Between 7 million and 10 million children in the United States lack health insurance. Many of these uninsured children experience difficulty obtaining needed health care. To expand health insurance coverage for children, in August 1997, Congress enacted the State Children’s Health Insurance Program (CHIP) as part of the Balanced Budget Act of 1997. CHIP, also known as Title XXI of the Social Security Act, offers states new federal funding in the form of block grants to provide “child health assistance to uninsured children in low-income families in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.” The program is authorized for 10 years and is expected to provide insurance coverage for millions of currently uninsured children. Federal expenditures on child health assistance under the law are estimated to total $40 billion to $50 billion over the life of the legislation.

The enactment of CHIP represents the most significant funding increase for children’s health insurance coverage since the enactment of Medicaid in 1965. Medicaid, a means-tested entitlement program financed by the state and federal governments and administered by the states, covered approximately 17.5 million children in 1995. Medicaid covers approximately two-thirds of all poor children and one-quarter of the children in families with incomes between 100% and 200% of the federal poverty level. Despite expansion of the Medicaid program in recent years, many children in low-income families remain uninsured. CHIP is intended to address this problem.

Although participating states must provide some funding, and states must meet a number of requirements to be eligible for federal CHIP funding, CHIP legislation gives states considerable flexibility in implementing the program. This short article reviews the basic decisions that states must make when implementing their CHIP programs and reports on the decisions that states participating in the program have made, as reflected in the plans they had submitted to the Health Care Financing Administration.
(HCFA) as of April 1, 1998. Because the implementation of CHIP is very much a work in progress, a guide to frequently updated, primarily electronic, sources of information about the CHIP program and other efforts to expand coverage for children and their families is also provided in Box 1.

**Choices That States Face**

**Participation**

Whether or not to participate in the CHIP program is the most fundamental choice states face. Although CHIP is expected to reduce the number of uninsured children and provide participating states with millions of federal dollars, CHIP does impose some burdens on states. Because federal CHIP funds are matching funds, states need to contribute to the program. In addition, participating states must maintain their Medicaid programs for children at pre-CCHIP levels, and Medicaid enrollment in participating states is expected to increase because outreach efforts for the new program will likely bring in children who were already eligible for existing Medicaid programs but were not enrolled. This will increase state outlays for Medicaid. States also face increased responsibilities to design, implement, administer, and evaluate their CHIP programs. In most states, action by the state legislature will be required. The need for legislative action may delay implementation of CHIP in states where legislatures meet biannually or where legislative sessions are brief.

Prior to CHIP, states had considerable flexibility to expand health insurance coverage for children in low-income families through waiver provisions and options in existing Medicaid statues and through state-only programs. As of mid-1997, some 41 states had expanded Medicaid programs for children and pregnant women beyond federal mandates, while at least eight states had state-only programs to subsidize the purchase of insurance with more limited benefits than Medicaid. Three key differences between CHIP and existing programs to cover children in low-income families have caused many states to more seriously consider using CHIP to expand children’s health insurance coverage: (1) the CHIP enhanced match rate essentially reduces by 30% the share of costs that states will pay, as compared to what they would contribute using their regular Medicaid match rate; (2) as described below, states have even greater program flexibility than was available under existing Medicaid waiver programs; and (3) publicity surrounding the launch of the new program has been very positive, with an emphasis on providing health insurance for children in working-class families, in contrast to the Medicaid program, which was frequently stigmatized as a “welfare” program.

Until recently, states needed to receive HCFA approval of their CHIP plans by October 1998 to pull down their allotments of federal funds for Fiscal Year (FY) 1998 (October 1997 to September 1998). In that context, some states filed limited plans with HCFA as placeholders to reserve their federal allotments for the year. However, with the enactment of a supplemental appropriations bill in May 1998, the deadline was extended for a year, giving states that had difficulty developing CHIP plans another chance to reserve their FY 1998 allotments. States that fail to gain approval before October 1999 will forfeit their FY 1998 and FY 1999 allotments, and the unused funds will be distributed to states with approved plans. States with approved plans are not required to use their full allotments of
Many organizations are actively participating in the ongoing development of Title XXI programs and are good sources of timely information. All of the organizations listed below can serve as resources on Title XXI, and will be able to provide, on their Web sites, updated information as the program progresses, and links to other organizations that also have an interest in Title XXI. Many also sponsor newsletters, teleconferences, and topical reports.

**FEDERAL GOVERNMENT**

**Health Care Financing Administration (HCFA)**
(phone number not available)
http://www.hcfa.gov/init/children.htm
Current regulatory information can be found at the HCFA Web site, including a model application template, the text of letters to state officials, and answers to frequently asked questions.

**OTHER SOURCES OF INFORMATION**

**American Academy of Pediatrics (AAP)**
(847) 228-5005
http://www.aap.org/advocacy/schip.htm
AAP publishes weekly updates on state-level activities related to CHIP on its Web site, which also includes downloadable reports on eligibility and funding, and detailed tables on state approaches to the new program. The site also provides a review of AAP’s recommended benefit package for children.

**Children’s Defense Fund (CDF)**
(202) 662-3551
http://www.childrensdefense.org/healthystart.html
CDF provides information about state implementation of CHIP and about related topics on its Web site. CDF also sponsors an e-mail listserver, which sends current information about health insurance–related issues to subscribers by e-mail (subscribe at http://www.childrensdefense.org/listserv_chip.html).

**Families USA**
(202) 628-3030
http://www.familiesusa.org
Families USA has developed a preliminary guide explaining the details of CHIP (which is available on its Web site), and also provides regular updates on the CHIP program.
Resources on Children’s Health Insurance

Institute for Child Health Policy
(352) 392-5904
http://www.ichp.edu/mchb/center/sites/titlexxi.html
This Web site provides information about work on policy and program development related to CHIP and also points to many related sites.

National Academy for State Health Policy (NASHP)
(207) 874-6524
http://www.nashp.org
In addition to descriptions of publications on the CHIP program, NASHP supports an interactive online forum called Chip Chat on its Web site, designed for those responsible for implementation of CHIP.

National Association of State Medicaid Directors (NASMD)
(202) 682-0100
http://www.medicaid.aphra.org
NASMD’s Web site includes position papers, legislative memorandums, and specific information about state plans and activity related to CHIP.

National Conference of State Legislatures (NCSL)
(303) 830-2200
http://www.ncsl.org
NCSL is a source for research, publications, consulting services, meetings, and seminars for state legislators and their staff. The Health Tracking Service of NCSL maintains a Web site at http://www.statesserv.hpts.org, which includes summaries of state children’s health programs, maps and charts, and information for ordering other resources.

National Governors’ Association (NGA)
(202) 624-5300
http://www.nga.org
NGA’s activities related to CHIP include descriptions and analyses of the state plans, seminars, an implementation status report (at http://www.nga.org/CBP/Activities/SCHIP.asp), and technical assistance to governors.

National Health Law Program (NHeLP)
(202) 289-7661
http://www.healthlaw.org/BBAtoc.html
The NHeLP Web site lists many publications, including a detailed summary of the CHIP program and other Medicaid provisions in the Balanced Budget Act of 1997.
federal funds during one fiscal year. Allotments are available to states for up to three years. States with approved plans may modify their plans in subsequent years. States that fail to file approved plans by the FY 1999 deadline may file plans and obtain approval in subsequent years without prejudice.

As of April 1, 1998, some 24 states and Puerto Rico had submitted CHIP plans to HCFA for review, and plans from 9 states (Alabama, California, Colorado, Florida, Illinois, Michigan, New York, Ohio, and South Carolina) had been approved. In two states, Washington and Wyoming, the legislatures initially voted not to participate in CHIP in FY 1998, but now, with the extension of the deadline, these states have another chance to participate for that year.8

Program Options
State CHIP plans may utilize one of the following program options: (1) expand an existing Medicaid program, (2) establish a new subsidized insurance program, or (3) use a combination of Medicaid and a new program. In addition, states may subsidize children’s enrollment in employer health plans and/or use a small portion of their allotments to pay for health services purchased directly from individual providers. Within these options, states face choices about eligibility, benefits, and plan administration.

Eligibility
Under the law, Title XXI targets children under age 19 in families with incomes below 200% of the federal poverty level ($32,900 for a family of four) or 50 percentage points higher than the Medicaid eligibility levels that existed in a state prior to the enactment of CHIP. States that expand their Medicaid programs must adhere to federal Medicaid eligibility rules, while states that establish new Title XXI insurance programs have broader flexibility to establish their own conditions of eligibility. States may not enroll children who are eligible for Medicaid in non-Medicaid CHIP programs. All of the state plans filed with HCFA as of April 1, 1998, combine income with other provisions (such as age) to determine eligibility. Twelve of the 23 plans extend eligibility to children in families with incomes up to or above 200% of the poverty level.

Benefits
When deciding on a CHIP benefit package, states may choose: (1) the Medicaid benefit package; (2) benefits contained in the standard preferred provider option of the Federal Employees Health Benefits Program (FEHBP), in the program for state employees, or in the health maintenance organization (HMO) in the state with the largest commercial enrollment; (3) a plan that meets the test of “actuarial equivalence”; (4) existing state plans for children in Florida, New York, and Pennsylvania; or (5) another benefit package that is approved by the Secretary of the Department of Health and Human Services.

Medicaid has a defined set of benefits that is comprehensive and child focused, and states can create non-Medicaid CHIP programs that use the Medicaid benefit package. However, because CHIP legislation specifies minimum benefits that must be included in state programs, states that do not use a Medicaid benefit package may need to add services to the plans chosen as benchmarks for their CHIP programs. As of April 1, 1998, some 17 states proposed providing the Medicaid package to at least some children newly eligible for coverage under CHIP. Two of the three states that will use their state employees’ benefit packages for their CHIP programs will supplement these benefits with additional services (dental, vision, and enhanced screening services, and specialized physical health and behavioral health care services). Three states will use FEHBP or commercial plan benefits; three states (Florida, New York, and Pennsylvania) will use existing program benefit packages, which were grandfathered in by the CHIP law; and three others will use alternative benefit packages.

Cost to Families
CHIP allows states to impose some cost sharing on enrolled families by requiring premiums or copayments when services are purchased. States that expand Medicaid
are bound by federal Medicaid cost-sharing rules. In non-Medicaid plans for families with incomes above 150% of the poverty level, the family’s share of costs may not exceed 5% of income. Ten of the state plans filed with HCFA by April 1, 1998, had no cost-sharing provisions, while 14 plans included premiums and/or copayments. Many of these plans used sliding scales based on family income to determine premiums and/or copayments. Premiums ranged from $4.00 per month per child in California in a family with an income level between 100% and 150% of the poverty level to $32.75 per month per child in Tennessee in a family with an income level between 170% and 199% of the poverty level.

**Outreach, Enrollment, and Coordination with Medicaid**

Millions of children in low-income families who are eligible for Medicaid are not enrolled in the program. In many states, the process for enrolling in Medicaid is difficult, and sometimes families don’t know that they are eligible for the program. Because CHIP is a new program, families’ lack of familiarity with the program may also serve as a barrier to enrollment. In addition, because federal law requires that CHIP enrollees first be screened for Medicaid eligibility, impediments to enrollment in Medicaid may also affect CHIP enrollment. Innovative and coordinated outreach and enrollment programs for both Medicaid and CHIP will be necessary in many states to enroll a substantial proportion of eligible children in the first few years of the CHIP program.

All of the 24 state plans submitted by April 1, 1998, call for states to conduct outreach through media campaigns, brochures, flyers, and presentations to community organizations. Many states will attempt to respond to cultural diversity among potential applicants and will target driver’s license offices, Head Start programs, job bureaus, schools, and child care centers for outreach. States also plan to enhance enrollment by using simplified application forms, mail-in applications, toll-free hot lines, and out-stationed eligibility workers. Seven states will use simultaneous applications for Medicaid and CHIP; however, in general, seamless eligibility between Medicaid and CHIP is not assured.

In addition to the creation of CHIP, the Balanced Budget Act of 1997 contained several innovations to strengthen Medicaid coverage for children. One provision, “presumptive eligibility,” allows states to enroll Medicaid children who are likely to be eligible but have not yet gone through the formal eligibility process. Presumptive eligibility facilitates enrollment and increases the likelihood that children will receive needed care promptly. Another provision, “continuous eligibility,” gives states the option of guaranteeing up to 12 months of coverage to all children enrolled Medicaid even if there is a change in family status that would otherwise render the child ineligible. This provision may reduce disruptions in coverage and health care, which can result when families gain or lose eligibility for coverage because of fluctuations in income.

**Conclusion**

Implementation of Title XXI is very much a work in progress. This article touches on only a select number of implementation issues as reflected in the law and in the state plans filed with HCFA as of April 1, 1998. Additional issues that may have important implications for the entire CHIP program may arise in the reviews of these plans and in conjunction with the actions of states that have yet to submit plans. How many states will submit plans and have them approved in time to begin enrolling children during calendar year 1998 is also uncertain. What is certain is that it will take a significant amount of time, ingenuity, skill, and resources to (1) plan, design, and implement these programs; (2) notify families about them; (3) staff and develop administrative systems; and (4) evaluate and modify programs in light of experience and public reaction to programmatic successes and failures. Box 1 in this article provides several sources of information about children’s health insurance. Readers of this article are urged to access these sources for more
detailed information than presented in this article, and to stay abreast of changing developments related to the expansion of health insurance for children (through Medicaid, CHIP, and any other programs) over the next few years.

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5. New York, Florida, and Pennsylvania, states with preexisting non-Medicaid children’s health insurance programs, are required to maintain their spending on these programs at pre-CHIP funding levels.

