



State Perspectives on Children's Coverage in the Changing Health Policy Landscape

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As federal policymakers consider significant changes to health coverage, the future of federal funding for the Children's Health Insurance Program (CHIP) beyond September 2017 remains uncertain leaving children's coverage issues in the balance. To examine ways to ensure children's health coverage needs continue to be met in the changing health policy environment, the National Academy for State Health Policy (NASHP) convened a group of CHIP and Medicaid officials in February 2017 to discuss key issues. Based on the group's discussions and

additional state input, NASHP has developed the following principles, which outline considerations about children's coverage that policymakers should take into account as broader health policy decisions are deliberated at the federal level.

Jointly covering nearly four in 10 children nationwide,¹ Medicaid and CHIP serve as essential sources of affordable and comprehensive coverage for low- and moderate-income children. In FY2015, together Medicaid and CHIP covered 45.2 million low-income children (Medicaid covered 36.8 million; CHIP covered 8.4 million).²

The Affordable Care Act (ACA) established a Medicaid eligibility floor of 138 percent of the federal poverty level (FPL) for children. CHIP covers children in families with incomes that exceed Medicaid eligibility levels but generally do not have access to or cannot afford employer-sponsored health coverage. The vast majority of children enrolled in CHIP—89 percent—are in families with incomes at or below 200 percent FPL³ (\$48,600 for a family of four in 2016). In total, 49 states provide coverage through Medicaid and CHIP to children in families with incomes up to at least 200 percent FPL,⁴ and the programs together provide coverage to two-thirds of children in families with income below 200 percent FPL.⁵ Also, 44 percent of children with special health care needs receive coverage through Medicaid, CHIP, and other public health insurance programs.⁶ Therefore overall both Medicaid and CHIP overwhelmingly serve low to modest income families and work together to serve the health needs of children, including those with special health care needs.

Both Medicaid and CHIP provide coverage to pregnant women. In Medicaid, pregnancy-related coverage is required up to 133 percent FPL, and some states have opted to provide coverage up to or above 185 percent FPL. States can also cover pregnant women through CHIP coverage or can take up the program's unborn child coverage option.⁷

Any major changes to these programs and/or a repeal of the ACA will significantly impact children's health coverage because of the essential role of Medicaid and CHIP in providing coverage. The [American Health Care Act](#) (AHCA)⁸ recently proposed in Congress includes a number of provisions that would directly affect children's coverage. Also, as the current appropriation of federal funding for CHIP expires in September 2017, it is currently unknown whether funding will be extended for the program. Further, the AHCA along with the Manager's Amendment to the bill proposes changing Medicaid's financing structure to a per capita cap or a block grant model that limits federal funds, which could necessitate states placing restrictions within their programs. Medicaid policy changes in particular could have significant consequences for children, as the program provides coverage to a substantial number of those who are in families with the lowest incomes.⁹ Medicaid also serves as the only source of coverage for 36 percent of children with special health care needs.¹⁰ Federal policymakers should take into account the implications such policy changes will have on children's coverage. Also, while this brief will focus on children's coverage, it is important to note that changes to Medicaid and/or CHIP would also affect pregnant women covered by these programs.

Principles for Keeping Children's Coverage Strong

Maintain Gains in Children's Coverage

There has been significant progress made in enrolling eligible children in Medicaid and CHIP, and together both programs have provided a stable source of coverage for children in low- and moderate-income families for many years. During the discussion at NASHP's February 2017 meeting, state officials emphasized that children's coverage rates should be maintained during any potential transitions in health insurance programs and markets. Children's coverage has reached a historic high, with 95.2 percent of children having health insurance coverage in 2015. This translates to a decline in the number of uninsured children by nearly one-third from 2013 (5.2 million) to 2015 (3.5 million). While employer-sponsored insurance (ESI) covers the largest share of children, Medicaid and CHIP are the main sources of coverage for low-income children (those with family income below 200 percent FPL) and together these programs are viewed as being essential in reducing uninsurance among children. Overall children's coverage from Medicaid and CHIP increased from 34.2 percent in 2013 to 35.7 percent in 2015.¹¹

One likely reason for the robust participation in Medicaid and CHIP are the cost sharing protections that keep the coverage affordable for families. In Medicaid, most children are exempt from most types of cost sharing. In CHIP, premiums and cost sharing are permitted, as long as total contributions for CHIP coverage are no more than five percent of a family's income. State officials indicated that affordability and coverage rates are inextricably linked, because of the low-income levels of the families served in Medicaid and CHIP.

Medicaid and CHIP coverage for children has been correlated with improved access to care as well as positive health outcomes, school performance and educational attainment, as well as economic success in future years.¹² Placing children's coverage through Medicaid and CHIP at risk could create negative consequences on care access, issues for individual youth as they transition to adulthood, as well as larger societal implications.

Possible Effects of ACA Repeal or Medicaid Financing Changes on Children's Coverage

If a repeal of the ACA results in exchange coverage not being affordable for families because of reduced subsidies, the number of uninsured children could increase significantly, and this number could be even greater if CHIP funding is also not extended. Ultimately, the scope of potential losses in children's coverage will be contingent on the specific aspects of the final ACA replacement bill(s),¹³ including whether coverage options would be affordable for low- and moderate-income families, as well as any other regulatory changes that may be implemented.¹⁴

Another factor for policymakers to consider is the ACA's maintenance of effort (MOE) provision that requires states to maintain Medicaid and CHIP eligibility levels and standards for children that were in place in 2010 through FY2019. The AHCA does not address MOE, but the [previous ACA repeal bill](#), passed by Congress in 2016 but vetoed by former President Obama, eliminated the MOE provision and future legislation may do so as well. Without the MOE, some states are likely to lower eligibility levels, which could result in more uninsured children. During the discussion with state officials, their predictions on how states might respond to an early elimination of the MOE varied. All indicated concern that it could result in coverage reductions for children, and that much would depend on other policy changes, such as what might happen with exchange coverage. However, if the MOE remains in place through FY2019, and federal CHIP funding is not extended and/or federal Medicaid funding is capped as proposed in AHCA, states will face even greater fiscal challenges. Ultimately, stable funding and the MOE have helped to support gains in children's coverage.

Changes to the health insurance exchanges or to the ACA tax credit allocations could affect children's coverage as well. If federal CHIP funding is allowed to expire in September 2017, the Medicaid and CHIP Payment and Access Commission (MACPAC) has estimated that approximately 3.7 million children would lose coverage. Of these children, 1.4 million would enroll in subsidized exchange coverage, 1.2 million would enroll in ESI, and 1.1 million would become uninsured.¹⁵ The 1.1 million children predicted to lose coverage and remain uninsured would be eligible for other sources of coverage, but their families would likely not be able to afford it.¹⁶ However, if the ACA is repealed and subsidized marketplace coverage is no longer affordable for low- and moderate-income families, there may not be adequate coverage options for children transitioning from CHIP and the number of uninsured children could be even greater.

Another factor that could affect children's coverage across both Medicaid and CHIP is that similar to the previous ACA repeal bill, the AHCA reverts mandatory minimum Medicaid eligibility levels for children ages 6-18 from 138 percent FPL to 100 percent FPL, which is the lower level that existed prior to the ACA. While it is unclear whether states would be required to shift children now covered by Medicaid back to CHIP or if it would be a state option, this provision could result in care disruptions and loss of coverage for children as they move between programs. This change could also mean that states would need to implement eligibility system changes as well, which would require significant time and resources.

One of the overall policy goals of the current administration and Congress is to reduce federal funding in Medicaid by implementing changes to the program's financing structure. As an example, the AHCA as introduced in the House along with the proposed Manager's Amendment changes the current structure of Medicaid financing and allows states to choose between a per capita cap or a block grant approach.

Under these models, there are pre-set limits on federal funding, and this could result in cost shifting to states if federal funds are not adequate. An additional potential fiscal challenge for states is that recently released estimates about the AHCA from the Congressional Budget Office¹⁷ indicate that federal Medicaid spending would be reduced by \$880 billion from 2017-2026. States facing budgetary challenges may opt to lower Medicaid program spending by limiting enrollment, cutting benefits, shifting costs to enrollees, or reducing provider payment rates, all of which could affect care access. These types of changes have the potential to affect children covered by both Medicaid and CHIP.

Maintain Pediatric-Centered, Comprehensive Benefits

Both Medicaid and CHIP are specifically designed to provide children with age-appropriate, child-centered, and comprehensive benefits. Also, while the primary sources of children's coverage (CHIP, Medicaid, exchange plans, and ESI) provide coverage for most major medical services, other benefits such as dental care, audiology, and certain services for children with special health care needs are more frequently covered by CHIP than exchange or ESI plans.¹⁸ Additionally, Medicaid must provide the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit for children under age 21, which requires coverage of preventive care and any medically necessary services, regardless of whether the service is available as a covered benefit under a state's Medicaid plan.¹⁹ The EPSDT benefit provides enrollees with a broad benefit package, which ensures that children with special health care needs receive appropriate services that might otherwise be cost-prohibitive in the private insurance market.²⁰

According to state officials at the meeting, there are certain types of benefits that are particularly important for children. These include behavioral health services, dental coverage, as well as therapy services such as physical, occupational, and speech therapies for children with special health care needs. State leaders also emphasized that providing children with timely, age-appropriate care is critical for meeting their unique developmental needs at each stage of growth. If children's care needs are not adequately met, children may end up requiring more extensive and costly care later. Further, not addressing children's medical and behavioral health needs at the appropriate time could have longer-term effects well beyond the health care system, affecting schools, child welfare or juvenile justice systems, and other sectors.

Possible Effects of ACA Repeal or Medicaid Financing Changes on Children's Health Benefits

If a repeal of the ACA results in children covered by Medicaid or CHIP needing to move to private market coverage because of eligibility level changes, children would likely receive less comprehensive benefit packages, especially because of the loss of the EPSDT benefit. Also, if the ACA's essential health benefits are eliminated or modified through regulatory changes, because they include pediatric services and other services for children with special health care needs, there could be significant implications for children currently covered by Medicaid or CHIP who may need to transition to private sources of coverage. While the AHCA as introduced keeps the ACA's prohibitions on lifetime and annual dollar limits on benefits and coverage of pre-existing conditions if individuals maintain continuous coverage, children covered in the private market may still face increased costs for coverage.

Under a per capita cap Medicaid financing model, as noted earlier, states would likely need to either increase state spending, or implement changes to the scope of Medicaid coverage, which could include reductions in benefit comprehensiveness. It is unclear how the benefit package currently available to children in Medicaid, including EPSDT, might be affected by financing changes to the program; but some analyses of the Manager's Amendment to the AHCA which allows states to implement block grants indicate that the EPSDT benefit is at risk under this option.²¹ Even if EPSDT remained unchanged

in Medicaid, during the discussion state officials noted that attempting to budget and plan for the associated costs of providing this benefit within a capped financing model would be very challenging. Also, although the AHCA's per capita cap spending targets are adjusted by the consumer price index²², a capped Medicaid financing model may not be sufficient to address cost increases in certain benefits that could have drastic price fluctuations, such as prescription drugs or medical devices, and the same issue could occur under a block grant model. As a result states would either need to reduce the availability of these types of benefits, pass on the increased costs to consumers, or incur these additional expenses directly in state budgets.

Maintain a Stable Care Delivery System and Health-Related Supports for Children

In addition to the importance of ensuring adequate coverage and benefits for children in Medicaid and CHIP, the state officials at the meeting highlighted that care delivery systems and other health-related supports for children should be taken into account as health insurance market changes are considered. For example, some states use Medicaid or CHIP funding to coordinate care for children with chronic medical or behavioral health needs through health home initiatives. These types of programs offer an integrated care delivery system for physical and behavioral health services and also often connect children with additional social support services. Also, Medicaid can cover school-based health services for children and Medicaid's EPSDT benefit allows for targeted case management services to coordinate medical, educational or social services. In addition, CHIP funding can support school-based services and is also used by states to provide support for some sister agency programs including Title V programs. Some states also use CHIP funding for [Health Services Initiatives](#) for preventive and intervention services, which can include support for poison control centers as well as more direct services such as lead screening, services for teen parents, or services for homeless youth. Medicaid and CHIP programs also enhance care delivery and improve care access through the use of telehealth services. Overall, they noted that it is important for federal policymakers to consider that changes to Medicaid and/or CHIP will not just affect the direct medical and behavioral health services provided through these programs, but would also have a "ripple" effect on the wider array of support services for low- and moderate-income families that Medicaid and CHIP are linked to and/or help finance.

Possible Effects of ACA Repeal or Medicaid Financing Changes on Care Delivery Systems and Health-Related Supports for Children

Children with chronic physical health and/or behavioral health needs benefit from Medicaid coverage that provides long-term care services and other care coordination supports.²³ CHIP often provides this coverage as well²⁴, and consequently children who need access to these critical services could be affected by any changes to these programs. It is unclear how care coordination initiatives in Medicaid and CHIP could be affected by a repeal of the ACA, such as whether these flexibilities would remain unchanged and/or if states would receive any enhanced funding for them or would instead need to take on additional costs. Clearly if federal CHIP funding is not extended then the unique care delivery models funded by the program would be affected and the Health Services Initiatives program would no longer exist. Also, if Medicaid is shifted from an entitlement program to a capped financing model, this would introduce the potential need for states to implement program limitations that could affect care access and service delivery.

Maintain States' Administrative Efficiencies in Program Design, Operation, and Implementation

States have made strides in achieving administrative efficiencies in operating Medicaid and CHIP for children. The best illustration of these efficiencies may be eligibility and enrollment simplification policies and practices that reduce unnecessary steps for families and eligibility workers. Examples of these optional policies include express lane eligibility, presumptive eligibility, and 12-month continuous eligibility, which have all helped states streamline enrollment and renewal processes. In addition, states invested significant resources to implement the ACA's new standards for eligibility determination and enrollment that were designed to increase efficiency. Also, since 2014, waiting periods for CHIP enrollment could be no longer than 90 days, and as a result many states even eliminated them, which further reduced administrative steps for state staff.

Within federal parameters, states have options for their CHIP program design and management. This has allowed states to structure their CHIP programs in different ways, with some designed as very distinct programs and others nearly identical to Medicaid. States can also design their CHIP programs to address state-specific needs such as regional differences in cost of living and political factors, which have guided state decisions in setting eligibility levels as well as in developing benefit packages, cost sharing mechanisms and provider networks. During the discussion state officials also commented that with CHIP being a smaller and more nimble program with fewer regulations, states have been able to be more innovative in program implementation.

Possible Effects of ACA Repeal or Medicaid Financing Changes on State Administrative Efficiencies in Children's Coverage

Making substantial changes to coverage programs, which could include allowing CHIP to end or changing how eligibility determinations are conducted in a repeal of ACA, would require additional state resources to make necessary modifications. Making such changes could involve considerable financial and staff investment from states as well as significant time to implement system changes. Repeal efforts could include changes to marketplace coverage and systems, which in turn would affect Medicaid and CHIP enrollment systems and processes.²⁵ While it is unclear what specific changes would be necessary, changes to either system have implications for both because they are intertwined. Also, whether federal health policy changes would allow for all of the existing enrollment simplifications to continue is currently unknown. Additionally, state officials at the meeting commented that if federal policymakers continue funding for CHIP but decide to reestablish longer waiting periods in the program it would be administratively burdensome to reinstate.

Proponents of changing Medicaid to a capped financing model frequently cite that states would gain greater flexibility in program administration. However, Medicaid currently provides states flexibility regarding many components of their programs and states can request waiver authority to pursue other options.²⁶ Also, although CHIP is funded through a block grant and not financed as an entitlement as Medicaid currently is, state officials noted unique factors about the program. They emphasized that the block grant model works well for CHIP because the population served is small in comparison to Medicaid and relatively healthy. While both programs serve children, Medicaid covers significantly more children, many of whom have special health care needs, in addition to covering other groups with complex health needs such as low-income seniors and disabled individuals. State officials worry that even if capped Medicaid financing offers greater state flexibility and regularly adjusts spending targets, it may not be responsive enough to economic downturns or public health outbreaks, which could then require additional state resources. Further, if reductions in Medicaid funding are coupled with the loss of federal CHIP funding, states would face greater overall financial pressures.²⁷

Conclusion

Medicaid and CHIP in tandem serve a critical role in providing health coverage for low- and moderate-income children, and federal policymakers should recognize that changes to either program directly affect the other. While states expressed interest in maintaining and even enhancing program flexibility in Medicaid and CHIP, officials stressed that these types of changes should not be implemented in a way that could put coverage gains or health service delivery for children at risk. Ultimately, state officials strongly recommended that federal policymakers should keep in mind how children's coverage through Medicaid and CHIP could be affected by broader health coverage and system changes and emphasized the importance of maintaining children's coverage gains, coverage affordability, pediatric-specific benefits, and high-quality care for children.

Endnotes

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