Children in Health Care Reform: Where Things Stand in the Senate and House Bills

The country has made significant progress covering children: in 2008, the number of uninsured children in the United States hit the lowest level in two decades, primarily due to the success of Medicaid and CHIP.[1] Health reform has the potential to build upon this success by opening new doorways so that all children have quality and affordable health insurance and providing coverage options to their parents and the other adults, who are uninsured at higher rates, in their lives. As policymakers work to combine the approved Health and Senate bills, and ultimately put the implementation pieces in place if a final bill is approved, they will need to address a broad array of issues impacting children and families, including:

- How to establish a guarantee of coverage for families without employer coverage, whether through Medicaid, CHIP, and/or the new health insurance Exchanges.
- How to ensure children receive child-specific benefits that address their unique health care needs.
- How best to integrate children into broader health reform efforts so that they can reap the benefits obtained when everyone in a family has insurance, while also ensuring that they secure coverage comparable to what is now available through Medicaid and CHIP.
- How to ensure that children and their families transferring between the coverage pathways can easily enroll and have no interruption of coverage.
- How to establish premium and cost sharing protections so that low-income parents can pay for coverage for themselves and their children.

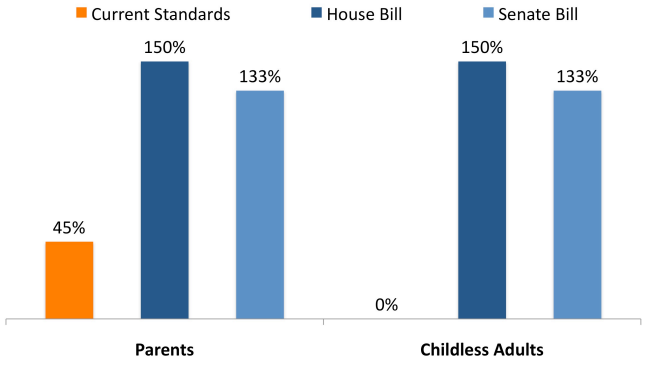
To help guide stakeholders through this process, this fact sheet provides basic information on the coverage pathways for children and their families in the current health reform bills (the House bill approved on November 7, 2009 and the Senate bill approved December 24, 2009).

Children and Families in the Leading Health Reform Plans

The health reform plans in Congress build upon the current health coverage structure in the United States. In addition to a number of insurance market and health delivery system reforms, the bills:

- Maintain employer-based coverage as the primary source of insurance for families.
- Expand Medicaid coverage to provide those at the lowest income levels with affordable benefits.
- Create a new avenue for coverage for the uninsured by establishing a new marketplace (referred to as Exchanges) where families can shop and buy health insurance and receive subsidies.

Figure 1. National Minimum Medicaid Eligibility Levels for Parents and Childless Adults, Current and Proposed



Note: The current income level for parents represents the median maximum AFDC payment level as of June 16, 1996. States may cover parents and childless adults above levels shown, and under both bills would be required to maintain any of these expansions. The House bill assumes current income methodology rules while the Senate bill uses a gross income standard.

[1] C. DeNavas-Wait, B. Proctor, & J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," US Census Bureau (September 2009).

Medicaid for Children and Families

Medicaid provides 32 million low-income children with health insurance, either through Medicaid financing or funds allocated through the CHIP program.[2] Medicaid coverage includes a child-specific benefit package (EPSDT) that addresses children's unique developmental and health care needs. In general, families cannot be charged premiums or cost sharing with a few limited exceptions. Under both bills, states are required to maintain and continue their existing Medicaid coverage of children.

In addition, the bills move a number of low-income children receiving coverage through separate CHIP programs into Medicaid. (In the House, CHIP children below 150 percent of the federal poverty level (FPL) will move to Medicaid and in the Senate those below 133 percent of the FPL will do so.) The bills also expand Medicaid for adults, who are often only eligible today at the lowest income levels, if at all. (See Figure 1 on page 1 for federal minimum eligibility levels for adults.)

	Senate	House
New National Medicaid Threshold	133% FPL for children and adults. Gross income test applied (but can not be less than current effective income level).	150% FPL for children and adults. Net income test applied to children and parents (childless adults to be determined).
Existing Medicaid Coverage for Children above Threshold	Continued through fiscal year 2019 (includes CHIP-financed Medicaid expansions).	Continued indefinitely (includes CHIP-financed Medicaid expansions).
Existing Medicaid Coverage for Adults above Threshold	Continued until December 31, 2013. After this date, states can eliminate coverage.	Continued indefinitely.
Medicaid for Legal Immigrants	5-year waiting period for legal immigrants maintained (with state option to eliminate for children and pregnant women).	5-year waiting period for legal immigrants maintained (with state option to eliminate for children and pregnant women).
Simplifying Medicaid Enrollment	No wrong door, uniform application, and no assets test.	Coordination with Exchange and no assets test.

CHIP Coverage for Children

CHIP was established in 1997 to provide funding to states to expand coverage to children and was renewed in February 2009 through the Children's Health Insurance Program Reauthorization Act. States utilize CHIP funding to expand Medicaid and/or create a separate CHIP program. Today, nearly all states provide coverage to children up to 200 percent of the FPL through a combination of Medicaid and CHIP, with 16 states covering children at or above 300 percent of the FPL.[3] In 2009, CHIP served 9.9 million children and is expected to rise to 14.1 million children in 2013 when the major elements of health reform go into effect.[4]

Policymakers continue to debate the future of CHIP within the context of health care reform. Currently, the House is planning to repeal CHIP and move the children that it serves into Medicaid,

[2] CMS, "FY 2008 Number of Children Ever Enrolled Year - SCHIP by Program Type" (January 20, 2009); and CMS, "Medicaid Children, Title XIX SEDS Report" (April 6, 2009).
[3] 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.
[4] In fiscal year 2013, 14.1 million children would be covered over the course of the year (9 million on any given day). Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Children's Health Insurance Program (CHIP)" (March 2009).

Exchange plans or employer-based coverage. In contrast, the Senate continues CHIP through 2019 (although funding for the program beyond 2015 has not been allocated).

	Senate	House
Status of CHIP	CHIP continued through fiscal year 2019. Program extended two years (until September 30, 2015), after which it must be reauthorized and funded.	CHIP terminated as of December 31, 2013.
Coverage through Separate CHIP Programs	Continued through fiscal year 2019 (but with no funding after 2015).	Children below 150% FPL moved to Medicaid; those above moved into Exchange plans or employer-based insurance.
Coverage through CHIP-financed Medicaid	Continued through fiscal year 2019 (but with no funding after 2015).	Continued indefinitely; financed through Medicaid rather than CHIP.
Funding	Two years of additional funding provided for CHIP after it renewal date (September 30, 2013).	No additional funding for CHIP can be appropriated after September 30, 2013.
Simplifying CHIP Enrollment	No direct changes to CHIP procedures.	Until CHIP repealed, 12-month continuous coverage for children in separate CHIP plans and restrictions on waiting lists.
Transition	After 2015 (or before if federal funding not available), children can be enrolled in CHIP-comparable coverage in the Exchange. Secretary of HHS must certify which Exchange plans provide comparable benefits and cost sharing.	CHIP children remain in CHIP until December 31, 2013; transferred to alternative coverage on January 1, 2014. Secretary of HHS must submit report to Congress by December 2011 recommending how to ensure Exchange coverage comparable and transition process in place.

Exchange Plans and Subsidies

Under both the Senate and House bills, families without other coverage options could purchase health insurance through an Exchange. Both bills provide financial assistance, in the form of premium subsidies, to low- and moderate-income individuals and families with income up to 400 percent of the FPL. In 2016 (three years after the Exchanges are operational), the maximum annual premium a family of three at 200% of the FPL is projected to pay is $2,609 in the House bill and $2,875 in the Senate bill.[5] The bills also reduce what a family would have to pay out of pocket for copayments and deductibles through annual caps and subsidies.

States have had many years of experience in setting premium and cost sharing levels in their Medicaid and CHIP programs. Under federal law, cost sharing in Medicaid and CHIP (premiums, deductibles, and copayments) must be no more than five percent of family income.[6] Even at more

[5] CCF calculations based on Congressional Budget Office, "Analysis of Exchange Subsidies and Enrollee Payments in 2016: Under HR 3962, Affordable Health Care for America Act" (November 2, 2009); and Congressional Budget Office, "Analysis of Exchange Subsidies and Enrollee Payments in 2016 Under the Patient Protection and Affordable Care Act" (November 20, 2009).

[6] States also cannot impose cost sharing on children below 150 percent of the FPL, except in a narrow range of circumstances. See http://ccf.georgetown.edu/index/legislative-authority-costsharing.

moderate-income levels, states have generally charged premiums well below this level and those proposed in the Exchange.[7] However, since CHIP is designed to cover only children and the Exchange will provide coverage to all members of a family, it is difficult to directly compare coverage costs. Moreover, while most CHIP children are in families with parents who already have insurance, a sizable minority (38 percent) is not.[8] In these families, in particular, the positive impact on the family's financial stability and well-being created by the opportunity to secure coverage for all family members would need to be taken into account.[9]

	Senate	House
Coverage[10]	Minimum coverage standards; 70% actuarial value for plan available to families obtaining subsidies.	Minimum coverage standards; 70% actuarial value for plan available to families obtaining subsidies.
Maximum Family Premium Contributions (as percent of income)	4% at 134% FPL, up to 12% at 300 to 400% FPL.	3% at 151% FPL, up to 12% at 400% FPL.
Maximum Annual Premium for Family of 3 at 200% FPL (in 2016)[11]	$2,875 (6.5% of income)	$2,609 (5.9% of income)
Cost Sharing	None for preventive services. Those with income up to 200% FPL receive reduction (resulting in an increased actuarial value).	None for preventive services. Those receiving premium subsidies receive reduction (resulting in an increased actuarial value).
Actuarial Value of Coverage for Family at 200% FPL	80% (Expenses paid by a health plan for a standard population).	85% (Expenses paid by a health plan for a standard population).
Family Out of Pocket Limits (excludes premiums)	$13,540 (reduced for families below 400% FPL ranging from $4,600 to $9,050, depending on income).[12]	$10,000 (reduced for families below 350% FPL ranging from $1,000 to $9,000, depending on income).

CCF is an independent, nonpartisan research and policy center based at Georgetown University's Health Policy Institute whose mission is to expand and improve health coverage for America's children and families. Contact CCF at (202) 687-0880 or childhealth@georgetown.edu. Visit us at ccf.georgetown.edu and theccfblog.org.

[7] Watson Wyatt Worldwide, "Children Currently Enrolled in CHIP Will Face Higher Costs if Moved into Exchange," First Focus (October 1, 2009).
[8] G. Kenney & A. Cook, "Coverage Patterns Among SCHIP-Children and Their Parents," Urban Institute (February 2007).
[9] S. Rosenbaum & R. Whittington, "Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature," First Focus (June 2007).
[10] The actuarial value is a measurement of the percentage of medical expenses paid by a health plan for a standard population.
[11] *op. cit.* (5).
[12] The out of pocket level would be tied to the yearly limit set for the Health Savings Account. The numbers provided are for 2013. Center for Children and Families calculation based on current HSA out-of-pocket limits and Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditure Projections, 2008-2018" (February 2009).