

Covering Kids



States are working to provide public health insurance to the growing number of eligible children.

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With more federal help on the way through the economic recovery program and the reauthorization of the federal Children's Health Insurance Program (CHIP), states have a new incentive to enroll more eligible kids in public health insurance programs.

There is no question state lawmakers are in a bind, with most having just closed deep budget gaps in FY 2009 and looking to close even larger gaps for FY 2010. But the same recession

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that is putting their fiscal back to the wall also means a growing number of parents and children are without medical coverage.

Many of these children are eligible, but their parents don't know it because they've never before needed this type of public help. States and the federal government are pushing efforts to get the word out to parents that coverage is available.

California learned the importance of outreach in tough economic times during the 2001-2003 economic downturn. The state increased eligibility levels and simplified enrollment procedures for Medicaid and the Children's Health Insurance Program. Enrollment did not grow as expected, however, because the state cut its budget for outreach

and stopped supporting community-based application assistance.

Under the federal economic recovery act, a 6.2 percent increase in federal matching funds for Medicaid programs through 2010 will help states cope with higher enrollment. In states with especially high unemployment, even more federal Medicaid assistance is available. To receive these funds, states must allow any child to enroll who was eligible under its standards in July 2008. Put simply, states cannot cut eligibility for Medicaid if they accept assistance under the recovery act.

The reauthorization of the Children's Health Insurance Program is expected to provide coverage for an additional 4.1 million children by

2013, using \$33 billion in federal funds.

None of this federal money is free. Both programs require state matching money. To help, the insurance program reauthorization set up a contingency fund for states that face shortfalls because of increased enrollment. To qualify, states must surpass target enrollment levels.

CHALLENGE TO STATES

With this silver lining—and some cash assistance to go with it—states have the opportunity to begin enrolling the nearly 9 million children under age 19 who were uninsured before the recession and the newly eligible ones whose parents are recently unemployed.

Each percentage point increase in the national unemployment rate sends state revenues down 3 percent to 4 percent, swells the ranks of Medicaid and the Children's Health Insurance Program by 1 million and increases the uninsured by 1.1 million, according to the Kaiser Family Foundation.

"The economic tendency [in a recession] is to push people out of coverage," says Maryland Delegate Dan Morhaim. "We're working to stem that tide and cover as many kids as we can."

Morhaim, who is an emergency room doctor, knows what happens when people don't have access to health care. "When people don't have primary care, we see them when they are sicker and their conditions are more expensive to treat."

The harsh reality for some states is that the resources simply aren't there to cover more kids. Last year California, which had to close a \$42 billion budget gap for FY 2009 and FY 2010, changed enrollment procedures and required people to submit Medicaid renewal forms every six months instead of annually. That change may leave 260,000 children without health care coverage by 2011. California probably will have to roll back the changes to receive the increased Medicaid funds.

ENROLLMENT GAP

The twist, however, is that even with cutbacks, about 70 percent of uninsured children nationally are eligible but not enrolled for public insurance programs. As of January 2009, Medicaid and the Children's Health Insurance Program were available to kids in families with incomes at or above 200 percent

of the federal poverty guidelines in 43 states and the District of Columbia. That amounts to about \$44,000 for a family of four.

Experts say states are focusing more on enrolling low-income children than on expanding overall enrollment.

The reauthorization of the children's health program offers states incentives to make it easier to enroll as many eligible kids as possible. The act includes \$10 million for a national publicity campaign, and \$90 million in grants for state and local governments and other organizations to reach out to eligible families. Priority will be given to projects aimed at groups that are hard to reach, including \$10 million in grants for efforts that target Native American children.

States are not required to match these new outreach grants, but to qualify they must maintain their outreach budget for the previous fiscal year, which may be difficult with current fiscal pressures.

A barrier to enrollment is simply that parents lack information, according to a 2007 Kaiser Family Foundation survey of low-income parents. "They are very interested in enrolling their children, but there are gaps in awareness about the existence of the programs, who is eligible and how to apply," says Julia Paradise, a principal policy analyst with the Kaiser group that worked on the survey.

The recession makes things worse, since families who never needed these sorts of programs now are eligible because of loss of income.

More than 5.1 million jobs have been lost in this recession, which translates into "more kids without health insurance coverage," says Paradise. "This highlights the need for vigorous outreach."

Most parents surveyed said they stumbled upon Medicaid and CHIP. A passing mention of the program by a friend, a day care provider, unemployment caseworker or an advertisement at a health clinic prompted them to look into the programs. Some parents indicated that once they started the application process, they found it difficult, degrading and frustrating. Simplified enrollment and renewal procedures could ease this frustration.

Getting help with filling out the application is crucial for newly uninsured families. It gives them initial eligibility information, helps them navigate the process and makes clear which documents are needed.

EASING ENROLLMENT CAN BRING BONUSES

States may be eligible for bonuses under the Children's Health Insurance Program Reauthorization Act. To qualify, states must meet five of these eight provisions to simplify enrollment and meet its target enrollment level. The Centers for Medicare and Medicaid Services determine the bonus amount and the target enrollment level for each state. Additional guidance is expected from the centers in coming months.

◆ **Establish continuous eligibility.** Kids are automatically covered for 12 months once they qualify for benefits. This is one of the most effective ways to make sure kids have a consistent source of primary care. By the end of 2008, 18 states allowed continuous eligibility.

◆ **Allow joint application and supplemental forms.** Parents fill out a single form for both Medicaid and the Children's Health Insurance Program. States also must have a single verification process for both programs.

◆ **Have a paperless or administrative renewal verification.** Renewal forms require families to fill in only new information.

◆ **Eliminate in-person interviews.** At the end of 2008, only three states required an in-person interview at application. Only two states required an in-person interview at renewal.

◆ **Eliminate asset tests.** At the end of 2008, four states took family assets—such as their house, car or savings—into account when determining eligibility. The law provides states with flexibility in fulfilling this provision, including allowing applicants to state their assets.

◆ **Put into effect presumptive eligibility.** Children and pregnant women can receive immediate care, until the application process is complete.

◆ **Allow new premium assistance options.** States can subsidize employer and individual insurance policies, using a public and private partnership to cover children.

◆ **Exercise the "express lane" option.** States can target children enrolled in other public programs by opening access to program databases. States also can automatically enroll eligible children in Medicaid and CHIP with family consent.


OLDER CHILDREN FACE INSURANCE HURDLES

The requirements are tougher for children over age 6 to obtain public health insurance. Only 17 states and the District of Columbia have the same income eligibility requirements for children from birth through age 19. The remaining 33 states have different income requirements for infants, children age 1 to 5, and children age 6 to 19. In some states, the annual income limit for children over age 6 is half of the income limit for infants.

Differing eligibility requirements confuse parents, who may find that some of their children are eligible for state programs while others are not.

Older children and teens have different health care needs than infants and young children, but they need care nonetheless. States require schools to verify that children have had immunizations and boosters before they can attend. For instance, the Centers for Disease Control and Prevention recommends children receive vaccines such as human papillomavirus and meningitis at age 11 or 12.

Adolescents' needs center on prevention. Young people can benefit from counseling and education about the dangers of tobacco, alcohol and illicit drugs, signs of mental illness, excess weight and sexually transmitted diseases. Risky behaviors in the teen years can lead to chronic diseases. And approximately 16 percent of adolescents have chronic illnesses, such as asthma, that require regular medical care to manage.

 **CHECK OUT** information about eligibility requirements at www.ncsl.org/magazine.

STATE OUTREACH

The truth is, states were trying to improve outreach and simplify the enrollment process long before federal funds provided incentives to do so.

Shared databases between state agencies are helping streamline the enrollment and renewal process in at least 11 states. In some states, CHIP application agents can verify an applicant's citizenship and income with other state agencies rather than having the applicant re-submit documents. Many states have online applications, which are often more convenient for the consumer and reduce the administrative burden for state employees.

Florida saved an estimated \$83 million after investing in technology that allows applicants to apply for a number of public programs at once.

Delaware requires school districts to provide the health department with information about families with children eligible for free and reduced school lunch programs. The department then informs families that their children may be eligible for state health care programs and how to apply.

States are even tapping tax records to reach out to eligible families. Iowa's 2008 children's health reform legislation allows parents to identify on their tax returns their dependent children who do not have health care coverage. If they meet the income eligi-

bility requirements for any of Iowa's medical assistance programs, they receive information about enrollment.

Maryland passed the Kids First Act in 2008, requiring its comptroller to review tax returns and send parents with incomes at or below 300 percent of the federal poverty guidelines information about their children's eligibility for CHIP. Parents also must indicate on tax forms whether or not their children are insured. In 2009, the legislature required parents or guardians of children in Baltimore who are enrolled in the national school lunch program—but not enrolled in a public insurance program—to receive information about how to enroll.

"Our state's resources for outreach are limited," says Delegate Morhaim, "so we targeted kids in Baltimore City because we think it will yield the highest number of low-income, uninsured children."

MARKETING, COMMUNITY OUTREACH

Marketing the insurance programs works. Pennsylvania insures more kids than ever before, thanks in part to marketing the Cover All Kids program, which started in 2007.

"We've gone every which way in Pennsylvania to get kids covered," says Representative Katharine Watson. "Parents see information that schools send home, information in doctors' offices, on television commercials. We've been so successful with outreach and



DELEGATE

DAN MORHAIM

MARYLAND



REPRESENTATIVE

KATHARINE WATSON


PENNSYLVANIA


enrollment that we're really down to those who are choosing not to enroll their kids. Four-year-olds can't sign themselves up. It's still up to parents."

Community partnerships also can help. One way is to expand the list of people who can enroll kids. By letting medical providers, insurance agents and other employees of community organizations act as application agents, families can learn about and sign up for programs with people they know and trust.

New Hampshire created a community-based education and outreach program in 2007 that trains volunteers to promote the state's CHIP program, Healthy Kids. Agencies that provide additional follow-up with applicants are reimbursed.

The Robert Wood Johnson Foundation reports that Montana increased enrollment of Native American children by 23 percent in a two-year period when it focused community outreach efforts on this specific population. The state enlisted the help of Indian Health Services, tribal health centers and organizations to engage the community and cover more kids.

"Outreach strategies cost less money than you might think," Watson says. "Children's health care is a natural, logical priority for Pennsylvania, even in a recession. It just makes sense to provide coverage because good health starts in childhood. It's the foundation for a healthy life." 

 **CHECK OUT** a story on Illinois' All Kids program, which made it the first state to give children universal access to coverage, and other resources related to children's health insurance coverage at www.ncsl.org/magazine.

Community-Level Care a Health Safety Net

Community health centers are the backbone of the nation's health care safety net, serving more than 18 million low-income and uninsured Americans in 2008 regardless of their ability to pay.

More than 5 million community health center patients are children, many of whom are enrolled in the Children's Health Insurance Program, a public health insurance program for children that is funded by state and federal dollars. Since the inception of CHIP in 1997, community health centers have served an increasing number of beneficiaries. One out of nine kids in the program was a patient of a community health center in 2008.

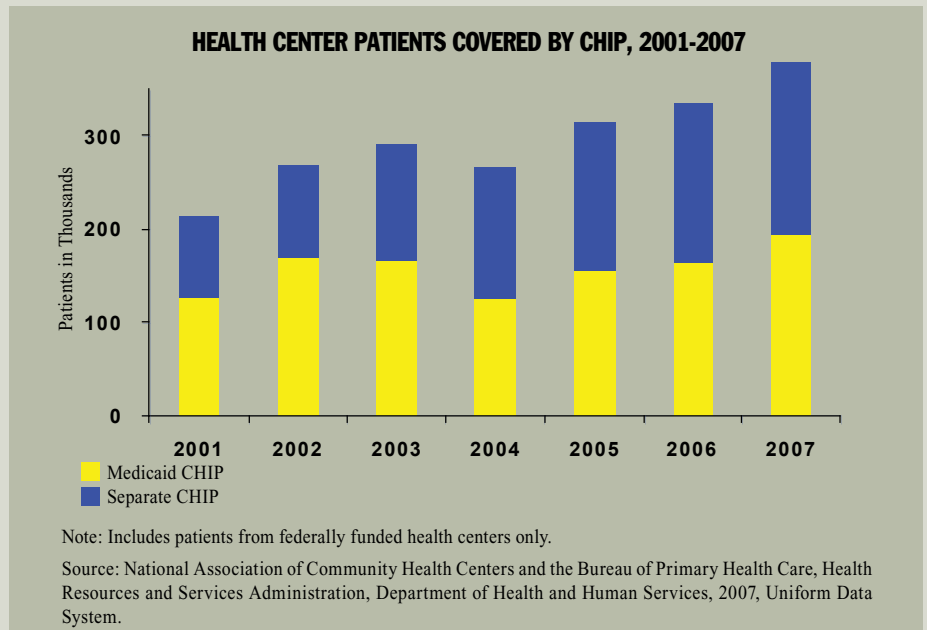
This number is expected to grow with the passage of the Children's Health Insurance Program Reauthorization Act that went into effect April 1. The act aims to add an additional 4.1 million children to the rolls of public health coverage programs by 2013. As the health care provider to more than 18 million traditionally hard-to-reach patients, including many uninsured children, community health centers are in a unique position to help states reach this enrollment goal.

Louisiana Representative Sam Jones, who serves on the board of his local community health center, says trust is a key benefit of community health centers.

"Anyone who walks through the door receives high-quality care, regardless of their ability to pay," he says. "Many patients continue to get care at [the center] after they get on private insurance or public assistance programs because of the quality of care they receive."

The act included a new payment system specifically for community health centers, a reversal of the five-year waiting period for coverage for legal immigrant children and pregnant women, a state incentive payment for enrolling new children and elimination of barriers for contracting with private dental providers for services.

These provisions will help community health centers meet the needs of kids. For example, the new payment system will put in place a reimbursement system that is similar to the Medicaid payment system, allowing health centers to receive reimbursement



for "reasonable costs." Payments will more accurately reflect the cost of providing care, recognizing the full scope of services that health centers provide, including transportation, translation and other support services. More adequate payments will improve the financial security of health centers and allow them to serve additional patients.

Community health centers offer care to people with nowhere else to go, including legal immigrant children. The new federal law also gives state Medicaid and CHIP programs the option to cover legal immigrant children and pregnant women without the previously mandated five-year waiting period. If the state chooses to cover this population, community health centers will receive payment for these previously uninsured patients, freeing up resources that can be used to serve additional patients.

The new federal law also includes fiscal incentives for states to enroll eligible low-income children in Medicaid. States could qualify for a bonus for new children enrolled based on how far actual enrollment exceeds target levels. Community health centers will play a significant role in enrolling uninsured families in the programs, a role they played in Massachusetts after passage of the state's 2006 health reform law that aimed for universal coverage.

Dental services are a required benefit under the children's health insurance plan, but not every community health center offers those services. This legislation allows federally qualified community health centers to contract with private dental practices to provide care.

Community health centers' ability to offer quality care with relatively low cost to the nation's most vulnerable populations has attracted both state and federal investment into this program. Under the Bush administration, federal funding for the creation of new community health center sites greatly increased, and about 2,500 new sites were created. The economic recovery act includes support for community health centers for capital, information technology and workforce needs. This funding will allow health centers to create jobs to stimulate their local economies and serve additional patients. In 2009, 38 states and the District of Columbia funded health centers for a total of \$518 million.

However, these investments have not protected community health centers from feeling the pinch of the current economic downturn. As a rule, community health centers operate on a thin margin with complex revenue streams, and any increase in the number of uninsured affects their operating budgets.

—Melissa Hansen, NCSL