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Health Reform that Works for Kids

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Introduction

Congress has set the stage for further steps toward providing affordable coverage for all Americans with the reauthorization of the Children's Health Insurance Program and significant investments in health care infrastructure in the American Recovery and Reinvestment Act in 2009. As the nation's attention turns to systemic health reform, one challenge will be to ensure that all children enjoy stable, affordable coverage.

Leaders of the push for health reform appear committed to ensuring that all children enjoy the health benefits and enhanced financial security of health coverage. Yet proposals currently under development in Congress will not automatically achieve this goal. Current proposals pay more attention to expanding coverage for uninsured working-age adults than for uninsured children, while delivery system reforms may not necessarily benefit pediatric patients. Congress must ensure that systemic health reforms work for children. Children's advocates will need to identify and pursue opportunities embedded within health care reform proposals to ensure that all children will have affordable, meaningful coverage that meets their unique needs.

Congress is now weighing new approaches to providing affordable coverage for all Americans. Congressional committees have not yet released initial legislation, but it is already evident from option papers and other materials that the legislation will build on the framework of "shared responsibility," also embraced by President Barack Obama's campaign plan. This approach seeks to expand health coverage and reform the health care delivery system through a combination of public insurance program expansions, subsidies for private coverage, restructuring the health insurance market, and investments in delivery system improvements.

How well these reforms will work for children is an open question. Policymakers must carefully consider their choices to ensure that all children can enjoy the benefits of health coverage.

The analysis that follows addresses critical questions, including:

- How to guarantee that children's coverage is available and affordable for all families.
- Whether private plans' benefit designs will include services critical to children's care.
- Whether low-income children can be enrolled in public plans with historically generous benefit packages.
- How to ensure equitable financing that does not ask families to bear a heavier tax or premium burden than other Americans.
- The scope of health system improvements.

Background

Approximately 55 percent of the nation's 79 million children held employer-sponsored health insurance through their working parents in 2007. Medicaid and the Children's Health Insurance Program—the other major sources of health insurance for American children—covered approximately 29 percent, or 22 million children.[1] Medicaid covers the vast majority of these low-income children; CHIP enrollment reached a monthly peak of 4.4 million children during 2007.[2] Another 9 million children had no health coverage.[3]

Recent efforts to expand children's health coverage are grounded in incremental approaches to health reform. The CHIP program, for example, can be traced back to the "children first" approaches that proliferated in late 1994, when it was clear to many policymakers and health reform advocates that the Health Security Act would die in Congress. Children's coverage was seen as a relatively inexpensive and politically palatable interim step that could establish important precedents and institutions for subsequent comprehensive reform efforts. In the end, this approach failed to gain traction, and Congress adjourned without taking serious action to cover children first.

By early 1997, however, Congress and the public showed significant interest in expanding children's health coverage, particularly through a Medicaid eligibility expansion or the creation of a new children's health insurance program. Congress ultimately dedicated nearly $40 billion over 10 years to children's coverage through a new block grant program that states could use to expand coverage to children living in families with too much income to qualify for Medicaid, but with too little income to purchase health insurance on their own.

Today, the CHIP program provides states with considerable flexibility in program design—such as eligibility and benefits—and covers a higher proportion of program costs through federal matching funds than the traditional Medicaid program. In contrast to the Medicaid program, states receive a capped federal allotment, which is immune to changes in health care costs, economic downturns, or successful outreach. Eligible children are not guaranteed coverage; if states run out of federal matching funds, they may freeze enrollment, cut benefits, increase premiums, or take other steps to weather their financial shortfall. During tough economic times, states have undertaken all of these strategies to make ends meet.

The Medicaid program has also faced significant shortcomings. Prior to CHIP, Medicaid was the traditional avenue for expanding children's health coverage through eligibility expansions and state-initiated waiver programs. Unlike federal CHIP funds, federal Medicaid funding is not subject to appropriation, and thus is effectively unlimited. But state funds—which drive Medicaid spending—are not. Over the years, states have reduced provider payment rates, established cumbersome application and renewal processes, and turned to private managed care contractors in efforts to control program costs. Such strategies threaten beneficiaries' access to coverage and access to care.

Key issues for health reform and children

Shared responsibility

A final proposal emerging from Congress will likely include a requirement that all individuals and families hold health insurance coverage—a requirement that the Obama campaign plan did not include.[4] The proposal will also likely require employers to provide coverage for their employees or make a contribution on their behalf to the financing pool that supports premium subsidies. These mandates—particularly if enacted in combination with strategies to make coverage more affordable—are intended to ensure that all Americans obtain coverage, but they raise some significant questions about children's coverage.

Because children who hold employer-based coverage obtain it through a working family member, it is hard to know the degree to which shared responsibility requirements may enable children to enjoy stable, affordable coverage. Instead, the interaction between individual and employer coverage requirements could leave some families with children facing significant new premium responsibilities. In particular, nearly 70 percent of uninsured children today live in a family with one or two full-time workers—workers whose employers, in many cases, do not offer dependent coverage.[5] These families will be required to purchase coverage on their own for their children, or face a financial penalty unless their employers begin providing dependent coverage.

Policymakers will need to address several questions to ensure that shared responsibility results in improved children's coverage. If employers are required to provide or otherwise pay for dependent coverage, children in working families would have a guarantee of coverage. If employers are not responsible for dependent coverage, policymakers will need to make sure that children's coverage is available and affordable to parents who do not receive an employer's help with their children's health insurance.

Some children will qualify for coverage through Medicaid or CHIP, and these working families will need easy access to these insurance programs in order to comply with a mandate that their children hold coverage. Other parents may need to purchase children's coverage as an add-on to their employer-sponsored health insurance, or the insurance exchange may need to make child-only policies available to these families. And policymakers will need to decide

whether families whose workers hold employer-sponsored coverage will also qualify for premium subsidies to cover the costs of children's coverage.

Appropriate benefits

The size and scope of the benefit packages—offered through the reformed health insurance market of the insurance exchange—is likely to be a matter of significant debate. This decision will determine whether coverage is truly affordable for lower and middle-income families—how much they will have to pay out-of-pocket on cost-sharing and services not covered by health insurance. It will also influence the price of coverage within the exchange and, by extension, the total cost for premium subsidies.

Decisions about benefit design will be particularly important for children. Health services play a significant role in a child's life—influencing lifelong skills such as speech and physical activity, as well as school performance. Policymakers should be careful not to shortchange children's services when considering benefit packages that feature cost-sharing incentives and other strategies for reducing overall premium costs.

The Early, Periodic Screening, Diagnosis and Treatment benefit under Medicaid has historically provided a comprehensive range of health services for children. This includes health supervision, specialized services for children with special needs, and other care necessary to manage children's growth and development. This comprehensive benefit package, in combination with low cost-sharing requirements, is particularly valuable to the low-income children who participate in Medicaid. Through EPSDT, Medicaid offers more generous benefits than most commercial insurance, or even the CHIP program. Some policymakers have suggested that low-income children (and low-income enrollees of all ages) could enroll in private plans and receive these cost-sharing protections, therapy services, enabling services like translation and transportation, and other "enhanced" benefits through a "wraparound" benefit. Rather than introducing this greater level of complexity—and uncertainty—Congress should commit to covering low-income children through public programs with comprehensive benefit packages.

Accessibility and adequacy of public insurance programs

The final health reform proposal may rely on Medicaid and CHIP as two of the major platforms for children's coverage, particularly for low-income children, but these programs should first be examined for their accessibility and adequacy. States have adopted many innovative approaches to ensuring that children can enroll and remain enrolled in public health insurance programs, yet gaps do remain. Approximately 6 million children are estimated to be eligible for but not enrolled in Medicaid and CHIP.[6]

Some of these families may be unaware that they qualify for public coverage, and others experience significant frustration when they try to enroll. Further efforts to streamline the

application process and ensure that children who remain eligible maintain their coverage will help determine whether reform can work for children. Some successful initiatives include simplified program applications, one-on-one enrollment assistance, "express-lane" eligibility that automatically applies income and assets information from other public benefit applications to health insurance applications, and online enrollment efforts.[7]

At the same time, children with public coverage—and other Medicaid beneficiaries—need to know that their health coverage guarantees meaningful access to health care. This may require addressing Medicaid's historically low provider payment rates to ensure that sufficient numbers of doctors, nurses, and other providers accept patients with public coverage. It may also require new federal financial commitments to ensure that in bad economic times states can continue to run robust programs. An additional option would be to address the disparity in federal matching rates between the Medicaid and CHIP programs by increasing the federal Medicaid match – and to require states to invest the savings they would experience from this increased federal payment into improving their children's coverage programs. Appropriate improvements could include increased provider rates, improved enrollment strategies, and reduced cost-sharing.

Equitable financing

Congressional leaders will consider a range of near-term cuts in Medicare and Medicaid provider payments, long-range savings from delivery system reforms, and new revenues as part of health reform. In the process, they must consider whether these approaches treat families fairly. For example, families on average already pay 27 percent of total premium costs for employer-sponsored coverage while individuals with single coverage pay 16 percent, and premiums for family coverage cost nearly three times more than premiums for single coverage.[8]

Changes to the tax treatment of employer-sponsored benefits may result in families with children bearing an unintentionally large share of new taxes to finance reform. Families' policies carry higher premiums, meaning that they currently receive a greater tax benefit from the current tax exclusion, which does not consider employer-paid premiums as income subject to the income tax. But they are therefore at greater risk for incurring increased taxes if Congress chooses to tax some portion of these benefits. If the tax exclusion is capped based on the annual premium, Congress may need to consider policy approaches that adjust the tax threshold for policy type or family size.

System improvements

Health reform is likely to include changes to the health care delivery system as well as health care financing. Investments in health information technology, an expanded health care workforce, and research that evaluates the comparative effectiveness of treatments, drugs, and devices have been signature components of the Obama campaign plan and the Finance

Committee's options papers. Policymakers are also considering changes to health care payment systems—particularly Medicare payments—to place greater emphasis on primary care and care coordination.

It will be important to ensure that these investments and new incentives consider children's unique needs. For example, most discussion of payment reforms designed to promote the development of medical practices that emphasize care coordination and primary care—the "medical home" model—focuses on patients with chronic illnesses, because these patients would most benefit from the improved coordination and disease management that may be offered by this emerging model. Congress appears to be contemplating changes to Medicare payment systems to entice providers to adopt this model of chronic care management.

Policymakers look to Medicare payment systems as a way to leverage delivery system reform because, given Medicare's sheer size, its payment incentives will drive provider behavior. But Medicare is not a major payer for pediatricians, and children are also likely to benefit from the medical home model's emphasis on continuity and care management. Policymakers will need to look to other payers—notably Medicaid and CHIP—to create similar payment incentives for improving children's care. Current state efforts— such as pediatric medical home initiatives in Colorado and North Carolina—may provide useful models.[9]

The American Recovery and Reinvestment Act implementation plans should also give appropriate consideration to children's unique needs. For example, as the Agency for Healthcare Research and Quality and the National Institutes of Health develop their plans for comparative effectiveness research, they will need to consider how to include common pediatric illnesses in their research portfolio. And as HHS implements new standards for electronic health records, they will need to anticipate the privacy complications related to adolescent health.

Conclusion

As policymakers and advocates prepare for the initial legislative efforts on health reform, they are responsible for not only considering how to fully include all Americans within the nation's health coverage system, but also for ensuring that the particular needs of subgroups are understood and addressed within the legislation. Children are one such group whose needs differ from those of the general population. The issues highlighted here—such as the application of shared responsibility, the adequacy of the benefit package, and the breadth of health system improvements—suggest that Congress will need to take special steps to ensure that children fully benefit from this historic effort to improve the nation's health care system.

Endnotes

1 Karyn Schwartz and Jhamirah Howard, "Health Insurance Coverage of America's Children," Kaiser Commission on Medicaid and the Uninsured, January 2009, available at http://www.kff.org/uninsured/upload/7609-02.pdf.

2 Vernon Smith and others, "SCHIP Enrollment in June 2007: An Update of Current Enrollment and SCHIP Policy Directions," Kaiser Commission on Medicaid and the Uninsured, January 2008, available at http://www.kff.org/medicaid/upload/7642_02.pdf.

3 Schwartz and Howard, "Health Insurance Coverage of America's Children."

4 The Obama campaign plan did require parents to obtain coverage for their children. This element, however, received relatively little attention and the campaign did not offer many details on how this requirement would be implemented.

5 Schwartz and Howard, "Health Insurance Coverage of America's Children."

6 Georgetown University, Center for Children and Families, "The Last Piece of the Puzzle: Providing High Quality, Affordable Health Coverage to all Children through National Health Reform," May 2009.

7 Dawn Horner and Beth Morrow, "Opening Doorways to Health Care for Children," Kaiser Commission on Medicaid and the Uninsured/The Children's Partnership, May 2006, available at http://www.childrenspartnership.org/AM/Template.cfm?Section=Health&Template=/CM/ContentDisplay.cfm&ContentID=9011; Southern Institute for Children and Families, "Covering Kids and Families: Promising Practices Report," April 2007, available at http://www.coveringkidsandfamilies.org/resources/docs/CKFPromisingPractices.pdf.

8 Kaiser Family Foundation/Health Research and Education Trust, "Employer Heatlh Benefits 2008 Annual Survey," available at http://ehbs.kff.org/.

9 National Academy of State Health Policy, "Results of Medical Home Scan," available at http://www.nashp.org/_docdisp_page.cfm?LID=980882B8-1085-4B10-B72C136F53C90DFB