

Federal Health Expenditures on Children on the Eve of Health Reform

A Benchmark for the Future

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Executive Summary

This brief provides a snapshot of federal spending on children's health in 2010 and analyses of changes in federal health spending on children over the past 50 years. It closes with a discussion of the key issues that will likely affect federal spending on children's health in the near future in light of pending health reform. Our analyses of federal health expenditures draw on a large database of federal expenditures on children age 18 and younger, from 1960 to 2010, developed by researchers at the Urban Institute and the Brookings Institution.

Over the past 50 years, children's health spending has greatly increased as a share of total health spending, although it remains modest. The federal government spent \$87 billion on children's health in 2010, accounting for 10 percent of all federal health spending that year, up from just 2 percent 50 years ago. The growth is even more striking because the children's share of the U.S. population declined from 33 percent to 24 percent over the same period.

The largest program in the children's health budget is Medicaid, which accounted for \$74 billion and 85 percent of all federal spending on children's health in 2010. Medicaid has dominated the children's health budget since its inception in 1965. Children's health spending accounts for about one-quarter of total Medicaid spending, according to our analysis. The next largest program, the Children's Health Insurance Program (CHIP), had \$7.1 billion in federal spending, accounting for 8 percent of federal spending on children's health in 2010.

Children's health spending constitutes the single largest category of federal spending on children. Health spending for children was about 20 percent of all federal outlays for children in 2010, a share that has grown from less than 1 percent in 1965 and 7 percent in 1985. Both the amount per child and the share of total federal children's spending directed to health vary with age: for the youngest children, those age 2 and younger, per capita Medicaid expenditures in 2008 were \$1,118, more than double the per capita Medicaid expenditures for older children.

In addition to spending on health programs, the federal government provides a tax subsidy for employer-sponsored health insurance (ESI) premiums that benefits many individuals and families covered by private health insurance. The most recent Census Bureau estimates indicate that 55 percent of children had coverage through an employer in 2010 (Blavin et al. 2012). We estimate that in 2010, about \$19 billion of the ESI tax expenditures went toward dependent children. This amount is not included in our estimates of federal spending on health because the ESI is categorized as a tax program.

State investments in children's health are also substantial. States and localities spent an average of \$526 per child on children's health in 2008, the most recent year for which state and local expenditure data are available, adding considerably to the \$764 per child the federal government spent on children's health (Isaacs et al. 2011).

The growth in children's health spending stems partly from the growing federal commitment to providing health insurance to low-income children; this commitment has decreased the share of



uninsured children at a time when uninsurance has been rising among nonelderly adults (Blavin et al. 2012). For example, while the shares of parents and adults without dependent children lacking health insurance coverage increased by 4.8 percentage points and 5.7 percentage points, respectively, between 2000 and 2010, the share of children lacking health insurance coverage declined by 1 percentage point. Rates of ESI coverage fell for both adults and children, but the drop for children was offset by an increase in the percentage of children covered by Medicaid and CHIP (Blavin et al. 2012).

The introduction of Medicaid in 1965 and the enactment of CHIP in 1997 have contributed to increases in insurance coverage among children and improved their access to health care (Howell and Kenney forthcoming). In the coming years, **both the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the ACA will likely lead to increased coverage for children**, which in turn should increase their receipt of well-child checkups and flu vaccinations and reduce their unmet health and dental needs and delays in getting needed care (MACPAC 2012; Kenney and Coyer 2012.)

The reauthorization of CHIP, through CHIPRA, included additional federal funding for CHIP and gave states new policy options and incentives for increasing participation and eligibility in Medicaid and CHIP among children. Since CHIPRA was enacted, a number of states have implemented eligibility expansions and/or simplifications to their enrollment and renewal processes, and children’s participation rates in Medicaid and CHIP have been rising (Kenney, Lynch, et al. 2011). Nationally, the participation rate in Medicaid and CHIP has reached 85 percent for children, which is high compared to Medicaid participation rates found for adults or participation in other means-tested programs (Kenney et al. 2012; Dorn 2007). Despite this progress, the most recent estimates suggest that almost two-thirds of all uninsured children are eligible for Medicaid or CHIP but not enrolled and that participation in Medicaid and CHIP among children varies across states (Kenney, Lynch, et al. 2011). CHIPRA also included a number of provisions aimed at improving the measurement of health care quality for children covered by Medicaid and CHIP and the quality of care those programs provide. For example, the Centers for Medicare & Medicaid Services (CMS) has awarded a total of \$100 million in grant funding to 18 states participating in CHIPRA Quality Demonstration projects.

The Affordable Care Act (ACA), which was signed into law on March 23, 2010, included a number of provisions that will affect the health insurance coverage landscape, including a Medicaid expansion, federal subsidies for coverage provided through health insurance exchanges, health insurance market reforms, and an individual requirement to obtain health insurance coverage.¹ The ACA also included a maintenance of effort (MOE) provision requiring that states retain their 2010 Medicaid and CHIP eligibility levels for children. While federal funding for CHIP was extended through fiscal year (FY) 2015, the future of CHIP coverage in 2016 and beyond is uncertain. With the maintenance of Medicaid and CHIP coverage for children, **the ACA is expected to increase health insurance coverage among both children and their parents, which in turn should increase their access to needed health care** (Kenney and Pelletier 2010a). Health insurance coverage has been shown to improve the likelihood of children having a usual source of care, well-child care, and necessary medical treatments (IOM 2009). In addition, to the extent that parents’ physical and mental health needs are better addressed, improvements in access to health care for parents could enhance children’s health and well-being (Golden and Fortuny 2011). Recent estimates indicate that the ACA could reduce the number of uninsured children and parents by 40 and 50 percent, respectively



(Kenney, Buettgens, et al. 2011). Thus, the ACA could affect children's lives through the changes in both their own health insurance status and that of their parents. The extent of coverage increases under the ACA will depend on the success of outreach and efforts aimed at streamlining enrollment and renewal processes, particularly for children living in families with mixed eligibility for Medicaid and exchange subsidies and for those who do not live with both their parents.

The magnitude of the estimated impact of the ACA on health insurance coverage for children appears to depend heavily on the continuation of CHIP coverage and whether states are required to maintain their current Medicaid and CHIP programs for children (Kenney, Buettgens, et al. 2011). Funding issues for CHIP will need to be addressed in the coming years. In addition, decisions regarding eligibility for exchange subsidies, particularly related to circumstances where premiums for employee coverage are less than 9.5 percent of family income, but family coverage is either not available or is very expensive, will affect uninsurance among children under the ACA (First Focus 2011). Coverage and access for children will also be affected by how premiums for child-only policies are determined within the new health insurance exchanges and how benefits are designed (CCIO 2011). Whether CHIP is continued or not, federal health spending on children as a share of overall federal health spending will likely decline after the major coverage provisions of the ACA are implemented, given that the ACA is projected to have larger increases in federally subsidized coverage for adults than for children, many of whom are already eligible for Medicaid or CHIP coverage (Buettgens, Garrett, and Holahan 2010).

The ACA includes a number of other provisions that could affect federal Medicaid and CHIP spending on children. For example, in 2013 and 2014, Medicaid rates are required to rise to Medicare levels for primary care services provided by primary care doctors, including pediatricians. The rate increases are federally funded for those two years. Thus, even with no enrollment growth in Medicaid, federal spending is expected to rise due to higher outlays associated with the increased provider payment rates.

Implications. Spending on children's health is an important component of the overall federal health budget and has constituted a growing component of total federal spending on children. The rapid increase in the share of the health budget spent on children may come as a surprise to many health decisionmakers, who tend to focus on policies affecting individuals who are on average more expensive, such as the elderly and disabled. It may also surprise child policy decisionmakers, who may not recognize how heavily children in America rely on Medicaid and CHIP. But the growth in federal health spending on children through Medicaid and CHIP and the success of those programs in ensuring that a large share of children have insurance argue for far greater attention by both health and children's experts to Medicaid and CHIP as key elements of the children's portfolio. Such attention may be particularly important for the well-being and long-term development of infants and toddlers, given that fully two-thirds of young children in low-income families rely on Medicaid or CHIP for coverage and in light of the evidence that health access can make key contributions to early childhood development (Kenney and Pelletier 2010b; Pelletier and Kenney 2010). With enrollment in public programs expected to increase dramatically in the coming years, it will be important to monitor access for children who receive care under Medicaid and CHIP to ensure that their critical health and developmental needs are being met.



Introduction

The federal government spent \$87 billion on children's health programs in 2010. At the same time, about 29 percent of children were covered by public health insurance and about 10 percent of children had no health insurance, with an additional 55 percent of children covered by employer-sponsored health insurance and many benefiting from a related tax break (Blavin et al. 2012). As the structure of federal expenditures on health begins to change with the implementation of the Patient Protection and Affordable Care Act (ACA), it is useful to examine current federal spending on children's health. How much of the overall federal spending on health is focused on children, and how has this changed over time? What are the items in the children's health budget? How much of federal spending on children is focused on health? What cost does the federal government bear for children covered by private health insurance? What is likely to change for the government and for children after implementation of the ACA?

To address these questions, this brief draws on a large database of federal expenditures on children from 1960 to 2010, developed by researchers at the Urban Institute and the Brookings Institution. Only programs directly benefiting children age 18 and younger or benefiting households because of the presence of these children are counted in our analyses. In addition to supporting annual reports on the children's budget overall, the database is sometimes used to examine special topics, such as this brief focusing on health spending.ⁱⁱ

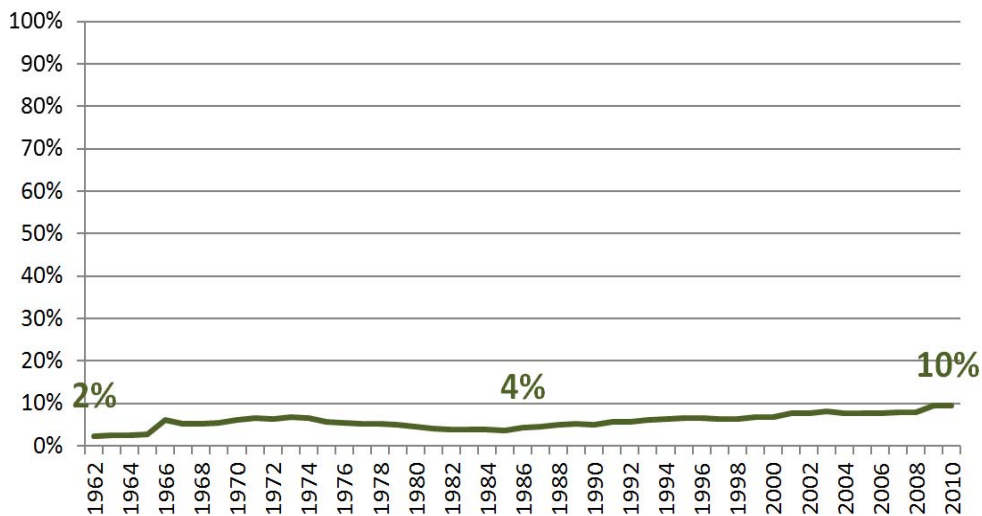
This report first examines the changes in federal health care spending over the past 50 years, following how health care has expanded as a share of the federal budget and the children's budget. Next it addresses the current composition of the children's health care budget and how it, too, has changed over the past 50 years. Next it looks at health spending as a share of the children's budget and federal expenditures for children covered by private health insurance. Finally, it examines the possible effects of health care reform on spending on children.



Kids' Share of Federal Health Spending

Federal spending on children's health is a modest share of overall federal health spending. Of the \$916 billion in total federal outlays for health in 2010, about 10 percent (\$87 billion) was for children's health. Although the children's share of federal health spending is relatively small, it has grown over the past 50 years, from about 2 percent in 1960 to its peak of 10 percent in 2009 and 2010 (figure 1). Meanwhile, the children's share of the U.S. population shrank from 33 percent in 1960 to 24 percent in 2010. The growth in federal spending relative to the size of the child population demonstrates, in part, the gradual increase in the federal commitment to children's health over the years.

Figure 1: Children's Share of Federal Health Spending



Source: The Urban Institute and the Brookings Institution, 2011. Authors' estimates based on data from the Budget of the United States Government Fiscal Year 2012 and previous years.

Note: Total health spending for fiscal years before 1980 does not include defense health.

States also spend considerable amounts on children's health. In 2010, federal expenditures on health averaged \$764 per child while state health spending averaged \$526 per child. Thus, the federal government contributed 59 percent and the states 41 percent of total public expenditures on children's health (Isaacs et al. 2011).

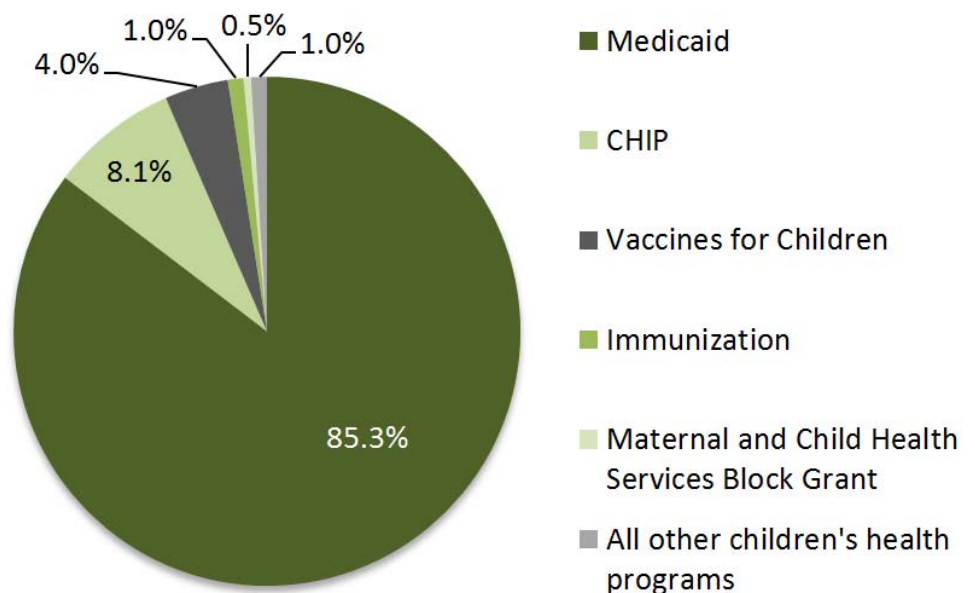


The Composition of the Children's Health Budget

Medicaid is by far the largest component of the children's health budget. With federal outlays of \$74 billion in 2010, Medicaid accounted for about 20 percent of total federal outlays on children for any purpose, and 85 percent of all federal spending on children's health. Medicaid and CHIP together accounted for 93 percent of federal spending for children's health in 2010. Medicaid and CHIP are means-tested benefit programs, funded jointly by the federal government and the states, that provide health coverage for nearly 60 million low-income adults and children. Federal law sets parameters for eligibility and requires that certain vulnerable populations be covered under these programs. Within these parameters, states determine exact eligibility criteria.

The remaining federal spending on children's health covered the Vaccines for Children (4 percent) and Immunization (1 percent) programs, the Maternal and Child Health Services Block Grant (0.5 percent), and other health programs for children, such as Healthy Start, Universal Newborn Hearing, abstinence education, and the Lead Hazard Reduction program (figure 2).

Figure 2: Composition of Children's Health Budget, 2010



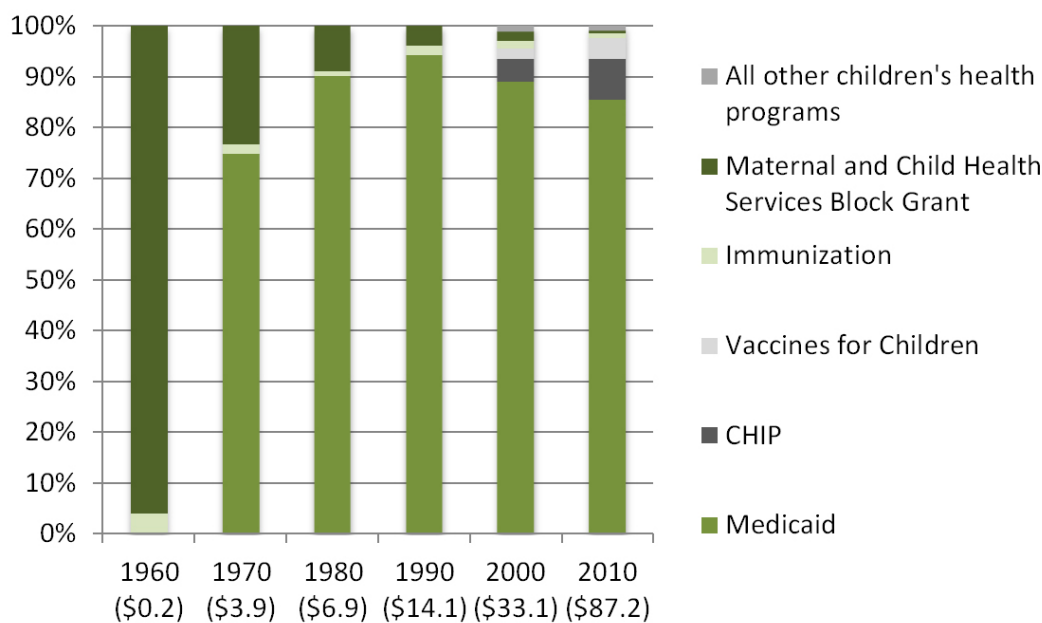
Source: The Urban Institute and the Brookings Institution, 2011. Authors' estimates based on data from the Budget of the United States Government Fiscal Year 2012.



Figure 3 illustrates both the change in composition of the children’s health budget as well as the increase in the size of the children’s health budget over the past 50 years. In 1960, the precursor to the Maternal and Child Health Services Block Grant consumed 96 percent of the children’s health budget. Since its implementation in 1965, Medicaid has dominated the children’s health budget, although the composition of the children’s health budget has changed slightly over time with the implementation of other programs. In 1970, Medicaid accounted for about 75 percent of the children’s health budget. Medicaid’s share of the budget peaked at 94 percent in 1990, then decreased to 85 percent in 2010 with the advent of the closely-related CHIP program. Spending on children’s health is about one-quarter of overall Medicaid spending.

Figure 3: Change in Composition of Children’s Health Budget, 1960–2010

(Total children’s health spending in billions, 2009 dollars)



Source: The Urban Institute and the Brookings Institution, 2011. Authors’ estimates based on data from the Budget of the United States Government Fiscal Year 2012 and previous years.

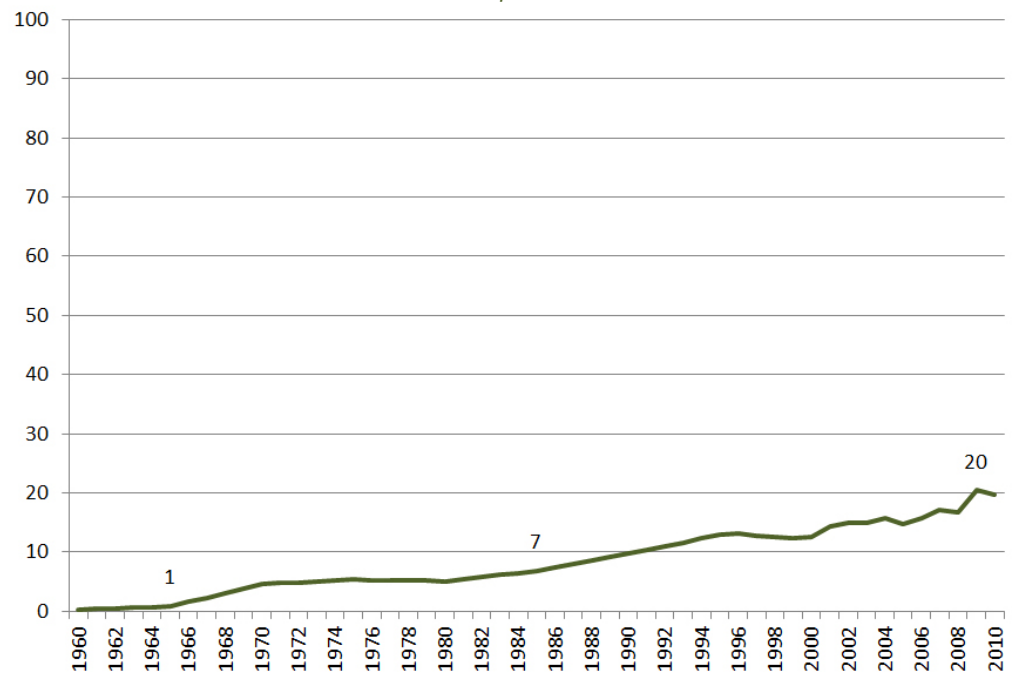
Federal health spending on children has grown substantially, from \$200 million in 1960 to \$87.2 billion in 2010 (in constant 2009 dollars). The introduction of Medicaid in 1965 quickly increased outlays on children’s health care by an order of magnitude, accounting for spending of nearly \$4 billion in 1970, when the entire children’s health budget was only \$0.2 billion just 10 years earlier. Health spending on children has more than doubled in each subsequent decade. Although Medicaid’s share of the children’s health budget fell slightly in the past decade, total spending on Medicaid so far has only grown. Federal spending on Medicaid was particularly high in 2009 and 2010 as a result of the recession increasing the number of needy children and the American Recovery and Reinvestment



Act of 2009 (ARRA) temporarily increasing the federal matching rate for this federal/state program. As the lingering effects of ARRA dissipate, federal spending on children's health through Medicaid is expected to decline between 2011 and 2012. After this small dip, spending on children's health is projected to increase between 2015 and 2020, due to increased spending through Medicaid and the new health insurance subsidies under the ACA. However, since the ACA is expected to have much greater effects on health insurance coverage for adults, federal health spending on children is expected to grow much slower than spending on nonelderly adults.

Per capita Medicaid spending is significant across all children's age groups, but it is especially high for infants and toddlers. In 2008, per capita Medicaid expenditures were \$497 for children age 3–5 and \$462 for 6–11-year-olds. For children age 2 and younger, per capita Medicaid expenditures in 2008 were \$1,118. The higher cost for the youngest children is due largely to higher medical costs for very young children (e.g., related to neonatal intensive care) and more expansive Medicaid eligibility rules for pregnant women and infants (Macomber et al. 2010).

Figure 4: Growth in Health Spending as a Share of Total Federal Spending on Children, 1960–2010



Source: The Urban Institute and the Brookings Institution, 2011. Authors' estimates based on data from the Budget of the United States Government Fiscal Year 2012 and previous years.

Note: Total health spending for fiscal years before 1980 does not include defense health.

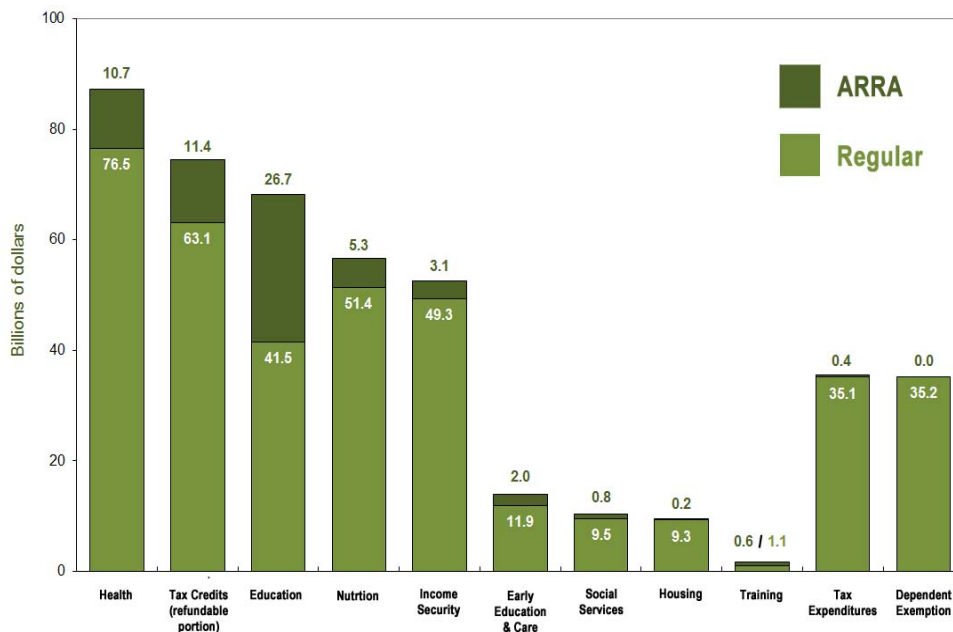


Health Spending in the Overall Children's Budget

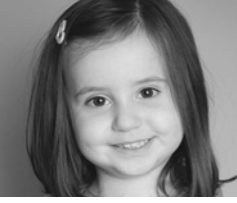
Health spending has consumed an ever larger share of the children's budget over the past 50 years. Health spending as a share of the children's budget grew from less than 1 percent in 1965 to 7 percent in 1985 to 20 percent of all federal outlays for children in 2010 (figure 4). The pattern of growth in children's health spending generally mirrors the growth of overall health spending in the federal budget. Federal spending on health as a share of total federal spending increased from 3 percent in 1965 to 12 percent in 1985 and 27 percent in 2010.

Health expenditures were the largest category of federal expenditures on children in 2010. Of the \$87.2 billion spent on children's health in 2010, the temporary expansions created by ARRA contributed \$10.7 billion (figure 5). Although the ARRA-related spending is expected to dissipate between 2011 and 2012, in the longer term health spending is expected to continue rising as a share of both the children's budget and overall federal budget. Moreover, health is the only category of federal expenditures on children that is expected to increase as a percentage of GDP between 2010 and 2020 (Isaacs et al. 2011).

Figure 5: Federal Expenditures on Children in Fiscal Year 2010, by Category



Source: Isaacs, J., H. Hahn, S. Rennane, C.E. Steuerle, and T. Vericker. 2011. *Kids' Share 2011: Report on Federal Expenditures on Children through 2010*. Washington, DC: The Urban Institute.



Federal Expenditures for Private Health Insurance

In addition to outlays on health, the federal government provides a tax exclusion (i.e., a subsidy) for employer-sponsored health insurance premiums (ESI). The exclusion of employer-provided health insurance from income tax is the largest tax expenditure for individuals, valued at approximately \$160 billion in 2010 in federal income tax revenues alone (the payroll tax preference is also significant, though not formally measured as part of the income tax expenditure budget). Because the cost of insurance for families, including dependent children, is greater than the cost for individuals, the resulting subsidy is greater for families than for individuals. Using the Urban-Brookings Tax Policy Center Microsimulation Model and the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimate that the share of ESI tax expenditure that went toward dependent children in 2010 was 12 percent or about \$19 billion.ⁱⁱⁱ Federal expenditures on ESI are counted as tax expenditures and are in addition to our estimates of federal spending on health.^{iv} This tax exclusion benefits a subset of the individuals and families covered by private health insurance, with the greatest gains going to families that face the largest taxes. The most recent estimates from the Census indicate that 55 percent of children had coverage through an employer in 2010 (Blavin et al. 2012.)

Future Health Care Spending on Children

Many factors will likely affect future federal health care expenditures for children. In particular, as described in more detail below, both CHIPRA and the ACA are expected to increase enrollment in Medicaid and CHIP coverage for children. Moreover, the increases in Medicaid payment rates slated for 2013 and 2014 will likely increase federal Medicaid spending levels for children, even with little or no enrollment growth. In 2013 and 2014, Medicaid rates are required to rise to Medicare levels for primary care services provided by primary care doctors, including pediatricians. The rate increases are federally funded for those two years. In addition, federal health care spending for children will be affected by changes in the health needs of children and in the delivery system that serves them. For example, the recent increases in childhood obesity rates may lead to increases in service costs (Cawley 2010). Alternatively, the service delivery system changes that are being adopted, such as the implementation of patient-centered medical homes and the greater reliance on electronic health records, may lead to greater efficiency and lower costs (HHS 2011a). Economic factors will also affect how many children enroll in Medicaid and CHIP; to the extent that the economy improves, enrollment in these programs should decline, which in turn will lower federal spending on them (Holahan and Garrett 2001).



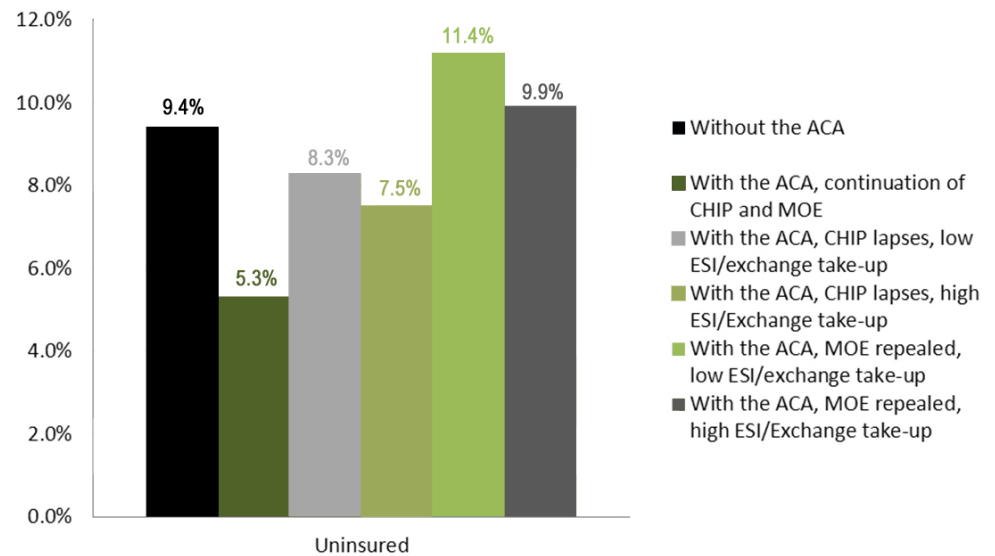
Future federal health spending on children will also depend on pending decisions regarding CHIP funding and eligibility for exchange subsidies, particularly related to circumstances where premiums for employee coverage are less than 9.5 percent of family income, but family coverage is either not available or is very expensive (First Focus 2011). Federal spending for children will also be affected by how premiums for child-only policies are determined within the new health insurance exchanges and how benefits are designed (CCIO 2011). Whether CHIP is continued or not, federal health spending on children as a share of overall federal health spending will likely decline after the major coverage provisions of the ACA are implemented, given that the ACA is projected to have larger increases in federally subsidized coverage for adults than for children, many of whom are already eligible for Medicaid or CHIP coverage (Buettgens et al. 2010).

Under CHIPRA, many states have expanded eligibility or streamlined their enrollment or renewal systems, which in turn will likely reduce uninsurance among children and increase spending levels. In 2009, 15 states expanded income eligibility levels to higher-income children; 13 states implemented expansions in 2010, followed by another 8 in 2011 (HHS 2010, 2011b, 2012). In addition to increases in the overall income eligibility level for children, states have implemented coverage expansions to groups not previously covered with federal funding under Medicaid and CHIP. As of January 2012, 23 states and Washington, DC, were covering lawfully residing children and pregnant women eligible for Medicaid/CHIP without a five-year waiting period. Moreover, in 2009, 17 states simplified their application and renewal systems; now, nearly two-thirds of states have an online application system and use data matching for eligibility determinations. In addition to these changes, the first wave of CHIPRA outreach grants were awarded in 2009 to 68 state agencies, community health centers, school-based organizations, and nonprofit groups in 41 states to support their efforts to identify and enroll children eligible for Medicaid and CHIP; a second wave of grants was awarded in 2011 to grantees in 23 states. In 2010, 16 states qualified for CHIPRA bonus payments (totaling over \$167 million) by enrolling more children in Medicaid coverage and implementing program features to promote enrollment of eligible children. The number of states qualifying for CHIPRA bonus payments increased to 23 in 2011, for nearly \$300 million in performance bonuses.

Between 2008 and 2009, participation among children eligible for Medicaid/CHIP increased by over 2 percentage points nationally (Kenney, Lynch, et al. 2011). Over that time, participation rates increased in 30 states (including DC). Nationally, the participation rate in Medicaid and CHIP has reached 85 percent for children, which is high compared to Medicaid participation rates found for adults or participation in other means-tested programs (Kenney et al. 2012; Dorn 2007). Despite this progress, the most recent estimates suggest that almost two-thirds of all uninsured children are eligible for Medicaid or CHIP but not enrolled and that participation in Medicaid and CHIP among children varies across states (Kenney, Lynch, et al. 2011).



Figure 6: Projected Uninsurance among Children under Alternative Affordable Care Act (ACA) Implementation Scenarios

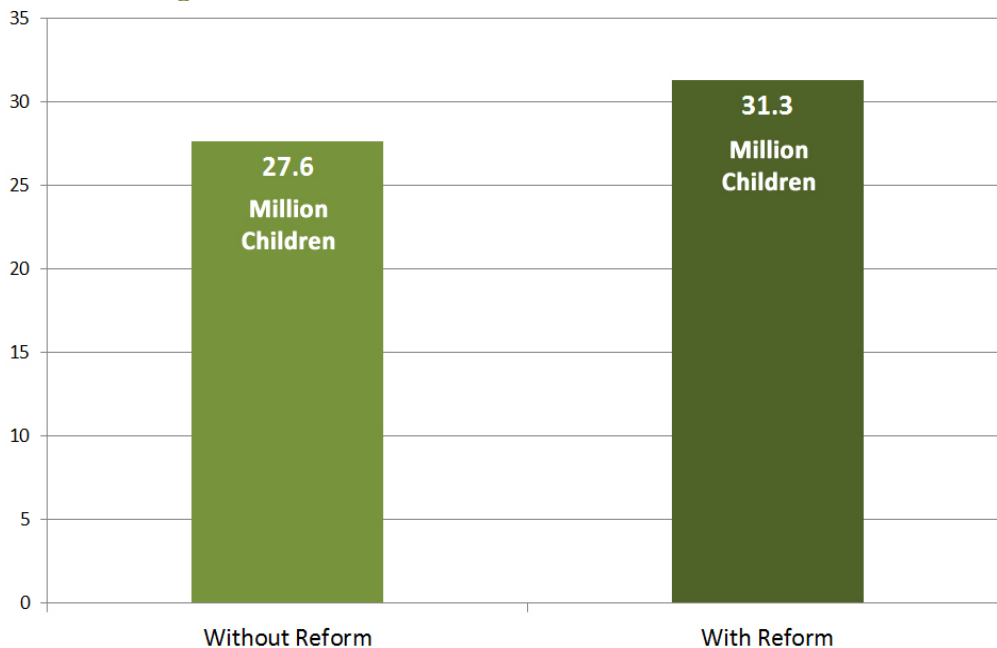


Source: Kenney, G., M. Buettgens, J. Guyer, and M. Heberlein. Improving Coverage for Children under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP. *Health Affairs*, 30, no. 12 (2011): 2371–81.

The Affordable Care Act, which was signed into law on March 23, 2010, included a number of provisions that will affect the health insurance coverage landscape, including a Medicaid expansion, federal subsidies for coverage provided through health insurance exchanges, health insurance market reforms, streamlined enrollment and eligibility determination procedures, and an individual requirement to obtain health insurance coverage. The ACA also included a maintenance of effort (MOE) provision requiring that states maintain their 2010 Medicaid and CHIP eligibility levels for children. While federal funding for CHIP was extended through FY 2015, the future of CHIP coverage in 2016 and beyond is uncertain. With the maintenance of Medicaid and CHIP coverage for children, the ACA is expected to increase health insurance coverage among both children and their parents, which in turn should increase their access to needed health care (Kenney and Pelletier 2010a).



Figure 7: Medicaid/CHIP Enrollment with and without Reform



Source: Buettgens, M., B. Garrett, and J. Holahan. "America under the Affordable Care Act." The Urban Institute. December 10, 2010.

The ACA is expected to lead to increased Medicaid and CHIP coverage for children and to new federal spending for children's coverage through the subsidized coverage that will be available through the health insurance exchanges (Kenney, Buettgens, et al. 2011).⁹ Future levels of Medicaid/CHIP enrollment for children will depend on the continuation of Medicaid and CHIP coverage for children:

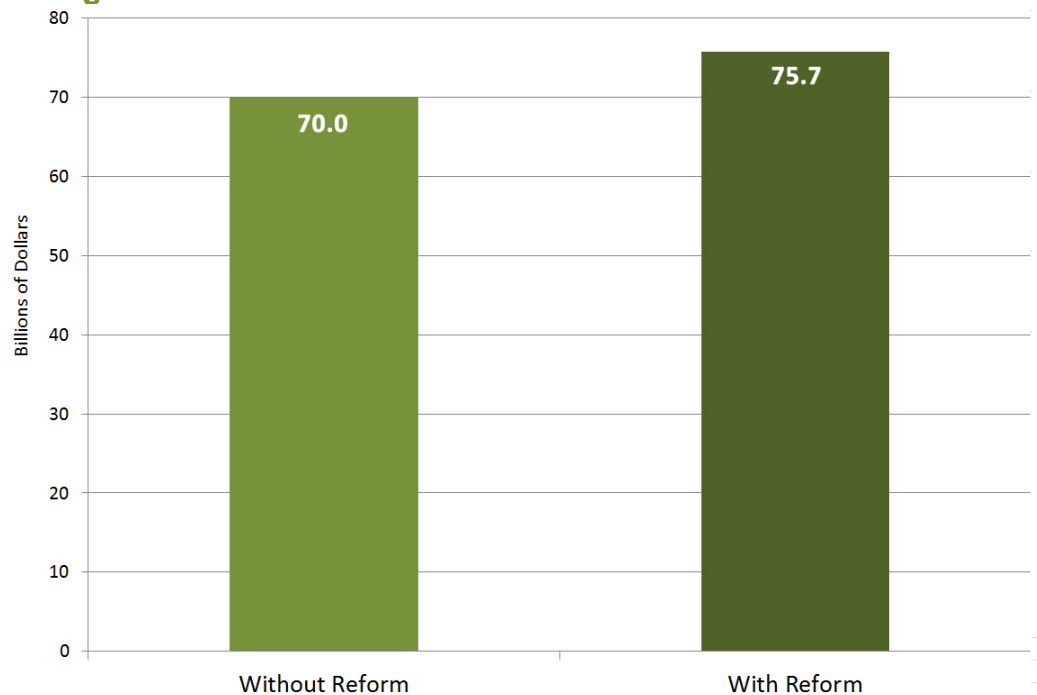
- Under the ACA with continued CHIP coverage and the MOE, Medicaid/CHIP enrollment among children is expected to increase by between 3 and 4 million.
- However, if federal CHIP funding lapses, Medicaid/CHIP enrollment among children is expected to decrease by about 1 million relative to the 2010 baseline; if, in addition, the MOE requirement is repealed, Medicaid/CHIP enrollment among children is predicted to further decline by about 4 million.
 - Additionally, the ACA is expected to enroll approximately 2 million children in exchange coverage through nongroup plans.

If federal funding for CHIP lapses in 2016, spending on CHIP would be reduced by an estimated \$8.2 billion for the federal government and \$3.7 billion for states (Kenney, Buettgens, et al. 2011). However, because some children previously eligible for CHIP would now be eligible for subsidized



exchange coverage, the federal government would spend an additional \$1.0–\$1.2 billion on subsidies. Additionally, a lapse in CHIP funding would likely increase financial burdens by \$3.4 billion for families, \$400 million for employers, and \$2.0 billion for state and local governments, mostly through increases in spending on uncompensated care. Moreover, children who switch from CHIP to exchange coverage will likely receive less comprehensive benefits and face higher cost sharing than under their current coverage.

Figure 8: Medicaid/CHIP Cost with and without the ACA



Source: Buettgens, M., B. Garrett, and J. Holahan. “America under the Affordable Care Act.” The Urban Institute. December 10, 2010.

Achieving large reductions in uninsurance among children under the ACA will depend on increasing participation rates in Medicaid/CHIP among uninsured children since around two-thirds (65.4 percent) of all uninsured children are eligible for Medicaid or CHIP but not enrolled (Kenney, Lynch, et al. 2011). A number of provisions in the ACA are expected to contribute to higher participation rates among the 4–5 million uninsured children who are eligible for Medicaid or CHIP but not enrolled: in particular, the expansion of Medicaid to adults with incomes below 138 percent of the FPL who meet the immigration requirements for coverage (i.e., who are either citizens or documented noncitizens who have been in the country for more than five years); the requirement for individuals, including children, to have coverage or to be at risk for penalties; and the new outreach and enrollment systems that will be put in place. When Massachusetts implemented health reform that included many of the same elements in the ACA, children who were already eligible for Medicaid experienced a 10.4 percentage point increase in Medicaid coverage and declines in uninsured rates



(Kenney, Long, and Luque 2010). Moreover, a number of prior studies have found that coverage expansions to parents have positive spillover effects on coverage for children (GAO 2011).

A particular concern is that some children may face more barriers to obtaining health insurance coverage due to variation in Medicaid and exchange eligibility within families and their living arrangements (McMorrow, Kenney, and Coyer 2011). Approximately 20 million children may face complex coverage scenarios under the ACA due to within-family variation in Medicaid/CHIP eligibility and potential eligibility for exchange subsidies, based on income and immigration status. Moreover, nearly 28 million children have at least one parent absent from the household, which could introduce additional complexity to subsidies and coverage. There is considerable overlap between these two groups: 6.5 million children face complex coverage scenarios due to within-family differences in eligibility and have at least one absent parent.

Table 1: Medicaid/CHIP Enrollment and Federal Costs for Children and for All Non-Elderly, with and without the ACA

	Without Reform			With Reform				Change		Percent Change	
	Medicaid/CHIP Enrollees	Cost (billions)	Average cost	Medicaid/CHIP Enrollees	Cost (billions)	Average cost	Cost per new enrollee	Medicaid/CHIP Enrollees	Cost (billions)	Medicaid/CHIP Enrollees	Cost
Children	27.6	70.0	2,536	31.3	75.7	2,419	2,046	3.7	5.7	13.4%	8.1%
Non-Elderly	42.9	246.1	5,737	59.7	297.7	4,987	3,175	16.8	51.6	39.2%	21.0%

Source: Buettgens, M., B. Garrett, and J. Holahan. "American under the Affordable Care Act." The Urban Institute. December 10, 2010.

Note: Enrollees in millions, costs in dollars unless otherwise noted

Under health reform, Medicaid would remain the primary driver of federal expenditures on health care for children. Buettgens and colleagues (2010) estimate that enrollment in Medicaid/CHIP would rise by 3.7 million among children and by 13.1 million among adults (table 1). Although Medicaid/CHIP enrollment growth is much larger for adults than for children, children would still be projected to outnumber adults among Medicaid/CHIP recipients. Currently, the Medicaid/CHIP cost per capita is far lower for children than for adults and would be expected to continue to be so under health reform (see table 1). Under this projection, health care reform increases Medicaid/CHIP enrollment among children from 27.6 million to 31.3 million, and it increases federal costs on these programs from \$70 billion to \$75.7 billion. Federal costs are projected to increase even faster for adults than children both because larger enrollment increases are projected for adults and because the federal matching rates will be higher for many newly enrolling adults than for children.



Conclusion

Health care has become an increasingly important part of the children's budget over the past 50 years. At the same time, spending on children has become an increasingly important part of federal spending on health. The growth in children's health care expenditures partly reflects a growing federal commitment to children's health. The introduction of Medicaid in 1965 and the enactment of CHIP in 1997 have contributed to increases in insurance coverage among children and improved their access to health care (Howell and Kenney forthcoming). In the coming years, both CHIPRA and the ACA will likely lead to increased coverage for children, which in turn should increase their receipt of well-child checkups and flu vaccinations and reduce their unmet health and dental needs and delays in getting needed care (MACPAC 2012; Kenney and Coyer 2012.)

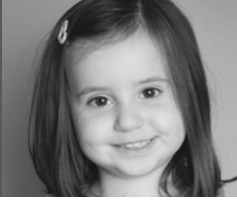
Recent estimates indicate that the ACA could reduce the number of uninsured children and parents by 40 and 50 percent, respectively (Kenney, Buettgens, et al. 2011). Thus, the ACA could affect children's lives, through the changes in both their own health insurance status and that of their parents. The extent of increases in coverage under the ACA will depend on the success of outreach and other efforts aimed at streamlining enrollment and renewal, particularly for children living in families with mixed eligibility for Medicaid and exchange subsidies and for those who do not live with both their parents.

The magnitude of the estimated impact of the ACA on health insurance coverage for children appears to depend heavily on the continuation of CHIP coverage and whether states are required to maintain their current Medicaid and CHIP programs for children (Kenney, Buettgens, et al. 2011). Funding issues for CHIP will need to be addressed in the coming years since the ACA only extended federal funding for CHIP through FY 2015. Whether CHIP is extended or not, federal health spending on children as a share of overall federal health spending will decline after the major coverage provisions of the ACA are implemented, given that the ACA is projected to lead to larger increases in federally subsidized coverage for adults as opposed to children (Buettgens et al. 2010).

Implications. Spending on children's health is an important component of overall federal spending on children and has constituted a growing share of the overall federal health budget. The rapid increase in the share of the health budget spent on children may come as a surprise to many health decisionmakers, who focus more attention on policies affecting individuals who are on average more expensive, such as the elderly and disabled. It may also come as a surprise to child policy decisionmakers, who may not recognize how heavily children in America rely on Medicaid and CHIP. But the growth in federal health spending on children through Medicaid and CHIP and the success of those programs in ensuring that a large share of children have insurance argue for far greater attention by both health and children's experts to Medicaid and CHIP as key elements of the children's portfolio. Such attention may be particularly important for the well-being and long-term development of infants and toddlers, given that fully two-thirds of young children in low-income families rely on Medicaid or CHIP for coverage and in light of the evidence that health care access can make key contributions to early childhood development (Kenney and Pelletier 2010b; Pelletier and Kenney 2010). With enrollment in public programs expected to increase dramatically for the adult population



in the coming years, it will be important to monitor access for children who receive care under Medicaid and CHIP to ensure that their critical health and developmental needs are being met.



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Notes

ⁱ By January 2014, all children in separate CHIP programs with incomes between 100 and 133 percent of the federal poverty level (FPL) will be covered under Medicaid.

ⁱⁱ See, for example, Isaacs et al. (2011). For a complete list of related publications, see http://www.urban.org/projects/kids_share.cfm.

ⁱⁱⁱ To estimate the children's share of the tax exclusion for employer-provided health insurance, we worked with analysts from the Urban Institute's Health Policy Center to combine estimates from HIPSM and the National Bureau of Economic Research's TAXSIM model. The total tax advantage for a family policy is allocated to children based on the marginal costs of providing health insurance to dependents, calculated as the difference between a family plan and individual coverage. In this case, we use marginal costs, rather than dividing the cost of the family plan equally among all members in a family, because dependent coverage is always in addition to primary coverage of the primary worker. The methodology also distinguishes between coverage for spouses and coverage for children. For more information, see *Kids' Share 2011: Report on Federal Expenditures on Children through 2010* and its *Data Appendix*.

^{iv} *Kids' Share 2011* and this brief do not incorporate the ESI into the overall estimates of federal spending on children. When the ESI is included in overall estimates of federal spending on children, then reductions in taxes becomes the largest category.

^v The estimates in Figures 6, 7, and 8 and Table 1 use HIPSM to estimate how the ACA could affect health insurance coverage and spending on health care (see Buettgens et al. 2010 and Kenney, Buettgens, et al. 2011 for more information on the microsimulation model). The authors simulate the ACA if it were fully implemented and compare the results to a pre-reform baseline.