WHAT TO DO TO IMPROVE CHILDREN’S PUBLIC HEALTH COVERAGE

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First Focus
Nineteen percent of all U.S. children live below the federal poverty threshold, and 41 percent of children live in low-income families. These children live with their parents, or a parent, their grandparents, or grandparent, their aunt or uncle, or another family member. Maybe they live with foster parents or in a residential care facility. Maybe they live in a neonatal intensive care unit or a juvenile detention facility. Maybe they live with siblings, cousins, foster siblings, or other patients. Maybe they are homeless. Maybe they live in a detention facility for unaccompanied minors. No matter where they live, or with whom, their need for healthcare coverage and access to continuous, accessible, appropriate, and affordable care doesn’t vary.

With 10 years of Children’s Health Insurance Program (CHIP) funding secured by Congress and the president on February 9, 2018, health coverage is guaranteed for millions of children and pregnant women through 2027. CHIP covers almost nine million children and pregnant women. Medicaid covers 36 million children from birth through age 21. “As of January 2017, 49 states cover children with incomes up to at least 200 percent of the federal poverty level (FPL) through Medicaid and CHIP. This count includes 19 states that cover children with incomes at or above 300 percent FPL. Only two states (Idaho and North Dakota) limit children’s eligibility to below 200 percent FPL.” With the funding and policies in place, state CHIP directors, Medicaid officers, governors, members of Congress, and child health advocates can think about new and innovative policies to cover the remaining uninsured infants, children, and youth.

Coverage for children from birth to 18 remains strong, with just under 5 percent uninsured, thanks to Medicaid, CHIP, the Affordable Care Act (ACA), and employer-sponsored coverage. However, even with long-term extensions of CHIP and the permanency of Medicaid, children may roll on and off coverage, going weeks or months without coverage if their renewal is slowed by a change of address, a change in living situations, or a form’s being lost in the mail. Children’s coverage and access to affordable healthcare should not be risked due to an array of steps potentially fraught with human error that could imperil their health and their families’ budgets.

Strategies and policies could be implemented within the public programs in place to enroll and retain the children who are uninsured. When we think of young children, infants from birth through age five, we think of brain development and the tremendous amount that infant and toddler brains and bodies grow. We think of their
fragility as well as their strength and abilities. When children begin school and as they enter the world as young adults, we think of them as strong, but susceptible to illness or injury. We think of them as vulnerable and in need of protection and safety. We should think about policies and procedures that best protect them and their families from poverty and harm.

POLICY IDEAS TO KEEP CHILDREN COVERED

Auto-Enrollment in Coverage from Birth

Over several sessions of Congress, bills\(^4\) were introduced to establish auto-enrollment procedures for children before they leave the hospital at birth. With around four million babies\(^5\) born each year in hospitals, that policy should be established and supported throughout the country. Parents schedule their first doctor’s appointment for their newborns just a few days after leaving the hospital, so their health coverage should be started or in process by the time the infant leaves the hospital. Language from the Start Healthy Act of 2013 was very clear: “a child that a state reasonably believes is a qualified newborn … on the date of such child’s birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance until such child is one year of age, unless a State determines that a child is not eligible for such medical assistance through a redetermination. …”\(^6\) Establishing a child’s health coverage immediately would reduce unpaid bills, parental stress, missed appointments, and paperwork at the medical practice.

Continuous Coverage from Birth through Age Five

Once children get health coverage at birth, be it through private insurance or a public program such as CHIP or Medicaid, coverage should be continuous through age five. During those first five years of life, children’s brains are developing, and they cultivate fine and gross motor skills, acquire language, and build their social and emotional competencies. Additionally, immunizations are recommended beginning at birth and throughout early childhood,\(^7\) and are typically required for school entry and admittance to childcare.\(^8\)

Early childhood, from birth until the start of school, encompasses one of the most
significant periods for brain development. The only organ not fully developed at birth is the brain, and 90 percent of the child’s brain develops by the age of five. The child’s brain doubles in size in the first year of life and keeps growing to about 80 percent by age three and 90 percent by age five. During a child’s first five years, the neurons create connections. At least one million neural connections are created during early childhood, far more than at any other time in an individual’s life. Lack of access to healthcare can negatively impact a child’s early development and, subsequently, his or her long-term success. Long before most children step into a classroom, their neurons are constructing networks, cognition is exploding, language is increasing, and the foundations are being laid for a lifetime of learning.

The American Academy of Pediatrics recommends that babies get checkups at birth, three to five days after birth, and then at 1, 2, 4, 6, 9, 12, 15, 18, and 24 months. Babies may receive referrals for additional assessment and treatment during or between any of these appointments. It is essential that parents and medical providers be aware of the child’s primary care and that any referrals be covered during this significant time in a child’s development. Parents should know, when they take their child to a medical appointment during those early years, that the care is covered. Medical providers should trust that their services will be reimbursed and that any tests they order or referrals to specialists they make will be covered as well.

A critical aspect of well-child exams during the first five years is that they include developmental, behavioral, and psychosocial screenings. If these screenings are missed or interrupted due to lack of coverage, needed screenings and necessary early interventions can be delayed. If a child with a developmental delay or suspected delay is not identified in an early well-child check-up, he or she will have to wait until someone identifies it in school. A child not identified until school age could have significant delays and may have lost many opportunities for early interventions, causing undue harm to the child and family, and increased costs later. Continuous coverage during the first five years of life would help to ensure that children see medical providers regularly and receive appropriate care and referrals on time.

Twelve-Month Continuous Eligibility from Age 6 through Age 21

From the time children enter school, their coverage should be continuous for 12 months at a time, up through age 21. During the grade school years, children begin
to get involved in team sports, participate in after-school activities, play outside, and engage with groups of friends. Their medical appointments, though less frequent than during early childhood, are still essential and could reveal a need for further care with a specialist. As stated so clearly by the Centers for Medicare and Medicaid Services (CMS), “Children who have health insurance continuously throughout the year are more likely to be in better health. Guaranteeing ongoing coverage ensures that children can receive appropriate preventive and primary care as well as treatment for any health issues that arise. Stable coverage also enables doctors to develop relationships with children and their parents and to track their health and development. Additionally, eliminating the cycling on and off of coverage during the year reduces state time and money wasted on unnecessary paperwork and preventable care needs.”

As children enter middle school and high school, athletic activities get more intense; they begin driving; and they face many factors associated with adolescence, such as exposure to drugs, alcohol, and sexual activity. Keeping them covered without gaps in insurance will help protect their health and their parents’ finances. Twelve-month continuous coverage allows them to grow and develop through their adolescence with the coverage and access to care they need.

Providing continuous eligibility through CHIP and Medicaid can save state administrative dollars by eliminating ongoing reporting. States redetermine eligibility every 12 months, and enrollees must report changes during that time. Children will lose coverage if these changes, such as a stated increase in income, make them ineligible. But states could make children eligible for 12 months continuously by simply disregarding changes in income until renewal. Twelve-month continuous eligibility promotes retention and decreases the number of children churning on and off of coverage due to minor changes in family income. Twelve-month continuous eligibility not only benefits children and families, but it lowers administrative costs to the state. It also improves states’ ability to monitor the quality of care, because many quality measures require at least a year of continuous enrollment.

Additionally, at beneficiaries’ annual CHIP or Medicaid renewal date, states should utilize the auto-renewal procedures Louisiana created and other states now utilize, including prepopulated forms and matching of parent incomes and addresses to data already held by the state, in order to decrease churn and children’s losing coverage.
In Louisiana, “Medicaid/CHIP renewal is completed through multiple strategies, including data matching. More than three in four (76 percent) of Medicaid/CHIP children’s renewals are based on data; nearly all children (95.4 percent) have eligibility continue at renewal; < 1 percent lose coverage for procedural reasons.” All states could utilize these practices and others from Louisiana, such as “ex parte” renewal for CHIP and Medicaid.

**CHIP Coverage through Age 21**

Upon turning 19 years old, instead of losing their CHIP coverage, children should remain eligible through age 21. The uninsured rate for ages 19–25 spikes to 13.1 percent. This is a critical transition period for young adults as they finish high school, enter the workforce, start college, or do both. If they are employed, they are more likely to have jobs that do not offer private coverage. “As young adults transition into the job market, they often have entry-level jobs, part-time jobs, or jobs in small businesses, and other employment that typically comes without employer-sponsored health insurance. Additionally, young people need health insurance: one in six young adults has a chronic illness like cancer, diabetes, or asthma. Nearly half of uninsured young adults report problems paying medical bills.”

Keeping young adults covered as they work part time and/or attend college or learn a trade would assist in keeping their health protected as well as their finances.

**Express Lane Eligibility for CHIP and Medicaid**

In order to enroll more eligible children and youth into Medicaid and CHIP, states should adopt the Express Lane Eligibility (ELE) option allowed under federal law. ELE permits states to enroll children and renew their coverage by using already proven eligibility for certain other programs. Enrollment and renewal processes for children are simplified because states can rely on findings from designated ELE programs. When programs such as school lunch, SNAP, Temporary Assistance for Needy Families (TANF), Head Start, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) share their enrollment data about income and household size, states can easily identify families with children who are eligible but unenrolled in health coverage. ELE is used in nine states now. With a 10-year CHIP extension, states should take advantage of this technological option and use it to reduce their uninsured rates even further.
In South Carolina, through ELE, “Children receive or renew Medicaid based on SNAP or TANF receipt unless parents opt out. Medicaid was provided to more than 92,000 uninsured children, increasing total enrollment by 15 percent. More than 276,000 children renewed through ELE. Net administrative savings of $1.6 million per year.”

Adoption of the Immigrant Children’s Health Insurance Act by All States

The Immigrant Children’s Health Insurance Act (ICHIA) was included in the CHIPRA legislation that passed in 2009. In the Personal Responsibility and Work Opportunity Reconciliation Act that Congress passed in 1996, new restrictions were implemented that barred most lawfully residing immigrants from receiving benefits from federal programs for the first five years they were in the United States. One of those public programs was Medicaid; CHIP was added upon its creation in 1997. ICHIA restored eligibility for Medicaid and CHIP to lawfully residing children and pregnant women.

The ICHIA option available under federal law allows states to waive the five-year bar for lawfully residing immigrant children and/or pregnant women. If children and pregnant women in a state that has taken the ICHIA option are otherwise financially eligible for CHIP or Medicaid and have the necessary documentation, they are enrolled in CHIP or Medicaid. In July 2010, CMS released guidance to states on implementation of this provision. The need for health coverage for these two populations cannot be overstated. Babies, children, young adults, and pregnant women, especially, cannot wait five years for medical exams, needed referrals, and treatment. As of March 2018, 31 states have waived the five-year bar for children and 33 states have waived it for pregnant women. All states should also waive this bar.

CONCLUSION

Children who experience gaps in health coverage due to enrollment barriers may not receive needed medical care, may go without refilling prescriptions, and may miss preventive doctor visits. Gaps in health coverage are particularly harmful for children with chronic health conditions who require frequent doctor visits and expensive medicine. From birth though early childhood, during the school years, and upon transitioning to young adulthood, coverage should be automatic, continuous, and easy to maintain. Access to affordable, appropriate medical care should be a part of
childhood as much as playing with friends and going to school. Protecting children and youth from preventable illness, treating diseases and injuries, shielding their parents from high medical costs by reducing financial liability, and providing simple access to coverage are goals we can meet through innovative policy steps.

By reducing the financial burden and risk of medical spending, public health insurance has the potential to reduce the extent to which families live in poverty, as defined using the Supplemental Poverty Measure.\textsuperscript{22} Enrolling infants at birth, keeping them covered through childhood, and making sure all coverage options are adopted in all states are the right steps to safeguard good health outcomes and to prevent low-income families from facing financial hardships due to their child’s health status.


8. “Vaccination Laws,” Centers for Disease Control and Prevention, accessed March 2, 2018, https://www.cdc.gov/phlp/publications/topic/vaccinationlaws.html. It is important to note that all states require children to be vaccinated against certain communicable diseases as a condition for school attendance. In most instances, state school vaccination laws expressly apply to both public schools and private schools with identical immunization and exemption provisions. All states also establish vaccination requirements for children as a condition for childcare attendance. These requirements often mirror the requirements for public school children and are often located in the same school vaccination provisions.


Child poverty remains high in the U.S., with nearly 1 in 5 children living in households below the poverty line.

Children experience poverty at a rate that is 62 percent higher than adults. Poverty is a particularly serious problem for children, who suffer negative effects for the rest of their lives after living in poverty for even a short time.

The U.S. Child Poverty Action Group is a partnership of child-focused organizations dedicated to cutting child poverty in half within a decade.

Recognizing the need for a national strategy to address child poverty, members of the U.S. Child Poverty Action Group drafted Our Kids, Our Future, a compendium of cross-sector solutions to significantly reduce child poverty in the U.S.