Covering All Children

by Kelly Whitener and Joan Alker

Ninth in a series of papers from the Georgetown University Center for Children and Families on the future of children's health coverage.

February 2020

Introduction

The nation made remarkable progress in reducing the rate of uninsured children, following decades of coverage expansions and policy changes that made it easier for children and their families to get and stay covered.[1] But, in 2018, the rate of uninsured children increased for a second year in a row to 5.2 percent.[2] Early warning signs pointed to a large increase in the uninsured rate in 2018, such as the historic decline of over 1 million children enrolled in Medicaid and CHIP between December 2017 and May 2019.[3]

Policymakers must renew their efforts to regain momentum on children's coverage and strive to reach all children, because research shows that having coverage as a child leads to better educational outcomes, higher-paying jobs as an adult, and improved health over the lifetime.[4] Coverage for parents and caregivers is also critical to child health. When parents are healthy and insured, their families are more financially secure, and their children are more likely to be enrolled in health coverage and have their health needs met.[5]

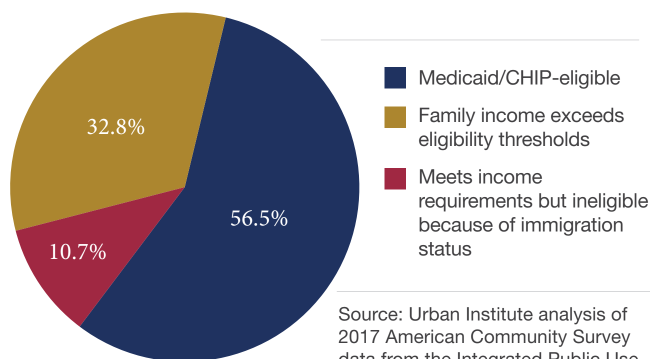
This brief focuses on the remaining 4 million uninsured children and makes recommendations for policy changes to reach them as well as to simplify and improve children's coverage overall. A menu of options is included that can be contemplated separately or in combination. If the number of uninsured children continues to grow, the need for bolder action by policymakers becomes increasingly urgent.

Who Are the Remaining Uninsured Children?

Uninsured children are more likely to fall into certain demographic groups. For example, children living in and near poverty have higher uninsured rates than children with family income above 250 percent of the federal poverty level (FPL).[6] The uninsured rate also varies by race and ethnicity, with American Indian/Alaska Native children having the highest rate at 13.2 percent in 2018.[7] Latino children, who can be of any race, also have higher uninsurance rates, climbing up to 8.2 percent in 2018.[8] School-aged children are also more likely to be uninsured than children under 6 years old, but the uninsured rate for young children jumped an alarming 13 percent to 4.3 percent in 2018. Finally, children are more likely to be uninsured in certain states, especially states that have not adopted the Medicaid expansion to cover more parents and other adults.[9] Half of the nation's uninsured children reside in just six states (Texas, Florida, California, Georgia, Arizona, and Ohio).[10]

Building on the strong foundation of Medicaid and CHIP, policymakers could achieve universal coverage for children by setting national standards for children's coverage, expanding insurance affordability programs to reach more children, and targeting outreach and enrollment efforts to make sure even the hardest to reach demographic groups are covered. For example, of the remaining uninsured children, 56.5 percent are eligible for Medicaid or CHIP but not enrolled (see Figure 1).[11] Clearly, policy solutions aimed at increasing Medicaid and CHIP participation rates would make significant strides toward covering all children. For the remaining uninsured children, policy changes are needed to make coverage more affordable and more accessible to all, regardless of income or immigration status.

Figure 1. Share of Uninsured Children Eligible for Medicaid/CHIP in 2017

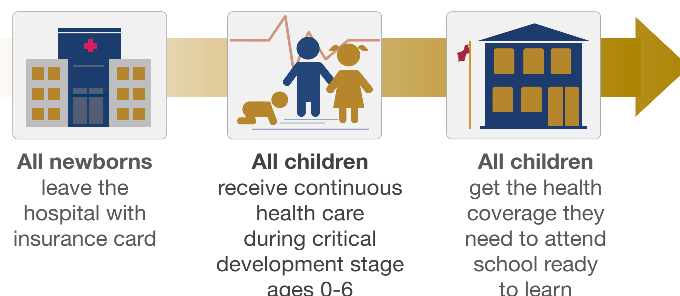


Source: Urban Institute analysis of 2017 American Community Survey data from the Integrated Public Use Microdata Series.

Create a National Children's Coverage System

U.S. children are significantly more likely to have health coverage if they happen to reside in certain states. Most notably, uninsured children disproportionately live in the South.[12] Children are almost twice as likely to be uninsured in states that have not adopted the Medicaid expansion to cover more parents and other low-income adults.[13] Some states have been able to make progress in reducing the percentage of uninsured children by adopting policies that make it easier for children to get and stay covered—the only two states to cover more than 98 percent of children cover all children regardless of immigration status—but states have not been able to achieve 100-percent coverage on their own. In order to have universal coverage for children, states need a stronger federal partner, and children need equal access to coverage regardless of where they live.

Figure 2. National Continuum of Children's Coverage



All newborns leave the hospital with insurance card

All children receive continuous health care during critical development stage ages 0-6

All children get the health coverage they need to attend school ready to learn

1. Create a national continuum of children's coverage

Policymakers should strive to improve technology and data systems to create a universal coverage system that begins at birth and continues through adolescence. Newborns should have coverage before leaving the hospital, and as children grow and income or other family circumstances change, that coverage should continue without gaps even if the source of coverage changes (i.e., from Medicaid to CHIP or CHIP to Marketplace). (See Figure 2 above.)

- Babies born to mothers covered by Medicaid and CHIP are automatically eligible for one year, but systems need to be improved to make sure all such newborns are enrolled. Oklahoma uses an automated newborn enrollment system, which allows hospital staff to enter newborn information and receive an assigned Medicaid number before the mother and baby are discharged.[14] In New Jersey, private insurance plans are required to cover their member's newborns from birth to 60 days.[15] Similar systems should be developed and implemented to ensure newborns enroll in coverage, regardless of the source, before leaving the hospital. Parents can indicate that their newborn will be covered on their private plan or the baby will be enrolled into Medicaid by default. This would create a simple, national system with an expectation that no baby should leave the hospital without insurance.

Recommendation State: Ensure that every newborn leaves the hospital with health coverage by improving technology and processes to immediately enroll them in available Medicaid, CHIP, or Marketplace coverage if they don't have employer-sponsored insurance.

Recommendation Federal: Enroll newborns without alternative coverage in Medicaid automatically.

- Medicaid and CHIP eligibility, once established at birth, should be extended for several years to ensure that children maintain continuous coverage during the first critical years of growth and development. This would establish continuous, reliable coverage during early childhood when children are developing very quickly and early interventions are critical. It would also ensure families have affordable access to coverage during the early years when children are expected to have frequent doctor's visits to be immunized and have developmental milestones assessed. In order to create a seamless coverage system, continuous eligibility periods in Medicaid and CHIP should extend from birth to kindergarten entry.

Recommendation Federal: Allow states to test longer periods of continuous Medicaid and CHIP coverage, such as for a five- or six-year period beginning at birth through kindergarten entry.

- Upon entering school and each school year thereafter, the school enrollment process should include information about enrolling in available health coverage programs. Using streamlined applications and partnerships with community health organizations, schools should be able to connect children to Medicaid, CHIP and Marketplace coverage as applicable. Older children are more likely to be uninsured than their younger counterparts, so additional efforts should be made to reach adolescents with specialized outreach programs. In Michigan, a health plan worked with schools to connect families who qualify for free and reduced-price meals to health coverage. In Oregon, school-based health clinics asked students whether they had coverage and helped eligible students apply or referred them to someone who could assist them. Some communities used back-to-school night and parent-teacher conferences to reach out to parents of teens.[16]

Recommendation State: As children enroll in school and at regular checkpoints throughout the school year, such as the beginning of a new sports season, states should ensure that all students are covered and facilitate enrollment for eligible children as needed.

2. Strengthen Medicaid and CHIP

Over 40 percent of uninsured children are ineligible for Medicaid/CHIP because family income exceeds the applicable eligibility thresholds (32.8 percent) or because of immigration status (10.7 percent).[17] Targeted coverage expansions to reach these two groups would help the U.S. achieve higher rates of insurance for children.

Once eligible for Medicaid and CHIP, children can receive affordable coverage because federal rules limit out-of-pocket costs significantly. In general, states may not impose premiums or cost-sharing in Medicaid for children with family income below poverty, and only very limited cost-sharing is allowed for children with higher family incomes. Federal rules allow more premiums and cost-sharing in separate CHIP programs but only up to an overall cap of 5 percent of household income. As the cost of dependent coverage for employer-sponsored insurance continues to grow,[18] expanding Medicaid and CHIP income eligibility would give more children access to affordable coverage.

Recommendation Federal: Enact a new, national standard setting the minimum income eligibility level for children in Medicaid at 200 percent of the FPL and in CHIP at 300 percent of the FPL.

Uninsured rates are higher for children in immigrant families. Four percent of citizen children with citizen parents were uninsured in 2017, compared to 7 percent of citizen children with a noncitizen parent, 19 percent of lawfully present immigrant children, and 31 percent of undocumented children.[19] About 385,000 uninsured children who met the Medicaid/CHIP income requirements in 2017 were ineligible because of immigration status.[20] Some ineligible immigrant children are lawfully residing but do not meet the specific immigration requirements for health coverage, while some are undocumented. Moreover, while it is hard to quantify the losses of coverage due to immigration enforcement fears such as public charge, the chilling effect of current immigration policies decreases the likelihood that eligible children will enroll in Medicaid and CHIP.

Medicaid and CHIP coverage for noncitizens is limited to certain lawfully present immigrants, such as legal permanent residents (LPRs or "green card" holders), refugees, and asylees; and such coverage is subject to restrictions. Thus, even among lawfully present immigrants, gaps in eligibility remain. For example, in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193), added a requirement that lawfully present immigrants have a "qualified" immigration status and wait five years after obtaining qualified status before being eligible to enroll in Medicaid. These rules were applied to CHIP at its creation in 1997. These restrictions continue to apply today, but states have the option to waive the five-year waiting period for qualified, lawfully residing children and pregnant women.[21] As of 2019, 34 states have waived the five-year waiting period for children.[22]

With the exception of emergency Medicaid services, federal funds are not available for undocumented children who would otherwise be eligible for Medicaid, CHIP, or subsidized Marketplace coverage but for their immigration status. Six states (California, Illinois, Massachusetts, New York, Oregon, and Washington) and the District of Columbia (D.C.) use state-only funds to cover Medicaid/CHIP income-eligible children regardless of immigration status.[23] These states have children's coverage rates well above the national average (ranging from 96.4 percent to 98.8 percent in 2018).[24] Though funded largely with state-only dollars (federal funds can continue to pay for emergency Medicaid services), these coverage programs look just like Medicaid/CHIP to the family, maximizing efficiency and offering the same scope of child-specific benefits.[25]

Despite efforts to streamline program operations, states are limited in what they can do because of complicated funding limitations and the federal rules requiring citizenship documentation. Covering all kids, regardless of citizenship status, would reduce program complexity and improve the insurance rate for children. Most children living in immigrant families are citizens, and the share of undocumented children is small. However, extending coverage to all children regardless of immigration status would make the overall system more efficient, eliminating the need for a citizenship documentation process that all children are currently subjected to and streamlining funding. A simple message that **all** children are welcome makes outreach efforts far more effective and as a result, more currently eligible children would be likely to enroll through the "welcome mat" effect.

Recommendation Federal: Remove eligibility restrictions based on citizenship status so that all children who meet the income eligibility requirements for Medicaid and CHIP are able to enroll.

Many of the proposals included in this brief would increase federal and state spending on Medicaid and CHIP and federal spending on subsidized Marketplace coverage. Under current law, state spending on Medicaid and CHIP is matched by the federal government through a formula known as the Federal Medical Assistance Percentage (FMAP), and in the case of CHIP, the enhanced-FMAP (E-FMAP). The matching rates vary from state to state, with states that have per-capita income below the national average receiving more federal funds. Matching rates may also differ by population, service, or type of expenditure such as administrative costs versus the cost to deliver benefits. Though outside the scope of this paper, policymakers may want to consider increasing the share of costs borne by the federal government in order to support more uniform coverage nationwide.

3. Reduce gaps in children's coverage

Once enrolled, it is critical that children stay covered without unnecessary administrative red tape. Even a short gap in coverage can result in a child missing needed care such as treatment for a chronic condition like asthma—which left untreated is likely to result in visits to the emergency room and missed school days. Gaps in coverage can also create financial hardship. Even if just one family member is uninsured, the whole family's economic security is at risk. Coverage expansions for children and adults decreased the percentage of poor and near poor families with trouble paying their medical bills by almost 30 percent.[26]

States have the option under current law to provide 12 months of continuous coverage for children in Medicaid and CHIP so that even as their family income fluctuates from month-to-month, children can remain covered. Almost half of all states have adopted this option in Medicaid, and more than two-thirds of states with separate CHIP programs apply it to CHIP, too. However, all states should be required to provide at least 12 months of continuous coverage in order to avoid gaps in children's coverage regardless of where they live. Providing families with continuous coverage will help reduce school absenteeism for children and, potentially, lost work days for their parents.[27]

Recommendation Federal: Set a national standard of at least 12 months of continuous coverage for children in Medicaid and CHIP.

Finally, it is important to allow states to expand coverage for children beyond these new federal minimums to reflect state and local needs. For example, states may want to cover all children at higher income levels to keep up with higher costs of living. Or, a state may want to expand coverage to a subgroup of particularly vulnerable children, like those with special health care needs. Currently, most states cannot expand their CHIP programs without a Section 1115 waiver, which is cumbersome, time-limited, and requires a budget neutrality test.

Recommendation Federal: Create a state plan option to cover children at higher income levels (i.e., without a waiver).

Medicaid plays a unique role for many vulnerable groups including low-income parents and adults, pregnant women, and people with disabilities. For children to grow up into healthy, productive adults, they need the support of healthy parents and caregivers and a safe, secure community. Children's positive development relies on healthy parents, and health coverage improves parents' health and access to needed care. Covering parents also provides financial security for the whole family, as having even one uninsured family member could lead to major medical debt. Moreover, as children age into adulthood, they will continue to have health care needs over their lifespan. Though not within the scope of this report, policymakers should also consider setting national standards to reduce state variation and improve coverage for everyone.

4. Improve affordability in the Marketplace and expand access to subsidized private coverage for immigrants

Over 1 million children remain uninsured because family income exceeds the Medicaid/CHIP eligibility thresholds, and yet private coverage is still out of reach. Families ineligible for Medicaid and CHIP may rely on employer-sponsored insurance (ESI) coverage if available, or they may purchase coverage through the Marketplace, but these coverage options may be unaffordable even for middle-income families. Premiums for ESI increased 55 percent, twice as fast as workers' earnings, in the past decade.[28] Marketplace plans offer subsidized coverage for families with income below 400 percent of the FPL, but for many families the cost of coverage is still a major barrier.[29] Additionally, some families are unable to access subsidized coverage under the current application of the test to determine whether the family has access to "affordable" coverage, also known as the "family glitch."

Approximately 460,000 children live in families where ESI is available, but very expensive, and yet they are ineligible for premium tax credits in the Marketplace due to the family glitch.[30] Regulations define employer coverage as "affordable"—making the employee, spouse and/or children ineligible for premium tax credits—if the cost to the employee for individual coverage is less than 9.86 percent of family income.[31] However, family coverage is generally far more expensive than coverage for the employee only.[32] The result is that families who have access to affordable individual coverage are excluded from premium tax credit eligibility even if the cost of family coverage exceeds the affordability thresholds.[33]

Recommendation Federal: **Congress or the Administration should redefine the affordability test based on the cost of family coverage not individual coverage, thereby eliminating the "family glitch."**

Even for families who do qualify for premium tax credits, the expected contribution to premiums and other out-of-pocket costs can be so high that coverage remains out of reach. An earlier brief in this series identified policy options to make Marketplace coverage more affordable, including decreasing the expected premium contribution amounts and making cost-sharing protections more robust and available to families with higher incomes.[34] A Commonwealth Fund analysis found that allowing families above 400 percent of the FPL to purchase subsidized Marketplace coverage would decrease the number of people without insurance by 1.2 million.[35]

Recommendation Federal: **Decrease the expected premium contributions for all families and make premium tax credits available to families with incomes above 400 percent of the FPL.**

Recommendation Federal: **Require insurers operating in the Marketplace to reduce deductibles and other cost-sharing so that total out-of-pocket costs are reasonable.**

There are fewer immigration-related eligibility restrictions for premium tax credits in the Marketplace compared to Medicaid and CHIP. In order to be eligible for premium tax credits, immigrants must be lawfully present but do not have to have "qualified" status and are not subject to the five-year waiting period. This creates confusion because certain groups, like those with temporary protected status, are lawfully present but not "qualified" and therefore ineligible for Medicaid and CHIP but eligible for premium tax credits in the Marketplace under current law.

Recommendation Federal: **Remove eligibility restrictions based on citizenship status so that all children who meet the income eligibility requirements are able to purchase subsidized Marketplace coverage.**

As policymakers work to provide health coverage for all children, it is also important to make sure such coverage is affordable and comprehensive. Medicaid and CHIP have important affordability protections already built-in, and Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit guarantees that children have access to all pediatrician-recommended services. Children whose coverage comes from other sources—like the Marketplace or employer-sponsored insurance—may need additional protections to ensure their coverage is affordable and comprehensive, too.

Interim Steps to Cover More Children

While the broader, more systemic policy changes outlined above would achieve universal coverage for children, political challenges and time and resource constraints may present insurmountable barriers. Thankfully, there are interim steps that could be taken immediately or in the nearer term. For example, research by the Urban Institute has found that following implementation of the ACA, children's participation rates in Medicaid and CHIP improved dramatically—from 88.7 percent of eligible children in 2013 to 93.7 percent in 2016. However, in 2017, the Medicaid and CHIP participation rate for eligible children fell back to the 2015 level of 93.1 percent.[36] This was the first time the participation rate has declined since the Urban Institute first began measuring participation in 2008. Efforts to improve the rate in the 2013 to 2016 period—such as streamlining Medicaid and CHIP enrollment processes and enhancing outreach and enrollment efforts, together with the welcome mat effect of providing affordable coverage options to parents through the ACA—paid off. Returning to a "culture of coverage" that includes policies to make it easier to enroll in Medicaid and CHIP and affirms the value and importance of covering children would help participation rates get back on track and help cover more children.

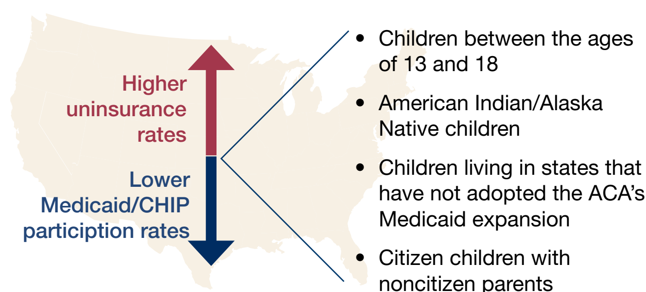
State Focus

Though **Nevada** still has a high percentage of uninsured children relative to the national average (8 percent versus 5 percent), the state had the sharpest decline in the rate of uninsured children during the ACA implementation period from 2013 to 2016.[37] Over that same period, the Medicaid and CHIP participation rate increased from 74.3 percent to 91.3 percent, the biggest jump across the country.[38]

Despite prior enrollment improvements, the Urban Institute data show that 2 million uninsured children were eligible for Medicaid or CHIP but unenrolled in 2017. Over half of eligible but unenrolled children lived in just eight large states (California, Florida, Georgia, Illinois, Indiana, New York, Pennsylvania, and Texas).[39] Moreover, certain socioeconomic and demographic subgroups are not only more likely to be uninsured, they are also more likely to have lower participation rates in Medicaid and CHIP (see Figure 3). In 2017, some gains in the participation rates were reversed. For example, participation rates for the lowest income children—family income below 100 percent of the FPL—and citizen children with noncitizen parents declined significantly between 2016 and 2017.[40]

Implementing policies and procedures that facilitate enrollment and retention as well as maximize use of technology would help reach eligible but unenrolled children.

Figure 3. Demographic Groups with Higher Uninsurance Rates and Lower Medicaid/CHIP Participation Rates, 2017



Source: Urban Institute tabulations of 2013-2017 American Community Survey data from the Integrated Public Use Microdata Series.

In the absence of new federal requirements described above, there are several options states may adopt under current law that have proven effective in expanding eligibility and promoting continuity in coverage. For example, all states should opt to provide 12 months of continuous coverage for children so that even as their family income fluctuates from month-to-month, children can remain covered. Twenty-four states have already adopted this option in Medicaid, along with 26 of 36 separate CHIP programs.[41] Extending the 12-months continuous coverage option to parents and other adults would also help ensure more children have coverage as research has shown that when parents are covered, the whole family is more likely to have coverage and be more financially secure.[42]

As noted above, federal rules generally require immigrant children to have a qualified status for five years before becoming eligible for Medicaid and CHIP. However, states may opt to waive the five-year waiting period for children and pregnant women.

Additionally, federal agencies could streamline eligibility rules for immigrant groups and help more youth obtain coverage by allowing Deferred Action for Childhood Arrivals (DACA) recipients to be eligible for Medicaid, CHIP, and premium tax credits in the Marketplace. Though children's use of Medicaid is exempt from the recent public charge policy changes, if federal agencies rescinded the regulations it would allow all eligible children to enroll without fear.[43]

As noted, six states and D.C. have opted to cover all children regardless of citizenship status; for those in the Medicaid income eligibility range, the state pays all of the costs beyond what emergency Medicaid covers. Other states should consider adopting this same approach, and CMS should streamline the process to make it easier for states to continue to draw down federal funds for emergency Medicaid expenses.

Finally, states have the option under current law to increase income eligibility for children in Medicaid and CHIP through a section 1115 demonstration waiver. The waiver process can be cumbersome, which is why it would be better in the long term to make eligibility expansions an option through the state plan amendment (SPA) process instead. Waivers are also subject to budget neutrality rules, so it may be difficult to do larger expansions. However, states may want to consider some eligibility expansions through the waiver process in the absence of statutory change.

Interim Steps to Improve Coverage

Recommendation State: Adopt the option to provide 12-month continuous coverage for children in Medicaid and CHIP.

Recommendation Federal: Allow states to provide 12-months continuous coverage for parents and adults in Medicaid as a state plan option (i.e., without a waiver).

Recommendation Federal: Remove the requirement to have qualified status in addition to being lawfully residing so that all lawfully residing children may be eligible for Medicaid and CHIP.

Recommendation State: Adopt the option to cover all lawfully residing children at current eligibility levels without requiring a five-year waiting period in Medicaid and CHIP.

Recommendation Federal: End the DACA exclusion from federally funded health coverage affordability programs, including Medicaid, CHIP and subsidized Marketplace coverage.

Recommendation Federal: Rescind the recent changes to public charge policy.

Recommendation State: Cover all children regardless of immigration status, using state-only funds as needed.

Recommendation Federal: Make it easier for states to cover populations with state-only funds by streamlining cost allocation processes.

Recommendation State: Expand income eligibility to cover more children in Medicaid and CHIP through a section 1115 demonstration waiver.

Improve Outreach and Enrollment Programs

Some coverage gains could also be achieved by simply doing a better job to make sure existing coverage options and related systems work well for children and families. Many such strategies are outlined in a separate report and blog series on the decline in Medicaid and CHIP enrollment.[44] For example, an important tool to reaching eligible children is in-person, culturally competent consumer assistance. The ACA created “navigator” programs to provide outreach, education and enrollment assistance for Medicaid, CHIP, and Marketplace coverage. However, in 2018, the Trump administration reduced navigator funding to just $10 million, a reduction of 84 percent from full navigator funding in 2016.[45] Free, in-person assistance is especially important for underserved communities—African Americans and Latinos were 43 percent more likely to seek in-person help than their white counterparts. And consumers with in-person assistance are twice as likely to successfully enroll compared to those who attempt to enroll online without help.[46]

In addition, states are required to provide opportunities for pregnant women, children, and parents to apply for Medicaid at certain locations such as hospitals, federally qualified health centers, and Indian health clinics. States also have the option to establish other enrollment sites in locations such as schools or family resource centers. These outstation locations and functions should be maximized to make it easier for eligible children to enroll.[47]

Interim Steps to Improve Outreach and Enrollment

F **Recommendation Federal:** Restore navigator funding to 2016 levels and increase funding for other forms of in-person, culturally competent consumer assistance for Medicaid, CHIP, and Marketplace coverage. Funding should also be reinstated for marketing and outreach, so that families are aware of their options. All such funds must be comprehensive, such as explicitly allowing in-person assistance for any of the insurance affordability programs.

F S **Recommendation Federal and State:** Ensure that community-based organizations and providers who serve hard-to-reach, low-income families are involved in outreach and enrollment efforts.

S **Recommendation State:** Expand and maximize Medicaid enrollment sites, especially in schools, Indian health clinics, and family resource centers in order to enroll harder to reach children.

F **Recommendation Federal:** Devote new resources to the national children’s coverage campaign, with a particular emphasis on increasingly marginalized populations such as children in immigrant families.

Conclusion

The nation has made incredible progress in improving the uninsured rate for children, but since 2016, policy changes and a lack of national focus on children’s health coverage have undermined that success. Between 2016 and 2018, the number and rate of uninsured children grew for the first time in nearly a decade. With a strong foundation of coverage in Medicaid, CHIP and the Marketplace, it is time to revisit national priorities and get back to the sustained progress that came about through a strong, bipartisan commitment to children’s health. Insurance coverage is the price of admission to the nation’s health care system, and without it, children are condemned to worse health and educational outcomes in the short and long term. Their families face the threat of medical debt and even bankruptcy that can arise when accidents happen, such as a child falling on the playground and breaking a bone. When an ear infection goes undiagnosed and untreated, it can lead to hearing loss and speech and language delays with life-long health and educational consequences for the child. This devastating impact could be prevented through health coverage providing access to care and early intervention. These financial and health burdens can have long term consequences even if the period without coverage is short. There are many issues facing a child’s successful trajectory, but without continuous affordable coverage it is hard to equip the next generation to address the complex challenges they and our nation will face in the future. It’s time to redouble efforts to ensure that all children are insured.

Acknowledgments

The authors would like to thank Sonya Schwartz for her thoughtful work writing an earlier version of this paper. The authors also thank Edwin Park for his review and Tara Mathias-Prabhu and Phyllis Jordan for editing assistance. Design and layout provided by Nancy Magill

About this Series

This issue brief is ninth in a series of papers from Georgetown University Center for Children and Families on the future of children's health coverage. Other briefs in the series include:

Promoting Health Coverage of American Indian and Alaska Native Children. *Focuses on improving access to health care for American Indian and Alaska Native children.* (September 2019)

How Medicaid and CHIP Can Support Student Success through Schools. *Examines how Medicaid can help schools better serve children and families and how schools can help students get the health care they need.* (April 2019)

The Questions to Ask When Assessing the Impact of Coverage Expansion Proposals on Children. *Focuses on a number of key questions to help assess the relative merits of coverage expansion proposals from the perspective of children.* (February 2019)

How to Strengthen the Medicaid Drug Rebate Program to Address Rising Medicaid Prescription Drug Costs. *Focuses on the effectiveness of the Medicaid Drug Rebate program and how to improve it.* (January 2019)

Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP). *Focuses on ways that state and federal policymakers can use Medicaid and CHIP to more effectively put young children on the best path for success in school and in life.* (October 2018)

How Medicaid and CHIP Shield Children from the Rising Costs of Prescription Drugs. *Focuses on how Medicaid and CHIP protect most children from the rising costs of prescription drugs.* (July 2017)

Fulfilling the Promise of Children's Dental Coverage. *Focuses on pediatric dental coverage and ways to improve children's oral health.* (August 2016)

The Future of Children's Coverage: Children in the Marketplace. *Focuses on ways to improve marketplace coverage and the associated financial assistance for children.* (June 2016)

Endnotes

[1] J. Alker and O. Pham, "Nationwide Rate of Uninsured Children Reaches Historic Low" (Washington: Georgetown University Center for Children and Families, October 2017), available at https://ccf.georgetown.edu/2017/10/22/nationwide-rate-of-uninsured-children-reaches-historic-low/.

[2] J. Alker and L. Roygardner, "The Number of Uninsured Children is On the Rise" (Washington: Georgetown University Center for Children and Families, October 2019), available at https://ccf.georgetown.edu/wp-content/uploads/2019/10/Uninsured-Kids-Report.pdf.

[3] T. Brooks, E. Park, and L. Roygardner, "Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again" (Washington: Georgetown University Center for Children and Families, May 2019), available at https://ccf.georgetown.edu/2019/05/28/medicaid-and-chip-enrollment-decline/; and T. Brooks, "Latest CMS Data Show Slight Improvement in Decline in Child Enrollment in Medicaid and CHIP" (Washington: Georgetown University Center for Children and Families, December 2019), available at https://ccf.georgetown.edu/2019/12/06/latest-cms-data-show-slight-improvement-in-decline-in-child-enrollment-in-medicaid-and-chip/.

[4] K. Wagnerman, A. Chester, and J. Alker, "Medicaid is a Smart Investment in Children" (Washington: Georgetown University Center for Children and Families, March 2017), available at https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.

[5] "Covering Parents Helps Kids," Georgetown University Center for Children and Families, https://ccf.georgetown.edu/2017/03/21/covering-parents-helps-kids/.

[6] J. Alker and L. Roygardner, op.cit.

[7] The Census Bureau does not consider eligibility for IHS services to be coverage when identifying individuals with health insurance. Those who respond to the American Community Survey (ACS) or the Annual Social and Economic Supplement (ASEC) to the Current Population Survey who indicate they are only covered by the IHS are considered to be uninsured because IHS coverage is not considered to be comprehensive. The Congressional Budget Office (CBO), in contrast, defines as publicly insured people who use the Indian Health Service for purposes of its coverage analyses. For consistency with health insurance coverage data presented in other CCF analyses, this brief uses the Census Bureau definition.

[8] J. Alker and L. Roygardner, op. cit.

[9] Under the Affordable Care Act, states may expand Medicaid coverage to include parents and other adults up to 133 percent of FPL. States that have not adopted the Medicaid coverage expansion typically limit non-disabled adult Medicaid coverage to very low-income parents under section 1931 of the Social Security Act (median income eligibility for parents under section 1931 was 49 percent of FPL in 2019).

[10] J. Alker and L. Roygardner, op. cit.

[11] J. Haley et al., "Improvements in Uninsurance and Medicaid/CHIP Participation among Children and Parents Stalled in 2017" (Washington: Urban Institute Health Policy Center, May 2019), available at https://www.urban.org/sites/default/files/publication/100214/improvements_in_uninsurance_and_medicaid_chip_participation_among_children_and_parents_stalled_in_2017_1.pdf.

[12] J. Alker and L. Roygardner, op. cit.

[13] Ibid.

[14] E. Burak, "Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)" (Washington: Georgetown University Center for Children and Families, October 2018), available at https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf.

[15] 2018 N.J. Laws P.L. 2017, CHAPTER 361, 2665th Senate and General Assembly, available at https://www.njleg.state.nj.us/2016/Bills/AL17/361_.HTM.

[16] H. Clapp Padgette, C. Webb, and P. Jordan, "How Medicaid and CHIP Can Support Student Success through Schools" (Washington: Georgetown University Center for Children and Families, April 2019), available at https://ccf.georgetown.edu/wp-content/uploads/2019/04/Student-Success-Report.pdf.

[17] J. Haley et al., op. cit.

[18] S. Collins, D. Radley, and J. Baumgartner, "Trends in Employer Health Coverage 2008-2018: Higher Costs for Workers and Their Families" (New York: The Commonwealth Fund, November 2019), available at https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.

[19] Kaiser Family Foundation, "Health Coverage of Immigrants" (Washington: Kaiser Family Foundation, February 2019), available at https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/.

[20] J. Haley et al., op. vit.

[21] Children's Health Insurance Program Reauthorization Act (CHIPRA), P.L. 111-3, §214 (2009), available at https://www.congress.gov/111/plaws/publ3/PLAW-111publ3.pdf.

[22] T. Brooks, "Hot Off the Press: Annual KFF 50-state Survey on Medicaid" (Washington: Georgetown University Center for Children and Families, March 2019), available at https://ccf.georgetown.edu/2019/03/27/kff-survey/.

[23] T. Brooks, op. cit.

[24] J. Alker and L. Roygardner, op. cit.

[25] The Children's Partnership, "A Golden Opportunity: Lessons from California on Advancing Coverage for All Children" (Washington: The Children's Partnership, January 2018), available at https://www.health4allkids.org/wp-content/uploads/2018/01/Golden-Opportunity-Lessons-From-Californias-Journey-to-Advancing-Coverage-for-All-Children-Report.pdf.

[26] R. Cohen and E. Zammitti, "Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates from the National Health Interview Survey, 2011-June 2017" (Hyattsville, MD: National Center for Health Statistics, December 2017), available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/probs_paying_medical_bills_jan_2011_jun_2017.pdf.

[27] Attendance Works, "Connecting School Attendance and Health Care Access" (Washington: Attendance Works, October 2015), available at https://www.attendanceworks.org/connecting-school-attendance-and-health-care-access/.

[28] L. Hamel, C. Muñana, M. Brodie, "Kaiser Family Foundation/LA Times Survey of Adults with Employer-Sponsored Health Insurance" (Washington: Kaiser Family Foundation, May 2019), available at http://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance.

[29] R. Fehr et al., "How Affordable are 2019 ACA Premiums for Middle-Income People?" (Washington: Kaiser Family Foundation, March 2019), available at https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/.

[30] United States Government Accountability Office Report to Congressional Requesters, "Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance" (Washington: United States Government Accountability Office, June 2012), available at https://www.gao.gov/assets/600/591797.pdf.

[31] Internal Revenue Service, R.P. 2018-34, available at https://www.irs.gov/pub/irs-drop/rp-18-34.pdf.

[32] Employers generally require that workers contribute towards the cost of the premium. Annual premiums for employer-sponsored family health coverage reached $19,616 in 2018, up 5 percent from the year before, with workers on average paying $5,547 toward the cost of their coverage. Kaiser Family Foundation and NORC at the University of Chicago, "2018 Employer Health Benefits Survey" (Washington: Kaiser Family Foundation and NORC at the University of Chicago, October 2018), available at http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.

[33] T. Brooks, "Health Policy Brief: The Family Glitch," *Health Affairs*, (November 2014), available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129.

[34] K. Whitener and J. Alker, "The Future of Children's Health Coverage: Children in the Marketplace" (Washington: Georgetown University Center for Children and Families, June 2016), available at https://ccf.georgetown.edu/2016/06/01/future-childrens-health-coverage-children-marketplace/.

[35] J. Liu and C. Eibner, "Extending Marketplace Tax Credits Would Make Coverage More" (New York: The Commonwealth Fund, July 2017), available at https://www.commonwealthfund.org/publications/issue-briefs/2017/jul/extending-marketplace-tax-credits-would-make-coverage-more.

[36] J. Haley et al., op. cit.

[37] J. Alker and O. Pham, op. cit.

[38] J. Haley et al., op. cit.

[39] Ibid.

[40] Ibid.

[41] T. Brooks, op. cit.

[42] Melissa Jenco, "Study: Parents' Medicaid coverage impacts children's health," *AAP News*, 2017, available at https://www.aappublications.org/news/aapnewsmag/2017/11/13/MedicaidExpansion111317.full.pdf.

[43] H. Bernstein et al., "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018" (Washington: Urban Institute, May 2019), available at https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_6.pdf and Protecting Immigrant Families, "Public Charge: Does This Apply to Me?" (January 2020), available at https://protectingimmigrantfamilies.org/wp-content/uploads/2020/01/Public-Charge-Does-This-Apply-To-Me-Updated-January-2020-ENGLISH.pdf.

[44] J. Alker and T. Brooks, "Strategies to Address Alarming Decline in Children's Health Coverage" (Washington: Georgetown University Center for Children and Families, September 2019), available at https://ccf.georgetown.edu/2019/09/30/regaining-enrollment-momentum-in-medicaid-and-chip/.

[45] K. Pollitz, J. Tolbert, and M. Diaz, "Data Note: Limited Navigator Funding for Federal Marketplace States" (Washington: Kaiser Family Foundation, November 2019), available at https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/.

[46] Enroll America, "In-Person Assistance Maximizes Enrollment Success" (Washington: Enroll America, March 2014), available at https://familiesusa.org/wp-content/uploads/2019/09/2014-In-Person-Assistance-Maximizes-Enrollment-Success.pdf.

[47] 42 C.F.R §435.904 (2013).

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. CCF is based in the McCourt School of Public Policy's Health Policy Institute.

Georgetown University Center for Children and Families

McCourt School of Public Policy

Box 571444

3300 Whitehaven Street, NW, Suite 5000

Washington, DC 20057-1485

Phone: (202) 687-0880

Email: childhealth@georgetown.edu

www.ccf.georgetown.edu

facebook.com/georgetownccf

twitter.com/georgetownccf