

The Questions to Ask When Assessing the Impact of Coverage Expansion Proposals on Children

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*Sixth in a series of briefs on the future of
children's health care coverage*

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With the outcome of the November midterm elections, the risk of federal legislation to repeal and replace the Affordable Care Act (ACA) and impose a cap on federal Medicaid funding has receded. Instead, there is renewed attention by some policymakers on how to once again make substantial progress toward the goal of universal coverage.

This has become more urgent with recent survey data showing that the ranks of the uninsured are increasing. For example, data from the Census Bureau's American Community Survey (ACS) show that in 2017, the uninsured rate among children increased for the first time since at least 2008 when the ACS first asked a health insurance question. The share of children without health insurance rose from 4.7 percent to 5 percent between 2016 and 2017 and the number of uninsured children increased by 276,000.¹

While the number of children with health insurance has reversed modestly, this troubling sign comes on the heels of extraordinary progress as a result of efforts at the federal and state levels to address children's health needs. Following decades of coverage expansions and eligibility simplifications through Medicaid and the Children's Health Insurance Program (CHIP), the percent of insured children reached a historically high level of 95.5 percent in 2016.²

Children are also at risk when their parents and caregivers lack health insurance. The latest results from the Gallup National Health and Well-Being Index, for example, find that the uninsured rate among adults has increased by 2.8 percentage points since 2016 (from a low of 10.9 percent in the third quarter of 2016 to 13.7 percent in the fourth quarter of 2018), which translates to an increase of about 7 million people. According to Gallup, this is the highest uninsured rate among adults since the ACA's major coverage expansions were implemented in 2014.³



The health coverage expansion plans being proposed not only by members of Congress but also by think tanks and health advocacy organizations vary considerably in their approach and scope. Some proposals would establish new universal coverage programs (often under the rubric of “Medicare for All”) that may or may not replace current coverage sources like employer-sponsored insurance and public programs such as Medicare, Medicaid and the ACA marketplaces. Some proposals would expand coverage to targeted populations (such as by lowering the age of Medicare eligibility or allowing a buy-in to Medicare or

Medicaid for those not currently eligible). Others would provide a public health insurance plan option for the ACA’s marketplaces.

There is a wide diversity among these coverage expansion proposals. This issue brief asks a number of key design questions to help assess the relative merits of expansion proposals from the perspective of children, especially the tens of millions of low-income children who rely on Medicaid and the CHIP today.

1. How would the coverage expansion proposal affect Medicaid and CHIP coverage of children?

More than 35 million low-income children rely on Medicaid and CHIP for their health coverage.⁴ Data from the American Community Survey indicate that 34.3 percent of children under age 19 (and 38.9 percent of children under age 6) rely on Medicaid and CHIP for their sole source of coverage.⁵

Medicaid is highly efficient, providing health coverage (including to children) at a lower cost per beneficiary than in private insurance largely due to lower provider payment rates and administrative costs. This is true even though Medicaid covers a more comprehensive array of benefits and does not generally require any cost-sharing charges for children.⁶ Moreover, overall Medicaid per-beneficiary costs have also been growing considerably more slowly than private insurance.⁷

Medicaid also delivers high quality care, providing children with needed access to care such as well-child visits and enabling children to have a regular source of care, at rates comparable to or greater than in private insurance. In addition, research has linked Medicaid with reduced infant and childhood mortality, because it leads to greater utilization of preventive and acute health services. Research has also linked Medicaid coverage in childhood to long-term benefits including higher educational attainment and better health and earnings in adulthood.⁸

Medicaid and CHIP enrollment increases, driven by eligibility expansions and efforts to increase participation among eligible families, were primary contributors to the dramatic reduction in the number and rate of uninsured children since CHIP was enacted in 1997. As a result, a key question about any major health coverage expansion proposal is how it would affect children’s existing eligibility. Would Medicaid and CHIP be replaced with a new coverage program? If not, would the coverage expansion build on Medicaid and CHIP or rely on a different or new program to cover children (both low-income and higher-income) who remain uninsured? Under a new coverage expansion proposal, would all eligible children be entitled to enroll, as under Medicaid today?

These questions have serious consequences for the future of children’s health. Medicaid and CHIP have evolved over decades to address the needs of children for whom the private market is too expensive or is unable to address their special health care needs. In addition, the growing recognition of the influence of poverty on development in early childhood underscores that a new coverage expansion program, if designed primarily for children living in families with middle class incomes, may not be adequate to serve Medicaid’s vulnerable low-income children.⁹



2. Would the new coverage expansion's benefit package be tailored to children's unique needs?

Whether a coverage expansion proposal replaces Medicaid and CHIP or establishes a new program that leaves Medicaid and CHIP in place but is intended to cover more uninsured children, another key question is what benefits would be provided, and how they would compare to those furnished under Medicaid and CHIP. Both programs have a pediatric benefits package designed with children in mind that provides a comprehensive array of services intended to fully meet the needs of low-income children, especially those with disabilities and special health care needs.

For example, Medicaid (including CHIP-funded Medicaid, in which more than half of CHIP child beneficiaries are enrolled) provides a comprehensive child-focused benefit: the Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT). It is designed to ensure that children receive recommended preventive screenings, follow-up diagnostic assessments, and all medically-necessary services that health care providers deem essential to prevent, treat or improve the diagnosed condition, even if the services they need are not otherwise covered under the state's Medicaid program. The intent of the EPSDT benefit is to ensure coverage for items and services that not only treat a condition but also prevent it from occurring or worsening.¹⁰ This includes coverage of long-term services and supports and other services that children with special health care needs require. According to the Kaiser Family Foundation,

about 48 percent of children with special health care needs are covered by Medicaid and CHIP.¹¹ Medicaid also serves children in the child welfare system who tend to have greater physical and behavioral health needs. While separate CHIP programs are not required to cover EPSDT benefits, all states are required to cover comprehensive pediatric benefits (with some states electing to provide EPSDT-like benefits).¹²

In addition, Medicaid increasingly covers a variety of screening and referral services, care management, program integration, health home and supportive housing services intended to help address the social determinants of health by more effectively connecting beneficiaries to needs within and outside the health sector. Lack of access to affordable housing, economic insecurity for families, unsafe neighborhoods and lack of access to adequate and healthy nutrition can all negatively affect the health of low-income children.¹³ Medicaid can also provide financial support for home-visiting programs for pregnant women and young children, which offer social, health and educational services that support healthy child development.¹⁴ The Medicare benefits package or the Essential Health Benefits provided in marketplace plans, for example, would not provide the same level of coverage to children that Medicaid's EPSDT benefit provides.

3. What would be the premium and cost-sharing requirements under the new coverage expansion?

To ensure access to needed care, most children covered by Medicaid are entirely exempt from premiums, deductibles and co-payments. Other children, including those covered by Medicaid with somewhat higher incomes and those enrolled in separate state CHIP programs, may be subject to modest premiums and nominal co-payments but with total out-of-pocket costs limited to no more than 5 percent of family income.¹⁵ Research is clear that even

relatively small levels of cost-sharing discourage use of needed care, particularly among low-income individuals. Cost-sharing increases can lead to poorer health outcomes and increased overall financial burdens.¹⁶ How much would families have to pay in premiums, deductibles and other cost-sharing charges under the coverage expansion proposal and how would that compare to Medicaid and CHIP?



4. How would the coverage expansion measure and ensure quality of care?

First enacted as part of CHIP's funding extension in 2009, the Child Core Set is a set of standardized, evidence-based measures to assess the quality of care provided to children covered by Medicaid and CHIP. Measures include, for example, well-child visits, immunization, timeliness of prenatal and postnatal care, percentage of low-birthweight births, preventive dental care, and followup care for children hospitalized for mental illness. While reporting on the full set of measures is not mandatory until 2024, the voluntary reporting to date has helped accelerate quality improvements in Medicaid and CHIP for children (and mandatory reporting will have an even larger impact). Standardized data reporting allows a comparison of quality of care across states and helps states identify gaps in

their performance. In the case of managed care, state Medicaid programs are also required to conduct other quality improvement activities including External Quality Reviews and Performance Improvement Projects.¹⁷ A number of states also adopt Bright Futures for their EPSDT periodicity schedule. Bright Futures is a national pediatric standard created by the American Academy of Pediatrics that establishes a recommended schedule of screenings, immunizations and procedures for children under EPSDT.¹⁸ A key question is how any new coverage expansion would measure quality of care for children and support significant quality improvements as Medicaid does today.

5. What would be the health care delivery system under the coverage expansion and how would health care providers be reimbursed?

In 2016, more than two-thirds of Medicaid beneficiaries were enrolled in comprehensive Medicaid managed care plans and more than 80 percent were in some type of managed care arrangement, including primary care case management.¹⁹ How would care be delivered under the new coverage expansion proposal? If a coverage expansion similarly relies on managed care, what requirements and other beneficiary protections would apply to ensure access to needed services, and how would they compare to those required under Medicaid today (as discussed further below)? How would health care providers be generally reimbursed under the coverage proposal, and how would the coverage expansion ensure sufficient participation by providers including pediatric specialists and children's hospitals?

In addition, in part because low-income children tend to reside in underserved urban and rural areas, children covered by Medicaid disproportionately rely on safety net

providers, such as community health centers and public hospitals. Would these institutions be included in the network of health care providers furnishing care under an expansion proposal? Moreover, Medicaid now reimburses non-traditional providers, such as schools, for providing Medicaid-covered services like screenings and therapy services to students covered by Medicaid.²⁰

Medicaid also provides additional payments to health care providers that disproportionately serve low-income patients. Examples include the Medicaid Disproportionate Share Hospital (DSH) program for hospitals that primarily serve Medicaid beneficiaries and the uninsured and other supplemental payments to hospitals and nursing homes.²¹ Moreover, community health centers are reimbursed under a special prospective payment system (or a comparable alternative payment arrangement) in Medicaid and CHIP.²² Would such payment mechanisms that support the health care safety net be part of the new coverage expansion?



6. What are the beneficiary access protections under the coverage expansion?

Medicaid includes a wide array of beneficiary requirements and protections. For example, because all eligible individuals are entitled to enroll, individuals (both applicants and beneficiaries) have a right to adequate notice and to a fair hearing, including the right to request a fair hearing before an impartial decisionmaker and the right to the continuation of benefits pending the hearing decision and any appeals. This protection also applies to denials or delays of covered services. Medicaid managed care plans are also required to establish a grievance and appeals process, treat enrollees with respect and dignity, and ensure timely access to services, among other enrollee rights.²³ Medicaid benefits must also be comparable across beneficiaries and not discriminate based on diagnosis, type of illness or condition. Pre-

existing condition exclusions have never been permitted in Medicaid. In addition, Medicaid payments to health care providers must be sufficient to ensure adequate participation so that care and services are available to the same extent as to the general population in the same geographic area.

There is also longstanding jurisprudence that has clarified and expanded these beneficiary rights and protections in Medicaid. For example, court cases interpreting the EPSDT benefit have made clear that coverage limits for children are prohibited, except in the case of a lack of medical necessity as determined from individual facts.²⁴ How would a proposed coverage expansion compare to these existing Medicaid protections and appeals processes?

7. How will the coverage expansion be administered?

States are responsible for administering Medicaid and CHIP programs, within federal requirements and with federal oversight. Because states have expansive flexibility under Medicaid and CHIP, this results in substantial variation across Medicaid programs including in eligibility, benefits and provider payments. If a coverage expansion uses a federally administered system, it could have the benefits of uniformity and continuity for children regardless of where they live, but this would not be beneficial if these standard protections for children were weaker than those in the existing Medicaid (or CHIP) program for children.

Moreover, states are well-positioned to establish linkages across federal, state and local programs to connect beneficiaries to needed services, including those outside

of health care such as education, housing and nutrition. Many states operate integrated eligibility systems and multi-benefit applications. These also include “hub and spoke” system changes in which a state Medicaid agency takes responsibility for coordinating and supporting an array of services and other government agencies and community organizations. As discussed above, these are all critical strategies in addressing the social determinants of health.²⁵ How would a new coverage expansion take on these kinds of administrative activities if taking the place of a state Medicaid agency?



8. What is the implementation timeline for the coverage expansion, and is there a transition period?

If a coverage expansion proposal moves some or all children now covered by Medicaid and CHIP to a new program, one critical question would be how would a transition of up to 35 million low-income children be implemented? For example, how would continuity of care be maintained, especially for those most vulnerable children with disabilities and special health care needs who require particular providers and services? How would

a transition from Medicaid and CHIP to a new coverage program ensure sufficient outreach and education for affected families to avoid children falling through the cracks and disruptions in coverage and care? Would sufficient resources be available for linguistically and culturally appropriate community-based outreach efforts to help families navigate an entirely new system?

9. How will children's needs specifically be addressed in any new coverage expansion?

The CHIP program has helped focus attention on how to make substantial improvements to the enrollment and retention of eligible children in Medicaid. Having a program focused explicitly on children has contributed to a successful decades-long, child-focused effort to reduce the rate of uninsurance and improve access to needed care among children. Because children are less costly on a per-beneficiary basis and have considerably less political

clout overall and because of the past progress towards covering all children, children's needs may end up being a lower priority in the design considerations for a new coverage expansion program. As a result, children may get lost in the shuffle in larger debates about health care system reform in the United States. How would children's needs be specifically addressed?

Conclusion

The Congressional midterm elections have resulted in a welcome, renewed focus on how to achieve universal health coverage, including for children. While there is significant debate about the merits of various coverage proposals in terms of policy and politics, one critical approach in evaluating such proposals is through the lens of children, particularly the tens of millions of low-income children covered by Medicaid and CHIP today. Expansions of Medicaid and CHIP have been largely responsible for the historic decline in children's uninsurance rates

with Medicaid covering the vast majority of low-income children. Medicaid's pediatric EPSDT benefit is the definitive standard for children's care recommended by the Academy of Pediatrics, and it is available to all eligible children nationwide at generally no cost. Any coverage expansion proposal should build on these successes and not allow children to fall through the cracks.



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About this Series

This issue brief is sixth 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:

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

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

[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.

[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.

[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.



Endnotes

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