ISSUE REVIEW

Iowa Legislative Fiscal Bureau

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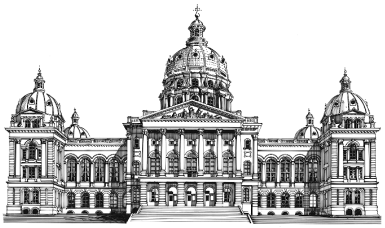


State Capitol
Des Moines, IA 50319
November 6, 1998

Implementation of the State Children's Health Insurance Program

ISSUE

Iowa's plan to implement the State Children's Health Insurance Program (SCHIP) includes expansion of Medical Assistance coverage to children in families up to 133.0% of the Federal Poverty Level and creation of the Healthy and Well Kids in Iowa (HAWK-I) Program for children in families up to 185.0% of the Federal Poverty Level.

AFFECTED AGENCIES

Department of Human Services (DHS)
Department of Public Health
Maternal and Child Health Centers
Public Schools

CODE AUTHORITY

Title XXI of the Social Security Act created in the Balanced Budget Act of 1997
House File 2517 (Healthy and Well Kids in Iowa [HAWK-I] Program Act of 1998)
Senate File 2410 (FY 1999 Human Services Appropriations Act)

BACKGROUND

Federal Enacting Legislation and Requirements

The federal State Children's Health Insurance Program (SCHIP) established in the Balanced Budget Act of 1997 included the following:

- Addition of a new Title XXI to the Social Security Act to provide health care coverage to uninsured targeted low-income children.
- Congressional appropriations specifying Iowa's allotment of $32.4 million annually, a State matching funds requirement of 25.37% (requiring an annual General Fund appropriation of $11.2 million to fully maximize federal funds).
- Option of participant cost sharing.
- Funding available October 1, 1997, with the ability to carry forward funds for three years.
- Coverage of targeted low-income children, under age 19, living in families below 200.0% of the Federal Poverty Level (annual income of $27,300 for a family of three), not Medicaid eligible or covered under an existing group health plan or other health insurance, and not the dependent of a State employee. States have the option of determining eligibility levels up to 200.0% of the Federal Poverty Level.

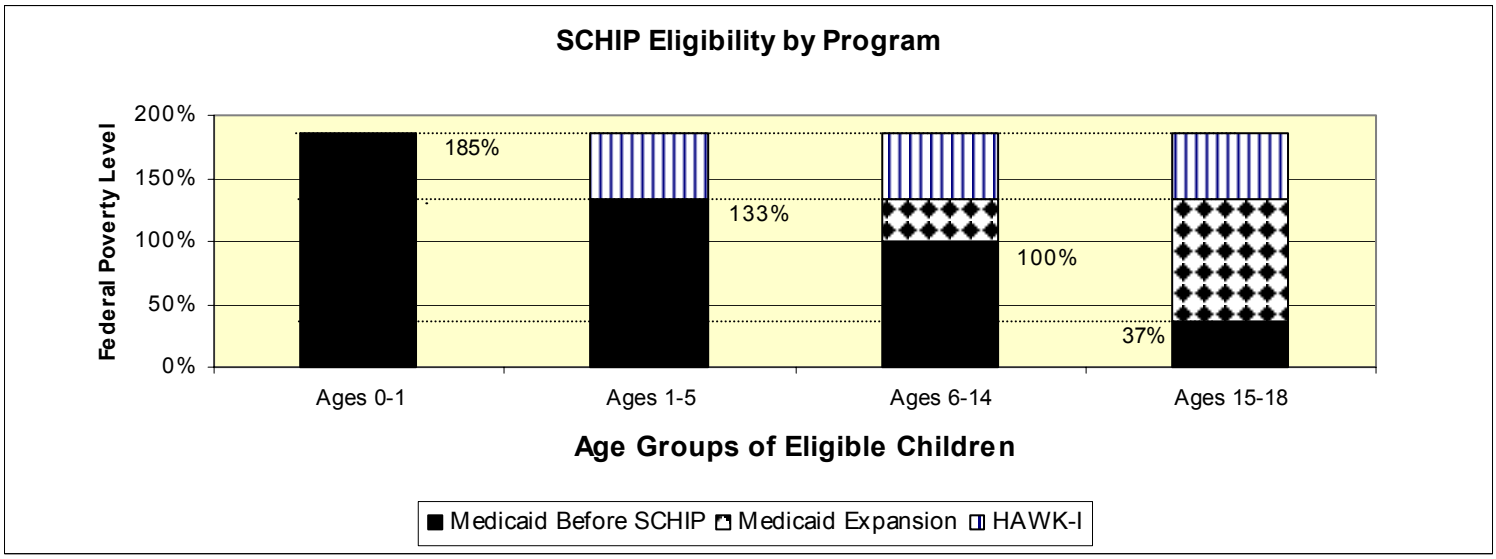
- Options for use of Title XXI funds including expansion of Medicaid, a new child health program, or a combination of the two.
- Basic program design elements including full Medicaid coverage or a benchmark equivalent benefit package, mandatory comprehensive benefits, optional benefits, and cost sharing permitted for families between 150.0% and 200.0% of the federal poverty level.

Iowa's State Children's Health Insurance Program

Iowa's chosen option for implementing the State Children's Health Insurance Program is a combination of Medicaid expansion and a new program. House File 2517 (HAWK-I Program Act of 1998) expanded Medicaid coverage for children to 133.0% of the Federal Poverty Level effective July 1, 1998, and created the HAWK-I Program for children in families with incomes up to 185.0% of the federal poverty level effective January 1, 1999. The Act designates State, public, and ex officio legislative Board members, provides mandates to the DHS including development of a two-page application form for both Medicaid and HAWK-I eligibility, and establishes Board duties and Program requirements.

Figure 1 indicates by Federal Poverty Level and age group, which Program option will cover eligible low-income children.

Figure 1



Outreach Efforts

Under Title XXI, the federal law requires that states create multifaceted outreach programs, including efforts to:

- Inform the public about the new programs.
- Identify all eligible children in the State.
- Assist families in enrolling children in the appropriate program.

CURRENT SITUATION

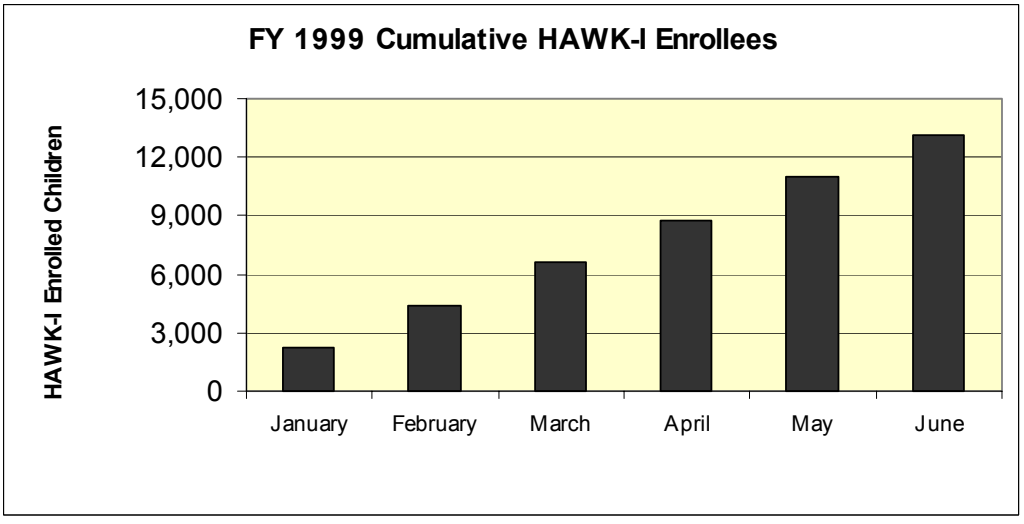
HAWK-I Board

Attachment 1 includes a list of appointed HAWK-I Board members and their affiliations. Staff support is provided by the Department of Human Services (DHS). At the July 20, 1998, Board meeting, Christopher Atchison, Director, Iowa Department of Public Health, was elected chairperson. House File 2517 (HAWK-I Program Act of 1998) specified the responsibilities of the HAWK-I Board. The Board has met monthly to conduct business since July.

Outreach Contract with the Zimmerman Company

The DHS received 12 proposals from various companies and selected Zimmerman Public Relations and Marketing Firm of Des Moines for the outreach contractor. The budget for contracted outreach activities in FY 1999 is $500,000. A public awareness campaign is expected to include posters, brochures, handouts, and television spots as specified in the Request for Proposals. The DHS estimates that 16,000 children in the State are newly eligible for the Medicaid expansion, many of them siblings of younger Medicaid eligibles, and 40,000 children in the State will be eligible for the HAWK-I Program effective in January 1999. The DHS has established an enrollment target of 15,500 children in the Medicaid expansion category and 39,500 children in the HAWK-I Program by the end of FY 2000. New enrollees in the HAWK-I Program during the second half of FY 1999 are anticipated per the schedule illustrated in Figure 2.

Figure 2



Third Party Administrator RFP/Contract

On September 28, 1998, HAWK-I Board members voted to award a Third Party Administrative (TPA) contract to Eligibility Services, Inc. of Dallas, Texas. Eligibility Services, Inc. is in the process of establishing an office in West Des Moines. As of this writing, the contract has not been signed, but will be retroactive to October 1, 1998. The duties of the contractor include development and implementation of a system to administer eligibility determinations, enrollment, premium collection, customer services, and data reporting for the HAWK-I Program.

Figure 3

TPA Implementation Timetable

Begin Contract	October 1, 1998
Begin HAWK-I enrollment	December 1, 1998
HAWK-I Program Effective	January 1, 1999

Children Enrolled in the Expansion Effort

The DHS has identified a minimum of 4,174 new children enrolled in Medicaid from July 1, through September 30, 1998. These new enrollees live in families with incomes between previous Medicaid eligibility levels and 133.0% of the Federal Poverty Level (FPL). Through the first quarter of FY 1999, some reporting challenges have been identified, including the addition of an estimated 8,000 children with a 0.0% reported FPL. Expected corrections to these reports will identify a portion of the 8,000 children as SCHIP eligibles. Although outreach efforts have been initiated to identify children eligible for the HAWK-I Program, enrollment will not begin until December 1, 1998, with coverage effective January 1, 1999.

Presumptive Eligibility

Presumptive eligibility is a state option, which would allow immediate coverage of a SCHIP applicant with subsequent determination of actual eligibility. Since the contract with the Third Party Administrator requires a 10-day time frame for complete processing of applications, the DHS recommended to the Board that presumptive eligibility be excluded from the initial process. The DHS and the Board agreed to study the issue to determine if there is a need for a presumptive eligibility process in the future.

Remaining Implementation Issues

The HAWK-I Board has established a monthly premium payment of $10 per child, not to exceed $30 per family for families with incomes above 150.0% of the FPL. The Board has not yet resolved issues of client copayment (copay) for office visits or any other medical care. However, Board members agreed to include a $25 emergency room visit copay in proposed Administrative Rules, and specified that inclusion in the proposed Administrative Rules would provide a forum for public comment. The $25 copay will be waived if the visit results in admission to the hospital or the ER visit is deemed necessary in accordance with lay person standards. Insurance packages typically include emergency room visit copays as a means of reducing overall costs (and premiums) of the coverage, thus costs of insurance may be increased if the copay is omitted from the Program. The proposed Administrative Rules, previously reviewed by Board members, are scheduled to be noticed to the public on November 4, and will be considered for adoption at the December 21 HAWK-I Board meeting.

Participating Insurance Carriers

The DHS and the HAWK-I Board are currently pursuing contracts with insurance carriers. Although no insurance companies have formally indicated participation in the Program, the DHS estimates at least three companies will likely participate.

Children with Special Needs

The HAWK-I Board has appointed a committee to study and make recommendations concerning the coverage of children with special needs or disabilities. The Board is to consider recommendations of the Children with Special Needs Committee at a future meeting. **Attachment 2** is a Fact Sheet, provided by the Maternal and Child Health Policy Research Center, funded by the Robert Wood Johnson Foundation. The Fact Sheet reports the national incidence of disability among uninsured children with variances from less than 2.0% to over 30.0%, depending upon what disabilities are included in the data. A 1994 National Health Interview Survey estimated that approximately 460,000 (6.3%) low-income uninsured children nationally experienced some level of disability in 1994. Most low-income families surveyed (77.5%) cited the high cost of health insurance as the primary reason for lack of coverage.

ALTERNATIVES

Other States' Activities – Summary of attachments: **Attachment 3** is a map of other states' activities concerning policy options of expansion of Medicaid, a new private program, or a combination of both, as determined by submission of state plans to the Health Care Financing Administration. **Attachment 4** provides a snapshot of state action, including various eligibility levels and timelines, as compiled by the National Conference of State Legislatures (NCSL).

Wait and Evaluate

This alternative allows the Program to be initiated while evaluating eligibility, enrollment, and possible costs or savings to other State programs as a result of receiving SCHIP benefits. Other State programs with potential cost differences minimally include Medicaid, Family Investment Program (FIP), Indigent Care, special needs education programs, and Department of Public Health programs for children.

Budget Management Options

Challenges during the implementation stage may include managing within the budget. If more individuals enroll than anticipated, the HAWK-I Board members or the General Assembly may need to review use of a waiting list, changes in eligibility levels, increased copays or premiums, or a decreased benefit package as possible budget management alternatives.

If enrollment is significantly less than anticipated but outreach activities are deemed sufficiently effective, the General Assembly may choose to expand eligibility to 200.0% of the FPL based on federal permissive language.

Additional Policy Options

Additional policy options include buy-in of coverage for families above 200.0% of the FPL for currently uninsured children, at no additional cost to the State, by allowing families to pay the entire monthly premium. Since the family would pay the premium, there would be no resulting State or federal fiscal impact, other than residual administrative expenses.

Federal legislation also allows inclusion of coverage for parents in families up to 200.0% of the FPL as long as no additional cost to the State is incurred. For example, if the monthly premium costs the same for family coverage as it costs for the State to cover the eligible children, inclusion of the parents is allowable. Section 2105(C)(3) "Waiver for Purchase of Family Coverage" of the Balanced Budget Act indicates that Title XXI funding is available to states for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the state establishes to the satisfaction of the Secretary (of Health and Human Services) that:

1. Purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage of only the targeted low-income children involved; and
2. Such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of the family coverage.

The General Assembly may decide to direct the DHS to proceed with waiver action if it is determined that extending coverage to parents of eligible low-income children at no cost to the State is desirable.

BUDGET IMPACT

With information obtained after the start of the HAWK-I Program in January 1999, it will be possible to determine the budget impact of expanding eligibility or instituting cost saving measures if it appears that Iowa will exceed the $7.0 million State General Fund appropriation and matching federal funds of $20.6 million anticipated in FY 1999. The federal government requires that Iowa's allocation be spent within three years.

The General Assembly may determine that the State has a responsibility for support of part or all of the Program if the federal government reduces federal financial commitment. For the Medicaid expansion, the costs would be the loss of the enhanced match rate, which for FY 1999, is 10.9% higher than the standard Medicaid match rate the State currently receives. The total fiscal impact to the State would be an increase of $4.7 million if the entire Program were included as a Medicaid expansion. The federal government would continue to match State Medicaid expenditures for the expanded eligibility group if the federal SCHIP commitment were withdrawn. The costs of the HAWK-I Program would presumably become a complete State financial responsibility if not a part of Medicaid. It is important to note that there has been no indication that the federal government will lessen or withdraw financial commitment to the SCHIP.

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HAWK-I Board, 1998-99 (cont.)

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The Child Health Insurance Project

MATERNAL & CHILD HEALTH
POLICY RESEARCH CENTER

FACT SHEET

December 1997

Number 1

Children with Disabilities Under the State Children's Health Insurance Program

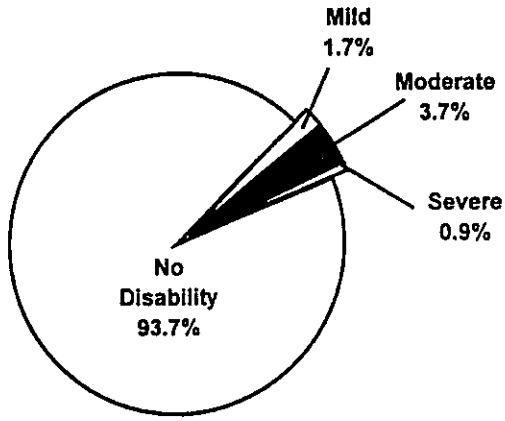
by Paul W. Newacheck

New Estimates from the National Health Interview Survey

Enactment of the State Children's Health Insurance Program as Title XXI of the Social Security Act affords states unprecedented opportunity to extend coverage to low income uninsured children, many of whom have disabilities. This fact sheet is intended as background material for states to better understand coverage issues for children with disabilities under Title XXI. Disability can be defined in various ways and the Title XXI statute provides no definition of the term. In prior studies using a variety of data sources, prevalence estimates for childhood chronic conditions have ranged from less than two percent to over 30 percent. Estimates at the higher end of the range include chronic conditions that have very modest effects on children's lives, while estimates toward the lower end of the spectrum include only conditions causing severe disability or need for personal assistance in carrying out basic activities of daily living.

In this fact sheet, we have defined disability in terms of social role limitations caused by chronic conditions. Specifically, children are defined as disabled if they are limited in or unable to conduct age-appropriate school or play activities due to chronic conditions. All data are drawn from the 1994 National Health Interview Survey and are specific to the target population for Title XXI, uninsured children living in families with incomes below 200 percent of the federal poverty level. Future fact sheets will provide similar information on the population of children with special health care needs.

Disability among Uninsured Children in Low Income Families



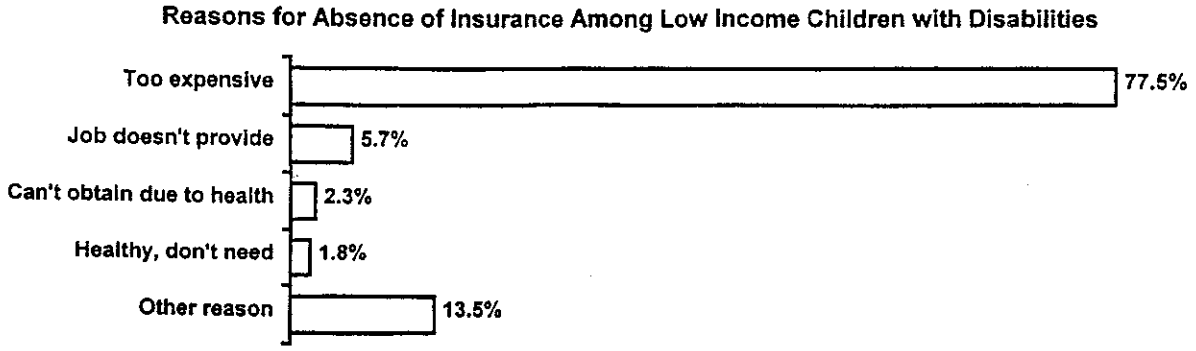
Source: 1994 National Health Interview Survey

How Large is the Disabled Population?

An estimated 6.3 percent of low income uninsured children experienced some level of disability in 1994. This translates to approximately 460,000 children nationally. Most of these children experienced disabilities of mild or moderate severity. That is, they were limited in the kind or amount of school, play or recreational activities they could engage in due to chronic conditions. Fewer than one in every hundred low income uninsured children experienced a severe disability. These are children who are unable to engage in age-appropriate school or play activities due to chronic health problems. These results suggest that although disability is not uncommon among the population targeted for the new Title XXI program, severe disability is in fact relatively rare. This is because the great majority of severely disabled children are already insured through existing private and public health insurance programs.

Why Do Children with Disabilities Lack Health Insurance?

Approximately 84 percent of low income children with disabilities had some kind of insurance coverage in 1994. The remaining 16 percent were uninsured for a variety of rea-



Source: 1994 National Health Interview Survey

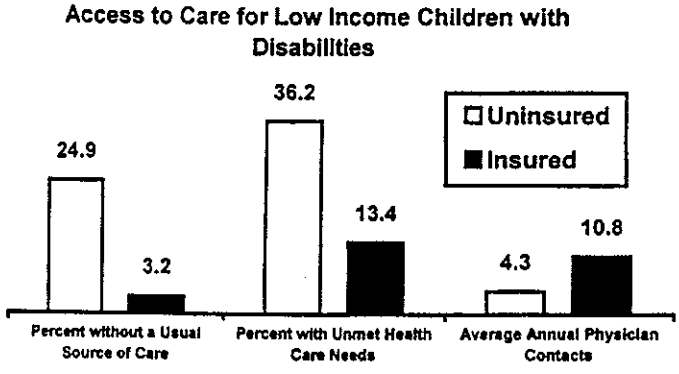
sons. Not surprisingly, most low income families cited the high cost of health insurance as the primary reason for lack of coverage for their disabled child. The high cost of coverage was cited by three of every four low-income families with an uninsured disabled child. Respondents in approximately one in every fifteen low income families responded that absence of employer coverage was the main reason for their disabled child being uninsured. Much smaller proportions of low income families reported either that they attempted to get health insurance coverage but were denied it, or that they felt their child was healthy enough as not to require health insurance coverage.

These survey results, indicating that expense is the primary reason for absence of coverage, suggest that many families would be interested in obtaining health insurance for their disabled child were the cost of that coverage lowered. Consequently, the availability of subsidized health insurance coverage under Title XXI, whether through state plans or Medicaid, should result in large numbers of disabled children gaining needed health insurance coverage.

What is the Impact of Insurance on Access to Health Care?

Uninsured low income children with disabilities face significant disadvantages when it comes to accessing health care. The chart below underscores the impact of health insurance on access to health care. Among low income children with disabilities, uninsured children were eight times more likely than insured children to be without a usual source of health care.

Uninsured children were also almost three times more likely to have unmet health needs. That is, times in the past year when the family felt their disabled child needed a service but couldn't obtain it. These services include medical and dental care, mental health care, prescribed medications and eyeglasses. Finally, uninsured children use less than half as many physician services as insured children within this population. Taken together, these results indicate that absence of insurance coverage puts disabled low income children at significant disadvantage compared to insured children. As a result, extending coverage to uninsured low income children with disabilities should result in substantial improvement in their access to care.



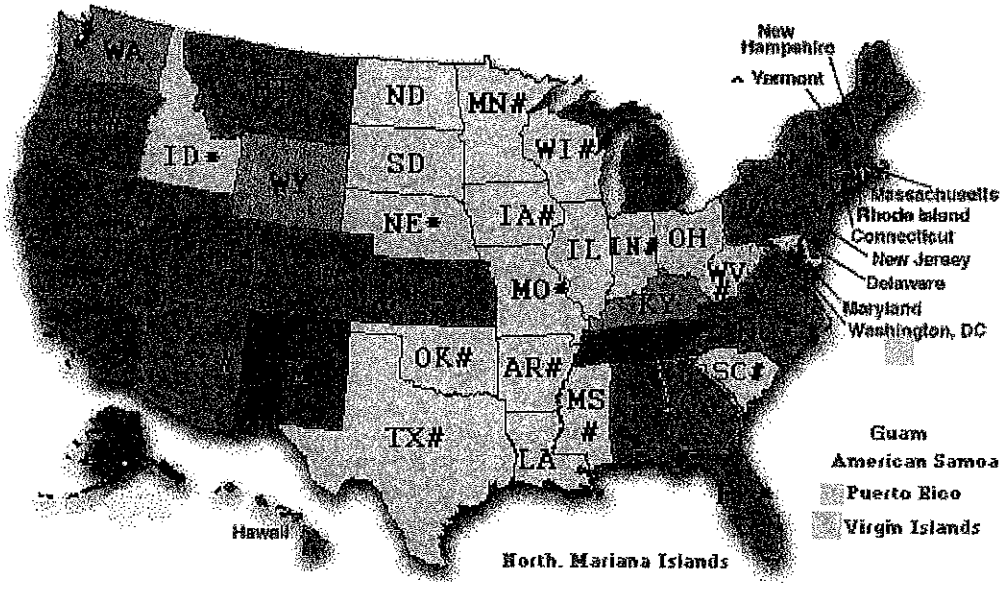
Source: 1994 National Health Interview Survey

Conclusion

Without health insurance, low income children with disabilities experience substantial difficulties obtaining needed health care. Obtaining health insurance is simply too expensive for most families with disabled children in the Title XXI target population. Expanding Medicaid eligibility thresholds or providing new state health insurance plans should enable children with disabilities to obtain the care they need to participate fully in society.

This fact sheet was funded by the Robert Wood Johnson Foundation with supplemental support from the federal Maternal and Child Health Bureau.

CHILD HEALTH INSURANCE PROGRAM
STATE PLANS



APPROVED

- Separate State Child Health Plan
- Medicaid Expansion
- Combination

PENDING

- Separate State Child Health Plan
- Medicaid Expansion
- Combination

NO SUBMISSION

* State Plan Amendment ^ State Has Withdrawn Plan

\# State has indicated submission is an initial phase; plan amendment is anticipated.

NOTE: This map is available in color from the LFB. Please call if you prefer this attachment in color.

SUMMARY INFORMATION

Number of Plans Submitted: 51
(AL, AK, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MA, MD, ME, MI, MN, MS, MO, MT, NH, NC, NE, NJ, NM, NV, NY, ND, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WV, WI)

Number of Plans Approved: 45
(AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, LA, ME, MA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NY, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TX, UT, VA, VI, WI, WV)

Number of Separate State Child Health Plans: 13
(AZ, CO, DE, GA, KS, MT, NC, NV, NY, OR, PA, UT, VA)

Number of Medicaid Expansions: 28
(AK, AR, DC, HI, ID, IL, IN, IA, LA, MD, MN, MS, MO, NE, NM, ND, OH, OK, PR, RI, SC, SD, TN, TX, VI, VT, WV, WI)

Number of Combinations Plans: 10
(AL, CA, CT, FL, KY, MA, ME, MI, NH, NJ)

Number of State Plan Amendments Approved: 7
(AL, CA, FL, MI, MO, NE, PA)

Number of State Plan Amendments Under Review: 2
(ID, NC,)

Attachment 4

National Conference of State Legislatures

CHILDREN'S HEALTH INSURANCE:
STATE ACTION SNAPSHOT

File size = 60KB (approx. 13 pages)

Updated September 24, 1998

50 state plans have been submitted and 40 states have received approval from the Health Care Financing Administration.

This chart is a revised version of the one accompanying **"Insuring More Kids"** published 1/98.

State	Pre-CHIP Medicaid Age/Eligibility*		Medicaid	Insurance Options	Remarks
Alabama [state plan on-line]	<1 1-5 6-14 14+	133% 133 100 15	Approved plan expands ages 15-18 to 100% as phase one. Proposed S 228 and H 92 allocate and appropriate funds for the expansion.	Phase II will be a private insurance plan that may include up to 200% up to age 18. The state plans on submitting this plan this year.	**Plan approved 1-30-98** proposed start 2-1-98 **Plan amendment approved 8-18-98** Plan amendment to institute state insurance program submitted 5-20-98 S 228 signed by the governor on 5-1-98 SJR 74 signed by the governor on 3-11-98 extends the life of the Children's Health Insurance Program Committee H 92 signed by the governor on 4-27-98 creates the Children First Trust Fund within the state treasury with about 10% of the funds earmarked for the Children's Health Insurance Program.
Alaska [state plan on line]	<1 1-5 6-14 14+	133 133 100 76	H369 proposes to expand Medicaid to 200% through age 19	State may study an insurance option for future expansion	**Plan submitted 8-31-98** H 369 was signed by the governor on 7-1-98
Arizona	<1	140		SB 1008 creates a children's	**Plan approved 9-18-98**

	1-5 6-14 14+	133 100 32		health insurance program administered by AHCCCS to provide coverage equivalent to the state employee benefits. For year one children through age 18 under 150% will be eligible. After year one, eligibility expands to 175%. The bill also creates an alternative to this program with direct services from DHS. Cost sharing for >150% is based on an income-related sliding scale not to exceed 5% of income.	Plan submitted 6-25-98 SB 1008 was signed by the governor on 5/20/98
Arkansas	<1 1-5 6-17	200 200 200	Recent 1115 waiver program called "ArKids First" covers all kids under 19 up to 200%. The first phase of the plan will narrowly expand Medicaid eligibility to children born between 9-30-82 and 10-1-83 with incomes below 100%.		**Plan approved 8-6-98** Plan submitted 5-12-98 Considering converting the waiver program into the state's Title XXI plan (Phase II.)
California [state plan on-line]	<1 1-5 6-14 14+	200 133 100 82	Accelerate eligibility for ages 14-18 up to 100% with asset test waived	Healthy Families Program for children ages 7-18 with incomes 100%-200% and ages 1-6 with income 133%-200%; proposes an insurance purchasing pool for families without access to employer coverage and an insurance purchasing credit to subsidize families with access to employer coverage. As of 3-4-98 the purchasing credit was on hold. S 1398 would make amendments to Healthy Families	**Plan approved 3-24-98** **Plan amendment approved 6-26-98** Plan submitted 11-20-97 legislation passed (A 1126, S 903) There are over a dozen bills being considered by the legislature that could affect Healthy Families. Proposed A 1373 which passed the Assembly as of 3-20-98 would allow charitable organizations and nonprofits to participate in the application assistance program.
Colorado	<1 1-5 6-14 14+	133 133 100 39	S134 expands to age 19 at 100% and changes the resource standard for eligibility	Phase I - The CHP+ state plan would be offered statewide to children through age 18 to 185%. Those with incomes above 185% may buy in at full premium. Phase II - may include a buy-in for family coverage.	**Plan approved 2-18-98** Plan submitted 10-14-97 Legislation passed in 1997 allowed state to move ahead quickly (HB 1304); plan expected to begin 1-98 H1325 signed by the governor on 4-22-98 made technical changes to the law including increasing the age of eligibility to children under 19 up to 185%.
Connecticut	<1	185	Healthcare for	HUSKY Part B, based on	**Plan approved 4-27-98**

	1-5 6-16	185 185	Uninsured Kids and Youth (HUSKY) Part A to accelerate eligibility for ages 14-18 to 185% and implement continuous eligibility for 12 months unless child reaches age 19	state employee benefit package, to subsidize coverage up to 185%-300%; children over 300% must pay full cost; two supplemental health insurance programs, Husky Plus proposed for children 185%-300% with special health care needs not met by the basic benefit package	Plan submitted 1-21-98 Legislation passed 10-97 (H 8601) H 5051 signed by the governor on 4-7-98 amends the HUSKY Part B eligibility to allow disregard of family income. H5021 appropriates funds for the program and was signed on 5-19-98
Delaware	<1 1-5 6-18	185 133 100		The Delaware Healthy Children Program (DHCP) proposes to cover children ages 0-18 with incomes up to 200%. Proposed by the Governor, S246 would create the Diamond State Health Plan for Children. The Department of Health and Social Services would administer the plan and integrate its administration with the State's Medicaid Managed Care Program. Gov. also proposed partnering with employers to open the Plan to uninsured children below 300%	**Plan approved 9-1-98** Plan submitted 6-30-98 S246 Introduced 1-22-98
District of Columbia	<1 1-5 6-14 14+	185 133 100 34	Medicaid expansion through age 18 to 200% called Healthy DC Kids		**Plan approved 9-17-98** Plan submitted 5-11-98
Florida	<1 1-5 6-14 14+	185 133 100 28	Phase I - accelerate eligibility for ages 15-19 to 100% H 4415 expands Medicaid eligibility for 15-18 up to 100%	H 4415 increases funding to the state's Healthy Kids Program, which subsidizes insurance for children up to 200% with no asset test. Families over 200% may participate without premium assistance.	**Plan Approved 3-5-98 (Phase I);** **Plan Amendment Approval 9-8-98** H 4415 was signed by the governor 5-28-98 S 1230 ensures confidentiality of Florida Health Kids Program information and became law on 5-22-98 without the governor' s signature.
Georgia [state plan on-line]	<1 1-5 6-18	185 133 100		S410 creates a health insurance program for ages 0 through 18 to 200% administered by the state's employee system. Those with higher incomes may be able to buy into the program.	**Plan approved 9-3-98** Plan submitted 5-29-98 Senate Bill 410 was signed by the Governor on 4-10-98
Hawaii	<1	300	The state's		HCFA submission is scheduled

	1-5 6-19	300 300	Medicaid program is undergoing changes resulting from a lawsuit, so plans are unclear. The state may reduce Medicaid eligibility from 300% for 6-18 to 100% and to 133% for children 1-6 and 185% for 0-1		for September. HCR 121 urges the children's health insurance program planning committee to develop universal health coverage for all children--a Medicaid expansion seems likely.
Idaho	<1 1-5 6-14 14+	133 133 100 29	Phase I - expand to cover children to age 19 with incomes up to 160% H 799 Appropriates Medicaid funds for the expansion and directs the Dept. of Health and Welfare to control program costs by raising or lowering eligibility but not exceeding 150%		**Plan approved 6-15-98** Plan submitted 2-13-98 H 799 **signed into law by governor on 3-25-98**
Illinois **[state plan on-line]**	<1 1-5 6-14 14+	133 133 100 46	Jan. 1998 expanded coverage to infants up to 200% and from age 1-18 to 133%	Phase II - possible private insurance program H 705 creates KidCare a state insurance program patterned after Medicaid for children through age 18 at 133 to 185%. This proposal also includes an employer premium contribution.	**Plan approved 4-1-98** Plan submitted 12-31-97 H 705 was signed by the Govenor on 8-12-98 H 455 was signed by the governor. It appropriates funds for the Children's Health Insurance program. S 106 also mentions appropriations for the Children's Health Insurance Program and was signed by the governor. A special task force is meeting to iron out issues, especially cost sharing requirements.
Indiana	<1 1-5 6-18	150 133 100	S19 Increases eligibility for children less than 19 years up to 150% for one year	S19 - As of July 1, 1999 establishes a children's health insurance program within the state's Department of Health with premiums and cost-sharing.	**Plan approved 6-26-98** Plan submitted 4-17-98 S19 was signed into law by the Governor on 3-12-98.
Iowa	<1	185	H2517	H2517 creates the HAWK-1	**Plan approved 9-1-98**

	1-5 6-14 14+	133 100 39	expands medical assistance to children under 19 up to 133%	Program for children under 19 and between 133 to 185%	**Plan submitted 6-1-98** H 2517 **was signed by the governor on 5-14-98** **S2410 appropriates funds for the program and was signed on 5-19-98**
Kansas	<1 1-5 6-17	150 133 100		Governor and S 424 propose a Kansas Insurance Coverage for Kids (KICK) program for children up to age 18 up to 200%	**Plan submitted 9-1-98** House sub for Senate sub for S 424 was signed by the governor on 4-21-98.
Kentucky [state plan on-line]	<1 1-5 6-14 14+	185 133 100 33	accelerating eligibility for ages 14-18 to 100% H125 would expand from birth to one up to 235% and from one to 18 up to 200% H255 and S128 propose an expansion for children between the ages of 14 and 18 to 100%	Kentucky Children's Health Insurance program will increase access to children through the age of 18 up to 200%. This program will include employer premium sharing. S128 would provide health care coverage to children through the age of 18 up to 200% through the Kentucky Children's Health Insurance Program. The Cabinet for Human Resources would establish the regulations for eligibility, copayments and premium contribution. Would give them authority to create an incentive program for employer-sponsored health 8nsurance, including partial subsidies of employee contributions to employer-sponsored programs. S 2 would create the Kentucky Healthy Children's Program and Foundation	**Plan submitted 6-12-98** S 128 was incorporated into S 5 and was signed by the governor on 4-2-98 H125 was incorporated into H131 and passed the Senate and the House as of 3-16-98 S 2 was carried over to the 1999 session as of 3-16-98
Louisiana	<1 1-5 6-18	133 133 100	Submitted plan to expand Medicaid for children under 19 up to 133% and an outreach campaign to existing Medicaid eligible children (Phase I).	The state will work to develop Phase II, a separate pilot program.	**Plan submitted 7-31-98** S 78a signed by the governor on 5-19-98 gives the Dept of Health and Hospitals authority to expand Medicaid and administer CHIP. It also requires the task force to study expanding LaCHIP for children under 19 between 133-200%
Maine	<1 1-5 6-19	185 133 125	H 1595 expands eligibility for children 1-18 who are below 150% of the nonfarm income.	H 1595 creates the Cub Care program, a state insurance program with monthly premiums, for children between 150 and 185% of the nonfarm income	**Plan approved 8-7-98** Plan submitted 5-19-98 H 1595 (Public Law No. 777) was signed by the governor on 4-16-98

Maryland	<1 1-5 6-14 14+	185 185 185 34	Governor proposes to expand eligibility through age 18 to 200% S 85 expands Medicaid up to 18 with an income at or below 185%	Governor proposes a revised Thriving E health insurance pr failed in 1997 S 125 appropriates federal funds for the health program. S 85 creates a vou for children in famili incomes 186 to 20C not eligible for Medi purchase employer health care or indivi benefit plans.
Massachu-setts [state plan on-line]	<1 1-5 6-17	185 133 133	Expand eligibility to 200% for infants and 150% through age 18	New Title XXI progr all kids up to 18 yea Medicaid eligible up pair with the Medica expansion. The plar provide premium as families with emplo sponsored insuranc to employer-sponsc insurance
Michigan [state plan on-line]	<1 1-5 6-16	185 150 150	H 5532 appropriated funds to provide comprehensive health care to children. Children in families below 150% would be included in a Medicaid expansion.	Submitted plan for I would provide comp health care to childı 19 up to 200%, with and co-payment for to 200%. H 5532 appropriate the MIChild Prograr under the age of 19 H 5385 changes the Michigan Caring pr MI CHILD program eligibility from 185 t adds benefits.
Minnesota	<1 1-5 6-19	275 275 275	Proposal to expand to children under age 2 in families between 275 and 280%	S 3346 proposes to coverage for familie who are ineligible fc MinnesotaCare due availability of emplc for which the emplo or more of the cost coverage
Mississippi	<1 1-5 6-18 14+	185 133 100 34	Proposal for Phase I is a Medicaid expansion for children ages 15-18 with incomes up to 100%.	Phase II proposes a program for children with incomes betwe 133%. S 2174 establishes Mississippi Children Insurance Program

				through age 18 and It is a Medicaid look the same administra and benefits as Me H 489 would appro funds for the state r H 1665 would expa to children 14 throu 133% with benefits the state employee insurance plan. There is also intere premium assistance families that have e sponsored insuranc
Missouri	<1 1-5 6-14	185 133 100	Submitted plan to amend state's 1115 waiver to expand to 300% through age 18 and uninsured children, regardless of income, attending schools in Chapter 1 districts. It also proposes to expand coverage to certain adults and families S 632 expands to children under the age of 19 up to 300%. Would also cover uninsured individuals transitioning off of public assistance up to 300% and uninsured custodial parents up to 100%	H 1638 would use t Tobacco Settlemen to purchase health children less than 3 would also be a slid premium.
Montana [state plan on-line]	<1 1-5 6-14 14+	133 133 100 41	.	Montana's Childrer Insurance Plan will insurance to cover zero through 18 at 150%. Families will option to purchase managed care. The annual enrollment f state match for yea limited to $210,000.
Nebraska [phase 1 plan on line] [phase 2 plan on line]	<1 1-5 6-14 14+	150 133 100 34	Governor and bill L 1063 proposes Kids Connection, an extension of Medicaid providing health care coverage for children up to age 18 and pregnant women up to 185%. Also allows caretaker relatives with children one year or younger and below 150% and relatives with children 1to 6 below 133% and relatives with children 6-15 at or below 100 to be eligible for Medicaid.	

Nevada	<1 1-5 6-14 14+	133 133 100 45		Establish a subsidiz program called Nev Up for children up t family incomes up t premiums and copa income.
New Hampshire [state plan on-line]	<1 1-5 6-19	185 185 185	Phase I - expand coverage to children up to age one up to 300%	Phase II - subsidiz for children betwee between 186 and 3 phase would includ and other cost-shar provisions.
New Jersey	<1 1-5 6-14 14+	185 133 100 41	Expand to 133% to age 18	KidCare program tc private insurance tc incomes between 1 families above 150 pay sliding scale pr
New Mexico	<1 1-5 6-14	185 185 185	Propose expansion for children under 19 up to 235%	
New York [state plan on-line]	<1 1-5	185 133		Expand existing Ch Health Plus prograr subsidized insuranc to 222% through ac

	6-14 14+	100 61		families with incom greater than 160% subject to cost shar A 5887 would expa eligibility and benef under the child hea insurance plan.
North Carolina [state plan on-line]	<1 1-5 6-18	185 133 100		S 2a establishes a program to insure c under the age of 19 200%. The program run b the Dept of H and Human Service the State Employee Health plan with the benefits 3qual to th employees plus der vision and hearing. 150% pay enrollme and copayments.
North Dakota	<1 1-5 6-18	133 133 100	Governor proposes expansion for children up to 18 below 100%.	Governor supports private health insur program for childre age 19 from 101 to
Ohio	<1 1-5 6-14 14+	133 133 100 32	Expansion was already underway to 150% through age 18	
Oklahoma	<1 1-5 6-14 14+	150 133 100 28	Expansion for children under 19 up to 150% S 1228 would expand up to 18 years and up to 185% S 1018 would expand up to 18 years up to 200% S 478 would expand to children under 18 and up to 250%with a sliding scale premium not to exceed 30% of the total premium	
Oregon [State Plan on-line]	<1 1-5 6-19	133 133 100		Medicaid look-alike cover children from age 6 from 133% tc and age 6 to 19 fro to 170%. A new prc called Family Healtl Insurance Assistan Program, created b law, will offer subsi employer-sponsore individual coverage those below 170%.
Penns-	<1	185		Expand on the exis

ylvania	1-5 6-14 14+	133 100 39		children's health ins program. S 91 provides free l care to a child unde or below 200%. Thc incomes between 2 235% must be subs at a rate not to exc 50%. HR 291 would urge Governor to elimina ceiling on the numb children enrolled in
Puerto Rico			Expand Medicaid to children through age 18 in families with incomes below 200% of the commonwealth poverty level ($8,220 for a family of four)	
Rhode Island	<1 1-5 6-17	250 250 250	Expand Medicaid up to 250% to age 18. Families 185-250% have a choice of premiums or copayments H 6276 H 8120 S 451 S 2391 S 2692	Exploring a Title XX waiver to subsidize employer-based co for family members including adults
South Carolina **[state plan on-line]**	<1 1-5 6-18	185 150 150	Expand to 150% through age 18-Partners for Healthy Children Program	
South Dakota [state plan on-line]	<1 1-5 6-19	133 133 100	expand for ages 6-18 to 133%	
Tennessee	<1 1-5 6-17	400 400 400	Expansion already underway to allow TennCare application for any uninsured child under 18 below 200% who has access to health care insurance; copays and deductibles will be reduced for children below 200%. S 1640 and H 1443 would address expansion of TennCare eligibility.	
Texas **[state plan on-line]**	<1 1-5 6-14 14+	185 133 100 17	Phase 1 of plan accelerates Medicaid eligibility for children 15-18 up to 100%.	Legislature already authorized the Heal Kids Corporation in based on Florida's p

Utah [state plan on-line]	<1 1-5 6-18	133 133 100		Utah Children Health Progra will cover between 100% 200% through age 18, with a benefit desigr based on the state employees' health plan HB 137 would create the Uta Children's Health Insurance Program for children unde 19 whose family income is at or below 200%
U.S. Virgin Islands				Proposal wou use CHIP money to pay existing Medicaid deb incurred after federal Medicaid func were depleted No new programs or services will b offered.
Vermont	<1 1-5 6-17	225 225 225	May propose to expand full benefit coverage up to 275% and limited benefit coverage for those 275%-300% for children up to age 18; may offer family coverage to those between 150%-175%	Proposal wou supplement services for some children with existing insurance
Virginia [state plan on-line]	<1 1-5 6-19	133 133 100	H 30 expands the Medicaid program from birth to 18 up to 150% H 1074 proposes to cover children up to 19 in families below 200%	Governor proposes new program calle KidsCare for ages 6-19 up 200% H 30 appropriates funds for the Comprehensi Health Investment Project of Virginia (CHIF It creates a separate child health insurance program to cover children up to 19 with incomes 150-185% with a Medicaid look alike benefit package.
Washington	<1	200	S 6374 proposes to expand to children up to 18	Governor

	1-5 6-19	200 200	years up to 250% H 2631 would expand to children with incomes at or below 150%	proposes to expand the existing Basic Health Plan tc 250% for eligible childre H 2632 would expand eligibility for tl Basic health plan for children unde the age of 19 between 200 and 250% H 3026 would create the children' healt initiative program for those under tl ate of 19 and between 200 250% S 6472 would create the children's health insurance initiative program for children unde the age of 19 between 200 and 250%
West Virginia	<1 1-5 6-19	150 133 100	Governor proposes to expand for children one through 5 up to 150% H 4299 would expand to children under age 6 below 150%	Governor proposes a private health insurance program for non-Medicaid eligible children under 19 up to 200%. Families above 150% would have a sliding scale premium and families above 200% may be allowed to purchase coverage at full premium. H 4299 also creates a separate state program which initially would cover children 6-18 up to 150%	**Plan approved 9-15-98** Plan submitted 6-18-98 H 4299 was signed by the governor on 4-8-98
Wisconsin	<1 1-5 6-14 14+	185 185 100 62	Pending 1115 waiver and extend eligibility to children born before 9-30-83 through age 18 up to 100%	Propose new BadgerCare insurance program similar to Medicaid and administered by the Medicaid agency; would cover uninsured children and adults up to 185% and allow families to remain covered until income exceeds 200%; cost-sharing for income over 143%; children with parents whose employers provide coverage of 80% or more are not eligible; will need a waiver of Title XXI to cover adults	**Plan (Phase I Medicaid expansion) approved 5-29-98** Plan submitted 3-12-98 Legislature approved program in the budget bill passed 10-97 (A 100)
Wyoming	<1	133		S.F. 50 would allow the state	S.F. 50 died in the Senate on 3-3-

	1-5 6-14 14+	133 100 55		to contract with private insurers to provide insurance to families with income of 175% or less. Families 150-160% would pay 25% of the premium and this would increase on a sliding scale up to 75% of premium for families 170-175%. Eligible individuals may elect coverage from private employer-based heath insurance; individual coverage under a group health insurance plan; a state-administered children's health insurance plan or a medical savings account.	98 Study groups exploring options

For further information on this chart, contact Laura.Tobler@ncsl.org or call (303) 830-2200 x 179

Sources & Resources:
NCSL chart: CHIP Federal Allotments & Statistics
NCSL's Health Policy Tracking Service (StateServ) - CHIP web resources on-line [updated 6/98]
Health Care Financing Administration - further HCFA information available on-line
National Governors' Association
American Academy of Pediatrics
State home pages and telephone interviews

Note: Information contained in this chart reflects the best information available from the list of sources as of the date at the top. It is not a comprehensive summary of all state actions or proposals. ver. d

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