The Last Piece of the Puzzle

Providing High-Quality, Affordable Health Coverage To All Children Through National Health Reform

May 2009

Georgetown University Health Policy Institute
Center for Children and Families

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Executive Summary

Introduction

A top priority for national health reform is to ensure that everyone has access to high-quality, affordable health insurance, especially the 45 million individuals, mostly adults, who are uninsured. Children also have a large stake in this debate—both because of its implications for their families and because more work is needed to ensure that all of America's children have high-quality, affordable health care coverage that assures access to care that meets their unique needs.

The United States has taken significant strides forward in ensuring children have health coverage—nine in ten children in the United States are now insured. This progress has occurred largely on the shoulders of Medicaid and CHIP. The signing into law of the Children's Health Insurance Program Reauthorization Act (CHIPRA) on February 4, 2009 was another major step forward but CHIPRA was never intended to be the broader reform needed to ensure all children have high-quality, affordable health coverage.

Almost nine million children are now uninsured and whether a child has health insurance can be a game of chance. It can depend on whether his mother works for a school district or a chain retail store, whether the family lives in Kansas City, Kansas or Kansas City, Missouri, or whether the family lives in a state with a simple or complicated Medicaid/CHIP application.

Even those children who have health insurance do not always get the child-specific care they need. In a country in which there is remarkably strong consensus that all children should have the health care coverage that they require to grow and thrive, it is clear that health reform needs to tackle these issues. The new CHIP law took us further in that direction, but now the goal is to put the last pieces of the puzzle in place by:

- Building affordable pathways to coverage for all of America's children;
- Taking further steps to ensure that every insurance card translates into children receiving the care that they need to develop and grow properly;
- Creating a unified, "no wrong door" enrollment and renewal process to ensure all families can easily access coverage; and
- Strengthening the financing of public programs, which serve as the backbone of the current coverage system for low-income children.

Gaps in Coverage, Gaps in Care

Children obtain their health coverage primarily through employer-sponsored coverage or public programs, specifically Medicaid and CHIP. But many children still fall through the cracks. Addressing these gaps in coverage and in care is critical to ensuring all children have high-quality, affordable health coverage.

- **Most children receive coverage through a parent's job, but a working parent is not a guarantee of coverage.** The rate of employer-based coverage has worsened in recent years, primarily due to rapidly rising health care costs.

- **Millions of children are enrolled in Medicaid and CHIP, but barriers continue to keep many eligible children out.** Despite considerable progress, complicated enrollment and renewal procedures and limited conformity among the programs and across states leave many eligible children uninsured.

- **While most uninsured children are low-income, moderate-income families also can face serious challenges securing coverage.** The individual market can be prohibitively expensive or simply unavailable to children with known health care conditions.

- **Even with coverage children do not necessarily receive the care they need** due to shortcomings in the health care delivery system, benefit limitations that fail to recognize the unique health care needs of children, and unaffordable cost sharing requirements.

What Children Need From National Health Reform

Health reform remains at the top of the domestic policy agenda, and congressional committees are moving forward to develop legislation. A key measure of success within this landscape will be whether national health reform ensures that all of America's children can secure health care coverage that promotes their healthy development. Achieving this outcome requires the following steps:

1. **Building Affordable Coverage Pathways for all of America's Children**

   The remaining gaps in coverage for children and their families can be addressed by: 1) expanding Medicaid to cover everyone up to 150 percent of the federal poverty level (FPL) and CHIP to cover children up to 300 percent of the FPL (and providing flexibility for states wishing to expand further); and 2) creating affordable coverage options for other families through a new insurance Exchange and related subsidy program. Both of these coverage routes should be available to lawfully-residing immigrants, and optimally, undocumented children

2. **Beyond Insurance—Ensuring Children Get the Care They Need**

   Health care reform offers the opportunity to ensure that children receive the care that they need to develop and grow properly by: 1) providing children with a child-specific benefit package (EPSDT in Medicaid and CHIP, and a pediatric benefit for Exchange plans); 2) improving children's access to care through adequate reimbursement rates, support of medical home models, and improvements to quality; and 3) supporting coverage for children with special health care needs by strengthening the Family Opportunity Act.

3. **Creating a Unified, "No Wrong Door" Enrollment and Renewal Process**

   Under a universal coverage system, it should be as easy for families to enroll their children in coverage as it is for them to sign up for employer-based insurance or to enroll their child in school. Implementing this type of system entails: 1) creating a "no wrong door" policy under which everyone can obtain coverage (whether Medicaid, CHIP, or subsidized coverage) regardless of where they originally apply using a simplified application process, including via an online portal; 2) implementing, across the system, easy-to-understand eligibility rules and simplified verification procedures that rely primarily on technology rather than paperwork to document eligibility; 3) implementing automatic enrollment efforts, such as ensuring all children born in the U.S. leave the hospital with an insurance card; and 4) providing children and others with 12-months of continuous eligibility for coverage.

4. **Strengthening Financing for Public Programs—the Backbone of Coverage for Low-Income Children**

   Assuring that all people, including children, have access to affordable high-quality coverage will require major new federal resources for: 1) ensuring that states can sustain existing coverage initiatives and provide new coverage up to the federally required Medicaid and CHIP minimum levels; 2) providing financial support to states wishing to cover more children, parents, and other groups through Medicaid and CHIP; and 3) establishing an automatic mechanism for stabilizing Medicaid funding during economic downturns.

Conclusion

The nation has made significant progress in covering children, but nine million children still lack insurance and many more are at risk of not receiving the health care services that they need to develop and grow properly.

To address these issues, children will need to be an integral part of the much larger health reform debate now underway. Based on the research and the experience gained over decades of efforts to cover children, this report provides a blueprint of what children and families need from health reform, including an overview of where the remaining gaps are for children's coverage and recommendations on the key challenges that must be addressed in order to complete the puzzle.

Introduction

A convergence of factors—new leadership, high health care costs, a continuing decline in employer-based coverage, and limited options on the private insurance market coupled with a weakening economy—has created a strong impetus for national health reform. In fact, no longer is the argument focused on whether health reform is needed, but on how it should be done. High on the list of priorities is ensuring that everyone has access to affordable high-quality health insurance, including the 45 million individuals who are uninsured, the large majority of whom are adults.[1] Children have a large stake in this debate, both because of its implications for their families and because more work still needs to be done to ensure that all of America's children have high-quality, affordable health care coverage that assures access to care that meets their unique needs.

The United States has taken significant strides forward in ensuring children have health coverage—nine in ten children in the United States are now insured.[2] This progress has occurred largely on the shoulders of Medicaid and its smaller companion program, the Children's Health Insurance Program (CHIP).[3] The signing into law of the Children's Health Insurance Program Reauthorization Act (CHIPRA) on February 4, 2009 was another major step forward in creating opportunities to cover more children and to improve the quality of care that children receive. But it was never intended to be the broader reform needed to ensure all children have high-quality, affordable health coverage. To reach this goal, children will need to be an integral part of the much larger health reform debate now underway.

Every child is guaranteed an education in this country, but that same kind of guarantee does not extend to health care.

Almost nine million children[4] are now uninsured and even if CHIPRA works exactly as intended, millions will remain so. To an alarming degree whether a child has health insurance continues to be a game of chance. It can depend on such arbitrary distinctions as whether his mother works for a school district or a chain retail store, whether the family lives in Kansas City, Kansas or Kansas City, Missouri, or whether the family lives in a state with a simple or complicated Medicaid/CHIP application. (Box 1.) Even those children who have health insurance do not always get the care they need due to shortcomings in the health care delivery system, a failure to recognize the unique health care needs of children, and/or benefit limitations and unaffordable cost sharing requirements.

BOX 1.

A TALE OF TWO FAMILIES

McIntyres of Washington State

Sarah McIntyre is an 8-year-old girl living in Yakima, Washington. Sarah was born with a hole in her heart and cysts on her lungs and her life depends on consistent, quality healthcare. She got that, thanks to the Washington's Apple Health for Kids program (the State's Medicaid/CHIP program) until her parents received small raises that boosted their income just over the program's eligibility level (250 percent of the FPL).

The family could not find affordable health insurance and was struggling to meet their $800 monthly prescription drug bill and other health care costs. Fortunately, in February 2009, Washington State expanded Apple Health for Kids up to 300 percent of the FPL. Now Sarah has health coverage and everyone is doing much better.

Demkos of Ohio

Emily Demko is a 3-year-old girl living in Albany, Ohio. Emily was born with Down syndrome and requires daily assistance. To care for her, Emily's mother had to quit her job, and subsequently lost her employer-sponsored coverage (her father is self-employed). The family qualified for Medicaid and Emily received physical, occupational, and speech therapies under which she thrived. However, within six months their income increased just over the program's eligibility level (200 percent of the FPL).

Her parents have explored numerous options for obtaining health coverage for Emily but due to her pre-existing condition, the Demkos have been denied private coverage. Facing monthly bills in excess of $3,500 the family now makes hard decisions about Emily's care. She has been reduced to 20 minutes of professional speech therapy a week and she has had to go without services, including hearing tests, corrective treatment for an eye conditions and physical therapy, while the family works to afford them. Hope may be on the horizon, however, as Ohio is considering expanding their health program up to 300 percent of the FPL.

In a country in which there is remarkably strong consensus that all children should have the health care coverage that they need to grow and thrive, it is clear that health reform needs to tackle these issues. (See Box 2 explaining why children need quality health coverage.) The new CHIP law took us far in that direction, but now the goal is to put the last pieces of the puzzle in place by:

- Building affordable pathways to coverage for all of America's children;
- Taking further steps to ensure that every insurance card translates into children receiving the care that they need to develop and grow properly;
- Creating a unified, "no wrong door" enrollment and renewal process to ensure all families can easily access coverage; and
- Strengthening the financing of public programs, which serve as the backbone of the current coverage system for low-income children.

Based on the research and the experience gained over decades of efforts to cover children, this report provides a blueprint of what children and families need from health reform, including an overview of where the remaining gaps are for children's coverage and recommendations on the key challenges that must be addressed in order to complete the puzzle.

The recommendations in this report primarily focus on improving coverage options for children through public programs and a new insurance Exchange, however employer-sponsored and individual market coverage will also be critical components in the national health reform debate. The Center for Children and Families will explore these issues further through other avenues.

BOX 2.

WHY CHILDREN NEED HEALTH REFORM TO BE HEALTHY

Children see pediatricians for a reason: they need preventive and specialized care to ensure proper physical development, which if they do not get can impact them throughout life. But many children do not receive this care.

- **Lack of coverage.** Uninsured children are 20 to 30 percent less likely to receive immunizations, prescription medications, asthma care, and basic dental care. Those with conditions requiring ongoing medical attention, such as diabetes, are six to eight times more likely to have unmet health care needs. Uninsured children are also more likely than insured children to miss school due to health problems, and to experience preventable hospitalizations.[5]

- **Health disparities.** Low-income populations and communities of color disproportionately experience worse health and safety outcomes across a broad spectrum of illnesses, injuries, and treatments, including higher rates of infant mortality and lower rates of immunizations.[6]

- **Limits on care.** Children, especially those with special health care needs, often miss out on the care that they need. About 30 percent of speical health care need children with coverage (private or public) have inadequate coverage.[7]

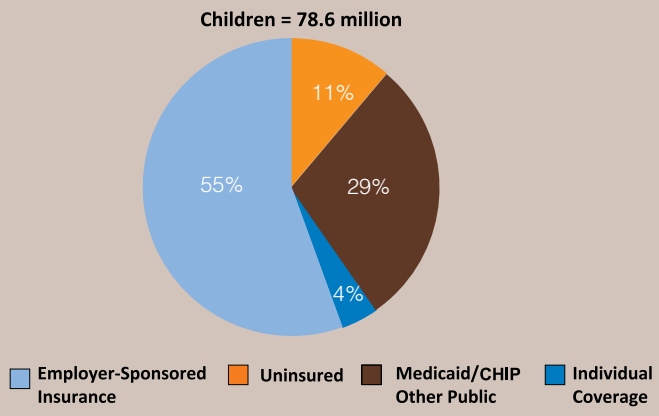
The Current Landscape: Gaps In Coverage and Care For Children

Children obtain their health coverage through two primary avenues: employer-sponsored coverage or public programs, specifically Medicaid and CHIP. On a much smaller scale, children receive coverage on the individual health coverage market. But many children still fall through the cracks—8.9 million children have no coverage and others are underinsured.[8] (Figure 1.)

- Most children receive coverage through a parent's job, but a working parent is not a guarantee of coverage. In recent years, there has been a sharp decline in employer coverage, driven in large part by dramatic increases in the cost of health insurance. Between 1999 and 2007 the total premium for family-based employer coverage increased from $5,742 to $12,608.[9] As premiums have increased, employers have dropped coverage and/or increased the employee share of the premium, including that for dependents.[10] This has occurred particularly among the lower-wage workforce. (Figure 2.)

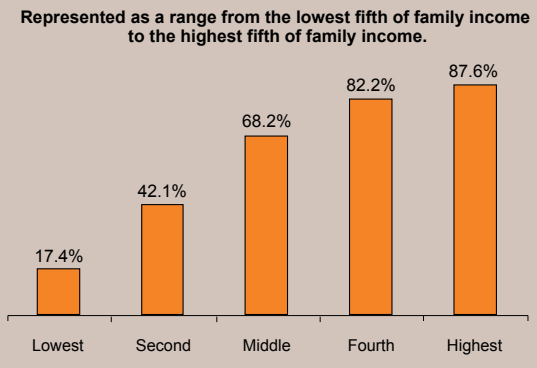
- Millions of children are enrolled in Medicaid and CHIP, but barriers continue to keep many eligible children out. Today, almost 28 percent of children (21.7 million children) receive health coverage through Medicaid and CHIP.[11] States have made considerable progress in enrolling children—the percent of eligible uninsured children who were enrolled in Medicaid and CHIP jumped from 66 to 78 percent in recent years.[12] However, some six million uninsured children are eligible for coverage but not enrolled.[13] While Medicaid and CHIP have made important strides in covering children, many still face enrollment obstacles, and others once enrolled, do not receive stable care and can be too easily dropped from coverage.[14] In addition, there is little conformity among the programs—every state sets its own income levels within federal guidelines, designs its own application and renewal processes, and makes other critical

Figure 1. Children's Coverage, 2007



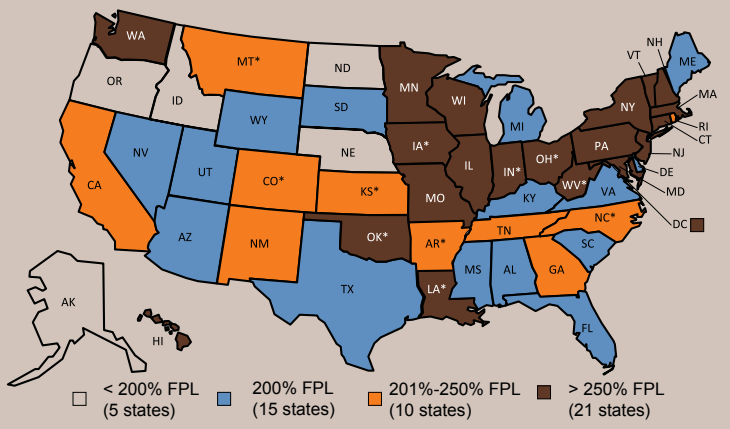
Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Figure 2. Employer-Sponsored Coverage, by Income 2007



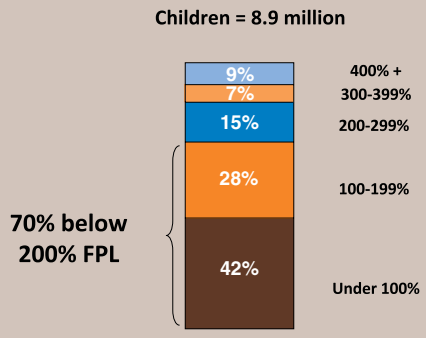
Source: E. Gould, "The Erosion of Employer-Sponsored Health Insurance: Declines Continue for the Seventh Year Running," Economic Policy Institute (October 9, 2008).

Figure 3. Medicaid and CHIP *Authorized* Eligibility Levels for Children, April 2009



Source: D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009); updated by the Center for Children and Families.
Note: States with asterisks (*) have enacted, but not yet implemented to the levels shown.

Figure 4. Income Levels of Uninsured, 2007



Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2008 ASEC Supplement to the CPS. Note: Percentages do not add to 100% due to rounding.

decisions on who can be covered, such as whether to impose a five-year waiting period on otherwise legal immigrant children. (Figure 3.)

- While most uninsured children are low-income, moderate-income families also can face serious challenges securing coverage. Many uninsured children live in families with moderate incomes—more than one in five (22 percent) of uninsured children have family income between 200 and 400 percent of the FPL ($44,100 to $88,200 for a family of four in 2009).[15] (Figure 4.) Children in these families often are not eligible for public programs and yet may not have affordable coverage options available through their parents' jobs. A few families may turn to the individual insurance market, but the coverage provided through this market can be prohibitively expensive or simply unavailable to children with known health care conditions, such as asthma, diabetes, or other special health care needs.

- Even with coverage children do not necessarily receive the care they need. Having a health insurance card does not necessarily mean that children are receiving child-specific and developmentally-appropriate care or continuity of care. One influential study found that insured children receive the recommended care that they should only about half of the time.[16] The issues with securing necessary care are particularly severe for children with special health care needs. For example, about a third of privately- and publicaly-insured children with special health care needs have inadequate coverage.[17]

What Children Need From National Health Reform

Health reform remains at the top of the domestic policy agenda, and congressional committees are moving forward to develop legislation.

President Obama and other leading policymakers have indicated that they intend to approach health reform by building upon the nation's existing employer-based system and public programs to reach coverage goals, while simultaneously working to improve care and address costs. Many of the leading proposals borrow heavily from the "Massachusetts model," under which Medicaid was expanded to cover more of the state's residents and a mechanism (typically referred to as an "Exchange" in the national debate) was established to create and organize insurance options for those lacking coverage. As under the Massachusetts plan, there is extensive discussion about the role of Medicaid and CHIP, development of a subsidy program to provide assistance to families with incomes above Medicaid and CHIP eligibility levels who are unable to purchase coverage on their own, as well as imposing a mandate on individuals to purchase coverage.[18]

Within the contours of this national health reform landscape, it is important that the specific, unique needs of children are addressed if all children are to have the high-quality health care that they need to grow and thrive. Recommendations on how to achieve this goal follow.

1. Build Affordable Coverage Pathways for All of America's Children

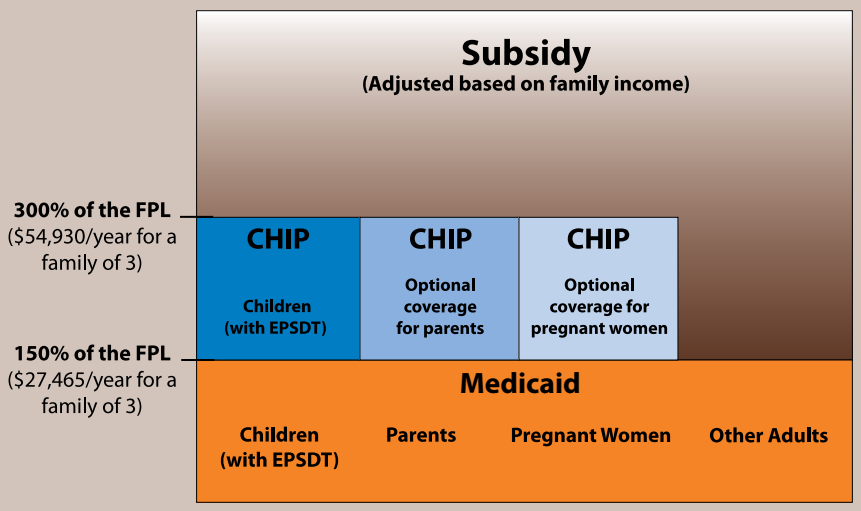
To address the remaining gaps in coverage for children and their families, policymakers likely will need to consider a dual approach: sustaining and strengthening the public programs that already serve many of the nation's children, and creating coverage options for other families not eligible for the public programs through an insurance Exchange. (Figure 5.)

Since a primary reason that people lack health insurance is that they cannot afford it, policymakers will also need to address this fundamental problem and ensure that all coverage options are affordable.[19] The stakes will be even higher for families if, as many policymakers have proposed, people face a mandate to enroll themselves and their children in coverage. The specific steps they could take include:

- Creating a consistent base of coverage for children and their families through Medicaid and CHIP. To simplify eligibility rules and minimize geographic differences that now occur across states, the federal government could establish a new, higher minimum eligibility threshold in Medicaid and CHIP for children and their families. In doing so, it should take into account that all states already cover children up to 150 percent of the FPL (and are required to provide Medicaid coverage to children under age 6 up to 133 percent of the FPL). In addition, 21 states have opted to expand public coverage through Medicaid and CHIP for children at or above 250 percent of the FPL, reflecting a growing sense that health care coverage otherwise is simply unaffordable for many families in this income range.[20] Specifically, health reform could:

    - **Establish a minimum federal income standard for Medicaid and CHIP.** Taking into account current state eligibility levels, the need to "level the playing field" for children,

Figure 5. Proposed Coverage For Those Without Employer-Based Insurance



Note: States would be required to maintain coverage, and could expand coverage, above the levels represented.

and when possible cover families together, Medicaid could cover children, their parents, and pregnant women (with other adults) up to 150 percent of the FPL. CHIP could cover children up to 300 percent of the FPL. As noted later, if income disregards and deductions are eliminated, the income level would need to be adjusted upward to reflect the changes.

- **Prevent loss of existing optimal coverage, and allow state flexibility to cover additional families with children in Medicaid or CHIP.** To prevent children and others from losing coverage as a result of states scaling back their public programs to the new federal minimum standards, states could be required to continue any Medicaid and CHIP coverage that they currently have above the standards, with federal funding. States would retain current flexibility to cover pregnant women in CHIP and be given flexibility to expand coverage above the federal minimum standards. If, for example, the benefit package available in the Exchange is not adequate or the cost is prohibitively high (especially in a high cost-of-living state), a state could be allowed to expand its CHIP program to more children.

- **Maintain Medicaid and CHIP cost sharing standards.** Federal standards in Medicaid and CHIP have kept the programs' cost sharing levels relatively low. (Box 3.) Still, experience and research shows that even small increases in premiums and other costs for these families can depress enrollment because the financial burden becomes too great in light of families' income and other expenses.[21] For this reason, Medicaid and CHIP cost sharing rules could be applied to the new federal minimum standards by prohibiting cost sharing for those at the lowest income levels (up to 150 percent of the FPL) and limiting all cost

BOX 3.
COST SHARING IN MEDICAID AND CHIP

Federal standards in Medicaid and CHIP have kept the program cost sharing levels (including premiums, co-payments, and other out-of-pocket costs) relatively low. Importantly, federal rules exempt preventive services, such as well-child visits, from any cost sharing, even for children with more moderate incomes. States have the discretion to impose certain cost sharing charges on beneficiaries within the following guidelines:

- **Medicaid:** States cannot impose any cost sharing on children with family income below 150 percent of the FPL except in a narrow range of circumstances (e.g., using an emergency room for a non-emergency). Cost sharing is allowed for families above 150 percent of the FPL, but the amount is capped at no more than five percent of family income.
- **CHIP:** States have more flexibility to set premium and other cost sharing levels in separate CHIP programs, but the overall amount is capped at no more than 5 percent of family income. Cost-sharing rules in CHIP-funded Medicaid expansions are the same as those in Medicaid.

Because of affordability concerns, most states have set cost sharing levels well below the federal limits.[22] For more information, see Cost Sharing for Children and Families in Medicaid and CHIP (http://ccf.georgetown.edu/index/cost-sharing-for-children-and-families).

sharing, including premiums, deductibles, co-payments, and co-insurance, to five percent of family income among less deeply impoverished families (150 to 300 percent of FPL, or higher if a state has expanded beyond the minimums).

- Creating affordable coverage options for children not eligible for Medicaid or CHIP through an Exchange. An insurance Exchange could be used to cover children, parents, pregnant women, and other adults who are not eligible for public programs but lack employer-based coverage. Under most of the leading proposals now being considered (and as in Massachusetts), a subsidy program would be established to ensure that the coverage provided through an Exchange is affordable for families, especially at more moderate-income levels. The subsidy could be based upon an affordability standard that takes into account what families, at different income levels, can reasonably be expected to spend on health care after paying for life's other necessities—food, clothing, shelter, etc.[23] The standard would need to take into account the range of health insurance-related costs, including premiums, deductibles, co-payments, and co-insurance, families may face within a health care plan. Regardless of how the subsidy is initially established, any affordability standard should be closely monitored for the impact on families, and updated as needed.

- Establishing further affordability protections for families. While an overall cap on the amount families are expected to spend on health care would go far in safeguarding families, additional protections should be considered in the context of national health reform. As is already the case for Medicaid and CHIP, preventive care services, including those for children, should have no co-payments or deductibles, even for families at moderate-income levels. Other protections that could be implemented across coverage options include: setting appropriate limits for what plans are allowed to charge for deductibles, co-payments, and co-insurance; applying cost sharing limits on a quarterly basis to provide relief to families whose expenses may fall within the cap for the entire year but face particularly high costs one month; and establishing firewalls to ensure that families facing high medical costs are not forced to forgo coverage or go into significant debt. In addition, standards for tracking families' out-of-pocket expenses could be established to ensure cost sharing protections work as intended.

- Extending affordable coverage options to immigrants. Health reform should ensure that all lawfully-residing immigrants are eligible for public programs and other coverage routes through the Exchange. Undocumented children also will continue to need and receive care, and any health reform should make it easier, not harder, for them to do so. Optimally, undocumented children could have the same coverage options that all other children would have. A number of states have already moved in this direction, recognizing that coverage options are most effective in reaching all eligible children when coverage is universal.[24]

This new structure could be coupled with efforts to ensure that the coverage options are fully integrated, families can easily enroll and stay enrolled, and that the benefits serve the needs of children. In addition, financing this coverage would require a strong federal commitment of resources. The following sections describe strategies for meeting these goals.

2. Beyond Insurance—Ensure Children Get the Care They Need

It is now widely recognized that an insurance card is not enough to ensure that children receive the care that they need to develop and grow properly. Health care reform offers the opportunity to address these issues for children, including those with special health care needs.

Even with insurance, children may be unable to find a provider that will see them, the services that they need may be outside the scope of benefits covered by their insurer, or they may not receive the care that they should when they do see a provider. For children, the consequences of such issues are particularly severe—a healthy childhood and early detection and treatment of issues can launch children on a better trajectory toward a successful adulthood. The strategies that could be implemented to address children's specific health needs include:

- Ensuring children receive a child-specific benefit package. Given their unique developmental and health care needs, children should have a child-specific benefit package. Created specifically to provide a prevention-based set of services for low-income children, the existing EPSDT benefit in Medicaid represents an excellent source for identifying the key elements of such a benefit.

(Box 4.) Specifically, to ensure children receive a child-specific benefit package, the federal government could:

- **Continue providing EPSDT to all children in Medicaid and extend it to children in CHIP.** The current EPSDT benefit for children in Medicaid should be continued and strengthened, such as by requiring the

BOX 4.
ABOUT EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid's comprehensive preventive and treatment program for children. Passed in 1967 and updated in 1989, EPSDT expanded Medicaid's role beyond the detection and treatment of illness to the promotion of healthy development. Under the program, children are entitled to periodic health screenings and treatment to ameliorate any diagnosed condition. The goal is to identify physical and mental conditions in childhood and provide timely intervention to support growth and avoid long-term disability. EPSDT provides critical child-specific benefits often lacking in private health insurance, such as speech therapy to help a child with hearing loss reach her maximum potential, and remains a critical component of the health care safety net for children.[25] As discussed, additional federal leadership is required to ensure that EPSDT delivers on its promise in all states.

Department of Health and Human Services (HHS) to provide greater federal leadership in ensuring that it provides children with the primary, preventive, and developmental care that they need. It also should be extended to children in CHIP. While the current CHIP benefit structure has worked relatively well for many children, it has fallen short in some places, failing to cover some key services (e.g., vision care in selected states), and leaving some children with special health care needs without access to critical therapies.[26]

- **Provide children in Exchange plans with a child-specific benefit package**. While children in Exchange plans may not need all of the elements of EPSDT, it remains an important model from which to draw for a child-specific benefit package in Exchange plans. Such a package should reflect the unique needs of children and be designed to support their optimal development. It could include appropriate preventive services, such as those identified in the American Academy of Pediatrics Bright Futures guidelines (which largely mirrors the prevention elements of EPSDT).[27] Beyond prevention, a child-specific benefit package also could include services needed to maintain or improve the developmental, physical, mental, and dental health of a child.

- Improving children's access to care, including by requiring adequate reimbursement rates. Access standards could be created for children and other populations in Exchange plans, with comparable provisions added to Medicaid and CHIP. The standards could be aimed at ensuring that children receive necessary benefits, including specialty services and dental care; and that enough providers are able and willing to treat children, especially those in rural areas or in ethnic and minority communities. As part of this, the federal government could specifically require that Medicaid and CHIP reimbursement rates are as good as or better than Medicare's

rates for comparable services (with adjustments to take into account that Medicare does not necessarily have reimbursement rates for the full range of services required by children, such as well-child visits).

- Building on CHIPRA efforts to improve quality. CHIPRA included a set of provisions designed to establish a major new pediatric quality initiative within HHS. The initiative includes the development of a core set of quality measures as well as the establishment of an ongoing Pediatric Quality Measures program, demonstration projects on both childhood obesity and electronic health records for children, and a grant program focused on child health quality.[28] Broader health reform creates the opportunity to integrate the child-specific quality initiatives in CHIPRA into oversight of Exchange plans and to make the child health measure reporting requirements stronger in Medicaid and CHIP. For example, the federal government could decide that some child health measures are sufficiently important that they must be reported by all states, rather than leaving them entirely optional.

- Supporting the establishment of medical home models. With the growing awareness of the need for family-centered and patient-centered care for children (and other groups), a number of states are exploring ways to provide that care in Medicaid and CHIP via a medical home model. (Box 5.) The federal government could play a leadership role in supporting states in developing medical homes for children that address their unique developmental, behavioral,

BOX 5.

NORTH CAROLINA'S MEDICAL HOME MODEL

Many states are looking to the North Carolina Medicaid program's medical home initiative as a model for how to combine quality improvement strategies with coordinated and cost-effective care in public programs. Community Care of North Carolina (CCNC) is an enhanced medical home model that provides care to Medicaid enrollees through non-profit community networks consisting of physicians, hospitals, social service agencies, and county health departments. The networks link each enrollee to a primary care provider that serves as his or her medical home. The primary care providers receive a small monthly fee to provide the enrollee with acute and preventive care, manage chronic illnesses, coordinate specialty care and provide 24/7 on-call assistance. Case managers within the networks work with the primary care providers to provide enrollees with disease and chronic care management. CCNC also has ongoing data monitoring and reporting to facilitate continuous quality improvement on a physician, network, and program-wide basis.

Studies show that the CCNC model improves care, demonstrates high achievement rates on performance measures, and saves the state money (in fiscal year 2006 the savings were estimated at $150 to $170 million).[29]

and physical health needs. This could include funding demonstration programs to evaluate and disseminate medical home models.

- Ensuring strong coverage for children with special health care needs. In response to the problem that children with special health care needs too often go without necessary care due to shortcomings in commercial insurance products, Congress adopted the Family Opportunity Act in 2005. The Act gives states the option of allowing families with privately-insured children with family income up to 300 percent of the FPL to purchase supplemental coverage through the Medicaid program. Medicaid, with its EPSDT benefit for children, is designed to provide the full range of services that are needed by all children, including those with special health care needs. As of May 2009, however, only two states, Louisiana and North Dakota, have taken up the option (three additional states have passed, but not implemented, legislation).[30] In the context of broader health reform, policymakers could require all states to adopt the Family Opportunity Act, with the support of additional federal resources, and at the same time eliminate the income cap so that more children could participate.

> An insurance card is not enough to ensure that children receive the care that they need to develop and grow properly.

While these recommendations are aimed at improving the health care delivery system for children, there is a range of other strategies that could be used to promote their healthy development. These include strengthening child and family health prevention and wellness initiatives, developing medical records for children, and public health initiatives.[31]

3. Create a Unified, "No Wrong Door" Enrollment and Renewal Process

It should be as easy for families to enroll their children in public coverage or the Exchange as it is for them to sign up for employer-based insurance or to enroll their child in school.

The national expectation that all children are eligible for one coverage option or another and will be covered means that enrollment and renewal barriers have no place in the new system. There should no longer be any cases in which eligible people miss out on coverage because of paperwork requirements and antiquated computer systems.[32] The specific strategies for creating a family-friendly enrollment process could include:

- Creating a simplified and uniform strategy for enrolling and renewing children in coverage. If, as expected, health reform keeps the current pathways to coverage for children and adds new ones, families could face a bewilderingly complicated system. To minimize confusion, the federal government could:

  - **Establish a "no wrong door" enrollment policy.** Families should not be expected to determine on their own whether their children should be in Medicaid, CHIP, or an Exchange plan; instead, they should be given the chance to apply for coverage through any of a number of different avenues (e.g., via an Exchange or a Medicaid office). Regardless of where they apply, they should have the chance to complete a simple, unified application that can be used to enroll everyone in the family in the appropriate program. If they accidentally apply for the wrong program, the administering agency should screen them for the right program and enroll them in coverage without requiring any additional, unnecessary paperwork.

  - **Create an online portal.** To simplify the coordination needed to make a "no wrong door" policy work seamlessly, much of enrollment could be done through an online enrollment and renewal portal that could be accessed at home, in hospitals, at doctor's offices, and at any number of public offices, including libraries, DMVs, and unemployment offices. The portal could allow families to enroll together, find out what program or programs they are eligible for, and enroll immediately.

  - **Assist families through the process.** Community-based assistors could be funded to provide families with application and renewal assistance, and other help as needed. In addition, help-lines could be established to help families understand the enrollment and renewal process, their health plan benefits and how to access care.

- Aligning and simplifying application rules to support family-friendly enrollment. To support a "no wrong door" enrollment policy, the income counting rules, the verification procedures and the renewal periods for Medicaid, CHIP, and the new subsidy should all be simplified and made parallel. This would include aligning definitions of countable income and verification of income, residency, and citizenship, with an emphasis on making the enrollment process as simple as possible. For example, for simplicity purposes:

  - **Ensure verification rules primarily rely on technology rather than paperwork,** such as replacing the current Medicaid citizenship documentation requirement with a national system for electronically checking citizenship;

  - **Require procedures that make enrollment and renewal easier for families,** such as guaranteeing coverage for 12 months and eliminating face-to-face interviews, waiting lists, and asset tests.[33]

  - **Remove administrative complexity,** for example by establishing a single category of eligibility based on only income and potentially eliminating income disregards and deductions. (Eliminating income disregards/deductions would require that the minimum federal income standards be adjusted upward to account for the loss.)

- Maximizing use of automatic enrollment. If eligibility rules and verification procedures are simplified, automatic enrollment could be used to enroll many of the country's uninsured children, such as through public programs or the tax system.[34] In addition, to move toward a true system of automatic enrollment policymakers could establish a requirement that hospitals, states, and the Exchange implement a system so that every child born in the U.S. would leave the hospital with an insurance card.

4. Strengthen Financing for Public Programs—the Backbone of Coverage for Low-Income Children

Assuring that all people, including children, have access to high-quality, affordable coverage is a national goal and, as is widely recognized, will require major new federal resources.

New federal resources are needed to ensure that states can sustain existing coverage initiatives; provide coverage to additional children, parents, pregnant women, and others in Medicaid and CHIP; and finance a subsidy for more moderate-income families purchasing coverage through the Exchange. Of particular importance is strengthening the financing for the public programs that serve as the backbone of the current coverage system for low-income children and others. More specifically, federal resources are needed for:

- Financing the cost of Medicaid and CHIP expansions. It would be both fiscally and politically infeasible to require states to cover significant numbers of new people without the federal government covering the new costs. Many states already find it challenging to sustain their existing Medicaid programs, especially during economic downturns.

  - **Finance new minimum federal income standards.** As discussed earlier, new federal income standards could require expansions for parents and other adults to 150 percent of the FPL and for children to 300 percent of the FPL. The federal government would need to finance much or all of the cost of these new expansions (e.g., at the CHIP enhanced matching rate for coverage of new children and at 100 percent federal funding for the more expensive adult populations). States that have already opted to voluntarily cover people in these income ranges also could be provided with an enhanced matching rate or federal payment to recognize their early commitment to coverage.

- **Support coverage above the minimum standards.** Moreover, if some states want to extend coverage beyond these new, higher federal minimum levels, they could be provided with an augmented matching rate to do so or be given the federal subsidies that otherwise would have been given to Exchange plans for the people they cover through their optional Medicaid or CHIP expansion.

- Establishing a simplified financing structure in Medicaid and CHIP. The occasion of providing new funding to states opens the possibility for simplifying the Medicaid and CHIP financing mechanism. For example, instead of the federal government establishing a separate and higher matching rate for the subset of parents who are newly eligible for Medicaid, it could create a new, single blended matching rate for all parents covered through Medicaid (i.e., those covered under both the old and the new eligibility rules). A single, unified (or "blended") matching rate could also be adopted for children in Medicaid and CHIP in order to simplify administration and to eliminate any inequities created by the federal government financing a greater share of coverage for CHIP- versus Medicaid-eligible children. Depending on the level set, a new blended rate could also help finance improvements in participation rates and access to care for children.

With appropriate resources and good policy we can put the last pieces of the puzzle in place to ensure that all children can easily access and maintain quality, affordable health coverage.

- Establishing an automatic mechanism for stabilizing Medicaid funding during economic downturns. States face strong fiscal pressures to cut Medicaid during difficult economic times even as more people qualify for and need the program. Congress has twice provided time-limited infusions of additional federal Medicaid funding to states during a recession.[35] The infusions have been critical in preventing and, in some cases, reversing cuts to Medicaid, but in both instances they occurred a number of months after the recession had started. To avoid such contractions in a downturn, an automatic stabilizer is needed to adjust federal Medicaid payments to states during economic downturns in a timely way.

- Eliminating the cap on federal CHIP funding to ensure all eligible children can enroll in coverage. In the context of broader health care reform that might well include a coverage mandate, eligible children should not be turned away from CHIP due to a shortage of available federal funds. In such a context, it would be important to consider eliminating the caps now imposed on national CHIP allotments to prevent states from running out of money for coverage of eligible children and being forced to establish waiting lists.

Conclusion

National health reform brings with it many challenges, but also a tremendous opportunity to guarantee that everyone in the country has health coverage. Within the creation of a national reform policy there will be many moving pieces, and only too easily, children and their families could be lost in the shuffle. Fortunately, Medicaid and CHIP have not only significantly closed the gap between insured and uninsured children, they have provided critical insight into what a successful universal coverage system could look like.

This report draws upon research and these experiences to provide a roadmap for how children's needs could be addressed within national health reform. It shows that with appropriate resources and good policy we can put the last pieces of the puzzle in place to ensure that all children can easily access and maintain high-quality, affordable health coverage.

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