Weathering The Storm

States Move Forward on Child and Family Health Coverage Despite Tough Economic Climate September 2009

CCF
GEORGETOWN UNIVERSITY
CENTER FOR CHILDREN
AND FAMILIES

Executive Summary

With the vast majority of states having concluded their legislative sessions, this report provides a first look at state activity after the passage of CHIPRA and the availability of increased Medicaid funding in the economic stimulus package. In addition, it reviews the implications of this state activity for national health reform. It finds that between January and September 2009:

- All but a few states held steady on children's health coverage, despite unprecedented state fiscal challenges. Except for California*, Arizona, and Wyoming, no state limited eligibility or implemented other changes that would cut children and families from Medicaid and CHIP.
- Twenty-three states implemented changes or enacted legislation to increase the number of children and families receiving health coverage through Medicaid and CHIP.
  - Eighteen states increased, or passed legislation to increase, their Medicaid and CHIP income eligibility levels so that more families can afford health coverage.
  - Eleven states (including six of those that also expanded eligibility) are working to cut red tape in Medicaid and CHIP to make it easier for uninsured children already eligible for the programs to enroll in and keep coverage.
- This positive activity on behalf of children builds on progress achieved over the past several years in Medicaid and CHIP. Today, all but three states provide or have adopted plans to provide coverage to children with family income at or above 200 percent of the federal poverty level (FPL) — with the majority (31 states) having decided to cover children at or above 250 percent of the FPL.

Coverage of children and their families is at a critical juncture. Even as states continue to cope with serious fiscal problems, the debate over broader health reform is expected to continue. The changes now under consideration could fundamentally alter the coverage landscape for children. While they hold the promise of providing help to millions of children and their families, if health reform fails to build on the key ingredients of successful Medicaid and CHIP programs, some of the gains made over the past several years and through CHIPRA may be at risk.

* Note: California implemented a waiting list for its CHIP program in July 2009 but the Legislature has subsequently identified funding to re-open the program.

Introduction

On February 9, 2009, just three weeks into his term as the 44th President of the United States, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

The law strengthened and renewed the Children's Health Insurance Program (CHIP) through September 30, 2013, provided states with funding to further expand eligibility for their programs, and created new fiscal incentives and tools for states to cover more children already eligible for CHIP and its larger companion program, Medicaid.[1] With enactment of the legislation, the federal government reaffirmed its commitment to covering children and bolstered state-based momentum to improve Medicaid and CHIP.

Even as CHIPRA was being signed, it was clear that the country was facing a deep economic crisis that could undermine the potential promise of the new law. For many years, governors and state legislatures have been working to get the nation's uninsured children covered and calling on Congress and the President to help achieve that goal. Much of this state-based activity, however, occurred before the full force of the recession had hit state coffers.[2] While CHIPRA puts significant new federal money on the table for states to cover more children, it also requires them to contribute some of their own funds to the effort. In light of unprecedented state budget deficits,[3] there was a very real threat that states would simply opt to pass on the new opportunities in CHIPRA, especially with the prospect of broader national health reform on the horizon.

In this report, the Center for Children and Families (CCF) takes a first look at how states have responded to passage of CHIPRA in the midst of this shifting landscape. With the vast majority of states having concluded their legislative sessions, it provides a review of state activity to improve child and family health coverage from January 1, 2009 through September 1, 2009. To a remarkable extent, given the recession, states have continued to respond to the strong political support for children's health coverage[4] and taken advantage of the passage of CHIPRA (as well

"In a decent society, there are certain obligations that are not subject to tradeoffs or negotiation – health care for our children is one of those obligations."

President Obama, in signing CHIPRA, February 4, 2009

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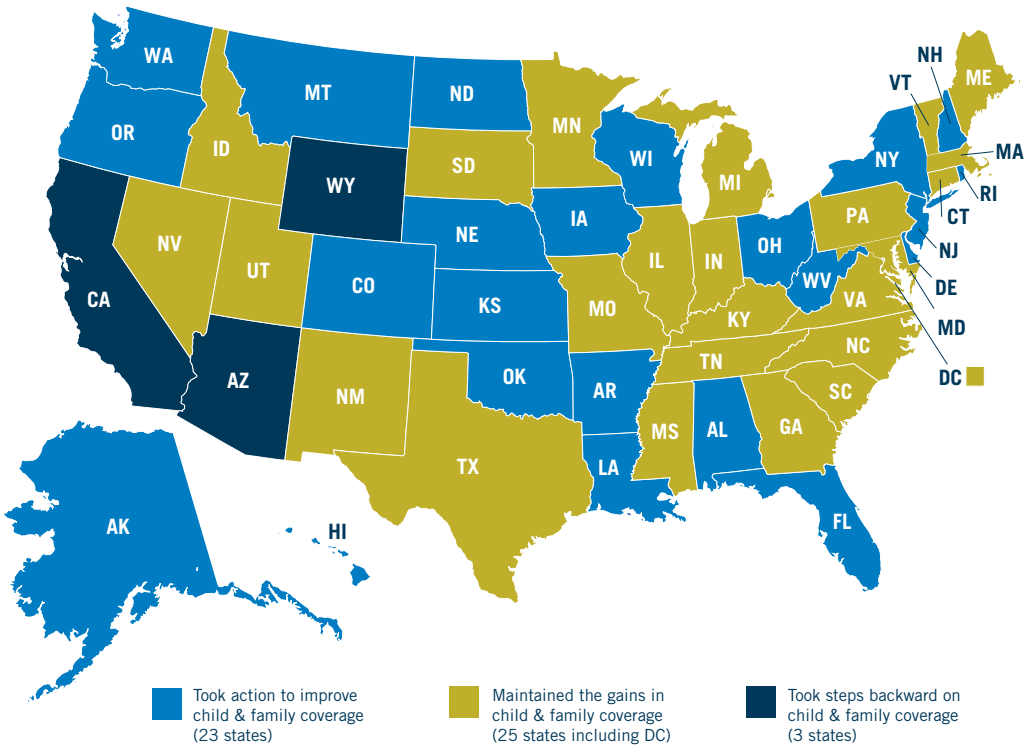
as a temporary increase in the Medicaid federal matching rate for states maintaining coverage provided under the economic stimulus package) to sustain and strengthen their efforts to cover more of the nation's children. Since the beginning of the year:

- **Nearly all states are "weathering the storm" when it comes to children's coverage.** With only a few exceptions, states avoided cutting children from Medicaid or CHIP, even as the weakening economy forced many to scale back other investments in vital social services. (See Figure 1.)

- **Close to half of all states are affirmatively moving forward in covering more children.** Despite major fiscal challenges, a significant number of states: 1) expanded eligibility for their Medicaid or CHIP programs, and/or 2) made it easier for uninsured children already eligible for Medicaid or CHIP to enroll in, and stay enrolled in, the programs.

Even as these early CHIPRA implementation results come in, the landscape on children's coverage is expected to shift again in the months ahead as states continue to cope with fiscal distress and broader health reform is debated. As part of national health reform, Congress is considering sweeping changes to child and family coverage, including the possibility of replacing CHIP with alternative coverage for children. The stakes for children in this debate are high. They and their families have much to gain from broader reform, but if it does not incorporate the key ingredients of successful CHIP and Medicaid programs—including strong affordability standards, a benefit package designed to address children's unique health care needs, and simple, family-friendly ways to enroll in coverage—the gains made by states in recent years and through CHIPRA may unintentionally be eroded.

Figure 1 | Nearly all States Maintained Gains or Improved Coverage for Children and Families in 2009



The Serrano family

Colorado Family Ready For Chip Expansion

The following e-mail is from Tobias Serrano, a father of three from Thorton, Colorado (pictured). His family is unable to find private coverage for their daughter, Maria (aged 14) as she has a pre-existing condition, and they very likely could not afford it even if it were available. Tobias is an auto technician and earns too much for Maria to qualify for Child Health Plan Plus (CHP+), Colorado's CHIP program. Maria could become one of the thousands of uninsured children in Colorado who will become eligible for CHP+ when Colorado's expansion of CHIP up to 250 percent of the FPL goes into effect. The legislation for the expansion was signed by Governor Ritter on April 21, 2009 and is awaiting implementation.

"Hi, my name is Tobias Serrano. I'm married and have three children. Two are older and have moved out. My youngest daughter Maria is 14. When she was 3, she was diagnosed with an AVM (arteriovenous malformation) in her brain. She went through 23 procedures to correct the problem. Maria is in good health, but I can't get anyone to insure her because of a pre-existing condition. When we didn't have much she was covered under Medicaid. But I make too much for Medicaid or CHP+. Yet, I cannot insure Maria. It gets very expensive for check ups, and even more expensive if she gets sick. I'm willing to pay for insurance if only I could!!!"

* Story provided by Metro Organizations for People in Denver.

Kids in Iowa

"One of my top priorities as Governor is to see that every Iowa child has access to the health care they not only need, but deserve....Our work is not done, and I look forward to working with the legislature and all Iowans as we continue our work to give our children a bright, healthy future."

Governor Chet Culver (D-IA), May 19, 2009

"[Iowa's efforts to provide health coverage to all children] is a solid example of when Government works well: when legislators, the Governor, and state agencies work together to accomplish what is best for children, families, and all Iowans."

Carrie Fitzgerald, Iowa Child and Family Policy Center, May 19, 2009

Covering All Kids in Iowa

Iowa has undertaken an impressive multi-year, bi-partisan effort to provide health coverage to all of its children. Due to the efforts of the Legislature, Governor, state officials, and advocates, this goal became within reach in 2008 with the passage of legislation to expand Iowa's CHIP program from 200 percent to 300 percent of the FPL. The strong leadership at work to provide coverage to children was most evident when the State committed to using state funds for the expansion, if federal support was not forthcoming (at the time, the passage and timing of a CHIP reauthorization bill was uncertain).

Iowa's efforts did not stop there either. Beyond an expansion of eligibility levels, stakeholders were dedicated to finding and implementing family-friendly enrollment and renewal procedures to ensure that eligible children actually received the care that they need. The State implemented changes to its Medicaid and CHIP program for children, including providing 12-month continuous eligibility, presumptive eligibility, simplified income verification, and paperless renewals. On the administrative side, the State sought ways to meet the unique needs of Iowans. For example, with a strong agricultural base, self-employed farmers represent a large group of potentially eligible families. To address the income fluctuations farmers can experience year-to-year, the State now bases income eligibility on a three-year average for these families.

Once the CHIPRA law was passed in February 2009, Iowa was also one of the first states to take advantage of new options available to them. They extended Medicaid/CHIP coverage to all lawfully residing immigrant children up to 300 percent of the FPL and implemented a CHIP dental-only option for children who have private medical, but not dental, coverage.

On July 1, 2009, Iowa's efforts culminated when the expansion to children up to 300 percent of the FPL took effect. A leader among states, Iowa is on the way to reaching its goal of covering all children.

Sources: H.F. 2539, 82nd General Assembly (Iowa, 2008); Child and Family Policy Center, "Iowa's Health Care Bill and Children's Health Coverage" (June 2008); S.F. 389, 83rd General Assembly (Iowa, 2009); and communication with Carrie Fitzgerald, Child and Family Policy Center (August 11, 2009).

A First Look at Children's Coverage After CHIPRA

Despite facing unprecedented fiscal challenges, in 2009 states maintained and, in a surprising number of cases, expanded their health programs for children and families. These efforts occurred across the country, among a diverse group of states, in both urban and rural areas, and with leadership on both sides of the political aisle. While this positive activity follows a much longer trend of support for children's coverage by legislators and governors alike,[5] new federal incentives and resources helped states to bolster their Medicaid and CHIP programs.

The approval of CHIPRA in February 2009, markedly increased federal funding for state CHIP programs and provided states with new incentives and tools for enrolling eligible but uninsured children in Medicaid and CHIP. For example, CHIPRA allows states to implement Express Lane Eligibility (a strategy for reaching eligible but uninsured children already enrolled in other public programs) and to receive federal funds for providing Medicaid and CHIP coverage to lawfully residing immigrant children and pregnant women without the imposition of a five-year waiting period.[6] CHIPRA also provides states with bonuses for increased Medicaid enrollment of children to encourage the implementation of streamlined enrollment and renewal procedures.[7]

In addition, the economic stimulus bill, the American Recovery and Reinvestment Act (ARRA), signed by President Obama on February 17, 2009, provided fiscal relief to states maintaining Medicaid eligibility, as well as enrollment and renewal procedures. The legislation allocated $86.6 billion through the end of 2010, and already has helped states to maintain their Medicaid programs in the face of budget deficits and increased demand for services.[8]

Based on a review of state activity through September 1, 2009, all but a few states held steady on children's health coverage and 23 states implemented changes or enacted legislation to increase the number of children and families receiving health coverage through Medicaid and CHIP. (See Table 1 on page 8 and Table 2 on page 9.)

This first look at state implementation of CHIPRA finds that the primary strategies that states used to increase children's coverage include expanding eligibility and reducing red-tape barriers enrollment for already-eligible children.

Despite facing unprecedented fiscal challenges, in 2009 states maintained and, in a surprising number of cases, expanded their health programs for children and families.

"One way we can assist working families is by helping them deal with the escalating cost of healthcare....[This plan will] provide thousands more children with timely, quality healthcare, and just as importantly, give thousands more parents the peace of mind that comes with knowing their children are protected."

Governor John Hoeven (R-ND), State of the State Address, January 6, 2009

1. Increasing Medicaid and CHIP Eligibility

In this time of economic uncertainty more and more families are finding it difficult to secure affordable health insurance. Those who have lost a job are facing the hard decision of how to pay for health coverage given the other bills piling up, and those with an offer of employer coverage are increasingly facing rising health care costs and steeper, unsustainable premiums.[9] A number of states have moved forward to meet the needs of uninsured children in these families by expanding Medicaid and CHIP income eligibility levels.

Between January and September 2009, 18 states expanded, or enacted legislation to expand, income eligibility for their Medicaid and CHIP programs. Of these states, four (Colorado, Iowa, Oregon, and Rhode Island) also expanded coverage to lawfully residing immigrant children, adding to the 17 states already covering this population with state funds.[10]

In light of these recent improvements, 31 states now provide, or plan to provide, coverage to children with family income at or above 250 percent of the federal poverty level (FPL). Every state, except for Alaska, Idaho, and North Dakota, has now opted to cover children at or above 200 percent of the FPL. (See Table 3 on page 12.)

Due in part to the increased awareness of the newly available coverage opportunities, these eligibility expansions are also expected to result in a "welcome mat" effect, in which participation rates are also boosted among already-eligible children.[11] In Arkansas, for example, the Governor signed legislation in March 2009 that increased CHIP eligibility from 200 percent to 250 percent of the FPL. The State estimates that this expansion will result in about 20,000 uninsured children receiving coverage, including several thousand who are already eligible for coverage and are expected to now apply because of the larger expansion.[12]

2. Finding, Enrolling, and Keeping Eligible Children Covered

Over the past several years, many states have made significant strides in modernizing their enrollment and renewal procedures for Medicaid and CHIP.[13] By cutting the red tape families face when signing their children up for coverage, states have demonstrated how to increase the number of eligible children enrolling and staying enrolled in Medicaid and CHIP, at the same time saving on administrative costs associated with processing duplicative and many times unnecessary paperwork.[14]

This progress continued in 2009, with 11 states (including six of the states that also expanded eligibility) deciding to improve enrollment and renewal procedures. States undertook a number of different strategies, including simplifying the Medicaid/CHIP application form, extending the length of time before families must renew their child's coverage, and using automated renewal procedures.

For example, Colorado enacted legislation to provide children in Medicaid with a full year of coverage, regardless of slight monthly fluctuations in family income.[15] Oregon approved simplifications to its application and renewal procedures, including the elimination of the asset test for CHIP.[16] Louisiana moved forward on plans to implement Express Lane

Eligibility by automating the Medicaid renewal process for children who have an active Food Stamp case.[17]

At the same time that this forward movement occurred, a handful of states took steps backward on child and family coverage**.** For example, California, hit particularly hard by the economic and housing crises, implemented a waiting list in its CHIP program on July 17, 2009, potentially resulting in a loss of 29,000 new enrollees monthly.[18]

California has subsequently identified alternative funding sources for eliminating the waiting list and restoring other budget cuts which could have resulted in the disenrollment of hundreds of thousands of CHIP children.[19] Also, Arizona has approved the elimination of coverage for parents in families with income between 100 percent and 200 percent of the FPL.[20] Slated to go into effect in October 2009, this change is expected to cause 9,000 parents to lose their coverage.

Table 1 | States Moving Forward on Child and Family Health Coverage in 2009

STATE	ELIGIBILITY EXPANSION	SIMPLIFICATION MEASURES
Alabama	X	
Alaska		X
Arkansas	X	
Colorado	X	X
Delaware	X	
Florida		X
Hawaii	X	
Iowa	X	X
Kansas	X	
Louisiana		X
Montana	X	
Nebraska	X	
New Hampshire	X	
New Jersey		X
New York	X	X
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	X
Rhode Island	X	X
Washington	X	X
West Virginia	X	
Wisconsin		X
TOTAL = 23	**18**	**11**

Source: Center for Children and Families. Note that the two columns do not add up to the total number of states since some states have enacted both eligibility expansions and simplification measures.

Table 2 | State Activity on Child and Family Health Coverage, January 1, 2009 to September 1, 2009

STATES MOVING FORWARD

Alabama	Eligibility in the State's CHIP program will increase from 200 percent to 300 percent of the FPL as of October 1, 2009. The expansion, part of the State budget adopted over the Governor's veto, is expected to cover an additional 14,000 children.[22]
Alaska	Designed to keep eligible children and others enrolled in care, the State made a regulatory change to its Medicaid program; as of April 1, 2009, enrollees will renew their coverage every 12 months as opposed to every six. In addition, effective October 1, 2009, children will no longer be required to be uninsured for a year before they can qualify for CHIP coverage.[23]
Arkansas	An expansion of the State's CHIP program, from 200 percent to 250 percent of the FPL, was signed by the Governor on March 18, 2009. The expansion will be funded by a tobacco tax and is expected to bring coverage to about 20,000 uninsured children, including several thousand that are already eligible for coverage and learn about their eligibility as a result of the expansion. Implementation was scheduled to begin on July 1, 2009; however, the State is awaiting CMS approval of its plans.[24]
Colorado	The Governor signed legislation on April 21, 2009 that expands CHIP coverage for children from 205 percent to 250 percent of the FPL and Medicaid coverage for pregnant women from 200 percent to 250 percent of the FPL, parents from 60 percent to 100 percent of the FPL, and childless adults up to 100 percent of the FPL. It also provides 12-month continuous eligibility for children in Medicaid, ensuring that children remain covered despite fluctuations in their income or family circumstances. Funded through a provider fee, the expansion is estimated to provide coverage for 100,000 uninsured persons. The State will implement the changes following CMS approval and once the provider fee is in place.[25] Legislation for telephone and online renewals and eliminating the five-year waiting period for lawfully residing immigrant children in Medicaid and CHIP also passed, although without funding.[26]
Delaware	The State established a full-cost buy-in program in its CHIP program for children above 200 percent of the FPL. The program will require children over the age of two to be uninsured for three months prior to enrollment, with good cause exceptions. Cost sharing levels, including premiums, co-payments, and deductibles, will be determined by the State, although the State estimates it will be $170, plus administrative costs, per month per child. Signed by the Governor on August 27, 2009, the buy-in program will begin January 1, 2010.[27]
Florida	Legislation, signed June 2, 2009, includes a number of measures that are intended to streamline Florida's Medicaid/CHIP enrollment process to make it easier for eligible children to obtain coverage. The changes include: allowing for electronic verification of income; reducing the amount of time an applicant must be uninsured prior to enrollment from six months to 60 days; providing good cause exceptions to the 60-day waiting period; and reducing the disenrollment penalty for non-payment of premiums from 60 days to 30 days. These changes went into effect on July 1, 2009.[28]
Hawaii	The Legislature approved a measure that will provide $200,000 per year for the next two years in state funding to Keiki Care, a limited-benefit coverage program for children who are not otherwise eligible for Medicaid. The bill requires that they receive care through federally qualified health centers. The Legislature overrode the Governor's veto in extending the funding.[29]
Iowa	The State implemented its CHIP expansion for children with family income from 200 percent to 300 percent of the FPL on July 1, 2009. In addition, in 2009, the State passed a bill designed to increase Medicaid and CHIP enrollment for children, which included provisions for presumptive eligibility, simplified income verification, paperless renewals, and an individual coverage mandate (although it does not include an enforcement mechanism). The bill also extends Medicaid and CHIP coverage to all lawfully residing immigrant children with family income up to 300 percent of the FPL and implements a CHIP dental-only option for children who have private medical, but not dental, coverage. Coverage for lawfully residing immigrant children went into effect on July 1, 2009; implementation dates for the other provisions have not yet been determined.[30]

STATES MOVING FORWARD

Kansas	The Governor signed the State budget on April 21, 2009, that includes funding for a CHIP expansion from 200 percent to 250 percent of the FPL, which passed the Legislature in 2008. The State estimates that an additional 9,000 children will gain coverage. Implementation will begin January 2010.[31]
Louisiana	The State has adopted plans to implement Express Lane Eligibility (ELE) by automating the Medicaid renewal process for children who have an active Food Stamp case. The State is waiting for federal guidance before it deploys the ELE procedure for new Medicaid applicants.[32]
Montana	The State budget provides funding for full implementation of the voter-approved Healthy Montana Kids Plan. The initiative will move children ages six to 19 with family income from 101 percent to 133 percent of the FPL from CHIP to Medicaid, allowing all children in the same family to be covered by the same program. The State will also expand CHIP eligibility for children from 175 percent to 250 percent of the FPL. The Governor signed the bill into law on May 14, 2009 and implementation will begin October 1, 2009.[33]
Nebraska	The Governor signed legislation on May 22, 2009 that increased eligibility in Medicaid from 185 percent to 200 percent of the FPL, as of September 1, 2009. The expansion is part of a larger bill that will also create a statewide hotline for families with children with behavioral health issues and provide additional funding for services and resources for these families.[34]
New Hampshire	On July 16, 2009, the Governor signed a bill that will allow the State to expand coverage through a full-cost buy-in to young adults ages 19 to 26 who cannot be included in their family's health insurance plan and whose incomes are at or below 400 percent of the FPL. Details on the plan and when it will be implemented have yet to be determined.[35]
New Jersey	As part of efforts to reach more eligible uninsured children, the State began sending out a one-page "Express Lane" application for Medicaid and CHIP to families that indicated on their state tax return that they have uninsured children at home. This outreach effort, which began in May 2009, is part of a coverage mandate passed in 2008 that requires all children to have coverage (although there is no enforcement mechanism). In addition, as part of the fiscal year 2010 State budget, Medicaid and CHIP premiums for children in families earning between 150 percent and 200 percent of the FPL were eliminated.[36]
New York	The State budget included a Medicaid expansion for parents from 150 percent to 200 percent of the FPL and for childless adults from 100 percent to 200 percent of the FPL. The expansion will begin April 1, 2010. The budget also included a number of simplification measures, including the elimination of the face-to-face interview requirement in Medicaid for children and parents and the elimination of finger printing and the asset test for parents.[37]
North Dakota	As part of the State budget, North Dakota passed a CHIP expansion from 150 percent to 160 percent of the FPL and dedicated additional funding for outreach to eligible but uninsured children. The expansion went into effect on July 1, 2009.[38]
Ohio	The State planned on implementing an expansion of Medicaid for children from 200 percent to 300 percent of the FPL on July 1, 2009. The State's fiscal year 2010-2011 budget called for funding the expansion, and other non-health related measures, with a portion of the State's tobacco settlement dollars; however, whether the State can use this funding source is unclear and the expansion remains on hold.[39]
Oklahoma	The State is awaiting CMS approval for an expansion of Insure Oklahoma, the State's Medicaid premium assistance program, to children with family income up to 300 percent of the FPL. The expansion has a planned implementation date of January 1, 2010.[40]
Oregon	On January 1, 2009 the State implemented 12-month continuous eligibility for certain low-income children enrolled in Medicaid. In addition, Oregon passed legislation signed by the Governor on August 4, 2009. The legislation will expand CHIP from 185 percent to 200 percent of the FPL, including coverage to all lawfully residing immigrant children, as of October 1, 2009. The legislation also provides 12-month continuous eligibility for Medicaid children under the age of 19, eliminates the asset test for CHIP, simplifies the application and renewal process, and provides funding to cover more adults. In addition, as of January 1, 2010, the State will provide subsidized coverage through private health exchanges for children with family income between 200 percent and 300 percent of the FPL and offer a full-cost buy-in for children with family income above 300 percent of the FPL.[41]

STATES MOVING FORWARD

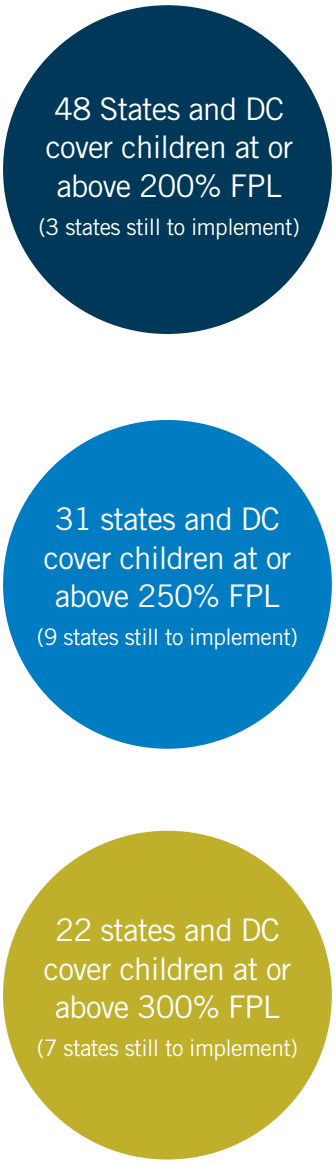
Rhode Island	The State's fiscal year 2010 budget reinstates coverage for lawfully residing immigrant children. Medicaid premiums, which were increased in Fall 2008, were restored to July 1, 2008 levels and the new monthly premium charged to families between 133 percent and 150 percent of the FPL was eliminated entirely.[42]
Washington	The State implemented its expansion from 250 percent to 300 percent of the FPL in CHIP on February 23, 2009, with retroactive coverage for those who applied after November 24, 2008.[43] Washington also passed legislation that includes ELE, administrative renewal, and program retention improvements. In addition, the State approved the development of a full-cost buy-in for children with family income above 300 percent of the FPL, but has not announced an implementation date.[44]
West Virginia	Continuing to implement a planned, phased-in CHIP expansion to 300 percent of the FPL adopted in March 2006, the State expanded eligibility for children with family income from 220 percent to 250 percent of the FPL on January 1, 2009.[45]
Wisconsin	Effective April 1, 2009, the State made changes to its presumptive eligibility system to encourage the timely enrollment of Medicaid-eligible children. The State expanded presumptive eligibility to newborns with family income at or below 250 percent of the FPL, to children ages one to five with family income at or below 185 percent of the FPL, and to children ages six to 18 with family income at or below 150 percent of the FPL. On January 1, 2009, Wisconsin extended 12-month continuous eligibility to infants eligible for Medicaid born to non-citizen women.[46]

STATES POTENTIALLY MOVING BACKWARD

Arizona	The Legislature passed a budget that eliminated CHIP coverage, effective October 1, 2009, for 9,000 parents with income between 100 percent and 200 percent of the FPL. Eligibility for parents through Medicaid up to 100 percent of the FPL will remain in place. It is unclear whether any further changes will be made to CHIP as a special session of the Legislature works to pass a budget for the remainder of the fiscal year.[47]
California	As part of budget legislation passed in July 2009, California cut $194 million from the CHIP program, which resulted in the State ceasing new enrollment in CHIP on July 17, 2009.[48] Due to the shortfall, the State also considered terminating almost 670,000 currently enrolled children beginning October 2009. The State has subsequently identified other funding sources, including monthly CHIP premium increases for families with income above 150 percent of the FPL, to prevent the disenrollments and eliminate the waiting list.[49] In addition, in March 2009, California temporarily reinstated an annual renewal period and 12-month continuous eligibility for children in Medicaid until January 1, 2011. To reduce coverage costs, the State originally proposed mid-year reporting requirements for these children.[50]
Wyoming	The Governor, under authority from the Legislature, instituted a cap of 5,900 enrollees in the State's CHIP program; 5,500 are currently enrolled. The cap is part of a nearly $43 million reduction in funding for the Department of Health.[51]

Table 3 | Enacted Medicaid & CHIP Eligibility Levels for Children, by State as of September 1, 2009

STATE	ELIGIBILITY LEVELS
Alabama	300%*
Alaska	175%
Arizona	200%
Arkansas	250%*
California	250%
Colorado	250%*
Connecticut	300%
Delaware	200%
District of Columbia	300%
Florida	200%
Georgia	235%
Hawaii	300%
Idaho	185%
Illinois	200% (300%)
Indiana	300%*
Iowa	300%
Kansas	250%*
Kentucky	200%
Louisiana	300%*
Maine	200%
Maryland	300%
Massachusetts	300% (400+%)
Michigan	200%
Minnesota	275%
Mississippi	200%
Missouri	300%
Montana	250%*
Nebraska	200%
Nevada	200%
New Hampshire	300%
New Jersey	350%
New Mexico	235%
New York	400%
North Carolina	250%*
North Dakota	160%
Ohio	300%*
Oklahoma	300%*
Oregon	300%*
Pennsylvania	300%
Rhode Island	250%
South Carolina	200%
South Dakota	200%
Tennessee	250%
Texas	200%
Utah	200%
Vermont	300%
Virginia	200%
Washington	300%
West Virginia	300%*
Wisconsin	250% (300%)
Wyoming	200%



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.

Notes: Eligibility levels reflect the highest income eligibility level in the state using federal Medicaid/CHIP funds, without regard to income disregards or deductions. Note that Illinois, Massachusetts, and Wisconsin provide state-financed coverage to children above Medicaid/CHIP levels; eligibility for state-funded coverage is shown in parentheses. States with asterisks (*) have enacted, but not yet implemented expansions to the levels shown.

Medicaid/CHIP Helps Arkansas Family Get Through Tough Times

The Simpson family

James and Rachel Simpson of Benton, Arkansas were already having a difficult time making ends meet when James was laid off from his job as an electrician. Fortunately, the couple's three children (ages 7, 8, and 18; pictured) did not lose access to health coverage as they were already covered through ARKids First, Arkansas' Medicaid/CHIP program.

Even when James had a job, the $400 in monthly premiums for employer-sponsored coverage was more than they could afford. "We would have had to decide to either pay the light bill or to eat groceries – or pay the light bill, eat groceries and not pay the rent," Rachel said.

ARKids First has provided the parents with the peace of mind that they will not face financial ruin if they seek medical treatment when one of their children is sick or injured. The children have been relatively healthy, but just like most children they need a little medical attention now and then. When their youngest child, Logan (now aged 7), was learning to walk, he fell and hit his head on a piece of furniture. His forehead began to swell up immediately. Instead of agonizing over whether or not to have him checked out, they were able to get him to the hospital to get the care he needed. When their oldest daughter, Randi (now aged 18), wanted to play volleyball in high school, they were reassured by the doctor that because they had managed her asthma well, she was healthy enough to participate in school sports. Without ARKids First, it would likely have been a different story.

While ARKids First provides an affordable coverage option for the children, and James has been able to temporarily continue his employer coverage under COBRA, the Simpson's have been unable to find an affordable health plan for Rachel.

"It's kind of scary but I'm the parent, so I really don't worry that much about myself," said Rachel. "Just so my family's taken care of."

* Story provided by Arkansas Advocates for Children and Families.

Implications for National Health Reform

Even as these early CHIPRA implementation results come in, Congress continues to debate broader national health reform. The recent progress that has been made, as well as the prospects for progress in the years ahead, will depend heavily on the outcome of this debate. Both the House and the Senate are considering bills with potentially sweeping implications for how children and their families secure coverage, including the possibility of eliminating CHIP as a primary source of coverage for millions of children and replacing it with alternative coverage through new "Exchange" plans for children and their families.[52]

Children and their families have much to gain from broader reform.[53] Health insurance is truly a family matter, as the well-being of children can be affected dramatically by the health and health coverage of their parents and the financial stability of their families.[54] By providing additional coverage options, health reform has the potential to provide this critical coverage to uninsured parents, as well as maintaining the momentum for children.[55] In addition, broader health reform is expected to strengthen federal financing of the coverage system, making it less likely that families would be left vulnerable to state cutbacks in coverage during economic downturns. At the same time, if health reform does not build upon the gains of recent years and assure that children losing their current coverage and moving into new arrangements secure comparable coverage (as is required in the House bill), there is a risk that some could inadvertently end up worse off.[56]

As this debate proceeds, the progress on children's coverage in recent years, including the passage of CHIPRA, has important implications for health reform.

1. Recent state progress highlights the importance of borrowing the key elements of successful Medicaid and CHIP programs for health reform. The recent improvements to coverage for children, in combination with the experience states, community-based organizations, and researchers have gained over the past decade, points to the importance of health reform incorporating some of the key elements of successful Medicaid and CHIP programs, including:

- **Strong affordability protections.** Thirty-one states have enacted coverage expansions to uninsured children in families with income at or above 250 percent of the FPL and several states have enacted eligibility levels up to 300 percent of the FPL. Under federal Medicaid and CHIP law, the cost to a family of providing their children with care, including premiums and cost-sharing charges, must be limited to five percent of the family's income.[57] In practice, however, most states offer significantly stronger cost-sharing protections to families.[58] If federal reform is to build on the successful ingredients of Medicaid and CHIP, strong, sliding-scale subsidies will be required to ensure that coverage is affordable for the entire family.

- **A benefit package designed for children.** Under Medicaid, states must provide children with a child-specific benefit package (known as "EPSDT") tailored to their unique developmental needs that covers all medically necessary services. Twenty-two states use the Medicaid benefit package, including EPSDT, in their CHIP programs.[59] Among the remaining states, the vast majority provides services such as hearing aides, eyeglasses, and speech, physical, and occupational therapy that may not be found in typical commercial packages.[60] Through CHIPRA, the federal government further strengthened the standards for CHIP benefit requirements by adding dental coverage and parity for mental health benefits.[61] In the context of broader health reform, it will be important to ensure that children secure comparable benefits whether they remain in public coverage or receive their coverage through the Exchange, and that other family members secure high-quality, comprehensive benefits.

- **Family-friendly enrollment procedures.** As can be seen by the simplification measures adopted in 11 states this year, CHIPRA provided states with new tools and fiscal incentives to simplify the enrollment and renewal procedures for children in Medicaid and CHIP. Even before CHIPRA was adopted, many states had made marked gains in simplifying their programs to reach eligible but uninsured children—between 2001 and 2005, the participation rate in Medicaid and CHIP jumped from 66 percent to 78 percent.[62] In health reform, it will be critical to sustain and build upon these gains by borrowing the well-known and tested strategies that have been developed by states over the years and that were emphasized in CHIPRA. These include the use of automatic enrollment whenever possible, electronic data to verify and continue coverage, 12-months continuous enrollment, Express Lane Eligibility, and coordinated application and renewal forms and procedures.

2. To protect the recent coverage gains, children and their families will need to secure comparable coverage if they are moved from CHIP and Medicaid into Exchange plans under health reform. If, as is now being considered, the CHIP program is dissolved and children are moved from Medicaid and CHIP into Exchange plans,[63] it will be important to assure that they secure comparable coverage and that their transition to the new coverage is carefully planned and implemented. Such changes will affect millions of children—for example, if CHIP was eliminated, more than 14 million children will need to be enrolled in an alternative source of coverage.[64] If their new coverage is not as strong in terms of cost-sharing protections and benefits, there is a risk that some could end up worse off as a result.[65]

3. In the short term, federal policy makers will need to assure that CHIP and Medicaid remain a strong bridge to broader health reform. Under the major bills, health reform will not be fully implemented until 2013 (although discrete changes may be phased in earlier). In the interim, families will continue to need affordable coverage options for their uninsured children, especially because economists predict that job growth will lag well behind any economic recovery.[66] State budgets are not expected to improve in the near future, with many already anticipating shortfalls for the upcoming fiscal year.[67] In the absence of a continuation of the state fiscal relief provided under ARRA that has contributed to the success story of 2009 and incentives for states to continue to move forward in covering children, there is a risk that states will scale back and children will lose coverage before the new Exchange plans are up and fully operational.

If CHIP is eliminated under national health reform, more than 14 million children will need to be enrolled in an alternative source of coverage.

Conclusion

Following the passage of CHIPRA, states across the country are continuing and strengthening their efforts to make health coverage available to more children and families. Despite the economic downturn, 48 states, including DC, maintained or built on their programs, of which close to half have affirmatively moved forward. The outcome of these initiatives, however, depends not only on the states, but also on federal action and federal political will to enact strong health reform. With children's coverage a clear national priority, health reform presents the opportunity to renew and strengthen the federal commitment to moving forward, at the same time providing new coverage opportunities to all Americans.

METHODOLOGY

The information for this report was gathered as part of Georgetown University's Center for Children and Families' (CCF) ongoing state monitoring efforts, which track and identify trends across the country to provide health coverage to uninsured children and families. This report includes a review of state activity from January 1, 2009 to September 1, 2009, a date by which the vast majority of states had concluded their legislative sessions and all but a few had enacted budgets.[68] It is based upon analysis of governors' state-of the-state addresses, state legislation, and budgets, as well as communication with state officials and advocates, and media accounts. Prior to publication, CCF shared the data with state officials and advocates; securing verification from at least one, but in most cases multiple stakeholders, in all states.

The review is not meant to be exhaustive of all activities that states undertook or considered in relation to child and family coverage, but instead provides an overview of proposals either implemented or enacted through legislation aimed at changing coverage or enrollment procedures. It does not include changes to Medicaid/CHIP benefits, provider payments, or outreach activities. It also does not address local or community programs, non-coverage initiatives (e.g., those that focus on quality), or insurance reforms. Enrollment numbers are included where available, as reported by the state.

ACKNOWLEDGEMENTS

This report was produced by the Center for Children and Families. Research and writing for the report was conducted by Martha Heberlein, with editorial and writing assistance from Jocelyn Guyer and Dawn Horner. We want to thank our colleagues at CCF for their counsel and guidance on the report, particularly Cathy Hope who developed the family stories. CCF greatly appreciates the assistance of state officials and advocates who provided information on their state programs and is grateful for comments provided by January Angeles, Sarah deLone, Maureen Hensley-Quinn, Rachel Klein, Sarah Lueck, Donna Cohen Ross, Jenny Sullivan, and Jennifer Tolbert.

A special thank you to the members of the Serrano and Simpson families for sharing their experiences and the Metro Organizations for People in Denver and Arkansas Advocates for Children and Families for uncovering their stories.

The report was made possible by support from the David and Lucile Packard Foundation and The Atlantic Philanthropies.

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