



## **CHIP: AN INTRODUCTION**

### **The Balanced Budget Act of 1997**

It is an inescapable fact that decisions made in Washington have profound impacts upon the states. Perhaps in no case is this more directly true than in situations concerning spending on public welfare. It was Washington which created such overarching programs as Medicaid, AFDC, and TANF. Once initiated, it becomes the work of the states to implement these concepts into the everyday lives of poor and disadvantaged citizens.

The year 1997 brought about another major change from Washington in regard to public assistance spending. At that time, President Clinton urged Congress to implement a plan which would allow the states to address the health care needs of some of the 10.6 million uninsured children in the United States. The plan he endorsed – the State Children’s Health Insurance Program (SCHIP or CHIP) – was passed as a component of the Balanced Budget Act of 1997, which was signed into law on August 5, 1997. The program was designed to set aside \$23.9 billion over five years to allow states to provide health insurance in some form to children not already covered by Medicaid.<sup>1</sup>

The Children’s Health Insurance Program was, in fact, an entirely new program under the Social Security Act and can alternately be referenced as Title XXI. The program allowed the

states three options for implementation: an expansion of Medicaid, a creation or expansion of insurance plans within the state, or a combination of these two approaches. There was some controversy over the breadth of the new program and its relation to a “universal health care” concept, but the states began implementation over the course of the next year notwithstanding.<sup>2</sup>

Funding for CHIP became available on October 1, 1997, but before a state could access federal funding, it first needed to develop a state plan which would then be approved by the federal Department of Health and Human Services. Furthermore, each state would be required to match the federal dollars with state dollars, at an enhanced match rate. In South Dakota’s case, that match rate was 77.43% -- \$7.5 million in federal funds to \$2.2 million in general funds.

### **Janklow Decides Upon a Course of Action**

After the Balanced Budget Act was signed it became the duty of each state to decide whether or not to participate in the new CHIP program. Since 1997, each state has decided to do so, but this was an important decision nonetheless.

After the federal legislation was signed, Governor William J. Janklow formed a working group comprised of representatives from the Department of Health, the Department of Social

Services, and the Division of Insurance. This group's mission was three-fold. First, they were to decide whether or not a need existed in South Dakota for such funding. Second, they were to decide whether or not it was prudent to accept the federal funding, thus promising a state match and adherence to additional federal regulations. Third, the group was to determine what form the state plan should take on, should one be proposed.<sup>3</sup>

The working group came to the conclusion that a need did exist in South Dakota – that there was a sizeable population of uninsured children in the state. The group also recommended that the state participate in the federal CHIP program. The final question was whether to expand the Medicaid program using CHIP funds, allow for a state plan utilizing private insurance carriers, or combine these two concepts.

Members of the insurance industry worked with the Governor's working group to set up a model of how the program would work should private insurers play a role. This model was compared to an extended Medicaid model. Due in large part to the fact that Social Services would have to be involved in determining eligibility no matter what plan was implemented, it was found that the Medicaid plan was more efficient and cost effective, and therefore an extension of Medicaid was proposed. [N.B., As of August 1999, 22 states, American Samoa, the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands had all chosen a Medicaid option.]

## The 1998 Legislative Session

After the start of the 73<sup>rd</sup> Legislative Session in early 1998, the Executive Branch revealed its decision to submit a plan to the Department of Health and Human Services expanding Medicaid in South Dakota to cover all children up to age eighteen who lived at or below 133% of the poverty level. Under normal Medicaid rules, children at or below 133% of poverty are covered only if under six years of age. Children ages six through eighteen are covered when at or below 100% of poverty. The Department of Social Services estimated that this expansion would cover an additional 11,000 children over time, with an estimated 7,352 children receiving assistance in the first year of the program.<sup>4</sup>

An informational hearing was held for any interested legislators on February 2, but for the most part there was little opportunity for legislative input since no legislation was needed to implement the program. The only legislative action necessary was the approval of the Governor's recommended budget for CHIP, which stood at \$7,522,023 federal funds and \$2,193,215 general funds.

Appropriations Committee members were told at the Social Services budget hearing that an amendment for more FTE would eventually be brought from the Bureau of Finance and Management to cover CHIP staffing needs. On February 25, the last day for appropriations action in committee, this amendment was submitted and approved, adding 2.0 FTE to the Division of Medical Services and 12.0 FTE to the Division of Field Management.

With the approval of the general appropriations bill for FY99, SB 242, the Executive Branch was able to prepare and submit a plan for South Dakota's CHIP program. A draft was available by April 20, 1998, and on August 26 it was approved.

### **The 1999 Legislative Session**

As the 74<sup>th</sup> Legislative Session opened, the Department of Social Services explained to the Appropriations Committee that it had adjusted its original figures regarding CHIP recipients. Now, instead of estimating that 7,352 children would be recipients, the department felt 6,000 might be a more accurate figure. Therefore, under the 133% of poverty level, the program would essentially be overfunded.

Because of this, the Governor proposed an adjustment in the Medicaid eligibility income limit to 150% of poverty. With no change in the appropriation for CHIP, the program could cover 9,000 children under this new income requirement – an expansion of 3,000 children.<sup>5</sup>

This expansion became a point of contention among members of the committee, however, who feared higher costs in time should the economy falter, as well as the possibility of insurance dumping – poor workers dropping insurance plans to become eligible for Medicaid.<sup>6</sup>

The committee voted 14-6 on March 2, 1999, to cut the Social Services, Medical Services Division, budget by \$530,449 general funds and \$1,884,743 federal funds. The purpose of this reduction was to implement a compromise plan to cover children at 140% of the poverty level or below, which in theory would cover

approximately 7,236 children instead of only 6,000, though less than the Governor's proposal of 9,000 children. This is how South Dakota's CHIP program stands today.

### **Characteristics of CHIP in South Dakota**

CHIP programs differ greatly among the states, and some states had already instituted health care programs for uninsured children before Title XXI ever came into existence. South Dakota's program, when compared to the programs in many states, is quite simple in form. Essentially, it is in every major way just like the already familiar Medicaid program.

As a Medicaid extension, there is a list of services that the program will cover. These include:

*R* Physician Services, including supplies and drugs given at a doctor's office, X-rays, and laboratory tests;

*R* Inpatient and outpatient hospital care, emergency services;

*R* Outpatient care at medical clinics;

*R* Limited chiropractic care;

*R* Rehabilitative therapy;

*R* Mental health care;

*R* Home health care;

*R* Basic personal care, grooming, and household services if related to a medical need;

*R* Prescriptions (most, but not all);

*R* Family planning;

*R* Reusable durable medical equipment which is primarily medical in nature;

*R* Ambulance services when medically necessary;

*R* Some other transportation services;

*R* Podiatric care;

*R* Dental care;

*R* Various optometric needs;

*Especially for individuals under 21:*

*R* EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services, which include screening and diagnostic services, certain medical equipment, nutritional therapy, chemical dependency treatment, braces for teeth, and inpatient psychiatric care; and

*R* Immunizations.<sup>7</sup>

There are no exclusions for pre-existing conditions in Medicaid or CHIP.

Under federal law, the states are also required to conduct an extensive outreach program to identify as many eligible children as possible and place them under the umbrella of the program. Since this expansion is still fairly new, many families are not necessarily aware of its existence, or if they are, are not aware of what their incomes are in relation to the federal poverty guidelines. Therefore, outreach is

needed to care for these otherwise uninsured children.

To this end, the Department of Social Services has set up an ongoing and extensive networking system among schools, counselors, social workers, and health care providers to “catch” children who may fall within the CHIP range of health care coverage. The department is optimistic about its success.

### **The Future of CHIP**

In South Dakota, as in the rest of our nation, the CHIP concept is still very new. Data regarding its successes (and failures) has not yet had much time to compile. However, it must also be remembered that CHIP is a potentially fluid program, as South Dakota’s last legislative session has helped prove.

Federal law allows CHIP coverage for children up to 200% of the poverty level. At an estimated cost per covered child of \$900 per year, it is a matter of demographics and mathematics to determine how many uninsured children *could* be placed under the program’s umbrella.

However, as this past session also demonstrated, not all policy makers are in favor of pushing CHIP to its mathematical limits. Once the promise of health care coverage has been made it is difficult to withdraw it. As the economy fluctuates, the population of uninsured children in South Dakota may very well rise. Our federal allotment will not, however. Therefore, CHIP expansions must be made prudently, or at the possible expense of more general fund dollars.

Also, the higher the earnings cap for CHIP rises, the more likely it becomes

that insurance dumping may occur. Very few families at or below 133% or even 140% of poverty even have private insurance. However, this number increases when talking about families approaching the 200% of poverty level. Though the concept of “insurance dumping” is definitely a disputed and under-studied area, its specter certainly haunts any discussion of CHIP expansion.

Changes can be made to South Dakota’s state plan at any time. There has been limited discussion in the past of allowing for a mixed program model, though as of now that concept has gained no apparent steam. Nevertheless, changes could be made in any year, with or without the voice or consent of the Legislature.

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**This issue memorandum was written by William E. Pike, Fiscal Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.**

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<sup>1</sup> King, Martha P., “Insuring More Kids: Options for Lawmakers,” National Conference of State Legislatures, January 1998 or HCFA Press Office, “HHS Fact Sheet: The Children’s Health Insurance Program,” October 6, 1997.

<sup>2</sup> King, Martha P., “Year of the Child in Health Care,” *State Legislatures*. December 1997, pp. 22-26.

<sup>3</sup> This decision-making process was outlined in an open meeting for legislators on February 2, 1998, presented by Deb Bowman, Sec. Doneen Hollingsworth, Sec. Jim Ellenbecker, and Dave Christensen.

<sup>4</sup> South Dakota Department of Social Services, “Major Initiatives: FY 1999,” 21 January 1998, pp. 8-9.

<sup>5</sup> South Dakota Department of Social Services, “Budget Overview: FY 2000,” January 20, 1999, p. 6.

<sup>6</sup> Brokaw, Chet, “Panel reduces scope of child-health plan,” *Sioux Falls Argus Leader*, March 3, 1999, 4A.

<sup>7</sup> [www.state.sd.us/social/Medicaid/Covered/index.htm](http://www.state.sd.us/social/Medicaid/Covered/index.htm) October 15, 1999.