

The Future of Children's Health Coverage



ALLIANCE FOR
HEALTH REFORM

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Over the past decade children's coverage has been a rare bright spot in coverage expansion in an era where, until the recent enactment of comprehensive health reform, there has been no progress toward reducing the overall number or percentage of uninsured individuals in the United States.

The portion of children who lack coverage declined from 12.9 percent in 1999 to 9.9 percent in 2008, according to the Census Bureau. The reduction in 2008 was mostly due to gains in Medicaid and the Children's Health Insurance Program, with 1.7 million more children covered than a year earlier.

The number of uninsured children below the federal poverty level decreased in 2008 to 2.2 million—a 5.7 percent drop. The number of uninsured African-American children below poverty showed a even more dramatic 15 percent decrease—to

In November 2009, the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, held a Capitol Hill briefing on the crucial role Medicaid and the Children's Health Insurance Program (CHIP) play in coverage for children. Panelists were Jocelyn Guyer of the Center for Children and Families at Georgetown University Health Policy Institute; Nate Checketts, director of Utah's CHIP program; and Stan Dorn of the Urban Institute. This issue brief draws from information presented at that briefing, and reflects changes made by the 2010 health reform law.

Fast Facts

- The Patient Protection and Affordable Care Act of 2010 affects children's coverage in a number of ways.
- Beginning in 2014, the law makes Medicaid coverage mandatory for kids from ages 6–19 in families between 100 percent and 133 percent of the federal poverty level (FPL).
- The reform law maintains the Children's Health Insurance Program (CHIP) through 2019. In 2015, states will receive a 23 percentage point increase in the CHIP match rate, up to 100 percent of costs. Current match rates range from 65 to 85 percent.
- Already some states are worried that the new law will impose new costs that they can ill afford given the state of the economy.
- Private insurers must offer coverage for children with preexisting conditions. This means both providing coverage for preexisting conditions for currently insured children and not excluding children with preexisting conditions from future coverage. This requirement becomes effective with the insurance plan year beginning after Sept. 23, 2010 (meaning Jan. 1, 2011 for most people).
- Almost two out of every three uninsured children in 2007 were eligible for Medicaid or the Children's Health Insurance Program (CHIP) but were not enrolled.

491,000. The recent passage of health reform, moreover, provides opportunities for increasing children's coverage even further and for improving the services that children receive—as well as the potential for unintended consequences that could erode coverage.

The Patient Protection and Affordable Health Care Act of 2010 will affect coverage for children in a number of ways. Most notably it makes Medicaid coverage mandatory for kids from ages 6–19 in families between 100 percent and 133 percent of the federal poverty level (FPL). (See text box, “2010 Federal Poverty Guidelines.”) State Medicaid programs are currently required to offer certain child-specific benefits and to cover children under age 6 up to 133 percent of the FPL and

children age 6–19 up to 100 percent of the FPL. The new standards go into effect in 2014.

Medicaid is jointly funded by the federal government and the states and administered by the states. It is an entitlement program; that is, states may claim federal matching funds for everyone who is eligible regardless of the total cost.

Under reform the federal government will initially pay 100 percent of the costs of expanding coverage from 100 to 133 percent of the FPL. Over time the federal share will be reduced to 90 percent, with states covering 10 percent of the costs for this income group. New federal funding is also provided to states to bring payments to Medicaid



Robert Wood Johnson Foundation

2010 Federal Poverty Guidelines

All states except Alaska and Hawaii, and D.C.

Family Size	Percent of Poverty Guideline		
	100%	133%	200%
2	\$14,570	\$19,378	\$29,140
3	\$18,310	\$24,352	\$36,620
4	\$22,050	\$29,326	\$44,100

primary care providers up to Medicare payment levels, but only for two years, 2013 and 2014.

While 47 states already cover children at 200 percent of the FPL or higher through Medicaid or the Children's Health Insurance Program (CHIP), the new law will make many low-income children eligible for Medicaid. This will guarantee them access to Medicaid's lower out-of-pocket spending protections and provide a richer benefit package than they would receive under CHIP in many states or in the new health insurance exchanges created by the law.

The reform law maintains CHIP through 2019. In 2015, states will receive a 23 percentage point increase in the CHIP match rate, up to 100 percent of costs. Current match rates range from 65 to 85 percent.

However, full funding of the CHIP program extends only until the end of FY 2015, and states can choose not to take part. States are allotted a capped amount of federal funding for their programs. It is possible that some may decide to end their CHIP programs after FY 2015 rather than spend more state dollars.

The children who would lose CHIP coverage would be required by the reform law to get insurance through a different channel. The new law requires most people (except those granted hardship or religious exemptions) to have health insurance. This may compel parents to switch their children to Medicaid, accept coverage offers from em-

ployers, or purchase coverage through an exchange, with the potential for making coverage for children near universal (provided they are in the U.S. legally).

But CHIP pays more of the cost of covered services than do the plans expected to be offered through exchanges.

And the disruption to a child's medical care during the transition from CHIP to other coverage could be substantial.

Private insurers also have new responsibilities under the reform pack-

age. Effective within six months of enactment they must provide coverage for children with preexisting conditions. The Secretary of Health and Human services recently clarified that this means both providing coverage for preexisting conditions for currently insured children and not excluding children with preexisting conditions from future coverage.

Beginning in 2014, state-based health insurance exchanges are established, through which those without access to affordable employer-sponsored coverage will be able to purchase private insurance. Low-income individuals not eligible for public coverage will receive subsidies to help them pay for their insurance. Small employers (and perhaps eventually, larger ones) will also be able to use the exchange to provide their workers with coverage.

The new reform law increases coverage among low-income parents through the Medicaid expansion and premium subsidies in the exchanges. That is likely, research shows, to also increase coverage for their low-income children.

Selected Provisions of Health Reform Law Affecting Children and Families Effective in 2010

March 23 (date of enactment)

- States must at least maintain the Medicaid and CHIP coverage and enrollment procedures that they have in place now.
- Small employers receive tax credits covering 35% (increasing to 50% by 2014) of health care premiums.

By June 24

- A high-risk pool established for qualified uninsured people with pre-existing conditions (until the exchanges are operational in 2014).

After September 23 (as the health plan year begins)

- Young adults can remain on their parents' health plan until they turn 26.
- Children under 19 with private insurance can no longer be denied coverage for pre-existing conditions.
- Insurance plans can no longer impose lifetime caps or restrictive annual limits on coverage, and cannot rescind coverage when a person becomes ill.
- New plans must provide free preventive services to enrollees

Source: Center for Children and Families, Georgetown Univ. (<http://ccf.georgetown.edu>)

But the potential benefits of the new reform bill for improved children's coverage are not without the potential to strain existing children's coverage programs. Already some states are worried that the new law will impose new costs that they can ill afford given the state of the economy.

Will state Medicaid programs—propped up in the near term by temporary federal assistance—be able to provide ample long-term access to care for children while absorbing an influx of new eligibles? How much will temporarily increased reimbursement rates to Medicaid primary care providers, one provision of the new law, alleviate these pressures?

And while newly eligible enrollees to these programs between 100 and 133 percent of the FPL will be mostly paid for by the federal government, provisions in the new law—such as the individual mandate—are sure to sweep in new enrollees below 100 percent of the federal poverty level as well. New enrollees who were previously eligible for Medicaid and CHIP will only generate the lower, regular federal match rates which may be very costly for states with existing high numbers of uninsured.

In February 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA, also known as the stimulus bill) to help states meet their fiscal needs under Medicaid. It increased by 6.2 percentage points every state's federal Medicaid matching percentage ("FMAP"). ARRA also awarded higher increases to states with higher unemployment rates.

Reflecting another facet of the immediate fiscal concerns of states, Congress is currently considering extending ARRA's temporary enhanced match to states from December 2010 to June 2011 to offset the impact of the still struggling economy on state revenues.

It will be 2014 until families can

A major boost for children's coverage happened in 1997 with the creation of what is now called the Children's Health Insurance Program (CHIP). Congress reauthorized and expanded the program in early 2009 with the Children's Health Insurance Program Reauthorization (CHIPRA).

Here are the main features of CHIPRA:

- Adds \$33 billion in federal funding to ongoing federal funding of \$25 billion to cover children under CHIP through FY 2013. Just over 4 million children of the 9 million children currently uninsured are expected to gain coverage because of CHIPRA.
- Establishes new options to cover pregnant women, limits options to expand coverage to parents, allows states the option to cover legal immigrants, and provides states with new tools and fiscal incentives to improve enrollment in Medicaid and CHIP.
- Provides for "express lane eligibility" based on information individuals have already provided to other government programs.
- Provides \$100 million in grants for outreach and enrollment to state agencies, community-based organizations, health centers, faith-based organizations and the Native American community.

appreciate all of the coverage expansions for children contained in the new health reform law. In the meantime, how have children been faring when it comes to health coverage?

After those age 65+, almost all of whom are covered by Medicare, children are the best-insured age group in the U.S. Most children are covered through employer-sponsored insurance or other private insurance. Fifty-eight percent of children (45.8 million) received their coverage in this way in 2007, according to an analysis by the Urban Institute.

Thirty-two percent of children were covered by Medicaid or CHIP in 2007. Medicaid insured 29 million children and CHIP another 7 million. That 32 percent of children insured under public programs compares to just 8 percent of non-elderly adults.

More than three quarters of children enrolled in Medicaid and CHIP are in families with incomes at or below 200 percent of poverty.

All but three states—California, Arizona and Wyoming—either maintained or increased existing levels of children's coverage under Medicaid

and CHIP during the first nine months of 2009. Twenty-three states actually took steps to increase the number of children and families receiving health coverage through Medicaid and CHIP.

In 2009, an additional 2.6 million children gained Medicaid or CHIP coverage. Most of them (2.2 million) were enrolled in Medicaid. Experts cite the temporary Medicaid enhanced match as a significant reason for the uptick in Medicaid enrollment among children.

Utah is an example of a state that has dramatically increased children's coverage despite the economic downturn. Utah operates a CHIP program separate from Medicaid that covers kids up to 200 percent of FPL. The state uses employer-sponsored coverage as a benchmark for its co-pays and premiums.

Utah has begun experimenting with other coverage options for children and adults. It operates a premium assistance program called Utah's Premium Partnership for Health Insurance, which subsidizes families to purchase employer-sponsored health insurance coverage.

Nate Checketts, Utah's CHIP

director, attributes part of his state's success in reducing the number of uninsured residents to the close coordination between the state's CHIP and Medicaid programs.

"So when an application comes in, it is given to one person and they determine CHIP or Medicaid eligibility. It doesn't need to be handed off to someone else," said Checketts.

Having health insurance coverage does not always ensure access. Low provider reimbursement rates may limit access to care for low-income children. That does come with a trade-off. . . there's often less access to services than families need." While the new health reform law does provide full federal funding for increased payment for some primary care services, it only lasts for two years.

And although more than 80 percent of eligible children are enrolled in Medicaid or CHIP—a higher participation rate than with any other need-based, state-administered program—nine million children remain uninsured. Nearly two-thirds of them (64 percent) qualify for public coverage but are not enrolled.

Research suggests that states' renewal policies are a significant factor

in whether children who are eligible for Medicaid and SCHIP are enrolled. One study found that 34 percent of eligible-but-uninsured kids had previously been on public assistance but disenrolled.

Enrolling those who are already eligible has been a focus of policy makers' attention. In CHIPRA, for example, states were offered "performance bonuses" if they adopted at least five of eight specified strategies to promote coverage and retention and actually showed enrollment gains. Among the eight:

- Providing 12-month continuous eligibility (i.e., income increases are disregarded until the next renewal period);
- Liberalizing asset tests;
- Eliminating the need for in-person interviews;
- Using the same forms for both Medicaid and CHIP;
- Allowing kids to enroll in Medicaid and SCHIP while an eligibility determination is being made;

- Coordinating between other programs such as school lunch and food stamps, including relying on information available from other programs ("Express Lane" eligibility);
- Automating enrollment, establishing eligibility based on data rather than application forms completed by families; and
- Allowing CHIP to help pay for private insurance.

Nine states received performance bonuses based on meeting on these criteria, earning payments ranging from \$788,000 to \$39 million. More states are expected to qualify for bonuses in 2010.

Even accounting for legitimate concerns about straining states' capacities, on balance the new reform bill and a recent history of coverage gains suggest a continued upward trajectory for children's coverage.

For the sources used in writing this issue brief, email info@allhealth.org or call 202/789-2300.

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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■ Jocelyn Guyer , Georgetown Center for Children and Families	202/687-0880
■ Genevieve Kenney , Urban Institute	202/833-7200
■ Bruce Lesley , First Focus	202/657-0670
■ Lawrence McAndrews , National Association of Children's Hospitals	703/684-1355
■ Sara Rosenbaum , George Washington University Department of Health Policy	202/530-2343

Websites

■ Alliance for Health Reform	www.allhealth.org
■ American Academy of Pediatrics	www.aap.org
■ Child Health Insurance Research Initiative	www.ahrq.gov/chiri
■ Child Welfare League of America	www.cwla.org
■ Children's Defense Fund	www.childrensdefense.org
■ Children's Health Matters	www.childrenshealthmatters.org
■ Children's Partnership	www.childrenspartnership.org
■ The Commonwealth Fund	www.commonwealthfund.org
■ Covering Kids and Families	www.coveringkidsandfamilies.org
■ Kaiser Family Foundation	www.kff.org
■ Kids Count Data Center	datacenter.kidscount.org/
■ KidsHealth (Nemours Foundation)	www.kidshealth.org
■ The Robert Wood Johnson Foundation	www.rwjf.org
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