

Children's Health Insurance: Hopes and Hurdles

by Sherisse Webb, M.A.

When the state Children's Health Insurance Program (CHIP) was first introduced in July, 1998, it was hailed by health advocates and the media as the initial phase of incremental reform that would eventually achieve the universal health coverage that the Clinton Administration failed to realize in 1994.

The purpose of the legislation is to assist states to expand health coverage to insure children whose family incomes exceed the requirements for Medicaid, but are insufficient to support private insurance coverage. One and a half years later, the program is once again receiving a great deal of media attention. However, disappointing enrollment figures have transformed the initial enthusiasm for CHIP into impatience and skepticism. An estimated 2.5 million children below the age of 19 from working poor families are eligible for the program nationwide. Yet only 800,000 previously uninsured children have been enrolled in CHIP since it began.

As a Policy and Procedure Analyst for Indiana's CHIP, I can attest to many of the hurdles that threaten the success of state programs and may explain the disappointing enrollment figures. Like several other states, Indiana realized that the development of a new health insurance program would require significant time and resources. Consequently, as Phase I of Indiana's CHIP, the state implemented a one-year Medicaid expansion to provide coverage to all children below the age of 19 with family incomes at or below 150 percent of the federal poverty level. In the meantime, Governor Frank O'Bannon convened a 21-member Advisory Panel of health care professionals, insurance executives, legislators, educators and parents to develop a blueprint for the long-term implementation of CHIP in Indi-

ana. It is now the responsibility of the legislature and Indiana's Office of the Children's Health Insurance Program to translate the recommendations of the Advisory Panel into state policies and procedures.

Therein lies the challenge. The goals and requirements of the program, as outlined in state and federal law, are time- and labor-intensive and do not necessarily concur with experiences in the field. For example, to increase enrollment, great emphasis has been placed on implementation of outreach

more of a challenge as the family incomes of the target population increase.

Despite the many political and logistical challenges that surround CHIP in Indiana, the state has succeeded in enrolling more than 70 percent of the estimated 91,000 uninsured children who are eligible for Medicaid since the Phase I CHIP expansion became effective July 1, 1998. I suspect, however, that when Phase II of the program is implemented to provide coverage to children in families with incomes between 150 and 200 percent of the federal poverty level, additional hurdles, similar to those being experienced in other states, will surface.

Considering the number of unexpected challenges that have afflicted CHIP programs throughout the United States, it is not surprising that the states are celebrating the enrollment of 800,000 children. The expectations that have been imposed on the program since it was introduced seem to have distorted that fact that CHIP has been a significant undertaking for states and remains a relatively new program.

In addition to all of the necessary technological, policy, and cultural adjustments, states will have to devise aggressive and innovative outreach strategies if they hope to regain CHIP's once positive image as a groundbreaking initiative. Indiana was recently awarded a grant from the Robert Wood Johnson Foundation to do just this.

Three innovative outreach initiatives will be piloted in eight communities that are representative of the state's racial, ethnic and geographic diversity. Only time will tell whether such efforts will be sufficient to ensure the future of the program.

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and education initiatives. However, outreach workers are beginning to realize that the target population for this program is not found in the same neighborhoods or reached with the same promotional strategies as the population traditionally targeted for Medicaid enrollment. Also, the federal legislation requires that states coordinate CHIP with other public health care programs for children. Yet the success of the program requires that states ensure that the stigma often associated with public health care programs does not taint CHIP. This balancing act becomes even