FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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# Coverage of Low-Income Children: Key Issues to Consider in Health Reform

## SUMMARY

A key element of health reform will be meeting the needs of low-income children. Overall, a major goal of proposals is to expand coverage by building on Medicaid, providing subsidies to low- and moderate-income individuals to buy coverage through new health insurance exchanges, and requiring individuals to obtain coverage. Current proposals also could significantly change coverage for some children already eligible for Medicaid and CHIP. Following are key issues to consider about low-income children's coverage under reform:

**Increased coverage of low-income children and parents will help improve access to care.** It is estimated that 5 million currently uninsured children are already eligible for Medicaid or CHIP. Current reform proposals are expected to increase enrollment of these children as well as to increase coverage for many low-income parents. Research suggests that this increase in family coverage will improve children's access to care, quality of care, and health outcomes.

**Simple eligibility standards and enrollment and renewal processes can facilitate participation in coverage.** A number of states have achieved significant success in enrolling eligible children in Medicaid and CHIP by implementing outreach activities and simplifying eligibility standards and enrollment procedures. Under reform, combining Medicaid and CHIP outreach and enrollment efforts with simple eligibility standards for low-income families and coordinated enrollment processes across coverage options would be important for facilitating participation in coverage and assuring that children are enrolled in the correct program and do not experience coverage gaps due to income changes.

**Low-income families have limited ability to pay premiums.** Research demonstrates that even relatively modest premiums can serve as an enrollment barrier for low-income individuals. As such, Medicaid and CHIP sharply limit premiums for low-income children today with most states charging less than permitted amounts. To afford exchange coverage, many low-income families would likely need subsidies to offset all or a substantial portion of premium costs.

**Adequate benefits and affordable cost-sharing help assure children's access to care and families' financial security.** Medicaid and CHIP provide comprehensive coverage with limited cost-sharing that is designed to meet the health needs and limited budgets of low-income families. In particular, Medicaid provides an EPSDT benefit that covers the full range of children's developmental and acute and long-term service needs. Current reform plans could move some children from CHIP to Medicaid, which would broaden their benefits. However, reform could also shift some low-income children from CHIP to exchange plans. Assuring that low-income children maintain a broad child-focused benefit package with affordable cost sharing would be key for preventing access barriers and protecting families from financial burdens.

**The provider network available to low-income children has important implications for their access to and quality of care.** Under reform, it will be important to consider not only how to assure adequate provider participation across programs and plans but also how any changes in coverage for low-income children might affect their existing relationships with providers.

Reform offers great potential to improve health care for low-income children by building on the successes of Medicaid and CHIP and increasing coverage for both children and parents. But, it will be equally important to assure that the coverage low-income children receive under reform meets their health needs and offers meaningful financial protections for families. Further, adequately planning and funding for the transition to reform will be key for preventing disruptions in children's care or coverage as reform is implemented.

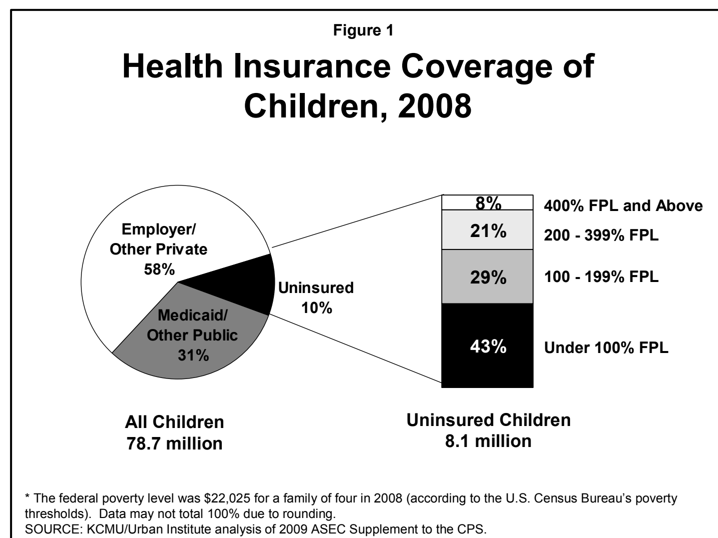
## INTRODUCTION

One primary goal of health reform is to meet the health needs of low-income children (with family income below 200% of the federal poverty level or $36,620 for a family of three in 2009). Children have broad and unique health care needs that are fundamental to their healthy development and growth. Health care for low-income children is particularly important as these children have increased health needs relative to those at higher incomes. The type of coverage low-income children receive under reform, as well as the coverage of their parents, would have important implications for their ability to access needed care and their families' financial security. Further, adequately planning and funding the transition to reform would be important for preventing disruptions in children's coverage or care as reform is implemented. This brief reviews key issues to consider regarding coverage for low-income children under reform.

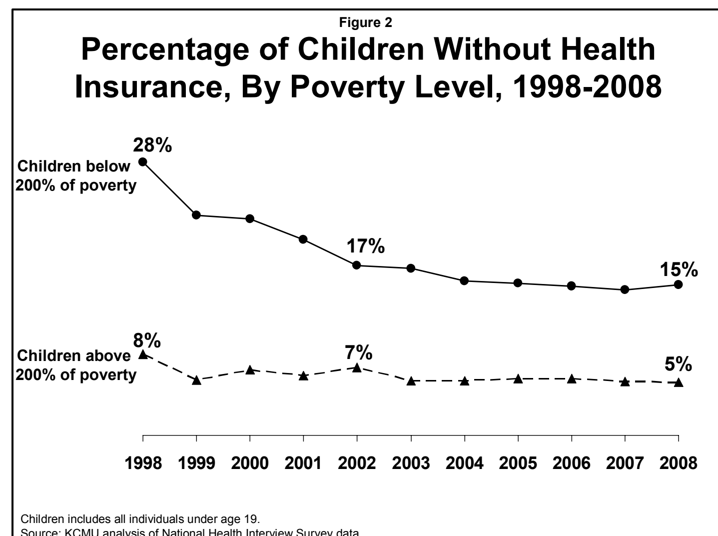
## BACKGROUND

### *Medicaid and CHIP Coverage for Low-Income Families*

Medicaid and the Children's Health Insurance Program (CHIP) are the primary sources of coverage for low-income children today, covering nearly one in three (30%) of all children and over half (56%) of low-income children (Figure 1).[1] As of FY2008, Medicaid covered nearly 30 million poor and near-poor children at some point during the year and there were an additional 7.4 million CHIP enrollees.[2] Over time, Medicaid and CHIP have made significant progress in reducing the uninsured rate for low-income children (Figure 2). However, some 8.1 million children still remain uninsured.[3]




While Medicaid and CHIP provide a strong base of coverage for low-income children, coverage for parents and other adults lags significantly behind. As of 2009, 47 states cover children in families with incomes at 200% of poverty or higher, with 24 states covering children in families with income at 250% of poverty or higher.[4] In contrast, 34 states limit parent eligibility to less than 100% of poverty and, under current law, states do not have authority to cover adults without dependent children through Medicaid regardless of their income level.[5]



Coverage of parents has important implications for children's coverage and care. Covering parents through Medicaid and CHIP leads to increased enrollment and retention of children in Medicaid and CHIP and lower uninsured rates for children.[6] Further, children of insured parents are more likely to see a provider and receive well-child care than children whose parents lack coverage.[7] Moreover, parent coverage affects the overall financial security of families, as one family member's medical bills can impact the economic stability of the entire family.[8]

***Key Differences Between Medicaid and CHIP***

Medicaid is the nation's major health coverage program for low-income children. CHIP was created in 1997 as a complement to Medicaid to provide coverage to low-income uninsured children above Medicaid eligibility limits. States have used CHIP to even out eligibility for low-income children based on age and to expand coverage to children in moderate-income families. States choose whether to implement CHIP through an expansion in their Medicaid program, by creating a separate CHIP program, or through a combination of both approaches.

Like Medicaid, the federal government matches state spending for CHIP, but at an enhanced rate compared to Medicaid. (On average, the federal government's share of Medicaid spending is 57% and it is 70% under CHIP.) The financing provided to states through Medicaid is open-ended, supporting an entitlement to both states and beneficiaries. In contrast, federal CHIP funds are capped nationwide and each state receives a capped allotment, which has contributed to some states experiencing funding shortfalls. Also, unlike Medicaid, there is no individual entitlement under CHIP and the program is contingent upon Congressional authorization and funding. CHIP was recently reauthorized through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which added $33 billion in federal funds. However, this reauthorization and funding will expire in 2013.

Beyond these differences in structure and financing, there are also differences in benefits and cost sharing for children under Medicaid and CHIP. Medicaid provides a comprehensive child-specific benefit package through the program's Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit that guarantees regular screenings and treatment for any identified health conditions. Further, Medicaid largely prohibits premiums and cost sharing for low-income children. Under CHIP, states have flexibility to cover a more limited set of benefits than Medicaid, although the benefits are still broad and designed specifically to meet children's needs. States also have more flexibility to charge premiums and cost sharing, but the total of these costs combined cannot exceed 5% of family income.

**CURRENT REFORM PROPOSALS**

A key goal of current health reform proposals is to increase coverage through a combination of an expansion in Medicaid, subsidies to low- and moderate-income individuals to purchase coverage through new health insurance exchanges, and a new requirement for individuals to obtain coverage. The proposed Medicaid expansion in the House Leadership bill (H.R. 3962 passed on November 7, 2009) would extend eligibility to all individuals with incomes at or below 150% of poverty and the Senate Leadership bill (H.R.3590) would expand eligibility to 133% of poverty, significantly expanding eligibility for low-income adults. States also would be required to maintain existing eligibility levels above the new minimum (although in the Senate bill this requirement only extends through 2019). Both bills would continue to bar most legal immigrants from enrolling in Medicaid during their first five years in the U.S., although states would continue to have the option provided under CHIPRA to eliminate this bar for children and pregnant women.

Beyond expanding Medicaid, current proposals also could significantly change coverage for some children already eligible for Medicaid and CHIP (Table 1). Both the House and Senate Leadership bills would maintain Medicaid coverage for children (until 2019 under the Senate bill). The Senate Leadership bill also would maintain CHIP through 2019; however, the bill does not provide reauthorization or funding for CHIP beyond its expiration in 2013. In contrast, under the House Leadership bill, CHIP would expire at the end of 2013. Children in separate CHIP programs with incomes below 150% of poverty would transition to Medicaid, while those with incomes above 150% of poverty would move to the new health insurance exchanges.

**Table 1:**
**Medicaid and CHIP for Children Under Reform Proposals as of November 20, 2009**

| | House Leadership | Senate Finance |
|---|---|---|
| **Medicaid** | ***Maintains Medicaid coverage for children***<br>States must maintain existing Medicaid eligibility for children above the new minimum of 150% FPL. This requirement applies to children in Medicaid expansion CHIP (M-CHIP) programs.<br>Maintains current benefit and cost-sharing rules. | ***Maintains Medicaid coverage for children***<br>States must maintain existing Medicaid eligibility for children above the new minimum of 133% FPL until 2019.<br>Maintains current benefit and cost-sharing rules until 2019. |
| **CHIP** | ***CHIP expires December 31, 2013***<br>Children in Medicaid expansion CHIP (M-CHIP) programs maintain Medicaid, financed at the enhanced CHIP matching rate.<br>Children in separate CHIP programs:<br>• 100%-150% FPL transition to Medicaid.<br>• >150% FPL transition to the Exchange.<br>Cost-sharing and benefits in Exchange based on minimums determined for Exchange plans.<br>Secretary of HHS must report to Congress by December 2011 on how to ensure Exchange coverage is comparable to CHIP and that the transition does not interrupt coverage or a written plan of treatment. | ***Maintains CHIP until 2019***<br>Anticipates a renewal and continued funding of CHIP prior to its expiration in 2013.<br>Maintains current benefit and cost-sharing rules until 2019.<br>CHIP-eligible children who cannot enroll due to federal allotment caps would be eligible for tax credits in the Exchange. |

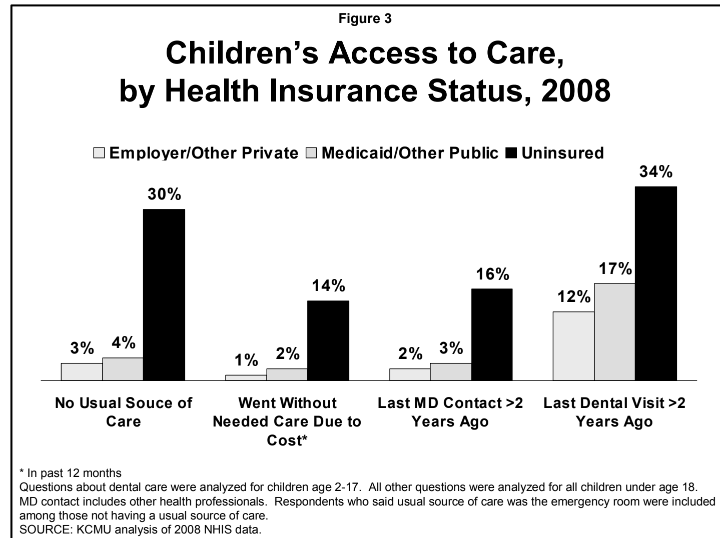
For more details, see “Medicaid and Children’s Health Insurance Program Provisions in Health Reform Bills: Affordable Health Care for America Act and the Patient Protection and Affordable Care Act,” at http://www.kff.org.

## ISSUES TO CONSIDER

As reform discussions continue, following are some key issues to consider regarding coverage for low-income children:

**Increased coverage of low-income children and parents will help to improve access to care.** Given that almost all states already cover children with family incomes at or above 200% of poverty through Medicaid and CHIP, the proposed Medicaid expansions in the proposals will not increase overall eligibility for children. However, it is expected that reform will encourage increased enrollment among the estimated 5 million currently uninsured children who are already eligible for Medicaid or CHIP.[9] To fully realize the potential of this opportunity to increase children’s coverage, it will be important for state programs to be prepared for increases in enrollment and for there to be no enrollment caps or waiting lists in place.

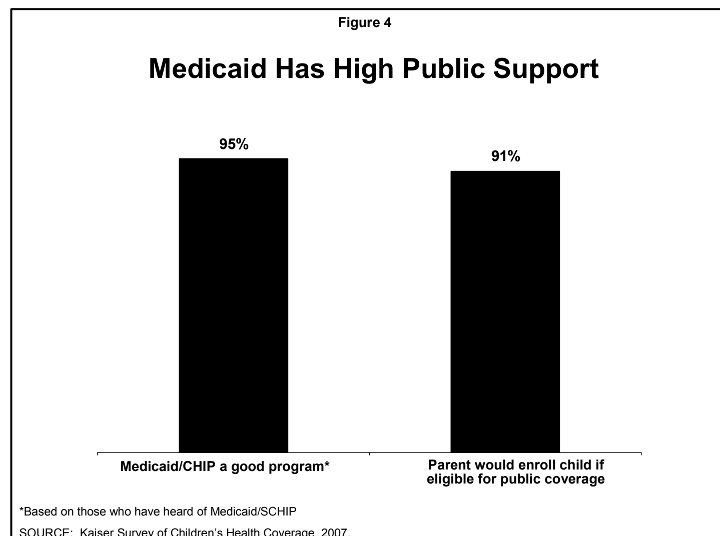
Research demonstrates that increased Medicaid and CHIP coverage for children will lead to significant improvements in their access to care, quality of care, and health outcomes. Children covered by Medicaid and CHIP are less likely to lack a usual source of care, have unmet health needs, and go without doctor and dental visits compared to uninsured children (Figure 3).[10] Further, across these measures, Medicaid and private coverage are roughly equivalent. Enrollment in Medicaid and CHIP also is associated with improvements in quality of care for previously uninsured children, such as reduced emergency room visits and hospitalizations for children with asthma, and improvements in physical and social health outcomes, including school attendance.[11]




Moreover, while the Medicaid expansion will not increase overall eligibility for children, it will significantly increase eligibility for low-income adults, likely leading to increased coverage for many low-income parents. As noted, research suggests that these increases in parent coverage will have positive spillover effects on children's coverage and care and the financial stability of families.

**Simple eligibility standards and enrollment and renewal processes can facilitate participation in coverage and stable coverage over time.** Survey data indicate that low-income families with an uninsured child view Medicaid and CHIP favorably and most would enroll their child if eligible (Figure 4). However, gaps in awareness and understanding of the programs and burdensome enrollment procedures can serve as obstacles to enrollment.

A number of states have achieved significant progress forward in enrolling eligible children by developing effective outreach strategies and simplifying eligibility standards and enrollment procedures.[12] For example, states like Illinois, Massachusetts, and Wisconsin have implemented broad eligibility expansions for children under a single program name, eliminating the administrative complexities and confusion for families that can stem from having multiple programs that serve low-income children. Further, these broad expansions enable states to present families with simple eligibility rules and outreach messages. For instance, since creating its All Kids program, Illinois has used the simple message that affordable coverage is available to all uninsured children in the state.



In addition, over the years, a number of states have adopted enrollment simplifications such as 12-month continuous eligibility, presumptive eligibility, and elimination of asset tests and/or in-person interviews, which have proven highly successful for helping to enroll eligible uninsured children.[13] Moreover, simplified renewal procedures have helped children maintain coverage and prevented churning (the disenrollment and re-enrollment of a child during a short period of time).[14]

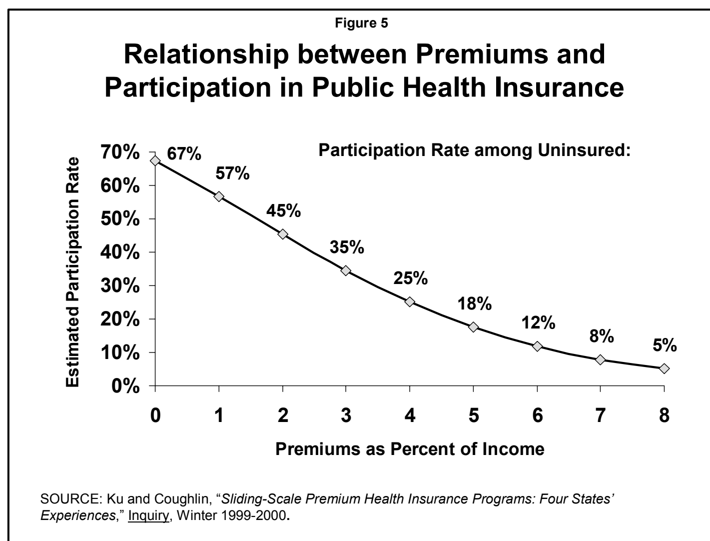
Recognizing the importance of outreach and simplified enrollment and renewal procedures, CHIPRA included provisions to encourage states to implement outreach activities and simplify their Medicaid and CHIP enrollment and renewal procedures. Specifically, CHIPRA provided $100 million in outreach grant funding and the opportunity for states to obtain bonus payments if they meet specified enrollment targets and implement five out of eight simplification efforts (including 12-month continuous eligibility, elimination of the asset test, elimination of the in-person interview, use of a joint application for Medicaid and CHIP, streamlined renewal, presumptive eligibility, Express Lane eligibility, and premium assistance subsidies).

In designing reform, it will not only be important to build upon the outreach and enrollment efforts advanced by CHIPRA but also to consider how to make eligibility standards as simple as possible for low-income families and to coordinate the enrollment process for Medicaid, CHIP, and new exchange plans so it is seamless to low-income children and their families. Aligning the rules, verification systems, and application processes across the different coverage options will help assure that children are enrolled in the correct program and do not experience coverage gaps as income changes. Further, integrating and coordinating enrollment systems can reduce administrative burdens and make it easier for families to navigate coverage options, especially in cases in which different family members qualify for different programs.

**Low-income families have very limited room in their family budgets to pay premiums.** Even relatively modest premiums can serve as an enrollment barrier to public coverage for low-income individuals (Figure 5). To prevent cost from serving as a coverage barrier, Medicaid and CHIP sharply limit premiums for low-income children. States cannot charge very low-income children any premiums; children at somewhat higher incomes may face modest premiums and cost-sharing, but total premium and cost-sharing costs combined cannot exceed 5% of family income.

Figure 5

Relationship between Premiums and Participation in Public Health Insurance




SOURCE: Ku and Coughlin, "*Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*," Inquiry, Winter 1999-2000.

Today, most states charge less than the amounts permitted under Medicaid and CHIP. For example, the median premium payment for two children in a family of three earning 200% of poverty ($36,620 per year in 2009) is $480 per year ($40 per month), which represents about 1% of family income.[15] Keeping premiums affordable for low-income children will be important under reform. However, analysis suggests that, under current proposals, low-income children would face substantially higher premiums than they pay for Medicaid or CHIP if they were to receive coverage through the exchange.[16] Some of this increase reflects the payment for family rather than child-only coverage. Regardless, if premiums are a financial burden for families,

cost may remain a barrier to coverage. To assure that exchange coverage is affordable for families with low-income children, many would need subsidies to offset all or a substantial portion of costs. Further, to assure affordability over time, subsidies would need to increase to keep pace with rises in premiums.

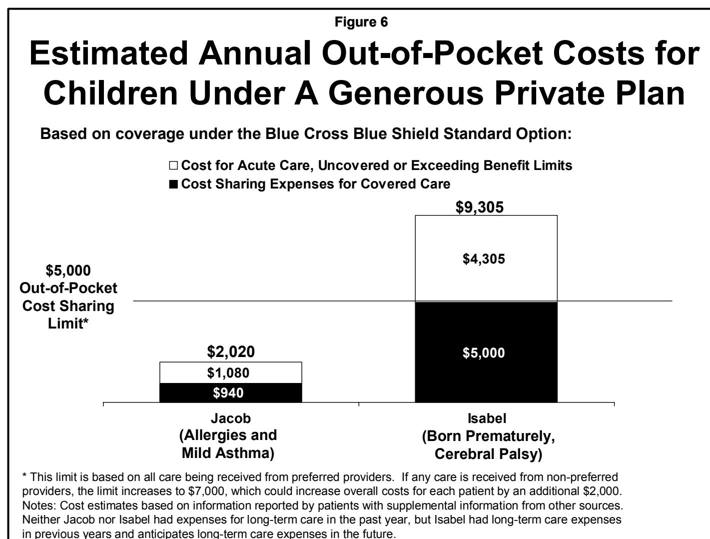
**Adequate benefits and affordable cost-sharing help assure children's access to care and families' financial security.** Children, particularly low-income children, have broad health needs. For example, they need ongoing preventive care, including vision, hearing, and dental care, to assure their healthy development and the early identification of any problems. In addition, one in seven children has special health needs that may require more intensive use of acute care services as well as specialized services such as physical, occupational, and speech therapy or durable medical equipment.[17] Moreover, for low-income children, benefits that help families overcome access barriers, such as transportation and interpretation services and case management, are often very important. Low-income families also need services to be affordable, as they have very limited ability to pay deductibles, copayments, and coinsurance.

Medicaid provides a comprehensive set of benefits with limited cost-sharing that is designed to meet the health needs and limited budgets of enrollees. For children, the program's Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit guarantees regular health screenings and treatment for any identified health conditions, including medical, developmental, mental, acute, and chronic conditions. Medicaid does not charge deductibles and limits copayments and coinsurance to modest amounts. While Medicaid provides broad benefits, there have been longstanding concerns about assuring adequate provider participation in the program so that enrollees are able to access the full range of covered services. Under CHIP, states can offer more limited benefits than Medicaid, but CHIP benefits are still designed for children and cost-sharing amounts are limited.

In general, private plans offer more limited benefits and charge higher cost-sharing than Medicaid and CHIP. Reflecting this difference, analysis indicates that low-income children currently covered by Medicaid or CHIP would face higher out-of-pocket costs if they received private coverage.[18] Further, out-of-pocket costs among privately insured individuals are often particularly burdensome for those with the most significant health needs, and families with ongoing or multiple health needs can experience large cumulative costs that may lead to significant medical debts.[19]

The scope of coverage that low-income children would receive under reform would have significant impacts on their access to care and their families' financial security. Under current proposals, some children could transition from separate CHIP programs to Medicaid, which would broaden their benefits and provide them EPSDT protections. However, some low-income children currently covered by CHIP could also shift to coverage through new exchange plans. If low-income children are covered through the exchange and have more limited benefits with higher cost-sharing requirements, they may be at increased risk for access problems and financial burdens.

A key determinant of the scope of coverage low-income children would receive under exchange plans would be the minimum requirements applied to the plans. If the requirements are based on a generous private plan offered today, children could still face significant coverage gaps and costs, particularly children with special needs (Figure 6).[20] Their coverage could be strengthened by establishing comprehensive minimum standards for children under exchange plans (that mirror Medicaid or CHIP) or by providing wraparound coverage for Medicaid or CHIP benefits not covered by an exchange plan and cost-sharing in excess of Medicaid or CHIP limits.




**Providing benefit and cost-sharing protections as "wraparound coverage" can be challenging for states and families.** Providing wraparound coverage for Medicaid or CHIP benefits not covered by a plan and cost-sharing in excess of Medicaid or CHIP limits is one approach that can be used to provide coverage protections for low-income individuals. In the past, some states have provided wraparound coverage for individuals enrolled in premium assistance programs. In the context of reform, wraparound coverage has been discussed as a potential method for protecting coverage for low-income children receiving coverage through exchange plans.

However, state experience suggests that providing wraparound coverage can be challenging and complex and that it can add significant administrative burdens.[21] Further, this approach may impede efforts to promote coordinated and efficient care, as it can be difficult to coordinate care, implement quality initiatives, and control costs when individuals receive coverage through more than one source. If wraparound coverage is not easily accessible and effective, low-income children and their families could experience access problems and financial burdens.

In order for wraparound coverage to provide effective protections, individuals must be fully informed about their rights to wraparound services, the services must be accessible and easy to use, and a system must be in place to track individuals' and families' out-of-pocket costs. Additionally, the state must have payment systems and infrastructure in place to pay for services, and providers need to be informed about individuals' right to wraparound coverage and how they can get reimbursed for services or cost-sharing charges not covered by an individual's primary plan. One approach that has been considered to deal with these challenges is for states to pay an add-on premium to plans to provide the additional services and costs covered through the wrap. This approach would prevent families from having to navigate two separate delivery structures for their coverage.

**The provider network available to low-income children has important implications for their access to and quality of care.** Today, many low-income children in Medicaid and CHIP receive their care through private managed care organizations that have contracts with the state to provide comprehensive services and a provider network.[22] Over time, some managed care organizations and other networks have developed that are geared specifically to meet the needs

of low-income populations. These plans often include safety-net providers that are trusted and known by the community. Further, some states have used Medicaid and CHIP managed care programs as a way to improve the quality of care for enrollees, for example, by establishing a medical home model of care to coordinate and manage care, particularly for individuals with substantial health needs.[23] At the same time, assuring adequate provider participation has remained a longstanding challenge in Medicaid.[24] This challenge is due, in part, to the program's relatively low provider payment rates, but it also reflects physician perceptions about the program as well as growing national physician shortages.[25] In response to these issues, the Medicaid and CHIP Payment and Access Commission (MACPAC) was recently created under CHIPRA to regularly review and assess Medicaid and CHIP payment policies and advise the Congress on a wide range of related issues.

One important dimension to consider under reform is the network of providers that will be available to low-income children. Actions that would increase Medicaid provider payment rates, such as the proposal in the House bill to increase payments to primary care providers, and to restructure payment systems have the potential to encourage increased provider participation in the program. However, broader efforts to address the growing national shortage of physicians, particularly primary care doctors, dentists, and some specialists, would also be vital. Additionally, if any children would be transitioned from Medicaid or CHIP to exchange coverage under reform, it would be important to consider how their provider networks and relationships might be impacted. While a private plan offered through the exchange might have a more expansive network of participating providers, the providers might lack expertise in caring for low-income individuals and the network may exclude key safety-net providers that already have established relationships with low-income patients.

**Conclusion**

Health reform offers great potential to increase coverage as well as to improve quality of care and reduce health care costs. Meeting the health needs of children, particularly low-income children who often have increased health needs, will be fundamental component of reform. Medicaid and CHIP are proven programs that have successfully covered millions of low-income children with diverse health needs. As reform efforts continue, it will be important to consider how to build upon the accomplishments of Medicaid and CHIP, develop effective relationships and transitions between public and private coverage, and assure that low-income children receive coverage that meets the full range of their health needs and offers meaningful financial protections for their families. Further, adequately planning and funding for the transition to reform will be key to preventing any disruptions in children's coverage or care as reform is implemented.

This brief was prepared by Samantha Artiga and Robin Rudowitz of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

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