

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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Executive Summary

States have been revitalizing their efforts to expand health coverage for low-income, uninsured individuals, particularly children. During 2007, states were bolstered by a positive fiscal outlook and the anticipation that strong SCHIP reauthorization legislation would be passed, conditions that led them to take affirmative steps towards improving access to health coverage through Medicaid and the State Children's Health Coverage Program (SCHIP). Successes at the state level mark 2007 as a pivotal year, with eligibility increases for children representing the most aggressive push forward since the early years of SCHIP.

Despite states' recent bold initiatives to advance children's health coverage, a string of federal developments is dampening the prospects for making real progress. First, states were counting on a strong SCHIP reauthorization that has not yet materialized. Although two bills were passed with large bipartisan majorities in Congress that would have enabled states to expand and strengthen their programs, they were vetoed twice by President Bush. Congress has since enacted a temporary extension of SCHIP that will be in place until the end of March 2009.

During the SCHIP debate, the Centers for Medicare and Medicaid Services (CMS) issued a new federal directive on August 17, 2007, that restricts states' ability to use SCHIP funds to cover children in families with gross incomes above 250 percent of the federal poverty line. CMS has also issued new federal regulations curtailing Medicaid funding, including one that eliminates administrative funding for outreach and enrollment activities conducted by school personnel. In addition, implementation of the Medicaid citizenship documentation requirement, a provision of the Deficit Reduction Act (DRA) enacted in early 2006 that requires new applicants and current enrollees to provide original documents to prove citizenship and identity has resulted in eligible U.S. citizens having their Medicaid benefits delayed, denied or terminated. These developments are impeding states' efforts to cover children made eligible through newly authorized expansions, as well as their efforts to enroll children who are already eligible for coverage but who remain uninsured.

This report presents the findings of a survey of eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP for children and families that were implemented or authorized between July 2006 and January 2008 in the 50 states and the District of Columbia. These policies are the driving forces behind efforts to reduce the number of low-income people who lack adequate insurance but cannot afford to pay for it on their own. The survey documents the steps states took to advance coverage, and also the impact of new hurdles that are constraining their efforts to reduce the number of low-income uninsured children, pregnant women and parents.

The survey's major findings are presented below.

Changes in Health Coverage Programs for Children

- **Nearly two-thirds of the states (32 states, including DC) took actions to increase access to health coverage for low-income children, pregnant women, and parents.** Twenty-six states authorized or adopted income eligibility expansions, 11 states reduced procedural barriers, and seven states reduced financial barriers to Medicaid and SCHIP. While the most vigorous activity was focused on children, modest improvements for pregnant women and parents also occurred.

- **Twenty-six states improved access to children’s health coverage.** Twenty states expanded eligibility, the most aggressive step forward since the early years of the SCHIP program. Of those 20 states, 12 raised (or authorized raising) SCHIP income limits to 300 percent of the poverty line or higher, more than doubling the number of states with eligibility at this level. Nine states simplified enrollment procedures, and seven states reduced financial barriers to coverage.
- **Over the next year, children’s health coverage in nearly half the states (23 states) will be hampered by the August 17th directive.** Just as states are pushing forward, a new federal directive issued by CMS on August 17, 2007 restricts states from using SCHIP funds to cover children in families with gross incomes above 250 percent of the federal poverty line, thus limiting states’ ability to reach uninsured children above this income level. The directive currently affects 23 states, including 10 states that passed eligibility expansions but had not obtained federal approval before the directive was issued and 14 states that had implemented coverage expansions above this level but will have to comply with the directive by August 2008. (Washington is counted in both sets of states.) In response to the directive, several states have scaled back or postponed their expansion plans or have decided to absorb the full cost of covering children with income above the CMS limit. As a result, thousands of children already have lost the opportunity to obtain health coverage. Many more may be adversely affected as states make decisions about going forward.
- **Fourteen states enacted children’s coverage expansions that were moderate in scope but focused on particularly vulnerable populations, such as infants or children discharged from foster care at age 18.** These changes include modest income eligibility expansions, increasing the SCHIP asset limit, and allowing children who are discharged from foster care at age 18 to retain Medicaid through age 21.
- **No state cut back income eligibility for children, but a few states took other actions to restrict eligibility.** Three states froze children’s enrollment; two states imposed or lengthened waiting periods. Experience from states that have endured enrollment freezes indicates that most children who are closed out of coverage have no alternatives and remain uninsured, missing out on needed health care including prompt medical treatment, medication, preventive exams and immunizations.
- **States have made progress in adopting simplified enrollment and renewal procedures in children’s Medicaid and SCHIP, with particular emphasis on strategies that reduce paperwork and jump-start enrollment.** Nine states took steps to simplify enrollment and renewal procedures for children. Several basic simplified strategies — disregarding assets in determining eligibility, allowing enrollment and renewal without an in-person interview, and limiting the frequency of renewal to once a year— have been adopted for children almost universally. Only one state, Georgia, retracted a simplified procedure in its children’s health coverage program during the survey period.
- **The Medicaid Citizenship Documentation Requirement included in the DRA enacted in 2006, continues to impede states’ simplification efforts by complicating enrollment, especially for children.** The requirement that U.S. citizens applying for Medicaid or renewing their coverage present original documents to prove their citizenship and identity has contributed to significant enrollment declines in states. These adverse effects have persisted even when states have employed strategies aimed at minimizing the loss of coverage, such as

conducting data matches with Vital Records agencies to obtain birth records. While many states find such systems helpful, others note that database constraints and technological challenges limit the effectiveness of the strategy.

- **Seven states reduced or eliminated premiums for children’s health coverage, but another seven either imposed new premiums or increased the amount of existing premiums.** Numerous studies find that premiums for low-income individuals can depress enrollment in health coverage programs.

Changes in Health Coverage Programs for Pregnant Women and Parents

- **One-quarter of the states (13 states, including DC) enacted modest coverage expansions for pregnant women and parents.** No state retracted income eligibility for these adults. Nine states increased eligibility for pregnant women, either by expanding income eligibility or by adopting the option to cover unborn children in SCHIP. Six states took steps to expand health coverage for parents.
- **Income eligibility for parents still lags behind eligibility for children.** The stark disparity between the availability of coverage for parents and children persists, although the situation improved slightly in 2007.
- **Efforts to simplify enrollment and renewal procedures for parents edged forward, but it remains harder for an eligible parent than for an eligible child to obtain and keep coverage.** A substantial body of research demonstrates that efforts to cover low-income parents in programs like Medicaid and SCHIP increases the enrollment of eligible children. In addition, when their parents are insured, children gain better access to health care and improve their use of preventive health services. Efforts to expand parent coverage will help advance enrollment of children as well, while limits on parent coverage could pose a barrier to enrollment of more children.

Several elements are critical if states are to realize the advances achieved in 2007. SCHIP reauthorization that provides support from the federal government to undergird states’ efforts to furnish health coverage for children is essential to continued progress in reducing the number of uninsured children. The concern that federal action will curtail longstanding federal financial support for children’s health coverage and states’ flexibility to design and operate their programs has created considerable tension at the state level. In addition, emerging state budget deficits and potential pressure to cut state spending is placing the hard-won progress on children’s health coverage at further risk. These conditions present new hurdles for states and will make it even more challenging to identify steps to maintain and promote coverage, especially if the economy and state revenue situation worsens.

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