Lessons from CHIP for Implementation of the Affordable Care Act

Successfully Navigating the CHIP State-Federal Relationship and Challenges to State Implementation

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INTRODUCTION

Although the name "Obamacare," focuses attention on the President, his administration and the federal bureaucracy, states have important roles to play in implementation of the Affordable Care Act (ACA). It was originally thought that most states would operate their own health insurance marketplaces, with the federal marketplace serving as a backup.[1] The failure of the majority of states, however, to take the initiative to develop their own marketplaces shifted more of the burden onto the federal marketplace. Even in states with a federally facilitated marketplace, states have important roles to play in regulating insurance companies and enrolling people found eligible for Medicaid and the Children's Health Insurance Program (CHIP) in those state-run programs. Coverage under the ACA was also predicated on the expectation that all states would undertake the expansion of Medicaid for poor and low-income adults, but the June 2012 Supreme Court ruling effectively made the expansion a state option. Poor adults in more than half the states, including parents and parents-to-be, will therefore find themselves without coverage - as will many uninsured children who would have enrolled in Medicaid when their parents did - unless and until those states implement the Medicaid expansion.

States also played important roles in the implementation of CHIP. Originally called the State Children's Health Insurance Program (or SCHIP), CHIP provided states with a generous annual block grant to fund the expansion of insurance coverage for low income children within a fairly broad set of federal guidelines (see Brief 1 in this series for a more detailed description of CHIP).[2] A spirit of collaboration marked the early days of CHIP implementation. Although the federal government exercised more control of CHIP over time, states maintained considerable flexibility to innovate and tailor their programs to their specific circumstances, political climates, and timetables. The result was a win-win, as children's coverage rates have grown almost every year since CHIP was enacted.

This brief highlights some important lessons for ACA implementation drawn from the relationship forged between states and the federal government during the early years of CHIP. Using Virginia and Texas as case studies, the brief also examines factors that motivated states initially reluctant to participate fully in CHIP to move to full implementation.

These are early days for ACA implementation and, as was the case with CHIP, implementation will take time. State decisions will continue to be important factors in the next phase of ACA implementation and the relationship between states and the federal government will impact both the form and tempo of that phase.

Federal State Relationships

Although now regarded as a prime example of bipartisanship, CHIP was enacted during a very turbulent time in American politics, not unlike today. Following the defeat of president Bill Clinton's health plan, Republicans gained control of Congress in 1995 for the first time in decades, and held onto control despite the re-election of President Clinton in 1996. Under the leadership of U.S. House of Representatives Speaker Newt Gingrich, the Congress moved to reduce government spending on entitlements, including Medicaid and other social programs. Ultimately the fiscal confrontation between the Republican-led Congress and President Clinton led to two government shutdowns. The emergence of CHIP as part of the Balanced Budget Act of 1997 (BBA) resulted from a complex process of negotiations involving Congress and the Administration, in which states played an important role.

Prior to the enactment of CHIP, several states took the initiative in expanding coverage for children in families with incomes above the federally mandated level for Medicaid. Some states (Minnesota, New Mexico, Vermont, and Washington) expanded coverage through their Medicaid programs, using waivers in some circumstances. Others (New York, Pennsylvania and Florida) created separate programs, often funded with a mix of public and charitable sources.[3] These state programs offered more limited benefits than Medicaid. National proponents of expanding coverage used the leadership by states as an argument in their favor. They reasoned that federal funding would allow existing state coverage programs to grow and improve their coverage and incentivize other states to do the same, while minimizing concerns about the federal government's takeover of health care, which had been an important factor in the defeat of the Clinton health plan.

Encouraged by the administration and led by Senators Edward Kennedy (D-MA) and Orin Hatch (R-UT), work on children's coverage moved in a series of fits and starts through Congress. Liberals favored expanding eligibility for Medicaid as was done in 1990, but Medicaid was not popular with the Republican leadership that had actually tried to turn the program into a block grant.[4] Recognizing that something might emerge from the discussions on children's coverage in Congress, states began to weigh in. Joan Henneberry, who began work in early 1997 as Director of Maternal and Child Health at the National Governors Association (NGA), recalls that she began working on CHIP right away and that the National Council of State Legislatures was actively involved as well.[5]

Governors vigorously opposed an expansion of Medicaid, which they criticized as being too inflexible and proscriptive. They favored a block grant approach with stable and consistent funding that maximized state flexibility to design and run their own programs with limited federal oversight.[6] They were particularly opposed to the inclusion of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits in any coverage expansion. For many, expanding children's coverage was viewed as a bridge to private coverage for low-income families who were thought to be more likely to enter the labor force following welfare reform in 1996. State demands however were countered by children's advocates' arguments for a comprehensive benefits package, quality assurances, and national standards.[7]

In the CHIP legislation that ultimately emerged, states succeeded in getting a large funding stream for many years and the flexibility to develop their own programs, including using Medicaid if they wished. Consumer groups got requirements on a comprehensive benefit package and limited cost sharing. Congress also included some accountability requirements, which also served to limit state prerogatives.

The ACA has a number of similarities to CHIP (as described in more detail in Brief 1 of this series),[8] including a Medicaid expansion, increased national funding, and state flexibility in designing marketplaces, and benefit design using a combination of actuarial values and federal requirements. Unlike CHIP, however, the ACA was not a bipartisan effort and the partisanship limited states' involvement in the design of the ACA.[9] The partisan bickering concerning the ACA has continued unabated since its enactment and arguably has made implementation more challenging. Given the important roles states play in ACA implementation,

limited state engagement in the design of the ACA may also pose problems during implementation. However, the federal government has the opportunity to address many state concerns during the implementation period.

Rulemaking and Implementation

Before laws can be fully implemented, they typically undergo the process of administrative rulemaking. The rules fill in many of the details about how a law will work in the real world and, usually, the more complex the legislation, the more involved the rulemaking process. Rulemaking is the purview of policy experts and lawyers but can be influenced by all the same interest groups that help shape legislation. Rulemaking for the ACA has taken years so far and included opportunities for public comment and revision. Implementation of certain pieces of the legislation, for example the state basic health plan option for low-income adults, has been delayed pending finalization of the rules for their implementation.[10] Even so, federal rules for the ACA to date total 10,535 pages, compared with 906 pages for the law itself.[11]

Rulemaking for CHIP proceeded on a different track than for the ACA. CHIP regulations were not even proposed, let alone finalized, before states began implementing their programs. There was just not enough time. The legislation establishing CHIP in August 1997, allowed states to begin drawing down federal funding a mere two months later in October 1997. And the legislation included strong incentives for prompt action, including forfeiture of the first year's federal funding if a state did not have a plan in place within the first year and forfeiture of federal money unspent after year two.

To meet the demands for action, the federal Centers for Medicare and Medicaid Services (CMS)[12] embarked on an expedited process, which included a fairly specific and rigorous template that states could use to submit their CHIP plans to CMS for approval, as well as a series of letters to state health officials providing guidance and answers to frequently asked questions. Debbie Chang, who had responsibility for CHIP in CMS at the time, recalls with pride that rather than being proscriptive and limiting state initiatives as was typical of CMS' guidance to states, several of the letters encouraged states to be creative and experiment with different approaches within broad guidelines.[13] CMS staff was divided into small teams that worked one-on-one with individual states using expedited time frames. Chang also recalls that, during the early days, CMS and state officials worked very collaboratively to resolve problems quickly, motivated in large part by a desire by both the administration and members of Congress for results. There was a lot of give-and-take on both the individual state plans and the guidance offered in the letters to states. Still, the federal government retained control of the process, as the state plans needed approvals from several layers of the federal bureaucracy, including senior White House staff.[14] CMS also engaged other stakeholders including child advocates, health care providers, and members of Congress in the process. Meetings with the states and other stakeholders were sometimes supported by philanthropy.

When Chang left CMS in June 1998, a draft of the proposed CHIP regulations based on the Q&A that CMS had used to guide early implementation was working its way through the federal system. There were other changes in personnel at CMS as well and the focus began to shift from getting the program up quickly to what might be appropriate to manage the program over the long term. With this shift in focus, the rulemaking became more formal and driven by CMS. CMS was used to managing the Medicaid program tightly, limiting state flexibility, and holding states accountable for the expenditure of federal dollars. While advocacy groups pushed for more Medicaid-like protections in CHIP, states felt that the earlier focus on flexibility and state prerogatives was being lost, and that separate CHIP programs were being subjected to unexpected and unnecessary enforcement measures and rules more typical of Medicaid.[15]

CHIP program rules and the way they are enforced by CMS touch every aspect of the program. A comprehensive review of the impact of the CHIP rules is beyond the scope of this brief. Instead, the brief examines two issues with which the author has personal experience and which provide important lessons for

ACA implementation. These are the "screen and enroll" and monitoring and reporting provisions of the CHIP law.

Screen and enroll. Despite its very strong emphasis on enrolling as many children as possible as quickly as possible, enrollment in CHIP was complicated by the restriction that no Medicaid-eligible child be enrolled in CHIP. This requirement was included in the CHIP legislation in part as a fiscal measure to prevent states from claiming CHIP's higher federal match rate (the share of every CHIP dollar paid by the federal government) for children for whom the lower Medicaid match rate was applicable, and to make sure that children who were entitled to Medicaid received the full benefits and protections of that program. Specifically, children's advocates and Medicaid champions pointed to Medicaid's advantages for poor children: more comprehensive benefits, no cost sharing, and a guarantee of coverage. Many were also concerned that allowing Medicaid-eligible children into CHIP might further undermine a Medicaid program already under attack from Republicans in the House of Representatives.

Even following welfare reform, which decoupled Medicaid for children from welfare, Medicaid retained some of the stigma associated with welfare, and many states maintained vestiges of the welfare system in determining Medicaid eligibility. These procedures, including face-to-face interviews, stringent documentation requirements, and asset tests, were burdensome for both families and states, and they were designed to limit program participation. States argued that screening all CHIP applicants for Medicaid required that CHIP applicants be treated like Medicaid applicants, which was counter to the goal of streamlining eligibility for CHIP. Many actually went further, citing anecdotal evidence of families who having applied for CHIP refused Medicaid for their children when told that they were only eligible for Medicaid. Medicaid advocates countered that the onus was on states to improve their Medicaid programs and reduce the stigma associated with Medicaid.[16]

Despite the back-and-forth, CMS stuck to a strict interpretation of the screen-and-enroll requirement. Even in states that agreed with the policy – that is to ensure that Medicaid-eligible children be enrolled in Medicaid and no other program – the administrative challenges were sometimes more difficult than expected. CMS encouraged states to develop a single application for both programs and required New York, which had enrolled many Medicaid eligible children in CHIP, to transfer them to Medicaid.[17] Arguably the strict screen-and-enroll policy retarded CHIP enrollment early on. Over time, however, both Medicaid and CHIP eligibility processes were simplified, with the result that more children were enrolled in both programs. Simplifying Medicaid eligibility was, however, challenging in many states, frequently requiring protracted efforts by advocates. CHIP had more flexibility than states had ever been given in Medicaid, so many states used more liberal enrollment procedures for CHIP than for Medicaid, although that difference has been narrowing over time.[18]

Reporting, Monitoring and Evaluation. Perhaps because of the flexibility allowed states under CHIP, the data collection and reporting requirements were substantial, and imposed an administrative burden on states. States were expected to report quarterly on their expenditures as well as the number and characteristics of children enrolled in CHIP. In addition to the quantitative financial and enrollment data, states also had to report on a number of qualitative measures, including efforts to boost enrollment, prevent "crowd-out" (movement from private to public coverage), and improve performance on a number of criteria. States were also required to report on their progress in reducing the number of uninsured children—a difficult task because estimates of the number of uninsured using available data sets were prone to error, and sample sizes for smaller states were inadequate for credible estimates of changes in the number of uninsured.

This was a situation where the interests of the states and federal government diverged. Data collection is costly and state efforts typically focus on collecting the information they need for program management and operations, using state-specific systems and definitions reflecting decisions and investments made over time.[19] The federal government was looking for a robust, consistent description of CHIP implementation and impact across states. What states were able to provide varied widely. The mismatch between federal expectations and

states' capacity to deliver came to a head during a two day workshop on Evaluating CHIP - A 'How To' for States, hosted by the National Academy for State Health Policy (NASHP) in December 1998. Just when it seemed that the entire data reporting and evaluation process could blow up, cooler heads prevailed and with leadership from Trish Riley of NASHP, Joan Henneberry from NGA, and Patricia MacTaggart from CMS, a workgroup was organized to come up with a framework that would be acceptable to both CMS and the states. Over a period of eight months, with support from the David and Lucile Packard Foundation, state officials and representatives from the federal government developed an Evaluation Framework and User's Guide, which would help states meet federal statutory requirements while "recognizing the diversity of state approaches to Title XXI (CHIP)."[20] The Framework was designed so that each state would be able to answer at least one question, and states were encouraged to do their best when they didn't have a robust answer to a question. The Framework, used as the basis of state reports to CMS for many years, was regularly updated and over time, states' capacity to provide the information improved as well.

Lessons

The CHIP experience suggests that successfully implementing an ambitious, innovative, and complicated program across the country requires the right mix of federal guidance and oversight, and an allowance for state innovation and problem solving so as to fit the program to state needs and circumstances. The onus may lie with the federal government to encourage cooperation and collaboration by balancing the need for uniformity with the needs of state officials to focus on local politics, operational realities, and priorities.

Getting the mix right may be a matter of trial and error, but there is evidence that current federal officials are reflecting somewhat on the lessons learned from CHIP. For example, following the United States Supreme Court ruling rendering the ACA's expansion of Medicaid eligibility for low-income adults optional, many states expressed a reluctance to implement the expansion, even though it was to be fully federally funded for the first three years. CMS responded by leaving the option available indefinitely, although the legislation stipulated a January 2014 implementation date. Experience with both Medicaid and CHIP has demonstrated that it can take time for some states to adopt new coverage options, and CMS is leaving the door open to allow that process to play out. CMS has also signaled a willingness to let states propose different, nontraditional approaches to the Medicaid expansion, and some states have indicated that being able to expand Medicaid "their way" is a more attractive alternative.[21] CMS, however, has said that it would not allow states to implement partial Medicaid expansions, a path that many states took with CHIP. Only time will tell whether this mix of flexibility and control will encourage states to move ahead with the Medicaid expansion, an important part of the ACA.

> "In a cooperative federalist program, the federal government establishes the program's core requirements and gives the states the freedom to implement their own programs. While expanding Medicaid's basic eligibility standards, the ACA does not disturb the states' autonomy and freedom to experiment that has always been a hallmark of the program."
>
> Amicus Brief of 13 States in Support of the ACA Medicaid Expansion[22]

Although CMS has not given states the same level of flexibility to develop their own health insurance marketplaces under the ACA that CMS provided states during the early days of CHIP implementation, CMS has allowed some flexibility in an attempt to encourage states to develop their own exchanges in lieu of the federal marketplace.[23] As a result, a number of different exchange models have emerged, in which the states and the federal government "to varying degrees, share the responsibilities for the basic exchange functions of eligibility and enrollment, plan management, consumer assistance and outreach and enrollment and financial management."[24]

WORKING THROUGH RESISTANCE TO CHIP IMPLEMENTATION

On the whole, the success and popularity of CHIP reflects the strong public support for expanding children's health insurance through CHIP. As a result, there has been much less political opposition to CHIP at both the national level and in the states than there has been to the ACA. Nonetheless, in some states, expanding children's coverage under CHIP was a controversial, partisan issue that impeded CHIP implementation. The CHIP experience suggests that building a successful program takes time, evidence of early success, and the need to build the political will to overcome active opposition and the inertia of traditional practice.[25] In addition, the flexibility states had under CHIP to implement the program in pieces and to match program design to local circumstances helped facilitate implementation in states where political opposition to the program was an issue.

The CHIP experiences may be relevant as state legislatures are in their 2014 sessions. In some states, there will likely be a push to take up and implement the ACA's Medicaid expansion for low-income adults as well as for states to establish their own marketplaces. Although it may take several years if not longer for all states to participate fully in the ACA, lessons learned from efforts in Virginia and Texas to implement robust CHIP programs in the face of high level resistance may inform the activities which emerge in 2014 and beyond.

Implementing CHIP Slowly in Virginia

> "This legislation (passed by the legislature) affronts my philosophy on limited government…and would create the largest expansion of welfare in Virginia's history... I cannot be part of any legislation that hurts children and shackles our families."
>
> James Gilmore, Governor of Virginia, 1998-2002[26]

Virginia is a politically purple state, with control of both the governorship and legislature passing back and forth between the Republican and Democratic parties with some regularity over time. At the time CHIP was enacted, in the summer of 1997, George Allen, a Republican, was Governor. Allen made reform of Virginia's welfare system a high priority, and with strong bipartisan support propelled Virginia ahead of the national welfare reform effort.[27] In January 1998, Allen was succeeded as Governor by the former Attorney General, James Gilmore, also a Republican, who had run on the twin promises of phasing out Virginia's tax on automobiles and hiring more teachers for the public schools.[28] Gilmore was, however, faced with a legislature divided just about evenly between Republicans and Democrats and interested in taking advantage of the new federal CHIP funding to create a CHIP program for the state.

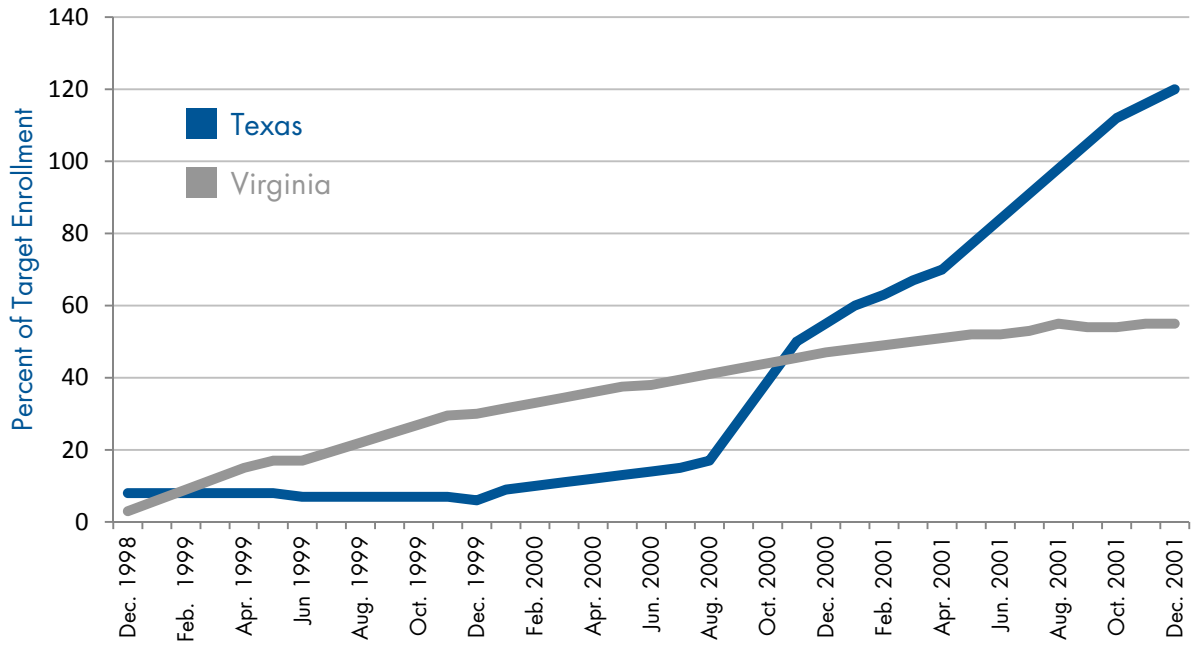
From the very beginning of Gilmore's term, the Governor and legislature, backed by the advocacy community, disagreed strongly on how to implement CHIP in the state. The legislature backed a plan advanced by Virginia's Joint Commission on Health Care, which would have implemented CHIP by expanding children's Medicaid income eligibility to 200% of the federal poverty level (FPL). The Governor, however, adamantly opposed any expansion of Medicaid, which he characterized as backsliding on welfare reform. The Governor advanced a proposal to only provide coverage to children in families with incomes up to 175% FPL using Key Advantage, the privately managed program for state employees.[29]

The Governor's proposal did not gain traction with the legislature, and the Governor vetoed the bills the legislature passed with large majorities until ultimately a last minute compromise was arranged. The compromise was a Medicaid-based combination program - children whose families earned up to 150% FPL received traditional Medicaid, but those whose families earned 150-185% FPL were eligible for the Children's Medical Security Plan (CMSIP). CMSIP provided a full Medicaid benefit at no cost and used the same eligibility system as Medicaid but was not an entitlement. It also included impediments to enrollment,

including a 12-month waiting period (the longest in the nation) before previously insured children could enroll and a requirement that parents cooperate with child support enforcement actions. (Beefed up child support enforcement had been an important piece of welfare reform in Virginia.)[30]

The compromise program encountered some difficulties getting approval from CMS but finally opened for business in late October 1998, over a year after CHIP was enacted. However, enrollment was very slow (see Figure 1) and prompted legislative hearings about the disappointing enrollment in May 1999, only eight months later. At the hearings, advocates highlighted the program's considerable enrollment barriers and characterized the state's outreach efforts as inadequate.[31]

Figure 1. CHIP Enrollment as a Percentage of Target Enrollment Virginia and Texas, December 1998 through December 2001



Sources: Joint Legislative Audit and Review Commission of the Virginia General Assembly, *A Review of Selected Programs in the Department of Medical Assistance Services*, January 2002. Page 13. Ian Hill, Hawkes, C., Harrington, M. *Congressionally Mandated Evaluation of SCHIP, Final Cross-Cutting Report on the Findings from Ten State Site Visits*, Revised June 2004. Mathematica Policy Research and The Urban Institute.

Concern about lackluster enrollment continued to plague the program. The focus was on low enrollment numbers relative to the estimated number of eligible children, low levels of enrollment compared to other states (North Carolina, with a successful program, was considered a reasonable benchmark), and the failure of Virginia to use its full federal CHIP allocation.[32] (CHIP legislation required that after two years, unused federal CHIP funding was forfeit and redistributed to other states.) In April 2001, the Gilmore Administration, with the support of the legislature, replaced CMSIP with a new program, Family Access to Medical Insurance Security (FAMIS). FAMIS is a stand-alone program designed to resemble private insurance and modeled on the state employee plan. Virginia also attempted to boost enrollment by shortening the waiting period to six months, eliminating the child support enforcement requirement, and allowing families to apply for the program at a central processing unit rather than at local welfare offices.[33]

Although the April 2001 changes were helpful, concern about disappointing levels of enrollment continued (see Figure 1). A December 2001 report from Virginia's Joint Legislative Audit and Review Committee (JLARC) pointed to difficulties related to the creation of separate Medicaid and CHIP programs, including having separate applications, and mixed program eligibility for some families.[34] And in the 2001 Virginia gubernatorial campaign, the Democratic candidate, Mark Warner, made an issue of the "failure" of the Gilmore administration to provide health care for more than 50,000 children eligible for CHIP in Virginia. Warner pledged, if elected, to increase enrollment of uninsured children in both FAMIS and Medicaid.[35]

Warner, a long-time advocate for children's access to health care, was elected by a comfortable margin and quickly went to work to boost enrollment as he had pledged. He brought people into his administration who were aligned with the goal and pursued modifications in both FAMIS and Medicaid to simplify the application processes and improve coordination between the two programs, and an aggressive outreach campaign was launched with contributions from philanthropy. Some of the modifications reflected the recommendations in the JLARC report, but additional changes were still required to Medicaid and CHIP to boost enrollment.[36]

> "It really comes down to leadership at the top. Every Friday, Governor Warner insisted that we send him the enrollment numbers. We also published the data. … The governor could pretty much quote the numbers, and made himself available for PSAs and other appearances. He considered this a hallmark of his administration and his "let's make it work" attitude lead to progress at all levels".
>
> Linda Nablo
> Director of Child Health Insurance, 2003-2007, Virginia Department of Medical Assistance

Over time enrollment in both FAMIS and Medicaid grew in Virginia and efforts to improve the programs and boost enrollment continued during the Warner administration. Nonetheless, it took several more years for enrollment in FAMIS to reach the level of coverage of the eligible population achieved in other states.

Starting Late but then Moving Quickly in Texas

> "A philosophical battle over who is responsible for Texas children getting adequate health care underlies the discussion about how Texas will spend its federal allotment for a Children's Health Insurance Program (CHIP). On one side are those who believe health care is not only good social policy but also good business policy. On the other are those wary of asking taxpayers to finance health care for people who won't take responsibility for their lives."
>
> Dave McNeely, Austin American-Statesman, May 28, 1998[37]

With the largest number of uninsured children in the country in 1997, about 1.4 million, or one in four children,[38] Texas was a strong candidate to move quickly to take advantage of federal CHIP legislation and aggressively enroll children in the new program, as well as in traditional Medicaid. But the timing was off. The Balanced Budget Act creating CHIP was enacted in August 1997, but the Texas legislature, which meets only every other year, had adjourned in May 1997. It would have taken a special session of the legislature to take up a major expansion of coverage for children, and the leadership in the state did not call for one. Unlike Virginia's Governor James Gilmore, who was openly hostile to significantly expanding children's coverage under Medicaid, observers noted that Texas Governor George W. Bush publicly expressed no opinion on the opportunity offered by CHIP to expand children's coverage. In fact, one newspaper noted that even two years later, in his January 17, 1999 speech to the next session of the legislature, Bush "covered more than a

dozen topics…from tax cuts to gambling machines to historic restoration – but was silent on children's health."[39]

Despite Bush's decision to keep a low profile on CHIP, some Bush advisors and appointees in the Department of Health and Human Services were opposed to CHIP and favored instead the Texas Healthy Kids program, a public-private program similar to the Healthy Kids program developed in Florida.[40] Nonetheless, efforts to take advantage of the CHIP legislation to expand children's coverage emerged. Advocacy on CHIP started almost immediately after the federal legislation passed in the fall of 1997. The advocates made providing coverage for children of all ages in families with income up to 200% of FPL a priority. There was a large advocacy coalition with active participation by the provider community. With funding from the March of Dimes, they held educational forums across the state and issued reports highlighting the state's high uninsured child rate and the opportunity CHIP provided to address that problem with hundreds of millions of federal dollars.[41]

As in other states, however, Texas did move quickly to get the enhanced match for expanding Medicaid eligibility for 15 to 18 year-olds whose families had incomes below the poverty level, as this action was already mandated under previous federal legislation. The Legislative Budget Board did this without need for a special session with enrollment to begin July 1998. A proposed second phase of the plan was to expand Medicaid again to include 8-18 year-olds in families with incomes between 100% and 133% of the FPL.[42]

The issue of what to do about CHIP and children's coverage in Texas continued to attract attention even while the legislature was out of session. The source of state funds for the modest Medicaid expansion became an issue. There was a well-publicized tussle between the Bush administration and the Texas Attorney General, a Democrat, who proposed using $1.2 billion of tobacco settlement dollars to finance the expansion of children's coverage.[43] Then the Texas Health and Human Services Commissioner resigned abruptly, and state health care policy experts cited the slow pace the state was following in getting its CHIP program going as a factor in the Commissioner's decision.[44] Moreover, the press, Democratic legislators, advocates, and others began to call attention to the risk that Texas would forfeit hundreds of millions of federal dollars if it did not expand coverage sufficiently to take advantage of its entire federal CHIP allotment.

The Democrats controlled the legislature in 1998, and between the legislative sessions, the legislative leaders engaged an interagency working group to develop some options for a CHIP program. When the legislature finally convened in January 1999, the discussion turned to how inclusive the Texas CHIP program should be. Some favored only expanding coverage to children in families with incomes up to 150% of the FPL, while others, backed by a coalition of children's advocates and providers, strongly advocated for a 200% of the FPL eligibility standard as contained to the federal law. Governor Bush was initially opposed to extending coverage to children whose family income was more than 150% of the FPL, but in the end, he signed legislation setting the income limit at 200% of the FPL.[45]

It appears that Governor Bush's presidential aspirations were a factor in the implementation of CHIP in Texas. Not a champion of children's health care in the first place, Bush initially eschewed taking a public stand on CHIP to avoid alienating his conservative base, while at the same time not wanting to be seen as opposed either. As CHIP was being implemented successfully in other states, public support for a CHIP program in Texas grew, as did concern that if Texas failed to act, the state would leave a lot of federal money on the table, and the Bush Administration became more receptive. In addition, while Bush kept the GOP presidential contest focused on tax cuts, he had to lay the groundwork for the general election in which voters ranked health care as a top priority.[46]

With the presidential campaign in full swing in 2000, the situation in Texas changed radically. The administration and legislative leadership made CHIP a top priority and gave the CHIP program staff great latitude in setting up the program and getting things going. In the words of the first Texas CHIP director,

"All they wanted to know was that things were going okay." The program people were even instructed to delay reporting enrollment numbers until enrollment was up.[47]

In April 2000, the state launched an ambitious public education and outreach effort for three children's health programs: Medicaid, CHIP, and the Texas Healthy Kids program. In the words of then Lt. Governor Rick Perry, "CHIP means fewer sick days. That is good news not only for our children and families but for our business leaders."[48] The response was immediate and substantial (see Figure 1). Less than a week after sign-up efforts began, the state reported that over 23,000 families had either asked for or sent in an application for the new CHIP program.[49]

By August, the number of children enrolled in CHIP reached 80,000, 17% of the total number of children estimated to be eligible. As state CHIP director Jason Cooke told a Texas legislative committee, "After five months, that compares very favorably with other states both in terms of where they were after five months and in terms of how many months it took them to get to where we are". Ironically, success with CHIP enrollment helped call attention to the poor job Texas was doing enrolling and retaining children in its Medicaid program. Cooke also testified that the state had only enrolled 2,000 of the 600,000 uninsured children in Texas eligible for Medicaid during the same five-month period.[50]

Despite the outreach effort, the failure of Texas, and Bush specifically, to move quickly on CHIP became a major issue in the presidential campaign. The Democratic candidate, Vice President Al Gore, attacked Bush for fighting to deny coverage to children in families with income between 150 and 200% of the FPL.[51] As the September 30, 2000, deadline approached for Texas to spend its initial CHIP allotment or forfeit the money for redistribution to other states, Gore made that an issue in the campaign as well. Although Bush countered that the federal CHIP law was to blame and that other states were also likely to have to return unspent funds, Bush's failure to call a special session of the legislature to take advantage of the 1997 CHIP legislation also became a campaign issue.[52]

The criticism of Bush, and by extension Texas, during the presidential campaign apparently influenced the tone of the 2001 Texas legislative session.[53] Several leading Democrats made it a priority to further boost enrollment in CHIP and eliminate many of the bureaucratic barriers to obtaining coverage in Medicaid.[54] Despite concerns raised by some Republicans about cost, in June 2001, Governor Rick Perry signed into a law a measure to boost children's enrollment in Medicaid. Modeled on the way children enrolled in CHIP, the law eliminated the need for children to enroll or renew in person, simplified verification requirements for children, and provided for six months of continuous eligibility in Medicaid for children. A Perry spokesperson observed, "Their futures and the future of Texas will be brighter for it."[55] And the changes had the desired effect, resulting in an increase of 300,000 in the number of children enrolled in Medicaid.[56] Several months later, Perry used an Austin elementary school event to announce that Texas had surpassed its goal of enrolling 428,000 in CHIP – only 18 months after the program opened for business.[57] However, less than two years later, with Perry still as governor and facing a large state budget shortfall, Texas increased premiums, established a waiting period, and moved from a twelve to a six-month eligibility period for its CHIP program. Within nine months, enrollment in the program declined by nearly 30 percent.[58]

Lessons

The experiences in Virginia and Texas demonstrate that, although it may take several years, policies can change, and programs can be implemented and improved. Sometimes things can change very quickly if there is a shift in the political environment and a strong push from the top to succeed, as in Texas. But in the absence of such a focus, as in Virginia prior to the election of Governor Warner, progress may be slow despite changes in program features and policies. As late starters, both Texas and Virginia were influenced by experiences in other states. Advocates and opposing politicians used success in other states and the risk of forfeiting federal funds to motivate action on CHIP. The enrollment targets required by CHIP and the amount of the state-specific block grants provided ready benchmarks against which to measure progress.

On the implementation side, CHIP directors from both states credited lessons learned from the experiences in other states as being critical in helping them get a good start once the policy environment was favorable and avoid mistakes as the program rolled out.[59] The focus on quick results in Texas especially put a premium on inclusive real time problem solving and the adoption of practices that seemed to be working well in other states.[60] The directors also highlighted the value added by opportunities for advocates and states officials to learn from each other. As examples of such forums, directors cited philanthropically supported programs such as Covering Kids and Families, funded by the Robert Wood Johnson Foundation, and the CHIP Implementation Center at the National Academy for State Health Policy, funded by the David and Lucile Packard Foundation.

In states, grassroots advocacy, policy analysis and public education – usually, by established organizations and coalitions - helped move the both the children's coverage and CHIP implementation agendas. In addition, by allowing states considerable flexibility in constructing their programs, CHIP provided an entry point and opportunity for proponents of coverage expansions to focus legislative debates on how to and how much to expand coverage, rather than whether to expand coverage at all. And success can breed success. Just as the experiences in other states helped both motivate and facilitate action on CHIP in Texas and Virginia, success with CHIP in many states led to changes and substantial growth in state Medicaid programs for children.[61]

CONCLUSION

As the ACA moves into implementation, the CHIP experience shows that a strong, collaborative relationship between the federal and state governments will be key to continued progress. That relationship seems to work best when the federal government focuses on desired outcomes while providing support to states and allowing states flexibility in program implementation. So far, the federal government seems to have demonstrated some flexibility with regard to the rules for the health insurance marketplaces, with the result that a number of different exchange models have emerged. How well the different models work and whether the flexibility offered the states will encourage more states to run their own health insurance marketplaces remains to be seen. The federal government has also evidenced some flexibility with regard to the Medicaid expansions for low-income adults, a particularly important issue for low-income children and families. Whether that flexibility will be sufficient to induce states that are resistant to the expansion of Medicaid to take up that option also is unknown, but the CHIP experience suggests that allowing states the flexibility to implement programs "their way" can result in both higher levels of state participation and more experimentation and innovation leading frequently to significant program improvement.

States that are reluctant to participate in the ACA will be more likely to participate if state policy makers see positive outcomes in other states, particularly if there is a growing perception that the state is losing out on federal dollars and assistance. The ACA's financial incentives to motivate states to act do not appear to be as strong as the incentives in the CHIP legislation. The match rate for the Medicaid expansion at 100% in the first three years and 90% thereafter is more generous than the CHIP enhanced match but the ACA's enhanced match does not come with the same sense of urgency generated by CHIP's use-it-or-lose-it policy. The possibility, however, that federal support for states to develop their own health insurance exchanges will end soon may motivate some states to action on that front. And the gradual reduction over the next several years in federal disproportionate share funds, which subsidize care for the uninsured, may create pressure for lagging states to take up the Medicaid expansion, even in circumstances where the very generous federal match rate was not a sufficient inducement.

Regardless of the strength of the incentives for states, engaged leadership will be needed to successfully implement the ACA in each state. Sometimes, as was the case Texas, political considerations will produce the needed level of engagement. Philanthropic organizations can, as they did with CHIP implementation, play an important role in bringing state, federal, and policy experts together to collaboratively solve problems and

learn from each other. As with CHIP, the ACA presents another opportunity to test whether the states can be successful laboratories of democracy while partnering with the federal government in a health policy arena that affects every American.

ABOUT THIS BRIEF

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