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HISTORICAL NOTES

Conviction and Compassion Creates the Federal Children's Health Insurance Program

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Abstract

Introduction For a quarter century, the Children's Health Insurance Program (CHIP) has provided essential health care coverage for children and pregnant women in working families. Established as part of the Balanced Budget Act of 1997, CHIP provides critical coverage for children living in families with incomes falling between eligibility for Medicaid and employment-based coverage. Since its enactment, CHIP has markedly reduced the number of children who were uninsured in 2020 to approximately 3.7 million children (5.0%), an extraordinary 67% reduction. This article traces the history of the federal CHIP legislation based in large part upon the success of Pennsylvania's innovative efforts.

Methods Review of the literature. Personal Communications.

Results Since its enactment, CHIP has markedly reduced the number of children who were uninsured in 2020 to approximately 3.7 million children (5.0%), an extraordinary 67% reduction.

Discussion This article traces the history of the federal CHIP legislation based in large part upon the success of Pennsylvania's innovative efforts. The authors certify that the material presented in this article was prepared in accord with prevailing ethical principles.

Significance

While CHIP has been heralded for greatly improving access to health coverage, little is known about its origins, especially the contribution of the Pennsylvania CHIP, and the history of prior efforts. This article reviews the history of providing insurance coverage for children and recounts the personal involvement of the authors for CHIP's enactment.

Keywords MCH History · Child health insurance · CHIP · Pennsylvania CHIP · Title XXI-SSA

Introduction

The pursuit of a coherent US public policy to assure receipt of needed health care has been checkered and allusive, even for children. Ideological dissonance and partisanship politics have been the primary antagonists. Fortunately, for a quarter century, the Children's Health Insurance Program (CHIP) –Title XXI of the Social Security Act (SSA) stands as a remarkable exception supporting "high-quality, cost-effective coverage for low-income children and pregnant women in working families, helping to secure their health and the United States' future"(Kessel&, 2018). There is "incontrovertible evidence" of the success of CHIP. The program has increased insurance coverage and access to primary and preventive care significantly improving children's health status (National Research Council (US) and Institute of Medicine

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(US) 1998; Lave et al., 1998a; Racine et al., 2014a; Hoag et al., 2011).

Established as part of the Balanced Budget Act of 1997, (State Children's Health Insurance Program. Public Law, 1997) CHIP provides critical coverage for children living in families with incomes falling between eligibility for Medicaid and employment-based coverage (Lambrew&, 2007; Shore-Sheppard, 2018). In 1997, there were 10.7 million (15.0%) uninsured children under age 18 (Bennefield, 1998). Many of these children lived in working families with incomes just above States' Medicaid eligibility levels (History & impact of CHIP: MACPAC, 2018). Since its enactment, CHIP has markedly reduced the number of children who were uninsured in 2020 to approximately 3.7 million children (5.0%), an extraordinary 67% reduction (Cha & Cohen, 2022). Bipartisan support for "creditable coverage" for America's children drove CHIP to become the largest taxpayer-funded expansion of health care insurance coverage for children, especially near-poor children, since President Johnson established Medicaid(Implementation principles and strategies for Title XXI (State Children's Health Insurance Program). 1998; Smith, 2017; Adeyinka et al., 2022; Racine et al., 2014b). While this is an extraordinary achievement, disparities remain among specific groups; American Indian and Alaska Native children experienced the highest uninsured rate (11.8%) in 2020, followed by Hispanic (11.4%) and non-Hispanic Black children (5.9%) (Assistant Secretary for Public Affairs (ASPA) 2022).

This article traces the history of the federal CHIP legislation based in large part upon the success of Pennsylvania's innovative efforts.

Chip Prequels

Federal proposals to expand health care and insurance for children date back several decades. Key measures included Title V of the 1935 SSA providing "grants to States for maternal and child welfare"(Social Security Act, 1935). Thirty years later, the 1965 SSA Amendments established Medicare—Title XVIII, for the elderly, and Medicaid—Title XIX, for poor families with children and the aged, blind, or disabled. However, Medicaid eligibility was tied to receipt of Aid to Families with Dependent Children (AFDC) leaving many children uninsured (Kronebusch, 2001).

In 1979, the Carter Administration lead by pediatrician and then Assistant Secretary for Health and Surgeon General Julius B. Richmond, co-founder of the Head Start Program, proposed a Medicaid expansion plan for children—Child Health Assessment Program (CHAP). CHAP called for nearly $180 million to increase the number of poor children receiving health care by: increasing the federal payment to the States; expanding coverage to 7,00,000 children under the age of 6 living in poor families; assuring continuity of care for children post family eligibility termination; and, improving program oversight. CHAP was designed to assure that more low-income children received regular, high-quality primary and preventive care for the 12 million children who were eligible for Medicaid (Carter xxxx).

While CHAP was not enacted, it led to incremental steps to expand coverage to children, including:

The 1981 Katie Beckett Medicaid Waiver permitted Medicaid coverage for the disabled child at home (Waiver xxxx);
The 1984 Deficit Reduction Act permitted States to expand Medicaid eligibility;
P.L.99-457, Education of the Handicapped Act of 1986, required early intervention services for infants and preschoolers; (Legislative History of Special Education, 2008)
The 1986 Emergency Medical Treatment and Active Labor Act required hospitals to stabilize all persons who use their emergency rooms regardless of ability to pay;
The 1985- 1988 litany budget reconciliation acts (COBRA/OBRA) allowed employees and their families who lose their jobs to continue with their health plan for 18 months; gave States a Medicaid option to cover infants, young children and pregnant women up to 185% FPL independent of AFDC; mandated coverage for pregnant women and children under age 6, at 133% FPL; and, expanded Medicaid coverage to all children ages 6 to 18 with family income less than 100% FPL.
The 1988 Family Support Act required States to extend 12 months of transitional Medicaid coverage to families able to leave welfare; and,
The Healthy Start Initiative, designed by the MCHB, promoted comprehensive quality prenatal care in cities with high infant mortality.

Yet despite all of these efforts, many children remained uninsured, lacking access to quality health care, especially children living in families with incomes just above the FPL, due largely to declines in private insurance coverage tied to employment (Cunningham & Kirby, 2004).

Gathering Momentum

In 1989 the Representative Claude Pepper (D-FL) Commission proposed a blueprint for universal coverage. Governor Jay Rockefeller (D-WV), who chaired the Commission following Pepper's death, promised to "pursue legislative action not only on the commission's full set of recommendations but also on a *down payment*

to expand public health coverage immediately for children and pregnant women." They proposed legislation that would guarantee Medicaid coverage for every American child living in poverty paid for by the federal excise tax on cigarettes (Rockefeller, 1990). Momentum for covering all children greatly increased following welfare reform and the unsuccessful passage of President Clinton's 1993 Health Security Act (HSA) (H.R.3600-Health Security Act. xxxx). After the HSA failed, then Senator Rockefeller argued for expanded coverage specifically for children (Rockefeller, 1995).

In 1996, Senator John Kerry (D-MA) proposed his Children's Health Care Initiative for low-wage working families (Farrell, 2003). The proposal would establish a subsidy program to help working families with incomes too high to qualify for Medicaid to purchase private health insurance for their children. President Clinton expressed his support for Kerry's initiative with Democrats seeking to cover "laid-off workers and their families with incomes too high to qualify for Medicaid but too low to meet the cost of private insurance" (Next Steps & on Health Care, 1996); The Washington Post 1996). Kerry's proposal was also included in the Democratic agenda entitled, "Families First" (Press Release, 1996).

In 1997, bipartisan congressional proposals emerged. Senators John Chafee (R-RI) and Jay Rockefeller (D-WV) suggesting expanding Medicaid. Congressman John Dingell (D-MI) introduced legislation to expand State health coverage for low-income children and pregnant women coupled with outreach to enroll eligible children. Representative John Kasich (R-OH) introduced legislation prescribing a children's health insurance program. Petitioned by Dr. Barry Zuckerman, director of pediatrics at Boston Medical Center, and John McDonough, a State legislator, Senator Kennedy (D-MA) proposed a plan similar to one already approved in Massachusetts (Milligan, 2008). Kennedy partnered with Senator Orrin Hatch (R-UT) and introduced the "Child Health Insurance and Lower Deficit Act (CHILD) (Pear, 1997; S.525-Child Health Insurance & Lower Deficit Act xxxx)—a State block grant program to purchase private health insurance for children supported by a tobacco tax. Despite support from the First Lady the legislation was never acted upon.

Child health proposals were also being considered by the Department of Health and Human Services (DHHS) and the White House. First Lady Hillary Rodham Clinton was a major force inside the White House helping to get this done (Clinton, 1997; Jackson, 2008). One such proposal promoted by DHHS was based on a successful Pennsylvania model supported by the MCHB helping to establish and evaluate Pennsylvania's innovative effort.

State Innovations

Often State and/or local communities lead in the development of innovative approaches to solving community problems well in advance of national policy. State-based health insurance efforts incorporated Medicaid expansions and waivers; State-financed subsidy programs; and private initiatives to cover children, especially those with special needs (Gauthier & Schrodel, 1997; Johnson & McDonough, 1998). States like Massachusetts, Hawaii and Michigan passed special employer-based insurance legislation and/or Medicaid enhancements as the primary mechanisms for improving health care coverage for children. Support from MCHB was used for data collection and analytic needs assessment for the enhancements.

Hawaii's 1974 Prepaid Health Insurance Act required dependent coverage, if offered to employees, to include such preventive care as immunizations and well-child visits from birth through age five. In 1998, employer-based health plans provided benefits for nearly three-quarters of the insured children in Hawaii with the remaining children covered by either the State's Medicaid fee-for-service program, or through the QUEST Medicaid expansion program—Hawaii's Sect. 1115 waiver program authorized by the DHHS to better serving Medicaid populations (Hawaii's, 2008).

In 1992, Michigan expanded Medicaid eligibility to cover pregnant women and infants up to age 1 in families at or below 185% FPL, to children ages 1–15 in families with income up to 150% FPL, and to children ages 16–18 at or below 100% FPL. Applications for Medicaid were simplified and ambulatory care coverage was provided through the Blue Cross Blue Shield of Michigan's "Caring Program for Children." This was part of the 1985 Pennsylvania Caring Program for Children expansion supported in part by a grant from the MCHB (Ellis et al., 2007; Michigan's, 2008).

In 1996, the Massachusetts legislature passed Chapter 203 restructuring and expanding health care access programs for children. It built upon their 1988 legislation mandating employer health care coverage for their workers; a 1994 Medicaid waiver proposal to expand access to care yielding to financial pressure from uncompensated hospital care. Chapter 203 expanded the Massachusetts Medicaid program to serve all children aged 0–18 whose family incomes fall below 133% FPL; children 0–12 up to 200% FPL; and increased dollars for the Children's Medical Security Plan to provide preventive and primary care services to Massachusetts children from birth through age twelve supported in part by a cigarette tax (Greenberg & Zuckerman, 1997).

Pennsylvania's Unique Approach

In the early 1980s, the steel industry in Pittsburgh began to collapse leaving more than 150,000 workers without a job. Families struggled to buy food and pay rent and mortgages. Unemployment was among the highest in the nation with neighborhood businesses from barber shops to grocery stores struggling, being dependent on the economic wellbeing of these old "steel" communities. Steel workers not only lost their jobs, but consequently lost their health care benefits, including family coverage. Families worried about paying for their basic needs as well as needed preventive and acute health care, especially for their children. As one displaced steelworker put it, *"You can pay for rent, groceries, or health care. You can't get all three. This is not a choice anyone should have to make for their children*."(LaVallee & Sunderman, 2003) Families became acutely aware of the consequences of being uninsured and previously financially independent families faced daunting challenges of applying for public assistance—Medicaid.

The laid-off Pittsburgh steelworkers held demonstrations, including at local churches. Two ministers—John Galloway, Jr. and William Ewart, from the Fox Chapel Presbyterian Church, heard the pain of the steelworker families, especially the worry for their children's wellbeing. The ministers met with Eugene Barone, then President and CEO of Blue Cross of Western Pennsylvania (BCWP), to share what they had learned about the struggling families. Barone and the BCWP leadership were moved by the stories of these out-of-work families and their distress. Consequently, in 1985, Highmark Blue Cross Blue Shield (HBCBS), then BCWP and Pennsylvania Blue Shield (PBS), launched a two-part initiative to help identify and meet the unmet needs of children in Western Pennsylvania—The Caring Program for Children (CPC) and the Highmark Caring Foundation (HCF). (Working & Solution. Health Care Coverage for Uninsured Children in Western Pennsylvania, 1997).

The CPC initially offered primary and preventive health care coverage, which was eventually expanded to more comprehensive coverage as the program grew. The enrolled children had access to the Blue Cross Blue Shield (BCBS) network of physicians, receiving the same care from the same providers, using the same type of identification card, as any other private BCBS customer. The dignity of these children and their families was upheld, as they were treated no differently than other HBCBS members. The program, was originally financed through charitable contributions and matched by Highmark with all of the administrative costs borne by Highmark as well. *The result was the first health insurance program in the nation provided by a private health insurance company offering primary and preventive health care coverage to uninsured children from low-income families.*

The CPC successfully reached tens of thousands of uninsured children throughout Western Pennsylvania, with thousands more referred to Medicaid. Success was based on community involvement, creating awareness, raising funds, and identifying eligible children. Listening to and then communicating the difficulties and worries faced by the families of children who lacked health care coverage was key in gaining and expanding community support. Collaborators included schools, religious groups, civic organizations, minority advocacy groups, county assistance offices, local stores and restaurants, town, borough and county programs, elected officials, WIC, unions, hospitals, job centers, businesses and corporations. The Pennsylvania Chapter of the American Academy of Pediatrics, the Pittsburgh Steelers, the Pittsburgh Pirates, and Mister Rogers were prominent enthusiasts.

The HCF, then the Western Pennsylvania Caring Foundation (WPCF), was created as a nonprofit affiliate of HBCBS to mobilize the community to raise funds and identify eligible children for the CPC. Fred Rogers, host of *Mister Rogers' Neighborhood,* was the HCF's Honorary Chairman and helped guide the initiative to maintain its core principles of kindness and compassion. In 1987, the HCF was awarded a four-year competitive Special Projects of Regional and National Significance (SPRANS) grant by the MCHB (Special Project of Regional & National Significance MCJ, 1993). The grant helped to expand and replicate the CPC through BCBS Plans in more than two dozen States. Consequently, more children received needed health care and the HCF was recognized as a pioneering leader and model for providing health care coverage for uninsured children. Another MCHB SPRANS grant was awarded to explore adding children with special health care needs, covering specialty care through the CPC (Indigent workers' children provided free health care, 1989).

The HCF worked in partnership with the community to serve uninsured children and adults, children and families coping with grief and loss, and now children with special health care needs. With clear *evidence* of CPC effectiveness and support from the Children's Defense Fund and noted pediatrician T. Berry Brazelton, the HCF advocated for statewide expansion for ALL eligible Pennsylvania children. *As a result, in 1992 then Governor Robert Casey signed into law the Children's Health Insurance Act establishing the Children's Health Insurance Program of Pennsylvania (CHIP of PA).*

Pennsylvania Children's Health Insurance Program

The primary driver of this legislation was Pennsylvania State Representative Allen Kukovich (D), who, along with Senator Allyson Schwartz (D) sponsored it. CHIP of PA, modeled after the successful CPC, covered children up to age 6 at 185% FPL and expanded eligibility for children aged 10–14 at 50% to 100% FPL, financed by a cigarette tax. Kukovich explained, "…the reasons for modeling CHIP after the Highmark CPC was that CPC worked, it was cost-effective, and it had a good image in the state."

Subsequently, the CPC expanded covering children up to 185% FPL and age 18. It worked in tandem with CHIP, covering office visits, well-childcare, immunizations, diagnostic tests, ER care, outpatient surgery, dental care, vision/hearing care, prescription drugs, hospital care and mental health services, regardless of any pre-existing condition. *Together the CHIP and CPC programs successfully provided seamless comprehensive coverage for working families throughout Pennsylvania.*

The Pennsylvania Children's Health Insurance Program was a unique State program providing insurance coverage for children whose families earned too much to qualify for medical assistance and could not afford to purchase private insurance. CHIP evaluators concluded that "Extending health insurance to uninsured children had a major positive impact on children and their families." They found that as the result of CPC and CHIP, access to health care services improved, children had a regular source of medical/dental care, and parents reported that having health insurance reduced stress and eased family burdens (Lave et al., 1998b). These results not only affirmed the Commonwealth of Pennsylvania's efforts but encouraged other States to adopt their real-world tested framework.

Federal Children's Health Insurance Program

As a representative of the MCHB, ASG Woodie Kessel, MD, MPH worked with Highmark and the HCF's Director—Charlie LaVallee and gained an "on the ground" perspective, witnessing first-hand the successful operation of the CPC in the field. Conversations with Barone and LaVallee provided key details regarding program implementation and administration. Dr. Kessel interviewed Pennsylvania's US Representative William Coyne and PA State Representative Kukovich, President of PA's Chapter of the American Academy of Pediatrics – Dr. Alan Kohrt, and most importantly listened to children and parents participating in the CPC and CHIP of PA. He reviewed the rigorous program effectiveness data, as well as the organizational and political parameters with the University of Pittsburgh's Graduate School of Public Health's evaluation team lead by Dr. Judith Lave and Dr. Edmund Ricci.

In 1996, based upon all of these data, Dr. Kessel submitted "a Highmark Caring Program for Children / CHIP of PA like" proposal to cover *all* of America's children to Donna Shalala, Ph.D., Secretary, DHHS. The proposal documented the key features of Pennsylvania's approach and for scaling its success. Kessel's proposal, reviewed by numerous DHHS policy channels, was specifically supported by the Office of The Assistant Secretary for Planning and Evaluation's Cheryl Austein. Similar to legislation already being considered (Internal DHHS/ASPE Memorandum, 1997), Pennsylvania's real-world evidence of success led Secretary Shalala to strongly endorse the proposal as she was a passionate advocate for helping children (Personal communication, 1997). Ultimately the Pennsylvania-based national CHIP proposal was submitted to The White House as an evidence-based effective program for improving child health that could serve America's children and families.

Successful passage of the Balanced Budget Act of 1997 (BBA) set forth the statutory authority for CHIP under Title XXI of the SSA. As previously referenced, CHIP resulted from years of work on Capitol Hill; a desire to recover from the unsuccessful enactment of the 1993 Health Security Act; and recognition of having an incremental, bipartisan approach to health care reform. The Chafee-Rockefeller proposal and the Kennedy-Hatch proposal were excellent collaborations that paved the way for bipartisan support and passage of CHIP. On the House side, Congressman Kasich, notably a republican from Ohio, introduced and sponsored the BBA. Although starting from disparate perspectives, the final legislative approach had strong bipartisan support, including from the White House, and focused on employing a federal-state partnership similar to Medicaid giving states flexibility in designing their CHIP policies. *The federal government's CHIP program was signed into law August 5, 1997 by then President Bill Clinton.*

Implementation

The federal CHIP built upon Medicaid's success in providing health coverage for eligible children, allowing States to adapt program components locally and use federal CHIP dollars to finance much needed coverage for children. The shared State/federal goal of CHIP was to help close coverage gaps for children whose families did not have or could not afford private coverage and had incomes too high to qualify for Medicaid according to State eligibility provisions set in 1997. States could either use CHIP funds to expand Medicaid eligibility levels for children, cover children via

a separate State CHIP program, or create a combination of the two approaches.

A key Republican provision of CHIP, critical for securing bipartisan support, allowed States flexibility to set their own eligibility rules related to income and program structure. By 2006, 28 States set upper-income eligibility at 200% FPL and eight States had lower eligibility criteria, while 15 States including DC, had higher eligibility limits (McClellan, 2006). Some States opted for Medicaid CHIP programs, others had separate CHIP programs, while still others had a combination of the two. To receive CHIP funding, States were required to submit a written plan for approval that involved the public in the design and implementation of the plan, set strategic objectives related to measuring the extent of "creditable" health coverage among targeted low-income children and other low-income children and collect data to assess State program administration and effectiveness of state plans.

While CHIP offered all-important State flexibility, benefits were required to meet certain standards or were "benchmarked" to other programs. Today, that coverage follows the care provisions set forth in *Bright Futures*, a MCHB/AAP product (Hagan, et al., 2017). To encourage States to adopt CHIP, the legislation provided an "enhanced" federal matching rate at 70 percent, a rate higher than the federal matching rate for Medicaid. CHIP also required States to reach out to families to promote enrollment in the program by allowing States to use up to 10 percent of their annual allotments on outreach, administration, and other health-related activities (The Children's Health Insurance Program, 2017). Systems of accountability for assuring CHIP's success were essential, as States took different steps to reduce the number of uninsured children in each State (Institute of Medicine, 1998).

Exercising the Republican supported provision allowing states flexibility regarding income eligibility thresholds, New York used its discretion to cover children at 4 times the poverty rate (400% FPL). New York did so to cover children whose families worked several low paying jobs sometimes multiplying income but all without health care benefits (Adeyinka et al., 2022). Ironically, Republican President George W. Bush vetoed CHIP renewal legislation twice, in part objecting to New York's use of the Republican proviso. It appeared to Bush that the program was moving "our health care system in the wrong direction," steering away from its core purpose of providing insurance for poor children and toward covering children from middle-class families (Stout, 2007).

Epilogue

On November 1, 2007, at a press conference, Senator Ted Kennedy said, *"It's a privilege to join my colleagues to support children's health. I commend too the former Assistant Surgeon General, Dr. Woodie Kessel for his courage in speaking out for children. He has worked tirelessly for children's health in Republican and Democratic Administrations alike – and he recognizes that a strong, bipartisan CHIP bill is the most important step we can take to improve the health of America's children. We're here today to say there's no higher priority in America than our children. When we shortchange our children, we shortchange our future. It's almost unimaginable that an American President could tell American parents that we can't afford health care for American children."*

For prevention and health promotion efforts to have their maximum benefit and payoff, the opportune time to provide these highly effective quality health care services is early in life—to pregnant women, infants, children, and adolescents to start life healthy and reduce the human and capital burden of preventable chronic disease. Modeled on the success of the efforts in Pennsylvania private insurance plans to deliver benefits and raise awareness of its highly effective elements and, in light of the program's successful path to implementation at the highest levels of public policy, the federal CHIP program helped advance health care coverage for ALL of America's children. Since its enactment in 1997, the Children's Health Insurance Program has played a crucial role in helping to reduce the rate of uninsured low-income children, covering many children who would otherwise have been uninsured. Providing needed access to health care has been spectacularly achieved. All of this was done in a manner reflecting the needs of each State's unique demographics and eligibility determinations.

The United States Children's Health Insurance Program certainly passes the moral test of government prescribed by Vice President Hubert H. Humphrey, *"how that Government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped."* Moreover, the successful establishment of a national insurance program for children is a grand testimonial to the tenacity, conviction and compassion of child advocates and provides an important prescription for resolving current and future challenges to help advance the health and well-being of children.

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