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Special Series: Health Reform Issues

November 6, 2009

HOUSE HEALTH BILL WOULD EXPAND AND STRENGTHEN COVERAGE FOR CHILDREN AND FAMILIES

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Summary

The health reform bill that House Democratic leaders introduced on October 29 (H.R. 3962) would provide affordable, comprehensive health insurance coverage to 36 million Americans who otherwise would be uninsured, according to the Congressional Budget Office.[1] This is 7 million more otherwise-uninsured people than CBO estimates would gain coverage under the Senate Finance Committee bill. These 36 million Americans include millions of children and parents; for many of them, the legislation would represent the largest improvement in their circumstances resulting from changes in government policy in years.

Since the large majority of uninsured parents and children have low or moderate incomes, the House bill would be particularly beneficial for this group. The bill would extend Medicaid to households up to 150 percent of the poverty line ($27,465 for a family of three in 2009) in all states. Today in the typical state, parents lose eligibility for Medicaid when their income reaches just 68 percent of the poverty line, with the result that millions of parents who work for low wages and have incomes below or modestly above the poverty line are uninsured.[2]

These parents' lack of coverage often adversely affects their children, as well. Studies have shown that when children are eligible for coverage but their parents are not, the children are less likely to be enrolled in coverage — and if the children do have coverage, they are less likely to receive the health care services they need. The House bill's Medicaid provisions, which would cover parents and

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[1] For an overall analysis of the House health reform bill and how it compares to the Senate Finance Committee bill, see Edwin Park, *et al.*, "House Health Reform Bill Expands Coverage and Lowers Health Cost Growth, While Reducing Deficits," Center on Budget and Policy Priorities, Updated November 6, 2009.

[2] The Medicaid income eligibility limit for working parents is 68 percent of the poverty line in the median state. This takes into account earnings disregards that are applied in most states. The income eligibility limit for parents who are not employed is 41 percent of the poverty line in the median state. Donna Cohen Ross, *et al.,* "Challenges of Providing Health Coverage for Children and Families in a Recession," Kaiser Commission on Medicaid and the Uninsured, January 2009.

children together up to 150 percent of the poverty line, would represent a major gain for millions of low-income families.

The House bill also makes children and parents who have incomes too high to qualify for Medicaid and lack employer-based coverage eligible for comprehensive coverage through the new health insurance exchange; the bill makes coverage affordable for most households who have incomes below 400 percent of the poverty line by providing credits to help cover these families' premium and cost-sharing costs. The credits would be substantially larger (and more adequate) than those that families would receive under the Senate Finance Committee bill, particularly for those at the lower end of the subsidy scale.

Establishing a new health insurance exchange, with subsidies to make coverage affordable to families up to 400 percent of the poverty line, represents another major advance. Low-income parents tend to work for firms, such as small businesses, that are less likely to offer health insurance to their workers. They thus have less access to employer-sponsored insurance than people with higher incomes. At present, parents in this income range who cannot obtain employer coverage have little opportunity to secure affordable coverage in most states.

Many children would benefit as well. Currently, a number of children in this income range are ineligible for public programs like Medicaid and the Children's Health Insurance Program (CHIP) because their family incomes are too high. In just over half of states, CHIP coverage is limited to children in families at or below 200 percent of the poverty line.

For low-income children currently enrolled in CHIP, the issues are more complex. On balance, however, the House bill — which would phase out CHIP after December 31, 2013 — represents a long-term advance for these children as well. CHIP has been very successful in expanding coverage to a substantial number of low-income children, and legislation enacted at the start of this year strengthened CHIP and fully funded it through fiscal year 2013. But, despite CHIP's important accomplishments and the improvements that the recent CHIP legislation makes, CHIP's structure contains some significant weaknesses. Unlike Medicaid, CHIP is a capped block grant that in some years may not provide sufficient funding nationally, or adequate funding in individual states, to cover all eligible children who apply; CHIP is dependent on sufficient funding at both federal and state levels. States may limit enrollment or impose waiting lists if either federal or state funding falls short.

In addition, CHIP's future prospects are uncertain. The debate over recent CHIP reauthorization legislation was highly contentious, with a number of policymakers calling for new funding for CHIP to be accompanied by various limits or reductions in CHIP coverage. If CHIP is retained beyond 2013, it likely will need to run this gauntlet again one or more times in the decade ahead. At that point, moreover, pressures on new government spending (which CHIP will need a large amount of just to maintain current state programs) will likely be much greater than they are today due to the worsening federal budget outlook, and the composition of Congress will likely be different, potentially making it harder to secure the needed 60 votes in the Senate to provide substantial new CHIP funding without scaling back eligibility limits or benefits.[3]

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[3] The dean of analysts of congressional races, Charles Cook, has said that he expects future Congresses to be more conservative, both because of expected changes in the 2010 mid-term election and because twice as many Democratic as Republican Senate seats will be up in 2012 and 2014.

The House Bill's Provisions Related to Children

Under the House bill, children with incomes *below* 150 percent of the poverty line who currently are insured under their state's CHIP program would move to Medicaid; these children would receive expanded health coverage as a result. Medicaid has a broader benefit package for children than CHIP does, since it includes the comprehensive Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit. In addition, Medicaid does not charge premiums and generally has lower cost-sharing than CHIP.

Children in separate state CHIP plans who have incomes *above* 150 percent of the poverty line would, starting in 2014, receive coverage through the health insurance exchange. However, states that use CHIP funds to operate an expanded Medicaid program for children above 150 percent of the poverty line rather than a separate state CHIP program would be required to maintain their current Medicaid eligibility criteria for children, so these children would remain in Medicaid. Similarly, states whose regular Medicaid income eligibility limits for children exceed 150 percent of the poverty line would have to maintain those eligibility criteria, and children above 150 percent of poverty currently in Medicaid would remain there.

On the one hand, for children *not* shifted into Medicaid, the benefit packages that would be available in the exchange would likely be somewhat less generous than those that CHIP provides today in a number of states, and the premiums and the cost-sharing charges for health services for children likely would be somewhat higher. On the other hand, *total* out-of-pocket health costs spending for these children's *families as a whole* generally would go down, because the parents would now be covered. Moreover, the House bill would require all health plans offered in the exchange — and ultimately, all employer-sponsored plans as well — to provide an "essential benefits package" that has comprehensive benefits, including vision, hearing, and dental care for children and well-baby and well-child care so *all* children would have access to these important benefits.

As noted, the current statutory authorization for CHIP and federal funding of the program run only through fiscal year 2013, and states must provide matching funds each year to secure their share of the federal funding. In contrast, the premium and cost-sharing credits that the House bill would provide to families with incomes up to 400 percent of the poverty line would be fully federally funded on an ongoing basis; they would not be dependent upon state budget decisions and the enactment of future federal legislation to provide substantial new federal funding, as would be the case with CHIP. Funding for these credits also would not be capped and would rise automatically when need increased, such as during a recession.

Finally, children who move from CHIP to either the exchange or Medicaid would generally be combined with their parents under a single health policy, with needed health care services becoming more accessible not only to the parents who newly gain coverage but, as research in the field indicates, to many of their children as well. All in all, the House health reform legislation, which would provide affordable and comprehensive coverage that is sustainable over time, represents a major step forward for low- and moderate-income families and children.

Medicaid and CHIP Coverage for Children and Families Today

Today, most low-income children are eligible for Medicaid or CHIP, although many are not covered and remain uninsured.[4]

- States currently must make children under age 6 eligible for Medicaid if their families' incomes are below 133 percent of the poverty line, and must make children aged 6 through 18 eligible if their families' incomes are below 100 percent of the poverty line. (States are allowed to set their Medicaid income limits for children above these minimum levels, and many do.)

- All states use CHIP funds to cover children with incomes above the state's Medicaid limits. Most states have CHIP programs that are separate from their Medicaid programs, but 11 states have used their CHIP funds solely to expand Medicaid.[5]

While most states provide CHIP or Medicaid to children in families with incomes up to at least 200 percent of the poverty line, the picture for parents is very different. As noted, the median Medicaid eligibility limit for parents is only 68 percent of the poverty line ($12,451 for a family of three). In many families, the parents are ineligible for Medicaid and thus remain uninsured even though their children have coverage through Medicaid or CHIP.

One noteworthy feature of Medicaid is that it provides coverage for all of those who are eligible without any waiting lists or limits on enrollment. CHIP, by contrast, is a block grant program that provides states with fixed annual allotments. Separate state CHIP programs can serve only as many children as their federal and state funding allows.

Children in Medicaid (including children in state Medicaid expansion programs that receive CHIP funds) are entitled to an important benefit known as Early and Periodic, Screening, Diagnostic and Treatment (or EPSDT). Under EPSDT, states are directed to insure that all children enrolled in Medicaid receive regular check-ups — including vision, dental, and hearing exams — and all necessary immunizations and laboratory tests. Of particular note, under EPSDT a child is covered for *all* follow-up diagnostic and treatment services that are medically necessary for the child, even if the state's Medicaid program otherwise does not cover the particular services the child needs. In contrast, states do not have to provide the EPSDT benefit to children enrolled in separate CHIP programs, and most do not, although CHIP benefit packages generally provide children with quite comprehensive benefits including dental and vision coverage.

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[4] Two-thirds of children who are uninsured today are estimated to be eligible for Medicaid or CHIP, but remain unenrolled. "The Uninsured: A Primer," Kaiser Family Foundation, October 2008.

[5] States can use their federal CHIP funds to finance coverage for children whose family incomes exceed the Medicaid income limits the state had in place in June 1997. States can use CHIP funds to raise their Medicaid income limits or otherwise expand their Medicaid eligibility criteria, to operate a separate CHIP program, or to adapt a combination of these two approaches. As of April 2009, 11 states (including the District of Columbia) opted to use CHIP funds solely to expand their Medicaid programs. In the remaining states, CHIP funds are used for a separate children's health insurance program or for a combination of both approaches. See Donna Cohen Ross, *et al.,* "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured, January 2009). Georgetown Center for Children and Families, "About CHIP," http://ccf.georgetown.edu/index/structure-schip.

Another difference between Medicaid and separate state CHIP programs is that whereas Medicaid does not require premiums for eligible children and charges only nominal co-payments for children above the poverty line, CHIP programs generally do charge premiums.[6] Under CHIP, total premiums and cost-sharing for enrolled children cannot exceed 5 percent of their family's income.

House Bill Much Stronger Overall than Current Law for Children and Parents

All children and parents who are eligible for Medicaid today would remain eligible under the House bill. (The bill requires states to maintain any current Medicaid eligibility standards for adults and children that are more generous than those the bill would establish. States also would have to maintain current enrollment procedures, such as allowing mail-in applications or providing 12 months of continuous eligibility.) In addition, millions more children and parents would become newly eligible for Medicaid under the bill.

- Beginning in 2014, in more than 20 states, children under age 6 with incomes between 133 and 150 percent of the poverty line — and children aged 6 to 18 in families with incomes between 100 and 150 percent of the poverty line — would become eligible for Medicaid for the first time. Children in these states currently are eligible for CHIP. Moving to Medicaid would generally improve coverage for these children: they would become entitled to EPSDT benefits, and their premiums and co-payments generally would decline.

- In the 11 states with CHIP-funded Medicaid expansion programs, children in these programs would continue to be covered by Medicaid, so their coverage would remain unchanged.[7]

- Beginning in 2013, *parents* in families with incomes below 150 percent of the poverty line would become eligible for Medicaid in all states.[8] As noted, an extensive body of research shows that covering low-income parents together with their children increases the enrollment of eligible children in health coverage.[9] A recent study also found that insured children were less likely to receive necessary health care services if their parents were uninsured.[10]

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[6] In Medicaid states can charge children under the poverty line nominal co-payments for drugs that are not on a state's preferred drug list.

[7] States would get federal matching funds at the CHIP matching rate to cover both children who are newly eligible for Medicaid and those who would have been previously covered through a CHIP-funded Medicaid expansion. The enhanced federal matching rate for CHIP is, on average, 70 percent, compared to the average Medicaid matching rate of 57 percent.

[8] The federal government would pay the entire cost of covering newly eligible parents in 2013 and 2014, and 91 percent of the cost thereafter.

[9] This research is summarized in Leighton Ku and Matt Broaddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, October 20, 2006.

[10] Jennifer E. DeVoe, *et al.,* "Children's Receipt of Health Care Services and Family Health Insurance Patterns," *Annals of Family Medicine,* September/October 2009.

The bill would phase out the CHIP program on December 31, 2013.[11] States would be required to maintain their current CHIP eligibility levels and procedures for determining eligibility until then.[12] Once CHIP is phased out, children in separate CHIP programs who have family incomes above 150 percent of the poverty line would be eligible for coverage in the exchange, together with their parents. These children would move into the exchange a year after the exchange began operations on January 1, 2013, an interval that should provide time for a properly executed transition.[13]

The House bill provides important protection both to children who would move from CHIP to the exchange and to children who would continue to receive coverage through their parent's employers. It would establish an "essential benefits package" that mandates coverage for well-baby and well-child care; dental, hearing, and vision care for children; and medical equipment and supplies for children. Health plans also would have to cover doctor's visits, hospital care, preventive services and prescription drugs, specialized benefits such as rehabilitative and habilitative services, and mental health and substance abuse treatment for everyone. Well-baby and well-child care and other preventive services would be provided without any cost-sharing.

All health plans in the exchange would be required to offer the essential benefits package starting in 2013, and all employers would be required to offer it starting in 2018. Benefit packages in the exchange also could not include any annual or lifetime limits on coverage, a standard that would be extended to employer-sponsored plans as well in 2018.

As noted above, families with incomes below 400 percent of the poverty line ($73,240 for a family of three) would be eligible for premium and cost-sharing credits. These credits would be provided on a sliding scale, with the amounts based on a family's income, and would be available for all eligible family members.[14]

A family's contribution to the cost of family coverage generally would be higher than what families now pay to cover their children in CHIP. But to compare coverage costs just for *children* to coverage costs for the *entire family* would be to make an apples-to-oranges comparison that does not yield meaningful results. On balance, most children would be better off under the House bill than under current law.

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[11] Earlier this year, Congress reauthorized federal funding for the CHIP program through the end of *fiscal year* 2013. It is assumed that states will have sufficient, unspent funds from fiscal year 2013 and previous fiscal years to fully finance their programs for the rest of *calendar year* 2013.

[12] A state could limit enrollment if its allotment of federal funds was insufficient to cover all eligible children, but this is unlikely to occur as CHIP funding levels appear adequate to cover eligible children in all states through 2013.

[13] The House bill requires the Secretary of Health and Human Services to make recommendations to Congress by December 31, 2011 on actions that would ensure coverage in the exchange is comparable to coverage in CHIP and that the transition of children to the exchange takes place without interruption in coverage or treatment. The bill would not, however, allow any child eligible for CHIP to actually move into the exchange until January 1, 2014. The bill would be improved by allowing for a gradual movement of children from CHIP to the exchange during 2013, rather than having all children who are moving from CHIP to the exchange move at the start of 2014.

[14] Cost-sharing credits in the House bill would be available to all families with incomes at or below 350 percent of the poverty line.

- Under the House bill, both coverage itself and protection against excessive cost-sharing would extend to *all* family members, not just to children as in the current CHIP program. If a parent became sick, families would no longer face the prospect of large, uncovered medical expenses that drain family income and can make it harder to adequately meet children's health — and non-health — needs.

- Many families whose children are *not* currently eligible for CHIP would receive help purchasing coverage. Just over half of states set their CHIP income eligibility limit at or below 200 percent of the poverty line; only one state in the nation goes up to 400 percent of poverty. The House bill, in contrast, would provide families up to 400 percent of poverty with premium and cost-sharing credits regardless of the state in which they live.

- Unlike the current CHIP program, in which funding is capped and states may set enrollment ceilings and impose waiting lists, the new federal premium and cost-sharing credits would be available for all of those who qualify. Families and children would never face waiting lists.

- Coverage for *all* families, including those who receive coverage through their employers, would eventually have to include the essential benefits package, with its important health benefits for children.

House Bill Stronger than Senate Finance Committee Bill for Families

The bill that the Senate Finance Committee approved on October 13 would extend Medicaid to children (and others) with family incomes up to 133 percent of the poverty line, as compared to the House bill's 150 percent of poverty. Like the House bill, the Senate Finance Committee bill would provide premium credits to families with incomes up to 400 percent of the poverty line, although the credits would provide less assistance than under the House bill. In addition, the Senate bill would provide less cost-sharing assistance than the House bill and, unlike under the House bill, this assistance would stop at 200 percent of the poverty line.

In contrast to the House bill, the Senate bill would keep the CHIP program in place until September 30, 2019.[15] However, the bill contains no additional funding for CHIP, which, as noted is currently funded only through September 30, 2013. Further funding would depend upon action by future Congresses.

The Congressional Budget Office budget baseline assumes that CHIP will be reauthorized but funded at only *$5.7 billion a year for 2014* and subsequent years, which is a small fraction of what CHIP would need just to maintain its current caseload. Indeed, CBO has estimated that an additional $6.8 billion in federal CHIP funds above the baseline level would be needed in 2014 just to allow states to maintain their current programs that year, and an additional $70.9 billion in federal

[15] The treatment of CHIP and Medicaid in the bill that will emerge from the Senate after merger of the bills reported by the Senate Finance Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee will likely be based on the Finance Committee bill. The Finance Committee has jurisdiction over the Medicaid and CHIP programs, while the HELP Committee does not.

CHIP funds would be needed under current law for the period 2014-2019.[16] A future Congress would have to provide — and pay for — a substantial increase in CHIP funding if states are to sustain their existing CHIP programs, and would have to do so at a time when mounting concern about the nation's severe long-term fiscal problems may be giving deficit reduction precedence over most other policy concerns. In short, it is uncertain whether Congress and most states would continue to provide sufficient funding to maintain all of CHIP's current attractive features over time.[17]

If CHIP continued after 2013 but federal funding remained at baseline levels, states would either have to sharply increase their own contributions or substantially scale back their CHIP programs by scaling back benefits, increasing cost-sharing, or closing enrollment.

The Senate Finance Committee bill's treatment of families and children is less favorable than the House bill's in another respect; under the Finance Committee bill, coverage in the exchange would be less affordable for many families with moderate incomes (including families whose children were unable to obtain CHIP coverage).[18] If health reform were in effect in 2009, for example, a family of three earning $32,000 (175 percent of the poverty line for a family of that size) would have to pay $1,360 premium costs for coverage in the exchange under the House bill. The same family would pay $2,013 — nearly 50 percent more — under the Finance Committee bill. In addition, the maximum out-of-pocket costs for such a family would be nearly twice as high under the Finance Committee bill as under the House bill. (These differences between the bills are among the reasons that comparisons of CHIP coverage to coverage through the exchange under the Finance Committee bill cannot be assumed to apply to a comparison of CHIP coverage to coverage through the exchange under the House bill.)

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[16] See Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Children's Health Insurance Program," March 2009. In its estimates, CBO assumes that under current law, some states would use Medicaid to cover some CHIP-eligible children when they face federal CHIP funding shortfalls. Providing full federal CHIP funding would thus lead to modestly lower federal Medicaid spending than otherwise would occur. As a result, CBO estimates that under current law, the net cost to the federal government of providing sufficient federal CHIP funding over the period 2014-2019 to allow states to sustain their current programs — which CBO estimates would require $70.9 billion in additional federal CHIP funds over the levels assumed in the baseline — would be $40.9 billion.

If health reform is enacted, the net cost of providing full federal funding for CHIP is likely to be somewhat lower. That is because when a state faces a federal CHIP funding shortfall, CHIP-eligible children would be eligible for subsidized coverage through the health insurance exchange. The cost of adding sufficient federal CHIP funding to allow states to sustain their current CHIP programs would be partly offset by reduced federal costs for subsidized coverage through the exchange for CHIP children in those families that can afford to purchase coverage in the exchange with the levels of assistance for paying premium costs that the Senate Finance bill would provide.

[17] States might need even more money to maintain their CHIP programs after 2013 than the CBO projection given here, because under the Senate Finance Committee bill, they would spend their CHIP allotments after fiscal year 2013 more quickly than under current law. The Finance Committee bill gives states a 23 percentage point increase in their CHIP matching rates. The minimum CHIP matching rates is now 65 percent. Under the Finance Committee bill, the new minimum matching rate would be 88 percent, and a number of states would not have to put up any state funds to cover children in CHIP. These higher federal matching rates would substantially increase the amount of new federal money Congress would need to find for CHIP.

[18] January Angeles and Judith Solomon, "Finance Committee Health Reform Bill Makes Improvements, But Still Falls Short of What is Needed for Many People to Afford Health Care," Center on Budget and Policy Priorities, October 13, 2009.

Adequate Funding for CHIP May Not Be Sustainable Over Time

As noted, CHIP is a block grant that requires periodic reauthorization by Congress and annual contributions by states. If Congress does not provide sufficient funding to cover all eligible children who apply, a state can establish waiting lists, cap enrollment, or take both actions.

Several factors raise concerns about the prospects for adequate CHIP funding over the long run if CHIP is retained after 2013. First, the federal budget is headed toward crisis, with nearly all analysts forecasting highly unsustainable deficit and debt levels over the long term. If legislation needs to be passed in 2013 to provide substantial amounts of new funding for CHIP, federal policymakers may, as part of that legislation, act to reduce CHIP income limits or benefit packages (or both) in order to reduce the amount of new funding needed. The prospects for such action are enhanced by the fact that such CHIP legislation would require 60 votes in the Senate.

Similar factors may operate at the state level. Most states face deep structural imbalances in their budgets that will grow over time as health care costs continue to rise faster than the economy (even if health reform is enacted and slows the rate of growth in health care costs) and the population ages. A growing number of states may be tempted to constrain state CHIP funding over time by scaling back the CHIP benefit package (a matter over which federal law accords state considerable flexibility) and increasing cost-sharing charges. Indeed, given the budget pressures that states will face, it is unclear whether — if CHIP is maintained — CHIP benefit and cost-sharing rules more generous than those used in the exchange can survive indefinitely in most states.

These considerations suggest devoting resources in the health reform bill to providing adequate federally funded subsidies and strong federal rules for children's benefit packages for coverage in the health insurance exchange — and locking in those features. That is the approach the House bill takes.

One other consideration to weigh is that maintaining CHIP as a separate program would likely make the health care system somewhat more complex and difficult for families to navigate. Health care reform already will require careful coordination between new programs and existing ones, such as Medicaid, plans offered through the new exchange, and employer-sponsored insurance. This may prove somewhat complicated for families, program administrations, and health plans. Keeping CHIP as a separate program would make the system somewhat more complicated (especially since, in some states, at least three separate agencies would be involved in administering coverage programs — the Medicaid agency, the CHIP agency, and, under the Senate bill, a state-based exchange[19]).

In addition, many parents would have different health plans for themselves and their children if CHIP is maintained. In states that end up capping CHIP enrollment, even different children in the same family could have different health plans. This could require a family to switch health plans and providers for one or more of their children if family income changed and the children lost eligibility for one program and became eligible for another.

[19] The House bill would establish a national exchange, while the Senate Finance Committee bill would require each state to set up its own exchange.