

How Will the Patient Protection and Affordable Care Act of 2010 Affect Children?

Timely Analysis of Immediate Health Policy Issues

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Health reform is expected to have a number of positive effects on the lives of children age 18 and under.¹ More children are expected to have health insurance coverage under reform, which in turn should increase their receipt of needed health care and ultimately improve their health and functioning.² The single most important way that the estimated seven to eight million uninsured children will gain coverage under health care reform is likely to be through increases in coverage through Medicaid and the Children's Health Insurance Program (CHIP) among the children who are already eligible for coverage under those two programs.³

Children Below 133 Percent of the FPL

The role of Medicaid, which covers four to five times as many children and accounts for more than twice as many eligible but uninsured children relative to CHIP,⁴ has been expanded under health care reform to cover all children with incomes under 133 percent of the federal poverty level (FPL). When this expansion goes into effect in 2014, children between the ages of 6 and 18 who are currently in non-Medicaid CHIP plans will shift into Medicaid.⁵ Currently, children within a single family can be split between Medicaid and CHIP, and children can be required to transition from Medicaid to CHIP at their first or sixth birthday.⁶ Under reform, having a higher, uniform Medicaid eligibility standard should provide

Millions of uninsured kids and parents will get coverage under health reform.

more continuity of coverage within families.

The combination of increased funding for outreach and streamlined enrollment/renewal procedures, the Medicaid expansion to parents, and the individual mandate to obtain coverage for both adults and children should increase participation in Medicaid and CHIP among the millions of uninsured children who are eligible for these programs but not enrolled.⁷ At the same time, however, federal matching rates will be lower on children than on new groups of adults gaining Medicaid eligibility under reform,⁸ possibly creating a greater incentive for states to enroll newly-eligible populations. It is therefore not clear how aggressively states will work to enroll and retain more eligible but uninsured children in Medicaid, which could lead to persistent gaps in coverage, particularly among poor children.

Children Above 133 Percent of the FPL

The uninsured children in families that have incomes too high to qualify for Medicaid and CHIP are likely to gain coverage either through their parents' employers or through the newly established health insurance exchanges.⁹ Some families with incomes between 133 and 400 percent

of the FPL will also be eligible for subsidies to purchase coverage in the exchanges.¹⁰ The exchange plans and other new health plans will be required to cover basic pediatric services, including oral and vision care, and to provide free preventive care and screenings for services that are recommended for children.

While health reform is expected to greatly reduce the number of uninsured children in this country, some children will remain uninsured due to citizenship and income restrictions on eligibility for Medicaid, CHIP, and the subsidies available for coverage through the exchanges. It is also likely that there will be shortfalls in participation in Medicaid and CHIP among eligible children and non-compliance with or exemption from the individual mandate due to economic hardship or other reasons.

Role of Parental Coverage

Health reform will benefit children, particularly those in low-income families, by increasing insurance coverage among their parents. Research shows that increasing insurance coverage for parents should benefit children by increasing the extent to which parents' physical and mental health needs are being met and by increasing children's coverage and



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receipt of care.¹¹ Currently, more than 40 percent of poor parents and 33 percent of near poor parents are uninsured.¹² Many of these low-income parents will gain coverage through the expansion of Medicaid to 133 percent of the FPL.¹³ It is also expected that the new outreach and enrollment efforts associated with health reform, combined with the individual mandate, will increase coverage among the millions of uninsured parents who are currently eligible for Medicaid. Coverage is also expected to increase among uninsured parents whose incomes exceed the Medicaid cut-off because of the new exchange subsidies and mandates.

Changes in Private Coverage for Children in 2010

While the major coverage provisions will not be implemented until 2014, some provisions that go into effect in 2010 could provide immediate benefits to some children, particularly those who have private coverage already. Under these provisions, private plans will no longer be able to set lifetime limits on benefits, they are prohibited from setting “unreasonable” annual limits,¹⁴ and they cannot exclude or delay coverage for particular services for children with pre-existing health conditions.¹⁵ While these provisions are unlikely to affect many children, they could provide important benefits to children with health problems.

While not explicitly included in the legislative language, the Secretary of the Department of Health and Human Services clarified in regulations the Administration’s interpretation of this provision as including a ban on denying coverage to children due to pre-existing conditions.¹⁶ There are concerns that, prior to 2014, this interpretation may discourage private carriers from offering child-only policies due to fears of attracting

high-cost enrollees. In fact, several major insurers have indicated that they will stop issuing new coverage under this type of policy.¹⁷ An estimated 3.4 percent of children age 18 and under have coverage through the private non-group market today, and the vast majority of these children obtain this coverage through family policies (unpublished Urban Institute tabulations of the 2009 Current Population Survey). Those with current coverage could maintain those policies, but premiums are likely to increase without new healthy enrollees purchasing such plans. Insurers can be expected to aggressively use medical underwriting for family policies in the non-group market prior to 2014 for the same reason.

Changes to the Children’s Health Insurance Program

The additional two years of federal funding allocated to CHIP should increase the likelihood that children retain coverage under CHIP through 2015 and possibly beyond. By staying in CHIP as opposed to switching to exchange plans, children will likely have access to a richer benefit package and lower cost sharing but may not have access to as broad a provider base. It is not clear how long states will be able to continue their CHIP programs, however. New federal funds for CHIP are only allocated through 2015 and the law specifies that the federal matching rates under CHIP will rise by as much as 23 percentage points at that point in time, meaning that the allocations will be spent more quickly. In coming years, Congress is likely to revisit the question of whether to extend federal CHIP funding beyond 2015. If and when states run out of federal CHIP funding, children in Medicaid expansion CHIP programs will stay in Medicaid, whereas children in separate programs will transition out

of CHIP.¹⁸ Some of these children transitioning out of CHIP may enroll in exchange plans provided the exchange plans have been certified to provide benefits and cost sharing comparable to those offered by CHIP; others may transition to employer plans that cover their parents, while some may become uninsured.

Medicaid Reimbursement Increases for Primary Care

Children who are covered by Medicaid will likely benefit from the increased Medicaid reimbursement rates for primary care that go into effect in 2013 and 2014. Medicaid rates will rise to Medicare levels for primary care doctors, including pediatricians, with 100 percent financing from the federal government. This increase should improve access to primary care for children who are covered under Medicaid, although it is not clear how long the rate increases will be maintained given that they are only mandated with full federal funding through 2014. In addition, the Medicaid reimbursement increases pertain exclusively to primary care, which may fail to address access problems related to specialty services like mental health and dental care.¹⁹ Health care reform also includes funding for a Medicaid and CHIP Payment and Access Commission whose purpose is to examine provider access issues in Medicaid and CHIP, which will provide a vehicle for assessing access and payment gaps and recommending approaches for addressing them.

Other Health Benefits

Other health care reform provisions could also have positive impacts on the lives of children. In particular, provisions to expand home visiting could improve the developmental trajectories of young children, while expansions of school-based health

centers could improve access to care, if Congress appropriates the necessary funding. Likewise, the legislation includes a new Public Health Fund for efforts related to development of national strategies for health improvement, prevention and wellness initiatives; public health activities including screenings and immunizations; care coordination for Medicaid enrollees with chronic conditions; and demonstration

programs to address behaviors associated with chronic conditions such as obesity and diabetes; all of which could have positive impacts on children and their parents.

Summary

Health reform is expected to have a number of positive effects on the lives of children. While questions remain about the future of the Children's Health Insurance Program and the

adequacy of provider access in Medicaid, coverage gains under Medicaid, new insurance subsidies for parents and children, health insurance market reforms, Medicaid reimbursement rate increases for primary care, and investments in public health and prevention are likely to benefit both children and their parents.

Notes

¹ Unless otherwise cited, all information contained in this brief is based on the authors' analysis of the Patient Protection and Affordable Care Act (PL 111-148).

² Institute of Medicine. "America's Uninsured Crisis: Consequences for Health and Health Care." Washington, DC: National Academy of Sciences, 2009 and McMorrow, Stacey. "Will the Patient Protection and Affordability Act Improve Health Outcomes for Individuals and Families?" Urban Institute Policy Brief. June 2010.

³ Kenney, G., A. Cook, and L. Dubay. "Progress Enrolling Children in Medicaid/CHIP: Who Is Left and What Are the Prospects for Covering More Children?" Washington, DC: Urban Institute, 2009.

⁴ Kenney, G., A. Cook, and L. Dubay. "Progress Enrolling Children in Medicaid/CHIP: Who Is Left and What Are the Prospects for Covering More Children?" Washington, DC: Urban Institute, 2009.

⁵ Kenney, G. and A. Cook. "Potential Impacts of Alternative Health Care Reform Proposals on Children with Medicaid and CHIP Coverage." Washington, DC: Urban Institute, 2010.

⁶ Hudson, J.L. "Families with Mixed Eligibility for Public Coverage: Navigating Medicaid, CHIP, and Uninsurance." *Health Affairs* 2009; 28(4): w697-w709.

⁷ Most Medicaid-eligible children and their parents will not be subject to penalties associated with lack of coverage due to their incomes. However, the presence of a requirement to obtain coverage is expected to increase participation in insurance programs none-the-less.

⁸ Center for Children and Families. "Summary of Medicaid, CHIP, and Low-Income Provisions in Health Care Reform." Washington, DC: Georgetown University Health Policy Institute, 2010; Kaiser Family Foundation. "Medicaid and Children's Health Insurance Program Provisions in the New Health Reform Law." Menlo Park, CA and Washington, DC: Kaiser Family Foundation, 2010.

⁹ Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." Menlo Park, CA and Washington, DC: Kaiser Family Foundation, 2010.

¹⁰ If an employee has an ESI offer with a contribution requirement that is 9.5 percent of income or less, the worker and their family members are generally not eligible for subsidies in the exchange, even if their income would otherwise make them eligible. However, if the actuarial value of the plan the employer offers is less than 60 percent, the family can access exchange subsidies if they are income eligible (100 to 400 percent of the FPL).

¹¹ Dubay, L. and G. Kenney. "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid." *Health Services Research* 38(5): 1283-1301, 2003; Davidoff, A., L. Dubay, G. Kenney, and A. Yemane. "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children." *Inquiry* 40:254-268, 2003.

¹² Urban Institute tabulations of the 2009 ASEC Supplement to the CPS.

¹³ Cook, A., L. Dubay, and B. Garrett. "How Will Uninsured Parents Be Affected by Health Reform?" Washington, DC: Urban Institute, 2009.

¹⁴ Annual limits will be completely prohibited beginning in 2014. The definition of "unreasonable" during the pre-2014 period is detailed in regulations. The regulations are available at: <http://edocket.access.gpo.gov/2010/2010-15278.htm>

¹⁵ Center for Children and Families. "Early Wins for Children and Families in Health Care Reform." Washington, DC: Georgetown University Health Policy Institute, 2010.

¹⁶ The regulations are available at <http://edocket.access.gpo.gov/2010/2010-15278.htm>. Earlier, several large insurers had agreed to comply with the Administration's interpretation of this provision (Pear, R. "Insurers to Comply with Rules on Children." *New York Times* 30 Mar 2010.)

¹⁷ Alonso-Zaldivar, R. "Some Insurers Stop Writing New Coverage for Kids." *Associated Press* 24 July 2010.

¹⁸ The maintenance of effort requirements for state Medicaid programs require that states continue to cover children in Medicaid through 2019 at the eligibility level in effect when the law was enacted. This requirement applies to children in both Title XIX Medicaid and Title XXI Medicaid expansion CHIP programs. See Georgetown Center for Children and Families and Center for Budget and Policy Priorities. "Holding the Line on Medicaid and CHIP: Key Questions and Answers About Health Care Reform's Maintenance of Effort Requirements." Washington, DC: Georgetown University Health Policy Institute, 2010.

¹⁹ Wang, E., M. Choe, J. Meara, and J. Koempel. "Inequality of Access to Surgical Specialty Health Care: Why Children with Government-Funded Insurance Have Less Access Than Those With Private Insurance in Southern California." *Pediatrics* 2004; 114(5): e584-e590; Mayer, M., A.C. Skinner, and R. Slifkin. "Unmet Need for Routine and Specialty Care: Data from the National Survey of Children with Special Health Care Needs." *Pediatrics* 2004;113:e109-e115; Mofidi, M., G. Rozier, and R. King. "Problems with Access to Dental Care for Medicaid-Insured Children: What Caregivers Think." *American Journal of Public Health* 2002; 92(1): 53-58.

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About the Authors and Acknowledgements

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