

The Children's Hour: The State Children's Health Insurance Program

Newly passed legislation to insure children is a key test of the popular concept of devolution from the federal to the state level.

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PROLOGUE: Estimates of uninsured Americans continue to tell a disturbing story: One of the largest groups of uninsured persons in this country (nearly one-quarter of all uninsured, by one recent estimate) is children. To partially fill this gap, the 105th Congress enacted the State Children's Health Insurance Program as part of the Balanced Budget Act of 1997. The program entails sharing of responsibility between states and the federal government and leaves a considerable amount of discretion in the hands of the states. This paper by Sara Rosenbaum and colleagues at George Washington University places the legislation in a policy context for insurance reform.

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ABSTRACT: The State Children's Health Insurance Program (CHIP) is the product of a series of policy and political compromises and generates numerous structural and policy issues for states. CHIP entitles states to federal financial aid to provide health assistance to targeted children, through Medicaid expansions, new program implementation, or a product of the two. States that elect to operate CHIP programs apart from Medicaid have enormous discretion under the law to determine how they will structure their programs, the services they will cover, the form that benefits will take, and the conditions of participation and consumer protections that will apply. Determining what approach to take, as well as how to respond to the choices posed by the statute, represents a major test of how states address the needs of children and families.

THE STATE CHILDREN'S HEALTH Insurance Program (CHIP) was enacted as part of the Balanced Budget Act of 1997.¹ CHIP holds the promise of extending insurance to a significant proportion of the nation's uninsured children. At the same time, the ambiguities of the law, as well as the sometimes conflicting policy and political undercurrents that run through the legislation, create numerous challenges for state policymakers, organizations, and individuals concerned with child health policy.

This paper begins with a summary of the legislation and then turns to the major implementation issues that the legislation raises.

The New Legislation

Codified as Title XXI of the Social Security Act, CHIP is a federal grant-in-aid program that entitles states that elect to participate to federal allotments to provide "child health assistance" to "targeted low-income children" who are ineligible for other insurance coverage, including Medicaid. The law is authorized for ten years; the total federal allotment available to participating states amounts to \$20.3 billion between fiscal years 1998 and 2002 and nearly \$40 billion over the life of the legislation.² The Health Care Financing Administration (HCFA) is responsible for administering CHIP, with joint oversight by the Health Resources and Services Administration (HRSA). The Congressional Budget Office (CBO) projects that CHIP will cover 2.8 million previously uninsured children assisted with CHIP funds and another 660,000 enrolled in Medicaid through CHIP outreach and eligibility screening efforts.³

CHIP is a reflection of numerous political and policy themes: health policymakers' concerns about the continued problem of uninsured children (an estimated 10.1 million children in 1996); belief on the part of the Clinton administration (whose own 1997 child health proposals were far more modest) and Congress that there should be at least some federal response to the problem of health coverage affordability; states' strong desire for flexibility in the cov-

erage of children; child advocates' demands for minimum legislative protections; and observers' concerns about the "crowd-out" effects of government insurance on private coverage.⁴

The final legislation is an attempt to blend all of these issues and concerns into one program; the result is an unusual statute that is far more complex than it first appears to be. To reduce the number of children without coverage while providing states with maximum flexibility, the legislation provides billions of dollars in new funding, which can be used in several different ways. To respond to the governors' concerns about the potential for uncontrolled spending and congressional opposition to new entitlements, the legislation entitles states, not children, to assistance and sets lower state financial obligation levels than Medicaid imposes. To respond to advocates' and policymakers' concerns that states will use the new funds to supplant previous state efforts as well as Medicaid coverage, the law requires aggressive Medicaid screening, precludes coverage of Medicaid-eligible children, and includes maintenance-of-effort requirements. Finally, to respond to policymakers' concerns about the crowding out of private insurance and uncontrolled federal spending on new government assistance, the law limits CHIP coverage to children without other forms of "creditable coverage," as defined in the Health Insurance Portability and Accountability Act of 1996, and caps federal financial contributions to state programs.⁵

Features Of The Program

CHIP offers participating states two basic approaches to the provision of "child health assistance": expansion of Medicaid, or establishment of a new child health assistance program to aid children who are ineligible for Medicaid or not covered by another form of "creditable coverage." States may combine these two approaches: That is, a state may use some of its CHIP funds to expand Medicaid and the rest to provide another form of child health assistance.

■ **Eligibility.** CHIP targets low-income children whose family incomes do not exceed 200 percent of the federal poverty level or 150 percent of a state's Medicaid income-eligibility level, whichever is higher.⁶

States that elect to expand Medicaid must follow all Medicaid eligibility rules regarding valuation of family income, geography, residency, and comparability of coverage. States that offer assistance through separate CHIP programs have broad discretion to set eligibility standards and can take into account geography, residency, disability status, access to other coverage, and age.⁷ However, a state may not deny coverage on the basis of a preexisting condition. Moreover, the law provides that states "shall, within any defined

group of covered targeted low-income children, not cover such children with higher family incomes without covering children with a lower family income.”⁸

Certain children are ineligible for CHIP as a matter of federal law. These are children who are eligible for Medicaid or who have other “creditable coverage” (such as coverage under an employer-group plan), children who are inmates of public institutions or patients of institutions for mental diseases, and children who are eligible for state employee health benefit plans.⁹

■ **Coverage of noncitizens.** CHIP is considered to be a “federal means-tested public benefit” under the immigration reform provisions in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.¹⁰ As a result, states that elect to create separate CHIP programs rather than to expand Medicaid may not use their federal funds to assist recently arrived (after 22 August 1996) “qualified alien” children (most noncitizen legal residents).¹¹ Furthermore, unlike Medicaid, CHIP is not a “designated” program available to long-term legal residents under the law. As a result, states that administer separate CHIP programs do not appear to have the option to use their federal funds to assist qualified alien children who resided in the United States on or before 22 August 1996.¹² Finally, unlike Medicaid, CHIP has not been classified as a program that can be used to finance emergency care to “nonqualified aliens” (including certain legal residents and undocumented persons). Consequently, states that administer a separate CHIP program may not use their federal funds to provide emergency assistance to such children.

■ **Benefits and cost sharing.** States that use CHIP funds to expand Medicaid must adhere to Medicaid benefit and cost-sharing rules. In the case of states that elect to establish a separate CHIP program, the statute authorizes states to offer “child health assistance” that is virtually as broad as that provided to children under Medicaid and also establishes minimum coverage and cost-sharing rules.

A state that operates a separately administered CHIP program must provide coverage that either meets one of several benchmarks or that is “equivalent to the benefits coverage in a benchmark package” and that covers certain “basic” services.¹³ Equivalence is determined in relation to the “aggregate value” of the benchmark for both “basic” services as well as “additional services” covered in the equivalent package.¹⁴ States may set the amount, duration, and scope limitations under their benchmark-equivalent plans and define the standard of medical necessity used to determine the extent of coverage, as long as the actuarial equivalency test is satisfied.¹⁵

Because CHIP is designed to aid low-income children, the law limits state discretion over premiums and cost sharing, with exten-

sive protection of children with family incomes under 150 percent of the federal poverty level and upper limits on cost sharing for other targeted children.¹⁶ The resulting permissible cost-sharing levels may be well below those found in the state's chosen benchmark package, as discussed below.

■ **Coverage choices.** States that elect to use CHIP funds to expand Medicaid have the same coverage choices as those that exist in Medicaid. Coverage can be furnished directly, with the state agency acting as an insurer. Alternatively, a state can elect to purchase coverage through a participating managed care organization or entity that meets federal conditions of participation.¹⁷ States that administer CHIP as a separate program appear to have similar options, including direct coverage, or coverage through the purchase of insurance or other products that meet state criteria.¹⁸ In addition, a state can apply to the secretary of health and human services (HHS) for federal waivers to provide coverage through "the use of a community-based health delivery system, such as through contracts with [federally funded] health centers and [disproportionate-share] hospitals." The secretary may grant such a waiver if the coverage offered by the system meets the benefit and cost-sharing requirements of the law and "if the cost of such coverage is not greater, on an average per child basis," than the cost of coverage under the state's other coverage arrangements.¹⁹ Finally, a state can apply to the HHS secretary for permission to offer coverage through premium payments to employer plans if the arrangement is cost-effective and will not lead to substitution of public for private coverage.²⁰

■ **Outreach and eligibility screening.** Outreach and enrollment are a required activity under CHIP. States must provide for "both intake and follow-up screening" and for enrollment in Medicaid of Medicaid-eligible children identified during the intake and screening process.²¹ States also must develop outreach programs for eligible children who are American Indians or Alaskan Natives.²²

■ **State/federal roles.** Under the statute, federal financial contributions for each state are capped at an annual aggregate level. Federal CHIP allotments are made in accordance with a formula that takes into account the number of low-income children, with and without insurance, with the formula weighted toward low-income children in the latter years of implementation, as the number of insured children grows.²³ The law provides for a minimum annual federal allotment; allotments to states are further adjusted to take into account geographic variations in health care costs.²⁴ Allotments to states remain available for three years, and the HHS secretary is authorized to reallocate unused funds to states that have used up their allotments. Certain federal Medicaid expenditures claimed by

participating states count against a state's individual allotment.²⁵

States draw down on their aggregate CHIP allotments by incurring costs for the provision of "child health assistance" to eligible children. The federal CHIP contribution is equal to a state's "federal medical assistance percentage" (FMAP) increased by 30 percent of the difference between 100 and the state's FMAP, but is capped at 85 percent.²⁶ As with Medicaid, CHIP expenditures may not supplant coverage obligations of legally liable third parties (which in the case of a separately administered CHIP program includes Medicaid). Thus, no federal payment for child health assistance can be made for state expenditures that are "duplicative" of payments that would have been the obligation of a private insurer or an employee benefit plan.²⁷ Moreover, CHIP coverage is residual to payments by "any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service."²⁸ Finally, states must use 90 percent of their federal allotments to provide child health assistance; in the absence of secretarial waivers to initiate certain community-based health care initiatives or to use funds to purchase family coverage through employer plans, states may spend only 10 percent of CHIP funds on administration, outreach, and enrollment and for broad-based health services initiatives aimed at improving child health.²⁹

States must contribute toward the cost of CHIP. The federal statute establishes certain criteria for determining allowable state expenditures, the most important of which is an extension to CHIP of Medicaid's prohibition against the use of provider taxes or donations to finance the state share of CHIP.³⁰ The law also requires that states maintain their Medicaid programs at June 1997 levels. States also must maintain a 1996 level of effort with respect to other state child health expenditures, including expenditures under existing state comprehensive benefit programs.³¹

■ **State plan requirements.** In developing their child health plans, states must use a process that "involve[s] the public in the design and implementation of the state plan" and methods "for ensuring ongoing public involvement." States are prohibited from eliminating or restricting eligibility without prior public notice, furnished in whatever form is required under state law.³² States also must satisfy certain requirements related to the content of state plans, the provision of data in a form and manner prescribed by the HHS secretary, and the performance of annual assessments and studies relating to program operation and progress in reducing the number of uninsured children.³³ Longer-term state evaluations of program performance also are required.³⁴

■ **Federal demonstration authority.** The statute makes the Social Security Act's Section 1115 authority applicable to CHIP and authorizes the HHS secretary to waive one or more federal state plan requirements to permit demonstrations under the program.³⁵

Key Implementation Issues

CHIP raises a series of complex policy, political, and programmatic choices for states. Furthermore, it is unlikely that HCFA will promulgate extensive formal regulations, particularly since states view CHIP as a block grant program. Consequently, states will be called upon to make most key decisions independent of detailed federal policy statements.

A series of choices confront states as they implement the program. The most basic is whether to entitle eligible children to aid and, if so, whether or not to establish the entitlement as a Medicaid benefit. States that choose a separate CHIP path in part or in whole (anecdotal evidence to date suggests that most states are leaning toward a mix of the two options) will face numerous choices: eligibility standards; benefit package; the form in which child health assistance will be furnished and the conditions of participation for CHIP providers and entities; and consumer protections. Finally, states will have to design outreach and enrollment programs (including a highly integrated Medicaid/CHIP eligibility determination process in the case of states with separate CHIP programs), generate state contributions, and design a public accountability mechanism.

■ **Medicaid versus a new program.** Important arguments for CHIP implementation through Medicaid expansion have emerged.³⁶ As a practical matter, this strategy avoids the problem of having to establish and staff a new state agency. It also avoids a potentially damaging policy and political debate over the scope of the benefits package (which was a significant component of the federal debate, reflected in the final, confusing provisions regarding minimum benefits requirements), as advocates of a relatively modest major medical package square off against those who believe that near-poor children with disabilities and chronic conditions should have the same unique breadth and depth of coverage given to the poorest children in Medicaid.³⁷ In the absence of evidence that the Medicaid benefit package leads to significantly higher premiums than a separately administered CHIP program would require, there is no reason to believe that the Medicaid route would be more costly per capita.³⁸

Such a strategy also permits states to unify the standards and methods used to determine eligibility, which is important because children must be deemed ineligible for Medicaid eligibility before they can receive CHIP benefits. Moreover, as noted, coverage

through Medicaid permits states to reach legally resident children. It also permits states with large American Indian populations to take advantage of highly preferential federal financial contribution rules with respect to the cost of medical assistance furnished through the Indian Health Service and tribal organizations.³⁹

In addition, a Medicaid expansion strategy permits a state to treat virtually all administrative costs as medical assistance costs, thereby avoiding the 10 percent aggregate upper limit on administration and case finding and freeing that portion of its allotment for populationwide child health initiatives. Finally, if the number of eligible children exceeds a state's projections, implementation through Medicaid assures federal financial participation up to the level of enrollment rather than merely up to an aggregate annual cap.

Advocates of a separate CHIP program counter that the new agency argument is incorrect, since the program can be administered by existing agencies. They also argue that whatever administrative ease and financial advantages are gained through Medicaid expansion are offset by the stigma attached to Medicaid.⁴⁰ They also point to the availability of the Medicaid "spend-down" program in states whose Medicaid plans include coverage for the medically needy as a way to cover children who need added assistance for long-term and chronic conditions.

Perhaps the most potent argument of proponents of a separate CHIP program is the entitlement argument. According to this argument, whole or partial CHIP implementation through Medicaid expansion obligates a state to offer assistance to all eligible children, thereby losing control over caseload growth. While no study of Medicaid points to the cost of covering children as the cause of states' Medicaid fiscal problems, the fact is that in the "post-entitlement" world of welfare reform, one of the most politically difficult issues to overcome is the specter of uncontrolled caseload, particularly when coupled with fears of private insurance crowd-out.⁴¹ Proponents of Medicaid expansion point out that this concern needs to be balanced against the equally powerful adverse political image of thousands of children on waiting lists for health care assistance, when, had the state chosen the Medicaid pathway, the children would have received aid. Finally, Medicaid proponents argue, the fact that Medicaid eligibility screening is a precondition to CHIP coverage blunts the argument that a separate CHIP strategy allows for caseload controls. It is conceivable that states' Medicaid child caseloads will grow significantly in any event, simply as a result of the Medicaid coordination requirements of CHIP.

A decision to establish a separate CHIP program does not end the entitlement discussion. Just because children are not entitled to

CHIP assistance as a matter of federal law does not mean that they cannot be entitled to assistance under state law. It is doubtful that any state would take this step outside of the Medicaid statute, since agreeing to entitle eligible children under a non-Medicaid capped assistance program obligates a state to spend its own funds to reach all eligible children. Nonetheless, the problem of waiting lists of eligible children is real enough in states that have established child health programs, so that the pressure not to produce such a list needs to be considered carefully.

Regardless of whether a state establishes a separately administered program as an entitlement, it must decide what eligibility standards to use. Under Medicaid, states are constrained in their eligibility options unless they operate under Section 1115 waiver authority. Coverage must be statewide. No preconditions to coverage that are not authorized under the statute can be imposed. Special rules for the evaluation of income and resources apply. The ability to limit coverage by age or disability status is seriously constrained. As a general matter, the statute prohibits states from applying different financial standards and methodologies to different subcategories of applicants within the same general category.

On the other hand, CHIP gives states broad discretion over eligibility standards, both financial and otherwise. Other than requiring that the poorest children be aided first, the law grants states significant leeway to impose residency or geographic limitations, waiting periods, and other conditions. Each condition adds to the complexity of the application process and reduces the number of eligible children; furthermore, each condition used that is prohibited under Medicaid increases the difficulties involved in screening applicant children twice: once for Medicaid and again for the separate CHIP program. In families with several children, it is conceivable that different children in a family would be eligible for different programs, thereby making that family's life even more difficult. Nonetheless, states may wish to target certain children or communities.

■ **The benefits package.** States that elect to administer separate CHIP programs must decide on the CHIP benefits package. The basic requirements are minimal (states can use a major medical "benchmark" or else devise an equivalent package of their own). As noted, however, the definition of "child health assistance" permits coverage of virtually any service that is recognized as "medical assistance" under the Medicaid statute. Consequently, states must decide which classes of services will be included and whether to limit the benefits package to major medical coverage or to include coverage for at least certain chronic and long-term care needs. States with separate CHIP programs also will have to decide whether to use the

“Whatever form a state ultimately is used to provide child health assistance, that form should be compatible with Medicaid.”

traditional exclusions and limitations, including the restrictive standard of medical necessity, that are used by private insurers.⁴²

Furthermore, states with separate CHIP programs will need to reconcile their “benchmark” choices with CHIP’s limitations on cost sharing. In calculating the value of a benchmark for premium and cost estimation purposes, both the classes and extent of benefits as well as the level of cost sharing must be considered. Because CHIP prohibits significant cost sharing, the value of the benchmark or equivalent package that is selected will increase, thereby reducing the estimated number of children that will be covered. HCFA’s interpretation of the provisions limits the use of a benchmark to the extent that the benchmark selected by the state contains cost-sharing requirements that exceed permissible statutory levels.⁴³

■ **The form of child health assistance.** One of the most interesting aspects of the statute is that the law does not spell out the form that separately administered CHIP benefits must take. CHIP requires that states furnish “child health assistance” to eligible children, just as Medicaid requires states to furnish “medical assistance” to eligible persons. As with Medicaid, benefits can be offered directly by a state agency acting as its own insurer or through private organizations. The CHIP statute places no limits on the types of private organizations that can contract with CHIP agencies. For example, the law appears to permit the use of primary care case management (PCCM) programs under which individual providers contract with a state to offer primary care and arrange for other covered services. This option is directly analogous to the Medicaid PCCM option under the Balanced Budget Act of 1997 as well as the Medicaid Section 1915(b) waiver program. States might be expected to pursue a combination of strategies, particularly if they wish to allow community providers to act as case managers or if states lack an insurance or HMO market that desires to respond to a CHIP solicitation.

In states that separately administer CHIP, whatever form ultimately is used to provide child health assistance, that form should be compatible with Medicaid with respect to enrollment options and conditions of participation. Otherwise, many children will effectively bounce among plans and providers, as monthly family income fluctuates and they move from Medicaid to CHIP and back again. Forcing families to also change plans and providers each time

their child's payer sponsorship changes will add to their difficulties.

States also will need to decide whether to seek federal waivers to offer child health assistance in the form of family contributions to employer-sponsored or other private insurance plans. This form of assistance more directly implicates the crowd-out problem, because the availability of such a contribution might encourage employers to eliminate family coverage. The evidence of crowding out is controversial, and HCFA has not yet announced the standards it will use to determine whether a state's plan encourages crowding out. Some states have considered imposing a waiting period on families. Although such an approach may deter a family from dropping private coverage in exchange for a government subsidy, it probably would do little to alter the behavior of employers that wish to drop coverage.⁴⁴

Unlike the Medicare and Medicaid statute, the CHIP law contains no minimum health plan enrollment and consumer protections. The Medicare and Medicaid amendments to the Balanced Budget Act of 1997 contain numerous provisions regarding safeguards against misleading or fraudulent enrollment, protections for persons enrolled in plans, and other provisions designed to safeguard individual interests.⁴⁵ Since CHIP is utterly silent on these matters, states will have to fashion their own safeguards and consumer protections.

■ **State financial share and accountability.** Regardless of how states administer CHIP, they will have to come up with the state share. As noted, many CHIP administration costs would qualify as state Medicaid administrative costs were CHIP implemented through Medicaid expansion, particularly costs related to outreach and screening. Since Medicaid costs will rise even under a separate CHIP program as more children are separately found eligible for and enrolled in Medicaid as a precondition, treating these costs as Medicaid expenditures may make the most sense.

A central issue for states is whether to reduce state spending on direct health care delivery programs (for example, grants to community clinics and school health programs) to fund CHIP. The advantages of generating new insurance funds must be offset against the potential impact of the loss of state funding by community providers and programs that serve both Medicaid and CHIP-eligible and -ineligible children. While it would seem that these providers could regain their funding by becoming Medicaid and CHIP providers, anecdotal information on Medicaid managed care suggests that community providers may lose revenues under Medicaid managed care because they are not positioned to participate in insurance programs and because many of their services are not considered insured services. Even if they do participate, these providers may

experience serious rate reductions that reduce their services.

■ **Outreach and enrollment.** States will have to design outreach programs that include enrollment screening and eligibility determinations for Medicaid in order to avoid the financial penalties (a disallowance of federal contributions) that apply when CHIP funds are used to cover children who are eligible for Medicaid. Case-finding activities thus will have to transcend outreach campaigns and will have to incorporate detailed screening procedures that ensure that CHIP is not used to supplant Medicaid coverage.

Challenges For The States

The law governing CHIP gives states extensive choices and is thus a key test of the concept of devolution. In making their choices, states will need to separate ideological arguments and concerns from pragmatic issues so that where an implementation choice rests on philosophical considerations, its costs are known. The most difficult choice of all is whether to run a separate program. The effort involved in doing so is much greater, and the potential for disallowance of federal funding, much higher. In the end, however, states may choose the separate program pathway either in part or in whole, because despite the difficulties raised, the potential for certainty in spending and the desire to avoid a new entitlement are more important than the practicalities of separate administration.

States might, of course, run “shadow” Medicaid programs with CHIP funds, to get the best of both worlds. Under such a program, the rules for Medicaid eligibility, benefits, cost sharing, provider participation, and consumer protection would apply, and Medicaid would bear the costs of identifying Medicaid children. However, because the program would operate under Title XXI authority, a state could impose an enrollment cap. This approach may offer states a strategy to gain experience with enrollment and gauge the potential for uncontrolled costs while avoiding the difficulties for families caused by running two separate programs.

In the end, whatever choices a state makes should be guided by the needs of its families and its children. To the extent that getting the best possible coverage for children becomes the defining criterion, a state’s choices are bound to be wiser than when separate considerations take priority.

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NOTES

1. P.L. 105-33, 105th Cong., 1st sess.
2. The total cost of CHIP is estimated by the Congressional Budget Office at \$23.9 billion over the FY 1998-2003 period. This figure includes the projected cost of certain child health-related Medicaid reforms also included in the Balanced Budget Act. See S. Rosenbaum and J. Darnell, *An Analysis of the Medicaid Provisions of the Balanced Budget Act of 1997* (Washington: Kaiser Commission on the Future of Medicaid, September 1997).
3. An estimated three million children are eligible for Medicaid but are not enrolled. Center on Budget and Policy Priorities, *Millions of Uninsured and Underinsured Children Are Eligible for Medicaid* (Washington: CBPP, 1996).
4. For 1996 estimates of uninsured children, see P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1996 Current Population Survey," *EBRI Notes* (January 1997). In the administration's 1997 child health proposals, President Clinton proposed certain modest Medicaid expansions, more case finding, and a new \$750 million child health block grant. *Budget of the United States* (Washington: U.S. Government Printing Office, 1997). Regarding states' desire for flexibility, Congress specifically rejected in 1997 a National Governors' Association request to build greater flexibility into children's coverage through revisions to Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. For a discussion of crowd-out, see the excellent series of articles in *Health Affairs* (January/February 1997).
5. P.L. 104-191. The term *creditable coverage* includes health insurance, employer health plans, Medicaid, and other public or private third-party assistance.
6. Sec. 2110(b)(1) of the *Social Security Act*. In 1997, 200 percent of the federal poverty level amounted to about \$32,000 for a family of four.
7. Sec. 2102(b)(1).
8. Sec. 2102(b)(1)(B). It is unclear whether this provision would require the termination of coverage under a state's Title XXI health insurance program of less-poor children in cases in which poorer children are awaiting coverage. Since children are not entitled to Title XXI state insurance coverage under federal law, unless a state establishes its program as a state entitlement and funds the program at sufficient levels to cover all children who apply and are determined eligible, it is highly possible that there will be queuing for services.
9. Sec. 2102(b).
10. Title IV, P.L. 104-93. See the Health Care Financing Administration's response to question 19(a) (11 September 1997).
11. Newly arriving qualified aliens are entitled to emergency Medicaid coverage if otherwise eligible for medical assistance.
12. Sec. 402(b)(3), P.L. 104-193. States that spend Title XXI funds to expand Medicaid, though, may elect to provide full coverage to children who were legal residents as of 22 August 1996.
13. For their benchmarks, states may select from among the following: (1) the standard Blue Cross/Blue Shield preferred provider option offered to federal employees; (2) the state employee health benefit plan; or (3) the plan offered by the health maintenance organization (HMO) with the largest non-Medicaid commercial health enrollment in the state. Sec. 2103(b) of the *Social Security Act*. Basic services are inpatient and outpatient hospital care, physicians' surgical and medical services, laboratory and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Benchmark-equivalent packages must cover these services up to 100 percent of their aggregate actuarial value. Sec. 2103(a)(1).

14. State benchmark-equivalent packages must cover certain additional services (prescribed drugs, mental health services, vision services, and hearing services) if such services are covered in the benchmark selected by the state, up to 75 percent of their aggregate actuarial value.
15. Unlike Medicaid, which does not operate according to insurance principles of coverage, standard insurance plans typically impose insurance-driven limitations on coverage. Thus, coverage may be limited to treatments for illness and injury and may deny coverage for conditions such as developmental disabilities. Similarly, insurance may deny coverage if there is no prospect of a full recovery, whereas Medicaid provides extensive coverage for chronic conditions from which recovery may not be possible. Finally, benchmark insurance may place limits on covered services that would not be permissible in the case of Medicaid for children (for example, covered services furnished in schools).
16. First, “state child health plans may only vary premiums, deductibles, coinsurance and other cost sharing . . . in a manner that does not favor children in families with higher income over children from families with lower income.” Sec. 2103(e)(1). Second, state plans may not impose cost sharing on well-baby, well-child, and age-appropriate immunization services. Sec. 2103(e)(2). Third, in the case of children from families with incomes at or below 150 percent of the federal poverty level, states are prohibited from imposing premiums or enrollment fees that would not be permissible under Medicaid sec. 2103(e)(3) and must maintain cost-sharing rules that are nominal. Sec. 2103(e)(3). Finally, in the case of targeted children with incomes above 150 percent of poverty, premiums, deductibles, and cost sharing may be imposed on an income-adjusted sliding scale basis. However, the “total annual aggregate cost sharing with respect to all targeted low income children in a family may not exceed 5 percent of the family’s income for the year involved.” Sec. 2103(e)(3).
17. See Rosenbaum and Darnell, *An Analysis of the Medicaid Provisions*.
18. The breadth of state options in this regard can be seen in HCFA’s answer to the question of whether a state could give health centers funds to expand and cover children for “certain services.” In HCFA’s view, “A State may pay a community health center to obtain the minimum child health assistance benefits coverage for eligible children. In that instance a community health center would, if qualified, furnish such coverage independently [o]r . . . provide some of the health benefits and develop arrangements with other providers to furnish the remaining scope of such coverage.” Presumably a state could enter into the same arrangement with other classes of providers.
19. Sec. 2105(c)(2). It is unclear why a state would pursue a federal waiver option in light of the broad discretion it has under its own authority.
20. Sec. 2105(c)(3).
21. Sec. 2102(b)(3).
22. Sec. 2102(b)(3)(D).
23. 62 *Federal Register* 48098 (12 September 1997).
24. Each state at a minimum receives an annual allotment of \$2 million. Secs. 2104(b)(4) and 2104(b)(3).
25. For example, federal contributions attributed to the cost of extending presumptive (temporary) Medicaid eligibility to children are counted against subsequent CHIP expenditures, as are the additional federal payments to states that use CHIP to expand Medicaid.
26. 62 *Federal Register* 48098 (12 September 1997).
27. Sec. 2105(c).
28. Sec. 2105(c)(6).
29. Sec. 2105(a)(2). States may apply for federal waivers of the “90 percent rule” to enter into agreements for community-based coverage offered by health centers

- and disproportionate-share hospitals or to purchase family coverage.
30. Sec. 2107(e)(1)(C).
 31. Sec. 2105(d). These expenditures can be applied toward the state's CHIP.
 32. Sec. 2106(b)(3)(B).
 33. Sec. 2108(a).
 34. By 31 March 2000 states must submit assessments that consider the effectiveness of a state's program in increasing the number of children with health insurance coverage, the number and characteristics of the children assisted, the quality of coverage, the sources of nonfederal funding the state uses, the service areas covered by the plan, and other matters. Sec. 2108(b).
 35. Sec. 2107(e)(2). HCFA indicated in September 1997 that it would entertain no demonstration proposals until the agency and the states had gained more experience with implementation of the law as enacted. Several states that already have expanded coverage to children and are interested in applying new funds toward expansion of coverage to adults have protested this decision.
 36. See, for example, A. Weil, *The New Children's Health Insurance Program: Should States Expand Medicaid?* (Washington: Urban Institute, 1997).
 37. R. Rosenblatt, S. Law, and S. Rosenbaum, *Law and the American Health Care System* (Old Westbury, N.Y.: Foundation Press, 1997), chaps. 2 and 4.
 38. Moreover, no state contracts with managed care organizations for the full Medicaid pediatric benefit package. S. Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (Washington: George Washington University, 1997). Thus, as a practical matter, proper comparison may be between the CHIP premium and the Medicaid managed care premium.
 39. These specialized, enhanced federal payment rates (amounting to 100 percent of the cost of covered services) are explained in a HCFA/Indian Health Service Interagency Agreement (Washington, D.C., 19 December 1996).
 40. Anecdotal evidence suggests that states whose Medicaid child health expansions include a new name and a simplified application and application process consistently report that enrollment rates rise and that families aggressively seek out coverage.
 41. Indeed, even the Medicaid child health expansions of the late 1980s, which caused a higher growth in the number of insured children than that predicted by the CBO under CHIP, added only modestly to Medicaid's overall cost increases. J. Holahan et al., estimates of Medicaid growth factors for the Kaiser Commission on the Future of Medicaid, Washington, D.C., 1995. As for caseloads, states have numerous overt and subtle ways to control caseload. Limiting expansions of eligibility standards can help to control growth. Furthermore, a small welfare agency workforce, coupled with a long application, short office hours, and a lack of aggressive application assistance, all can help to keep caseload growth down.
 42. See Rosenblatt et al., *Law and the American Health Care System*, chap. 4, for a general discussion of the distinctions between insurance and Medicaid concepts of medical necessity. See also Rosenbaum et al., *Negotiating the New Health System*, vol. 2, chap. 2.
 43. Title IV, P.L. 104-93. See HCFA's response to question 2(b) (11 September 1997).
 44. Of course, a family earning, for example, 175 percent of the federal poverty level faces such difficult choices in meeting its daily living costs that one cannot help but wonder why such a family should not have the option of using an available subsidy and applying the money previously spent on health insurance to some other good use such as child care or food.
 45. Rosenbaum and Darnell, *An Analysis of the Medicaid Provisions*.