Issue Brief

Great Expectations: *Fulfilling the Promise of the Children's Health Insurance Program*

R. Mollica

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ISSUE BRIEF

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Prepared by

Robert L. Mollica

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NATIONAL ACADEMY
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50 Monument Square, Suite 502
Portland, Maine 04101
Phone [207]874-6524
Fax [207]874-6527
E-Mail info@nashp.org

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Executive Summary

As of April 27, 1998, twenty-four states had submitted CHIP plans to the Health Care Financing Administration. Together, these states hope to extend health insurance coverage to nearly 1 million previously uninsured children in the first year of CHIP implementation and to increase that number to well over 2 million by the third year of the program. However, an analysis of the plans by the National Academy for State Health Policy suggests that the states may not be able to serve as many low-income, uninsured children—or to serve them as quickly—as was originally envisioned by Congress. As the report notes, the expectations for the program are considerable, so, too, are the challenges states face in implementing it.

The report—*Great Expectations: Fulfilling the Promise of the Children's Health Insurance Program*—notes that in establishing CHIP, Congress recognized the significant challenges facing states in their efforts to decrease the number of low-income, uninsured children. In order to provide states with the time and flexibility needed to establish or expand health coverage systems, the federal government has allowed states with approved plans to carry over—for two additional years—unspent appropriations from the first year of funding. According to the NASHP study, all nine of the states with plans that had been approved by the Health Care Financing Administration (HCFA) by April 7, 1998, will take advantage of this option.

The NASHP study, prepared by Robert L. Mollica, identifies and discusses five key barriers states have encountered in their efforts to achieve full enrollment and spending in year one. They are:

- **The time required for plan development, approval, and implementation**: Implementation requires states to have designed a program based on one of several models, secured authorization and funding from the state legislature, and obtained HCFA approval--all time-consuming tasks. As of mid-April, only 9 states had received HCFA aproval. Few states will begin implementating the program before the end of 1998.

- **State decisions that decrease the number of eligible children**. CHIP allows but does not require states to serve uninsured children in families with incomes up to 200% of the federal poverty level. Numerous states have chosen a more restrictive guideline due to concerns over crowd-out, limited state revenues, and/or historical, philosophical, or political reasons.

- **Lack of sufficient state matching funds**. Some states are reluctant to commit funds for large, on-going programs.

- **The impact of various crowd-out provisions on eligibility.** Efforts to restrict crowd-out, the substitution of private coverage for government funded programs, may make some children ineligible--at least for a period of time--from participating in CHIP.

- **The existence of state Medicaid expansions.** In an early effort to decrease the number of uninsured, low-income children, some states have already implemented Medicaid expansion programs, lowering the number of uninsured children needing CHIP coverage.

As the report notes, the pace and extent of implementation should not diminish the value and importance of CHIP. The 24 plans submitted to HCFA by early April 1998 and included in the NASHP study suggest that CHIP will not only significantly increase the number of low-income children with access to health insurance, it will also help to diminish the patchwork of Medicaid eligibility criteria that allows younger children to be eligible and older children in the same family to remain uninsured. It will also result in a streamlining of application forms and will expand outreach to identify those who are eligible for the existing Medicaid program.

The more cautious implementation schedule contained in the 24 plans will enable states to build infrastructure, test new program models, especially models that support employer coverage, and create a base for further expansion after the "shake-down cruise."

Summary

The Balanced Budget Act of 1997 (PL 105-33) created Title XXI of the Social Security Act, the State Children's Health Insurance Program (CHIP), perhaps the most significant expansion of health care coverage since passage of Medicare and Medicaid in 1965. As the implementation process begins, CHIP holds great promise to serve all eligible low-income, uninsured children, an estimated 2.9 - 4.0 million.

Yet warning signs already exist. The Congressional Budget Office has projected that only 2.3 million will be served by the third year of the program and that spending will be well below the amount appropriated by Congress. A NASHP review of CHIP implementation plans submitted by 24 states to the Health Care Financing Administration (HCFA) projects that no more than 1 million children will be served by these states in the first year. There is also disagreement about the number of eligible low-income children nationally and in states whose populations may not be accurately represented in national samples.

Do these early warning signs mean that the program will fail to achieve expectations? Do they reflect the fact that this worthwhile and valuable program addresses very complicated problems that are difficult to solve?

Early indications suggest that people interested in CHIP--Members of Congress, Governors, state legislators, state and federal policymakers, advocates, and families--need to have realistic expectations about what is possible and how soon it can be done. This paper examines what might be expected in the coming years as state and federal agencies begin the lengthy implementation process.

Background

As of April 7, 1998, 24 states had submitted CHIP plans to HCFA. In all, these states expect to cover up to 1 million low-income, uninsured children during the first year of CHIP implementation. How many children are actually eligible for the program in these states and in the nation is a matter of ongoing discussion.

CHIP may serve children in families with income below 200% of the federal poverty level. Given that upper limit, States may choose to limit coverage to a lower percentage of the poverty level. Estimates differ on the number of uninsured children in this country who belong to families with income below 200% of poverty. Of the estimated 11.3 million uninsured children, HCFA based its state CHIP allocations on the assumption that--if every state set eligibility at 200%--7.1 million uninsured children would potentially qualify for health coverage or Medicaid. Three million of these qualified children are eligible for, but do not participate in, Medicaid, and four million are eligible for the new CHIP program. However, the Urban Institute, using

Current Population Survey CPS data and its own simulation model, estimates that the number of potentially eligible children is between 4.6 and 7.6 million of which 2.9 million in both models are eligible for CHIP.[1] The remaining children would be eligible for Medicaid coverage.

However, the Congressional Budget Office (CBO) projects that 2.3 million uninsured children will enroll in CHIP by the third year of the program. The CBO also estimates that an additional 460,000 beneficiaries a year will be served by Medicaid as a result of the expanded outreach efforts that accompany CHIP. A review of the initial implementation plans submitted by 24 states confirms that the program will cover an estimated 1 million children in those states in the first year. This does not include children who are found eligible for and enroll in Medicaid due to the enhanced outreach. CHIP enrollment will build over time but is not likely to reach the enrollment and spending levels authorized by the law, at least in the near term.

The Balanced Budget Act of 1997 provides $20.15 billion to states over five years and $39.45 billion over ten years. For the first year of the program, allotments totaling $4.2 billion are available to states whose plans are approved by September 30, 1998. The allocation formula is based on each state's relative share of targeted low-income children and a cost adjustment factor that reflects variations in the cost of health care among states. To receive funding, states must submit a plan and receive approval from (HCFA). By April 7th, plans had been approved for Alabama, California, Colorado, Florida, Illinois, Michigan, New York, Ohio, and South Carolina. Plans have also been submitted to HCFA by Connecticut, Idaho, Massachusetts, Missouri, Nevada, New Jersey, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, and Wisconsin.

States may use the funds to cover "targeted low-income uninsured children," that is children in families with income below 200% of the federal poverty level, who are not eligible for Medicaid and do not have health insurance. Income eligibility levels may be raised 50 percentage points above the current threshold in states that have already raised eligibility standards. Hence, a state covering families and children with incomes up to 200% may set the CHIP standard at 250%. CHIP may be implemented by expanding Medicaid, developing a subsidized insurance program, or combining Medicaid and a subsidized program.

In addition to covering newly eligible uninsured children, CHIP requires that states screen for and enroll any child eligible for Medicaid under rules in effect on April 1997. To help states reach out and identify potential eligibles, President Clinton has announced an intensive effort to enroll eligible children in Medicaid. The initiative clarifies the use of existing Medicaid administrative funds and adds $25 million to the fund. The proposed budget also expands the range of organizations that can establish children's presumptive eligibility for Medicaid. This provision permits groups--child care resource and referral agencies, schools, child support

[1] Frank Ullman, Brian Bruen and John Holohan. "The State Children's Health Insurance Program: A Look At the Numbers." The Urban Institute. March 1998.

agencies, and CHIP eligibility workers--to approve temporary Medicaid coverage to uninsured children while the application is processed by the state Medicaid agency.

President Clinton has also directed eight Federal agencies administering programs that serve children to ensure that potentially eligible children are informed about Medicaid and CHIP, to develop outreach initiatives, and to simplify and coordinate application forms for multiple programs.

Expectations

Passage of CHIP has raised expectations that significant reductions will be achieved in the number of uninsured children. A recent news release from the U.S. Department of Health and Human Services proudly noted that enrollment in the eight states with approved plans is projected to reach one million children within three years.

Expectations are high and so are the stakes. Proponents of the program share an urgent desire to cover as many uninsured children as possible and fear that delays mean lost opportunities, risks to the program's future, and higher future costs both to society and to the health care system. Opponents, meanwhile, fear large government programs will increase spending, intrude on market forces, and undermine employer coverage. These opposing concerns put pressure on both federal and state governments to administer the program effectively by developing successful outreach and enrollment efforts, ensuring access to care, improving health outcomes, monitoring contracts, preventing workers or employers from dropping coverage (crowd out) because of the availability of insurance through CHIP, and other measures.

As states implement CHIP, expenditures and enrollment are the two simplest criteria to monitor progress. Yet, behind the figures lie complex political, administrative, and policy issues. A close examination of the challenges facing federal and state policy makers suggests that states will make significant progress during the first three years. Congress realized the limitations states will face during the start-up years when they allowed states to carry over unspent allocations for two years beyond the year for which the allocation was made. The barriers to full enrollment and spending are:

- Design, approval and implementation time
- State eligibility decisions
- Availability of sufficient state matching funds
- The differential impact of alternate crowd-out provisions
- Existing state Medicaid expansions which may lower the number of insured children.

Design, approval and implementation time

CHIP was signed into law in August 1997. To implement CHIP, states must submit a plan to HCFA, receive approval of the plan, and obtain authorization and funding from the state legislature. States have difficult design decisions to make before a plan is submitted, approved, and implemented. States may expand Medicaid, develop a private subsidized plan, provide services directly, or combine these options. The implications of these decisions are significant. Medicaid is an entitlement program, and states must enroll and serve all eligible applicants. States have more control and can limit participation in private subsidized plans based on the amount of funding available. In fact, federal funds will drop from $4.275 billion in FFY 2001 to $3.15 billion in FFYs 2002-2004 and increase to $4.1 billion in FFYs 2005 and 2006 and to $5.0 billion in FFY 2007. This drop may be cushioned by unspent carry-over funds, but the decline may raise caution flags for state policy makers who anticipate increased pressure on state Medicaid funding over time.

On the other hand, private subsidized programs require additional infrastructure that takes time to build. Provisions to prevent "crowd out" must be included in private programs and Medicaid expansions, and procedures for implementing these provisions must be designed. While the Act gives states welcomed flexibility, it means more time must be devoted to the design and implementation phase, which will delay plan submissions and therefore approval and start up.

By the middle of April, 24 states had submitted plans to HCFA, and nine had been approved. Implementation requires both HCFA approval and authorization and funding from each state's legislature. Colorado's legislature authorized a program but has not yet approved the state matching funds. The Massachusetts legislature has approved the program but will have to consider changes in the cost-sharing structure that were submitted to HCFA as part of the plan. Legislatures in many states are considering CHIP programs this year. Legislatures in Montana and Texas will not consider CHIP plans until 1999, although Texas may be able to implement a preliminary Medicaid expansion while further initiatives are developed.

Although nearly half the states have submitted plans, implementation will not begin in many states until the end of 1998, after the close of the federal fiscal year, or during 1999. Funds allocated to states for federal fiscal year 1998 can be carried over for two more years if the state's plan has been approved by HCFA. Enrollment and spending even among states with approved or submitted plans will likely be slowed because of the time needed to develop the infrastructure and fully implement the program. States developing new programs will probably take longer to develop and implement than Medicaid expansions.

While Tennessee plans to spend 80% of its allocation in FFY 1998, the highest of any state that had submitted a plan to HCFA as of March 1, 1998, the other states that have submitted plans project spending 21% of the federal allocation in the first year and carrying over unspent funds

for spending in subsequent years.[2] (See Table 1 for enrollment and federal allocation spending projections for each of the state's that have submitted a plan.)

Among the states with approved plans, Alabama's preliminary plan raises eligibility for children 14-18 in families with incomes under 100% of poverty. A broader expansion is being planned and may be submitted later in 1998. The state's approved plan will serve a projected 20,000 children and spend $5.9 million or 7% of its total available federal allocation of $85.9 million for Federal Fiscal Year (FFY) 1998. Total expenditures in FFY 1999 are expected to increase to $10 million in Alabama.

Once approved by the state legislature, Colorado projects spending $2.8 million in FFY 1998 of a potential $41.8 million allocation, and expects to increase that amount to $6.3 million in FFY 1999. South Carolina expects to spend $24.6 million, or 39% of its $63.5 million allocation. Figures for FFY 1999 were not included in the plan submitted by South Carolina.

Highlighting the need for additional start-up time, California's plan projects spending $33.1 million of its $854.9 million federal allocation in FFY 1998. Spending in FFY 1999 will be $172 million and $320 million in FFY 2000. Enrollment is projected to increase from 57,000 in FFY 1998 to 261,000 in FFY 1999 to 501,000 in FFY 2000. Most of the enrollment will occur in the subsidized plan operated by the Managed Risk Medical Insurance Board which has successfully developed and managed a sizeable small employer purchasing pool. Such steep growth curves would be considered highly successful in any start-up business.

The enrollment and expenditure data submitted by states is consistent with projections developed by the Congressional Budget Office (CBO). In a recent report, CBO projects that federal outlays for CHIP will be $1.1 billion in FFY 1998, $3.2 billion in FFY 1999, and $4.0 billion in FFY 2000.[3] As the report notes: "...Because of the start-up time necessary for states to develop their programs, submit plans to HCFA, and have those plans approved, most states will probably not be able to spend their full allotments for the first two years of the program anyway."

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[2] Spending for states submitting data based on their state fiscal year were adjusted to reflect the federal fiscal year: Colorado, Florida, Michigan and Ohio.

[3] Congressional Budget Office. "Expanding Health Insurance Coverage for Children Under Title XXI of the Social Security Act. Washington, DC. February, 1998.

Table 1. State CHIP Plans: Enrollment and Federal Allocation Spending Projections*								
State	**Eligibility**	**Federal Allotment (millions)**	**FFY 98 Projected Spending**	**FFY 98 Enrollment**	**FFY 99 Projected Spending**	**FFY 99 Enrollment**	**FFY 00 Projected Spending**	**FFY 00 Enrollment**
AL	100%	$85.9	$5.9	20,000	$10.0	NA	NA	NA
CA	200%	$854.9	$33.1	57,000	$172.4	261,000	$321.3	501,000
CO	185%	$41.8	$2.8	8,564	$6.3	10,701	$9.3	23,047
CT	300%	$34.9	$5.2	2,735	$19.2	13,403	$25.3	16,581
FL	185%	$270.3	$45.2	127,089	NA	NA	NA	NA
ID[1]	160%	$15.9	$15.9	7,538	NA	NA	NA	NA
IL	133%	$122.6	$18.5	40,400	$24.9	40,400	$25.3	NA
MA	200%	$42.8	$20.3	50,700	$50.1	NA	$53.6	NA
MI	200%	$91.6	$40.3	50,000	$85.2	NA	$86.1	NA
MO	300%	$51.7	$63.8	71,748	NA	NA	NA	NA
NV	200%	$30.4	$5.7	30,000	$30.7	43,000	NA	NA
NJ	200%	$88.4	$16.8	37,107	$70.2	85,944	$87.6	102,225
NY	222%	$255.7	$100.4	159,000	$138.4	NA	$134.6	NA
OH	150%	$115.8	$19.4	48,336	$44.5	102,749	NA	NA
OR	170%	$39.1	$1.5	17,000	$15.7	NA	$16.8	NA
PA	185%	$117.5	$50.2	56,548	$80.3	121,800	NA	174,000

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RI	250%	$10.7	$1.9	3,000	NA	NA	NA	NA
SC	150%	$63.6	$24.7	75,000	NA	NA	NA	NA
TN	200%	$66.2	$52.9	50,000	NA	NA	NA	NA
TX	100%	$561.5	$13.9	15,500	$45.7	45,800	NA	NA
UT	200%	$24.2	—	—	$7.6	10,500	$5.5	21,000
VT	300%	$3.5	$0.3	2,320	$3.9	7,763	NA	NA
WI	100%	$38.5	$1.1	2,092	$3.0	2,092	$3.1	2,092

* Note: The projected spending figures reflect the federal allocation, not the total projected federal and state spending.

1. The budget submitted by Idaho as part of its plan is based on drawing down the full allotment for year 1 although it is not assumed that the full allotment will be spent on enrollees during the first year.

2. Missouri has submitted an 1115 waiver which would serve children in families with incomes below 300% of poverty and spending would exceed the available federal allotment.

Eligibility decisions: Why states limit eligibility

CHIP allows, but does not require, states to serve uninsured children in families with incomes up to 200% of the federal poverty level. States which have expanded Medicaid eligibility are allowed to set CHIP eligibility 50 percentage points above the current level. However, states may set eligibility below this level for several reasons:

- Concerns about crowd-out (substituting government for employer coverage),
- Limited state revenues for matching funds,
- Historic differences in state Medicaid eligibility levels, or
- Philosophical or political reasons.

Of the plans submitted, eleven set eligibility below 200% of poverty. Alabama raised Medicaid eligibility for teenagers from 16% of the federal poverty level to 100% in Phase I (a further increase is anticipated); Illinois has set eligibility at 133%; Idaho, Ohio, and South Carolina, 150%; and Colorado, Florida, and Oklahoma, 185%. These decisions mean that uninsured children in families with income between the state's eligibility level and 200% of poverty will not be covered, thus reducing enrollment and the ability to fully draw down federal funds. Several states expect to implement CHIP in phases. They have submitted plans for Phase I with eligibility levels lower than 200% and anticipate raising the level in later phases. Six states have set eligibility above 200% of poverty which will partially offset "under" enrollment in states with lower eligibility levels.

Eligibility decisions affect potential enrollment. The 24 states that had submitted plans to HCFA by April 7 (and which account for 5.2 million Medicaid or CHIP-eligible uninsured children) estimate that they will enroll 1,044,548 children in Title XXI programs during the first year of implementation.[4] First-year enrollment projections range from 2,092 in Wisconsin to 159,000 in New York. Lacking solid baseline estimates of the number of CHIP eligible children makes it difficult to determine the impact in states that set eligibility below 200% of poverty. Illinois, which has 211,000[5] uninsured children under 200% of poverty (including Medicaid eligible children), will increase eligibility to 133% of poverty and expects to serve 10,400 children. Under its Phase I plan, Texas expects to serve 15,500 children in the first year and 45,800 in the second year. Like many states, Texas is working on a Phase II plan which may be submitted later in 1998 and would raise eligibility. (See Table 1 for projected enrollment levels).

[4] These figures do not reflect increased enrollment of children who are eligible for the regular Medicaid program.

[5] See HCFA Allotment to States for Fiscal Year 1998.

Lack of matching funds

While state legislatures are still meeting, two states (Wyoming and Washington) have voted against funding CHIP. In Washington, which already serves uninsured families and children with income up to 200% of poverty under the Basic Health Plan, the legislature voted not to appropriate funding to raise eligibility to 250% through CHIP. The Wyoming legislature has put off a decision until its next session. A school funding mandate and a weak economy were cited as reasons the legislature rejected a CHIP plan this year. Idaho's legislature reduced eligibility from 160% which was proposed in the state's CHIP application, to 150%. Action on legislation in North Carolina and Virginia has been hampered by disagreements about the nature and scope of the program. State contacts in at least three other states report that obtaining matching funds may be difficult in the first year. Congressional efforts have extended by a year the deadline for states to claim their first-year allotment. While revenues are strong in most states today, many legislators and governors are reluctant to commit funds for large, ongoing programs, in part fearing a "rainy day" when funds are not available.

Crowd out

CHIP's definition of a targeted low-income child does not allow any low-income child with employer coverage to participate in a subsidized, or non-Medicaid, program,[6] and states are required to describe how they will prevent employers from dropping dependent coverage or families from switching from employer coverage to CHIP. States with approved or pending plans have described several approaches to crowd out:

- Charge premiums
- Uninsured at enrollment, no waiting period
- Uninsured for three months
- Uninsured for six months
- Uninsured three months and employer paid at least 50% of premium
- Must enroll in employer plan with CHIP subsidy
- Uninsured for 12 months

Some states allow exceptions for people who have lost employer coverage because of lay-offs, death, a switch to self-employment or employment that does not offer dependent coverage, or expiration of COBRA coverage. Children in states that do not include the exceptions and families who may have made the decision to drop coverage without understanding the consequences will not be eligible for CHIP and will be counted as uninsured for the period of the exclusion. Requiring twelve months without coverage is more likely to affect the count of

[6] §2110(b)(1)(C) states that a targeted low-income child means a child who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

uninsured children than shorter periods. Two states have submitted proposals to support employee "buy-in" when employers offer coverage.

States operating existing programs for uninsured children (Florida, Minnesota, New York, and Washington) contend that the number of families switching from employer to public coverage is minimal. New York indicates that charging premiums has discouraged families from dropping existing coverage. A study of the MinnesotaCare program published in the October 1997 issue of the Journal of the American Medical Association found that "there was not significant evidence the MinnesotaCare enrollees are gaming the system, or that the program has resulted in significant erosion from the private market.[7]

Other studies have concluded that crowd-out occurs more frequently. A recent assessment of crowd-out states that "14% of the increase in Medicaid enrollment of pregnant women between 1998 and 1992 and 17% of the increased enrollment of young children was due to crowd-out."[8] An Urban Institute study[9] concluded that little crowd-out occurred for people below poverty; however, crowd-out resulted in 45% of the increased enrollment of pregnant women between 100% and 185% of poverty and 21% of the children between 100% and 133% of poverty. The CBO projections assume that 40% of new participants have access to existing and/or future private coverage. Some of these participants would drop employer coverage or fail to enroll in available plans while others, who do not now have access to insurance, work for employers who would have offered coverage in the future but will decline to do so because of government programs. The CBO report states that "over time, labor markets will adapt to the existence of federal subsidies, with low-income workers receiving more compensation in the form of cash wages and less in the form of health insurance."[10]

These findings suggest that future shifts from employer to public coverage are likely as CHIP is implemented, particularly through Medicaid expansions. The crowd-out controls proposed by states to meet the federal requirements could mean that income eligible children will be counted as uninsured during the period between losing or dropping employer coverage, serving the waiting period, and gaining CHIP eligibility. The frequency with which crowd-out does occur could increase among uninsured children. Although the increase would be offset by the children

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[7] Kathleen Thiede Call, PhD; Nicole Lurie, MD, MSPH; Yvonne Jonk; Roger Feldman, PhD; Michael D. Finch, PhD. "Who Is Still Uninsured in Minnesota? Lessons From State Reform Efforts." JAMA. October 8, 1997.

[8] Mark Merlis. "Employer Coverage and the Children's Health Insurance Program Under the Balanced Budget Act of 1997: Options for States." Institute for Health Policy Solutions. Washington, DC August 1997.

[9] Jean Hearne. "Coordinating Children's Coverage Expansions with Employer Sponsored Coverage." Institute for Health Policy Solutions. December 1997. Also: Lisa Dubay and Genevieve Kenney. "Did the Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" The Urban Institute. November 1995.

[10] Congressional Budget Office. Ibid.

added to coverage, it could affect state performance measures. If crowd-out does not occur, as the experience in some states predict, this effect would not occur.

Existing state Medicaid expansions

Market penetration experience

Since January 1993, HCFA has approved 18 comprehensive health care reform demonstration projects under Section 1115. The enrollment experience in 1115 demonstrations may give some indication of the likely penetration in CHIP. Nine have been implemented. Several of these demonstrations, and other state funded programs for the uninsured, have expanded eligibility beyond the 200% of poverty allowed under CHIP: Hawaii, 300%; Minnesota, 275%; Rhode Island, 250%; Vermont, 225%; and Washington, 200%. Tennessee provides subsidized coverage to families with incomes up to 300% of poverty, and families with higher income pay the full premium. These states account for 289,000 uninsured children, or 4% of targeted uninsured children, and $164.4 million of the $4.2 billion available for 1998.

While the majority of information available to date suggests cautious enrollment, three states which have implemented Medicaid expansions under §1115 demonstration program waivers experienced higher than expected enrollment during the initial start-up phase. In Hawaii, the state expected a total enrollment of 115,000 adults and children, but actual enrollment reached 161,000 in one year. Due to Hawaii's economic down turn, enrollment is now capped at 125,000 because state matching funds are limited.

Oregon raised Medicaid eligibility to 100% of poverty for adults, families, and children. A 2-7% drop in the percentage of uninsured residents between 1991 and 1995 was credited to the Oregon Health Plan, depending on the data source, while nationally the uninsured rate increased from 14% to 15%.[11] Oregon officials estimated that between 170,000 and 180,000 children and adults with incomes below 100% of poverty were uninsured. Enrollment of this expansion group reached 120,000 or 67% to 70% of the potential eligibles.

The experience in Tennessee, Minnesota, and Rhode Island suggests that penetration may be 50-56% of the potential eligibles. Tennessee expanded eligibility for subsidized coverage up to 300% of poverty and enrolled 400,000 uninsured adults and children in its first year. Enrollment for uninsured residents who were not eligible under previous Medicaid criteria was closed at the end of 1994 because budgetary ceilings had been reached. In April 1997, enrollment was re-opened, and 28,000 previously uninsured children have enrolled, 56% of the 50,000 children state officials expected to enroll.

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[11] Thomas Bodenheimer. "The Oregon Health Plan — Lessons for the Nation." New England Journal of Medicine. Volume 337. Number 9. August 28, 1997.

Rhode Island expanded eligibility for pregnant women and children under age 6 with incomes up to 250% of poverty through RIteCare in September 1994. The projected enrollment of 70,000 people included about 9,000 newly eligible uninsured women and children under age 6. Enrollment was phased in, grew steadily in the first year, and stabilized between September 1995 and March 1997 at 69,000 to 72,000 people. Under CHIP, Rhode Island raised eligibility for RIteCare to cover children age 8-18. Since the expansion, over 3,000 uninsured children have enrolled bringing total penetration of uninsured children to almost 50%. State surveys indicated that RIteCare has reduced the number of uninsured children from 10% to between 6-7%. For every applicant eligible under the expansion, one-and-a-half to two applicants were found eligible for Medicaid under the old rules. In August, the application and eligibility process will be streamlined and applications can be submitted by mail. These changes are expected to help increase penetration.

Minnesota implemented a major expansion for families and children with incomes up to 275% of poverty. At the outset, state officials projected that 50% of uninsured children would enroll in MinnesotaCare. Enrollment climbed steadily and reached 50% in three years. Based on state survey data, state officials estimate that another 50,000 children are uninsured, well below the CPS estimate of 91,000.

The experience in these states with Medicaid expansions suggests that enrollment projections of 50% of the potentially eligible uninsured children would be realistic and could take 2-3 years to achieve. However, state officials responsible for "stand alone" programs enrolling uninsured children contend that charging premiums further lowers enrollment, and 50% penetration may well exceed the likely enrollment in states which choose private plan approaches rather than Medicaid expansions.

Enrollment implications

Rhode Island and other states which expanded eligibility prior to CHIP have already lowered the rate of uninsured children and cannot claim expenditures for children enrolled through expansions implemented prior to May 1, 1997. Because it has already expanded eligibility, Rhode Island projects that the state will spend less than 20% of its federal allotment because there are fewer uninsured children who potentially qualify for CHIP. Other states expect a similar impact. These states are interested in developing family plans, but federal law prohibits using CHIP funds to pay for parents of uninsured children. State officials in some states contend that this penalizes states that expanded coverage prior to CHIP and provides additional funds to states that have not taken this initiative. A change in the law to allow family coverage would make use of the funds that otherwise will not be spent and would further extend health coverage to low-income families.

Factors affecting enrollment

While the majority of eligible children participate in state Medicaid programs, the presence of three million eligible but not enrolled children justifies an intensive effort to increase enrollment. President Clinton's widely publicized initiative and budget proposals will help states increase participation. Lack of participation has been attributed to several factors: complicated application procedures, lengthy verification requirements, frequent redetermination of eligibility, absence of information to families, and Medicaid's stigma as a "welfare program."

CHIP requires that states coordinate outreach and enrollment activities with Medicaid. In addition, states are already simplifying eligibility requirements and the application process to facilitate enrolling eligible families and children. HFCA and state Medicaid agencies have worked together to facilitate enrollment by standardizing income for all ages, using income alone and dropping an assets test to establish eligibility, streamlining the application form, allowing mail-in applications, and outstationing staff to community locations most likely to be used by potential eligibles. Other strategies include making staff available during evenings and weekends so working adults do not have to take time off from work to apply. HCFA has developed a prototype application that states might consider for both Medicaid and CHIP applications. In addition to the single application, using staff that can process applications for both programs eliminates the need for parents to go to another location to complete the application. HCFA and the Center on Budget and Policy Priorities report that 24 states use or plan to allow applications by mail, 29 states are shortening the application, and 36 states plan to drop the assets test.

CHIP offers states an opportunity to develop simplified and coordinated strategies for reaching families with uninsured children. These strategies are likely to increase Medicaid enrollment and improve penetration among CHIP eligibles; however, enrollment is not likely to reach 100% of the eligible children, and some states may be limited by the amount of state matching funds. When matching funds are limited, enrollment must be capped, and waiting lists may be used. Intensifying Medicaid outreach will also add pressure to state spending. Based on 1995 spending data, enrolling 3 million eligible children in Medicaid would raise expenditures by an estimated $4.1-4.4 billion. CBO projections suggest an average Medicaid enrollment of 460,000 and expenditures of $.6 billion. Some states are planning for increased Medicaid spending as a result of CHIP. Others may anticipate increased spending which is not reflected in their CHIP plans. As they formulate their budgets, states will have to approve funding for increased Medicaid enrollment due to enhanced outreach and CHIP matching funds. States will be entering a new arena and a cautious approach may lead some states to adopt lower eligibility levels at least until there is some enrollment experience.

Conclusion

CHIP constitutes a substantial expansion of health care coverage for uninsured children.

Congress gave states significant responsibilities for setting policy, implementing, and managing the program. States must also contribute financially, although at a reduced rate compared to Medicaid. Nevertheless, the early state plan submissions indicate that states, despite their cautious approach, will cover over 1 million uninsured children in the first year and well over 2 million by the third year. Establishing a state program requires a series of complicated decisions[12] that involve the approach (Medicaid, subsidized plan or combination), eligibility levels, benefits, the source and availability of state revenues, future growth and financial impact, impact on employer coverage, and equity. The result is that spending and enrollment will not reach the levels authorized by Congress certainly in the near term.

Congress recognized the difficulty of starting a complicated program when it allowed states to carry over unspent federal money for two years. CBO projects enrollment of 2.3 million children in CHIP after 1999, and federal outlays will be well-below appropriations. Our preliminary analysis confirms that many states will not spend their full allocation during the initial years of the program, and perhaps not even after stabilization, for the following reasons:

- The time required for plan development, approval and implementation.
- States may decide to set eligibility lower than the 200% of poverty allowed by statute.
- Matching funds may not be approved by state legislators in this first year.
- Participation rates are likely to be between 50% and 70% of eligible children.
- Participation rates for "stand alone" programs are likely to be less than 50%.
- The actual number of uninsured children may vary from the estimates used to allocate funds.

Underspending and measuring enrollment as a percentage of potentially eligible CHIP children may overshadow the real gains of CHIP. The methodologies for generating estimates of uninsured children who meet state Medicaid eligibility guidelines may under- or over-estimate potential enrollment for Medicaid and, therefore, CHIP.[13] Since many states are starting by setting eligibility levels below 200% of poverty, measuring actual enrollment may be the most realistic measure of progress. Determining the actual enrollment as a percentage of the total number of CHIP eligible children is likely to obscure the real benefit of the program.

The pace and extent of implementation should not diminish the value and importance of the program. The 24 plans submitted to HCFA by early April 1998 and included in the NASHP study suggest that CHIP will not only significantly increase the number of low-income children

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[12] See Elizabeth Mitchell and Trish Riley. "A Policymaker's Guide to the State Children's Health Insurance Program (CHIP)." National Academy for State Health Policy. January 1998.

[13] See Ullman et. al. The State Children's Health Insurance Program: A Look at the Numbers." Urban Institute.

with access to health insurance, it will also help to diminish the patchwork of Medicaid eligibility criteria that allows younger children to be eligible and older children in the same family to remain uninsured. It encourages and requires streamlining of application forms and expands outreach to identify those who are eligible for the existing Medicaid program. The more cautious implementation schedule will enable states to build infrastructure, test new program models, especially models that support employer coverage, and create a base for further expansion after the "shake-down cruise."