A Policy Maker's Guide to the State Children's Health Insurance Program (CHIP)

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A POLICYMAKERS' GUIDE TO
THE STATE CHILDREN'S HEALTH
INSURANCE PROGRAM
(CHIP)

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*National Academy for State Health Policy*
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INTRODUCTION: WHAT IS CHIP?

In the first session of the 105th Congress, the State Children’s Health Insurance Program (CHIP) was enacted as part of the Balanced Budget Act of 1997. CHIP is a federal-state program, authorized for 10 years and funded for 5, granting states up to 48 billion dollars to provide "child health assistance" to children who are not eligible for any other insurance coverage, including Medicaid. States must provide matching funds which will be matched at a rate of approximately 75%, almost half again what the Medicaid match would be. CHIP is intended to bring health insurance coverage to children of the working poor, whose families earn too much to qualify for Medicaid, but not enough to afford private, employer-sponsored coverage. The program is expected to provide coverage for an additional 3.4 million children of the estimated 10.1 million children who are currently uninsured.

The CHIP program is structured much like a block grant; states are given a significant amount of money to meet federal policy objectives (in this case insuring poor children), but make most of the program design and implementation choices themselves. States must submit plans to the Health Care Financing Administration (HCFA), which will administer CHIP, for their review and approval prior to starting the program. CHIP gives states extensive implementation choices, including whether or not to participate at all. For this reason, each state may have a unique program, tailored to its population, budget and political will. However, there are certain requirements that states must meet to be eligible for CHIP funding, and parameters within which programs must be designed.

This brief is designed to help policymakers through the basic decisions they will have to make regarding their state’s CHIP program. It outlines the basic decisions that must be made, the pros and cons of each option, and experiences from other states. It is not an exhaustive guide, but a tool to help policymakers think through and weigh the options presented by CHIP.
Should our state participate in the CHIP program?

This is the first and most basic question each state will need to address. Many states see CHIP as a unique opportunity to achieve a long standing policy goal; to provide health care to kids. The reasons to participate may be:

**PROS ✓**

- *CHIP is expected to reduce the number of uninsured children.* Many states have been trying to provide insurance coverage to children for years, but have often found it too expensive and too challenging. Studies show that insurance coverage increases access to health care which in turn increases the chances that children will grow up healthy. However, an increasing number of families are not offered coverage from their employers or cannot afford it when it is offered. Preventive health care for kids is also likely to bring down medical costs by avoiding more serious, and more expensive, health problems.

- *States choosing to participate in CHIP will receive millions of federal dollars.* Each state’s allocation comes from a formula based on the number of uninsured kids in the state, changing in the coming years based on a state’s success at reducing the number of uninsured kids. The CHIP program is one of the largest federal health grants in recent history and may allow states to achieve some of
their health policy goals that had previously been unaffordable.

Other states may see CHIP as a financial and administrative burden, whose responsibilities outweigh its benefits. Some states are concerned about the CHIP program for the following reasons:

**CONS ×**

- **States must contribute to the cost of CHIP.** CHIP funds are matching funds and, though the match is generous (more than Medicaid), state contributions are a prerequisite to eligibility.\(^1\) And start-up costs for the program must be paid with 100% state funds. In addition, states choosing to participate are not permitted to cut their Medicaid programs below 1997 levels, and must maintain other existing state health programs at 1996 levels. This requires states to maintain ongoing financial support for existing health programs in addition to new money for CHIP.

- **Existing Medicaid programs will grow.** Another significant cost associated with implementing a CHIP program will be the increase in Medicaid enrollment. CHIP outreach efforts are expected to bring in many children who were already eligible for the existing Medicaid program but not enrolled. Some states project

\(^1\) State contributions may not come from provider taxes, donations, or beneficiary premiums.
that this may be as high as 30-50% of their Medicaid program. These children will only be eligible for the Medicaid match rate, not the enhanced CHIP rate. States will need to budget for this increase in their traditional Medicaid program as well as their new CHIP program.

- Each state must design and administer its own CHIP program. This will require time and effort to determine and implement program design, scope and administration. States must also provide data about the plan and perform annual assessments and studies about their progress in reducing the number of uninsured kids. States must also operate within federal guidelines.

A state which chooses to participate in CHIP, must submit an implementation plan to HCFA by July 1, 1998 in order to obtain approval by October and receive the 1998 federal allocation.

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STEP 2: WHAT SHOULD YOUR PROGRAM LOOK LIKE?

Should our state:
- Expand Medicaid?
- Create a state-run or privatized program?
- Combine Medicaid and a state-run program?

If your state has decided to participate in the CHIP program, policymakers face a number of choices. There are three basic design options: Medicaid expansion; a new program (using a benefits package that meets specific standards), or a combination of the two. Expanding Medicaid is often the easiest approach, but a new program provides the most flexibility. Within these options are many choices about eligibility, benefits, and administration. Many states have created commissions or work groups to explore these options, and legislatures, governors and the public should have a great deal of input into the proposal. States need to determine the number of uninsured children as a base for discussion. Some states use census data, others believe they need more detail and have developed household surveys to gain more information (ME, GA).

It is important to note that whatever choice a state selects, the federal government allows states to redesign their program through amendment to the original plan. Thus a state may choose the option which seems easiest to begin, thereby securing Federal funds, and later apply to the Federal government to redesign the program once experience has been gained. Many states indicate that they plan to amend their plans once they are up and running to either re-structure their programs or to include more ambitious goals such as family coverage.
A number of states will be expanding their Medicaid programs to implement CHIP. Many child advocates support Medicaid expansions over other options.

Some of the reasons to choose a Medicaid expansion may be:

- *Medicaid has a rich, child-centered benefit package.* Medicaid covers almost all health services a child may need for preventive, acute, and even long term care. Medicaid’s requirement for Early Periodic Screening Diagnosis and Treatment (EPSDT) makes it particularly child focused. EPSDT requires that children must not only receive early screenings, but also treatment for any medical need that may be diagnosed. This makes Medicaid very different from private insurance which may not provide a child-focused benefit and which may have limits on covered services. Private plans may also decide that a service is not "medically necessary" if it does not restore normal functioning following an illness or injury. Because children with disabilities may need ongoing services for conditions that are not expected to improve, EPSDT may be the only way to ensure those services will be covered. Low income children are at greater risk of disability and since CHIP is targeted to poor children, special consideration for coverage of disabilities will be important.

- *Expanding Medicaid entitles everyone who is eligible for coverage to receive it.* States who expand Medicaid create an entitlement to eligible children and must assure
that all children who qualify for coverage are allowed to enroll. Under Medicaid, states may not create waiting lists or otherwise deny coverage to those eligible. States can avoid cost overruns by establishing limits on their Medicaid expansions consistent with spending projections, or in other words, figure out how much they can afford to expand based on recent history.¹

- **Expanding Medicaid allows for a uniform eligibility process.** Children are not eligible for CHIP if they are eligible for Medicaid. All children enrolling in CHIP must first be screened for Medicaid eligibility. A Medicaid expansion allows a state to do a single enrollment process and avoid duplication of effort. Also, families with several children would be assured that all children will be in the same program, rather than separated by eligibility categories.

- **Medicaid has an existing infrastructure in place.** As a practical matter, expanding Medicaid avoids the problem of needing to establish and staff a new program. More than 22 million children are already receiving health coverage under state Medicaid programs. Because states are required to begin their programs by July, 1998 or forfeit some of their grant money, this is often the fastest and easiest way to get their programs up and running.
• **Medicaid offers ongoing fiscal support.** If a state expands Medicaid with CHIP funds, when those funds are exhausted before the end of the fiscal year, a state can still use Medicaid matching funds to cover costs of serving eligible kids. If the program is run separately, the state will have to cover all additional costs or create waiting lists. Also, since federal CHIP funding drops in later years, states will be able to continue using Medicaid matching funds, guaranteeing at least a 50% match.

• **Medicaid generally has lower administrative costs than private health plans.** Typically, Medicaid administrative costs average about 3-5% of program costs, while private health plans require about 10-15% or more for administration. The CHIP law requires that a state use 90% of its funding on direct services, allowing only 10% for administrative and other costs. That 10% may also be used for innovative health projects, such as school-based care or preventive programs, creating an incentive to keep administrative costs low.

• **Medicaid may cover state employees.** State employees are explicitly excluded from the CHIP program regardless of their income. Unlike a separate program, a Medicaid expansion may cover those state workers who are eligible based on their incomes.
A number of states are creating separate, state-run or contracted CHIP programs instead of expanding their Medicaid programs. Many believe that they can design a program more appropriate and more cost-effective for their state. Some of the reasons to create a state-run program may be:

- **States have much more flexibility if they design their own programs.** States who wish to pursue innovative strategies for coverage expansions, limit benefits or change eligibility rules, may be given much more latitude under a state program. For instance, in Medicaid every change must be made statewide, but in a state program, CHIP may be targeted and/or phased-in, helping states direct funds to those who need it most or limit expansion by geographic areas. However, they will need to meet numerous federal requirements and complete a detailed application.

- **It may be easier to control costs in a state run program.** The Medicaid entitlement may force states into spending more than they intended. Once Medicaid is expanded, the expanded program must meet all of the Medicaid rules, such as minimal cost-sharing, fair hearings, and EPSDT requirements. Because EPSDT guarantees unlimited treatment coverage, some states worry that this benefit can make cost-control especially difficult. Though Medicaid is likely to insure the greatest number of children, states may have trouble limiting the program should funds become scarce. Though states may at any
time reduce the eligibility levels, this is often difficult politically. A state-run program can be capped or children may be placed on waiting lists should costs be greater than expected.

- **A state-run program may provide better access.** Because payment rates to providers are very low in Medicaid, beneficiaries can have trouble finding a doctor who will see them. A private plan typically includes mainstream provider payment rates (which are higher) and provides the same ease of finding a doctor as everyone else in the commercial market. Some states have identified this as the main reason for choosing a state-run plan.

- **A state run, private program may be more popular than Medicaid.** Until recently, Medicaid eligibility was linked with welfare eligibility, and Medicaid still has many negative associations as a welfare program. Recent studies show that many families who are eligible for Medicaid may choose not to apply because of its stigma. These same families may eagerly pursue health programs that are not known as Medicaid.

- **State-run programs allow cost sharing.** CHIP allows most forms of cost-sharing as long as it does not exceed 5% of a family’s income for those over 150% of poverty. For those with lower incomes, cost sharing must comply with Medicaid law. Though studies show that even minimal costs are a major barrier for low-income people and an administrative burden on providers, cost-sharing
is very popular politically and is believed to promote personal responsibility.

- **State-run programs may have simpler administrative procedures.** States deciding to design new programs have the opportunity to streamline and simplify the administrative process. It is likely that states would be innovative in designing new family-friendly systems. States also have the option to buy coverage from the private sector, either by subsidizing employer coverage or purchasing private insurance for CHIP enrollees as long as the benefit offered meets Federal standards.

- **State-run programs are more like the commercial market.** Many policymakers like state-run plans because they are more like the commercial market and less like a welfare program. Some policymakers believe that by structuring CHIP as a commercial product with cost sharing, beneficiaries will more easily make the transition from Medicaid to commercial coverage, where premiums and cost sharing are required, as they move from welfare to work.

Some states are concerned that private plans could prove as or more costly than Medicaid. Increased reimbursement rates, additional costs of a separate administration and the inclusion of additional benefits may actually increase costs. States will need to determine their willingness to pay more for care in order to avoid Medicaid’s entitlement. Other
states fear that paying higher rates to CHIP plans than to Medicaid will reduce the number of plans participating in Medicaid.

States have the option of using some of their block grant funds to expand Medicaid and some to fund a separate state program. With this approach, a state would cover some low-income children under its Medicaid program and cover some additional higher-income children under a separate program. They believe this will give them the best of both worlds: the ease and comprehensiveness of Medicaid and the opportunity for innovation and cost-sharing in their own plan. Some reasons for combining the plans may be:

- *A combination approach ensures all of Medicaid's protections for the lowest-income children.* Many states want to target assistance to lower-income children first. A combination approach allows them to offer Medicaid's rich benefit package to the lowest income group. This approach also protects those least able to afford it from cost-sharing requirements, while moving those who can pay into cost-sharing arrangements. By beginning cost-sharing for higher-income families, programs may avoid the "cliff effect" of moving from a fully subsidized program to a commercial plan requiring substantial family contributions, which families may not be prepared for.

- *States can cap enrollment but still benefit from Medicaid funding.* In a partial Medicaid expansion, states would still be able to take advantage of open-ended federal funding for its lowest-income children. At the same time
the state could cap enrollment for higher-income kids if necessary.

- **A combination can provide for simplicity and continuity of care.** Policy makers want to keep eligibility simple, assure continuity of care and help families have all children in one health plan. States can achieve these goals by expanding Medicaid for a portion of eligibles and creating a "look-alike" state-run, private program for higher income eligibles. Both programs would look the same to the family, although the state-run portion may require cost-sharing.

- **A combination approach may be a good political compromise.** Some say that a combination offers the best of both worlds; maximizing the Medicaid program while preserving flexibility and state control. This may be a way for various groups to agree.

Another benefit states may enjoy regardless of their design choice, is increased purchasing power and greater leverage. When states are negotiating with health plans and providers, the more enrollees they have, the greater their leverage. Medicaid already covers one out of four children nationally, and increasing Medicaid's bargaining power can help assure the best value for state dollars. Leverage will also be increased with a private program if a state combines the bid with Medicaid for greater numbers.
### MEDICAID EXPANSION
- Creates coverage entitlement
- Uniform eligibility process
- Ongoing fiscal support
- Lower administrative costs
- Rich, child-centered benefit package
- May cover eligible state employees

### STATE-RUN PROGRAM
- More flexibility
- Easier to control costs
- Better access to care
- No stigma
- Can do cost-sharing
- Simpler administrative procedures

### COMBINATION
- Best of both programs
- Medicaid financial benefits
- May cap enrollment
- Good political compromise
- Keep Medicaid protections for lowest income families
- Cost-sharing for higher income families
STEP 3: WHAT ARE THE PROGRAM ELEMENTS?

Regardless of program design, the CHIP legislation requires decisions and action on a number of issues. Every state will need to make these basic choices:

**Benefits: What's Covered?**

Should our state choose:
- a. The Medicaid benefit plan?
- b. A benchmark option?
- c. A plan that meets the test of "actuarial equivalence?"

The range of benefits that will be covered is a very important question for families and one that will influence program decisions. States may choose among: A) the Medicaid benefit plan; B) three other benchmark options; or C) a plan that meets the test of "actuarial equivalence".

Medicaid Benefits: As discussed before, Medicaid has a defined set of benefits that is comprehensive and child-focused. Medicaid covers all services, including acute, rehabilitative and long term care, needed by children with disabilities. Any state choosing a Medicaid expansion adopts this predetermined benefit package. Some states, notably Maine, propose to create a state run program but still use the Medicaid benefit package.
For those states who do not choose a Medicaid expansion, careful consideration must be given to the benefits offered in their CHIP program. The CHIP legislation specifies minimum benefits that must be included in child health assistance. These include coverage of hospital care, physician services, lab, x-ray and well-baby and well-child care, including immunizations. Mental health services, prescription drugs and vision and hearing services must also be covered. These may be made available through plans that were identified as "benchmarks" by the federal government. These benefit packages were chosen as examples of reasonably comprehensive and mainstream packages. States that choose one of the following benchmark options are also free to provide additional services other than those available in these plans. States may choose from among the following benchmark options:

- The benefits offered to Federal employees: Federal employees have available to them a Blue Cross standard PPO plan.

- The benefits offered to state employees: The benefits available to state employees vary widely by state. States may use their own state employee benefit package as a benchmark for their CHIP program.

- The benefits offered in the most popular plan in the state: The CHIP benefit package can also be modeled after the HMO in the state with the largest commercial enrollment.

- A new program and benefit which must be an actuarially equivalent package: States may also design their own benefit package if it is of the same actuarial value as one of the benchmark plans listed above. These must include coverage
for hospital care, physician services, lab, x-ray, and well-baby and well-child care, including immunizations. This is likely to be the least expensive option for benefit packages. States may provide fairly minimal coverage (without long term care, dental, or other options) and still meet basic CHIP requirements.²

Of the options listed above, the state employee health benefit plan will likely have the widest variation. A state with minimal state employee health benefits could provide fairly minimal CHIP coverage. The most popular HMO plan will also vary by state. But, as noted above, the actuarially equivalent plan will allow the widest variation and the least expensive option.

Many states considering these options see an explicit trade-off between cost and coverage; with a more expensive benefit package, fewer people will receive it and, conversely, with a less expensive package, more people can be covered.

OTHER CONSIDERATIONS

Special Needs Kids

One of the most important things to keep in mind while designing your benefit package is services for children with special needs. While these services are covered under Medicaid, most commercial plans deny or limit coverage for rehabilitative or long term care, making standard coverage inadequate. Comprehensive coverage is especially important for the uninsured because they have little or no money to buy these services.

² Actuarial value must be determined by each state and tends to be a long and complicated process. Many states have opted out of this because of the difficulty determining what an actuarially equivalent plan would be.
if they are not included in their health plan. Services that are often excluded include: mental health, substance abuse (potentially important for adolescents), therapies, durable medical equipment, hearing and vision services, and dental care. Some commercial plans may also include waiting periods for preexisting conditions.

☐ **Supplemental services** may be provided by states if the commercial plan they choose does not include important coverage. Sometimes states may use some of their Medicaid money to buy additional, or "wrap-around", coverage for services that are not included. Some states are considering Medicaid "buy-ins" to allow families to purchase Medicaid coverage at full cost. While few families will be able to afford this, it could provide an important option for children with special needs who cannot get full coverage otherwise. Others may create a private CHIP program with a basic benefit but make special needs children eligible for a unique CHIP buy-in to the Medicaid program for access to the full range of services they require. Still others are considering creating CHIP programs that are available only to special needs children.

States have also expressed interest in coordinating CHIP with Title V funded services of the Maternal and Child Health Block Grant which support special needs children.
Eligibility for CHIP is usually established by age and poverty level. The legislation specifies that "targeted low-income children" are those who are under age 19 with family income below 200% of the federal poverty level. That is, states may provide coverage for a family of three with an annual income up to $26,660 (1997). Targeted low income children may also include those above 200% of the federal poverty level if the state does not expand Medicaid eligibility levels more than 50 percentage points above current levels. CHIP matching funds can only be used for expansions of coverage, not current Medicaid levels. For example, Alabama now covers 14-19 to 16% of the poverty level and plans to increase coverage for 14-19 year olds up to 100% of the federal poverty level. (They are also considering a state-run program up to 200% of FPL for the future). Some states, like Missouri, currently have higher eligibility levels and are considering raising their Medicaid eligibility level much higher, possibly to 300% of the federal poverty level with a Medicaid waiver.

For state-operated programs, states have broad discretion over financial and other eligibility standards. Typically, eligibility levels are determined by previous and current levels of coverage, a state’s overall economy, and the political climate. In an effort to target particular areas or groups, states may impose limits on residency or geographic location, and may also impose waiting periods. It is important to remember, however, that each condition of eligibility makes administration more difficult and may limit the number of children served by the program.
CHIP allows states to impose cost sharing requirements. For families above 150% of the poverty level, co-payments, premiums or deductibles may be charged, as long as they do not exceed 5% of the family’s income and do not favor wealthier families over poorer ones. If a state establishes a discrete, non-Medicaid CHIP program, the law allows cost sharing under 150% of poverty, as long as it is consistent with Medicaid law or is approved by the Federal government.

Should our state require cost sharing?

Many states will be including cost-sharing as part of their CHIP programs. Some of their reasons include:

**PROS ✓**

- **Equity:** Many policymakers believe that it is unfair to require low-income workers to contribute to their employer-sponsored health insurance, but provide free care to those on public programs. Because CHIP includes families with incomes above poverty, it is more likely that CHIP participants will have the same income as many workers who are struggling to afford employer coverage.

- **Reduced state costs:** Requiring beneficiaries to contribute to the cost of their coverage, can reduce the public costs of the program. (However, premiums may not be used to meet the Federal match.)
• *Cost-sharing makes CHIP different from a "welfare program":* Cost sharing is common in the private market, but limited in Medicaid. Some states consider cost-sharing like a bridge from Medicaid to private insurance which builds personal responsibility.

Other states are opposed to cost-sharing for some of the following reasons:

**CONS**

• **Fewer people will sign up:** Even minimal cost-sharing ($5-$10 a month) has been shown to dramatically reduce the number of families who will enroll in a public program. This is because low-income families often lack any "extra" income beyond what is needed for food and shelter, and health insurance is often forfeited.

• **Only the sickest kids will join:** Because cost-sharing is so difficult for low-income families, only those with serious health needs (those who need it most) may join. If programs have too many high-cost members, it will make the program more expensive.

• **Administration:** Collecting premiums, co-payments or deductibles adds to the cost and difficulty of administering a CHIP program. Doctors and administrators often find that collecting fees is difficult and billing can be expensive. When fees are not paid, it is the provider who loses revenue.
If our state does want to do cost sharing, should we use:
   a. Copayments and deductibles?
   b. Premiums?

Co-payments are a form of cost-sharing in which the beneficiaries pay a small fee (typically $5-$10) each time they see a doctor or fill a prescription. Deductibles are charges for services up to a set limit. Some of the benefits of co-payments and deductibles are:

PROS ✔

- **Appropriate use of services:** When people must pay each time they visit a doctor, they may be more careful and judicious about when they choose to go, avoiding overuse or abuse of services. Many states are particularly interested in raising co-payments and/or deductibles for emergency room use.

- **Cost-savings:** If services are used more appropriately, costs are kept down. Also, family contributions may offset some of the costs of the program.

- **Personal Responsibility:** Many policymakers believe that families should be expected to share in the cost of their health coverage.

Others argue against co-payments and deductibles for the following reasons:
**Step 3: What Are the Program Elements?**

**Cons**

- **Barriers to care:** With very poor families, even $5-$10 for co-payments (and higher for deductibles) can keep them from going to the doctor until kids are very sick.

- **Collection:** Deductibles and co-payments are often difficult to collect and often just don’t get paid. Unpaid co-payments come out of the provider payments and doctors may forfeit thousands of dollars a year in lost copayments.

- **Administration:** Tracking deductibles and co-payments can be a costly and time-consuming undertaking. Moreover, HCFA will reduce from a state’s allotment the amount anticipated from cost-sharing, whether or not the payments are received from beneficiaries.

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**Premiums**

Cost-sharing can also be achieved through premiums. Premiums may be determined as a percentage of family income or with a flat rate. States may establish premiums on a sliding-scale which may help meet the CHIP requirement that lower-income families are not disadvantaged compared to higher income families. Payment schedules also vary. Methods for charging premiums serve many purposes, including:
**PROS ✓**

- _Targeting the program:_ If premiums are on a sliding scale, higher income families can contribute more to their own coverage while poorer families receive more highly subsidized care. In this case the program is targeted so that the families who need the most help get the highest subsidies.

- _Transitioning off welfare:_ Welfare reform will move more low income workers off of welfare and into jobs. However, these jobs are typically low wage, part time jobs that do not offer benefits. Low wage workers may still qualify for Medicaid. CHIP creates incentives for workers to seek higher wages because higher wages won’t disqualify them from health coverage.

- _Shared Responsibility:_ Some policymakers believe that families should be required to contribute to the cost of their care both because it is required in the private market, and because it should be a shared responsibility between families and the state.

Reasons for opposing premiums include:

**CONS ✗**

- _Barriers to participation:_ As with other forms of cost-sharing, studies show that premiums will prevent families from joining the program.

- _Premiums are at odds with the goals of simplified administration:_ If families fail to pay their premiums,
states must establish sanctions, typically terminating coverage. Rules must then be established to deal with waiting periods, re-enrollment and enforcement, complicating administration. Also, as families' income change, premium rates may change. States will also need to determine who will collect premiums (eg. state? plan?) and cover the cost of administration of premiums.

- **Continuity of Care**: Many low-income families experience significant fluctuations in income, either because they are seasonally employed or because they lose hours at their jobs. If families are unable to pay premiums for certain months, kids will come on and off the program making consistent care difficult and undermining clinical goals. Importantly, kids will be punished if their parents' income drops.

- **Political challenges**: States must impose sanctions for non-payment of premiums for enforcement purposes. This typically means termination of coverage for at least some period of time. Regardless of the circumstances, there may be significant political costs involved with kicking children out of a health program.

At least two states (KY and CO) are exploring the possibility of using payroll deductions to collect premiums; others are skeptical, noting that many uninsured do not have permanent workforce connections.
Crowd-out is the phenomenon in which private health coverage is replaced by public health coverage. For instance, families drop their employer-sponsored dependent coverage in favor of less expensive public programs. This is most likely when public programs are offered to higher income families who typically have dependent care available, but at high premium rates. Some worry that employers will decide to stop offering dependent coverage if they know a public program is available.

Evidence of crowd-out is controversial. Some say that public programs are to blame for the decline in employer sponsored coverage because employers drop coverage if they know a less expensive public alternative is available. Employees have little incentive to contribute to the cost of employer-sponsored dependent coverage, if a free or less-expensive alternative is available. Recent studies show that 17% of uninsured children have a parent with employer coverage.

Others say that offering public programs has little or nothing to do with employer practices, especially if only children and not all dependents are covered. Some states with state-run coverage expansions in effect prior to CHIP, such as Florida and Washington, have decided not to develop extensive crowd-out policies. They claim that crowd-out is minimal if at all, and that the benefits of expanded coverage to kids outweigh the small numbers who leave private coverage for public programs. Minnesota is considered to be instructive because of their long history of expanding subsidized coverage to low income residents. MinnesotaCare was created in 1992 as a statewide subsidized health plan covering families up to 275% of poverty with sliding
scale premiums. A recent JAMA study found that during a period when uninsurance rates increased nationally, the proportion of Minnesotans without insurance remained stable and the proportion of children who were uninsured for 12 months or more decreased significantly, suggesting that state initiatives targeting this group are effective. This same study found that only 3% of enrollees gave up insurance benefits offered through their employer to take advantage of MinnesotaCare. (Additionally, 5% gave up Medicaid coverage for MinnesotaCare creating substantial savings for the state.)

Others fear the loss of employer contributions to health care and are establishing extensive provisions to block employers from dropping coverage. Some states are investigating the purchase of CHIP coverage through vouchers or other subsidies of private, employer-based coverage as a means of reinforcing employer-based health insurance. Others worry that such an approach will create incentives for the private sector to drop coverage and cite issues of equity. If employer A has chosen to provide coverage while employer B has not, is it equitable to provide government support to employer B? Does this create an unfair advantage to employer B in the marketplace?

<table>
<thead>
<tr>
<th>Which provisions (strategies) should our state include to prevent crowd-out?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Eligibility limits</td>
</tr>
<tr>
<td>b. Firewalls</td>
</tr>
<tr>
<td>c. Subsidies</td>
</tr>
<tr>
<td>d. Cost-sharing</td>
</tr>
<tr>
<td>e. Prohibitions</td>
</tr>
</tbody>
</table>

The CHIP legislation states that "no payment may be made to a state for expenditures for child health assistance under its plan to the extent that a private insurer would have been obligated to provide the assistance but for a provision of its insurance contract which has the effect of limiting or excluding the obligations because the child is eligible for or is provided child health assistance under the plan". In other words, children are ineligible for CHIP if they are covered by other insurance. This is done to avoid
replacing private spending for health coverage with public spending. Although there are no conclusive findings about the extent of crowd-out, the CHIP legislation requires states to include provisions to prevent crowd-out in their state plans (for Medicaid expansions or state programs). Depending on how strongly a state feels that crowd-out is a problem, there are a range of strategies that states have devised.

- **Eligibility Limits:** Crowd out may be indirectly minimized when programs are limited to poorer (generally under 150% of FPL, but ranging among states) families with less income. Because these families are less likely to have private insurance offered to them in the first place, they give nothing up to join the public program. Studies show that crowd-out increases as eligibility extends to families with higher incomes.

- **Firewalls:** "Firewalls" are designed to keep families who have private insurance available to them from giving it up in favor of public programs. Some firewalls require kids to be without coverage for at least 3 months (Oregon now requires 12 months of being uninsured) before being eligible for CHIP. Exceptions are often made if the parent lost a job or COBRA coverage expired. Some states require that to be eligible for CHIP, enrollees must have no access to any private insurance, regardless of its cost.

- **Subsidies:** Some states, rather than excluding otherwise eligible applicants, choose subsidies to help low-income workers purchase employer-based coverage for themselves.
or their dependents when it is available. Some argue that subsidizing employer-based coverage is the most cost-effective way to increase coverage and discourage families from giving up employer coverage for public programs.

- **Cost-sharing:** Cost-sharing has the indirect effect of limiting crowd-out. By making the required out-of-pocket cost to the enrollee more similar to cost-sharing levels required in the employer-sponsored market; cost-sharing may mitigate a currently insured families’ financial incentives to drop coverage in order to enroll in the government program.

- **Prohibitions:** Some states prohibit employers from reducing coverage and encouraging employees to take advantage of public programs. California not only prohibits insurance representatives from referring families to their CHIP program, but prohibits employers from reducing coverage in order to encourage employees to enroll in the public program.

- **Reduced participation:** In some cases, eligibility limits presume that people above a certain income have access to private insurance. While this may be true, many people in low wage jobs are required to pay large percentages of their premiums and often cannot afford to take advantage of coverage. Often eligibility limits keep people out of a public program who cannot afford private insurance either, leaving them uninsured.
**SOME STATE PLANS FOR CROWD-OUT:**

**California**
1. No children will be covered if they have had employer-sponsored coverage within 3 months of applying for the CHIP program. The state is authorized to increase to 6 months if they find that crowd-out is a more substantial problem.
2. Insurance agents and insurers are prohibited from referring dependents to the program if they already have employer-sponsored coverage.
3. Employees who purchase coverage are not allowed to refer employees to the CHIP program for dependent coverage or to change dependent coverage or the employee share of that coverage to get employees to enroll in the CHIP program.
4. The state will provide vouchers for families to purchase dependent coverage from their employer's plan when they can't afford the employee share of dependent coverage. The state will also provide supplemental coverage if the employer-sponsored coverage is not as comprehensive as the state program.

**Wisconsin (BadgerCare)**
1. Wisconsin will use premiums (of those over 143% of poverty) to help discourage crowd-out.
2. Families with access to employer-sponsored coverage that is at least 80% subsidized are not eligible for BadgerCare.
3. Purchase or subsidize employer plans.
4. Limited enrollment periods.
5. Restrictions on enrollment (based on time previously uninsured); and
6. Enacting other insurance reforms to improve broad-based coverage.

- **Poorly conceived firewalls:** Firewalls that are meant to target the program to the uninsured may be overly restrictive and prevent any coverage expansion from reaching a large number of uninsured children.

- **Access vs. affordability:** States may define their crowd out strategies to prohibit participation by people with "access" to private health insurance, meaning that coverage is offered. Many times, however, "access" does not consider affordability of that coverage. Families expected to pay very high cost sharing on very limited income may find coverage inaccessible because they simply cannot afford it. Some states are defining access to employer coverage as access to coverage that is at least 40%-60% subsidized.

- **Forced periods of being uninsured:** Temporary exclusions (such as 3 month waiting periods) may unfairly punish kids by requiring them to be uninsured for periods of time.

- **Enforcement:** Many of these provisions will be difficult to enforce. It is unclear how states would know the motivations behind employers' or families' decisions to drop coverage. Employers could easily attribute coverage reductions to the cost of coverage rather than the availability of CHIP. The state would then be charged with investigating and determining causes behind employer actions. In the case of subsidies to allow employees to purchase employer coverage, it is difficult to target them to only those who would otherwise be uninsured. It would
be administratively cumbersome and costly to determine who could not otherwise afford insurance without the subsidy vs. those who are simply taking advantage of reduced costs.

### Outreach and Enrollment: Finding Eligible Kids

<table>
<thead>
<tr>
<th>What opportunities for improvement of outreach and enrollment may our state want to consider?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Innovative outreach</td>
</tr>
<tr>
<td>b. Simpler applications</td>
</tr>
<tr>
<td>c. Keeping families in same program</td>
</tr>
</tbody>
</table>

States are finding that significant numbers of families who are eligible for Medicaid are not enrolled. In many cases this is because the process for enrolling in Medicaid is difficult and intrusive. Many states have lengthy forms with detailed questions about income and assets. Families are often required to go to the welfare office to sign up for Medicaid, which discourages families both because of the logistical difficulties as well as the stigma attached. Other times, families simply don’t know about the program or that they are eligible. Since many of the uninsured are working, they will be hard pressed to visit an office to apply for CHIP during the work day.

CHIP also requires that everyone who enrolls in the program must first be screened for Medicaid eligibility. If families are found to be eligible for Medicaid, they may not sign up for CHIP. This creates an incentive for states to have a single application for CHIP and Medicaid, since they will have to determine eligibility for both anyway. States may want to take advantage of the opportunity to redesign and simplify their applications.

Federal laws differ regarding outreach for Medicaid and CHIP; Medicaid now prohibits
direct marketing by plans to beneficiaries but CHIP allows it. Because states must work to increase the number of eligibles actually enrolled in Medicaid, coordination of outreach for the two programs is important and states will need to consider how to develop outreach that meets Medicaid’s direct marketing restriction. This is particularly important since many states plan to build on Medicaid’s outreach (at least at first) because CHIP’s outreach funds are not available to states at program start-up.

**Innovative outreach:** States are rethinking their outreach and marketing strategies. Some are putting enrollment forms in grocery stores and health clinics rather than welfare offices. Other states are coordinating with schools, community health centers, and child care centers to inform families about coverage. While federal law limits who can actually determine Medicaid eligibility, there are incentives in the law for creative outreach activities. Some states plan to use Federally Qualified Health Centers (FQHCs) to help with outreach and enrollment; others caution that some FQHCs have developed preferred provider arrangements with a single HMO and in that instance may lack the needed independence to conduct enrollment.

**Simpler applications:** States expanding Medicaid may let families mail in their applications. They are also creating shorter and simpler applications, using toll-free telephone information lines and reducing paperwork requirements.

**Keeping families in the same program:** If states are creating separate state-run programs, they may want to assure that all the children in one family are served in the same
program. Often, children of different ages have different Medicaid eligibility levels. For instance, in one state children up to 1 year old may be eligible if their families earn 150% of the poverty level, but from 1-6 years old they would only be eligible if their families earn 100% of the federal poverty level. CHIP expansions could allow these same 1-6 year olds to be covered in the CHIP program, but states may want to consider having uniform Medicaid eligibility levels across age groups.

It is important to note that states are unlikely to enroll 100% of those eligible in the first years of the program. Many states are predicting (and it may be fair for legislators to expect) a 50% enrollment rate of targeted uninsured children within the first three years of the program. Policymakers need to plan for phased-in enrollment and for likely increases to the existing Medicaid rolls due to expanded outreach. It will take a significant amount of time to notify people about the program as well as design and staff administrative systems, develop contracts with providers and HMOs, and allow adequate time to plan and design the program.

Simplifying Eligibility

In addition to simplifying application and eligibility procedures noted above, states have two other opportunities.

Should our state allow presumptive eligibility?

Presumptive Eligibility

The Balanced Budget Act of 1997 included other provisions that also effect CHIP programs and Medicaid expansions. One of the provisions is for "presumptive eligibility" which allows states to
enroll kids into Medicaid who are likely to be eligible, but have not yet gone through the eligibility process. States may allow community health centers, Head Start centers, or other "qualified entities" to enroll these kids into Medicaid, based on basic information given by the family. (After presumptive eligibility is granted, a formal application is required.)

PROS ✔

Presumptive eligibility allows children to begin receiving care promptly, without waiting for the formal eligibility determination. Though many physicians will serve children regardless of their insurance status, many families are reluctant to go when they cannot afford to pay for a visit. Presumptive eligibility may promote outreach and preventive care by giving families "permission" to visit the doctor because they know the visit will be paid for. If a child walks into a clinic with a health problem, the clinic could do a basic assessment to presume eligibility for Medicaid and then treat all the health issues that are identified without waiting for a lengthy approval process. This not only gets more kids enrolled who are eligible and encourages the involvement of community providers, but also meets the important clinical goals of increased preventive care.

CONS ✗

The potential downsides of presumptive eligibility are that: 1) it creates an administrative burden to determine eligibility retroactively; and 2) some children will be approved for coverage who are later found to be ineligible. In this case, the state will end up paying for care for children who would not otherwise have been covered. Some fear that presumptive
eligibility will encourage children to enter the system when they are ill but not continue in care over time.

Should our state allow continuous eligibility? If yes, for how many months?

Continuous Eligibility

States are also given the option to guarantee up to 12 months of Medicaid coverage to all children who are enrolled in Medicaid or state-run programs, regardless of whether a child is determined to be ineligible anytime during that 12 month period (unless the child reaches the age of 19). The provision is important because many families move on and off of Medicaid as their employment or income changes, making consistent and continuous care difficult.

PROS ✔

Continuous coverage is intended to reduce disruptions in health coverage and health care. States may also realize administrative savings by reducing the number of times cases are reviewed.

CONS ×

The downside of continuous eligibility, like presumptive eligibility, is that some children will receive Medicaid coverage and medical care who would not have been eligible otherwise. The provision is expected to increase Medicaid enrollment by up to 1 million children nationwide.
"10% Funds"

What percentage of our state's program costs will be for administering the CHIP program?

Up to 10% of the money spent for the CHIP expansion may be used for administrative and other purposes. Within this 10% states are required to cover administrative costs of the program and to conduct required outreach. Any money within the 10% not used for administrative costs may be used for such things as additional outreach, direct services or other children’s health initiatives. Because the total of this spending may not exceed 10% of program expenditures, states have an incentive to keep administrative costs low.

Many states had hoped to use these "10% funds" for innovative and/or pilot health programs, improved outreach and program start-up costs. However two important limitations have emerged: 1) these funds are not available until program funds have actually been expended; that is, states must fund start-up costs themselves; and 2) program administration and outreach is likely to be expensive and draw heavily on the 10% funds. States will need to establish data collection and billing mechanisms, oversight and quality assurance systems, and, depending upon the choices they make, develop systems to collect and account for cost-sharing. Medicaid programs have much of this infrastructure but states may not elect to build on that base. Further, the program requires extensive outreach, including efforts to find Medicaid eligibles not previously enrolled.

President Clinton’s 1999 proposed budget includes provisions that, if enacted, will help states pay for and expand outreach (see HCFA’s 1/23/98 letter to state health officials).
STEP 3: WHAT ARE THE PROGRAM ELEMENTS?

Program Oversight and Ensuring the Quality of Care:
Data, Public Input and Other Strategies

How will our state conduct oversight of CHIP?
What data and reports will be developed?
How will public input be achieved?
What procedures will be in place to monitor and enforce quality standards?

The sustainability of CHIP will require evidence to Congress that the states are managing the program effectively, reducing the number of uninsured children and providing needed, quality health care. States, then, need to consider during their design phase what goals they plan to meet and what data they will collect and analyze to determine if those goals are met and how those data and evaluation systems will be designed, funded and administered.

In addition to hard data, states can use the input of consumers and concerned professionals. Federal legislation requires states to seek public input in designing programs. That input can be channeled to become an "early warning system" of potential problems through advocacy groups, on-going meetings and public hearings or the creation of ombudsman programs, independent entities which can field questions and complaints. Gaining effective and representative public input is always a challenge for policymakers. Vocal advocates for consumers and providers can become "the squeaky wheel that gets the grease" while masking broader public concern or support. Some states have developed small, working advisory groups to brainstorm and serve as a sounding board throughout plan design and implementation. Representatives who serve on these groups gain knowledge of the program and become partners in its success. Others fund independent ombudsmen; still others rely on local meetings and statewide public hearings.
STEP 3: WHAT ARE THE PROGRAM ELEMENTS?

Oversight needs to examine the entire CHIP program from enrollment and eligibility, through plan and provider contracting and service provision, expenditures and quality of care provided. For example, steps must be taken to assure that no Title XXI CHIP funds are expended on services for children who are Medicaid eligible. More specifically, states will need to determine how quality of care is provided. Some states are developing quality monitoring that mirrors their Medicaid programs'. Others are crafting new or simplified procedures, asking plans to submit HEDIS pediatric measures and/or conducting consumer surveys and reports through the Consumer Assessment of Health Plans (CAHPS) process.

The effective management, accountability and evaluation of CHIP will require states to have sufficient staff and technological capacity. Legislators will want to carefully consider state agency capacity and assure needed resources are available to implement the new program. Such state agency capacity will assure legislators will have the information they will seek regarding the success and outcomes of CHIP. Without needed resources, that accountability will be difficult to achieve.

CONCLUSION

States have a unique opportunity — and significant Federal funding — to reduce the number of uninsured children. But reaching those children, getting quality care delivered to them and accounting for the new program place significant responsibilities on state governments. The important new flexibility provided to states in the Federal legislation is also a challenge — are states up to the task? This guide summarizes states’ options but a final reminder may be important — state activities need not set one program in stone. The Federal government has signaled openness to program revisions over time. In that partnership, states and the Federal government can help millions of children receive needed health care.
CHIP is a federal-state partnership. States are required to submit their plans for approval by the Secretary of the Department of Health and Human Services. In order to be eligible for payment, the plan must detail how the state intends to use the funds and to fulfill other requirements of the law. Under the law, the plan is considered approved in 90 days unless the Secretary notifies the state in writing that the plan is disapproved or that additional information is required.

The Health Care Financing Administration (HCFA) has developed a model application template for states to use which outlines the information that must be included in a state plan. HCFA also has a web site (www.hcfa.gov/init/children.htm) with useful information and frequently asked questions and answers. States with questions may contact their regional HCFA office. The Department of Health and Human Services will be working with states to facilitate and expedite the approval process.
STEP 4: SUBMITTING THE PROGRAM PLAN
1997 Federal Poverty Level Guidelines For All States (Except Alaska & Hawaii) and the District of Columbia

What does the poverty level mean in terms of annual income? Following are the levels of poverty by family size for the Continental U.S. (Alaska and Hawaii are higher).

<table>
<thead>
<tr>
<th>Size of Family Unit</th>
<th>Percent of Federal Poverty Guideline Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>1</td>
<td>$7,890</td>
</tr>
<tr>
<td>2</td>
<td>10,610</td>
</tr>
<tr>
<td>3</td>
<td>13,330</td>
</tr>
<tr>
<td>4</td>
<td>16,050</td>
</tr>
<tr>
<td>5</td>
<td>18,770</td>
</tr>
<tr>
<td>6</td>
<td>21,490</td>
</tr>
<tr>
<td>7</td>
<td>24,210</td>
</tr>
<tr>
<td>8</td>
<td>26,930</td>
</tr>
</tbody>
</table>

For family units with more than 8 members, add $2,720 for each additional member at 100% level. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

### State Children's Health Insurance Program

#### Key state statistics:
Federal grant amounts and number of uninsured children through age 18

*December 18, 1997*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>$86,405,380</td>
<td>179,000</td>
</tr>
<tr>
<td>Alaska</td>
<td>5,664,899</td>
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<tr>
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<tr>
<td>Arkansas</td>
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<td>California</td>
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<tr>
<td>Colorado</td>
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<tr>
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<td>Maine</td>
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<td>Maryland</td>
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<td>Massachusetts</td>
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<td>Michigan</td>
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<td>Minnesota</td>
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<td>Mississippi</td>
<td>56,297,379</td>
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<td>Missouri</td>
<td>51,931,664</td>
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<td>Montana</td>
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<tr>
<td>Nebraska</td>
<td>14,937,291</td>
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<tr>
<td>Nevada</td>
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<td>New Hampshire</td>
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<tr>
<td>New Jersey</td>
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<tr>
<td>New Mexico</td>
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<tr>
<td>New York</td>
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<tr>
<td>North Carolina</td>
<td>79,906,274</td>
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</tr>
<tr>
<td>North Dakota</td>
<td>5,065,962</td>
<td>14,000</td>
</tr>
</tbody>
</table>
## Key State Statistics

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Children (in thousands)</th>
<th>Number of Families (in thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>116,313,427</td>
<td>309,000</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>81,568,137</td>
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<tr>
<td>Oregon</td>
<td>39,317,403</td>
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<tr>
<td>Pennsylvania</td>
<td>118,044,201</td>
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</tr>
<tr>
<td>Rhode Island</td>
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<tr>
<td>South Carolina</td>
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<tr>
<td>South Dakota</td>
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<tr>
<td>Tennessee</td>
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<tr>
<td>Texas</td>
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<tr>
<td>Utah</td>
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<td>Vermont</td>
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<tr>
<td>Virginia</td>
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<td>Washington</td>
<td>46,894,677</td>
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<tr>
<td>West Virginia</td>
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<tr>
<td>Wisconsin</td>
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</tr>
<tr>
<td>Wyoming</td>
<td>7,750,222</td>
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</tr>
<tr>
<td>United States</td>
<td>$4,224,262,500</td>
<td>11,300,000</td>
</tr>
</tbody>
</table>

**Notes:** The final column contains an estimate of the number of uninsured children in the U.S. in 1996, taken from the March 1997 Current Population Survey (CPS) of the U.S. Census Bureau. At the state level, the most recent three-year averages (1994-1996) are used, because the CPS has small sample sizes in many states. Under the new State Children’s Health Insurance Program, federal grant amounts, by state, are available only for 1998.

RESOURCES

Fact Sheet: Cost Sharing and Low-Income People, Families USA, Washington, DC

Hearne, Jean, Coordinating Children’s Coverage Expansions with Employer-Sponsored Coverage, Institute for Health Policy Solutions, Washington, DC, December 1997


Organizations

Center on Budget and Policy Priorities, Washington, DC, (202) 408-1080

Center for Health Policy Research, The George Washington University Medical Center, Washington, DC, (202) 296-6922

Families USA, Washington, DC, (202) 628-3030

National Academy for State Health Policy, Portland, ME, (207) 874-6524; www.nashp.org

National Conference of State Legislatures, Denver, CO, (303) 830-2200

National Governors’ Association, Washington, DC, (202) 624-5300

United Hospital Fund, New York, NY, (212) 494-0776