figure 2: State Responses to the Children's Health Insurance Program

Alabama	Alabama's approved Title XXI plan expands Medicaid to children up to age 19 with family incomes up to 100% of poverty. Further expansions are being discussed.
Alaska	Gov. Knowles proposed a Medicaid expansion to cover children up to age 19 with family incomes up to 200% of poverty.
Arizona	Gov. Hull proposed an expansion of the Arizona Health Care Cost Containment System (AHCCCS) to cover children up to age 19 with family incomes up to 200% of poverty.
Arkansas	Children's health care plans are currently being developed.
California	California submitted a Title XXI plan to expand Medicaid to children up to age 19 with family incomes up to 100% of poverty. In addition, California will create a non-Medicaid program for children up to age 19 between 100% and 200% of poverty.
Colorado	Colorado's approved Title XXI plan expands the state's Child Health Plan to children up to age 18 with family incomes up to 185% of poverty. The governor has since announced his support for an additional Medicaid expansion for children up to age 19 with family incomes up to 100% of poverty.
Connecticut	Connecticut's submitted plan, called HUSKY (Healthcare for Uninsured Kids and Youth), has three parts. HUSKY Part A expands Medicaid to children through age 18 with family incomes up to 185% of poverty. HUSKY Part B is a new state program providing subsidized coverage for children up to 300% of poverty. The third portion, HUSKY Plus, provides supplemental benefits for children with severe behavioral and physical health needs.
Delaware	Gov. Carper proposed a Medicaid expansion for children up to age 19 with family incomes up to 200% of poverty. Uninsured children with higher family incomes could receive coverage at a reduced rate.
District of Columbia	The District of Columbia's financial control board is considering a Medicaid expansion for children up to age 19 with family incomes up to 200% of poverty.
Florida	Florida's approved Title XXI plan expands Medicaid and the Florida Healthy Kids program. Medicaid will be expanded to cover older children up to 100% of poverty. The Florida Healthy Kids program will be expanded to cover more children with family incomes up to 185% of poverty. Gov. Chiles has since proposed further expansions. Under the governor's proposal, Medicaid would be expanded to infants up to age 1 with family incomes up to 235% of poverty; children up to age 6 with family incomes up to 200% of poverty; and children ages 14 to 19 with family incomes up to 100% of poverty. The Florida Healthy Kids program would be expanded to children ages 6 to 19 with family incomes between 100% and 200% of poverty.
Georgia	Gov. Miller proposed a Medicaid expansion for children up to age 6 with family incomes up to 200% of poverty. Under the plan, a non-Medicaid program will be created for other children ages 6 to 19 with family incomes up to 200% of poverty. Further expansions are under consideration.
Hawaii	Hawaii's coverage of children is through Hawaii QUEST, a Section 1115 waiver managed care program. Due to recent eligibility changes and a legal challenge to the QUEST program, it is not clear which child populations may be eligible to receive coverage under the CHIP program.
Idaho	In October 1997, Idaho expanded Medicaid to children up to age 19 with family incomes up to 160% of poverty. Further expansions are under consideration.
Illinois	Illinois submitted a Title XXI plan to expand Medicaid to infants with family incomes up to 200% of poverty and older children with family incomes up to 133% of poverty. Further expansion proposals are being developed.
Indiana	Indiana recently enacted a Medicaid expansion up to 150% of poverty, to go into effect October 1, 1998.
Iowa	Gov. Branstad proposed a Medicaid expansion for children up to age 19 with family incomes up to 133% of poverty. In addition, the governor proposed a non-Medicaid program, Iowa Kids, for children with family incomes between 133% of poverty and 185% of poverty.
Kansas	Children's health care plans are currently being developed.
Kentucky	Gov. Patten announced a plan to expand Medicaid and create a state-run program. Medicaid would be expanded to older children up to age 19 with family incomes up to 100% of poverty. The state-run insurance program, KCHIP, would offer coverage to children with family incomes between 100% and 200% of poverty. KCHIP would also include a program to subsidize worker contributions for children's coverage by employer-sponsored insurance.
Louisiana	Children's health care plans are currently being developed.

(continued)

Figure 2: State Responses to the Children's Health Insurance Program (continued)

Maine	The Maine Commission on Children's Health Care recommended a Medicaid expansion and the creation of a new state health insurance program, Cub Care. Under the proposal, Medicaid would be expanded for children up to age 19 with family incomes up to 150% of poverty. The Cub Care program would provide subsidized health care coverage to children with family incomes between 150% and 185% of poverty.
Maryland	Gov. Glendening proposed a Medicaid expansion for children with family incomes up to 200% of poverty.
Massachusetts	Massachusetts submitted a Title XXI plan to expand the MassHealth program. MassHealth Standard would provide free Medicaid coverage to children up to age 19 in families with income below 150% of poverty. MassHealth Family Plan will provide subsidized Medicaid coverage to children up to age 19 in families with incomes between 150% and 200% of poverty. (Legislative approval is still needed for the state to impose premiums.) Children not eligible for CHIP are referred to the Children's Medical Security Program (see figure 1). Outside of the CHIP program, the Division of Medical Assistance would also implement a premium assistance program for families with higher incomes.
Michigan	Michigan submitted a Title XXI plan to provide non-Medicaid coverage to children up to age 19 with family incomes up to 200% of poverty.
Minnesota	Minnesota's coverage of children is through MinnesotaCare, a Section 1115 waiver managed care program. Children up to age 22 in families with family incomes up to 275% of poverty receive subsidized coverage. An official decision on the state's participation in the CHIP program has not been made.
Mississippi	Children's health care plans are currently being developed.
Missouri	In August 1997, the state submitted an amended Section 1115 waiver that would expand Medicaid to children up to age 19 with family incomes up to 300% of poverty. Under the state's Title XXI plan, these children would be eligible to obtain coverage under the enhanced federal match used for CHIP.
Montana	Children's health care plans are currently being developed.
Nebraska	Gov. Nelson proposed a Medicaid expansion for children up to age 19 with family incomes up to 185% of poverty.
Nevada	Gov. Miller proposed to provide non-Medicaid coverage to children up to age 19 with family incomes up to 200% of poverty.
New Hampshire	Children's health care plans are currently being developed.
New Jersey	New Jersey enacted a Title XXI plan to expand Medicaid to children up to age 19 in families with incomes up to 133% of poverty. The state will also offer non-Medicaid coverage to children with family incomes between 133% and 200% of poverty. Additional proposals for children's health care expansions are under consideration.
New Mexico	The state's Health Policy Commission has developed a plan to expand Medicaid to children up to age 19 with family incomes up to 235% of poverty.
New York	New York submitted a Title XXI plan to expand enrollment through the Child Health Plus program. The program provides coverage to children up to age 19 with family incomes up to 222% of poverty. Further expansions are under consideration.
North Carolina	Gov. Hunt proposed a non-Medicaid expansion for children up to age 19 with family incomes up to 200% of poverty. A special legislative session to address the CHIP program will be held during the week of March 23rd.
North Dakota	Children's health care plans are currently being developed.
Ohio	Ohio submitted a Title XXI plan to obtain funds for the state's recent Medicaid expansion. In January, Ohio expanded Medicaid to children up to age 19 with family incomes up to 150% of poverty. Since submission of the plan, Gov. Voinovich proposed an additional expansion to cover children with family incomes up to 200% of poverty.
Oklahoma	Oklahoma submitted a Title XXI plan to obtain funds for the state's recent expansion of the SoonerCare program, a Section 1115 waiver program. In December 1997, SoonerCare was expanded to provide free health care coverage to children born after October 1, 1983, with family incomes up to 185% of poverty. Under the expansion, the state plans to provide coverage, by December 1998, to children and families with incomes up to 250% of poverty.
Oregon	Health officials are devising a plan that would expand Medicaid for children up to age 18. In addition, the plan would expand the Family Health Insurance Assistance program to subsidize coverage for families with incomes up to 170% of poverty.

(continued)

Figure 2: State Responses to the Children's Health Insurance Program (continued)

Pennsylvania	Pennsylvania submitted a Title XXI plan to expand the state's CHIP program. Under the plan, the CHIP program would provide free coverage to children through age 16 with family incomes up to 185% of poverty and subsidized coverage for children up to age 6 with family incomes up to 235% of poverty. Since submission of the plan, Gov. Ridge has proposed an additional CHIP expansion to provide free coverage to children up to age 18 with family incomes up to 200% of poverty and subsidized coverage for children up to age 18 with family incomes up to 235% of poverty.
Rhode Island	Rhode Island submitted a Title XXI plan to obtain funds for the state's recent expansion of RIte Care, a Section 1115 waiver program. Under the plan, RIte Care would cover children up to age 19 with family incomes up to 250% of poverty. Further expansions for children and/or families are under consideration.
South Carolina	South Carolina's approved Title XXI plan will enable the state to obtain funds for the state's recent Medicaid expansion. The state expanded its Medicaid program to provide health care coverage to children up to age 19 with family incomes up to 150% of poverty. Further expansions are under consideration.
South Dakota	Children's health care plans are currently being developed.
Tennessee	Tennessee submitted a Title XXI plan to obtain funds for the state's recent expansion of TennCare, a Section 1115 waiver program. Beginning in January 1998, TennCare was expanded to children up to age 19 with family incomes up to 200% of poverty. Unique circumstances allow uninsured children to enroll in TennCare until March 30, whereupon new enrollment will be closed, except to children up to age 19 in families with income up to 200% of poverty.
Texas	Children's health care plans are currently being developed.
Utah	Gov. Leavitt proposed to create a non-Medicaid program for children up to age 19 with family incomes up to 200% of poverty.
Vermont	Children's health care plans are currently being developed.
Virginia	Children's health care plans are currently being developed.
Washington	Washington is unlikely to participate in CHIP at this time.
West Virginia	Gov. Underwood proposed an initial Medicaid expansion for children up to age 6 with family incomes up to 150% of poverty. In a later phase, the governor hopes to provide non-Medicaid coverage to children up to age 19 with family incomes below 200% of poverty.
Wisconsin	The state has submitted a Section 1115 waiver program, BadgerCare, to provide health insurance to all children and families with incomes up to 185% of poverty.
Wyoming	Wyoming is unlikely to participate in CHIP at this time.

Sources: The National Conference of State Legislatures' Health Policy Tracking Service; the Bureau of National Affairs Health Care Policy Report; the National Journal's American Health Line; the National Governors' Association; and the Children's Defense Fund.

Note: States in bold had submitted CHIP plans as of 2/28/98.

Conclusions

The flurry of legislative activity devoted to children's health during 1997 state legislative sessions demonstrates that states are interested in expanding coverage for children. CHIP will help states expand coverage for children by providing an enhanced federal match for Medicaid expansions for children and new federal funds for non-Medicaid children's health initiatives developed by the states. Eighteen CHIP plans have already been submitted to HCFA for approval, four have been approved, and many more are under consideration.

One of the first choices states face is deciding whether to use CHIP funding to expand Medicaid or to create or expand non-Medicaid programs. During the debate leading up to the passage of CHIP, states demanded the flexibility to design their own plans. They did not want to be forced into a particular benefit package or delivery system. The inclusion of both options is a key feature of the CHIP legislation. The variety of proposed and submitted plans is a visible result of this freedom. A majority of states are choosing Medicaid expansions, but there are several non-Medicaid and mixed plans.

Three factors might explain why many states are leaning toward a Medicaid expansion in their initial proposals and submitted plans, even though a Medicaid expansion affords less flexibility than the creation of a state program. First, administrative structures and benefit packages for Medicaid are already in place, an advantage for states that want to act quickly. States with small numbers of uninsured children may also prefer Medicaid expansions because they do not have to set up a whole new program for relatively few individuals. Second, CHIP guidelines released by

HCFA assert that states choosing Medicaid expansions will receive federal funds at *Medicaid* matching rates if the state exceeds its CHIP allotment, whereas states that choose non-Medicaid plans cannot receive federal funding beyond the allotted amount. Lastly, states may want to establish consistent Medicaid eligibility criteria for children of all ages. Connecticut, Massachusetts, and New Jersey all plan to have one Medicaid income threshold for children through age 18. This type of change will simplify administration and outreach efforts, keep children from the same family in the same program, and make it easier to determine eligibility.

As states have more time to develop plans, the number of non-Medicaid programs will grow. The House Commerce Committee recently prepared a guide that suggests states would be better off creating new insurance programs, primarily due to the increased flexibility it affords.[6] For example, it is easier to impose cost-sharing requirements at higher income levels under a state plan. Another common argument in favor of non-Medicaid programs is that they are less expensive to the states, although the lower cost often reflects less generous benefit packages.

Ultimately, each state will determine which method of expansion is most appropriate for that state—a Medicaid expansion, a new state program, or both—based on its unique variety of programmatic and political considerations.[7] The resulting CHIP programs will likely be even more diverse than their predecessors.

Notes

1. The Balanced Budget Act of 1997 contains several children's health initiatives: the State Children's Health Insurance Program (Title XXI of the Social Security Act), provisions to enroll more Medicaid-eligible children, presumptive Medicaid eligibility, creation of pediatric diabetes programs, and restoration of Medicaid benefits for children who lost SSI as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

2. Congress initially legislated that states' Medicaid eligibility criteria as of June 1, 1997, would be used to determine CHIP eligibility limits and maintenance-of-effort requirements. Specifically, states with expanded eligibility for children on June 1, 1997, could set income eligibility standards for CHIP up to 50 percentage points higher for the affected age groups. If a state covered children up to age 18 with family incomes up to 185 percent of poverty, that state could set the income limit for CHIP as high as 235 percent of poverty for children up to age 18. In addition, states that reduce Medicaid eligibility may not use CHIP funds to cover children who would have been covered by Medicaid under the rules in effect on June 1, 1997. A legislative amendment changed this date to March 31, 1997, after Tennessee protested because it expanded eligibility only a few weeks before the original date (without this amendment, Tennessee would not receive CHIP funds for children covered by this expansion).

3. It should be noted that our categorization of states is meant only to illustrate the variety of coverage offered by states with respect to income and eligibility criteria. Some people may disagree with our classifications. We do not assume that they are immutable.

4. Sources include the National Conference of State Legislatures' Health Policy Tracking Service; the Bureau of National Affairs Health Care Policy Report; the National Journal's American Health Line; the National Governors' Association; and the Children's Defense Fund.

5. Children's Defense Fund, *Progress Report: Implementing the State Children's Health Insurance Program* (Washington, D.C., January 30, 1998).

6. House Committee on Commerce, *State Children's Health Insurance Program (S-CHIP) Implementation Guide* (Washington, D.C., November 1997).

7. For further discussion of these considerations, see Alan Weil, *The New Children's Health Insurance Program: Should States Expand Medicaid?* (Washington, D.C.: The Urban Institute, October 1997).

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This series is a product of Assessing the New Federalism, *a multi-year project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director, and Anna Kondratas is deputy director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.*

The project is funded by the Annie E. Casey Foundation, the Henry J. Kaiser Family Foundation, the W.K. Kellogg Foundation, the John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, the Commonwealth Fund, the Robert Wood Johnson Foundation, the Stuart Foundation, the Weingart Foundation, the McKnight Foundation, and the Fund for New Jersey. Additional support is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through grants to the University of Wisconsin at Madison.

The series is dedicated to the memory of Steven D. Gold, who was co-director of Assessing the New Federalism *until his death in August 1996.*

Publisher: The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037

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