May 22, 2009

Comments from the Children's Defense Fund: Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans

Contact:

Alison Buist, PhD
Director, Child Health
Children's Defense Fund
abuist@childrensdefense.org
202-662-3586

The Children's Defense Fund (CDF) is pleased to have the opportunity to comment on "Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans," released by the Senate Finance Committee on May 11, 2009.

CDF's Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start*, and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities. CDF provides a strong, effective voice for all the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, into trouble, drop out of school, or suffer family breakdown. We have worked with others for more than three decades to increase children's access to affordable, comprehensive, and seamless health and mental health coverage.

CDF greatly appreciates the commitment of the Finance Committee to develop comprehensive health and mental health coverage reform proposal this year, and the effort you have made to establish a range of options to "guarantee all Americans affordable, quality coverage, regardless of age, health status or medical history." We especially appreciate the options you propose that recognize the unique health and mental health needs of children and attempt to simplify the health care system to make it easier for children to enroll and retain comprehensive coverage. However, we also have a number of concerns about the options and provide suggestions below as to how to further strengthen the health system for children. We look forward to continuing to provide input as the Committee further refines its proposals and releases additional details.

Our recommendations are arranged around three basic principles that CDF believes must be incorporated in health reform to ensure that all children in America will be covered, will benefit from such coverage, and will be better – not worse - off than they were before. We urge the

Committee not just to maintain existing protections for children and pregnant women, but to strengthen and improve these protections. Additionally, CDF strongly recommends the adoption of an effective date as early as possible, because children's health and development won't wait.

1. Affordable Coverage for All Children and Pregnant Women in America

Eligibility for Medicaid

CDF recognizes that many of the options under consideration by the Committee are an attempt to achieve health coverage for all. Therefore, we are very concerned that the Committee is again considering the option to allow states to impose a five-year ban on legal immigrants receiving coverage through Medicaid. [Pages 60-61] CDF believes that just as all children in the United States are entitled to a free public education, *all* children should be equally entitled to health care. At a minimum, however, CDF recommends that all states at least be required to waive the five-year ban for Medicaid and CHIP coverage for pregnant women and children legally residing in the U.S., which the Congress approved earlier this year as an option in CHIPRA.

CDF supports requiring all state Medicaid programs to set an eligibility floor of *at least* 150% of the Federal Poverty Line for pregnant women and children [Page 15], but recommends that you set the income eligibility higher. Additionally, as discussed below, we support allowing states to use income disregards in determining eligibility and coverage. More than half the states already cover pregnant women and children with incomes above 150% FPL, and in fact, all states are currently required to cover infants under age 1 and pregnant women to at least 185% FPL. In no case should children and pregnant women be subject to lower income protections than they currently have. If you do not require a higher income eligibility level, we urge the Committee to allow states to go above this level and to provide a fiscal incentive, perhaps in the form of a higher FMAP rate, to encourage states to do so. We are particularly concerned that a federally-established eligibility level not provide states any incentive to lower coverage levels to the 150% minimum threshold, resulting in children and pregnant women losing current protections.

CDF strongly supports the Committee's option requiring states to increase CHIP income eligibility to 275% FPL, creating a new national eligibility floor [Page 21]. Additionally, we applaud the Committee's proposal to set a new national policy to limit cost sharing under CHIP to Medicaid's cost sharing rules. However, even with a new national eligibility floor that will benefit millions of children, 14 states and the District of Columbia currently cover children in families with incomes above 275% FPL. For this reason, we support a state option to allow states to cover children in families with incomes above 275% FPL if they elect to do so. Such a policy change must include changing CHIP's funding structure to eliminate the funding cap, so that all eligible children can be enrolled without waiting lists. The current wide variation among states for income eligibility state leaves children subject to a lottery of geography, where the state in which they live determines the benefits and treatment they are eligible to receive. To accommodate the new eligibility floor, a strong maintenance of effort provision that protects currently covered populations is essential. We do not believe that the maintenance of effort proposed by the Committee is sufficient. Instead, we support a maintenance of effort provision that does not expire at the discretion of the Secretary because we believe that Congress should have the authority to terminate it only when other affordable comprehensive coverage options are in place.

With regard to both Medicaid and CHIP, we have concerns that the proposed modified adjustable gross income (MAGI) measurement to define income eligibility will cause some currently eligible children and pregnant women to lose their coverage and leave them worse off. This is not acceptable. It is important that states continue to have the option to maintain income disregards in the Medicaid program and CHIP. As of January 2008, all but four states disregarded some portion of a family's earning to determine eligibility for Medicaid. Most frequently they included a basic disregard of earnings, usually $90 a month, a portion of their child care expenses and child support payments received. These disregards are generally are provided to cover varied work-related expenses that all families incur which reduces available income to purchase health coverage.

Affordability in the Exchange [Pages 9-12]

CDF is pleased that the Committee is considering making available refundable, advanceable tax credits to consumers on a sliding-scale up to 400% FPL. Making the tax credits assignable would be an additional improvement. However, CDF is concerned that this eligibility level is still too low. Further, we recommend a cost of living adjustor be applied by service area with a hold harmless provision for those in lower cost areas.

Although the structure in the coverage options paper includes limits on premium costs as a percentage of income for individuals eligible for a tax credit, it does not include a limit on total out-of-pocket spending (including deductibles, co-payments, co-insurance, and other out-of-pocket expenses). The four-level benefit packages scheme in the proposed Exchange that relies on standard actuarial values does not provide adequate out-of-pocket protections for all individuals, especially those with high health care needs. Meaningful caps, as a varying percentage of income (with lower percentages applicable to lower-income people and families), should be established for people who would purchase coverage through the Exchange.

In addition, without knowing further details on how the credit will be set, CDF respectfully urges the Committee to peg the premium credit to a level of coverage tied to a standard of coverage with EPSDT benefits. Our recommended approach will ensure that consumers have access to adequate health care, rather than using the more arbitrary option of the enrollment-weighted average premiums of the qualified low coverage option offered in the service area.

Finally, CDF is concerned that the Committee proposal does not allow undocumented individuals to qualify for tax credits or other financing mechanisms. We believe that this will deny the children of undocumented workers the health care they need. This is of particular concern given that nearly 82% of children in households with parents of mixed immigration status are U.S. citizens.

2. Comprehensive Health and Mental Health Benefitsfor *All* Children and Pregnant Women

Benefits in the Children's Health Insurance Program [Pages 19-21]

CDF strongly supports the option to expand the EPSDT benefit to children enrolled in CHIP, and urges that the Committee implement this policy effective immediately. Through EPSDT, Medicaid has always guaranteed children comprehensive all medically necessary services. In contrast, CHIP plans provide "benchmark" benefit packages that tend to exclude essential services and impose financial requirements (co-payments and premiums) and arbitrary treatment limits that can prevent children from accessing critical care. Guaranteeing EPSDT benefits to children in CHIP will ensure them mental health benefits (which states are not now required to provide under CHIP) and dental and vision services (just added to CHIP in January 2009). EPSDT guarantees that children's health and mental health will not be compromised by arbitrary limits on scope and duration of services or treatment exclusions. It also ensures that children will be able to get services, such as case management and transportation, which are necessary to help them actually benefit from health and mental health treatment, and to receive health care treatments in non-traditional settings like mobile vans, homeless shelters, and schools and child care programs.

Benefits in the Exchange [Pages 8-11]

CDF is pleased that maternity and newborn care are required in the non-group, micro-group and small-group markets, and in the health insurance Exchange. Far too many women, including the 800,000 pregnant women now uninsured, receive only seriously delayed care or no prenatal care at all. Research shows that uninsured women are at greater risk than insured women of poor outcomes during pregnancy and delivery, including maternal complications, low birthweight, and infant death.

CDF is extremely concerned, however, that the required benefit package in the Health Insurance Exchange does not specifically include pediatric care, beyond the newborn period. *All* children should be guaranteed access to all medically necessary services. In addition to requiring actuarially sound plans, EPSDT or its equivalent should be provided to all children in the Exchange. Coverage must provide a *developmental and preventive standard* of care to promote healthy growth and development, as opposed to the restorative standard of benefits which most commercial plans use. The benefit must reflect the unique health care needs of children and be designed to support their optimal development. This benefit standard should apply to all health plans, inside and outside the Exchange, and to employers of all sizes.

If the Committee chooses to defer the definition of minimal creditable coverage to a Board, we recommend that the Committee (a) establish in statute coverage parameters for children to ensure their unique health and developmental needs are met and (b) require appropriate, pediatric and consumer representation on the Board to ensure that the unique health and mental health needs of children are addressed.

CDF strongly supports the Committee proposal that plans in the Exchange cannot charge cost-sharing (deductibles, copayments) for preventive care services. We are pleased that health plans with annual or lifetime benefit maximums would be prohibited in and out of the Exchange. We

also supports the exclusion of any restrictions on pre-existing conditions for children and pregnant women, which will end the practice of allowing pregnancy to be considered a pre-existing condition for purposes of denying coverage.

Medicaid and CHIP Children and the Exchange [Pages 16-21]

To ensure that children in Medicaid and CHIP truly benefit from the full range of services necessary to meet their needs, it is important that children and parents not be required to take extra steps to obtain services for their special needs. We are very troubled by the proposal to have children in Medicaid and CHIP receive EPSDT services through a benefit that wraps around coverage in the Exchange. Experience to date in managed care and state responses to the Deficit Reduction Act makes clear the barriers children encounter in attempting to obtain services outside their plans. It is often extremely difficult to maintain continuity of care and a consistent medical home for a child. It is especially challenging in such arrangements for parents or other caregivers to know when and where they should take their child for specialized services and treatment and whether they will have access to trained pediatric providers, including for mental health and other specialties.

It is especially difficult to envision how such a system could work successfully for children in foster care or others with special health care needs. For example, care coordination between multiple health, mental health and child welfare agencies is often key to these children being appropriately served but it is difficult to envision the Exchange playing this coordinating role. These children also often need a range of services that are not covered by commercial insurers, so even routine services may require providers not accessible through the Exchange.

We respectfully request in the strongest possible terms, that the Committee not place the low-income children in Medicaid and CHIP, many with special health care needs, into an untested Exchange. Instead, we recommend the Committee wait and reconsider any such move only after the Exchange is up and running and there is strong evidence that the EPSDT benefit, care coordination, and cost sharing protections can be preserved and enhanced by such a move.

Reduction in Infant Mortality [Page 61]

CDF commends the Committee for its commitment to reduce infant mortality and improve maternal well-being. Approximately 28,000 children die each year in America before their first birthday—ranking the U.S. 27th among 30 industrialized countries. CDF is pleased to see the increased federal funding for states, tribes and territories to develop and implement targeted approaches to reducing infant mortality. We look forward to working with the Committee and other advocacy groups to ensure the funding includes programs that expand access to health services among women and infants most at risk for poor birth outcomes. Quality evidence-based home visiting programs, such as the Nurse Family Partnership and Healthy Families America, for example, have successfully worked to improve birth outcomes. These and other models connect pregnant women to the services and supports they need to improve maternal health and achieve healthy births.

3. A Simple, Seamless System for Children

Enrollment [Page 23]

CDF commends the Committee for proposing numerous steps to ease Medicaid enrollment, including eliminating the state option to use face-to-face interviews to determine Medicaid eligibility, requiring states to implement 12-month continuous eligibility, and extending automatic renewal and Express Lane renewal to all Medicaid beneficiaries. These new requirements should be applied to children in CHIP as well. The fact that approximately two-thirds of the 9 million currently uninsured children are already eligible for Medicaid or CHIP but are not enrolled is clear evidence that the current systems are not simple or seamless, as they must be to ensure that all enroll in and retain coverage. The steps proposed by the Committee would help to prevent frequent, unnecessary, costly, and harmful coverage gaps for children. They also build upon advances in simplification that were recognized in CHIPRA.

In addition to requiring automatic *renewal* and Express Lane *renewal* to all Medicaid and CHIP recipients, CDF respectfully recommends that the Committee also require automatic *enrollment* and Express Lane *eligibility* in Medicaid and CHIP. Just as the Medicare default for our nation's seniors is enrollment in the program, this should also be the case for children. Critical junctures such as birth, annual enrollment in school, and health visits must all be used to enroll uninsured children in health coverage unless the parent affirmatively declines enrollment. No infant should leave the hospital after delivery without coverage. Additionally, children identified as income eligible in other programs, such as the National School Lunch Program or food stamps, should be automatically enrolled in health coverage. CDF's Texas Office has successfully enrolled thousands of children in CHIP and Medicaid in Texas by working with schools districts to get them to add questions about insurance coverage to enrollment cards to identify the number of uninsured children and then to arrange to have them enrolled on site.

Additional Recommended Improvements

There are several additional improvements that we believe can help to ensure that all eligible children will get enrolled and stay enrolled. We strongly urge the Committee to eliminate waiting periods for children eligible for public programs. Also, states should be required to implement presumptive eligibility for all pregnant women and children in Medicaid and CHIP. Presumptive eligibility allows states to cover applicants temporarily until eligibility can be fully determined. States should also be specifically allowed and encouraged to permit health care providers, schools, and other agencies to determine presumptive eligibility.

We also urge the Committee to ensure that people who apply for coverage through the Exchange but are found to be income eligible for CHIP or Medicaid are automatically enrolled in those programs.

Finally, CDF strongly encourages the Committee to support and fund community-based, culturally and linguistically-appropriate outreach services to ensure that all eligible but hard to reach populations are enrolled.

Strengthening the Medicaid and CHIP Programs for Children [Page 31]

CDF is pleased that the Committee has proposed a mechanism to help FMAP respond more quickly to economic downturns. CDF has repeatedly endorsed FMAP increases during times of need and recommended similar increases in times of natural disasters, such as Hurricane Katrina, to ensure that states are able to cover the increasing number of Medicaid eligible children without making cuts to eligibility or benefits precisely when they are needed most. When economic conditions or natural disasters result in job loss and loss of health insurance, it is extremely important for the federal government to be able to respond quickly to help states ensure Medicaid coverage is made available to children and adults who qualify for the program.

CDF also strongly agrees with the need to increase reimbursement to Medicaid providers. Medicaid's low provider payment rates are a significant barrier to providers' willingness to treat Medicaid-insured children, seriously limiting children's access to needed services. CDF is concerned, however, that requiring payments not fall below 80% of Medicare reimbursement rates would still result in inferior access to care for lower income children. In 2006, Medicaid payment rates for service providers were roughly 31% less than Medicare, and less than 50% of what private health plans paid providers. To ensure that children with health coverage can obtain services where and when they are needed, CDF recommends that provider reimbursement rates be set at least at Medicare rates. At the same time, it would be useful to require a review of states' compliance with the Equal Access clause of Medicaid which requires that Medicaid eligible children have the same access to physicians that commercial health plans have in the same geographic area.

Health Disparities [Pages 56-60]

CDF appreciates the Committee's attention to improving health disparities. The data and reporting requirements will help to ensure that children across programs get the coverage and benefits to which they are entitled. The disparities in coverage are significant. While one in nine children overall lacks health coverage, one in eight Black and one in five Latino children lack health coverage, compared to one in 13 White children. The disproportionate lack of health coverage among minority children affects their access to both preventive health services and treatment for illnesses. Strengthening federal data collection, especially in Medicaid and CHIP, will provide critical information on the serious disparities in coverage and health status so that we can improve federal policies to address these issues.

Design of the Exchange [Pages 4-6]

If the final health reform proposal developed by the Senate includes an Exchange, CDF favors the creation of one national Exchange. To the extent that state or regional Exchanges are necessary to accommodate local plan options, these should be government-run. The other options under consideration by the Committee - to establish multiple regional Exchanges and to establish multiple competing Exchanges within one region – are likely to create considerable confusion for consumers and generate risk selection across Exchanges. If multiple Exchanges are competing in one region, there could be up to four Exchanges competing in a single area during the first five years of the proposal, with the possibility of even more after the first five years. CDF is concerned that it will be

difficult for consumers to choose not only between several available plans at different benefit tiers, but also multiple Exchanges.

Design of the Public Plan [Pages 13-14]

CDF strongly supports the creation of a strong public health insurance option that competes with private insurers to extend comprehensive benefits through first-rate health care providers at an affordable price. A public health insurance option would encourage competition on the basis of cost and quality, which, as clearly demonstrated in our current system, cannot be accomplished through a purely private system. Competition in the current market is very limited in those states where a few companies control large portions of the market. An American Medical Association survey reveals that one private insurance company controls more than half the insurance market in 16 states and a third of the market in 38 states.

CDF supports the Medicare-like public plan option proposed by the Committee. Medicare has been a more cost effective source of coverage than private coverage. Traditional Medicare has administrative costs of 2-3%, compared with 12% in the private group market, 16% among Medicare Advantage plans, 25% for small businesses, and up to 40% in the individual market.

CDF opposes the proposed Third Party Administrator public option and the State-Run public option. In particular, state-run plans would create disparities in quality and affordability of coverage, compared with a federally-operated plan. As mentioned, having each state administer its own Medicaid and CHIP programs has led to a patchwork of eligibility, benefits, and enrollment procedures and disparities in children's coverage and benefits. CDF is very concerned that the establishment of 50 state public plans would create similar disparities and variations such that children's access to affordable, comprehensive health coverage would continue to be dependent on the lottery of geography we discussed earlier.

Conclusion

Thank you for your leadership in reforming our health care system. CDF urges that you remember that children are one-third of the nation's non-Medicare population – and their health and developmental needs differ greatly from those of adults. CDF firmly believes we must invest now in comprehensive, affordable health and mental health coverage for all children and pregnant women to improve their lives and strengthen our communities and nation. We look forward to continuing to work together to ensure that all children in America will be covered and will indeed be better off as a result of health reform.