

POTENTIAL IMPACTS OF ALTERNATIVE HEALTH CARE REFORM PROPOSALS FOR CHILDREN WITH MEDICAID AND CHIP COVERAGE

Genevieve M. Kenney and Allison Cook

January 2010

Update: On December 24, 2009, the Senate passed H.R. 3590 (Patient Protection and Affordable Care Act). The provisions of this bill with regard to Medicaid and CHIP are similar to the provisions in the Democratic leadership bill which are described in this brief. One difference is that H.R. 3590 reauthorizes CHIP through 2019 and fully funds the program through 2015. For a full description of the final Senate bill go to http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm.

SUMMARY

Health reform legislation currently under consideration in Congress has the potential to reduce the number of uninsured children and, for many children, will provide coverage for their parents. However, for children currently enrolled in public coverage, the health reform bills in the House and Senate present both potential benefits and risks in terms of the type of coverage these children would have and their access to needed care. This brief uses data and Medicaid/CHIP eligibility rules from 2007 to estimate the number of children enrolled in Medicaid and CHIP who would be affected if provisions in pending House and Senate health reform bills were implemented. If these changes had been implemented in 2007, our analysis shows that 1.3 million children (House bill) and 0.7 million children (Senate bill) would have been transferred from separate CHIP into Medicaid. Under the House provisions, about 1.8 million children with incomes above 150 percent of the FPL would have lost separate CHIP coverage in 2007 and potentially moved into new exchange plans. Had these changes been implemented in 2007 with adequate CHIP funding, the Senate bill would have resulted in no change for the estimated 2.3 million children with incomes above 133 percent of the FPL who had separate CHIP coverage. However, the Senate bill does not currently include adequate CHIP funding and, as a result, these 2.3 million children could have lost CHIP coverage and potentially moved into the exchange. These estimates understate the number of children who would likely be affected by the proposed changes because they do not take into account enrollment growth between 2007 and 2014 and because they reflect coverage at a point in time, and thus are lower than estimates that reflect coverage in Medicaid and CHIP over the course of a year. Using CBO estimates to adjust for both of these factors would imply that the number of children affected in 2014 would be about 2.5 times as high as the estimates found for 2007.

There are a number of tradeoffs involved with shifting children from CHIP into Medicaid or into new exchange plans. Key considerations include whether CHIP receives sufficient federal funding beyond 2013, what types of cost-sharing and benefits protections would exist under CHIP and under exchange plans, and the willingness of providers to participate in Medicaid, CHIP and exchange plans. Additionally, it will be important to minimize the extent to which children losing public coverage fall through the cracks and become uninsured, which may be a particular risk for citizen children in mixed immigrant status families, those in kinship care, and those subject to firewalls for whom employer coverage is available but deemed unaffordable by the family.

I. INTRODUCTION

Federal health care reform is taking place against a backdrop of more than a decade of progress reducing uninsurance among children. Indeed, according to new coverage estimates, the number of children lacking insurance coverage declined by 800,000 between 2007 and 2008, despite the economic downturn.¹ In 2008, uninsurance among children reportedly reached its lowest level in over twenty years. In contrast, uninsurance rates have been on the rise for adults.² While employer-sponsored insurance (ESI) has been declining for both children and adults, children have gained public coverage at much higher rates than adults.³ The gains in public coverage for children are due to a combination of factors including the eligibility expansions that have occurred following the creation of the Children's Health Insurance Program (CHIP (Title XXI)) in 1997, investments in outreach and enrollment simplification in Medicaid (Title XIX) and CHIP that raised participation in those programs, and more expansive Medicaid eligibility for children than for adults.⁴ Numerous studies have found that these policy changes have led to reductions in uninsurance among children and improvements in their access to care.⁵ In addition, gaps in insurance coverage and access to health care by race/ethnicity and income have narrowed for children.⁶

CHIP reauthorization legislation enacted in February 2009 provides new funding and policy options intended to increase coverage among children who are eligible for Medicaid and CHIP but not enrolled. Such eligible but unenrolled children constitute the majority of uninsured children.⁷ CHIP reauthorization increased federal allotments through 2014 to support enrollment growth in CHIP and strengthened Medicaid and CHIP coverage for children in other ways, but it did not address all concerns about CHIP such as the lack of an entitlement for coverage.⁸

The health care reform proposals under consideration have the potential to contribute to additional coverage gains for children, while also increasing coverage for parents and other family members. Given that so many children covered under Medicaid and CHIP have uninsured parents, increases in parental coverage resulting from health reform would likely improve the health and functioning of many of these children and their parents.⁹ However, these proposals also contain changes to Medicaid and CHIP which makes it important to consider their potential impact on the children who are served by these programs. Accordingly, this brief uses information from 2007 to estimate the number of children enrolled in Medicaid and CHIP who would be affected if provisions in the pending House and Senate health care reform bills were implemented. This brief only considers possible coverage changes for these children and does not address other possible effects of the alternative health care reform proposals under consideration. Since these bills differ in a number of important respects in the way that they treat Medicaid and CHIP, the estimates developed in this brief reflect the potential impact of alternatives currently under consideration and do not attempt to anticipate provisions that may end up in a final bill.

The following section describes changes in public programs for children over the last decade to provide a context for considering changes to Medicaid and CHIP under health care reform. Subsequent sections describe the proposed changes in both the recently passed House health care reform bill (H.R. 3962) and the recently introduced Senate leadership bill (Patient Protection and Affordable Care Act), the data and methods used to produce the estimates, and the key findings. The final section concludes with a discussion of the implications of the findings.

II. BACKGROUND

Together, Medicaid and CHIP cover an estimated 31 percent of all children, disproportionately covering children from poor and near-poor families, those from racial and ethnic minorities, and those with special health care needs.¹⁰ By federal law, under Medicaid (authorized under Title XIX of the Social Security Act), states must cover children ages 6 to 18 in families with incomes below 100 percent of the federal poverty level (FPL) and children ages 0 to 5 in families with incomes below 133 percent of the FPL. Some states, however, have opted to expand Title XIX to other groups of children. CHIP was created in 1997 (under Title XXI of the Social Security Act) to address coverage gaps for near-poor children whose family incomes were too high to qualify for Medicaid but too low to afford private coverage. While CHIP coverage is optional, all states have a CHIP program. As of October 2009, all but four states had eligibility limits at 200 percent of the FPL or higher and 14 states had limits at 300 percent of the FPL or higher under either Medicaid or CHIP.¹¹ While millions of children rely on CHIP for coverage, Medicaid covers four to five times as many children as CHIP.

In early 2009, CHIP was reauthorized through 2013. Additional federal dollars were allocated to the program to ensure that states had sufficient funding to meet program needs. In addition, the legislation included new incentives and tools aimed at increasing participation among the millions of uninsured children who are eligible for Medicaid and CHIP but not enrolled. It also included provisions designed to improve access to care, quality of care, and health outcomes for children.

For some or all of their CHIP coverage, states may expand their Medicaid programs and/or operate a separate non-Medicaid program, subject to some federal requirements. Fourteen states rely on a Medicaid expansion alone, 19 rely on a separate program and 18 use a combination of the two approaches.¹² All children covered under Medicaid, regardless of whether federal matching funds come through Title XIX or Title XXI, have a benefit package that includes Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits and minimal cost-sharing both in terms of premiums and copayments. Children enrolled in separate, non-Medicaid CHIP programs do not have the same legal protections as children covered under Medicaid. While federal law allows separate CHIP plans to have a less generous benefit package and higher cost-sharing levels than under Medicaid, states have generally chosen benefits and cost-sharing levels that are more similar to Medicaid coverage than to commercial coverage and many states have chosen to provide EPSDT benefits.¹³ In some states, children in separate CHIP programs have access to different providers than children in Medicaid programs, which may make it easier for them to obtain particular services.¹⁴

III. PROPOSED POLICY CHANGES UNDER HEALTH REFORM.

Under the health reform bill recently passed by the House (H.R. 3962), Medicaid coverage for children through both Title XIX and Title XXI would remain intact due to maintenance of effort (MOE) requirements, but separate non-Medicaid CHIP programs would be disbanded by 2014. Children covered under these separate CHIP programs with incomes below 150 percent of the FPL would be shifted into Medicaid while those with incomes above 150 percent of the FPL could be shifted into new “exchange” plans authorized by the bill or into employer plans that cover their parents. If some families cannot gain access to coverage in the exchange due to affordability or other issues, some children who previously had or would have had CHIP coverage could lose coverage altogether.¹⁵

Under the House bill, Medicaid eligibility for children would be based on family income net of disregards (deductions allowed for expenses such as child care, employment, etc.). Children, parents,

and other adults with incomes below 150 percent of the FPL would be covered under Medicaid. Those with incomes between 150 and 400 percent of the FPL, excluding children covered under Medicaid whose coverage would be maintained, would qualify for sliding scale subsidies to purchase one of the insurance plans offered through the new health insurance exchange.^{16,17} While the exchange plans would be required to include benefits important to the health and functioning of children, such as dental, hearing, vision, and well-child care, the benefits and cost-sharing requirements would not be as generous as those currently offered under CHIP plans.¹⁸

The proposed Senate leadership bill (Patient Protection and Affordable Care Act), which has not yet been approved by the Senate, differs in a number of important respects from the approach taken under the House bill. First, Medicaid eligibility for children, parents and other adults is set at 133 percent of the FPL rather than at 150 percent of the FPL. Second, while the House bill eliminates CHIP, the Senate bill includes a maintenance of effort (MOE) requirement on states for both Medicaid and CHIP through 2019, but does not allocate any additional federal funds to the program (though it does raise federal matching rates under CHIP). As a consequence, unless additional funding for CHIP is added to the final health care reform legislation, federal funding levels for CHIP will fall short of what would be required to maintain existing programs in 2014 and beyond. Should states run out of CHIP allotments, children would be eligible for coverage in the new exchange plans. An amendment to the Senate leadership bill introduced by Senator Casey on November 30, 2009 addresses many of the concerns that have been raised about maintaining CHIP under health reform. Among other things, it would increase federal funding levels through 2019 to automatically adjust to program need, would mandate a minimum eligibility threshold of 250 percent of the FPL in all states and not allow states to reduce their thresholds below that level after 2014, and would not allow states to scale back their current benefits and cost-sharing arrangements under CHIP. Children in CHIP could be transitioned into the exchange after 2019 pending an analysis of how exchange coverage would differ from CHIP coverage.¹⁹ At this point, the Casey Amendment has not been voted on.

De facto, the Senate leadership bill requires coverage under Medicaid for children up to 133 percent of net income.²⁰ This has the effect of shifting children in families with incomes below 133 percent FPL who are in separate CHIP plans into Medicaid. Children in Medicaid with income above 133 percent of the FPL would remain in Medicaid due to MOE provisions and it appears that children enrolled in Medicaid expansion CHIP coverage would also retain that coverage due to the MOE requirement although there is some uncertainty about this given the other provisions in the bill. Children in separate CHIP would either remain in CHIP if it is fully funded or potentially move into the exchange. Under the Senate bill, parents and other adults with incomes below 133 percent of the FPL would be shifted into Medicaid and those above 133 percent of the FPL could qualify for subsidies to purchase plans in the new health insurance exchange(s). Overall, the subsidies provided to families who purchase coverage through the exchanges for both premium payments and out-of-pocket cost-sharing on health care in the Senate bill are lower than those in the House bill.²¹

IV. DATA AND METHODS

The main source of data for this analysis is the March 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS), representing income and health insurance coverage for 2007. We rely primarily on survey data for this analysis because the existing administrative Medicaid and CHIP data files do not contain sufficient information on income to classify enrollees according to whether their incomes are above or below a given threshold level (such as 133 or 150 percent FPL). The only published analysis of administrative data in all 50 states found that in 2007, 91.4 percent of

children enrolled in CHIP were in families with net income of 200 percent of the FPL or lower.²² In order to address current policy questions, information is needed on enrollment levels for more detailed income breaks. An additional complication with the administrative data is that there may be some overlap in enrollment in the two programs due to children transferring from one program to the other over the course of a year.²³

This analysis relies on the Urban Institute's Health Policy Center Eligibility Simulation Model developed by Dubay and Cook to estimate the income distribution of the children under 19 who are currently enrolled in Medicaid or CHIP.^{24,25} The model simulates eligibility for Title XIX Medicaid, Medicaid expansion CHIP and separate CHIP in each state, using available information on eligibility guidelines for each program and state in place in 2007, including the amount and extent of disregards.^{26,27} Family-level characteristics used in determining eligibility, such as income, are based on the health insurance unit (HIU).²⁸ HIUs are derived from information available on household structure from the CPS and are used as the family unit of analysis because they more closely align with the family groupings used by states when determining eligibility than Census households or families. Estimates of income as a percent of the federal poverty level reflect net income, the residual income remaining after disregards are deducted.

The CPS includes questions on Medicaid and CHIP coverage. However, because many states use the same names for their Medicaid and CHIP programs, and because many families are confused about the specific type of public coverage their child has, it is not possible to reliably distinguish between Medicaid and CHIP coverage on the CPS.²⁹ Instead, we define Medicaid enrollees as those who report Medicaid/CHIP on the CPS and are identified by our model as meeting the eligibility criteria for Medicaid. CHIP enrollees are those with public coverage who meet the eligibility criteria for CHIP. In this analysis, we interpret estimates of Medicaid and CHIP coverage as point-in-time, (i.e. average monthly) estimates current to 2007.³⁰ Because of imprecision in the use of household data to model eligibility, we make three primary adjustments to Medicaid and CHIP estimates to make them more consistent with point-in-time administrative enrollment totals for 2007.

First, in order to improve the accuracy of the insurance coverage estimates, we make an adjustment to account for the underreporting of Medicaid on the CPS.³¹ This adjustment has the effect of reducing the number of uninsured children from 8.9 million to 7.8 million and increasing the number of children with Medicaid coverage by 3.2 million, resulting in an increase in the total number of children with public coverage from 21.7 million to 24.9 million. Second, estimates of Medicaid expansion CHIP coverage and separate CHIP coverage are adjusted to be consistent with administrative enrollment data, which show that 72 percent of CHIP enrollees were enrolled in separate CHIP programs on the last day of the second quarter of FY 2007.³² The estimated numbers of children with CHIP coverage and Medicaid expansion versus separate CHIP coverage in our analyses are consistent with administrative data from the same period.³³

Third, we adjust estimates of Medicaid to take into account nearly 3 million children who are reported to have Medicaid or CHIP on the CPS but for whom no eligibility pathway can be identified in our model. This phenomenon has occurred in other models that simulate Medicaid and CHIP eligibility and is likely due to measurement error in the income and household structure measures that are available and the fact that they are not measured on the survey at the same point when public coverage was obtained.^{34,35} We reassigned cases for which no eligibility pathway could be identified to Title XIX Medicaid.³⁶

Estimating the number of children in Medicaid or CHIP whose coverage could be affected by alternative health reform options requires making numerous assumptions given that household survey data are used to identify the children who are enrolled in Medicaid and CHIP and their income levels. As a result, measurement error is inevitable. In addition, these estimates reflect income and eligibility as of 2007 and do not reflect states' coverage expansions since then, nor do they reflect growth in the population below 200 percent of the FPL as a result of the economic downturn.

V. FINDINGS

The following provides estimates of the distribution of children who had CHIP or Medicaid coverage in 2007 with respect to income and program type. Given the current structure of the House and Senate bills, we focus on Medicaid income thresholds of 150 and 133 percent FPL, respectively. As indicated above, in the current House bill the minimum eligibility level for Medicaid would be set at 150 percent of the FPL, whereas it would be set at 133 percent of the FPL under the current version of the Senate bill. We include estimates for children in separate CHIP programs, Medicaid expansion CHIP programs, and Title XIX Medicaid programs. We focus on children in separate CHIP programs since the changes that have been proposed have the most direct effects on their coverage status.

Exhibits 1 and 2 show the income distribution of separate CHIP enrollees and all CHIP enrollees, respectively, according to estimates based on 2007. Under the current structure of the House bill, which raises Medicaid eligibility to 150 percent of the FPL and eliminates separate CHIP programs, an estimated 42 percent (1.3 million as of 2007) of the children enrolled in separate CHIP programs would have shifted into Medicaid and the remaining 58 percent (1.8 million as of 2007) would have lost CHIP coverage and could have become eligible for subsidized coverage through the health insurance exchange

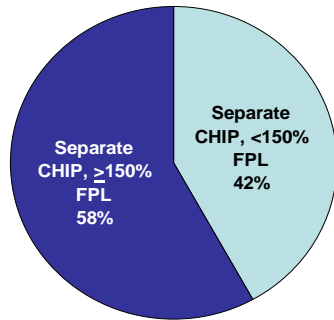
(Exhibit 1). With the maintenance of effort (MOE) requirements, there would be no impact on the children who are currently enrolled in Title XIX and Medicaid expansion CHIP programs. Without the MOE requirements, another 0.8 million children (with income above 150 percent of the FPL) would have been affected in 2007, of whom an estimated 0.4 million had coverage under Title XIX and the remainder had coverage under Title XXI (data not shown).

Under the current structure of the Senate bill, an estimated 24 percent (0.7 million as of 2007) of the children enrolled in separate CHIP programs would have shifted into Medicaid and the remaining 76 percent (2.3 million as of 2007) would have either remained in CHIP or, without adequate federal CHIP funding, would have lost CHIP coverage and could have become eligible for subsidies in the exchange (Exhibit 1). As with the House bill, under the MOE requirements in the Senate bill, there would be no impact on the children who are currently enrolled in Title XIX and Medicaid expansion CHIP programs. Without the MOE requirements, another 1.3 million children with income above 133 percent of the FPL would have been affected in 2007, including 0.6 million children with Medicaid coverage under Title XIX and 0.7 million children with Medicaid coverage under Title XXI (data not shown).

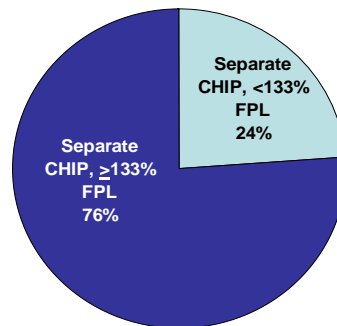
In summary, if the House and Senate bills had been implemented in 2007, our analysis shows that 1.3 million children (House bill) and 0.7 million children (Senate bill) would have been transferred from separate CHIP into Medicaid. Under the House provisions, about 1.8 million children with incomes above 150 percent of the FPL would have lost separate CHIP coverage in 2007 and potentially moved into new exchange plans. Had these changes been implemented in 2007 with adequate CHIP

Exhibit 1: Composition of Children Enrolled in Separate CHIP Programs by Income, 2007

Medicaid income threshold at 150% FPL



Medicaid income threshold at 133% FPL



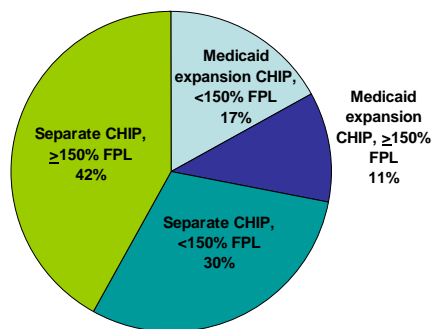
3.1 Million Separate CHIP Enrolled Children

Note: Income as a percent of FPL reflects net income which is derived from total income net of disregards (work expense and childcare expense) taken into account in determining eligibility for separate CHIP.

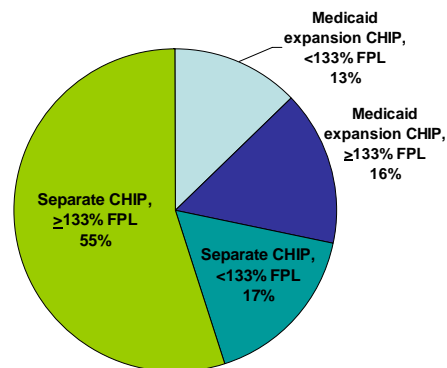
Source: Health Policy Center Eligibility Simulation Model based on data from the 2008 ASEC to the CPS

Exhibit 2: Composition of All Children Enrolled in CHIP by Income and Program Type, 2007

Medicaid income threshold at 150% FPL



Medicaid income threshold at 133% FPL



4.3 Million CHIP Enrolled Children

Note: Income as a percent of FPL reflects net income which is derived from total income net of disregards (work expense and childcare expense) taken into account in determining eligibility for Medicaid expansion CHIP and separate CHIP.

Source: Health Policy Center Eligibility Simulation Model based on data from the 2008 ASEC to the CPS

funding, the Senate bill would have resulted in no change for the estimated 2.3 million children with incomes above 133 percent of the FPL who had separate CHIP coverage. However, the Senate bill does not currently include adequate CHIP funding and, as a result, these 2.3 million children could have lost CHIP coverage and potentially moved into the exchange.

VI. DISCUSSION

The proposed changes to Medicaid and CHIP in both the House and Senate bills have a number of implications for children who currently qualify for coverage under those two programs. These changes could affect both the number of low-income children who have insurance coverage and the type of coverage they have, which in turn could affect their access to needed care and ultimately their health and development. There are a number of tradeoffs involved in shifting children from separate CHIP plans into Medicaid or into new exchange plans. Key considerations include whether CHIP would receive sufficient federal funding beyond FY 2013, what types of cost-sharing and benefits protections would exist under CHIP and under exchange plans, and the willingness of providers to participate in Medicaid, CHIP and exchange plans. Overall, differences in benefits, cost-sharing requirements, and access to providers and provider networks for both children and their parents will determine the nature and impacts of those tradeoffs.

In this brief, we examine how many children could be shifted out of Medicaid/CHIP coverage using data from the 2008 Annual Social and Economic Supplement to the Current Population Survey. Our estimates are based on an eligibility simulation model that reflects eligibility for Medicaid and CHIP in 2007. Since that time, the level of public coverage has increased due to a combination of increased enrollment in Medicaid/CHIP coverage, more recent eligibility expansions under Medicaid/CHIP, and increases in the number of children in low-income families arising from the economic downturn.³⁷ Indeed, 19 states have expanded eligibility for public coverage since 2007.³⁸ Moreover, given that our estimates pertain to 2007, they understate the number of children who would be affected when major aspects of health care reform would be implemented in 2014. CBO baseline estimates assume that CHIP enrollment will grow by about 7 percent per year through 2013. If that growth rate is applied to our 2007 estimates, the point-in time enrollment levels would increase by over fifty percent between 2007 and 2014.³⁹ Moreover, these estimates reflect coverage estimates at a point-in-time—i.e., on an average monthly basis—rather than the number of children enrolled in that program at some point over the course of the year, which CBO assumes to be 1.6 times higher than the average monthly estimates. Thus, the proposed changes would affect the lives of more children when considered over the course of a year. If both adjustments are applied to our estimates, more than 2.5 times as many children would be affected by the proposed changes than are reported in this brief.

Both the current Senate and House proposals would add more children to Medicaid programs nationally and would include a large Medicaid expansion for adults. The Medicaid expansion would benefit children by providing them with EPSDT benefits and with minimal cost-sharing, and by providing their parents with affordable, comprehensive coverage. However, since access to Medicaid providers is limited in some areas, there is a danger that access will erode further with large increases in Medicaid caseloads unless steps are taken to increase the supply of providers both for primary and specialty care. The House bill includes federally funded increases in Medicaid reimbursement for evaluation and management services, which may be needed but not sufficient to address this issue. It may also be important to consider broader increases in Medicaid reimbursement and other policy changes designed to increase access to care. In addition, due to the current weak economy, states are under extreme pressure to cut their program budgets and staff. Given the budget problems projected for

many states in 2010 and 2011,⁴⁰ extending the higher federal matching rates for Medicaid beyond fiscal year 2010 may be critical in order for states to maintain their programs. Since states would share in the financing of Medicaid coverage for children under health reform, it will be vital that states have the resources they need to ensure high participation and high quality care in Medicaid under reform and that they be held accountable for doing so. It will also be important to consider the ramifications of the MOE requirements in the current bills given that they apply to only a subset of states and thus have uneven distributional impacts across states.

If the House and Senate bills had been implemented in 2007, our analysis shows that 1.3 million children (House bill) and 0.7 million children (Senate bill) would have been transferred from separate CHIP into Medicaid. Under the House provisions, about 1.8 million children with incomes above 150 percent of the FPL would have lost separate CHIP coverage in 2007 and potentially moved into new exchange plans. Had these changes been implemented in 2007 with adequate CHIP funding, the Senate bill would have resulted in no change for the estimated 2.3 million children with incomes above 133 percent of the FPL who had separate CHIP coverage. However, the Senate bill does not currently include adequate CHIP funding and, as a result, these 2.3 million children could have lost CHIP coverage and potentially moved into the exchange. To the extent that CHIP is eliminated, it will be essential to assess how coverage and access under the exchange plans compares to that available under CHIP, and to develop an implementation plan that minimizes disruptions of care for these children. It will also be important to track changes in access to care for children who experience changes in coverage that affect their benefits, cost-sharing requirements, and provider networks. Concerns about affordability are greater in the Senate leadership bill because the subsidy schedules for both premiums and out-of-pocket costs are less generous than in the House bill, which increases the risks that children who lose CHIP coverage will experience lower access to care.

Finally, attention must be paid to the possibility that some children who lose CHIP coverage could fall through the cracks and become uninsured. Some children could become uninsured if their parents find the coverage available through the exchange to be unaffordable and do not enroll, despite the presence of an individual mandate. This group could also include citizen children in mixed immigrant status families whose parents cannot qualify for subsidies through the exchange and children in kinship care. An estimated 14 percent of citizen children with public coverage have non-citizen parents.⁴¹ Whether and how the proposed exchanges would accommodate the potential need for child-only policies and subsidy schedules have not yet been determined. Likewise, it would be important to track how access to care evolves for children who currently qualify for CHIP but who are denied access to subsidized coverage through the exchange because of firewalls—i.e., policies that would limit the availability of subsidies for low-income families with access to employer-sponsored coverage.⁴² It is not known how many children who would have qualified for CHIP under current rules would face these firewalls if reform legislation passes, but many children who currently have CHIP coverage have parents with employer coverage.⁴³ Parents with access to employer coverage who enroll their children in CHIP coverage often indicate that concerns about affordability and benefits under their employer plan led them to make that choice.⁴⁴ Therefore, the elimination of CHIP could mean that these children experience lower access to care or that, despite the mandate, they lose coverage altogether if their parents cannot afford the dependent coverage available through their employer.

Notes

- ¹DeNavas-Walt, C, BD Proctor, and JC Smith, U.S. Census Bureau, Current Population Reports, P60-236. "Income, Poverty, and Health Insurance Coverage in the United States: 2008." Washington, DC: Government Printing Office, 2009.
- ²DeNavas-Walt, C, BD Proctor, and JC Smith, U.S. Census Bureau, Current Population Reports, P60-236. "Income, Poverty, and Health Insurance Coverage in the United States: 2008." Washington, DC: Government Printing Office, 2009.
- ³Holahan, J and A Cook, "Changes in Health Insurance Coverage, 2007-2008: Early Impact of the Recession" Kaiser Commission on Medicaid and the Uninsured, October 2009; Kenney, G, A Cook and L Dubay, "Who is Left and What are the Prospects for Covering More Children?" Washington, DC: Urban Institute, November 2009; Dubay, L, A Cook, and B Garrett. "How Will the Uninsured Be Affected by Health Reform?" Washington, DC: Urban Institute. 2009. <http://www.urban.org/publications/411950.html>
- ⁴Ellis, E, D Roberts, D Rousseau, and T Schwartz. "Medicaid Enrollment in 50 States: June 2008 Data Update." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2009; Smith, V, D Roberts, C Marks, and D Rousseau. "CHIP Enrollment: June 2008 Data Snapshot." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2009; Cohen Ross, D, and C Marks. "Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2009.
- ⁵Hudson, J and T Selden. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs* 2007; 26(5):w618-w629; Dubay, L and G Kenney. "The Impact of CHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families." *Health Services Research* 2009; 44(6); LoSasso, A and T Buchmueller. "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage." *Journal of Health Economics* 2004; 23:1059-1082. Gruber, J and K Simon "Crowd Out 10 Years Later: Have Recent Public Insurance Expansion Crowded Out Private Insurance?" *Journal of Health Economics* 2008; 27(2): 201-217.
- ⁶Shone, LP, AW Dick, JD Klein, J Zwanziger, and PG Szilagyi. "Reduction in Racial and Ethnic Disparities after Enrollment in the State Children's Health Insurance Program." *Pediatrics* 115(6): e697-e705. 2005; Dick, AW, C Brach, RA Allison, E Shenkman, LP Shone, PG Szilagyi, JD Klein, and EM Lewit. "SCHIP's Impact in Three States: How Do The Most Vulnerable Children Fare?" *Health Affairs* 23(5): 63-75. 2004.
- ⁷Kenney, G, A Cook, and L Dubay. "Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering More Children?" Washington, DC: Urban Institute. 2009.
- ⁸Soloman, J, E Park, and R Greenstein. "House Health Bill Would Expand and Strengthen Coverage for Children and Families." Washington, D.C.: Center on Budget and Policy Priorities. November 2009. <http://www.cbpp.org/files/11-6-09health.pdf>
- ⁹Davidoff, A, L Dubay, G Kenney, and A Yemane. "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children." *Inquiry* 40: 254-268. 2003; Dubay, L and G Kenney. "Addressing Coverage Gaps for Low-Income Parents." *Health Affairs* 2004, 23(2): 225.
- ¹⁰Kenney, G and S Dorn. "Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize Gains and Prevent Harm?" Washington, DC: Urban Institute. 2009. <http://www.urban.org/publications/411899.html>
- ¹¹Georgetown University Policy Institute Center for Children and Families. "Eligibility Levels in Medicaid & CHIP for Children, by State as of October 1, 2009", October 2009, <http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/eligibility%20expansions%20by%20state.pdf>.
- ¹²Kaiser Family Foundation. State Health Facts Online. www.statehealthfacts.org Accessed November 20, 2009.
- ¹³Wysen K, C Pernice, T Riley. 2003. "How Public Health Insurance Programs for Children Work." *Future of Children* 13:171-191; forthcoming National Academy for State Health Policy (NASHP) brief on 2008 NASHP 2008 CHIP Survey.
- ¹⁴Wooldridge, J, G Kenney, C Trenholm, L Dubay, I Hill, et al. "Congressionally-Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress." Submitted to the Department of Health and Human Services, Office of the Secretary, Assistant Secretary for Planning and Evaluation. 2005.
- ¹⁵Congressional Budget Office. "Insurance Coverage Under the Health Care Reform Proposal Approved by Senate Finance Committee." December 2007. <http://cboblog.cbo.gov/?p=397>. No information is currently available from CBO on how coverage might be affected for children with and without CHIP under the subsidy structure in the House bill.
- ¹⁶The income definition used to determine eligibility for childless adults would be determined by the Secretary of the Department of Health and Human Services.
- ¹⁷Georgetown Center for Children and Families. "Key Medicaid, CHIP, and Low Income Provisions in H.R. 3962: The Affordable Health Care for America Act of 2009." Washington, DC: Georgetown Health Policy Institute. November 2009. <http://ccf.georgetown.edu/index/key-provisions-in-hr-3962>; Kaiser Family Foundation. "Medicaid and Children's Health Insurance Programs Provisions in the House Leadership Bill: Affordable Healthcare for America Act (HR 3962)." Menlo Park, CA: Kaiser Family Foundation. 2009. <http://www.kff.org/healthreform/7952.cfm>

¹⁸Watson Wyatt Worldwide, “Implications of Health Care Reform for Children Currently Enrolled in CHIP Programs,” September 25, 2009, <http://www.firstfocus.net/pages/3635>; Solomon J, E Park, and R Greenstein. “House Health Bill Would Expand, Strengthen Coverage for Children and Families.” Washington, DC: Center on Budget and Policy Priorities, November 2009. <http://www.cbpp.org/cms/index.cfm?fa=view&id=2983>

¹⁹“Casey Amendment Would Protect and Ensure Children’s Health Care.” Press Release. November 30, 2009. <http://casey.senate.gov/newsroom/press/release/?id=0CD01E4E-5A2B-4D84-8080-291B21BC7F57> Accessed December 3, 2009.

²⁰The bill text states that the Secretary of Health and Human Services will determine the percent of FPL based on adjusted gross income that would be equivalent to 133 percent of the federal poverty level (FPL) based on income net of disregards. Our model incorporates this by considering children with net income of less than 133 percent of the FPL to be eligible for Medicaid.

²¹Angeles, J and J Solomon. “Changes in Senate Health Bill Make Coverage More Affordable for Millions of Low-Income Families, Although Not for Those on Low End of Subsidy Scale.” Washington, DC: Center on Budget and Policy Priorities, November 2009. <http://www.cbpp.org/cms/index.cfm?fa=view&id=3004>

²²Peterson, C. “REVISED: Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees, FY2007.” Washington, DC: Congressional Research Service. 2008.

²³Continuous eligibility policies may result in administrative data that overstate the number of children enrolled during a point in time and may lead to greater disconnects between the income found on survey data and the eligibility category. (Dubay L, Kenney G. “Assessing SCHIP Effects Using Household Survey Data: Promises and Pitfalls.” *Health Services Research* 35(5, Part III):112-127. 2000.)

²⁴Dubay, L and A Cook. “How Will the Uninsured Be Affected by Health Reform?” Kaiser Commission on Medicaid and the Uninsured, August 2009, <http://www.kff.org/healthreform/upload/7971.pdf>.

²⁵The eligibility model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person and family level data from the March Supplement to the CPS to simulate the eligibility determination process. Because the CPS does not collect information on monthly income, it is not possible to determine how eligibility status changes as a result of income fluctuations throughout the year. To account for the possibility that some foreign-born individuals are unauthorized immigrants and therefore not eligible for public health insurance coverage, the model takes into account immigrant status. Immigrant status is predicted based on a simulation model of immigrant status derived from the March 2004 CPS. March 2004 CPS estimates of immigrant status were developed by Passell, and estimates derived from the two sample estimation technique are consistent with those produced using the March 2008 CPS (Passel, J and D Cohen Ross. “A Portrait of Unauthorized Immigrants in the United States.” Washington, DC: Pew Hispanic Center, April 2009).

²⁶National Center for Children in Poverty. “Public Health Insurance for Children.” http://www.nccp.org/profiles/index_32.html; Cohen Ross, D, A Horn, and C Marks. “Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles.” Kaiser Commission on Medicaid and the Uninsured, January 2008; Cohen Ross, D, A Horn, R Rudowitz, and C Marks. “Determining Income Eligibility in Children’s Health Coverage Programs: How States Use Disregards in Children’s Medicaid and SCHIP.” Kaiser Commission on Medicaid and the Uninsured, May 2008.

²⁷In cases where complete eligibility information was not available for 2007, other available sources were used. The model takes into account childcare expense, work expense and earnings disregards in determining eligibility, but does not take into account child support disregards.

²⁸Health insurance units include the member of a nuclear family, including the family head, spouse, and own children under 19 years of age, or own full-time student children 19-22 years of age.

²⁹Nelson, CT and RJ Mills. “The Characteristics of Persons Reporting State Children’s Health Insurance Program Coverage in the March 2001 Current Population Survey.” U.S. Bureau of the Census, August 2002.

³⁰A long-standing debate exists regarding whether insurance estimates from the CPS represent people who responded by providing their coverage at the time of the survey or responded about their health insurance coverage over the course of the year (as intended) but with recall error because of the long reference period. The Census Bureau has commented on this issue and stated that CPS estimates are more closely in line with point-in-time estimates of the uninsured (DeNavas-Walt, C, BD Proctor, and JC Smith, U.S. Census Bureau, Current Population ³¹The undercount adjustment partially adjusts the CPS to administrative estimates of Medicaid enrollment. For Reports, P60-236. “Income, Poverty, and Health Insurance Coverage in the United States: 2008.” Washington, DC: Government Printing Office, 2009.)

³¹The undercount adjustment partially adjusts the CPS to administrative estimates of Medicaid enrollment. For more information, see Dubay, L, J Holahan, and A Cook. “The Uninsured and the Affordability of Health Insurance Coverage.” *Health Affairs* 26(1): w22-w30. 2007.

³²Centers for Medicaid and Medicare Services, “FY 2007 Second Quarter – Program Enrollment Last Day of Quarter by State – Total SCHIP”, <http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/SecondQuarterFFY2007PIT.pdf>.

³³In addition, the distribution of Medicaid expansion CHIP and separate CHIP coverage with respect to income was found to be comparable to unpublished estimates derived from the Medical Expenditure Panel Survey.

³⁴Kenney G, L Dubay, and J Haley. "Health Insurance, Access, and Health Status of Children Findings from the National Survey of America's Families." Washington, DC: Urban Institute. 2000.; Dubay L and G Kenney. "Assessing SCHIP effects using household survey data: promises and pitfalls." *Health Services Research* 2000; 35(5 Pt 3): 112–127; Hudson, J, and T Selden. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs*, 26(5), 2007.; Davidoff, A, A Yemane, and E Adams. "Health Coverage for Low-Income Adults: Eligibility and Enrollment in Medicaid and State Programs, 2002", The Kaiser Commission on Medicaid and the Uninsured, February 2005; Dubay L, J Haley, and G Kenney. "Children's Eligibility for Medicaid and SCHIP: A View from 2000." *Assessing the New Federalism* No. B-41. Washington, DC: Urban Institute. 2002.

³⁵An estimated 23 percent of Medicaid reporters on the 2000-2001 CPS who were linked to administrative data reported income on the CPS at or above 200% of the FPL. This suggests that for some Medicaid enrollees, the income reported on the CPS may not reflect income at the time of eligibility determination. (Davern, M, J Klerman, J Ziegenfuss, V Lynch, D Baugh, and G Greenberg. "A Partially Corrected Estimate of Medicaid Enrollment and Uninsurance: Results from an Imputational Model Developed off Linked Survey and Administrative Data", *draft*.)

³⁶These three adjustments narrow but do not close the gap between the administrative enrollment totals and those in our analysis. Our estimate of CHIP enrollees is similar to that found in administrative data (4.3 million vs. 4.4 million), though we have fewer Title XIX Medicaid enrollees (20.2 million vs. 22.0 million). (Centers for Medicaid and Medicare Services, "FY 2007 Second Quarter – Program Enrollment Last Day of Quarter by State – Total SCHIP", <http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/SecondQuarterFFY2007PIT.pdf>; Ellis, ER, D Roberts, DM Rousseau, and T Schwartz. "Medicaid Enrollment in 50 States: June 2008 Update." The Kaiser Commission on Medicaid and the Uninsured, September 2009, <http://www.kff.org/medicaid/upload/7606-04.pdf>.)

³⁷Holahan, J, and A Cook, "Changes in Health Insurance Coverage, 2007-2008: Early Impact of the Recession" Kaiser Commission on Medicaid and the Uninsured, October 2009; Kenney, G, A Cook and L Dubay, "Who is Left and What are the Prospects for Covering More Children?", The Urban Institute, November 2009.

³⁸Heberlein, M, C Mann, J Guyer, and D Horner. "States Moving Forward: Children's Health Coverage in 2007-08." Washington, DC: Georgetown Center for Children and Families. 2008.

³⁹Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Children's Health Insurance Program (CHIP)", <http://www.cbo.gov/budget/factsheets/2009b/chip.pdf>

⁴⁰McNichol, E and N Johnson. "Recession Continues to Batter State Budgets; State Responses Could Slow Recovery." Washington, DC: Center on Budget and Policy Priorities. 2009.

⁴¹Urban Institute analysis based on data from the Health Policy Center Eligibility Model.

⁴²Curtis, R and E. Neuschler, "Affordable Coverage for Low-Income Families Eligible for Employer Plans." Institute for Health Policy Solutions, September 2009.

⁴³Sommers, A, S Zuckerman, L Dubay, and G Kenney. "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States." *Health Affairs* 26(2): 529-537, 2007; Kenney, G and A Cook. "Coverage Patterns Among SCHIP-Eligible Children and Their Parents." Washington, DC: Urban Institute. 2007.

⁴⁴Kenney, G, C Trenholm, L Dubay, et al. "The Experiences of SCHIP Enrollees and Disenrollees in 10 States: Findings from the Congressionally Mandated SCHIP Evaluation." Princeton, NJ: Mathematica Policy Research and Washington, DC: Urban Institute. 2005.

ACKNOWLEDGEMENTS

This research was funded by the David and Lucile Packard Foundation. The authors gratefully acknowledge the helpful comments and background information provided by Eugene Lewit, Lisa Dubay, Sarah DeLone, Stan Dorn, Eileen Ellis, Jocelyn Guyer, Ian Hill, John Holahan, Dawn Horner, Julie Hudson, Bruce Lesley, Donna Cohen Ross, and David Rousseau, and the research assistance of Jennifer Pelletier. The views expressed are those of the authors and should not be attributed to the David and Lucile Packard Foundation, the Urban Institute or its funders, or to those acknowledged here.