

POLICYLAB

EVIDENCE TO ACTION BRIEF | 2021 UPDATE

UNIVERSAL HEALTH COVERAGE FOR CHILDREN:

CURRENT BARRIERS AND
NEW PATHS FORWARD



AUTHORS' NOTE, JANUARY 2021*

Since we published this brief in spring of 2020, the United States has weathered not only the COVID-19 pandemic and its associated financial crisis, but also a presidential election that illuminated deep divisions within our country. Throughout the pandemic, public insurance programs have served as an important safety net to those losing employer-sponsored insurance or families qualifying for the first time due to a changing financial situation. Although *we know that* working families were already increasingly reliant on public programs for affordable and comprehensive pediatric coverage, the pandemic has highlighted the importance of a system that provides all children with continuous, stable coverage not tied to employment.

We believe that the policy options put forward in this *Evidence to Action* brief, which could put us on a path to achieve universal health coverage for children, are more important now than ever. Between 2018–2019, 320,000 children lost health insurance coverage, the biggest uptick in more than a decade. Notably these data pre-date the COVID-19 pandemic, and we expect to see uninsurance continue to rise when we can fully account for the loss of families' employer-sponsored insurance in this economic crisis.

As of late 2020, Medicaid and Children's Health Insurance Program (CHIP) enrollment *has risen by 6.1%* nationwide compared to right before the pandemic. While this demonstrates the importance of these programs for children and families, it has also strained them at a time when less funding is available—due to lower tax revenues and balanced budget requirements—to cover a greater need.

State-level efforts to improve and expand children's coverage will be essential to moving us forward, and yet we know budgets are tight. For this reason, it continues to be vitally important to understand the financial implications of any path to universal health coverage for children, including which ones present potential cost savings or opportunities to support economic recovery, for small employers in particular. At the federal level, the Biden Administration's interest in a "public option" may also open up new opportunities for action, and it is our hope that the new administration will help to address the barriers to enrollment in Medicaid/CHIP that have driven an increase in children's uninsurance since 2016.

Ensuring access to health insurance coverage for children has long been considered a bipartisan issue and one that is ripe for cooperation across party lines. It is our hope that as leaders at the state and federal levels look ahead to a post-pandemic world, they will find value in the menu of policy options presented in this brief in order to ensure comprehensive and affordable health insurance coverage for all children.

**The remaining content of this brief has not changed from original publication.*

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EXECUTIVE SUMMARY

Thanks to robust public health insurance programs and generous employer health benefits for dependents, the U.S. has been on the brink of reaching universal health coverage for children, a potential stepping stone to achieving it for the population as a whole.¹ Yet, current trends in the insurance and policy landscapes have recently decreased children's coverage rates for the first time in 10 years.² The increasingly complicated and costly landscape of children's health coverage has also created new challenges for families as they access health insurance for their children.

Despite the well-documented benefits of and broad bipartisan support for children's coverage, the U.S. has seen rising numbers of uninsured children since 2017, with nearly half a million children losing insurance coverage.³

In the commercial insurance market, increasing premiums, insufficient coverage of essential health services, and rising out-of-pocket costs have led many employed families with modest annual earnings to either go without needed care or seek refuge in public health insurance programs.⁴ For families with public insurance—namely through Medicaid or the Children's Health Insurance Program (CHIP)—enrollment barriers, even when eligible, and continued threats to the future availability of these programs are forcing families to go without health insurance for their children.¹

Overall, these trends signal a crisis in affordability and adequacy of children's health insurance, particularly for children in low- and moderate-income families, who now make up the majority of the uninsured.⁵

They also likely underestimate a larger underinsurance crisis now facing many families, and are symptomatic of the quickly changing and volatile policy and funding environment surrounding public health insurance programs.

This *Evidence to Action* brief reviews the fragmented children's health insurance market, the factors contributing to the erosion of benefits and affordability, and the barriers to accessing coverage. It then pivots to a review of policy options for state and federal policymakers to consider if they wish to achieve universal, affordable, comprehensive coverage for children.

The options span from ambitious universal coverage proposals, which leverage the strong comprehensive benefits available in Medicaid and CHIP, to modifications of existing programs and enrollment and retention processes for public insurance programs, which have more precedent, but are more incremental solutions. In this time of escalating barriers to affordable and comprehensive coverage, ambitious action is likely necessary in order to stabilize the market for dependent coverage, much less achieve gains in the years ahead. However, by presenting a spectrum of options, we hope to engage with policymakers throughout the country on solutions that best fit the local context, and that when considered together have the potential to achieve universal health coverage for children.

This brief was written before the COVID-19 pandemic and, therefore, does not reflect analysis of the inevitable impact the pandemic will have on these issues.



BACKGROUND

Public insurance options such as Medicaid and the Children's Health Insurance Program (CHIP) have led to a steady, multi-decade decline in the rate of uninsured children, from 14% in 1997 to a historic low of 4.7% in 2016.⁶ In 2017, however, the uninsured rate climbed to 5%—the first increase in nearly a decade.² The rate increased again in 2018 to 5.5%, representing a one-year increase of 425,000 uninsured children (from 3.9 to 4.3 million).³

While the uptick may appear small, it came in the midst of historic economic growth and halts 20 years of progress in children's coverage.⁷

The 2017 increase in children's uninsurance was greatest among children in families with incomes below the federal poverty level (FPL), and in states that did not participate in the Affordable Care Act's (ACA) Medicaid expansion for adults.⁸ In 2018, the increase was greatest among children in families with incomes at or above 400% FPL, reflecting a significant hole in affordability and coverage for families who earn too much to qualify for financial assistance offered through the ACA's health insurance marketplaces.⁹ Some of these families may lack affordable family coverage options through both their employer and the marketplace, falling into the "family glitch."¹⁰

Children's coverage rates vary greatly by geography, with children in the South experiencing the highest rates of uninsurance.⁹ About 20% of uninsured children live in Texas, where approximately 872,000 children (11.2%) were without coverage in 2018 (Figure 2).¹¹

While the precise reasons for the growth in children's uninsurance (and underinsurance) are complex and likely intertwined, this brief explores three main barriers to children's health coverage:

- 1) **Obstacles to Medicaid/CHIP enrollment and coverage renewal;**
- 2) **The rising cost and declining prevalence of family coverage on the employer market; and**
- 3) **Gaps in consumer protections in the individual and small group market and marketplace.**

These barriers contribute to a weakening in both access to and quality of children's coverage. Although they cut across health care markets and family income levels, they pose a particular challenge for low- and moderate-income families, who are experiencing the most significant coverage declines.^{8,9}

Figure 1

THE NUMBER OF UNINSURED CHILDREN IN THE U.S. HAS BEEN RISING SINCE 2017



The number of uninsured children (in millions) in the United States by year, from 2008–2017

Source: Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2017, Health Insurance Historical Tables, U.S. Census Bureau American Community Survey (ACS). [census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf](https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf)

*Change is significant at the 90% confidence level. Significance is relative to the prior year. 2013 was the only year that did not show a significant one-year increase or decrease in the national rate of uninsured children. The Census began collecting ACS data for the health insurance series in 2008, therefore there is no significance available for 2008.



While the uptick in uninsured children may appear small, it came in the midst of historic economic growth and halts 20 years of progress in children’s coverage.

i COVERAGE FACTS
Public Health and Economic Benefits of Health Insurance for Children

Children have unique health and developmental needs that differ from adults. Health insurance—through both public and private sources—increases access to care that helps children become healthy and productive as they grow, while also providing important financial protection for families.⁹ In 2018, of insured children (under age 19), approximately 62% had private coverage, while 36% had public coverage.⁹

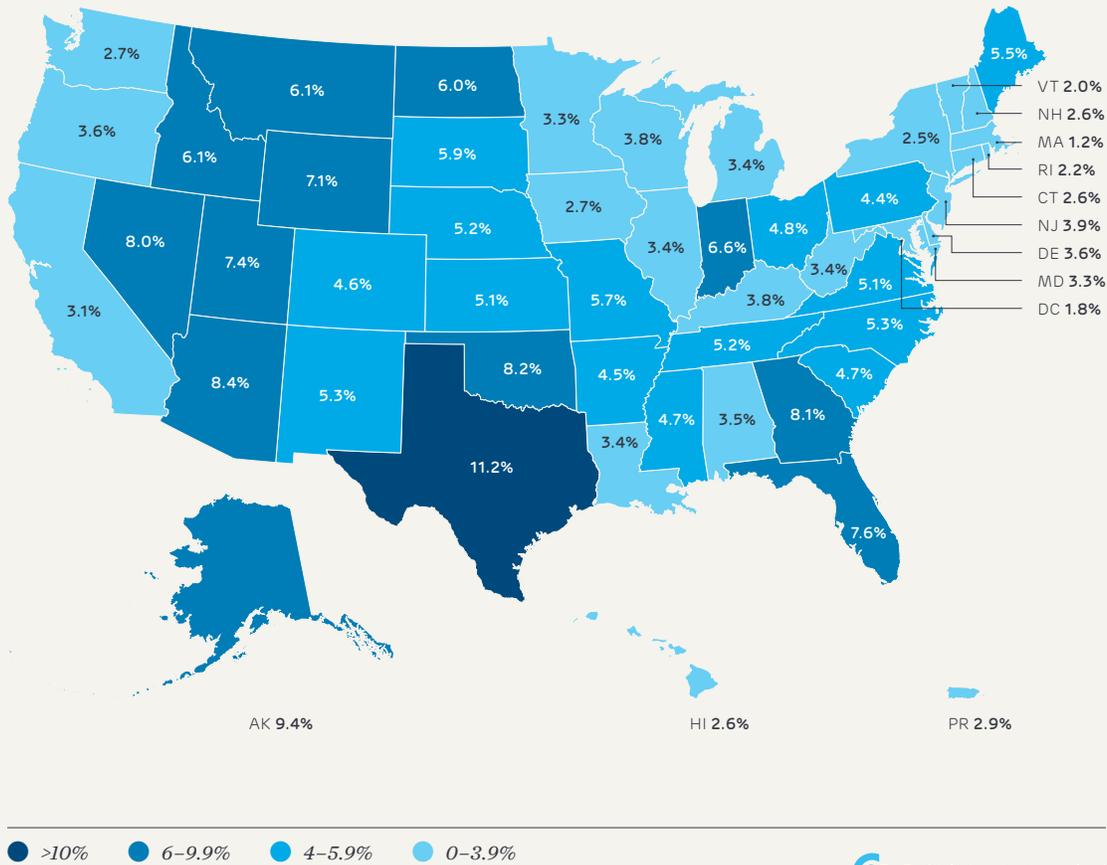
Most of the evidence on the short- and long-term positive effects of children's coverage comes from studies of Medicaid and CHIP.¹² Children with Medicaid coverage have been more likely to report a usual source of care and to receive well-child care than low-income, uninsured children.¹³ They have also been less likely to report having unmet or delayed needs for medical care, dental care and prescription drugs because of cost.¹³

Longer-term, gaining Medicaid coverage early in life has been linked to increased high school graduation rates, lower rates of chronic conditions as adults, and fewer diabetes and obesity-related hospitalizations.¹⁴ More years of childhood Medicaid eligibility are associated with fewer hospitalizations in adulthood, particularly for African Americans and patients living in low-income areas, as well as reduced health care utilization related to chronic illnesses.¹⁵ Other studies link greater Medicaid eligibility with increases in college enrollment, higher-wage income for females, and lower adult mortality and disability.¹⁶⁻¹⁸ One study estimated that each year of childhood Medicaid eligibility reduces public insurance coverage as adults by roughly 4% and increases federal tax revenue by \$6.1 billion.¹⁸ Another study estimated that from ages 19–28, the federal government recovers 57 cents of each dollar it spends on childhood Medicaid, forecasting that Medicaid pays for itself by age 32 and delivers positive fiscal returns thereafter.¹⁹



Figure 2

CHILDREN'S UNINSURANCE RATES VARY GREATLY BY STATE



Percent of people under age 19 without health insurance in 2018

Source: Analysis of 2018 Census Small Area Health Insurance Estimates



Children's coverage rates vary greatly by geography, with children in the South experiencing the highest rates of uninsurance. About 20% of uninsured children live in Texas, where approximately 872,000 (11.2%) children were without coverage in 2018.

BARRIERS TO ADEQUATE, AFFORDABLE CHILDREN'S COVERAGE

-  **OBSTACLES TO ENROLLMENT AND COVERAGE RENEWAL IN MEDICAID AND CHIP**
-  **COST OF FAMILY COVERAGE THROUGH EMPLOYER-SPONSORED INSURANCE**
-  **GAPS IN CONSUMER PROTECTIONS ON THE INDIVIDUAL AND SMALL GROUP MARKETPLACE**

COVERAGE FACTS

Medicaid and the Children's Health Insurance Program (CHIP)

In 2018, approximately 29.3 million children (39.7% of all children) were covered by public insurance.²⁰ Medicaid, a joint federal-state entitlement program, provides coverage to low-income parents and children, pregnant women, seniors, children in foster care and individuals with disabilities.^{21,22} States may also cover other populations, including children with special health care needs, young adults formerly in foster care and low-income adults without dependent children.^{23–25} Child Medicaid eligibility varies by state and age group, but under the ACA, all states must provide Medicaid to children under age 19 in families with incomes up to 133% FPL.^{26,27} Nearly every state has opted to extend child Medicaid eligibility above this limit, with the most generous levels reaching over 300% FPL.²⁸ With the exception of certain state waivers, states may generally not impose premiums for families with incomes below 150% FPL, and only four states charge premiums to families above this level.^{29,30}

Medicaid covers a robust package of child-specific benefits called "Early and Periodic Screening, Diagnostic, and Treatment," or EPSDT.³¹ Designed to meet the needs of low-income children who may not receive comprehensive services without coverage, EPSDT services include regular screenings, immunizations, well visits, lab tests, and other diagnostics, as well as treatment for vision, dental, hearing, and all additional services considered medically necessary to correct or treat illness in children.

CHIP is also jointly run by states and the federal government, as a block grant, and covers uninsured children up to age 19 with family incomes too high

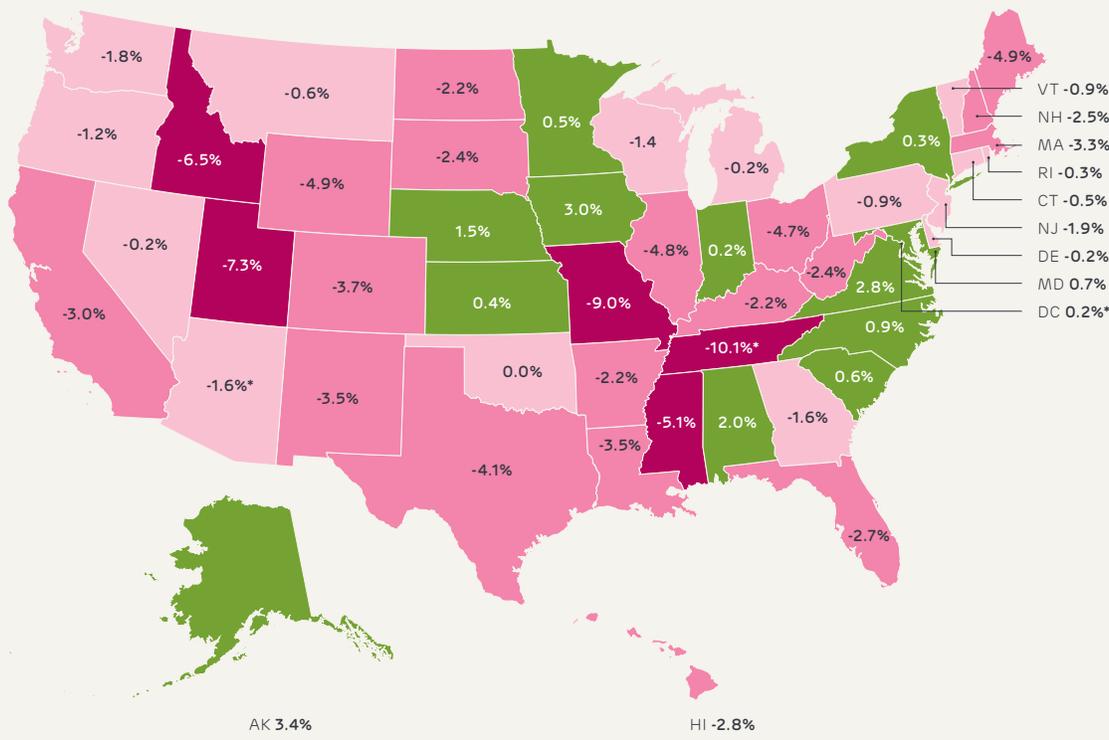
to qualify for Medicaid.³² States may also cover pregnant women and unborn children. States can run their CHIP programs separate from their Medicaid programs ("separate CHIP"), as an expansion of their Medicaid program ("Medicaid-expansion CHIP," or Medicaid coverage funded by CHIP dollars), or a combination of the two.³³

CHIP-funded Medicaid expansions operate under the same rules as the state's Medicaid program, cover EPSDT benefits and generally do not charge premiums or copays for services. Separate CHIP programs operate under different rules and have more flexibility in program design.³⁴ State eligibility levels range from family income of 170% to 400% FPL, but are at or above 200% FPL in most states; the median eligibility level across states is 255% FPL.²⁸ In some states, premiums are based on a sliding income scale.³⁵ In 2015, total premiums and cost-sharing per child in separate CHIP among 36 states averaged \$158 per year.³⁶ Premium and cost-sharing are capped at 5% of family income in both Medicaid and separate CHIP.³⁷

States with separate CHIP programs can provide full EPSDT benefits (and 16 states do) or create a "benchmark" plan with certain defined services.³⁰ While benefits are generally comprehensive, they vary by state and can be subject to cost-sharing and visit limits.³⁴ A 2013 study found that all separate CHIP programs covered inpatient and outpatient services, physician and clinic services, laboratory and X-ray services and prescription drugs.³⁵ Separate CHIP must also cover dental services, well-baby and well-child care and emergency care.³⁵

Figure 3

MOST STATES EXPERIENCED A DECLINE IN CHILDREN'S MEDICAID AND CHIP ENROLLMENT IN 2018



- States with Percentage Decline $\geq 5.0\%$
- States with Percentage Decline 2.0%–4.9%
- States with Percentage Decline 0.0%–1.9%
- States with Percentage Increase

Percentage change in child enrollment in Medicaid and CHIP from January to December, 2018

Source: ccf.georgetown.edu/2019/05/28/medicaid-and-chip-enrollment-decline

*The CMS enrollment data does not provide a breakdown of child enrollment for Arizona, the District of Columbia and Tennessee. Data for those states was collected by Georgetown CCF from state sources. Data for Arizona and Tennessee represented enrollment in January 2018 and 2019. The District of Columbia data is for November 2017 and November 2018.



A OBSTACLES TO ENROLLMENT AND COVERAGE RENEWAL IN MEDICAID AND CHIP

A 2019 report found that 828,000 fewer children were enrolled in Medicaid and CHIP in 2018, a 2.2% decline from the previous year (Figure 3).¹ The same report highlights that the largest increases in uninsurance are among children in families with incomes 138–249% of FPL (approximately \$36,000–\$64,000 annually for a family of four in 2019) and more than 250% of FPL. It shows little evidence that the enrollment decline was driven by a strong economy (i.e. that children are moving to private coverage).¹ Instead, about three in five uninsured children (56.5% in 2017) remain eligible for but not enrolled in Medicaid, CHIP, or another public program, highlighting the importance of addressing barriers to enrollment and coverage renewal.³⁸ Furthermore, the increase in uninsurance for children >250% of FPL may be driven by economically vulnerable populations above the income eligibility for CHIP in their state.

A number of states have not taken up the option to automatically renew Medicaid and CHIP coverage, and others have seemingly failed to comply with ACA renewal requirements that aim to make it easier to maintain coverage.

State policies on Medicaid and CHIP enrollment and renewal

States can streamline children’s enrollment in Medicaid and CHIP in various ways, although many states have not chosen to do so. For instance, states can adopt continuous eligibility to allow children to remain eligible and enrolled in Medicaid or CHIP for 12 months regardless of changes in family income, but only 31 states have implemented this option.³⁹ Instead, some states continue to require families to verify eligibility, including through periodic paper mailings during the plan year.¹ Additionally, only 20 states have enacted presumptive eligibility for children in Medicaid and/or CHIP (when run as “separate CHIP” and not as part of their Medicaid program), which allows states to grant children temporary coverage while they process final eligibility determinations.⁴⁰

The CHIP Reauthorization Act of 2009 allows states to make “express lane” determinations in which they can rely on data from other public agencies to streamline Medicaid and CHIP eligibility decisions and enrollment; however, only 13 states and the U.S. Virgin Islands use this option.^{41,42} The ACA made other improvements to streamline enrollment, including by creating a single, simplified application for determining Medicaid, CHIP and marketplace subsidy eligibility; supporting the use of online and telephone applications; and requiring states to use reliable electronic data sources to more easily verify eligibility and “automatically renew” coverage without requiring action from families.⁴³⁻⁴⁵

However, a number of states have not taken up the option to automatically renew coverage, and others have seemingly failed to comply with ACA renewal requirements that aim to make it easier to maintain coverage.⁴⁶ Some states continue to rely on outdated and burdensome paperwork processes, resulting in application delays and coverage disruptions.⁴⁷ For instance, an estimated 50,000 children in Texas are losing Medicaid each year because families do not file eligibility paperwork on time, but one in three of these children re-enrolls within the year.⁴⁸

Increasing churn

Barriers to enrollment and coverage renewal that contribute to churn, or the phenomenon by which children cycle in and out of Medicaid and CHIP coverage or between coverage types, have significant implications for children.⁴⁹ Small income fluctuations can drastically change families’ eligibility for Medicaid or CHIP and marketplace financial assistance, causing children to churn between coverage types or on and off coverage.^{49,50}

The stability of coverage affects children’s access to and use of care. One study found that even short gaps in coverage negatively affect children’s likelihood of having a usual source of care, and they can impact their likelihood of utilizing health care in the long-term.⁵¹ Another study found that being uninsured for part of the year negatively affects doctor visits for children with both public and private coverage.⁵² The growing uncertainty and obstacles to Medicaid and CHIP enrollment and coverage renewal signal that churn will likely increase in the near future, which could result in further coverage losses for children.

Parents’ loss of coverage

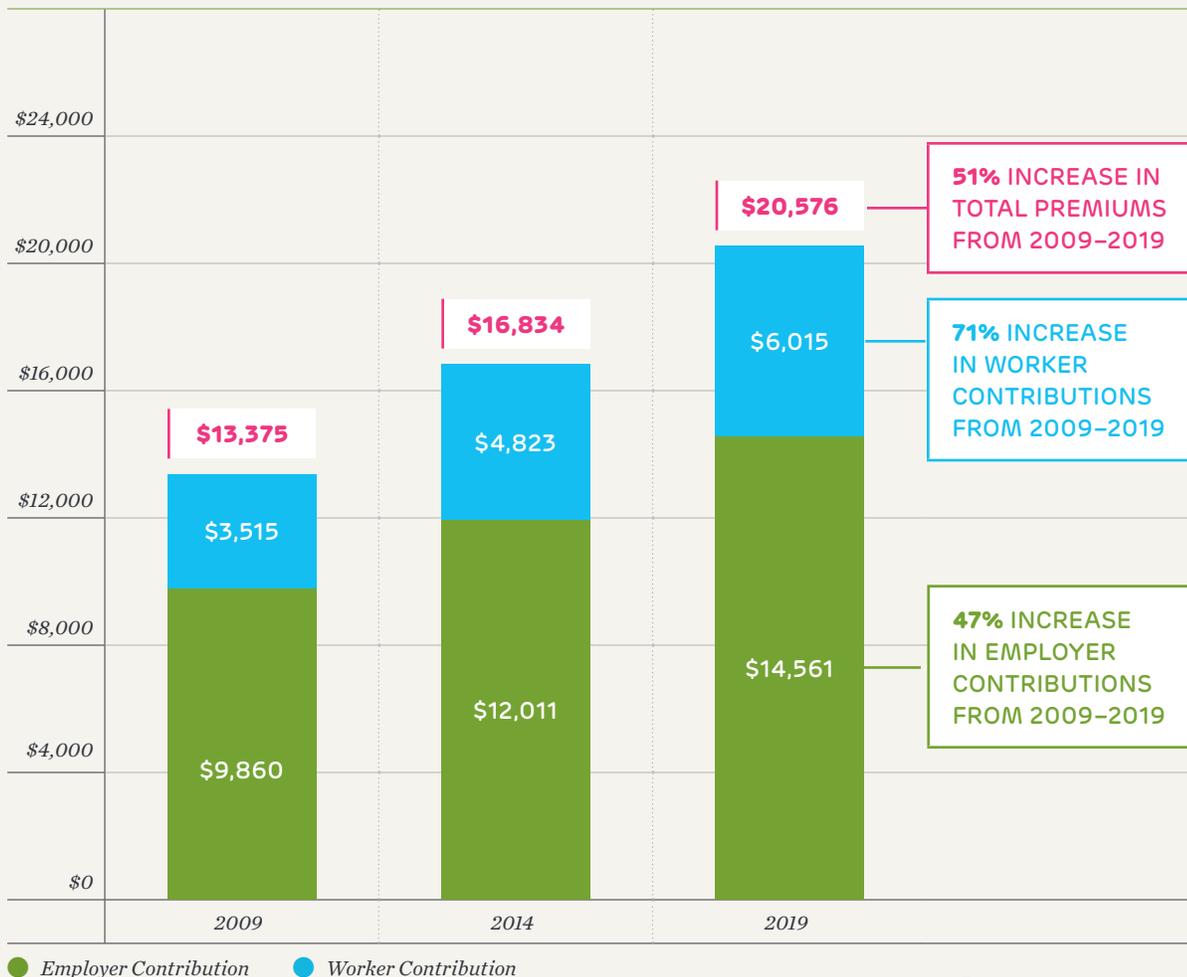
Research shows that children are more likely to be insured when their parents have insurance.⁵³ Thus, policies impacting parents’ access to coverage may affect children’s coverage.⁵⁴ For example, between 2017 and 2018, 65,000 Medicaid and CHIP enrollees—including 12,000 children—lost coverage in Arkansas as the state implemented work requirements for adult Medicaid beneficiaries.⁴⁶

Furthermore, a 2019 analysis suggested that “public charge” policies could result in 2 to 4.7 million beneficiaries disenrolling from public coverage.^{55,56} The 2019 final rule, which still faces legal challenges, allows the federal government to consider adult immigrants’ participation in Medicaid and other public programs in determining their admissibility and legal permanent resident status. Early reports suggest that the rule has created a “chilling effect” and that some immigrant parents, including those whose children are U.S. citizens, may be disenrolling themselves or their children from Medicaid and CHIP, not renewing coverage or not enrolling even when eligible.^{55,57}

In addition to the public charge rule, some commentators also point to the “unwelcome mat” created by the uncertainty surrounding ACA insurance offerings, CHIP funding delays, and decreased federal funding for outreach and enrollment activities as additional reasons children and parents are enrolling in coverage at lower rates.^{1,2}

Figure 4

EMPLOYEES’ FAMILY HEALTH INSURANCE PREMIUMS FOR EMPLOYER-SPONSORED INSURANCE HAVE SUBSTANTIALLY INCREASED



Average annual worker and employer premium contributions and total premiums for family coverage in 2009, 2014 and 2019
 Source: KFF Employer Health Benefits Survey, 2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009 and 2014



A 2019 PolicyLab study found that working families are increasingly relying on Medicaid and CHIP to cover their children.

COVERAGE FACTS Employer-Sponsored Insurance

In 2018, nearly half of all children (48.5% or 37.4 million) were enrolled in private coverage on the large and small group employer markets.²⁰ Under the ACA, large firms (defined as having more than 50 full-time employees) must offer “affordable” insurance to their full-time employees and dependents up to age 26.⁵⁸⁻⁶⁰ Employer plans must also meet “minimum value” by covering, on average, at least 60% of all enrollees’ costs.⁵⁹

Employer coverage is subject to the same out-of-pocket limits as marketplace coverage.⁶¹ However, the price families are expected to pay for employer coverage is steadily increasing, while wages have largely stagnated.⁶²

Benefits are generally determined by employer choice and state coverage mandates. Unlike Medicaid, CHIP or marketplace coverage, employer plans are not required to cover a specific category of pediatric benefits.³¹ However, some state mandates require employers to cover certain services, such as autism care or pediatric immunizations.^{31, 63}

Small firms (defined as having 50 or fewer full-time employees) are not subject to the same requirements and do not have to offer insurance to their employees.⁶⁴ Since the market is more concentrated, families’ costs on the small group market are typically higher. According to the most recent data in 2018, the average deductible for family coverage was more than \$1,000 higher among small group plans (\$4,364 per employee across plan types) than large group plans (\$3,263 per employee across plan types).⁶⁵

COST OF FAMILY COVERAGE THROUGH EMPLOYER-SPONSORED INSURANCE

From 2017–2018, the share of children covered by employer-sponsored insurance (ESI) largely remained stable in a strong job market.³ However, longer-term trends reveal that ESI is covering fewer children in low- and moderate-income families.⁶⁶

Rising premiums

Evidence suggests that ESI is becoming increasingly unaffordable for working families.⁶⁷ According to adult family members, cost is the most commonly cited reason a child is uninsured (35.5%), followed by a family member losing or changing jobs (19.6%).⁹ Annual premiums for family coverage rose 54% from 2009–2019, outpacing wage growth, and now average \$20,576 a year (Figure 4).⁶⁸ Employees are also continuing to pay a significant share of their premiums relative to their employers. In 2017, among firms offering family coverage, 45% of small employers (in this work defined as less than 200 workers) and 15% of large employers (more than 200 workers) contributed the same dollar amount regardless of whether the employee received single *or* family coverage.⁶⁹ This leaves employees with families to pay the additional premium cost to cover the rest of their family.

Higher cost-sharing

Cost-sharing is becoming more common and burdensome for families in the form of copays or higher deductibles, the amount people have to pay toward health care before insurance kicks in.⁷⁰ Between 2009 and 2019, the percentage of employees with a deductible increased from 63% to 82%.⁶⁸ Between 2009 and 2018, the average deductible for family coverage nearly doubled from \$1,761 to \$3,392.⁶⁵

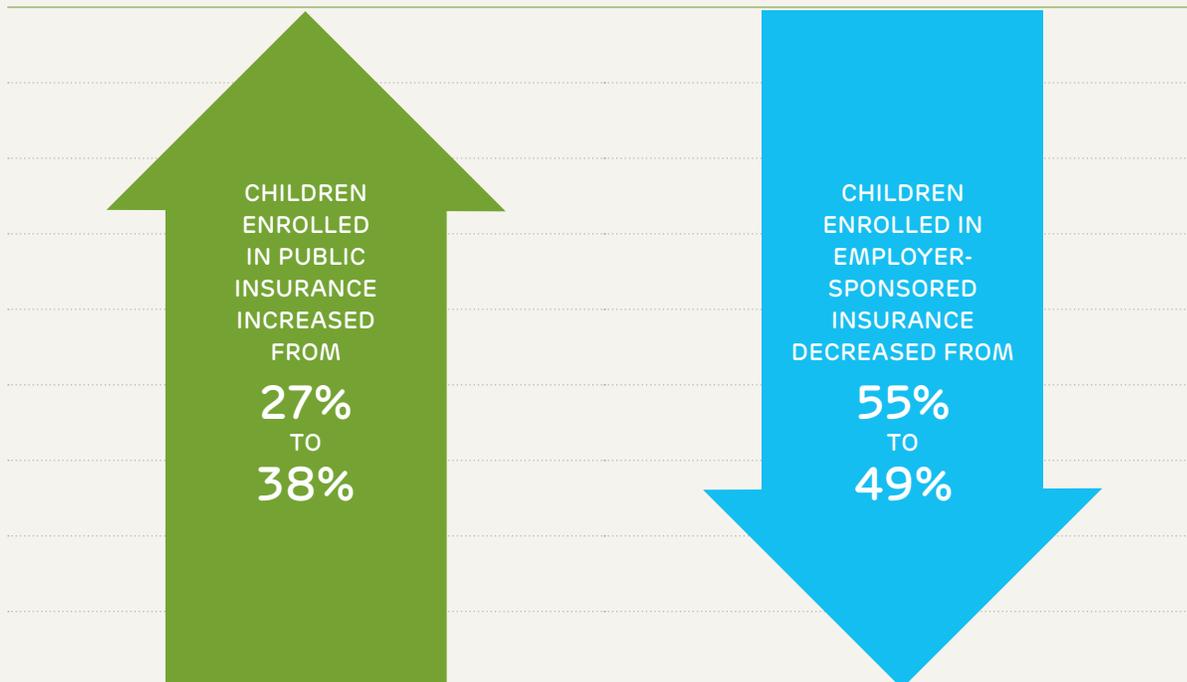
This cost-sharing may have detrimental effects for children in low- and moderate-income families who have private insurance. For example, one study found that higher cost-sharing was associated with exacerbation of asthma symptoms in children; a similar study found that families with higher cost-sharing were more likely to skip recommended care for their children with asthma than those with lower cost-sharing or Medicaid.^{71,72} In families with chronic conditions, high-deductible health plans were associated with increased reports of delayed or foregone care due to cost.⁷³ Alternatively, cost-sharing may pose a financial disincentive to parents seeking care for themselves, and children’s health and well-being may suffer when their parents have unmet health needs.^{74,75}

Declining share of children on employer-sponsored insurance

Over the last decade, the declining share of children with ESI has been offset by a greater prevalence of public coverage (Figure 5). This may be due, in part, to low- and moderate-income families gaining greater access to public insurance following the 2009 CHIP Reauthorization Act and the subsequent implementation of the ACA provisions. For instance, beginning in 2010, states were required to maintain their Medicaid and CHIP eligibility and enrollment standards for adults and children through 2014 and 2019 (respectively), a provision known as “maintenance of effort.”⁷⁶ Many states also expanded their Medicaid programs and their upper threshold for childhood Medicaid eligibility.⁷⁷ However, other low- and moderate-income families have turned to public programs as the cost burden of ESI grows.⁶⁷

Figure 5

PUBLIC INSURANCE COVERAGE FOR CHILDREN INCREASED FROM 2008–2017 WHILE EMPLOYER-SPONSORED COVERAGE DECREASED



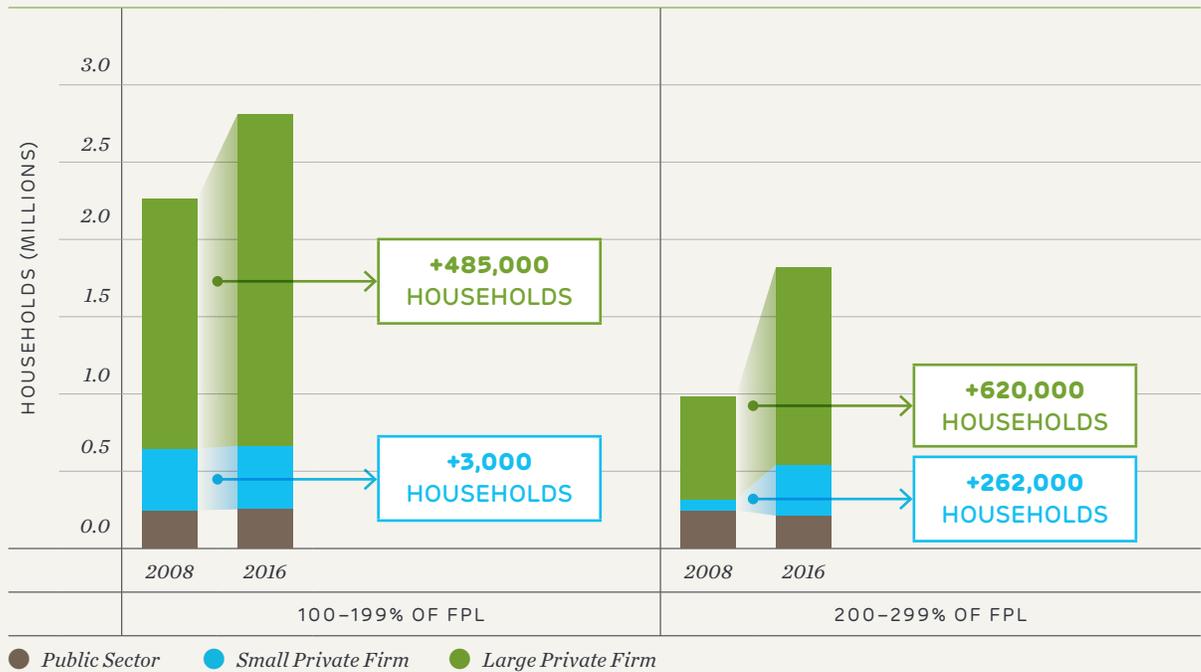
Health insurance coverage of children ages 0–18 between 2008 and 2017, by employer-sponsored private insurance and public insurance (Medicaid and CHIP)

Source: Kaiser Family Foundation’s State Health Facts



Figure 6

FAMILIES WORKING FOR LARGE COMPANIES DRIVE THE BIGGEST INCREASES IN MEDICAID AND CHIP ENROLLMENT



Number of households earning 100-299% of FPL with at least one child enrolled in public insurance, by parents' sector of employment in 2008 and 2016

Source: Health Affairs Study; authors' analysis of data for 2008-2016 from the Medical Expenditure Panel Survey. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05286>

Notes: Public insurance is Medicaid or the Children's Health Insurance Program. The sectors of employment are explained in the text. FPL is federal poverty level.



A 2019 PolicyLab study found that working families are increasingly relying on Medicaid and CHIP to cover their children (Figure 6).⁶⁶ Between 2008 and 2016, the number of families earning 100-199% FPL with a child enrolled in public insurance increased from 2.3 to 2.8 million. The number of families with incomes between 200-299% FPL with a child enrolled in public insurance also increased by 800,000. Families with parents employed at small firms were most likely to turn to public insurance for their children, but families with parents employed at large firms have accounted for the largest growth in pediatric public coverage in working families in the last decade.

To make employer coverage more affordable and prevent “crowd-out” (the substitution of private health care spending with public dollars), some states have implemented “premium assistance” programs for working families who are income-eligible for Medicaid or CHIP and cannot afford family coverage under their employer plan.^{29,78} Thirty-six states currently offer these programs, which involve using Medicaid or CHIP funds to help families pay all or part of their employer-based premiums and copayments.⁷⁹ Premium assistance programs look different in each state and have not, as yet, been designed or implemented in ways that have enrolled significant numbers of children.⁸⁰ They often have high administrative costs for the relatively low numbers of enrollees who have participated.

i COVERAGE FACTS
Individual and Small Group Marketplace and Off-Marketplace Coverage

Approximately 1.1 million children (1.4% of all children) are enrolled in private coverage on the individual and small group health insurance marketplace; 700,000 (1% of all children) are enrolled in off-marketplace private coverage.⁸¹ Non-grandfathered health plans on the marketplace must comply with the ACA's coverage rules and consumer protections, which have increased access to and quality of private coverage for children.^{82, 83} ACA-compliant plans off the marketplace must also provide the same protections.⁸⁴ Children may no longer be denied coverage on the basis of a pre-existing condition, do not face annual and lifetime limits on coverage and can remain on their parent's health insurance up to age 26.^{60, 85, 86} Plans also must meet a set of minimum essential health benefits (EHBs), which are based on a state-designated benchmark plan.⁸⁷ The EHBs include pediatric services such as vision and dental care, as well as preventive care like child vaccines and well-child visits that are covered without copays.⁸⁸

In marketplace plans, families have an annual limit on how much they can pay out-of-pocket for care; in 2019, the limit for family coverage was \$15,800.⁸⁹ Marketplace premiums vary by plan and are not included in the out-of-pocket limit.⁹⁰ However, the ACA established two types of subsidies to help low- and moderate-income families afford marketplace coverage. First, families with income between 100% and 400% FPL can qualify for premium tax credits that reduce their monthly premium.⁹¹ Second, until 2018, the federal government provided funding for families with incomes between 100% and 250% FPL to receive cost-sharing reduction payments to lower their out-of-pocket costs.⁹²

Ideally, marketplace coverage offers a private insurance option for children in families who do not qualify for public coverage and cannot access ESI. However, due to the ACA's subsidy structure, millions are ineligible for financial assistance due to their family income or may fall into the "family glitch."^{93, 94}

In 2018, according to the most recent data, the average deductible for family coverage was more than \$1,000 higher among small group plans (\$4,364 per employee across plan types) than large group plans (\$3,263 per employee across plan types).



A family may fall into the family glitch when one family member is offered “affordable” employer coverage (in 2019, equal to or less than 9.86% of their income), making the entire family ineligible for marketplace financial assistance.



GAPS IN CONSUMER PROTECTIONS ON THE INDIVIDUAL AND SMALL GROUP MARKETPLACE

The “family glitch” and marketplace subsidies cliff

The ACA drastically decreased the uninsured rate, but its coverage expansions and private insurance marketplace subsidies did not reach all families.^{38,95} Approximately 6 million adults and children remain in the “family glitch” because they lack affordable family coverage through both their employer and the marketplace.^{10,93} A family may fall into the family glitch when one family member is offered “affordable” employer coverage (in 2019, equal to or less than 9.86% of their income), making the entire family ineligible for marketplace financial assistance. Because this standard only applies to the *employee’s* contributions to individual coverage rather than the *family’s* contribution to coverage, it does not account for the possibility that covering the family on the employer plan may be unaffordable.

Other low- and moderate-income families are left without access to affordable coverage options because their income puts them above the cut-off for marketplace subsidies (400% FPL, or around \$100,000 for a family of four in 2019). Many of these families also do not have access to ESI. However, in either scenario, cost remains a primary barrier to coverage for families.

Variable implementation of the essential health benefits standard

The ACA’s EHB standard has played a key role in ensuring that children have both adequate and affordable coverage options on the marketplace.⁹⁶ It sets a minimum standard of benefit categories that all non-grandfathered plans (on- and off-marketplace) must cover, including pediatric services.⁹⁷ These plans, as well as large and self-insured employer plans, must also cover all preventive services described in the American Academy of Pediatrics’ “Bright Futures” guidelines, without copays.^{98,99} Additionally, the EHB standard created important cost protections for enrollees by setting actuarial values (or the average percentage of total costs a plan pays for covered benefits) based on plan metal levels, which range from 60% for bronze plans to 90% for platinum plans.^{100,101}

However, evidence suggests that implementation of the EHB standard has varied greatly among states, and that significant gaps remain in children’s marketplace coverage. Although the EHBs include pediatric benefits, states are only specifically required by federal law to adjust their benchmark to cover pediatric vision and dental services.¹⁰² Without a well-defined scope of required services for children, the result is a “patchwork” of state benchmark plans that have variable coverage of certain pediatric services, such as those related to autism, learning disabilities and speech therapy (Figure 7).¹⁰³

With the exception of meeting actuarial value requirements and requirements around certain preventive services, insurers also continue to have broad discretion over the cost-sharing limits they set for EHB benefits, creating significant variation across plans that can affect children’s coverage.¹⁰³

Marketplace plans do not include Medicaid’s comprehensive Early and Periodic Screening, Diagnostic, and Treatment benefit for children, or “EPSDT.” Overall, the primary difference between public and private benefit packages lies in the “T” of EPSDT: treatment, particularly the treatment of certain vision, dental, behavioral and developmental conditions.¹⁰³ A 2017 actuarial estimate of the savings four states experienced by excluding certain services from their EHBs showed that as a percentage of premiums, the savings are quite small.¹⁰⁴ For example, if excluded, pediatric vision saves .42%; speech, occupational and physical therapy saves .07%; applied behavioral analysis for autism saves .27%.

Figure 7

PEDIATRIC BENEFITS MOST FREQUENTLY EXCLUDED IN SUMMARIES OF STATE BENCHMARK PLANS



BENEFIT EXCLUDED	# STATES
LEARNING DISABILITIES	13
SPEECH THERAPY FOR DEVELOPMENTAL DELAYS AND / OR STUTTERING	10
DEVELOPMENTAL DELAYS / DISABILITIES	9
SERVICES FOR ASD (AT LEAST IN PART)	9
INTELLECTUAL DISABILITY	8
BEHAVIORAL PROBLEMS	7
FAMILY OR PARENTAL COUNSELING	6

Source: [healthaffairs.org/doi/10.1377/hlthaff.2014.0743](https://doi.org/10.1377/hlthaff.2014.0743)

Note: ASD is Autism Spectrum Disorder.

POLICY OPTIONS TO IMPROVE AND EXPAND CHILDREN'S COVERAGE

LEVERAGE MEDICAID AND CHIP TO ACHIEVE UNIVERSAL AND COMPREHENSIVE COVERAGE FOR ALL CHILDREN

IMPROVE MEDICAID/CHIP ENROLLMENT AND RETENTION

IMPROVE AFFORDABILITY AND STRENGTHEN QUALITY OF EMPLOYER-SPONSORED AND MARKETPLACE COVERAGE

Until recent years, the U.S. was on track to achieve universal health coverage for children, which could serve as an important stepping stone on the path to universal coverage for all.² Rising costs for families and threats to public insurance programs, however, threaten to derail this monumental opportunity.¹ In the midst of declining rates of children's health care coverage, it is time to consider new strategies to improve access to affordable, quality coverage for all children—particularly those from low- and moderate-income working families who are being left behind. It is important to learn from previous efforts, while considering what has changed in insurance markets over time.

This section reviews policy options to address the barriers laid out in this brief and offers different paths to achieve universal health coverage for children. The options span from systemic structural changes to the children's health insurance market, to more incremental regulatory changes that aim to improve affordability, continuity of coverage and benefits for families (Figure 8). Policymakers will need to consider the trade-offs inherent in these options in terms of coverage gains, financing mechanisms and downstream effects on insurance markets.

Proposals for systemic change to achieve equity in access and comprehensive coverage for all children would more quickly get us to universal coverage. However, they require further analysis of financing mechanisms and impacts on access to care, and must be looked at within the context of potential changes to Medicaid funding.^{105,106} While there is greater precedent for expanding and improving children's coverage by building off of existing buy-in programs and improving Medicaid/CHIP enrollment and retention, such reforms may only achieve incremental progress and will not on their own reverse the decline in children's coverage.

While it is not the goal of this brief to recommend one particular path forward, it is clear that we need bold, decisive action to counteract an erosion in access and affordability of children's coverage that has accelerated in recent years. Although the spectrum of options we present here provides ample solutions to fit the political context and needs of different communities, the more ambitious proposals may be necessary to stabilize the market and achieve meaningful gains toward accessible, affordable coverage for all children in the future.

Figure 8

CONTINUUM OF OPTIONS TO IMPROVE AND EXPAND CHILDREN'S COVERAGE





SYSTEMIC CHANGE →

LEVERAGE MEDICAID AND CHIP TO ACHIEVE UNIVERSAL AND COMPREHENSIVE COVERAGE FOR ALL CHILDREN



Create state option for universal coverage plan with Medicaid benefits

Given the evidence on the positive effects of Medicaid and CHIP coverage for children, and the share of children already insured by these programs, policymakers might consider creating an option for states to enact a universal state plan for children with benefits modeled after those available in Medicaid. This would mean a fundamental shift of dependent coverage, and state policymakers would need to examine potential funding streams, such as the degree to which a universal state plan would require employer or employee contributions vs. public subsidies.

The most expedient and comprehensive option to achieve a universal program would be to capitalize on the broad benefit entitlement for EPSDT within the Medicaid program. Nationally, nearly 40% of children are already covered with EPSDT benefits (in Medicaid and CHIP), and more than half of the children enrolled in state CHIP programs receive their benefits through Medicaid.²⁰

States would need to address reimbursement under a universal Medicaid option, considering that Medicaid reimbursement rates largely remain well below rates afforded to clinical providers through ESI and Medicare.¹⁰⁶ A compromise with precedent may be to restore the Medicaid reimbursement bump from the ACA that was time-limited, but which created parity to existing Medicare reimbursements.¹⁰⁷

Policymakers could also consider leveraging the state CHIP programs as the basis for creating universal coverage, particularly among the greater majority of children who do not have significant complex medical needs.¹⁰⁸ This would, however, require major adjustments to the program, including to its funding structure and to ensure parity with EPSDT benefits.

A fundamental barrier to building off of CHIP is that it is subject to capped funding, and is not an entitlement like Medicaid.³³ Federal payments can fall short of need, and relying on Congress to reauthorize CHIP has created dangerous funding gaps. It would be more expedient to rely on the Medicaid program as the foundation for universal coverage for children as it covers most children already and is structured as an entitlement. Politically, a CHIP solution might find broader bipartisan support that traces back to the program's inception, but using CHIP as a pathway to universal coverage would require a political appetite to convert the program to an entitlement.¹ This seems unlikely in the present climate where the Centers for Medicare & Medicaid Services is moving in the opposite direction and giving states the option to "block grant" Medicaid.¹⁰⁹

Furthermore, though many CHIP programs have elected to offer comprehensive EPSDT-like benefits, there is no requirement to do so, as states are given flexibility to determine their own benefits packages.³² As such, stronger protections for essential and comprehensive benefits would be required for CHIP to become a universal coverage option.



Enhance opportunities for employers to buy-in to Medicaid/CHIP coverage

If policymakers are hesitant to pursue such fundamental reform, there remain other, more incremental steps to leverage the benefits that Medicaid and CHIP offer for children. These steps would strengthen and expand the reach of programs that already insure nearly half of all children in the U.S.

For example, *employers* could be given the option to carve out CHIP buy-in coverage for their employees with dependent children. In other words, the employer and employee contribution to the child's insurance coverage would go to enrolling them in the state's CHIP plan instead of a

← INCREMENTAL CHANGE

plan managed by the employer. There are reasons, conceptually and practically, for employers to consider this, including the fact that adult coverage in ESI often lacks child-specific benefit packages like those available through Medicaid and CHIP.³¹ CHIP buy-in plans could result in both better benefits and lower copayments.¹¹⁰ While it is uncertain how this option would impact overall family premiums for health care among those with ESI, it could significantly lower out-of-pocket costs for children's coverage.

Additional premium protections could ensure that families are not paying higher overall premiums as a result of this “split” arrangement. The bargaining power of the state, and a much larger pool of children in a CHIP plan, might exert downward pressure on premiums, although it would require further analysis to determine if that pressure is enough to offset incremental costs of children under existing family plans. A state might also consider providing small subsidies to moderate-income families beyond CHIP eligibility levels and families with multiple children.

As costs rise in the commercial market, and provider networks and benefit packages potentially narrow, the option to “buy-in” to Medicaid and CHIP may become attractive for employers seeking comprehensive, affordable benefits for families, and for the families themselves seeking to access comprehensive, affordable pediatric coverage. To some degree, there is an existing pathway for this, albeit only for smaller employers with fewer than 250 employees, contained within the 2009 CHIP Reauthorization Act.¹¹¹ To date, no states have yet exercised this option, but its inclusion in the law as a state option makes it a viable starting point for smaller employers.



Enhance opportunities for families to buy-in to Medicaid/CHIP coverage

States might also consider implementing or improving an individual “buy-in” program that allows families to purchase Medicaid or CHIP coverage for their children when their income exceeds Medicaid and CHIP eligibility limits. At least five states offer a Medicaid buy-in program targeted to children with special health care needs, which offers a Medicaid pathway for children with significant disabilities in families with incomes up to 300% FPL.¹¹²

More broadly, four states (Florida, Maine, New York and Pennsylvania) currently offer CHIP buy-in programs to children with family incomes ranging from over 157% FPL in Maine to over 400% in New York.¹¹² Unlike traditional Medicaid and CHIP, families that “buy-in” are typically responsible for the full cost of their monthly premium.¹¹⁰ However, buy-in coverage allows children to access the more comprehensive, robust pediatric benefits available under Medicaid's EPSDT benefit and in most separate CHIP programs.

A 2020 analysis found that CHIP buy-in can offer a more affordable coverage option for moderate-income families when compared to unsubsidized, child-only coverage on the marketplace.¹¹⁰ However, the analysis also suggests that states may need to offer subsidies to families eligible for CHIP buy-in to make this a viable option, and that paying full-cost premiums and cost-sharing could be particularly difficult for families with multiple children or those with special health care needs. That said, given that child-only coverage on the individual marketplace has not been a generally affordable option for families, CHIP buy-in programs may offer a way to undercut those costs while providing better benefits.¹¹³

IMPROVE MEDICAID/CHIP ENROLLMENT AND RETENTION

 **Raise state-level eligibility for Medicaid/CHIP**

States with lower Medicaid/CHIP income eligibility levels account for a disproportionate number of uninsured children, and these numbers are growing.¹¹⁴ States with Medicaid/CHIP upper eligibility levels below the national median (255% of FPL) could consider raising their eligibility levels to the national median, at least.

 **Streamline enrollment and simplify coverage renewal**

Given that 57% of uninsured children in 2017 were eligible for but not enrolled in Medicaid or CHIP, policymakers should consider increasing the ease with which families can sign up, maintain and renew their coverage.¹¹⁵ In particular, federal and state policymakers should incentivize states to take up the options already available to them under federal law, including the enhanced federal matching rate to states to upgrade their eligibility systems.¹¹⁶

Only 31 states have enacted continuous eligibility in children's Medicaid and/or CHIP, while only 20 states have enacted presumptive eligibility.^{39, 40} Further, express lane eligibility continues to be the most-underutilized option of the three, as it is used in only 13 states and the U.S. Virgin Islands.⁴²

Policymakers should also consider strategies to help states reduce the administrative burden of enrollment and coverage renewal. Significant delays remain in states' implementation of automated renewals, which could improve retention of eligible children, lower administrative costs and eliminate burdensome paperwork processes. Although more than 40 states have systems that enable them to conduct automated renewals, roughly half report that they are not using this process for most applications.¹

States could also consider implementing integrated enrollment systems that allow individuals to apply for coverage, receive eligibility determinations and enroll in coverage.¹¹⁶ These systems reduce the likelihood of churn by creating a “warm handoff” between each stage of the process.¹¹⁶ However, broader health literacy concerns or language barriers would still warrant continued in-person navigation strategies.

 **Boost outreach and enrollment assistance**

Policymakers should consider helping state Medicaid and CHIP programs overcome the “unwelcome mat” created, in part, by significant cuts to outreach and enrollment assistance, and exacerbated by uncertainty around policies such as the public charge rule.^{2, 117} A 2018 analysis by the Medicaid and CHIP Payment and Access Commission (MACPAC) found that despite advances in technology, demand for in-person assistance remains high.¹¹⁸ A series of case studies found that most Medicaid and CHIP applicants came to state agency or community assister offices because they lacked access to a computer, needed help understanding application questions or interpreting notices or needed assistance with documentation. Thus, policymakers at both the state and federal levels should consider boosting funds for direct, in-person consumer assistance and outreach, particularly to low- and moderate-income families.¹¹⁸ The CHIP reauthorization in 2018 also provides \$120 million to states to conduct targeted outreach and enrollment activities to children who are eligible for but not enrolled in Medicaid or CHIP.^{119, 120}

Given the evidence on the importance of parents' coverage to the insurance and health status of their children, policymakers should also consider outreach and enrollment strategies that account for the whole family, such as allowing parents and siblings to enroll in Medicaid or CHIP based on one child's eligibility.¹²¹

In states that have taken up the ACA's Medicaid expansion, all parents also now have their own path to coverage, but state policymakers should consider expanding Medicaid eligibility for working-age adults if their state has not done so.¹²² As long as the public charge rule remains in effect, non-citizen (or mixed citizenship) immigrant families will face uncertainty about accessing Medicaid and other public programs.¹²³ While it is likely that only doing away with this policy will remove this barrier, it will be important for policymakers to support enhanced outreach to these families to help them understand their options and how the public charge rule will be applied. Finally, certain Medicaid policies being explored through state waiver flexibility create additional barriers to enrollment, such as work requirements that affect parents, and will likely have spillover effects on children.^{124, 125}

IMPROVE AFFORDABILITY AND STRENGTHEN QUALITY OF EMPLOYER-SPONSORED AND MARKETPLACE COVERAGE

Strengthen the EHB standard and other marketplace protections

Policymakers could strengthen the EHB standard to improve children’s coverage on the individual and small group insurance marketplace.¹⁰³ Specifically, federal policymakers can modify the standard to explicitly address the types of benefits that states should include in the pediatric services category, beyond vision and dental.

Alternatively, states could consider using their CHIP plan as a benchmark for pediatric services on the marketplace; states are currently only permitted to use their CHIP plan to add pediatric vision and dental to their benchmark.¹⁰³ In data from 2016, the average actuarial value of separate CHIP plans was around 98%, compared to 82% for most marketplace benchmark plans.¹²⁶ Thus, allowing states to offer CHIP as a benchmark for pediatric services could provide subsidized families on the marketplace with better coverage for their children at slightly lower costs; however, unsubsidized families may see premium increases as a result of better benefits.

Provide premium assistance for moderate-income families who cannot afford employer coverage

Thirty-six states already offer employer coverage premium assistance to working families who cannot afford their employer’s family coverage and are eligible for Medicaid or CHIP.²⁹ States implementing premium assistance must ensure that enrollees’ cost-sharing and benefits are the same as those in their state Medicaid plan; otherwise, the state must provide “wrap-around” coverage (when Medicaid provides secondary coverage).¹²⁷ Providing premium assistance must also be cost-effective for the Medicaid program.²⁹

Although appealing in theory, the programs have not attracted many enrollees.⁸⁰ A 2009 survey found that most programs had fewer than 1,000 enrollees and high administrative costs.¹²⁸ Nevertheless, it remains a politically and potentially financially attractive option for some states.

Finally, states could consider providing additional, state-funded financial assistance to families who have trouble affording marketplace coverage. For instance, in 2019 California approved a strategy to provide temporary subsidies to individuals with incomes up to 600% FPL and enhanced subsidies for individuals with incomes from 200–400% FPL.¹²⁹ This could help make coverage more affordable by extending subsidy eligibility to more moderate-income families. It would also better align marketplace subsidy eligibility with eligibility for separate CHIP, allowing children to transition between markets more easily with fewer coverage disruptions.



CONCLUSION

In recent years, growing barriers to public coverage enrollment, the increasing cost of family coverage, and continued gaps in consumer protections for children have contributed to a decline in children's coverage, particularly for low- and moderate-income families.^{1,2}



The second consecutive annual increase in children's uninsurance largely underestimates a broader underinsurance crisis now facing many families.

Even when children are insured, families are experiencing rapidly escalating out-of-pockets costs that impact their financial stability and restricted benefit designs that impact children's access to high-quality care.⁵ Furthermore, rising uninsurance among children may also foretell continued coverage losses for Americans more broadly.

These trends create urgency for policymakers to ensure that children's coverage does not continue to erode, and that families have access to the services their children need to become healthy, productive adults. The policy options presented here could help to address the barriers to affordable, comprehensive coverage that families are experiencing, and offer several pathways to attain universal health coverage for children, a potential stepping stone for achieving it for the population as a whole. Incremental approaches will not on their own remedy the unprecedented decline in children's coverage in recent years, suggesting that new, bolder approaches may be necessary to achieve universal and affordable coverage for children in the years ahead.

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