A Preliminary Guide to

Expansion of Children's Health Insurance in the Balanced Budget Act of 1997

A Report from

Families USA

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A Preliminary Guide to Expansion of Children's Health Coverage

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INTRODUCTION

The Balanced Budget Act of 1997,[1] signed by President Clinton on August 5, 1997, provides billions of dollars over the next 10 years to expand health insurance for uninsured low-income children. These funds will be available to states that choose to expand Medicaid or to purchase insurance coverage under the new State Children's Health Insurance Program (SCHIP).

This major investment of public funds in children's health comes in response to a growing crisis. Currently, 10 million children are without insurance for 12 months or longer in a two-year period.[2] The great majority of uninsured children live in families in which one or both parents are working.[3] However, despite a strong economy, there has been a steady decline in employment-based coverage for children.[4] The expansion of Medicaid eligibility for children, which began in the mid-1980s, offset some of the decline in employer-based coverage, but there are also nearly 3 million uninsured children eligible for Medicaid who are not receiving it.[5] Insurance coverage matters because uninsured children receive significantly less medical care than insured children do.[6] Uninsured children frequently go without doctor visits—even children age five and under—and are twice as likely as insured children to get care in emergency rooms.[7] Yet health insurance coverage for children is significantly less expensive than insurance for adults.[8]

The Act provides the greatest opportunity in decades to expand health insurance coverage to millions of America's low-income children. Children's advocates have a critical role to play in assuring that their states make the most of this opportunity. The first step for consumer advocates is to find out who will be making decisions and how advocates can participate in the planning process. The next step is to ensure that all states commit the state funds required to obtain all available federal matching funds.

Once states decide to fully participate in the new program, they must then decide whether to expand Medicaid, create a separate children's health insurance program, or combine both options. States should make this decision only after a thoughtful process that assesses the characteristics of uninsured children in the state and the strengths and weaknesses of the alternatives for providing coverage. For many states, Medicaid expansion will be the fastest and least expensive way to provide a good benefit package to children on a statewide basis. However, in those states that elect to create a new children's health program separate from Medicaid, it will be important to coordinate with Medicaid and incorporate the best of the Medicaid model.

This preliminary guide provides a framework for people in states facing these initial implementation decisions. However, the Department of Health and Human Services has just begun to address many key questions, so some of the information presented is only provisional, based on our reading of the statute. Families USA is preparing a comprehensive Guide to Expansion of Children's Health Insurance, which will incorporate future interpretations by the agency as well as developments in the states.

CAPSULE SUMMARY OF THE ACT

The Balanced Budget Act creates a new Title XXI of the Social Security Act, called the State Children's Health Insurance Program (SCHIP). Title XXI authorizes federal matching funds at an enhanced matching rate for states that elect to provide health insurance coverage to uninsured children. States can cover uninsured children by expanding Medicaid, creating or expanding separate state insurance programs, or a combination of both options. Most of the provisions in Title XXI describe the requirements for the separate state health insurance option. This guide will refer to the separate state program as ***SCHIP***. The Act also amends the Medicaid statute to provide an enhanced match for states that expand Medicaid to cover children who are not currently eligible. This guide will refer to this option as ***Medicaid expansions***. We will use the term ***Title XXI*** when discussing requirements applicable to both the SCHIP and the Medicaid option.

Key Provisions of the Act

- **Funding**
  - $40 billion in federal matching funds will be available to states over the next 10 years to expand children's health insurance coverage, beginning October 1, 1997.[9]
  - Each state is eligible for a maximum annual allotment of federal matching funds, based on a formula that takes into account the number of low-income uninsured children in the state.
  - Federal dollars will match state dollars at a rate that, in fiscal year 1998, is from 9 percent to 30 percent higher than the federal matching rate for general state Medicaid spending.
  - The enhanced federal matching rate is available for expansions either through Medicaid or through a non-entitlement children's health insurance program.
  - A state with an approved state plan has three years to spend its allotment before unused funds are reallocated to other states.

A state-by-state list of allotments, enhanced federal matching rates, and the number of uninsured low-income children used to calculate the allotments is attached to this report.

- **Uses of state allotments**
  - States can choose whether to expand children's health insurance by expanding Medicaid, purchasing insurance coverage that is equivalent to the coverage in certain commercial plans, or a combination of both options.
  - Up to ten percent of total spending on expansion can be used for other purposes, including outreach, direct services, other children's health initiatives, and reasonable administrative costs.

- Medicaid expansions eligible for the enhanced match include accelerating the phase-in of children living in families with incomes under 100 percent of poverty (states must now cover such children born after September 30, 1983) or covering a new category of "targeted low-income children" (defined below).
- Eligible Medicaid expansions must cover children not otherwise eligible for Medicaid based on the state plan in effect on April 15, 1997.
- If states choose to expand Medicaid, all of the current provisions of the Medicaid Act apply. Medicaid remains an entitlement.
- States using funds to create a children's health program other than Medicaid are given great flexibility in covering some or all "targeted low-income children." The benefit package, premiums, and cost-sharing must meet certain requirements, but all other aspects of the program, including which targeted children will be covered and whether the program will operate statewide, will be up to the states to decide. Such a program will not be an entitlement.

Eligibility

- "Targeted low-income children" must live in families with incomes at or below 200 percent of poverty (or up to 50 percentage points higher in certain states with current Medicaid income levels that are higher than 150 percent of poverty), and they must not already be covered by Medicaid or other health insurance. In 1997, 200 percent of federal poverty guidelines for a family of four is $32,100 per year.

Maintenance of Effort

- Participating states cannot change their Medicaid eligibility rules for children to make them more restrictive than they were on June 1, 1997.
- States cannot meet the state match by using premiums, cost-sharing or federal funds. The current Medicaid restrictions on the use of provider taxes and donations also apply to SCHIP. However, the Act contains no restrictions on maintaining current state-funded services for children, except that Florida, Pennsylvania and New York cannot spend less under the Act than they did on their respective state children's health initiatives in fiscal year 1996.

Outreach and Coordination

- States must develop procedures to assure outreach to families of children eligible under the plan or under other public or private health coverage programs.
- States must assure coordination with other public and private health insurance programs.

SECTION I:
HOW FULLY WILL STATES PARTICIPATE?

The bipartisan vote for the child health provisions in the Balanced Budget Act, as well as the proliferation of child health expansion programs at the state level, testify to the broad political support for the goal of insuring more children. Despite this broad support, at least 23 states[10] have not taken advantage of Medicaid's existing offer of federal matching funds to cover all children under 100 percent of poverty. Only seven states provide Medicaid to children living in families at or above 200 percent of poverty,[11] and most non-Medicaid state health insurance initiatives cover only a small percentage of uninsured children in the state.[12] The Act is designed to encourage states to cover more children.

The enhanced matching rate provides a powerful new incentive for states to commit additional state dollars to their uninsured children. It comes at a time when states are in a strong financial position and should be able to raise the required state match. However, some states may have difficulty raising the state match and be tempted to use the enhanced match to save state dollars rather than to maximize opportunities for expanding children's health services.

How Much Does a State Have to Contribute?

The federal government will pay from 65 to 85 percent of program costs, a higher percentage than it pays under the current Medicaid program. A state must be willing to spend state money to expand children's health coverage, but it can spend less of its own funds than a Medicaid expansion would have required before the Act. Under the enhanced federal match, the state share is reduced to 70 percent of the state's Medicaid matching rate (but the state share must be at least 15 percent of total program costs). For example, in New York, the state's share of Medicaid costs in 1998 is 50 percent and the federal share is 50 percent. New York's share of the costs for child health expansion will be only 35 percent (50 percent x 70 percent), and the federal share of New York's expansion will be the remaining 65 percent. A list showing each state's regular and enhanced matching rates—as well as how much money the state must spend to receive its full allotment of federal funds—is appended to this guide.

How Does the Act Affect Welfare-to-Work Initiatives?

States are now implementing welfare reform legislation that seeks to move families from welfare to work. For some families, entry into the work force will mean low-wage employment that does not offer health insurance coverage. Providing insurance coverage for the children of

low-income working families will be an important contribution to the state's investment in welfare reform. In addition, some Title XXI funds may be available to cover more family members than just targeted children. Waivers are available under Title XXI for purchase of family coverage that is cost-effective relative to coverage of only the eligible children in the family.[13] However, HCFA has not yet clarified the scope of this waiver.

Could the Act Help Cover More People through 1115 Medicaid Waivers?

In the past, several states have used 1115 waivers to cover individuals not otherwise eligible for Medicaid. (The Secretary can waive requirements of the Medicaid Act to permit states to test innovative projects designed to promote the objectives of the Act). However, in order to obtain a waiver, the state must demonstrate that it will be "budget neutral." Under Title XXI, a state that elects to expand Medicaid to cover targeted children will receive additional federal funds. Because it will start with a larger pool of federal funds, the state may be more successful in showing that its 1115 Medicaid waiver expanding coverage to new groups—like the parents of targeted children—is budget neutral. Missouri, for example, has applied for an 1115 Medicaid waiver, including child health funds, to cover children up to 300 percent of poverty and adults up to 100 percent of poverty.

Will the New Federal Funds Replace Existing State Spending?

The Act protects existing state spending on Medicaid by prohibiting participating states from making eligibility rules for children more restrictive than they were on June 1, 1997. However, there is no similar protection for non-Medicaid spending. Only Florida, New York and Pennsylvania are precluded from spending less on child health initiatives than they did in the past.

Many states will have available funds to commit to children's health from Medicaid surpluses due to declining numbers of beneficiaries or managed care savings or from additional revenue sources such as cigarette taxes or tobacco settlement proceeds. However, some states are facing budget shortfalls, and the political and financial climate may be such that the only way the state will expand children's health insurance is by obtaining federal matching funds for existing state spending. Advocates must monitor such spending proposals closely to assure that the outcome is an expansion of children's health services and not merely a shift in costs for the same level of services.

By obtaining an enhanced match for state spending on an existing program, a state can expand the total dollars available for children's health services at no additional cost to the state. Existing state programs that might qualify for the enhanced match include state programs to purchase insurance, provided the coverage meets the required criteria (see

below). In addition, state spending on children's health services other than insurance may be eligible for an enhanced match. However, states may not use more than 10 percent of the funds they receive under the Act for children's health services other than insurance.

A state may also be tempted to redirect spending from existing programs. To the extent that an expansion program truly makes an existing state program redundant, redirecting funds will do no harm. For example, a state program to purchase drugs for children with cancer living in families with incomes under 200 percent of poverty may no longer be needed if the state expands Medicaid to cover all children under 200 percent of poverty. However, if some of the children helped by the cancer program were legal immigrants who entered the U.S. after August 22, 1996, those children not only will lose the benefit but also will not be eligible for Medicaid. States should exercise great care in redirecting existing state funds, and consumer advocates should scrutinize such funding proposals closely. Another dangerous possibility is that states might be tempted to take funds away from existing child health programs that are in no way redundant, solely to obtain the enhanced match for such funds.

Will All Children Who Are Eligible Be Entitled to Coverage?

If a state chooses Medicaid expansion, all eligible children will be entitled to benefits, and once a state has exhausted its Title XXI allotment for the enhanced match, it will still qualify for federal matching funds at the regular Medicaid rate. If a state choose SCHIP, all eligible children will not be entitled to benefits. States can control costs in SCHIP, a non-entitlement program, by capping state expenditures and closing enrollment or establishing waiting lists for eligible children once funds are exhausted. Once the state's has spent its Title XXI allotment for SCHIP, it can draw down no additional federal matching funds.

What Concerns about Participation Are Commonly Mentioned by States?

- **The dip in 2002**. States may be concerned because total federal funding drops beginning in 2002. The reduction in funding was apparently a political compromise required to balance the budget in 2002. However, because states with approved plans have three years to draw down their allotments, they can plan for the dip in 2002 by carrying over funds from year to year. Also, if some states fail to use their entire allotments, there will be a reallocation of unspent funds to those states that need additional funds.

Federal Funds for States to Expand Children's Coverage

1998	$4.275 billion	2003	$3.15 billion
1999	$4.275 billion	2004	$3.15 billion
2000	$4.275 billion	2005	$4.05 billion
2001	$4.275 billion	2006	$4.05 billion
2002	$3.150 billion	2007	$5.00 billion

- **The specter of crowd out**. "Crowd out" refers to the substitution of public programs for private ones. In the context of health insurance, it can occur if either employers or employees drop dependents' coverage in favor of a public insurance program. Title XXI requires state to describe how they will avoid substitution for private coverage. Several studies have tried to determine the extent to which substitution occurred when Medicaid expanded coverage for pregnant women and children.[14] One study found that for every two people who enrolled in Medicaid, one person dropped private insurance.[15] However, other researchers have criticized the methodology of this study, and found different results. Recent studies have shown that either there was no crowd out over the expansion period [16]or that, at most, for every five people who enrolled in Medicaid, only one person dropped private coverage.[17]

  There are various program design features that can minimize the risk of crowd out, but states should not overreact to this issue before the extent of the problem has been convincingly documented. Further, even when substitution occurs, it may provide better coverage for children and needed financial relief for working poor families. States can learn from the experience of those states that have already expanded insurance coverage for children of the working poor. For example, in Florida, the Healthy Kids Corporation originally restricted eligibility to children who were uninsured for the prior six months. However, Florida found verification of prior insurance status to be so cumbersome to administer and unfair to low-income families struggling to pay high premiums that they discontinued the requirement.[18] Minnesota's Medicaid expansion program retains its requirement of no prior insurance, but accepts self-verification of prior insurance status.

  California is the first state to address the issue in its new child health legislation. California looks back to see that a child has been uninsured for three months prior to application the child is uninsured for reasons other than crowding out, like a parent's loss of employment, for example. The state also prohibits employers from modifying health insurance benefits in order that employees' dependents enroll in the program. HHS has promised technical assistance to the states in this area.

SECTION II:
ADVOCATES SHOULD BE INVOLVED IN STATE DECISION-MAKING

In the coming weeks and months, states will be making decisions about whether to participate in children's health expansion, and whether to do so through Medicaid, SCHIP, or both. If states elect SCHIP, they face a wide array of decisions about eligibility, the benefit package, the delivery system, and a host of other factors. One of the first tasks for advocates will be identifying who will be making the decisions and assuring that consumers and their advocates have a meaningful opportunity to participate in the planning process.

What Do You Need to Know about the Federal Process?

SCHIP will be administered by the Center on Medicaid and State Operations within the Health Care Financing Administration (HCFA), the federal agency that now administers Medicaid. A departmental steering committee is currently preparing guidelines for the states. It is co-chaired by HCFA and the Health Resources and Services Administration (HRSA), the agency that now administers grants to Federally Qualifying Health Centers and the Maternal and Child Health programs, among others.

As of the end of September, HCFA has released the following documents relating to the new children's health provisions: a letter to the states that outlines the new legislation; a list of state allotments, enhanced matching rates, and the number of uninsured low-income children used to calculate allotments; answers to 22 preliminary questions; and a draft model application template for Title XXI plans. It plans to release additional guidelines in question and answer format. Among the questions HHS has not yet answered is what kind of public participation will be required from the states, and what opportunities there will be for notice and comment to HCFA after a state's SCHIP plan is submitted.

> *All information from HCFA should be available on their web page (http://www.hcfa.gov). (Consumer advocates who do not have access to the World Wide Web can contact Families USA for copies of HCFA materials.)*

Who Will Be the Key Actors in Your State?

The executive branch, the governor's office, and the lead state agencies, including the Medicaid agency, will undoubtedly play important roles in developing any child health program. However, because participation requires spending state money, in most states, legislation will be required. Many state legislatures will convene in January 1998; others may be called into special sessions. Planning is well underway at the state level. It is imperative that consumer advocates communicate with key state officials to learn what is going on in their state.

States are using a variety of approaches in developing plans for expanding children's health insurance. In California, the Governor's office submitted a legislative proposal within weeks of the Act's passage. In some states, public health departments or the Maternal and Child Health program director may be taking the lead. In Kansas, both the Insurance Commissioner and the Medicaid director have set up task forces. In other states, existing or newly organized commissions may be developing the state's plan. For example, Maine has established a commission to develop a plan and submit a legislative proposal for the 1998 session. Some states, like Wisconsin, have incorporated implementation of the new legislation into ongoing negotiations with HCFA over an 1115 waiver. In a few states, like South Carolina, that have already appropriated funds for Medicaid expansion in 1997, executive officers may be able to take advantage of the enhanced match without new legislation.[19]

What Steps Are Involved in Getting State Plans Approved?

In order to participate in children's health expansion, the state must submit a state plan that is then approved by the Secretary of HHS. The state plan is a document that contains assurances that the state will comply with applicable federal mandates, describes which state options the state has elected, and contains other required information. Separate state plans are required for Medicaid and for Title XXI. If a state elects Medicaid expansion, it must amend its Medicaid plan and file an abbreviated Title XXI plan. If a state elects to expand coverage through SCHIP, it must file a complete Title XXI plan. States may implement expansions before their state plans are approved, but they will receive the enhanced match retroactively only if the plan, as implemented, is approved by HCFA.

- **Medicaid state plan amendments**. Amendments to Medicaid will be filed with the central office of HCFA rather than the regional offices. Amendments are deemed approved if not disapproved within 90 days of submission. There is currently no requirement for public notice when a state amends its Medicaid plan.

- **Child health plans under Title XXI.** A state plan is deemed approved unless the Secretary of HHS notifies the state within 90 days of transmittal that the plan has been disapproved (and the reasons for disapproval) or that additional information is required. A process of public participation is required for Title XXI plans (see below).

What Information Will a Title XXI Plan Include?

HCFA has released a draft format for a Title XXI state plan which it calls a "model application template." It is divided into ten sections. A state that is only expanding Medicaid must complete sections one, two, five, nine and ten, and check off a box stating that the topics in the remaining sections will be addressed in the state's Medicaid plan. A state that is creating or expanding a SCHIP must complete all ten sections.

What Opportunities Are There for Public Participation?

In addition to the usual ways that consumer advocacy groups can try to influence public policy, applicable state and federal laws create some formal opportunities for the public to provide input to state decision-makers on child health implementation.

a. **Medicaid Advisory Committee.** Under the Medicaid Act, states must have a Medical Care Advisory Committee which must be given the opportunity to participate in policy development and program administration.[20] The Committee must include Medicaid recipients and other consumers as well as health professionals. The state's decision whether or not to expand Medicaid is the kind of policy that should involve the Committee.

b. **Title XXI.** ***The state must develop a process to involve the public in the design and implementation of the child health plan and a method for ensuring ongoing public involvement.*** For example, a state could provide information summarizing the federal law and its preliminary ideas for implementation, followed by a series of regional hearings around the state to involve the public in program design. An advisory committee that includes consumers and meets regularly with program administrators is another method of achieving ongoing public involvement.

c. **Rule-making.** In addition to state legislation and the state plan, states will be fleshing out further details of implementation in the form of state rule-making. Rule-making procedures under state administrative procedure laws vary, but typically provide an opportunity for public comment and sometimes a public hearing before proposed regulations become final. (However, if the state intends to enroll SCHIP beneficiaries in managed care, many important provisions of the program may not be set out in rules but rather in Requests For Proposals and contracts with managed care organizations).

About the Title XXI Model Application Template

The ten sections of the draft template and some of the issues to be addressed in each section follow:

1. **General Description and Purpose of the State's Child Health Plan**. Identify options: Medicaid, separate insurance program, or combination.

2. **General Background and Description of State Approach to Child Health Coverage**. Describe the extent children now have insurance, and current state efforts to provide coverage through public or private/public partnerships, and how Title XXI will be coordinated with such programs. Also, how children identified as Medicaid eligible will be enrolled.

3. **General Contents of State Child Health Plan**. Describe proposed delivery systems, contracting standards, plans for enrolling providers, and utilization control systems. Also, describe any plans to use up to 10 per cent of funds for purposes other than insurance coverage.

4. **Eligibility Standards and Methodology**. Describe eligibility standards, methods of establishing and continuing eligibility, screening and coordination with other programs. Also, assure nondiscrimination.

5. **Outreach and Coordination.** Describe methods for outreach to children eligible for this program or any public or private health insurance program, and procedures to accomplish coordination with other programs.

6. **Coverage Requirements for Children's Health Insurance**. Identify the scope of coverage and benefits, and the option selected (benchmark, equivalent, or Secretary-approved, and in NY, FL, & PA, the state program). Check boxes of eligible services to be covered. Select the waiver for cost effective alternatives (direct service by community-based providers) or the waiver for family coverage.

7. **Quality and Appropriateness of Care**. Describe methods to assure quality and appropriateness of care. Check boxes of techniques to be used. Describe methods to assure access to services.

8. **Cost-sharing and Payment**. Identify and describe any premiums or cost sharing. Assure compliance with limitations.

9. **Strategic Objectives and Performance Goals**. Identify objectives for increasing coverage of low-income children, and a performance goal for each objective. Describe how performance will be measured. Check boxes of performance measures used. Make assurances about data collection. Describe the public participation process. Attach the budget.

10. **Annual Reports and Evaluations**. Record progress in reducing the number of uninsured children.

What Is the Timetable for Implementation?

The earliest a state plan can take effect is October 1, 1997. States with an approved plan can use a fiscal year allotment in that year and the two succeeding years. HCFA has interpreted this to mean a state must have its state plan for fiscal year 1998 approved before the end of the fiscal year or lose access to the 1998 allotment. As a practical matter this means state plans should be submitted by July 1, 1998 in order to give HCFA 90 days to review them. For example, Texas is alloted over $561 million in fiscal year 1998. If its state plan is approved before October 1, 1998, it will have until October 1, 2000 to spend its 1998 allotment.

SECTION III: DESIGNING THE OPTIMAL CHILDREN'S HEALTH PROGRAM: MEDICAID EXPANSION, SCHIP, OR BOTH?

States will have to decide whether to expand coverage by expanding Medicaid, purchasing health insurance under SCHIP, or a combination of both options. The best program for uninsured children will not be the same in all states. Some states, like Rhode Island, may have just enacted Medicaid expansions that will now qualify for an enhanced match. Florida, Pennsylvania, and New York are specifically authorized to use SCHIP for the benefit package in their current state children's health programs. For many states, Medicaid will be the fastest and easiest way to provide a comprehensive benefit package for children on a statewide basis. In those states in which Medicaid expansion is not politically popular, SCHIP plans should be designed to incorporate the best of the Medicaid model, and, at the very least, Medicaid should be expanded to cover all poverty level children.

The Pros and Cons of Medicaid Expansion

■ Fiscal and Operational Advantages

The Medicaid program exists in every state and already covers over 18 million low-income children. If a state elects to expand Medicaid, the only aspect of the program that will operate differently is the creation of a new category of eligible children (and some of the record-keeping requirements). Procedures for enrolling beneficiaries, paying providers, and monitoring and regulating quality of care are well established, and the parameters of the program are well understood. Medicaid can be expanded without designing yet another new state program in the already confusing patchwork of existing services. Further, Medicaid for children is not a budget buster. Children make up over 50

percent of Medicaid beneficiaries but account for only 17 percent of Medicaid spending.[21] The Medicaid system offers public administration and accountability. Medicaid has lower administrative costs than private insurance. In addition, once the state's Title XXI allotment is exhausted, Medicaid will continue to make federal payments at the regular matching rate for targeted children. Finally, the larger the Medicaid pool, the greater the bargaining power of states in negotiating rates with providers and health plans.

■ Eligibility and Coverage Advantages

In many ways, Medicaid offers optimal conditions for child health coverage. All eligible children will receive benefits. Medicaid offers a comprehensive benefit package at no cost to low-income families. For children, it covers any medically necessary treatment identified during the course of a well-child screening. It does not exclude pre-existing conditions. Expanding Medicaid enables lower-income children to maintain continuity of care as their parents move from welfare to work and as family income fluctuates. Medicaid is statewide, and offers a delivery system that extends throughout the state. For the large number of Medicaid beneficiaries in managed care, Medicaid requires important basic protections. Further, all children in Medicaid have procedural due process protections.

■ Administrative Disadvantages and Welfare Stigma

There are also problems with Medicaid. In some states, Medicaid has low participation rates because of cumbersome application procedures, limited access to participating providers, and "welfare stigma." However, many of these problems can be solved. Indeed, the Act's goal of reducing the number of uninsured children and the enhanced match for outreach services provide a good opportunity to identify and correct barriers to Medicaid participation.

■ Removing the barriers to Medicaid participation

Many states have streamlined enrollment and facilitated the "de-linking" of Medicaid and cash welfare through a variety of methods including:

- dropping the assets test,
- shortening the application process,
- making expedited eligibility determinations,
- allowing mail-in application, and
- renaming the program. Vermont, for example, has renamed its children's Medicaid program "Dr. Dynasaur."

The Balanced Budget Act gives states two additional tools to improve outreach and continuity of care. It authorizes, at state option:

- presumptive eligibility for children and
- 12-month minimum eligibility periods for children.[22]

Presumptive eligibility permits Medicaid providers, as well as Head Start, WIC, and certain child care programs qualified by the state, to make preliminary Medicaid eligibility determinations and immediately qualify children for benefits. The 12-month eligibility option permits children to retain Medicaid coverage regardless of whether the family experiences increases in income during the year.

■ Fiscal and Political Disadvantages

The National Governor's Association, while strongly endorsing the expansion of children's health coverage, has called for the "budgetary certainty" of a non-entitlement program.[23] In some states, expanding an entitlement program like Medicaid simply may not be politically feasible. In those states, it will be important that any state-designed program adopt as much as possible of the best of Medicaid. Further, at the very least, all states should accelerate the phase-in of coverage for poverty level children.

The Pros and Cons of SCHIP

■ Eligibility and Coverage Disadvantages

A fundamental disadvantage of SCHIP is that eligible children will not be entitled to benefits after budgeted funds are exhausted. In the design of the program a state has great discretion. Some states may exercise that discretion to design a program as good as the best of Medicaid, but the Act authorizes the states to design a program that provides considerably fewer protections for children than they would receive under Medicaid. SCHIP need not operate on a statewide basis. This means funds can be allocated to districts based on political expediency rather than the needs of children.[24] SCHIP can be much more restrictive than Medicaid in terms of eligibility standards, the benefit package, coverage of pre-existing conditions, affordability, managed care protections, due process, and other factors. A new health plan for children will add to the confusion of multiple programs all operating under different rules. Some families may have to perform a juggling act with younger children in the Medicaid program and older children in a SCHIP. Fluctuations in family income may mean going back and forth between Medicaid and SCHIP. When family income rises, it will be easier for children who lose Medicaid eligibility to fall through the cracks.

■ **Fiscal and Operational Disadvantages**

The state will have to devote considerable time and resources to the many implementation issues raised in designing an entirely new program. Further, once the state's allotment is exhausted there will be no further federal matching funds as there are under Medicaid. Finally, it may be more difficult to hold a state accountable for expenditures under a block grant program.

■ **Fiscal and Political Advantages**

On the other hand, some states do not want to expand entitlement programs. Since SCHIP is not an entitlement, states will be able to close enrollment when funds are exhausted rather than allocate more money to the program or cut back on benefits for those already covered. In addition states will not have to comply with federal mandates governing the Medicaid program.

■ **Flexibility and Opportunities for Innovation**

Some states will welcome the flexibility of SCHIP. Benefits may be available to certain immigrant children ineligible for Medicaid (discussed below). Several states have successfully implemented innovative children's health programs on a small scale that provide good coverage for children, are not perceived as welfare programs, and are popular with families. SCHIP programs might be able to offer a broader choice of mainstream benefit plans and outreach to families through schools and childcare centers. Because a state must coordinate SCHIP with other health programs, and enroll children it finds eligible into Medicaid, SCHIP may become an effective Medicaid outreach program.

Comparison of Key Features of Medicaid and SCHIP

Thirteen key features of a children's health insurance program under Medicaid and SCHIP are set out in Table 1 and described in further detail in this section.

Note: Some parts of the following description of the Medicaid program may have been modified in states with 1115 waivers.

Eligibility

- **Targeted low-income children.** Both Medicaid and SCHIP eligibility rules refer to the definition of targeted low-income children. The Act defines such children as follows:
  - Under age 19
  - Living in families with incomes at or below 200 percent of poverty or a level up to 50 percentage points higher if the state currently provides Medicaid to children in families with incomes over 150 percent of poverty. For example, Washington State already covers children under 19 in families with incomes at or below 200 percent of poverty; therefore, it will be able to cover children in families with income at or below 250 percent of poverty.
  - Not covered under a group health plan or under health insurance[25] (this does not exclude children covered by a state program operating prior to July 1, 1997 without federal funds). In its September 11, 1997 set of answers to frequently asked questions, HCFA said this section excludes a child who has insurance with high premiums and minimal benefits. However, HCFA is re-examining this conclusion.
- **Exclusions from eligibility.** The following are *not* considered targeted children:
  - A child who is an inmate of a public institution or patient in an institution for mental diseases; or
  - A child who is a member of a family eligible for health benefits on the basis of a family member's employment with a state public agency.
- **Medicaid eligibility criteria.** Under a Medicaid expansion, Medicaid eligibility rules apply to targeted low-income children. How some of the criteria in the definition of targeted low-income children that are inconsistent with Medicaid eligibility rules will apply to Medicaid expansions is unclear.[26] States will receive matching funds for all Medicaid-eligible children, but may not receive the enhanced match for children who are not also targeted low-income children.
  - A child cannot already be eligible for Medicaid based on the state plan in effect on **April 15, 1997.** On this date, all states covered at least children under age six living in families with incomes under 133 percent of poverty and older children born after September 30, 1983 in families with incomes under 100% of poverty. Forty-one states have expanded Medicaid eligibility for children beyond these federally mandated minimums.[26]

Table 1

Summary Comparison of Medicaid and SCHIP

	Medicaid	SCHIP
Process	Amend state Medicaid plan and file abbreviated Title XXI plan	Design a new children's health insurance program and file Title XXI plan
Eligibility	Lower income children under age 19	Additional criteria including duration limits
Immigrants	Option to cover "qualified aliens" who entered the U.S. before 8/22/96	Unclear. Possible optionto cover more children
Geographic area	Statewide	Any area within state
Benefits	Comprehensive, including vision, hearing, mental health and dental	Can be less than least generous commercial "benchmark" plan
Pre-existing Conditions	Not excluded	Group health and group insurance can exclude
Premiums and Cost-sharing	None	Up to 5% of family income over 150% federal poverty line; nominal if at or under 150% of poverty
Children with Special Health Needs	Home and community-based care, no service limits, no mandatory managed care without a waiver	No discrimination based on diagnosis; plan can exclude home and community-based care services and impose service limits; no cap on cost share for those under 150% of poverty
Managed CareSafeguards	Choice of plans, Basic consumer protections	None beyond state law
Entitlement	Federal match available (at lower rate) after allotment exhausted	No federal match after allotment exhausted; waiting list allowed
Procedural Protections	Right to notice and hearing before termination or denial	No requirements beyond Constitutional minimum
Provider Payment Rates	Rates sufficient to assure equal access	Access to be addressed in state plan
Continuity of Care	Changes in family income less likely to disrupt coverage.	Children of different ages more likely to change coverage when family income changes

- The enhanced federal match is also available for accelerating the phase-in of children living in families with incomes under 100 percent of poverty. Federal law now requires states to cover poverty level children born *after* September 30, 1983. States that elect to cover older children born *on or before* September 30, 1983 can now get an enhanced match to do so until these children are phased in as mandatory.

- **SCHIP eligibility standards**. Children eligible for Medicaid must be enrolled in Medicaid and are not eligible for SCHIP. SCHIP permits states to cover only targeted low-income children and to establish additional eligibility standards relating to the following factors:

- **Geographic areas to be served**. The program need not be available statewide. It can be limited by city, county, or indeed, even neighborhood.
- **Age**. The state may set an age limit lower than 19.
- **Income and resources, including standards relating to spenddowns**. The state can set a lower income ceiling than 200 percent of poverty. However, within any defined group of eligible children, the state cannot cover higher-income children without also covering lower-income children. The word "spenddown" is not defined in Title XXI, however in the Medicaid program a spenddown enables over-income persons to qualify for benefits once medical expenses equal the amount by which the person exceeds the applicable income ceiling.
- **Residency**. The state can impose residency requirements. Disability status. The state can condition eligibility on disability status, so long as this does not restrict coverage based on disability.
- **Disability status**. The state can condition eligibility on disability status, so long as this does not restrict coverage based on disability. For example, a state could have more liberal income deductions for children with disabilities than for other children.
- **Access to or coverage under other health coverage**. The state can exclude children who have access to insurance (e.g., through a parent's employer), but who are uncovered because their parents cannot afford to pay the premium. States can also exclude children with coverage that does not cover primary and preventive care like a catastrophic illness policy.
- **Duration of eligibility**. The state can set maximum time limits for coverage even if the child has no access to other health insurance at the end of the time period.

Immigrant Eligibility

- **Medicaid for immigrants.** States have the option of covering "qualified aliens" who entered the country prior to August 22, 1996. Among qualified alien children who entered after August 22, 1996, all but certain exempt categories of children are barred from Medicaid for a five-year period.[27] Children who are not qualified aliens are not eligible for Medicaid. These rules exclude not only children here illegally, but many legal residents, too.
- **SCHIP for immigrants.** In its September 11, 1997 Answers to Frequently Asked Questions, HCFA says that SCHIP is subject to essentially the same restrictions on covering immigrants as Medicaid. However, several immigration law experts say HCFA's interpretation is wrong.[28] They say, in the absence of any specific provision on immigrants in Title XXI itself, state funds administered by the states under SCHIP are "state public benefits." Therefore, states have the option of covering immigrants, including those who arrived after August 22, 1996 and those who are not "qualified aliens," with state funds and getting a federal match for such expenditures. Only the federal funds subject to restrictions like those that apply to Medicaid. The final word on this issue must await further developments.

Continuity of Care

- **Medicaid Continuity.** Currently, Medicaid covers children at different ages and income levels. Expanding Medicaid will enable all children within the same family to have the same health insurance program, and will allow family income to fluctuate within a wide range without disrupting existing coverage. For example, Iowa's Medicaid program now covers children under age one at or below 185 percent of poverty, children age 1 to 6 at or below 133 percent of poverty, children 6 to 15 at or below 100 percent of poverty, and children 15 and older, who also meet AFDC criteria, at or below about 39 percent of poverty. Were Iowa to increase Medicaid levels to 185 percent of poverty for all children under age 19, all children in the same family will be covered by the same program. Further, family income can fluctuate from no income to 185 percent of poverty without disrupting insurance coverage. Frequent changes in income are common among the near poor. Administrators of the Children's Medical Security Plan in Massachusetts say for three-quarters of their enrollees income changes monthly.[29]

- **SCHIP Continuity.** Children who are eligible for Medicaid must be enrolled in Medicaid and are not eligible for SCHIP. This means under SCHIP, families are more likely to have children of different ages in different programs, and will be obliged to switch coverage more often as family income fluctuates. If Iowa were to create a SCHIP which covers all eligible children under 185 percent of poverty, children under age one in the family will still be enrolled in Medicaid while older children are enrolled in SCHIP. Further, if family income drops to 133 percent of poverty, the children in the family under age six must switch from SCHIP to Medicaid. If family income drops to 100 percent of poverty, the children in the family age six to 15 must change coverage. If family income drops below 39 percent of poverty, and the family meets AFDC criteria, the older children must switch to SCHIP. If the family does not meet AFDC criteria, the older children will remain in SCHIP while the younger children are in Medicaid.

Geographic Area

- **Medicaid geographic area.** Medicaid must operate on a statewide basis.

- **SCHIP geographic area.** SCHIP does not have to be statewide.

Benefits

- **Medicaid children's benefit package.** Medicaid provides a special benefit package for children called Early and Periodic Screening, Diagnosis and Treatment, or EPSDT. (It may go by a different name in some states. For example New Hampshire calls it CHAP,

the Children's Health Assurance Program.) EPSDT effectively establishes a national benefit package for children in the Medicaid program. EPSDT benefits include periodic well-child medical, dental, vision, and hearing checkups; immunizations; laboratory tests; and health education. A broad package of diagnostic and treatment services is covered for both newly diagnosed conditions and pre-existing conditions. Moreover, EPSDT includes aggressive outreach to notify children and their families about the importance of preventive care and the availability of benefits.

The diagnosis and treatment components of EPSDT require that when a provider discovers a medical need, states must arrange for corrective treatment. This requirement is not limited by the usual "amount, duration, and scope" restrictions permitted in Medicaid. When medically necessary, a state must provide children all mandatory and optional services included in federal Medicaid law, even if the state has not otherwise selected the optional service. *A list of Medicaid-covered services is in the Appendix.*

- **SCHIP children's benefit package**. The complex benefit provisions of SCHIP reflect the conflicting desires to ensure meaningful benefit packages and to permit state flexibility. The state can choose coverage equivalent to any one of the benchmark plans described below, or it can design its own plan—so long as the state benefit plan includes certain services and is at least the actuarial equivalent of one of the benchmark plans. Also, the Secretary of HHS can approve an alternative plan.
  - **Benchmarks**. A state can choose coverage equivalent to *any one* of the three following benchmark benefits packages.
    - *Federal employee health benefits, FEHB*. One benchmark is the standard Blue Cross/Blue Shield preferred provider option offered to federal employees. A list of the benefits under the FEHB option is in the Appendix.
    - *State employee health benefits*. Another benchmark is the health benefits coverage plan offered and generally available to employees of the state. Most states offer more than one health plan to employees, and any such plan that is generally available to state employees can serve as a benchmark.
    - *HMO benefits.* The HMO plan that has the largest commercial, non-Medicaid enrollment in the state is another benchmark. The American Association of Health Plans is compiling a list of such plans; it is not yet available.
  - **Actuarial equivalence to benchmark coverage**. Another option available to the state is to offer coverage that has, at least, an aggregate actuarial value equivalent to one of the benchmark packages. A state electing this option must offer "basic services" (see below). If the state selects a benchmark that includes "additional services," the state must offer additional services that have an actuarial value equal to 75 percent of those in the benchmark.

Actuarial equivalence will almost always result in fewer services than will those in the benchmark plan because SCHIP permits much less cost-sharing than most commercial plans. However, a state is free to offer a more generous package of benefits than the minimum required.

- *Basic services*. The following are classified as basic services: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations.
- *Additional services*. The following are additional services: prescription drugs; mental health services; vision services; and hearing services. Dental services are not among the additional services. Additional services must be offered only if the benchmark package includes additional services.

- **Other Secretary-approved coverage**. The Secretary of HHS can also approve any other benefits package that provides "appropriate" coverage. How the Secretary will interpret this section remains to be seen.
- **Special rule for Florida, Pennsylvania and New York.** These three states can provide coverage offered on August 5, 1997 under Florida's Healthy Kids Program, Pennsylvania's Children's Health Insurance Program, and New York's Child Health Plus Program. However, the cost-sharing rules in SCHIP still apply. Beginning in 1999, if any of these three states spend less on these programs than they did in 1996, their federal allotments will be reduced.

Pre-existing Conditions

- **Medicaid coverage of pre-existing conditions.** Medicaid excludes no services because of pre-existing conditions.
- **SCHIP coverage of pre-existing conditions.** Under SCHIP, a group health plan or group insurance can refuse to cover pre-existing conditions to the extent permitted under current law.[30]

Affordability

Note: Families USA Foundation will soon be releasing a *Guide to Cost-Sharing and Low-Income People*. The Guide provides an overview of states' use of cost-sharing and premiums in Medicaid and other programs covering low-income families and children, a discussion of problems associated with cost-sharing and premiums, and suggestions for ways to reduce these harmful effects. For ordering information, write to Publications, Families USA, 1334 G Street, NW, Washington, DC 20005.

- **Medicaid premiums and cost-sharing.** Premiums are a charge for obtaining health coverage, and unrelated to the cost of using health services. Cost-sharing refers to out-of-pocket costs incurred for using health services. Children covered by a Medicaid expansion cannot be charged premiums or cost-sharing. Medicaid permits premiums for some households, but premiums are not allowed for "categorically eligible" individuals like the new category of targeted low-income children. Medicaid also permits cost-sharing for some services, but it does not allow cost-sharing for any services for *children*.[31]

- **SCHIP premiums and cost-sharing.** A state's SCHIP plan may impose premiums, deductibles, coinsurance and other cost-sharing, but subject to certain protections. The following limitations apply to a states' use of premiums and cost-sharing in SCHIP:

  - **No favoring of higher income children.** A SCHIP cannot vary premiums and cost-sharing based on income in a way that favors higher income children over lower income children.
  - **No cost-sharing on preventive services.** A SCHIP may not impose deductibles, coinsurance or other cost-sharing with respect to well-baby care, well-child care, and age appropriate immunizations.
  - **SCHIP Children in families with incomes at or below 150 percent of poverty.**
    - **Premiums.** Children in families with incomes at or below 150 percent of poverty can be charged premiums, enrollment fees, and similar charges so long as such charges do not exceed the sliding scale schedule which the Secretary has established for certain medically needy families.[32] See Table 2.
    - **SCHIP Cost-sharing.** Children in families with incomes at or below 150 percent of poverty cannot be charged deductibles, cost-sharing or similar charges that are more than "nominal." Nominal will be interpreted as it is in the Medicaid program, subject to further adjustment by the Secretary. Currently, nominal charges are set out at 42 CFR 447.53 and 447.54, as follows:

      Outpatient Services: Cost-sharing is considered nominal if it does not exceed the following maximum allowable charges:

Deductible:	May not exceed $2 per month per family for each period of Medicaid eligibility.
Coinsurance:	May not exceed 5 percent of the payment the state Medicaid agency makes for the services
Copayment:	May not exceed: $ 0.50 for state payment for a service of $10 or less; $1 for state payment for a service of $10.01 to $25; $2 for state payment for a service of $25.01 to $50; $3 for state payment for a service of $50.01 or more.

Inpatient Services: The maximum deductible, coinsurance, or copayment for each hospital admission may not exceed 50 percent of the payment the state Medicaid agency makes for the first day of care in the hospital.

Prohibition on the imposition of more than one type of cost-sharing: States may not impose more than one type of cost-sharing on a particular benefit or service. For example, a state may not require a deductible as well as a copayment for outpatient services.

Table 2

Maximum Monthly Premium for Families at or under 150 percent of poverty under SCHIP

Gross Familiy Income (per month)	Family Size		
	1or 2	3 or 4	5 or more
$150 or less	$ 1	$ 1	$ 1
$151 to $200	2	1	1
$201 to $250	3	1	1
$251 to $300	4	1	1
$301 to $350	5	2	1
$351 to $400	6	3	2
$401 to $450	7	4	3
$451 to $500	8	5	4
$501 to $550	9	6	5
$551 to $600	10	7	6
$601 to $650	11	8	7
$651 to $700	12	9	8
$701 to $750	13	10	9
$751 to $800	14	11	10
$801 to $850	15	12	11
$851 to $900	**16**	**13**	**12**
$901 to $950	17	14	13
$951 to $1000	18	15	14
More than $1,000	**19**	**16**	**15**

The 1997 federal poverty level is $884 per month for a 2-person family, and $1111 per month for a 3-person family.

- **SCHIP Children in families with incomes above 150 percent of poverty.** Any premiums, cost-sharing or other charges must be imposed on a sliding scale related to income, and the total annual aggregate cost-sharing with respect to all targeted low-income children cannot exceed **five percent** of such family's income.
- **State match.** Premiums and cost-sharing received by the state cannot be used to meet the state match.

Children with Special Health Care Needs, Chronic Illness or Disability

- **Medicaid.** The absence of service limits in the Medicaid benefit package for children and the inclusion of home and community-based care are particularly important for children with special health care needs. Important, too, are the prohibitions on cost-sharing for children's services and the coverage of pre-existing conditions. In addition, continuity of care is of great concern for children with complex health care needs. Under a Medicaid expansion, existing provider relationships are less likely to be disrupted when family income fluctuates. Finally, children with special needs cannot be enrolled in mandatory managed care without a waiver. This is important to assure that access to specialty services and other issues important to disabled children are specifically addressed in any managed care plan.
- **SCHIP.** SCHIP cannot deny a child eligibility on the basis of a pre-existing condition or discriminate on the bases of diagnosis. However, most commercial plans, such as the FEHB benchmark plan, typically do not cover long-term care and impose service limits on such services as mental health care and physical and occupational therapy. SCHIP restricts cost-sharing for families under 150 percent of poverty to a nominal payment per service, but, for such families with high usage of services, it imposes no cap on total expenditures. Despite recent health care reforms, group health plans and group insurance can still exclude coverage of pre-existing conditions in certain circumstances. Finally, if family income falls below Medicaid eligibility levels, a child covered under SCHIP must enroll in Medicaid, which may disrupt existing provider relationships. There is no limitation on mandatory managed care for children with special needs.

Managed Care

- **Medicaid managed care.** States can now require enrollment in managed care as a state option. The state option provides certain basic consumer protections. Children with special needs cannot be enrolled on a mandatory basis without a waiver. Beneficiaries must have a choice between two plans (different choice protections are required for rural areas). Enrollees may change plans for cause at any time, within 90 days of enrollment and once a year. States may guarantee eligibility for six months.[33] States must assure

that all enrollment notices and informational materials are easily understood. They must provide specified information about the plan and comparative information about all participating plans. Plans cannot discriminate on the basis of health status or need for services. Other safeguards exist for children enrolled in managed care pursuant to 1915b or 1115 waivers (although once 1915b waivers expire, their safeguards will be lost).

- **SCHIP managed care**. If a state chooses to enroll children in a managed care plan, the Act does not require that any specific consumer protections or oversight—such as a choice between at least two plans—be in place. However, the state plan must generally describe the state's method for assuring quality and appropriateness of care. Of course, managed care organizations must meet consumer protections defined in state law; the protections offered by such laws vary considerably among the states.

Entitlement

- **Medicaid entitlement**. Medicaid is an entitlement. This means any child the state has determined to be eligible for Medicaid will be able to get it. Medicaid will provide a federal match (at the regular rate) for targeted low-income children after the state's allotment for the enhanced rate is exhausted.
- **SCHIP non-entitlement**. The Act states that SCHIP will not constitute an entitlement for individuals. One consequence of this is that the state does not have to assist every eligible family, but can establish waiting lists or other procedures to allocate limited resources. The Act provides no guidance as to what kind of allocation methods a state may use. Also, federal funding will end once the allotment is exhausted.

Procedural Due Process Protections

- **Medicaid due process**. Medicaid provides families with a written notice explaining the reasons for any denial or termination of assistance. If a family believes the reasons for the adverse action are erroneous, the family has an opportunity to appeal the decision and obtain a fair hearing. If a family is already receiving benefits, the family is entitled to advance notice of any adverse decision and the opportunity to continue receiving benefits until a timely appeal is resolved.
- **SCHIP due process**. The Act contains no specific requirements for notice and hearing or other procedural protections for beneficiaries. However, the due process clause of the U.S. Constitution requires states to administer public benefit programs in accordance with basic standards of fairness. In the first instance, the states must interpret what the Constitution requires, subject to review by the courts. Also, state laws may provide procedural protections.

Provider Payment Rates

- **Medicaid payment rates.** Medicaid payment rates and methods of payment must be sufficient to attract enough providers so that care and services are available to people with Medicaid coverage at least to the extent they are available to the general population in the area. The Balanced Budget Act gives states greater flexibility in setting rates that meet this standard by repealing several specific rate-setting mandates.[34] In addition, Medicaid requires that providers accept the Medicaid payment rate as payment in full. Where Medicaid does permit cost-sharing, the provider cannot deny care for the patient's inability to make the payment.
- **SCHIP payment rates.** There are no federal standards for SCHIP provider payments. However, the state plan must describe its methods of assuring access to covered services.

CONCLUSION

The Balanced Budget Act creates an exciting opportunity for states to make significant inroads in reducing the number of uninsured children in this country. The benefits that will accrue to children, their families, and the communities in which they are live are profound. Families USA urges advocates concerned with children's health to get involved in the deliberations that are surely underway in every statehouse and governor's office in the country. In addition to this preliminary guide, Families USA will be preparing a comprehensive guide and other materials for advocates to influence their states' implementation of the Act.

Index To P.L. 105-33
Subtitle IV J of the Balanced Budget Act of 1997
The Children's Health Insurance Program

The text of the Act is available at http://speakernews.house.gov/child.htm.

This index is designed to help locate the specific section of the law in which a topic is addressed.

ENDNOTES

[1] P.L. 105-33, Title IV-J. The full text is available at http://speakernews.house.gov/child.htm.[2] Families USA, *One Out of Three: Kids Without Health Insurance, 1995-1996*, March 1997.

[3] *One Out of Three*, op. cit.

[4] U.S. General Accounting Office, *Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases*, (GAO/HEHS, 97-35, February 1997).

[5] U.S. General Accounting Office, *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate*, (GAO/HEHS, 96-129, June 1996).

[6] *One Out of Three*, op. cit.; Families USA, *Unmet Needs: The Large Differences in Health Care Between Uninsured and Insured Children*, Special Report, June 1997.

[7] Unmet Needs, op. cit.

[8] Gauthier, A. and Schrodel, S., State Initiatives in Health Care Reform: Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform, pp. 22-24 (May 1997, Alpha Center).

[9] Spending is authorized for 10 years, but can only be appropriated for five years.

[10] AL, AK, AZ, CO, CT, FL, ID, IL, IA, KY, MD, MS, MO, NE, NV, NJ, NY, OH, OK, PA, TX, WI, WY. Source: National Governors' Association Survey in July and August 1997.

[11] AR, HI, MN, RI, TN, VT, WA. Source: NGA Survey, op. cit. Under Medicaid, any state can elect to cover all children under 200% of poverty (or higher). 42 U. S.C. 1396a(a)(10)(A)(i)(III) and 42 U.S.C. 1396d(n) (qualified children under age 19); 42 U.S.C. 1396a(r)(2) (use of less restrictive methodology for qualified children); 42 U.S.C. 1396b(f)(4) (FFP income limits not applicable to less restrictive methodologies).

[12] Gehshan, Shelly, State Options for Expanding Children's Health Insurance: A Guide for Legislators, Table IV, May 1997, National Conference of State Legislatures.

[13] Section 2105(c)(3) of Title XXI of the Social Security Act.

[14] Studies cited in U.S. General Accounting Office, Health Insurance for Children: Declines in Employment-Based Coverage Leave Millions Uninsured; State and Private Programs Offer New Approaches, p.4. (GAO/T-HEHS-97-105,April 1997) and Employee Benefit Research Institute, Expanding Health Insurance for Children: Examining the Alternatives. EBRI Issue Brief No. 187, July 1997.

[15] Cutler, David M., and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications." *Health Affairs* (January/February 1997): 194-200.

[16] Yazici, Esel, Medicaid Expansions and the Crowding Out of Private Health Insurance, paper presented at the 18th Annual Research Conference of the Association for Public Policy Analysis and Management, Pittsburgh, Pa., Nov. 2, 1996.

[17] Dubay, Lisa C., and Genevieve M. Kenney, "The Effects of Medicaid Expansions on Insurance Coverage of Children." The Future of Children (Spring 1996): 152-160.

[18] Gauthier, A., Lessons from State Initiatives, op. cit. at p. 30.

[19] Ten states expanded Medicaid eligibility for children in 1997 according to the NGA survey. Expansions in state plans in effect after April 15, 1997 will be eligible for the enhanced match.

[20] 42 U.S.C. 1396a(a)(4),(22)(D); 42 C.F.R. 431.12.

[21] The Kaiser Commission on the Future of Medicaid, "Medicaid Facts," November 1996.

[22] Sections 4912 (presumptive eligibility) and 4731 (12-month eligibility) of the Balanced Budget Act of 1997.

[23] Executive Committee of the National Governor's Association, Interim Policy on Children's Health, May 22, 1997.

[24] For example, in Wisconsin, the Governor's school-funding formula took millions of dollars from poor districts and gave it to rich districts. "Wisconsin School Aid: Take from Poor, Give to Rich," Chicago Tribune, January 10, 1996.

[25] The Act uses the definitions from last year's Health Insurance Portability and Accountability Act to define "group health plan," "health insurance coverage," and "creditable coverage." 42 USC 300gg-91.

[26] NGA survey, op. cit.

[27] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, codified at 8 U.S.C. 1601 et seq.; 62 Federal Register 45256, August 26, 1997 (proposed rule defining federal means-tested public benefits to include Medicaid).

[28] Personal communications with attorneys at the National Immigration Law Center and the Center for Budget and Policy Priorities.

[29] Gauthier, op. cit. 34.

[30] More information on current law as amended by last year's Health Insurance Portability and Accountability Act will soon be available on the Families USA web site, www.familiesusa.org.

[31] Medicaid does permit premiums for children under age 1 living in families with incomes over 150 percent of poverty. 42 U.S.C.1396o(c). Families receiving extended Medicaid during a welfare to work transition, can also be charged a premium of no more than 3 percent of income for the second 6-months of coverage if family income less child care exceeds 100 percent of poverty. 42 USC 1396r-6. Medicaid also permits cost-sharing for 18-year-olds. 42 U.S.C. 1396o(a)(2)(A).

[32] 42 CFR 447.52

[33] The 12-month eligibility period option is limited to children, but is not limited to only those enrolled in managed care. See text for n. 22.

[34] The Balanced Budget Act of 1997 repeals the Boren amendment regulating rates for inpatient hospital services and long term care, phases out specific rate-setting provisions applicable to federally qualifying health centers, and repeals special rules relating to pediatric and obstetric rates.

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