



THE FUTURE OF **Children's Health Coverage** IN COLORADO

FULL REPORT

*Policy Considerations
for Insuring Colorado's Kids*



**Healthy Kids
A Healthy Colorado**

Acknowledgements

All Kids Covered is a statewide, non-partisan coalition dedicated to increasing access to affordable, high quality health insurance coverage and health care services for all children in Colorado. Since 2006, All Kids Covered has worked together with elected officials, health care leaders, state and county agency staff and community-based organizations to improve, expand and protect health insurance options for children and families in Colorado.

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Introduction

Health care coverage is essential to ensuring kids grow up healthy and strong. Insured children are more likely to get the care they need to stay healthy and recover from illness or injury. Families with uninsured children report that they often do not have a usual source of care, postpone or forgo care they need because of cost and cannot afford prescription medications, putting their children's health and success at risk.

We've made tremendous progress in reducing the number of uninsured children in Colorado. This is due in large part to the fact that making sure kids have health coverage is a shared value. In a time of increasing political polarization, kids' coverage is an issue where Democrats, Republicans and Independents have common ground. Since 2008, Colorado policymakers from both political parties have approved legislative and regulatory changes that have protected and expanded access to coverage for children through public programs and in the private market.

In the midst of this progress on coverage for kids, a broader, complimentary health reform effort has gotten underway. The centerpiece of this effort, the 2010 federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA), has garnered lots of attention, but Colorado has been pursuing health reform through state-level efforts predating the ACA. Colorado is continuing to capitalize on opportunities made possible through the federal framework in ways that are most appropriate for our state and our residents. For example, Colorado elected to create a state-based insurance marketplace rather than use the federal exchange, took state legislative action to ensure the continuation of child-only health insurance products in the private market and opted to streamline Medicaid eligibility for children by eliminating the so-called "stair-step" prior to the federal requirement to do so.

While children will benefit in many ways from policies in the Affordable Care Act, the focus of coverage expansion has shifted to adults, including parents and adults without dependent children, and the ACA addresses issues outside the scope of kids' coverage. This paper aims to identify the key considerations for ensuring health care coverage for children remains a priority in the coming years: **How will Colorado protect the gains made in kids' coverage and ensure continued progress toward the shared goal of ensuring all Colorado children have affordable, quality health coverage in the context of broader health reform?**

Of particular importance is the open federal policy question about the future of the Children's Health Insurance Program (CHIP). This critical piece of the health care safety net provides coverage to children and pregnant women who earn too much to qualify for Medicaid, but cannot afford private health insurance. The federal-state partnership program, which was a bi-partisan policy initiated in 1997, is funded only through 2015. Some have argued that new subsidies for private health insurance, made available through the Affordable Care Act, should negate the need for the CHIP program, allowing federal policymakers to discontinue it without significant consequences for children and pregnant women. Others, however, caution that that may not be the case and urge federal policymakers to extend funding of CHIP to allow more time and analysis of the new coverage options before ending a successful program that has provided critical care benefits to millions of American women and children. The federal policy debate over the future of CHIP is likely to start in 2014 and the outcome of that decision will have profound impacts on children's health insurance coverage nationally and in Colorado.

The future of CHIP is a critical part of the conversation about the future of kids' health coverage, but it is not the only one. This paper identifies and explores seven key topics that policy leaders committed to children's health coverage will grapple with in the months and years to come.

- 1. Continued attention to children's health coverage.** Champions for children's health care – elected officials, health care providers, community leaders and advocates – must remain vigilant about how implementation of health reform and the ACA are impacting affordability, access and quality of coverage for kids. Children live in families and communities that are stronger when adults also have coverage and are healthy, so this should not be an issue of children versus adults. However, we should also endeavor to ensure pediatric-specific needs are not ignored or lost in the shuffle of policy debate and implementation of new programs that are primarily designed to benefit adults.
- 2. The future of coverage for children currently enrolled in CHP+.** An important question regarding health coverage for children is what future coverage options would be available to the approximately 70,000 Colorado kids served by CHP+ today if Congress discontinues funding for CHIP at the federal level. Tens of thousands of families in Colorado have come to depend on and trust the safety net that has been built through the CHP+ program. It is popular with families, providers, and state policymakers because it offers quality coverage at an affordable cost. If it is significantly altered or discontinued, would Colorado families be able to find comparable coverage at a similar cost elsewhere?
- 3. The impact of complex coverage for families with health insurance of various types.** The Affordable Care Act, by design, creates new opportunities for and types of health coverage, which for some families will create complex coverage situations. In these "blended" families, individuals within the same family will have different sources of coverage because of the availability and cost of employer sponsored insurance, varied eligibility requirements of different publicly funded programs (Medicaid and CHP+), and differing immigration status. Research has shown that when parents have coverage, the enrollment and take-up rate of eligible children being enrolled in coverage is greater. Child advocates will need to pay attention to how successful expansions for families are implemented, particularly through newly operating health insurance marketplaces like Connect for Health Colorado. If parents have difficulties with coverage and access, children could be impacted.
- 4. The movement of family members between different types of coverage and being uninsured.** Inevitably, people will move from one type of health coverage to another, or between being insured and uninsured, due to changes in income, age, marital status, disability status, or changes in public program eligibility rules. This is sometimes called "churn" or "movement". While movement from one program to another has been the reality for years, because of changes mandated by ACA, there is concern that this issue may become more problematic. Advocates and policymakers must be vigilant about details of program implementation to minimize movement and ensure that transitions between coverage types are as smooth and seamless as possible for consumers.

- 5. The affordability of coverage.** Private insurance, even with premium assistance, may be more expensive for families than CHP+ or Medicaid and out of reach for working families, especially when considering co-pays and deductibles on top of premiums. Advocates and policymakers should pay close attention to this question and collect baseline information about the current premiums and out-of-pocket expenses families pay now, and compare that to what families will pay when they buy a plan in the new marketplace, including factoring in the additional subsidies for lower income families.
- 6. The adequacy of benefits for children.** Under the Affordable Care Act, states are required to establish a benchmark plan that meets certain minimum benefit requirements. Colorado has chosen the Kaiser small group plan (Kaiser Ded HMO 1200D) as the Essential Health Benefits package for our state. For most children, this benefit plan will adequately meet their needs. However, for low-income and vulnerable children with disabilities, there is a lower level of confidence that a private insurance product administered by companies without experience serving children of this income range and health status will be sufficient. Benefits for children in publicly funded programs like Medicaid and CHIP have a child-centric focus, and program administrators, providers and advocates have worked long and hard to assure that children of all backgrounds get the benefits and protections they need to grow up healthy. That same level of attention will need to be paid to ensure newly covered children served by private insurance have the level of coverage needed to support their overall success.
- 7. The ability of immigrant children to acquire coverage and access services.** A portion of Colorado's uninsured children are not eligible for Medicaid, CHP+ or subsidized coverage through Connect for Health Colorado due to their immigration status. There are barriers for both legally residing and undocumented children accessing publicly subsidized health care. An important question for the future is whether policymakers, providers, and advocates will be interested in supporting the safety net providers that currently serve all children regardless of their immigration status, in encouraging the state to use federal options to cover legally residing immigrants in Medicaid and CHP+, or in creating new programs or funding streams to provide health care to this population.

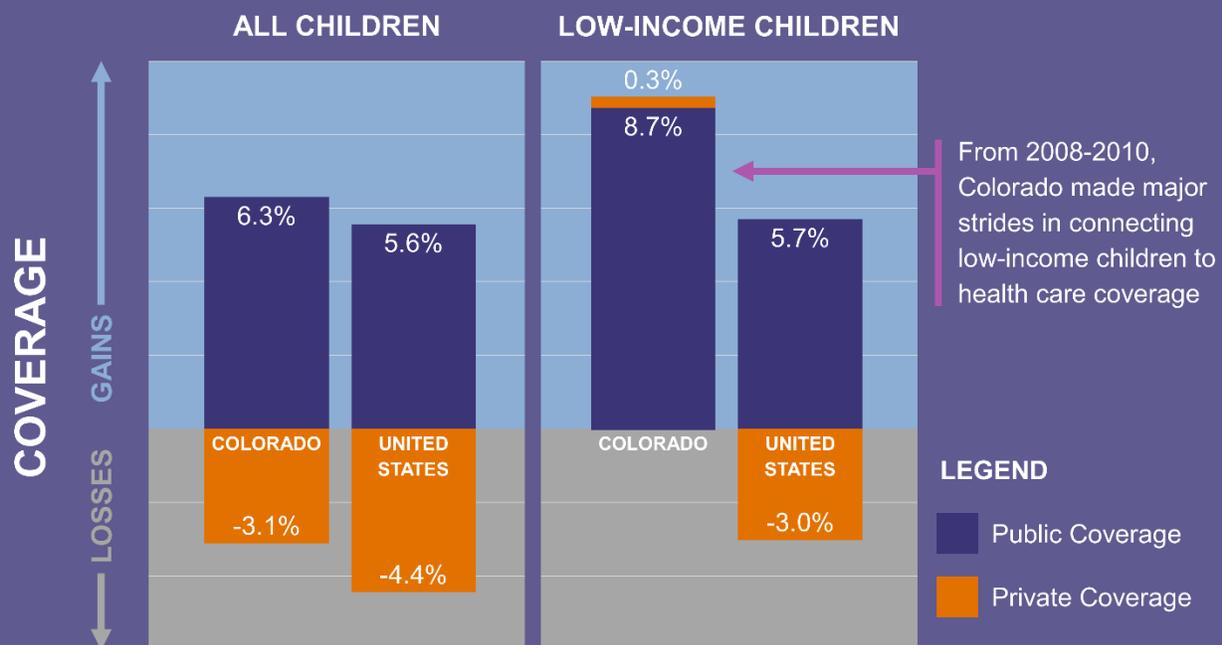
Colorado has made incredible progress in providing health care coverage to children, but the work is not done. Together we can capitalize on the opportunities presented by health reform and reach our shared goal of ensuring every Colorado child has high quality, affordable health care.

Benefits of Health Coverage

Studies have shown that children with health insurance coverage, whether public or private, have better access to care and better health outcomes than their uninsured peers. Children enrolled in CHIP have much lower rates of unmet health care needs, with one study finding that 2 percent of children enrolled in public programs have unmet health care needs, compared with 11 percent of uninsured children (Bloom and Dey 2004). As children move from being uninsured to being enrolled in CHIP, they receive more preventive care and better access to health care providers overall (Woolridge, Kenney, and Trenholm 2005). A 2007 study showed that in states in which rates of employer-based insurance declined significantly, public coverage through CHIP and Medicaid prevented children from experiencing the same coverage loss that adults did as a result of this change in employer-based insurance (Zuckerman and Cook 2006).

In the last several years, rates of coverage for children have varied as economic conditions have changed. Table 1 provides information about changes in children's coverage nationally and in Colorado, with specific information about rates of private coverage and public coverage for children in higher income and lower income families, as well as rates of uninsurance. In Colorado and nationally, we are making progress in insuring more children. In Colorado, the percent of uninsured children overall has gone down 3.1 percentage points, with the rate of uninsurance for low-income children going down dramatically, by 9.1 percentage points. Gains in insurance have come through expanded enrollment in public coverage programs, Medicaid and CHIP. In fact, employer-sponsored insurance coverage for dependents has decreased.

Change in Rates of Children's Insurance Coverage, 2008 to 2010



Source: SHADAC. August 2012. Keeping Kids Covered: Number of Children with Health Coverage Increases During Economic Downturn: A State-by-State Analysis.

Medicaid and CHIP Overview

Medicaid and CHIP serve different populations of children and often provide different benefits and cost-sharing. The lowest income children, those in families with income up to roughly 133 percent of the federal poverty level, are served by Medicaid, though some states provide Medicaid coverage to children and youth with higher family incomes. Nationally, nearly 31 million children are covered by Medicaid (Kaiser Commission 2012). Medicaid provides comprehensive benefits through the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), and cost sharing is prohibited for children with family incomes under 100 percent of FPL. Premiums are not allowed below 150 percent FPL. Children who do not qualify for Medicaid because their family income is too high may be eligible for CHIP. In 2012, there were 8,128,397 children and youth in the U.S. under 18 covered by CHIP (Kaiser 2013). The benefits associated with CHIP programs vary from state to state. States may also set premiums and cost-sharing amounts under an overall limit of five percent of a family's income (CMS 2008). The median eligibility threshold for children across the nation in 2012 was 235 percent FPL, while Colorado's maximum eligibility level is 250 percent FPL (Heberlein 2013).

Access and Quality of Care in Public Coverage

Two important metrics of success for public health coverage programs are access and quality of care. Generally, research suggests that both Medicaid and CHIP significantly improve access to care, especially primary and preventive care and that children enrolled in Medicaid or CHIP have nearly the same access as children on private insurance (Georgetown 2013). Most major data sets do not distinguish between the two public programs. However, there is growing concern about the ability of Medicaid to ensure adequate access to care with states shifting children's eligibility groups to Medicaid as required by the ACA, and perhaps exacerbated in states that are also expanding Medicaid to newly eligible adults, creating additional demand for services in 2014.

In terms of quality of care in CHIP programs nationally, studies suggest it is similar to quality of care for children enrolled in Medicaid, and that problems in CHIP seem to be similar to problems found in private insurance coverage (Kaye, Pernice, and Cullen 2006). Very few studies have compared health outcomes for children in CHIP versus Medicaid or private insurance, and those that have looked at health outcomes tend to focus on specific clinical conditions. For example, one study found that having coverage, whether Medicaid, CHIP or private insurance, resulted in fewer asthma-related attacks, compared to the number when the child was uninsured (Szilagyi, Dick, and Klein 2006).

Children's Health Insurance Program

Background

The Children's Health Insurance Program (formerly the State Children's Health Insurance Program or SCHIP) was created via the Balanced Budget Act of 1997, and enacted by Title XXI of the Social Security Act to help fill a gap in insurance coverage for low-income children who are not eligible for Medicaid but whose families cannot afford private insurance coverage.

Between 1997 and 2011, the percentage of low-income children and youth under age 19 who were uninsured decreased from over 25 percent to 15 percent. Among children and youth who are eligible for CHIP or Medicaid, almost 86 percent participate (Rosenbach 2007; Kaiser 2011; Kennedy 2012). Despite this, about 8 million children are still uninsured, with well over half of those eligible for Medicaid or CHIP but not enrolled (Kaiser 2012). In Colorado, it is estimated that in FY 2010, 42,288 children (12.8 percent of Medicaid eligible children) were eligible but not enrolled in Medicaid and 39,748 (37.2 percent of CHIP eligible children) were eligible but not enrolled in Colorado's CHIP program (Child Health Plan Plus or CHP+) (Colorado Health Institute 2012).

Both the states and the federal government pay for CHIP, with the state receiving a federal match for the funds they spend. On average, the federal government pays about 70 percent of the costs, with state governments paying about 30 percent. In FY 2013, the Federal Medical Assistance Percentage for CHIP in Colorado was 65 percent, with Colorado paying the remaining 35 percent (Kaiser 2013). Unlike Medicaid, there are annual limits on the amount of funding states receive for their CHIP programs. While the limits were originally based on a calculation of the number of low-income children in a state and geographic variations in costs between states, they are now based on states' past and projected levels of CHIP spending. Originally, states had to spend their entire annual federal allotment within the year and unspent funds were reallocated to other states. Beginning in 2000, the federal government began giving states extra time to spend out those allotments, essentially rolling forward unspent amounts into a subsequent year or years. This allowed states to have a cushion in years when expenditures were higher than that year's allotment. However, by 2007, 80 percent of states were spending more than their allotment, and the aggregate spend across all states was higher than the federal allotment (Lambrew 2007). In more recent years, a state's allotment has been adjusted every two years to align it to the state's actual spending on CHIP.

In 2007, Congress extended the CHIP program through March 2009. In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was approved by Congress and signed by President Obama. In 2010, the signing of the Patient Protection and Affordable Care Act (ACA) extended funding for CHIP through September 30, 2015, and required that states maintain current eligibility levels for CHIP through September 30, 2019. Specifically, states are prohibited from implementing eligibility standards, requirements, or procedures that are more restrictive than those that were in place as of March 23, 2010, with the exception of enrollment waiting lists.

Benefit Design

Children are not small adults. They have differing health care needs and therefore need different benefits in their health coverage. Medicaid and CHIP were both designed to serve a pediatric population and include benefits important to children. While Medicaid has a nationwide standard for children's benefits in EPSDT, CHIP allows for more flexibility in benefit design, with certain minimum standards that must be met (Lambrew 2007; NCSL 2011). States can offer benchmark coverage, benchmark equivalent coverage, a Secretary-approved plan (including the state's Medicaid package, for example) or, for states that expanded this coverage prior to CHIP legislation, existing comprehensive coverage that was already in place. Allowable benchmarks include federal employee benefits, state employee benefits, and benefits from the state's largest HMO. Regardless of the benefit package, states are required to include certain

services such as well-child care, hospital and physician care, dental services, some pharmacy benefits and mental health benefits at parity with other services. Cost-sharing and premiums are limited. These requirements are intended to ensure the unique health care needs of children are met.

Federal Eligibility Rules

States may cover children in CHIP under age 19. A total of 46 states and the District of Columbia cover children up to or above 200 percent of FPL (www.medicaid.gov), and 25 states, including Colorado, and the District of Columbia cover children at or above 250 percent of the FPL (Heberlein 2013). States are required to have processes and rules in place to help target enrollment of uninsured children, while not encouraging movement of children from private coverage to CHIP (known as “crowd out”). Additionally, states must screen children for Medicaid first and enroll them in Medicaid, if they are eligible.

Colorado’s History with CHIP

Prior to 1997, Colorado, like many other states, recognized the need to expand health insurance coverage to children of low-wage, working parents. In the mid-1990s there was interest in and discussion of expanding Medicaid eligibility in Colorado to higher income children, but the political support did not exist to expand an entitlement program in which the state would have little control over growth of cost and expenditures. The business community, in particular, was supportive of designing a public-private partnership that would provide coverage to children that looked more like the commercial coverage that most children have through working parents. In key informant interviews for this paper, several people remembered, and commented, that in some ways it would have been easier to implement a Medicaid expansion rather than creating a new, separate program. Some cited administrative and operational problems that still exist today because of having a separate program with separate rules, benefit design, delivery systems, and cost-sharing requirements. However, the political context of the time led to the creation of a stand-alone children’s coverage program.

Colorado’s CHIP program, Child Health Plan Plus (CHP+) was developed in alignment with the federal goal of helping fill a gap in insurance coverage for low-income children who are not eligible for Medicaid, but whose families are not covered through their employer plan and cannot afford private insurance coverage.

Current Status and Benefit Design

In some ways, the CHP+ program operates more like private health insurance than a public coverage program. Currently, four private health insurance companies contract with the State of Colorado to manage benefits for CHP+ clients. CHP+ benefits differ from Medicaid benefits. CHP+ also has cost sharing requirements that Medicaid does not have. For example, families with children enrolled in CHP+ with income above 150 percent FPL pay an annual enrollment fee of \$25 for one child or \$35 for more than one child, while families with incomes of 225 percent FPL or above pay \$75 for one child or \$105 for more than one child. Families also pay copays for services, ranging from \$3 to \$50 depending on family income and the type of service. There is an annual out-of-pocket limit, capped at 5 percent of the family’s annual income, for CHP+ expenses.

Copays in Colorado's CHP+ Program

Summary of Copayment Changes Effective July 1, 2012

Family Income (% FPL)	Emergency Room	Urgent Care	Ambulance Transport	Inpatient Care	Physician at Hospital	Outpatient Care	Prescriptions	Lab & X-Ray
0-100%	\$3	\$1	--	--	--	--	--	--
101-150%	\$3	\$1	\$2	\$2	\$2	\$2	\$1	--
151-200%	\$30	\$20	\$15	\$20	\$5	\$5	\$3-10	\$5
201-250%	\$50	\$30	\$25	\$50	\$10	\$10	\$5-15	\$10

Source: Health Care Policy and Financing: <http://www.cchp.org/index.cfm?action=fees&language=eng>; accessed July 30, 2013.

Eligibility

CHP+ provides coverage to legal resident children age 18 and under and pregnant women age 19 and older up to 250 percent FPL who are not eligible for Medicaid and who do not have other health insurance. Due to a change in state law approved with bi-partisan support in the 2013 legislative session, beginning Oct. 1, 2013, the three-month waiting period for enrollment for applicants who had been previously covered by an employer health insurance plan in which the employer paid 50 percent or more of the premium cost has been eliminated (Colorado Department of Health Care Policy and Financing).

The Value of CHP+

The greatest value of CHP+ is the successful coverage it provides to children who otherwise would not have access to Medicaid or private insurance. As stated earlier, research has shown that coverage in general leads to better access and appropriate utilization of services which, for children, is essential to their development, health and well-being. Having access to the standard, recommended set of well-child checkups, immunizations, and anticipatory guidance and parenting support is important to ensure children get off to a healthy start. The families who were interviewed as part of the stakeholder interviews noted that having CHP+ had been invaluable to them. Both noted that, without CHP+, they would have to make difficult financial choices (i.e., buying medications or buying food) or would be unable to “stay afloat”. One interviewee said: “I don’t know how we would survive without CHP+.” For them, and other people they know whose children have been enrolled in CHP+, the program has meant financial security for the family, and has allowed them to feel safe in the knowledge that their children will be able to get the care they need if they get sick or injured, and to get medications they need.

In spite of great efforts to market and educate about children’s health coverage in general, Medicaid continues to have some stigma associated with it that CHP+ does not. CHP+ is perceived as being more popular with providers and parents. CHP+ has a broader network of providers, with families getting some protections and guaranteed access from being in health plans versus having children in fee-for-service, and the benefit is better defined. Parents know

what they are going to get from their insurance plan and provider network and what is not covered. Although the Medicaid benefits are better spelled out now than they were at the time Colorado established CHP+, there is still some ambiguity about what may or may not be covered, especially under EPSDT and the requirement that Medicaid cover any service that is deemed medically necessary.

Since the inception of CHP+, there has been a debate in Colorado about the pros and cons of having separate CHIP and Medicaid programs. While some people believe there would be efficiencies to gain from having CHP+ and Medicaid be more integrated, there are political and perception advantages to maintaining separate programs. There continues to be broad support for covering children, and some think that if there were one, blended program or approach the program might be less vulnerable to “waves of political change.” However, with the overlay of the Affordable Care Act and requirements of CHIPRA, the programs are less vulnerable than in the past. The more programs are integrated and seamless, the easier they can be for families and medical providers to navigate and the less vulnerable they are when there are political or economic changes.

One word of caution heard from a provider in a key informant interview was that as programs are designed, implemented, merged, or modified, policymakers should not assume that all children are the same. It is common to talk about the support for children’s coverage as being widespread because children are a sympathetic population and generally do not have complex medical conditions that are difficult and expensive to manage. However, there are significant differences between the needs of children on many levels including their health care needs, the influence of geography and availability of services, and socioeconomic status. There can be marked differences between the needs of children who have lived in a family or community that has been chronically poor and uninsured or underinsured, versus a child who has experienced access to commercial insurance and continuity of care but who uses publicly financed insurance such as CHP+ episodically. Any move to blend programs must keep these differences in mind.

Key Considerations in the Context of Health Reform

Colorado policymakers have largely embraced health care reform and capitalized on opportunities in the ACA to improve health care coverage and access for Coloradans. For children’s advocates, the key long-term question should be whether and how health care reform makes a difference in improving the health status of children in Colorado.

In the short term, these are the seven key consideration that have emerged as essential focus areas for evaluating the impact of health reform and the ACA on kids’ health coverage.

1. Continued attention to children’s coverage
2. The future of coverage for children currently enrolled in CHP+
3. Complexity of family coverage
4. Movement between different types of coverage and uninsurance
5. Affordability
6. Benefits
7. Coverage for immigrant children

1. Continued Attention to Children's Coverage

Directly and indirectly, there are many important components of the Affordable Care Act that benefit children and youth, including the elimination of preexisting condition exclusions, dependent coverage to age 26, new Medicaid eligibility for parents, the inclusion of pediatric services within the essential health benefits, premium tax credits to make private coverage more affordable and cost-sharing reductions. However, because there has been such success in expanding coverage and access for children in the past 20 years, children are not the primary focus of the ACA. Most new resources and initiatives under the ACA, including Medicaid eligibility expansion, demonstration projects for dual Medicare/Medicaid-eligible individuals, new approaches to managing long-term care support services, are focused on adults and adult health. While marketplaces or exchanges are intended to provide new coverage options for families and children who are not eligible for Medicaid and CHIP, they are largely being built to serve adults because that is who makes up the majority of the uninsured. Some stakeholders fear that this focus on adults will shift resources away from ongoing monitoring and research about children's coverage and children's health.

Champions for children's health care – elected officials, health care providers, community leaders and advocates – must remain vigilant about how implementation of health reform and the ACA are impacting affordability, access and quality of coverage for kids. Those concerned about children's coverage should work to ensure that attention is paid to questions such as: What is an ideal benefit for kids that would lead to better health outcomes? What are the non-health benefits kids need to thrive? What are the components of a package of services that make a difference in a child's development and well-being, and how does a state or health plan with community support fashion the benefits to meet those goals? Recognizing that children live in families and communities that are stronger when the adults also have coverage and are healthy, this should not be an issue of children versus adults, but we should also endeavor to ensure pediatric-specific needs are not ignored or lost in the shuffle of ongoing policy debate and implementation of new programs.

2. Future of Coverage for Children on CHIP+ Today

An important question regarding coverage for children is what future coverage options would be available for the approximately 70,000 Colorado kids currently served by CHIP+ if Congress discontinues funding for CHIP at the federal level or significantly alters the program. Thousands of families in Colorado have come to depend on and trust the safety net that has been built through the CHIP+ program. It is popular with families, providers, and state policymakers. During the debate about the Affordable Care Act, Congressional champions for kids' coverage felt that until we have something as dependable and efficient to replace CHIP, Congress should appropriate funds beyond 2015, then evaluate and consider reauthorization after 2019. These same individuals felt that to build something new for children in this political environment would be very difficult, and that it would be better to continue with and build on what we have now. However, as the law stands today, no new federal CHIP funds will be available after Sept. 30, 2015, though states are required to maintain eligibility levels for children through Sept. 30, 2019. (This requirement will not be effective when states run out of federal CHIP dollars).

3. Complexity of Family Coverage

The Affordable Care Act, by design, creates new opportunities for and types of coverage, which for some families will create complex coverage situations. In these “blended” families, individuals within the same family will have different sources of coverage because of the availability and cost of employer-sponsored insurance, varied eligibility requirements of different publicly funded programs (Medicaid and CHP+), and their immigration status. One solution being adopted in many states is to conduct family-centered outreach, rather than individually focused outreach. Providing assistance to a family and helping guide them to coverage for all family members will help families navigate the system, but differences in coverage will still be complicated. Another policy option would be to allow CHIP funds to be used to purchase plans sold on health insurance exchanges for CHP+-eligible children in families that are purchasing products on the exchange for the adults. This would allow parents and children to be in the same health plan and provider network.

Having different programs for children based on age-related eligibility is also complex, and is not a seamless process for families. If a pregnant woman’s delivery is covered by Medicaid, the infant is automatically Medicaid-eligible for the first year of life, and care is provided by a Medicaid provider in fee-for-service or in a Regional Care Coordination Organization (RCCO). When the child turns age one, the child may stay in Medicaid or become eligible for CHP+, so may have to switch to another plan or provider, then switch again as she or he gets older. The ACA requires states to eliminate these “stair steps” of eligibility for children in Medicaid. Colorado chose to implement that policy change prior to 2014, which should help reduce this complexity. The new policy calls for all children under 133 percent of FPL, regardless of age, to be enrolled in Medicaid.

The positive impact of having total family coverage on children is not well known. Research has shown that when parents have coverage, the enrollment and take-up rate of eligible children being enrolled into public programs is greater. Child advocates will need to pay attention to how successful expansions for families are implemented, particularly through newly operating health insurance exchanges. If parents have difficulties or bad experiences with coverage and access, children could be indirectly impacted. As one interviewee stated:

“Families we serve don’t live in cultures that take coverage for granted like mid-to-higher income working families do; so continuity of care and access to their trusted provider is important.”

4. Movement Between Different Coverage Types and Uninsurance

Another concern is related to the issue of people moving from one type of coverage to another, or between being insured and being uninsured, due to changes in eligibility status. Often, these changes occur because of changes in income, but sometimes occur because of changes in age, marital status, disability status or changes in eligibility rules. This is sometimes called “churn” or “movement”. While movement from one program to another has been the reality for years, because of changes mandated by ACA, there is concern that this issue will become more problematic. For example, as a result of changes to how income will be calculated under ACA, some children will move from one program to another. Additionally, because private insurance will be available to more families in 2014, if family income goes up some children may move to private insurance that is more costly and less comprehensive than CHP+ or Medicaid.

Some solutions to these problems that are being discussed nationally are implementation of 12-month continuous eligibility for Medicaid, *ex parte* and administrative renewals, and use of Express Lane Eligibility at enrollment, renewal, and for transitions between Medicaid and CHIP programs (NASHP 2013). Colorado is poised to implement 12-month continuous eligibility for children in Medicaid in 2014, thanks to the state's hospital provider fee legislation that approved this change as part of a broader Medicaid expansion effort (House Bill 09-1293). Additionally, if a state picks an essential health plan for its individual and small group markets that aligns with Medicaid's alternative benefit plan and/or CHIP's benefits, and the provider network is the same, this would mitigate some of the problems associated with churn. At a state level, one blended program for children with varying levels of subsidies that are managed in the "back room" of operations, and transparent to families, could also reduce the risk of children having disrupted access and services when their program eligibility changes (for example, from Medicaid to CHP+ or vice versa) due to changes in family income or other circumstances. One interviewee noted that, for her family, being able to see the same doctor, regardless of whether her kids were covered by Medicaid or CHP+ had made a tremendous difference in her family's ability to access care.

Several key informants interviewed for this paper expressed concern about operational issues and coordination between Connect for Health Colorado (the new insurance marketplace), Medicaid and CHP+. Much attention has been paid to the intersection between the exchange and Medicaid, primarily due to the adult populations impacted, but less attention has been given to the impact of movement between the exchange and CHP+, and children impacted when their parents are eligible to purchase subsidized products through the exchange. If children are moved from one eligibility category to another and it impacts their provider network and access to their health care home, there is a risk of interrupting continuity of care and services. Movement from one eligibility category to another also can cause disruptions in coverage. One of the family member stakeholders who was interviewed noted that a problem she has faced with CHP+ was that one of her children lost CHP+ coverage, but she was not aware of the loss until she took her daughter to a doctor's visit, and it was nine months before she could get her daughter enrolled in Medicaid. This caused a disruption in care for her daughter, and anxiety about what would happen if her daughter got sick or injured during the time of lapsed coverage.

5. Affordability

There are concerns that private insurance, even with premium assistance, may be more expensive for families than CHP+ or Medicaid. For example, families between 200 percent and 400 percent FPL will pay up to 9.5 percent of their income, on a sliding scale, for just the premiums (Kaiser, July 2012), even though total cost sharing, including premiums, in CHIP is limited to 5 percent of family income and, in Medicaid, even lower. Additionally, when families have multiple sources of coverage for different family members, premium costs can add up—meaning families might pay a CHIP enrollment fee for their children in addition to their required contribution for subsidized marketplace coverage for the adults. Another concern about affordability relates to the Family Affordability Test, commonly referred to as the "Family Glitch". Under ACA, premium tax credits are not available when a family has access to affordable employer-sponsored coverage. Coverage is determined to be affordable when the premium costs less than 9.5 percent of the family's income, but the amount that is used for comparison is the *individual* premium, not the family coverage premium. This may mean that individual

coverage through an employer could be determined affordable, and the family would be ineligible for tax credits, even if the cost of covering all of the family members in the employer plan is far in excess of 9.5 percent of the family's income. Some families otherwise affected by the Family Affordability Test will be able to enroll their children in CHP+, but those with income over 250 percent FPL will not gain a more affordable coverage option under the ACA.

The Family Affordability Test and potential impact on coverage for children is one argument for continuing a separate CHIP program, even with the ACA and coverage through exchange marketplaces. If families cannot find a product that is truly affordable, and the adults in the household go without coverage, CHP+ would still be in place for the eligible children even though some parents could remain uninsured.

There is speculation that the total out of pocket (OOP) amount a family spends now in CHP+ is probably lower than what they will likely spend when purchasing a product in an exchange marketplace. While CHP+ limits out-of-pocket spending (including premiums) to 5 percent of family income, federal rules permit maximum OOP amounts (not including premiums) of up to \$6,350 for marketplace plans for families at 200 percent FPL, or more than 16 percent of a three-person family's income at that FPL (Kaiser, July 2012). While Colorado's plans may not set OOP maximums at the full level allowed by law, the potential for high OOP costs is real.

Advocates and policymakers should pay close attention to this question and collect baseline information about the current premiums and OOP expenses families pay now in CHP+, and compare that to what families will pay when they buy a plan in the exchange, including factoring in the additional subsidies for families with incomes below 250 percent FPL. Will the plans sold in the exchange be affordable or will families see an increase in premiums and OOP? What is an acceptable total cost burden for families? Is the current 5 percent test set as a maximum at the national level for CHP+ the right standard?

6. Benefits

Under the Affordable Care Act, states are required to establish a benchmark plan that meets certain minimum benefit requirements for the individual and small group private insurance plans, including those offered through marketplaces. Colorado has chosen the Kaiser small group plan (Kaiser Ded HMO 1200D) as the Essential Health Benefits package (EHB). For most children, this benefit plan will adequately meet their needs. Though there is not as much concern about the actual list of services that children will get, there is a lack of clarity about differences in amount, duration and scope of services. One known difference between the EHB benefits and Medicaid benefits is a limitation on physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. The EHB limits these to 20 visits per year per therapy type, while CHP+ provides up to 30 visits per year per diagnosis, with no limitations for children birth to age 2. Other differences include EHB limitations in coverage for mental health services, including an exclusion in the EHB for special education, counseling, therapy or care for learning deficiencies or behavioral problems. These differences can create significant challenges for children with disabilities who require such care to live a productive life.

However, for low-income and vulnerable children, there is a lower level of confidence that a private insurance product administered by companies without experience serving people in this income range will be sufficient. Benefits for children in publicly funded programs like Medicaid

and CHIP have a child-centric focus, and providers and advocates have worked long and hard to ensure that children get the benefits and protections they need to be and stay healthy. While most children are healthy, and qualified health plans purchased through the health insurance marketplace should be adequate for the majority of children, stakeholders have concerns about the kids who have higher health care needs. There is considerable concern that traditional health plans that have little or no experience serving low-income or previously uninsured populations will not have the expertise or interest in meeting the needs of children from families that are challenged to meet basic needs like housing and food. As one key informant said, “healthiness is more than medical care,” and they are concerned that health plans will not understand what traditional safety net providers do understand—that parents with less education and resources need simpler ways to get care for their kids. Traditional, commercial plans may not attend to these non-medical concerns that some parents bring to the exam room.

There is also concern about what will happen when a child is identified as having special health care or developmental needs? Do private health plans and their provider networks have adequate experience serving children with special health needs and providing community support to parents? Additionally, there is skepticism that commercial plans have the relationships with community-based organizations that provide non-health services to vulnerable and high-needs families. Finally, what happens to children whose families make the “financial leap” to buying products through the exchange marketplace but struggle because benefits and OOP costs are different than what they have experienced in publicly funded programs? For instance, pharmaceutical formularies and management of pharmaceutical benefits can be very different in commercial versus public plans.

Although the ACA creates a new requirement for providing a set of standard essential health benefits for children who are covered in the marketplace, a flaw in the implementing federal regulation has created a disparity for children in terms of access to dental benefits. Pediatric dental benefits are a “mandatory offer” in the marketplace, but are a “mandatory purchase” outside the marketplace. This creates troublesome marketplace inequities and the potential for children to receive differing levels of benefits depending on how they purchase their coverage. This is a clear example of where the ACA has created a new barrier related to an issue that is critical for, and specific to, kids.

7. Immigrant Children

The question of who will speak for, and advocate for the needs of immigrant children—both legally residing and undocumented—came up repeatedly in the stakeholder interviews. It is estimated that 12.4 percent (over 15,600) of the uninsured children in Colorado are ineligible for Medicaid or CHP+ “based on documentation or citizenship status” (Colorado Health Institute 2013). Additionally, while Colorado passed House Bill 09-1353 in 2009 to allow for coverage of legally-residing immigrant children in Medicaid and CHP+ without the traditional five-year waiting period for eligibility, and could receive the enhanced CHIP match for these children enrolled in either Medicaid or CHIP, state funding to cover these children has not been made available (Colorado HB 09-1353). Important questions for the future are whether policymakers, providers, and advocates are willing to continue supporting safety net providers that currently serve this population; will advocate for the state to utilize the option to cover legally-residing immigrants; and / or interested in creating new programs or funding streams to provide health care to this population.

Conclusion

A number of issues and concerns related to kids' coverage still need to be addressed as we fully implement health care reform and the ACA. Policymakers, state officials, insurers, health care providers and advocates must work collaboratively to assess the impact of expanded coverage under the ACA on the health and well-being of Colorado's children. Key questions and issues that need on-going evaluation and reporting include:

- What is Colorado's specific and quantifiable coverage goal? Public/private partnerships will be required in order to access timely and appropriate data to monitor and analyze progress towards this goal, which includes the following objectives:
 - Reducing the number of eligible but unenrolled children.
 - Reaching coverage take up rates at the projected/anticipated rate.
 - Increasing retention of coverage from one year to the next.
- How are families accessing care for their children, and what are appropriate measures of satisfaction regarding the care of the children? Policy leaders should monitor state and federal affordability policies, using access and utilization as proxies, to ensure the new pathways to coverage and new policies are as affordable for families as CHP+.
- What does access to care for undocumented children look like? What support exists for safety net providers who serve all patients, regardless of immigration status? Have other coverage options become available?
- What is the impact of movement or churn between commercial and public coverage and uninsurance?

State leaders must work with other child health advocates across the country and with Colorado's federal delegation to explore and fully understand the impact that federal changes to the CHIP program would have on Colorado's children and develop contingency plans for how our state will support the needs of families currently served by the program, if it is significantly altered or ended.

The answers to the evaluation questions should drive an in-depth conversation about the future of coverage for children in Colorado. The underlying value for any future discussions or changes in the structure or financing of coverage for kids is that **all Colorado kids have quality, affordable coverage that is convenient and comfortable for families to access and use.**

References

- Basini, Leigha O. 2011. *What a Difference a Dollar Makes: Affordability Lessons from Children's Coverage that can Inform State Policymaking under the Affordable Care Act*. National Academy for State Health Policy.
- Bloom, B. and A. N. Dey. 2006. "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2004." *Vital Health Statistics*, Feb. 2006 10(227):1–85.
- Centers for Medicare and Medicaid Services. 2008. "Deficit Reduction Act Important Facts for State Policymakers." February 21, 2008. <https://www.cms.gov/Regulations-and-Guidance/legislation/DeficitReductionAct/downloads/Costsharing.pdf>.
- Centers for Medicare and Medicaid Services. 2013. <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Eligibility-Standards-.html>
- Colorado Health Institute. March 2012. http://www.coloradohealthinstitute.org/uploads/downloads/EBNE_Kids_Fact_Sheet.pdf.
- Colorado Health Institute. March 2013. County-Level Estimates of Children Eligible But Not Enrolled in Medicaid or CHIP+. http://www.coloradohealthinstitute.org/uploads/downloads/EBNE_Kids_Data_Sheet2.pdf
- Colorado House Bill 09-1353. 2009. http://www.leg.state.co.us/clics/clics2009a/csl.nsf/fsbillcont3/71A0E2C9470E3F7B872575990078A694?open&file=1353_enr.pdf.
- Georgetown University Health Policy Institute Center for Children and Families. 2013. "Medicaid Provides Needed Access to Care."
- Heberlein, Martha, et al. 2013. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.
- Hensley-Quinn, Maureen and Catherine Hess. 2013. *How CHIP Can Help Meet Child Specific Requirements and Needs in the Exchange: Considerations for Policymakers*. Portland, ME: National Academy for State Health Policy.
- Hodgetts, Cate. 2011. *The ACA and Essential Benefits for Children in the Exchanges*. Washington, DC: National Health Law Program.
- Johnson, Kay and Jill Rosenthal. 2009. *Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States*. Portland, ME: National Academy for State Health Policy.
- Kaiser Commission on Medicaid and the Uninsured. 2012. *Health Coverage of Children: The Role of Medicaid and CHIP*. Washington, DC: The Kaiser Family Foundation.
- Kaiser Family Foundation. 2012. Explaining Health Care Reform: Questions About Health Insurance Subsidies. Menlo Park, CA: The Henry J. Kaiser Family Foundation. www.kff.org/healthreform/upload/7962-02.pdf.

Kaiser Family Foundation. 2013. Statehealthfacts.org. Health Insurance Coverage of Low Income Children 0-18 (under 200 percent FPL), states (2010-2011), U.S. (2011). <http://www.statehealthfacts.org/comparetable.jsp?ind=129&cat=3>.

Kaiser Family Foundation. 2013. Enhanced Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program (CHIP). <http://kff.org/other/state-indicator/federal-matching-rate/>.

Kaiser Family Foundation. July 2012. Explaining Health Care Reform: Questions About Health Insurance Subsidies. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf>

Kaye, N., C. Pernice, and A. Cullen. 2006. *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs*. Portland, Maine: National Academy for State Health Policy.

Kenney, Genevieve M., et al. 2012. *Medicaid/CHIP Participation Among Children and Parents*. Washington, DC: The Urban Institute.

Ku, Leighton. 2007. *Comparing Public and Private Health Insurance for Children*. Washington, DC: Center on Budget and Policy Priorities.

McManus, Peggy. 2012. *A Comparative Review of Essential Health Benefits Pertinent to Children in Large Federal, State, and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans*. Washington, DC: American Academy of Pediatrics.

McMorrow, Stacey, Genevieve M. Kenney, and Christine Coyer. 2012. *Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas*. Washington, DC: The Urban Institute Health Policy Center.

National Conference of State Legislatures. 2013. Children's Health Insurance Program. <http://www.ncsl.org/issues-research/health/childrens-health-insurance-program-overview.aspx>

Rosenbach, Margo, et al., 2007. *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access*. Cambridge, MA: Mathematica Policy Research, Inc.

State Health Access Data Assistance Center. 2012. Keeping Kids Covered: Number of Children with Health Coverage Increases During Economic Downturn: A State-by-State Analysis.

Szilagyi, P. G., A. W. Dick, J. D. Klein et al. 2006. "Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York." *Pediatrics*, Feb. 2006 117(2):486-96.

Woolridge, J., G. Kenney, C. Trenholm et al. 2005. *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress*. Washington, D.C.: Mathematica Policy Research.

Zuckerman S., and A. Cook. 2006. "The Role of Medicaid and SCHIP as an Insurance Safety Net." Washington, D.C.: Urban Institute.

All Kids Covered Colorado is a statewide, non-partisan coalition dedicated to increasing access to affordable, high quality health insurance coverage and health care services for all children in Colorado. For more information, visit www.allkidscoveredcolorado.org.