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Eligibility Options Under the State Children's Health Insurance Program

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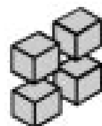

Maternal & Child Health
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ELIGIBILITY OPTIONS UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The new state Children's Health Insurance Program (CHIP) offers states enormous opportunities to extend health insurance to the vast majority of uninsured children in the United States. States can set a specific income eligibility level for all potentially eligible children or they may consider income in combination with age, or even disability and geography. Given the divergent path that states have pursued in the past with regard to Medicaid eligibility expansions for children, it is reasonable to assume their continued interest in a variety of eligibility approaches.

This issue brief was prepared by the Maternal and Child Health Policy Research Center to identify and examine the different eligibility choices available to states under CHIP. An overview of Title XXI's eligibility provisions is presented along with a summary of the potential child eligibility groups. Then six different types of eligibility options are analyzed:

- income options,
- access-to-coverage options,
- age and income options,
- disability and income options,
- geography and income options, and
- family coverage options.

This analysis of eligibility options is based on telephone surveys with selected CHIP and Medicaid program officials, key informant interviews with federal HCFA staff and health services researchers, analysis of national data sets, and reviews of published and unpublished literature. Subsequent issue briefs will be prepared on plan and benefit selection, cost-sharing options, and other topics.

THE POTENTIAL CHIP POPULATION

Brief Overview of Eligibility Provisions

Title XXI gives states considerable flexibility in establishing target groups of children for coverage under the new program. CHIP basically is intended to extend Medicaid or other health insurance protection to children up to age 19 living in families with incomes up to 200 percent of poverty. However, the statute authorizes states that have already raised income eligibility to above 150 percent of poverty for some or all targeted groups of children to make health insurance available to children with family incomes up to 50 percentage points above the state's applicable Medicaid poverty level. Perhaps more significantly, the statute gives states broad discretion in determining eligibility to choose whether gross, net, or countable income will be used and what, if any, resource tests will be applied -- although there are certain restrictions under the Medicaid option.[1]

Additionally, states have been given wide latitude in establishing eligibility criteria unrelated to income and resources. These criteria may address: age, residency, geographic area, access to other coverage, and disability status (provided that disability standards are not used to restrict eligibility). States may also set policies regarding the duration of eligibility.

Once eligibility criteria are established, a state may extend CHIP coverage to any child who meets these criteria, is not eligible to participate in a state employee health benefit plan as a child dependent, is not eligible for Medicaid, and does not have coverage under a group health plan or other health insurance. Such private coverage is defined very broadly to include benefits for any

1 States choosing the Medicaid option would have to revise their income and resource methodologies under the authority of Section 1902(r)(2) if they wanted to liberalize income and resource standards for CHIP participants. Despite this liberalization of regular Medicaid income and resource policies, children in families with incomes above the regular Medicaid eligibility level would qualify as CHIP participants at the higher federal matching rate (and not as regular Medicaid participants at the regular matching rate) because they would have been ineligible for Medicaid benefits prior to March 31, 1997. States choosing the Medicaid option could not, however, use more restrictive income and resource methodologies than were in effect on June 1, 1997.

items and services related to medical care, except where the care is limited to a specific disease or condition.[2]

Families may also receive health insurance coverage under Title XXI if a state obtains a special waiver (or variance[3]) approved by the Secretary. To obtain such approval, however, the coverage offered to families must include coverage of targeted low-income children, it must be "cost-effective" relative to what would have been spent to insure these children, and the funds used must not substitute for funds that would have otherwise been used to insure these children.

Potential Child Eligibility Groups Across States

Looking at income alone, it is clear that the size of the potential CHIP-eligible population varies substantially across states, mirroring the considerable variation in states' Medicaid income eligibility policies. Ten states could use their Title XXI allotment to extend health insurance coverage to uninsured children in families with incomes beginning at the upper limit of federally required Medicaid eligibility and going as high as 200 percent of poverty, while eight others have the option to insure children whose family incomes begin at 200 percent of poverty and in some instances higher.[4]

Current state estimates of the number and characteristics of children who would be eligible for CHIP, and not Medicaid, are not yet available, even for the basic coverage group below 200

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2 Title XXI references the definitions used under the Health Insurance Portability and Accountability Act, 42 U.S.C. § 300gg-91.

3 HCFA is using the term "variance" rather than waiver to avoid any confusion with the 1115 wavier authority, which the agency is not yet extending to CHIP.

4 Based on an analysis of information gathered by Fox Health Policy Consultants through telephone interviews with state Medicaid agency staff during the fall of 1996, and Mann C, Ross DC, Cox L: *Medicaid Has Been the Program of Choice for Most States that Have Expanded Coverage for Uninsured Children.* Washington, D.C.: Center on Budget and Policy Priorities, June 4, 1997; and National Governor's Association: *State Medicaid Coverage of Pregnant Women and Children, MCH Update*. Washington, D.C.: NGA, September 30, 1997.

percent of poverty.[5] It is known, however, that nationally 24 percent of children in this income group are uninsured and that the majority of these -- 31 percent -- are adolescents ages 13 to 19.[6]

ANALYSIS OF ELIGIBILITY OPTIONS

Income Options

An obvious threshold decision for states is where to set the income eligibility ceiling for CHIP coverage. The amount of resources a state is able to commit to CHIP is a major factor in whether it can offer coverage to all children in families with incomes up to the allowable maximum -- 200 percent of the federal poverty level or 50 percentage points above a state's current Medicaid level, whichever is higher -- and whether it might also offer additional children coverage by permitting extensive income and other disregards.

Gauging the adequacy of state resources to cover all potentially allowable children, however, requires an estimate not only of health plan costs but also of expectations regarding enrollment. States presumably would not want to make children up to the highest allowable income levels eligible if it lacked the funds to cover all children at lower income levels.[7] National data show that 24 percent of children in families with incomes between 100 and 200 percent of poverty are uninsured and that 13 percent of those with incomes between 200 and 300 percent of poverty are

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5 The Urban Institute is in the process of estimating the number of children eligible for CHIP and not Medicaid.

6 Estimates from the March 1997 Current Population Survey prepared by the Employee Benefit Research Institute for Fox Health Policy Consultants.

7 After exhausting their Title XXI allocation, states that expanded Medicaid can continue to receive federal funds at their regular matching rate, while those states that established a separate state health insurance program cannot receive additional federal funding.

uninsured,[8] but state-specific uninsurance rates for these children would vary considerably.[9] In addition, actual enrollment is difficult to project. A 1997 study of premium subsidy programs for children reported Medicaid take-up rates ranging from 5 percent in Rhode Island to 52 percent in Hawaii.[10] The same variation was found when states extended free Medicaid coverage to children ineligible for cash assistance.[11]

Another critical factor affecting where a state sets its income eligibility ceiling for CHIP coverage is the extent to which public coverage would be substituted for private sector coverage, the phenomenon known as "crowd-out." Many states, like the drafters of the Title XXI legislation, are concerned that crowd-out be minimized. There has been some evidence to suggest that crowd-out occurred when children and pregnant women in families above the poverty level were made eligible to enroll in Medicaid at no cost.[12] However, the cost and quality of the coverage dropped and the

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8 Estimates from the March 1997 Current Population Survey prepared by the Employee Benefit Research Institute for Fox Health Policy Consultants.

9 In addition to differences in employer coverage of workers' dependents, states vary in their income eligibility for Medicaid and state-only health insurance programs. Using the Current Population Survey for March 1997 to estimate state uninsurance rates is problematic because the sample size for some states is not sufficient to produce a reliable estimate. Merged data from multiple years do not fully capture the impact of recent Medicaid expansions on health insurance rates for children but are the most reliable estimates available. Data from the March 1995, 1996, and 1997 Current Population Survey show that state uninsurance rates for children vary between 6 percent in Wisconsin and 24 percent in Texas. Purcell P: *Health Insurance: Uninsured Children by State, 1994-1996.* Washington, D.C.: Congressional Research Service, October 3, 1997.

10 Gauthier AK, Schrodel SP: *Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform.* Washington, D.C.: Alpha Center, May 1997.

11 Summer L, Parrott S, Mann C: *Millions of Uninsured and Underinsured Children are Eligible for Medicaid.* Washington, D.C.: Center on Budget and Policy Priorities, April 7, 1997. As a result of generally low take-up rates, the GAO reported that in 1993, at least one-quarter of uninsured children -- 2.3 million -- were eligible for Medicaid in a mandatory eligibility category. Were optional eligibility groups included in this analysis, the percentage would have been higher. U.S. General Accounting Office: *Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion*. Washington, D.C.: GAO, July 1995.

12 Three studies have examined the effects of expanded Medicaid eligibility on private insurance coverage for children. Two of the studies found no evidence of crowd-out while the other found a crowd-out rate of 17 percent. Yazici EY: Medicaid Expansions and the Crowding Out of Private Health Insurance. Paper presented at the annual research conference of the Association for Public Policy Analysis and Management, Pittsburgh, November, 1996. Shore-Sheppard LD: The Effect of Expanding Medicaid Eligibility on the Distribution of Children's Health Insurance Coverage. Paper presented at the Cornell / Princeton conference on Reforming Social Insurance Programs, May 1996. Dubay L, Kenney G: The Effects of Medicaid Expansions on Insurance Coverage of Children. *The Future of Children*, 6:152-161, 1996.

impact of Medicaid on health status outcomes is not known.[13] Also, there is no literature examining crowd-out where premiums are charged. Yet, the introduction of a premium charge, rather than capping income eligibility at or near the poverty level, is generally thought to be an effective strategy for dissuading families from dropping existing private insurance in favor of publicly subsidized coverage. (Other strategies are discussed below.)

Access-to-Coverage Options

In setting their eligibility policies for CHIP coverage, states also are focusing on criteria that would exclude from participation children with access to other insurance. Various options are possible. A state could, for example, simply require that a child be uninsured for a specified period of time, perhaps three months for children in families with incomes up to 200 percent of the poverty level and longer for children at higher income levels.[14] Another approach would be for a state to specify one period of time during which a child had to be uninsured and specify a somewhat longer period of time during which he or she had to be ineligible for employer-based coverage -- so as to further discourage families from dropping private coverage in order to enroll in CHIP. A third approach would be for a state to require a period of uninsurance but exempt from this requirement those who had lost Medicaid or employer-based coverage -- thereby assuring immediate CHIP participation for children who had lost coverage through no fault of their own. Still another approach would be for a state to require a specified period of uninsurance and exempt children who had lost coverage through no fault of their own, but also permit a much shorter period of uninsurance

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13 There is research to suggest that there were important gains from Medicaid expansions in terms of improved use of preventive care and reduced mortality of infants and children. Currie J, Gruber J: Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women. *Journal of Political Economy*, 104:1263-1296, 1996. Currie J, Gruber J: Health Insurance Eligibility, Utilization of Medical Care and Child Health. *Quarterly Journal of Economics*, 61:431-466, 1996. However, it is not known how these gains are linked to children that drop private health insurance coverage for Medicaid.

14 Crowd-out is generally thought to be a more serious problem for children at higher income levels due to their higher rates of insurance. Children in families with incomes between 200 and 300 percent of poverty, for example, have an insurance rate of 87 percent, compared to the 76 percent rate for children in families with incomes between 100 and 200 percent of poverty. Estimates from the March 1997 Current Population Survey prepared by the Employee Benefit Research Institute for Fox Health Policy Consultants.

for children deemed to have been “underinsured” -- thereby making adequate coverage quickly available to all similarly situated low-income children without penalizing those whose families had purchased particularly expensive or limited coverage.

The length of time that a child would have to be uninsured is obviously the key issue a state would need to address in structuring an eligibility policy to avoid participation by children with access to other coverage. Setting the period of uninsurance much beyond six months might result in higher insurance costs. Children who have been without insurance protection may initially incur higher annual insurance costs when they enroll in a plan than those who have had continuous coverage. Research looking at the experience of newly insured families under a state-subsidized program found that those who were uninsured for a year or longer had significantly higher insurance costs than those who were uninsured for less than a year or who had never been insured.[15]

For states that choose to institute a shorter waiting period for underinsured children, setting a standard for what constitutes underinsurance is another important issue. A state standard for underinsurance could address both the adequacy of pediatric benefits and the affordability of premiums and other charges to the family. A state could set strict criteria for underinsurance or it could establish that any health insurance that provided a lesser benefit package or required more cost-sharing than its CHIP coverage would be considered underinsurance. The only published study on underinsurance, which used a definition of out-of-pocket expenses greater than ten percent of family income, found that an estimated 18 percent of privately insured children were underinsured in 1994. At greatest risk of being underinsured are those below 200 percent of poverty and in poor health and those with individually purchased private health insurance plans.[16]

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15 Martin DP, Diehr P, Cheadle A, Madden CW, Patrick D, Skillman SM: Health Care Utilization for the “Newly Insured”: Results from the Washington Basic Health Plan. *Inquiry*, 34:129-142, 1997.

16 Short PF, Banthin JS: New Estimates of the Underinsured Younger than 65. *Journal of the American Medical Association*, 274:1302-1306, 1995.

Of course, some states may determine that the administrative costs associated with the verification and enforcement of eligibility criteria to avert crowd-out outweigh the benefits.[17] They may elect to focus exclusively on policies aimed at deterring employers from discontinuing or reducing coverage for dependent children eligible to enroll in CHIP. This could be accomplished through a state law to prohibit employers who offer health insurance benefits from discriminating against lower wage workers.[18]

Age and Income Options

Many states may be considering whether to vary income eligibility for CHIP by age group. States that have already raised Medicaid eligibility to a level above 150 percent of poverty for infants or other age groups may be examining the option to make health insurance coverage available to these children at the maximum allowable income ceiling -- 50 percentage points above the level at which they currently provide Medicaid. Also, states that are facing budget constraints and are unable to cover all children up to 200 percent of poverty may be thinking about covering younger children at higher income levels than older adolescents, just as Congress has done under Medicaid.

Certainly there are compelling reasons to provide health insurance protection to all children and the choices for states will be difficult. Infants, for example, require insurance for costs related to

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17 Most premium subsidy programs for children do not impose strict requirements to avert crowd-out. Chollet DJ, Birnbaum ML, Sherman MJ: *Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience.* Washington, D.C.: Alpha Center, October 1997.

18 With respect to health plans, neither the federal Employee Retirement Income Security Act (ERISA) nor the federal tax code require employers who purchase group health insurance for employees to establish uniform eligibility and benefit policies for all employees without regard to the amount of their compensation. The tax code requires that the same health benefits offered to highly compensated employees be offered to all employees -- but only with respect to employers that self-insure. Regulation of health insurance, and indirectly the employers who purchase it, is left to states.

California, as part of its CHIP program, has enacted state legislation to amend its tax code to prohibit employers from discriminating among their employees in the offering of health insurance. The law applies to employers who purchase insurance as well as those who self-insure. California law also forbids employers from shifting employees' children into CHIP by directly referring employees to the program or by modifying coverage so as to make CHIP enrollment more attractive.

their birth; regular preventive and primary care to monitor their physical, emotional, and social development and to treat common acute conditions; and, for some, specialized medical services and therapies to manage congenital anomalies and other chronic conditions. Among those in families with incomes between 100 and 200 percent of the poverty level, 23 percent of infants are uninsured, and among those with incomes between 200 and 300 percent, 14 percent are uninsured.[19] Older adolescents as a group require insurance for preventive interventions to address psychosocial adjustment, injuries, eating habits, sexual behavior, and substance abuse; family planning and pregnancy services; mental health and substance abuse services; and chronic care services that may include durable medical equipment and assistive devices as well as specialized medical treatment and therapies. Their rates of uninsurance are even higher. Twenty-nine percent of adolescents ages 13 to 19 in families with incomes between 100 and 200 percent of the poverty level are uninsured, and 15 percent with incomes between 200 and 300 percent are uninsured.[20]

Disability and Income Options

Another option available to states is to establish a more generous income eligibility policy for children with disabilities than for children without disabilities. States unable to cover all children up to 200 percent of poverty might still want to make children with disabilities eligible at this income level, and those able to cover all children at the maximum allowable income level might want to use a separate income methodology for this target group, disregarding a set amount of their family income [as permitted under 1902(r)(2)]. Even states that expect to have a uniform income eligibility policy for all children could elect to use income disregards specifically applicable to disabled children so as to extend CHIP protection to more children with disabilities. Such disregards might include uninsured medical expenses for supplies, equipment, assistive devices, ancillary

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19 Estimates from the March 1997 Current Population Survey prepared by the Employee Benefit Research Institute for Fox Health Policy Consultants.

20 Ibid.

therapies, mental health treatment, and other items and services; specialized child care expenses; respite care expenses; and expenses related to home and car modifications.

States choosing to make children with disabilities eligible for CHIP at higher income levels than other children would be able to establish their own criteria for disability. They might elect to use SSI disability criteria or they might select an alternative approach, perhaps based on functional impairment, specific service requirements, or expected treatment costs. The particular criteria selected probably would be determined on the basis of the cost and administrative feasibility of identifying these children and on how liberally the state wanted to interpret disability. States not interested in using SSI disability determination approach may want to design their own instrument for determining disability and administering this as part of their CHIP application process. There are several existing instruments that states could use as a guide.[21]

The reason to provide children with disabilities easier access to CHIP is that their medical expenses are about three times greater than that of their healthier peers[22] and their families are more likely to experience difficulties in obtaining affordable coverage for them. Still, children with disabilities have lower rates of uninsurance than healthier children. Their families are apparently more likely to pay for whatever coverage is available to them. National data reveal that 16 percent

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21 One instrument is the Questionnaire for Identifying Children with Chronic Conditions (QuICCC), which addresses both functional and service needs among children under age 18 in Stein RI, Westbrook LE, and Bauman LJ: Manual for the Questionnaire for Identifying Children with Chronic Conditions (QuICCC). Bronx: Albert Einstein College of Medicine/Montefiore Medical Center, 1997. All of the questions together will identify approximately 18 percent of all children. Another instrument is the questionnaire used for the 1994-1995 Disability Supplement to the National Health Interview Survey (NHIS). It allows for multiple approaches for defining disability, and estimates of the proportion of children with disability will vary according to the questions selected. A third instrument is the set of questions used in the NHIS to identify children with limitations of activity, which can be mild, moderate, or severe. These questions combined will identify approximately seven percent of children. Both sets of questions in the NHIS can be found in Adams PF, Marano MA: Current Estimates from the National Health Interview Survey, 1994. *Vital Statistics*, 10 (193), 1995.

22 Trupin L, Rice DP, Marc W: *Medical Expenditures for People with Disabilities in the United States, 1987.* Washington, D.C.: National Institute on Disability and Rehabilitation Research. US Department of Education, 1995.

of children with disabilities in families living between 100 and 200 percent of the federal poverty level are without health insurance.[23]

Geography and Income Options

Geography is another variable that states can take into account in designing their CHIP eligibility policies. Some states may be considering using this option to target children in distressed urban or rural areas where health status is poor and provider shortages persist. Children in these geographic areas might be covered at a higher income eligibility level than other children in the state.

Focusing limited CHIP resources on children in a particular community could result in positive health outcomes for these children and for the community as a whole (particularly if the state obtained a special waiver to cover their families as well). Just as states have done with Medicaid managed care enrollment, CHIP coverage could also be phased-in over time in certain geographic areas until the entire state is covered. Nevertheless, the option is likely to raise concerns about equality across jurisdictions and a state would need to be sure that geographic and income targeting was politically acceptable before proceeding.

Family Coverage Option

Finally, states have the option under Title XXI to seek a special waiver so that CHIP coverage can be offered to families at a cost-effective rate without precluding coverage of the state's defined group of targeted low-income children. For larger families it may be less expensive to purchase family coverage than individual child coverage. This option would seem to be most

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23 Provisional estimates from the 1994 National Health Interview Survey prepared by Paul Newacheck of the University of California, San Francisco.

attractive to states that are able to extend CHIP coverage to children in families with incomes above 200 percent of poverty and that had projected a relatively low rate of uninsurance among the CHIP-eligible child population.[24] Other states that might be interested in this waiver option are those that currently provide coverage to low-income families under an 1115 Medicaid demonstration waiver and wish to build on this model as well as those that use state-only funds to subsidize family coverage and wish to secure federal financial support.

The main reason for offering insurance to families is that, to a large extent, the health and well-being of children depends on that of their parents. Strong evidence exists showing that children whose parents have a chronic health problem are more likely to have developmental delay; increased rates of anxiety, depression, and other emotional and behavioral problems; and inadequate dietary habits.[25] These effects can only be exacerbated when parents are unable to afford appropriate treatment. Still, insuring adult family members is costly and will limit a state's capacity to cover uninsured children at higher income levels. In addition, states offering CHIP coverage to families are more likely to have concerns about crowd-out than those offering coverage to children only.

SUMMARY AND CONCLUSIONS

Policymakers seeking to implement CHIP have many choices available for determining which low-income children to cover. The simplest of these options is to establish CHIP eligibility for all children up to a certain income level. States with constrained resources, however, can phase-in coverage for children at higher income levels by age, as they have done with Medicaid.

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24 Current Population Survey data on uninsurance show a relatively low rate of uninsurance -- eight percent -- among children in families with incomes above 200 percent of poverty. Estimates from the March 1997 Current Population Survey prepared by the Employee Benefit Research Institute for Fox Health Policy Consultants.

25 Steele RG, Forehand R, Armistead L: The Role of Family Processes and Coping Strategies in the Relationship Between Parental Chronic Illness and Childhood Internalizing Problems. *Journal of Abnormal Child Psychology*. 25:83-94, 1997. Drucker PM, Greco-Vigority C, Coil G, Moore-Rusell M, Avaltroni J: Depression and Anxiety in Children of Substance Abusers. *Psychological Reports*. 80:723-732, 1997. Garley D, Gallop R, Johnson N, Pipitone J: Children of the Mentally Ill: A Qualitative Focus Group Approach. *Journal of Psychiatric and Mental Health Nursing*. 4:97-103, 1997.

Alternatively, states can choose a combination of eligibility options, including covering all children up to a certain income level and also targeting children at higher income levels who have disabilities or reside in certain geographic areas. These options provide states with flexibility to focus their resources on child populations who have the greatest health care needs and the least access to private health insurance. Finally, states can request a special waiver to purchase family coverage if it is more cost effective than child-only coverage.

Regardless of the eligibility decisions selected, states must assure that enrolled children are not eligible for Medicaid or a state employee's health benefit plan and are not covered by group or other private insurance. Most states will also want to assure that enrolled children have not dropped private coverage to enroll in CHIP. CHIP was intentionally designed to build on existing Medicaid and private health insurance systems. States' success will be evaluated in terms of their ability to reduce the number of uninsured children who are eligible for Medicaid as well as those who have incomes up to 200 percent of poverty, or higher in some states. In addition, they will be judged in terms of their ability to maintain or even increase the number of privately insured children. Clearly, in the next few years, states will be attempting to structure a coordinated system of free, subsidized, private health insurance for all children.