

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

With passage of the Affordable Care Act, the stakes for children's coverage perhaps have never been higher. Children and youth potentially have much to gain in coverage for themselves and especially for their parents. At the same time, they also have much to lose in shifting attention, and in gaps or unintended consequences of reforms focused primarily on adults. To examine the issues and options for keeping children's coverage strong in future, NASHP initiated discussions with both Medicaid expansion and separate CHIP program directors. This *State Health Policy Briefing* highlights themes from those discussions, focusing on four key considerations for children's coverage that NASHP and most CHIP directors believe policy-makers should take into account in making policy decisions that may affect children's coverage.

NATIONAL ACADEMY
for STATE HEALTH POLICY

Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

MAY 2012

Keeping Children's Coverage Strong in the Context of the Affordable Care Act: Perspectives from State Children's Health Insurance Leaders

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More than 9 out of 10 children in the United States are insured¹ — an accomplishment that owes much to the bipartisan creation and successful implementation of the state-federal Children's Health Insurance Program (CHIP). Beginning in 1997 and continuing through today, CHIP focused the nation's and the states' attention on providing good health insurance coverage for children. CHIP has provided coverage for millions of previously uninsured children and driven successes in increasing enrollment of lower income eligible children in its older and larger sister program, Medicaid. Due to efforts over the past 15 years or more, some states now are close to having nearly all their children covered by public or private health insurance. With the passage of the Affordable Care Act (ACA), the stakes for children's coverage have perhaps never been higher. Children and youth potentially have much to gain in coverage for themselves and especially for their parents. At the same time, they also have much to lose as attention shifts, and gaps or unintended consequences of reforms focused primarily on adults surface.

To examine the issues and options for keeping children's coverage strong in future, the National Academy for State Health Policy (NASHP) initiated discussions with both Medicaid expansion and separate CHIP program directors through a workgroup of 16 states, as well as at an annual convening in October 2011 attended by 35 state directors. Since shortly after enactment of CHIP, with the support of the David and Lucile Packard Foundation, NASHP has reported on and supported states' work in increasing health insurance coverage for children through CHIP, Medicaid, and public-private strategies.²

CHIP directors from states with varying CHIP program types, populations, geography, political leanings, and fiscal situations worked with NASHP from early 2011 to early 2012 to inform this brief. The workgroup's primary goal was to facilitate a process through which CHIP directors could share their perspectives and identify common and diverging points of view regarding key policy questions and options for meeting children's coverage needs in the context of ACA implementation and beyond. This brief reflects key perspectives of most CHIP directors, but does not reflect the views of any one or all states.

Both state and federal policymakers will continue making policy decisions about the ACA, as well as more broadly about health care priorities, budgets, and costs in 2012 and beyond. Many of these decisions will have major implications for children's coverage, and by extension, for children's health and well-being. The purpose of this brief is to highlight four key considerations for children's coverage that NASHP and most CHIP directors believe policymakers should take into account when making health policy decisions that may affect children's coverage. Recognizing that health care reform policies and systems are very much in process, NASHP and state officials intend to continue to contribute further information and analyses of issues and options to inform decision-making as it affects children's coverage.

1. The nation's focus on children's coverage during the past 15 years has yielded tremendous success that we do not want to put at risk.

CHIP was created in 1997 to provide quality health coverage for children in families that earned too much to qualify for Medicaid but did not have access to affordable private coverage. In many ways, it was a forerunner for and an incremental step toward the coverage provisions for uninsured adults in the ACA. CHIP gave states the option to expand their Medicaid programs, create new coverage programs within broad federal parameters, or combine both approaches.

Over the years, the CHIP program has succeeded in increasing children's health insurance coverage. CHIP has been overwhelmingly successful in reducing the number of low-income uninsured children, spurring enrollment not only in CHIP, but also in Medicaid. In 1997, before states began implementing CHIP programs, 23 percent of children at or below 200 percent of the Federal Poverty Level (FPL) were uninsured.³ By 2010 the rate had fallen to 10 percent,⁴ and 85 percent of children eligible for these programs were enrolled.⁵ Furthermore, CHIP and Medicaid helped reduce the uninsured rate among children of color, with the greatest impact on Hispanic children. From 1997 to 2010, the rate of uninsured Hispanic children dropped from more than one in three to less than one in five. Among African-American children, the rate dropped from nearly 22 percent to under 12 percent.⁶ The most recent data indicate that CHIP covers 8 million children and Medicaid covers nearly 36 million.⁷ Together, these programs cover more than half of all children nationally.⁸ It is notable that recent gains in CHIP and Medicaid coverage for children occurred at the same time as private market coverage, particularly employer-based coverage, continued to erode.⁹

CHIP also has succeeded in improving access, utilization, and outcomes of care.^{10,11} For example, in 2010, 36 states reported that more than 95 percent of children in CHIP aged 12-24 months had at least one visit to a primary care physician (PCP), comparable to children with private insurance.¹² A 2012 Medicaid and CHIP Payment and Access Commission report to Congress noted that children enrolled in Medicaid and CHIP have better access to care compared to uninsured children. Medicaid and CHIP children are more likely to have a usual source of care, a well-child visit in the past year, and seen a specialist in the past year, and less likely to have had their medical care delayed.¹³

State-focused studies also demonstrate the positive impact CHIP has had on care management, for example for children with asthma. A study demonstrated that children with asthma who were newly enrolled in the New York CHIP program had fewer emergency department visits and asthma-related hospitalizations, and had better access to a usual source of care after being enrolled for a year.¹⁴ A study of the Alabama CHIP program provided similar results and found an associated cost savings due to improved disease management resulting from continuous enrollment for three years.¹⁵

In addition, CHIP enrollment has been found to improve school performance. Studies have shown that children enrolled in CHIP demonstrated improvements in their ability to pay attention in

class, school attendance, reading scores, and participation in school and normal childhood activities.¹⁶

While CHIP's enactment can be viewed as an incremental step toward addressing the broader problem of the uninsured, it also was driven strongly by a focus on meeting the specific needs of children. Supporters recognized the particular vulnerability of children and the value of investing in health coverage that could promote their healthy growth and development and prevent conditions that could affect adult health and productivity. Continuing to recognize and explicitly address children's unique vulnerabilities and health care needs is imperative to maintaining and achieving further progress in ensuring children have coverage that provides access to quality care that promotes healthy growth and development.

2. Key policy and operational issues in health reform implementation raise uncertainties for children's coverage in future.

While the ACA holds the promise of major coverage gains for the currently uninsured, many details remain to be worked out to develop new policies, systems, and processes to implement the law's provisions. Federal and state officials understandably are focusing heavily on enrollment of newly eligible populations, who are primarily adults. These efforts should have a beneficial impact on children, both directly in improved systems and indirectly in improved coverage and access for their parents. Studies have shown that gains in coverage for parents result in gains in coverage for children and that the health of the parent is a major determinant in the physical and mental health of the family.^{17,18} However, with the focus on the newly eligible comes the risk of unintended consequences for the currently eligible and currently enrolled — particularly children.

Some of the concerns for children's coverage center around a set of issues related to the affordability of subsidized coverage in the new insurance exchanges, especially when compared to CHIP. In a study of 17 states, the median actuarial value of CHIP plans ranged from 98 to 100 percent, meaning that families in these states paid, on average, up to 2 percent out of pocket.¹⁹ While CHIP now provides affordable coverage for eligible children, if CHIP is not funded beyond 2015 and if identified issues around affordability of exchange coverage are not remedied, the lack of affordable options for families is likely to result in a decline in coverage of children.

One concern is that proposed rules for determining premium subsidies do not take into account the other premiums fami-

lies need to pay, including those for CHIP. As a result, those families who qualify to purchase insurance through exchanges beginning in 2014, and who live in the 30 states where CHIP premiums apply, could be subjected to "premium stacking," meaning they may need to pay premiums for CHIP as well as for the health plan they select in the exchange.²⁰

The other concern about affordability of subsidized exchange coverage is that under proposed rules, only the cost for insuring the employee, rather than the whole family, is considered in determining if employer-sponsored insurance (ESI) coverage is affordable. The proposed exchange eligibility rule defines affordable ESI as not exceeding 9.5 percent of household income.²¹ Thus, if an employee has to pay more than 9.5 percent of income for a *family* premium, the employer coverage will still be considered affordable and the employee will be ineligible for premium tax credits. The average cost of ESI family coverage is about 30 percent of median household income.²² An estimated 3.9 million dependents, including spouses as well as children, will be excluded from receiving premium tax credits that are intended to increase the affordability of exchange coverage.²³

There are also other specific concerns for children's coverage in the transition to new exchange and Medicaid policies and systems. As a result of new Medicaid eligibility rules aimed at simplification, in 2014 some children will move from CHIP to Medicaid and some from Medicaid to CHIP. This shifting creates the potential for some children to get "lost in the cracks" during this transition. Estimating exactly how many children may move and in which way is challenging, given current variation in state policies as well as the various family situations of children, which are more complicated than for adults. These situations can involve stepparents, child custody agreements, different insurer service areas for custodial parents, seasonally-employed parents, non-parental guardians, and mixed-status families in which a parent is not lawfully present but has citizen children. Even without these situations, most parents who are eligible for subsidized coverage in exchanges will have children eligible for Medicaid and CHIP.²⁴ Ensuring that new policies and systems do not create new gaps or complicate—rather than simplify and streamline—coverage is a major challenge for states and the federal government. Such a challenge requires sufficient time to plan, test and evaluate new systems before relying on them fully, particularly where vulnerable children are concerned.

States faced significant design and implementation challenges even with the much smaller and more focused new CHIP program 15 years ago. Many states opted at first to operate Medicaid expansion CHIP programs, allowing them to use an

existing program structure, while they took the time necessary to design and implement the separate programs that today operate in 40 states. The ACA extended CHIP funding until September 2015, raised the CHIP federal match in 2016, and required state maintenance of CHIP and Medicaid children's eligibility and enrollment policies through September 2019, signaling an intent for CHIP and Medicaid coverage for children to remain in place through the transition to new systems. Based on their experience in policy and systems development, and on concerns about when and how these uncertainties will be resolved, many CHIP directors believe it may be important to ensure continuation of the program until and unless it is clear that other coverage alternatives are working smoothly to provide children with affordable, quality coverage comparable to what they receive under CHIP.

Federal policies have recognized that full implementation of the ACA requires some interim approaches and extended timelines to support successful state implementation. CMS has allowed an additional two years beyond the start of expanded eligibility—through 2015—for states to obtain higher Medicaid matching funds for eligibility systems development.²⁵ Additionally, federal rules that allow for conditional health insurance exchange approvals and for federal-state partnership approaches provide states with more options and time for full implementation of exchange requirements.²⁶

CHIP implementation experience demonstrates that building new programs presents unanticipated challenges and that change is harder than expected. As focus shifts to covering a large newly eligible adult population, it is important to ensure that children's coverage gains are built on and not lost either in the transition to or during the ongoing implementation of new coverage policies and systems. Gaining assurance that new coverage options, eligibility rules, enrollment systems, policies and procedures, benefits, plans and provider networks are all working well for children will take some time. This need to test and adjust new policies and systems as needed argues for extending CHIP funding beyond September 2015 to ensure that children have an effective, trusted option in place as the bugs are worked out in new and expanded options.

3. State flexibility in design and administration remains key to keeping children's coverage strong while integrating it with new coverage options.

In addition to its focus on the needs of its target population and its explicit aim of increasing insurance coverage, another CHIP hallmark is the flexibility it accords states. This flexibil-

ity allowed states to tailor programs based on their cultures, populations, health care delivery systems, and finances. This flexibility also enabled many states to innovate in aspects of program design and implementation—in outreach, enrollment, affordability, benefits, plans, and provider networks. Many of these innovations have been adopted by state Medicaid programs, and are relevant to expanding Medicaid coverage for adults, developing health insurance exchanges and qualified health plans, and creating Basic Health Programs in states electing this latter option.²⁷

Continued flexibility is needed to allow states to effectively maintain and further children's coverage gains in the context of new individual and family coverage requirements, options, policies, and systems. States will vary in the ways in which they implement new coverage expansions and options, and the timetables on which they phase in optional changes over time. These timelines should allow for careful advance planning as well as implementation assessment of how children's coverage needs are met, whether through Medicaid, separate CHIP programs, exchanges, or other options.

Safeguarding children's coverage and maintaining the program structures that are working now will be important through the transition to new coverage options. At the same time, these new options may provide the opportunity to consider innovative ways to maintain and improve children's coverage in future. For example, states have raised the possibility of using CHIP funds to "buy in" or subsidize coverage for children through health insurance exchange plans, similar to programs that currently allow employers or families to "buy in" to CHIP or Medicaid programs, or programs where CHIP or Medicaid assist families with premiums for private coverage. Such cross-program and public-private strategies would seem important to explore in the context of new coverage options for individuals and families. Another option might be to design Basic Health Programs, currently a state option for adult coverage, to serve children as well. Yet another idea generated among CHIP directors was the possibility of offering separate CHIP plans through health insurance exchanges. While parameters and standards would need to be set, allowing such state flexibility via waivers or new statutory options could yield innovative ways to achieve CHIP purposes and make further progress in covering children while implementing new systems that will provide coverage for families.

Such flexibility should extend to review and where needed, adjustment, in current CHIP policies and processes. For example,

in a context of near universal coverage, the common CHIP policy of requiring a waiting period before otherwise eligible children can enroll may need to be reexamined. As of January 2012, 40 state CHIP programs had waiting periods ranging from 1 to 12 months.²⁸ Waiting periods were put in place in an effort to discourage families from dropping private coverage. There is little evidence to support that waiting periods are effective in deterring families from dropping affordable private coverage for CHIP coverage.²⁹

The flexibility accorded to states in designing their CHIP programs has contributed to their success in substantially reducing the number of uninsured children in the United States over the past 15 years, as well as in innovating new approaches to health insurance coverage. Continued state flexibility similarly could pave the way for developing, testing, and instituting innovative and effective approaches for integrating children's coverage with new options for families.

4. Continued support for CHIP and Medicaid children's coverage through full implementation and assessment of new policies and systems is essential.

Although the ACA extended CHIP program funding through September 2015, increased federal CHIP matching funds effective 2016, and required state maintenance of CHIP and Medicaid coverage for children until October 2019, substantial uncertainty exists about the future of CHIP post ACA implementation. This uncertainty, as well as the focus on implementation of ACA, can have an impact now as well as in future, slowing if not stalling state progress in covering eligible but uninsured children, as well as in making other program improvements such as improved dental coverage, that were included in CHIP reauthorization.

A 2011 analysis concluded that full implementation of the ACA could reduce the number of uninsured children by 40 percent, as well as the ranks of uninsured parents by 50 percent. However, if support for CHIP and Medicaid coverage for children is not sustained through continued funding for CHIP beyond 2015 and maintenance of Medicaid and CHIP eligibility levels and enrollment policies, the uninsurance rate

for children might be higher than it was before the ACA.³⁰

Although funding for CHIP currently extends only until 2015, the ACA provisions related to CHIP and Medicaid coverage for children suggest intent to continue the CHIP program and Medicaid and CHIP coverage policies through a transition period of more than five years, until 2019, following implementation of new coverage options and systems in January 2014. Nonetheless, economic and political pressures have and could in the future generate policy proposals that could run counter to that intent, with potentially negative consequences for children's coverage. Most CHIP directors believe it is important to maintain the program and sufficient funding for children's coverage at least through a transition period long enough to work through the policy and operational issues of implementing new coverage programs and systems. Doing so could help states maintain and achieve further progress in providing children with the coverage they need as a foundation for growth and development into healthy, productive adults.

CONCLUSION

CHIP and Medicaid have been exceedingly successful in finding uninsured children and providing them with quality, affordable coverage. CHIP directors are clear that a strong focus on the coverage needs of children must continue in a post-reform world, and that focus should transcend political or policy debates. State flexibility in ACA, Medicaid, and CHIP implementation is essential to maintaining and furthering progress in covering children, as well as to informing and working through the design and operational issues in implementing new, as yet untested coverage mechanisms through exchanges. Maintaining CHIP and financing for CHIP and Medicaid children's coverage through the transition to full ACA implementation will help ensure that states can continue to build on the successes achieved in covering children, as they also forge ahead in covering new populations. CHIP directors look forward to continuing work with their state and federal partners to plan for children's coverage that is easily accessible, affordable, and meets children's unique health care needs.

ENDNOTES

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Acknowledgments

The authors wish to thank the CHIP directors who contributed to the development of this brief, particularly workgroup members who dedicated time to participate in discussions and provide feedback on drafts. We also want to thank other colleagues who reviewed drafts, including Jocelyn Guyer of the Center for Children and Families and Genevieve Kenney and Stan Dorn at the Urban Institute. The David and Lucile Packard Foundation has provided ongoing support for NASHP's work on children's coverage, including development of this brief. We especially want to thank our Project Officer, Gene Lewit, for his thoughtful review of drafts and his ongoing commitment to supporting states in improving children's coverage.

Citation:

Catherine Hess, Leigha O. Basini and Carla I. Plaza, *Keeping Children's Coverage Strong in the Context of the Affordable Care Act: Perspectives from State Children's Health Insurance Leaders*, 2012 (Portland, ME: National Academy for State Health Policy).

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