The Impact of the Healthy Americans Act on Children's Health Coverage

Executive Summary

One of the first health reform proposals of the current debate is the Healthy Americans Act (S. 391) introduced by Senator Ron Wyden (D-OR) and Senator Robert Bennett (R-UT). While it achieves health care for all and promotes better health, it does so by making significant changes to the coverage system we have today through employers and federal insurance programs. The consequences of these changes are not yet well understood.

The Healthy Americans Act places the burden on the individual to purchase private insurance through a new "Health Help Agency" or state purchasing pool. This breaks with the long-standing system composed of employer-sponsored insurance for workers and their dependents, and public insurance programs for vulnerable populations.

In particular, the Healthy Americans Act dramatically changes health coverage for children through Medicaid and the Children's Health Insurance Program (CHIP), the two primary federal coverage programs for children. Given the critical role that these programs play in today's system, the changes are worthy of close analysis. Under the Healthy Americans Act, Medicaid and CHIP would be converted into supplemental insurance programs that "wrap around" the private plans offered in the new pools by offering additional benefits and premium assistance.

Certainly, the Healthy Americans Act achieves important positive changes to the current health care system. However, the Act proposes changes to the Medicaid and CHIP programs, which, absent modifications, could affect children negatively. Specifically, the Healthy Americans Act could:

Fracture Coverage for Low-income and Special Needs Children

Medicaid and CHIP provide health insurance for the country's vulnerable populations. Altering the structure of these two programs to wrap-around private insurance may cause many children, especially those with special health care needs, to lose access to needed services and face increased costs for care. Also, wrap around coverage is often difficult to implement without causing a disruption, and even loss, of coverage. This can be attributed to beneficiaries' confusion in navigating the insurance plans and understanding coverage benefits. Also, insurers and public programs may face increased administrative burden and complexity in establishing effective coordination between insurance plans.

Cause Children to Lose Coverage or Needed Benefits

Medicaid and CHIP include comprehensive services that are often needed but not provided through private insurance. By not requiring states to maintain Medicaid and CHIP eligibility levels, reform may encourage states to end coverage for Medicaid "optional" populations, such as those children in families with incomes between 100 and 300 percent of the Federal Poverty Level (FPL), and to end their CHIP programs entirely.

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Undermine the Health Care Infrastructure

The Medicaid program provides funding for public hospitals that care for underserved populations, as well as medical training for pediatric health care providers. The Healthy Americans Act is unclear as to how this important role is continued, though it is clear that specific safety net funding is reduced.

Recommendations

The following four recommendations would improve the Healthy Americans Act:

Maintain Medicaid and CHIP Coverage for Low-Income Families: The Healthy Americans Act does not account for the critical role Medicaid and CHIP play in providing low-income children with affordable access to a comprehensive array of needed medical services. Medicaid and CHIP are a critical safety net for America's most vulnerable children. They should continue to operate in the new coverage system and provide children with the cost sharing protections and services that go beyond those covered under typical insurance products.

Strengthen Medicaid's Ability to Serve Vulnerable Populations: The Healthy Americans Act misses an opportunity to improve Medicaid policies that would increase coverage for all low-income individuals and improve the entire health care system. Health reform should improve Medicaid and CHIP's ability to serve children by expanding access to coverage for more children and expanding access to care for beneficiaries.

Increase Standards for Private Insurance: Although the Healthy Americans Act requires that plans offered through the state purchasing pools be similar to the Blue Cross Blue Shield Standard Plan provided under Federal Employees Health Benefit Plan (FEHBP), these benefits are not required to meet the developmental needs of children. There should be a national set of comprehensive health care services for children that private health plans should be required to cover, thus ensuring all children have access to care needed for healthful development.

Continue Public Support for Critical Health Care Infrastructure: The Healthy Americans Act should ensure that Medicaid's role in funding infrastructure remains intact or is continued by other means. This funding is critical to providing children with access to safety-net care providers in their local communities, and for training health care professionals, including pediatricians.

Introduction

Policymakers and the public seem to be in agreement that the time is ripe for health reform. Members of Congress and stakeholders are collaborating to develop legislation to create a new system of health care coverage for all. The most commonly discussed model is shared responsibility, where the government, employers, and individuals all contribute their fair share towards expanding coverage. A key issue is how any new coverage system would interact with existing public programs. Recognizing that one-quarter of U.S. children get coverage through public programs, primarily Medicaid and the Children's Health Insurance Program (CHIP), children in particular have much at stake in this debate.

While the committees of jurisdiction have expressed their intention to introduce new legislation in the near future, only one legislative proposal has been introduced this year, the Healthy Americans Act (S. 391), introduced by Senators Ron Wyden (D-OR) and Robert Bennett (R-UT). It includes an individual responsibility to purchase coverage and the creation of new state insurance pools. This paper provides an assessment of the strengths and weaknesses of the Healthy Americans Act for children and provides recommendations that should be considered if this approach is pursued as part of national health reform.

Summary: The Health Americans Act

The Healthy Americans Act creates a new private insurance system in the United States. The Act would require all Americans, with certain exceptions, such as of those in the military and those on Medicare, to purchase private health insurance in new state-based group purchasing pools, or a state Health Help Agency (HHA). This eliminates the employer's role in health care. Each pool must offer at least two plans, which must be similar to or actuarially equivalent to the Blue Cross Blue Shield Standard Plan in the Federal Employees Health Benefit Plan (FEHBP). Plans must include a standard set of benefits, including preventive care (at no cost), wellness programs, catastrophic coverage, and other basic services, such as hospital and physician care. The value of this standard set of benefits will increase annually by per capita growth in the economy (which historically grows more slowly than health care costs). States can mandate benefit requirements in addition to the standard, and insurers can offer additional services at additional cost.

The health insurance premiums offered in the state-pools would be "community rated" and could only vary by geography and tobacco use in the state, as well as family size. Premium subsidies would be provided on a sliding scale based on income to assist low- and moderate-income Americans in affording insurance in the new purchasing pool.[1] The Act would eliminate the tax exclusion for employer-sponsored insurance and replace it with a new standard income-tax deduction. However, neither the new tax deduction nor the subsidy would necessarily be equal to the premium cost of the health insurance plan chosen.[2]

Medicaid and CHIP would be converted into supplemental insurance programs that "wrap around" the private insurance offered through the new pools. Medicaid and CHIP would continue to provide long-term care and other services not covered by the new private insurance plans available in the state.[3] Additionally, Medicaid would continue to offer premium assistance.

Positive Impact on Children: Improving Coverage and Increasing Affordability

The Healthy Americans Act includes positive aspects that would increase coverage and improve the health of our children.

Achieves Health Care Coverage for All: The Healthy Americans Act includes a personal requirement for everyone to purchase private insurance. It also includes automatic enrollment in an effort to achieve universal coverage for all citizens and legal residents. According to an independent study of the 2006 version of the Act, this would lead to 99 percent of Americans having health coverage, including 75.8 million children.[4]

Offers Subsidies to Offset Health Coverage Costs: The Healthy Americans Act would offer full premium subsidies and ban cost sharing for individuals with incomes below 100 percent FPL. This would continue to provide affordable coverage to the 23 percent of children in America living in families with incomes below 100 percent of FPL who are currently eligible for Medicaid.[5] Premium subsidies would also be available on a sliding-scale for individuals with incomes between 100 and 400 percent of FPL.

Builds on the Group Insurance Market: The Healthy Americans Act creates new group health insurance pools that prohibit insurers from varying insurance premiums based on an individual's health status, age, and genetic predisposition. This is called "community rating," and can help children with special health care needs find affordable health coverage in the private market.

Promotes Wellness and Disease Prevention: The Healthy Americans Act includes policies that require insurance plans to cover various benefits such as wellness programs, disease prevention and management, and chronic disease management. Additionally, cost-sharing requirements for these services are prohibited. This is intended to encourage families to take advantage of the benefits of preventive services at early ages to promote childhood development and to lower overall health care costs.

While this Act would make important achievements in reforming the health care system, understanding the true impact of the bill must involve assessing where there are potential failings, especially those that may fall heavily upon children.

Negative Impact on Children: Weakening the Medicaid and CHIP Programs

Medicaid and CHIP are crucial pillars of the American health care system. In their current form, these public programs play a unique role in providing coverage to 21.7 million children left out of the private health insurance system due to cost, health status, and other factors. Children with public coverage have improved access to preventive care and are less likely to delay seeking care due to cost. In addition, just 4 percent of children in Medicaid and CHIP lack a usual source of care, compared to 32 percent of uninsured children.[6] Because minority children are more likely to be in low-income families, Medicaid and CHIP also help to address racial and ethnic disparities in health care by providing coverage for two of every five African American children and Hispanic

children, and one in every five white children.[7] Additionally, Medicaid is a low-cost program: administrative spending is lower in Medicaid than private insurance.[8]

These federal health insurance programs insure our most vulnerable populations, including children in low- and moderate-income families and children with special health care needs. As discussed below, the Healthy Americans Act could put children at risk to lose access to coverage, face reduced benefits and increased costs when obtaining coverage, and confront an inadequate health care safety-net structure.

The Healthy Americans Act Could Fracture Coverage for Low-income and Special Needs Children

The Healthy Americans Act would shift Medicaid and CHIP enrollees into private insurance plans offered through the new state-based purchasing pool. Generally, Medicaid is more generous than private coverage, requiring much lower cost sharing and offering more comprehensive benefits.[9] This can also be true in CHIP, particularly as it relates to cost sharing. To ensure that low-income and special needs children currently covered by public programs continue to receive the same level of coverage, Medicaid and CHIP benefits would wrap-around private insurance that falls short. This is done through:

- **Supplemental Coverage:** Medicaid and CHIP provide services tailored to the needs of the populations the programs currently cover. Under the Healthy Americans Act, any benefit covered by Medicaid or CHIP and not offered in the private plan would need to be provided through some means by the state.

- **Premium Assistance:** Medicaid and CHIP also ensure affordability of coverage for families with low and moderate-incomes. Medicaid generally does not charge premiums and limits its copayments to $3 per service.[10] CHIP limits its out-of-pocket expenses to no more than 5 percent of a family's annual income. Under the Healthy Americans Act, families would be expected to pay no more than they would under the public program for which they are enrolled.

Wrap-Around Assistance Could Cause Confusion for Families

Experience has shown that wrap-around benefits and cost-sharing can be difficult to implement without causing beneficiary confusion and disruption. Indeed, the limited number of states that have attempted premium assistance through Medicaid and CHIP have experienced difficult administrative barriers and low enrollment rates.[11] The possible sources of confusion include:

- **Beneficiaries May Not Understand Their Coverage:** While state Medicaid programs use private managed care plans to cover children, some benefits, such as mental health and Early and Periodic Screening, Diagnosis and Treatment (EPSDT), typically remain outside the private plan as a responsibility of the state. Such an approach is a real-world example of wrap-around coverage where some Medicaid benefits come from a private plan and others through the state. The results can be negative. Beneficiaries and their families do not always understand that there are benefits available beyond the private plan.[12] At the same time a denial of care by the managed care plan may be taken as a complete denial of coverage.[13] In fact, since the early 1990s, at least 28 states have been sued by beneficiaries or advocacy groups for not providing required access to EPSDT services.[14]

- **Care coordination could suffer:** It is difficult to coordinate care across programs due to confusion on the part of the beneficiary, states and provider. For example, Medicare has experienced problems with coordinating care for "dual eligibles" – or Medicare beneficiaries whose low income also qualifies them for Medicaid coverage. For these beneficiaries, Medicaid provides a wrap-around benefit to cover Medicare cost-sharing requirements, including premiums and cost-sharing charges for their private Medicare Advantage plans.[15]

Unfortunately, the Healthy Americans Act does not provide much information on how the wrap-around services (both supplemental coverage and premium assistance) would work in practice. Experience with past efforts provides insight into the hurdles that must be overcome to implement this reform successfully. Ultimately, this additional confusion and complexity would increase barriers to accessing coverage for families and children.

Wrap-Around Assistance Could Increase Administrative Costs

By definition, wrap-around coverage creates an additional layer of administration, which could raise costs in the following ways:

- **States Will Need to Understand What Benefits Need to be Supplemented:** Today, states have the authority to provide premium assistance to low-income families through their Medicaid and CHIP programs. As of 2006, only 15 states have chosen to do so because of the administrative complexity posed by the large number of employers and the wide variation in benefits, premiums and cost-sharing among employer plans.[16] It is administratively difficult to determine what benefits private plans cover and then tailor a benefit plan to fill these holes across a wide array of public plans.

- **Multiple Insurance Plans Will Need to Coordinate Services:** Coordination between the primary and wrap-around insurers can also impose costs. Some managed care plans have reported administrative burdens and complexity in establishing effective coordination with the state to provide the needed supplemental benefits.[17] California has had difficulties in coordinating its Medicaid premium assistance program for eligible Medicare beneficiaries, which in some cases has led to beneficiaries being erroneously billed for services.[18]

- **Private Insurance Already has Higher Administrative Costs:** Public programs have lower administrative overhead than private insurance.[19] In recent years, Medicaid and CHIP costs have grown much slower than the vast increases seen in private and employer insurance cost. Transferring coverage from public to private insurance plans may automatically increase administrative costs and also may be ineffective in controlling health care costs over time.[20]

Transitioning to Wrap-Around Coverage May Leave Some Children Behind

Moving children to a system where they have differing sources of coverage could make care coordination difficult and disrupt continuity of care. Breaks in coverage, and their resulting interruptions and shifts in care, can have a detrimental effect on child health and development. Transitioning from a full Medicaid program to private coverage plus public wrap-around, as the Healthy Americans Act would do, could disrupt coverage for some children.

The Act could put many children in low-income families eligible for Medicaid or CHIP at greater risk for not

obtaining the supplemental coverage offered through these programs. Families, for example, may allow their child's enrollment to lapse when it comes up for renewal because they perceive that they already "have insurance," and therefore do not see the need complete the cumbersome paperwork for additional public program coverage. Families also may not know they are eligible for additional coverage in the first place. For example, a class action complaint filed in 2001 by families in Tennessee identified a "lack of outreach and information" from the state regarding receiving and enrolling in programs that would ensure timely EPSDT services.[21]

Wrap-Around Coverage Puts Special Needs Children at Risk

Public programs play an important role in providing access to services for special needs children who do not have access to the care they need through private insurance. A wrap-around approach to coverage would put these children at especially high risk for losing access to needed health care services. Medicaid provides critical supports targeted at helping special needs children function at the highest level possible.[22]

The Healthy Americans Act Could Cause Children to Lose Coverage or Needed Benefits

Medicaid and CHIP are both optional programs for states that come with significant flexibility. There are some populations and benefits that are mandatory, and many populations and benefits which are optional. (See Fig. 1) Many of these "optional" populations are still low-income and often without other coverage options, and many "optional" benefits are important to maintaining the health and well being of children, including prescription drugs.

FIGURE 1: Medicaid Mandatory and Optional Child Populations and Services

Mandatory Populations	Optional Populations
• Children under age 6 below 133 percent of FPL. • Children age 6 and older below 100 percent of FPL ($17,600 for a family of 3). • Pregnant women at or below 133 percent of FPL.	• Children under age 6 above 133 percent of FPL. • Children age 6 and older above 100 percent of FPL. • Pregnant women above 133 percent of FPL.
Mandatory Services: Partial List	**Optional Services: Partial List**
• Physician Services • Inpatient and outpatient hospital services • Labs and x-rays • EPSDT for individuals under 21 • Family Planning supplies • Federally qualified health center services • Rural health cline services • Certified nurse practitioner services • Home health care services	• Prescription drugs • Dental services • Clinic services • Primary care case management • Physical therapy • Other specialist medical or remedial care • ICF/MR services • Inpatient psychiatric hospital services for individuals under 21 • Home health care services • Case management services

Source: The Kaiser Commission on Medicaid and the Uninsured, Medicaid Optional Populations: Coverage and Benefits, September 2005.

Children Could Lose the Coverage They Need

Currently, every state includes an optional or expansion population in its Medicaid or CHIP programs: 41 states increase income eligibility limits for infants; 26 states increase income eligibility limits for children between 1-5 years old; and 30 states increase income eligibility limits for children between 6-18 years old.[23] Additionally, 39 states have a stand-alone CHIP program that provides coverage for children and families at higher income limits than those required through Medicaid.[24] (See Figure 2).

Under the Healthy Americans Act, these states could end their expansion efforts, placing millions of children in jeopardy of coverage and protections offered by public plans. More specifically, states do not have to maintain their current Medicaid and CHIP programs. Private insurance plans, offered through the HHAs, would now be responsible for this coverage. States would be obligated to help cover the cost of the new system through annual "maintenance-of-effort" payments to the federal government equal to their existing spending.[25] This creates the possibility that some states will reduce their optional coverage and benefit levels in an effort to reduce costs. After all, children in Medicaid and CHIP already receive a basic level of private coverage through the new federal program.[26]

FIGURE 2: Medicaid Income Eligibility Limits for Optional Populations

	Medicaid/CHIP Expansion Infants Ages 0-1	Medicaid/CHIP Expansion Children Ages 1-5	Medicaid/ CHIP Expansion Children Ages 6-19	Stand Alone CHIP Programs
National Standard	133%	133%	100%	N/A
Alabama	None	None	None	200%
Alaska	175%	175%	175%	N/A
Arizona	140%	None	None	200%
Arkansas	200%	200%	200%	N/A
California	200%	None	None	250%
Colorado	None	None	None	205%
Connecticut	185%	185%	185%	300%
Delaware	200%	None	None	200%
District of Columbia	300%	300%	300%	N/A
Florida	200%	None	None	200%
Georgia	200%	None	None	235%
Hawaii	300%	300%	300%	N/A
Idaho	None	None	133%	185%
Illinois	200%	None	133%	200%
Indiana	200%	150%	150%	250%
Iowa	200%	None	133%	200%
Kansas	150%	None	None	200%
Kentucky	185%	150%	150%	200%
Louisiana	200%	200%	200%	250%
Maine	200%	150%	150%	200%

Maryland	300%	300%	300%	N/A
Massachusetts	200%	150%	150%	300%
Michigan	185%	150%	150%	200%
Minnesota	280%	275%	275%	N/A
Mississippi	185%	None	None	200%
Missouri	185%	150%	150%	300%
Montana	None	None	None	175%
Nebraska	185%	185%	185%	N/A
Nevada	None	None	None	200%
New Hampshire	300%	185%	185%	300%
New Jersey	200%	None	133%	350%
New Mexico	235%	235%	235%	N/A
New York	200%	None	None	250%
North Carolina	200%	200%	None	200%
North Dakota	None	None	None	150%
Ohio	200%	200%	200%	N/A
Oklahoma	185%	185%	185%	N/A
Oregon	None	None	None	185%
Pennsylvania	185%	None	None	300%
Rhode Island	250%	250%	250%	N/A
South Carolina	185%	150%	150%	200%
South Dakota	140%	140%	140%	200%
Tennessee	185%	None	None	250%
Texas	185%	None	None	200%
Utah	None	None	None	200%
Vermont	300%	300%	300%	300%
Virginia	None	None	133%	200%
Washington	200%	200%	200%	250%
West Virginia	150%	None	None	220%
Wisconsin	250%	250%	250%	N/A
Wyoming	None	None	None	200%

SOURCE: State Health Facts, Kaiser Family Foundation, "Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009."

Children Could Have Reduced Benefits

Medicaid ensures that a wide range of benefits, often not found in private coverage, are available to low-income and special needs children. In contrast, CHIP benefit standards must meet a certain benchmark of services provided in private insurance, including the Blue Cross Blue Shield Standard Option Plan and Medicaid. In fact, 33 states use CHIP funds to expand Medicaid, giving those children greater protection than private coverage.[27] Both programs, therefore, generally provide a comprehensive scope of benefits that are critical given the low-incomes and complex health care needs of the children they serve.

Whereas these public programs were designed with children in mind, the Blue Cross Blue Shield Standard Option is not. While mandatory benefits such as hospital and physician services would continue to be provided under the Healthy Americans Act, the comprehensive suite of services and benefits covered by Medicaid, and not always covered by private insurance, could be lost:

- Medicaid covers all developmental assessments for infants and young children.
- Medicaid provides vision services without limit.
- Medicaid provides case management, and in-home support, which are essential to treating children with chronic conditions, or disabled children needing long-term care.

Please see Appendix 1 for a complete list of difference in Medicaid and FEHBP covered benefits.

Additionally, the Healthy Americans Act does not provide a standard floor of benefits for all private insurance plans regarding the services the plans participating in the new state insurance pools provide. Instead, the Act requires insurers to provide plans that are actuarially equivalent to the standard option Blue Cross/Blue Shield Health Plan in the Federal Employees Health Benefits Plan. While this gives insurance companies the flexibility to offer Americans choice among insurance plans, it poses several problems. First, it likely will make it more difficult for families to compare plans and choose one that provides all the services children need.

Also, this approach could create adverse selection in the private insurance market. Insurance companies are likely to design plans to discourage enrollment by those with chronic disease or special needs. Such benefit packages will help enable insurers to "cherry pick" healthier families. This will drive up the cost of comprehensive plans for those who need health care the most and are least likely to be able to afford it, undermining the benefit of risk sharing in the group insurance market. This could put children at risk of not having affordable access to the services they need.

Finally, the benefits offered in the plans would likely decrease over time. The Healthy Americans Act requires that the value of the benefits offered in the plan increase by per capita growth in the economy. However, health care costs have historically grown faster than general inflation. If such health cost increases continue, the actual value of health benefit plans to consumers will deflate.

The Healthy Americans Act Would Undermine the Health Care Infrastructure

The Medicaid program provides significant funding towards health care infrastructure. Even with a reformed health care system that includes universal coverage, Medicaid will remain invaluable to maintaining the long-standing system of care for vulnerable populations.[28]

Service Coordination for Vulnerable Populations is at Risk

Medicaid often ensures that care coordination for children is possible. Medicaid provides a case-management benefit that supports vulnerable populations, such as special needs children, by coordinating services across state

organizations and agencies.[29] This can cut across programs, like child welfare and mental health, which are typically needed by the most vulnerable children. For example, New York State developed innovative ways to utilize Medicaid funding to coordinate services that support the healthy mental development of children. The statemodified Medicaid managed care contracts to more clearly specify the responsibilities and opportunities of managed care contractors, primary care physicians, and mental health providers in ensuring young children's healthy mental development.[30]

The private health coverage promoted by the Healthy Americans Act often does not offer coordination of medical services for policyholders, let along the myriad social services vulnerable populations rely on.[31] Without Medicaid, states could be challenged to continue effective coordination of health and social services provided by multiple state agencies.

Public Hospitals and Community Clinics Could Lose Funding

Medicaid provides funding for public hospitals that serve a disproportionate share of individuals who are uninsured or have special health care needs; these hospitals are known as disproportionate share hospitals (DSH). While the Healthy Americans Act would reduce the need for uncompensated care funding by ensuring most Americans have health coverage, hospitals and hospital-based community clinics that receive DSH funding also use it for many other critical safety-net activities:

- **Access to Care for Low-income Families:** DSH funding supports hospitals and clinics in underserved areas. DSH payments help compensate for low public program reimbursement rates to keep these critical links in the health care infrastructure operating.
- **Operating Poison, Trauma and Burn Centers:** These services are underprovided by private health care providers, but will still be needed in a reformed health care system that ensures health coverage for all. Of the more than 2 million poison exposures reported in 2000, more than 53 percent were children under age six.[32]
- **Reducing Health Care Disparities:** DSH funding supports community health centers that are often located in urban areas. Minority children in particular often depend on these centers for care because they have a higher likelihood of living in urban areas.[33] Furthermore, public hospitals that receive DSH funding often use the funds to develop innovative approaches for addressing health disparities and promote cultural competency,[34] which is an expense rarely covered by private insurance.

Under the Healthy Americans Act, states would only receive 10 percent of their current DSH allotments. If this act had been in effect in fiscal year 2009, total DSH allotments would have been reduced by more than $10.2 billion. (See Fig. 3). This funding reduction has the potential to reduce access to care for underserved children, even with a coverage expansion.

FIGURE 3: FY 2009 DSH Allotments: Actual and Estimated Under the Healthy Americans Act

	Actual Federal DSH Allotment FY 2009	*If Healthy Americans Act Was In Effect FY 2009:*	
		Federal DSH Allotment	Lost DSH Funding
Alabama	$308,756,666	$30,875,667	$277,880,999
Alaska	$20,452,939	$2,045,294	$18,407,645
Arizona	$101,663,780	$10,166,378	$91,497,402
Arkansas	$43,314,075	$4,331,408	$38,982,668
California	$1,100,730,067	$110,073,007	$990,657,060
Colorado	$92,878,022	$9,287,802	$83,590,220
Connecticut	$200,817,344	$20,081,734	$180,735,610
Delaware	$9,090,194	$909,019	$8,181,175
District of Columbia	$61,500,312	$6,150,031	$55,350,281
Florida	$200,817,344	$20,081,734	$180,735,610
Georgia	$269,848,306	$26,984,831	$242,863,475
Hawaii	$10,000,000	$1,000,000	$9,000,000
Idaho	$16,504,676	$1,650,468	$14,854,208
Illinois	$215,878,645	$21,587,865	$194,290,781
Indiana	$214,623,536	$21,462,354	$193,161,182
Iowa	$39,542,079	$3,954,208	$35,587,871
Kansas	$41,418,577	$4,141,858	$37,276,719
Kentucky	$145,592,574	$14,559,257	$131,033,317
Louisiana	$750,259,000	$75,025,900	$675,233,100
Maine	$105,429,106	$10,542,911	$94,886,195
Maryland	$76,561,612	$7,656,161	$68,905,451
Massachusetts	$306,246,450	$30,624,645	$275,621,805
Michigan	$266,082,981	$26,608,298	$239,474,683
Minnesota	$74,994,108	$7,499,411	$67,494,697
Mississippi	$153,123,225	$15,312,323	$137,810,903
Missouri	$475,686,084	$47,568,608	$428,117,476
Montana	$11,397,164	$1,139,716	$10,257,448
Nebraska	$28,413,868	$2,841,387	$25,572,481
Nevada	$46,439,011	$4,643,901	$41,795,110
New Hampshire	$160,752,800	$16,075,280	$144,677,520
New Jersey	$646,380,826	$64,638,083	$581,742,743
New Mexico	$20,452,939	$2,045,294	$18,407,645
New York	$1,612,814,294	$161,281,429	$1,451,532,865
North Carolina	$296,205,582	$29,620,558	$266,585,024
North Dakota	$9,591,017	$959,102	$8,631,915
Ohio	$407,910,230	$40,791,023	$367,119,207
Oklahoma	$36,360,778	$3,636,078	$32,724,700
Oregon	$45,450,973	$4,545,097	$40,905,876

Pennsylvania	$563,543,672	$56,354,367	$507,189,305
Rhode Island	$65,265,637	$6,526,564	$58,739,073
South Carolina	$328,838,401	$32,883,840	$295,954,561
South Dakota	$11,089,783	$1,108,978	$9,980,805
Tennessee	$305,451,928	$30,545,193	$274,906,735
Texas	$960,157,926	$96,015,793	$864,142,133
Utah	$19,698,157	$1,969,816	$17,728,341
Vermont	$22,591,951	$2,259,195	$20,332,756
Virginia	$87,965,603	$8,796,560	$79,169,043
Washington	$185,756,043	$18,575,604	$167,180,439
West Virginia	$67,775,854	$6,777,585	$60,998,269
Wisconsin	$94,919,150	$9,491,915	$85,427,235
Wyoming	$227,254	$22,725	$204,529
Total	$11,337,262,543	$1,133,726,254	$10,203,536,289

SOURCE: State Health Facts, Kaiser Family Foundation, "Disproportionate Share Hospitals (DSH) Allotments under the American Recovery and Reinvestment Act (ARRA), FY2009."

Workforce Training Could Be Impaired

Having a strong supply of health care providers is imperative in a reformed health care system where everyone has insurance. Medicaid provides critical funding for teaching hospitals and graduate medical education (GME), one policy that effectively decreases barriers to having needed health care providers.[35]

For example, children's hospitals play a key role in training the nation's pediatricians and pediatric specialists. Freestanding children's hospitals train 35 percent of all pediatricians and nearly 50 percent of pediatric specialists.[36] While Medicaid is not the only source of income for these programs, such hospitals often rely heavily on Medicaid to support their programs.[37] Despite its importance, the Healthy Americans Act does not mention this policy area.

Recommendations

While the Healthy Americans Act achieves many of the goals of a reformed health care system, such as achieving universal coverage and making health promotion and wellness a priority, the analysis in this paper has highlighted several weaknesses. There are changes that could be made to the plan in order to help protect services for children. The Healthy Americans Act could be improved by taking the following steps.

Maintain Medicaid and CHIP Coverage for Low-Income Families

Medicaid and CHIP are two critical pillars of the health care system. Nearly 22 million low- and moderate-income children are covered through these programs that provide services often not covered in private insurance. These services help meet the complex health care needs of low-income children and special needs children in a way that private coverage does not.

The Healthy Americans Act would change this. By fracturing public programs into supplemental coverage, the Act puts children at increased risk of losing coverage or having less coverage. The administrative burden and complexity increases confusion not only for families, but for state administrators and insurers as well.

To improve the Healthy Americans Act, the Medicaid and CHIP programs should maintain their current structure. These programs ensure access to services that go beyond those covered under typical insurance products, including care management, vision and dental care, and ensuring children have access to services such as physical therapy for as long as they need them. In particular, Medicaid provides low-income children with the full complement of services they need to meet their unique health and developmental needs. States should be required to maintain the benefit and eligibility levels the programs they have today, with the flexibility to increase such levels. Instead of creating incentives for states to scale back Medicaid and CHIP coverage and services, the programs should be used as part of the foundation for building a new health care system.

Strengthen Medicaid and CHIP's Ability to Serve Vulnerable Populations

Recognizing that Medicaid is a vital component of the safety net, there is much that states and the federal government could do to improve its ability to support care and services for children. The Health Americans Act could take this opportunity to strengthen the program by:

- **Expanding Eligibility for Children:** Removing asset tests and expanding income eligibility limits will give more low-income children access to affordable coverage.

- **Improve Enrollment and Retention:** Procedures for enrolling in public programs can be complex, and identification and proof of citizenship requirements add additional barriers for families. Once in the program, families have to recertify their eligibility on a regular basis. Automating and simplifying these procedures could increase the number of eligible families that enroll and stay covered.

- **Promoting Family-based Coverage:** Studies have shown that children with insured parents are more likely be insured, have adequate access to health care they need ,and less likely to have unmet health needs. Expanding public coverage programs to include parents, and allowing entire families to have the same health insurance plan and physician, could improve children's health.[38]

- **Increase Medicaid Reimbursement Rates:** Too often access to services in public programs is hampered by low provider participation rates. This is particularly true for pediatricians, who report that low payment rates – which for most pediatricians do not cover overhead costs – were the top reason they did not participate in Medicaid and CHIP.[39] Paying providers adequately for their services will expand access to care for children.

- **Pay for Performance:** While Medicare and the VA have long been leaders in promoting pay for performance and other quality of care initiatives, public programs for children have not kept pace. The federal and state governments could leverage their buying power to drive quality improvements in the system that will directly benefit children. For example, providers could be provided incentives for ensuring every publicly insured child receives child wellness visits and exams.

- **Funding for Comparative Effectiveness Research:** Dedicated funding streams could be made available to provide information on the comparative benefits of different treatments to help patients and their doctors make informed decisions about what care is right for them. Medicaid could help drive research that is specific to children's special health care needs, which would complement existing and predominately adult-care-directed research.

- **Long-term Care Reform:** Medicaid currently is the payer of last resort for disabled children and others who need long-term care. Policies are needed to ensure that families have access to adequate coverage for such needs.

Increase Standards for Private Insurance

Medicaid provides beneficiaries with a basic set of services, and states have the option of expanding that benefit package to include services such as prescription drugs and mental health. There is no comparable minimum set of benefits which must be provided in the private market. And although state governments require private insurance plans to include certain benefits in the small group and individual market, those mandates vary state-to-state.

The Healthy Americans Act misses an opportunity to fully address this flaw in the coverage system. By allowing insurance plans participating in the new state HHA's to include benefits that are equal in value to the Blue Cross/ Blue Shield Standard Plan Option in FEHBP, insurers may be able to design benefit packages which do not meet the special needs of children and families. Over time, the value of services covered is not required to keep pace with the fast growth in health care costs.

To strengthen the Healthy Americans Act, private health plans should be required to cover a set of comprehensive benefits to ensure families have access to the services they need, and to ensure benefits increase in value with health care inflation. The national set of comprehensive benefits should extend the benefits that some states currently mandate, such as maternity care and child wellness visits, to every child. Insurers should be allowed to provide additional benefits above this standard package. This will provide American families with meaningful choice in health insurance plans.

Continue Public Support for Critical Health Care Infrastructure

Medicaid not only ensures coverage for our most vulnerable populations, it contributes to the funding of the health care infrastructure. The Healthy Americans Act largely does not address the role of Medicaid outside its primary function of providing health insurance for low- and moderate income families. It also reduces DSH funding, which supports vulnerable populations and provides services local communities rely on – and which helps address disparities in access to care.

To address this weakness, the Act should include policies that would ensure care coordination among state agencies for children remain intact regardless of the structure of Medicaid. The Act also should dedicate funding for public health care facilities and graduate medical education to address workforce shortages.

Conclusion

Medicaid and CHIP are an essential part of the health care safety net for children. By fracturing and weakening these programs, the Healthy Americans Act has the potential to reduce health care coverage and access to care for children. Without significant changes to this proposal to maintain and strengthen Medicaid and CHIP's role in covering and supporting children – as well as ensuring safeguards for children on the private market – this Act will hurt children's health.

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About FIrst Focus

First Focus is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. Children's health, education, family economics, child welfare, and child safety are among the core issue areas around which First Focus is working to promote bipartisan policy solutions.

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Appendix 1: Comparison of Medicaid and FEHBP Standard Option Blue Cross Blue Shield Plan

BENEFIT	MEDICAID	STANDARD OPTION
Developmental assessment	Covered	Limited to "healthy newborn visits," "routine screening," "routine physical examinations," "neurological testing," and initial examination of a newborn needing "definitive treatment," when the infant is covered under a family enrollment.
Anticipatory guidance	Covered	Not explicitly covered
Physical, speech, and related therapies	Covered without limitations other than medical necessity; no "recovery" requirements; therapy covered for conditions identified through early intervention and child care programs.	Limited to inpatient coverage. "Maintenance therapy" expressly excluded. Also excluded are "recreational and educational" therapy and "any related diagnostic testing except as provided by a hospital as part of a covered inpatient basis." All services billed by schools or a member of school staff are excluded.
Hearing services	Covered without limitations, including tests, treatment, hearing aids, and speech therapy related to hearing loss and speech development.	Testing covered only when "related to illness or injury." Routine hearing tests excluded other than as standard part of "routine" screening for children; hearing aids excluded along with testing and examinations for the prescribing or fitting of hearing aids.
Eye examinations and eyeglasses	Covered without limitations, as medically necessary.	One pair of eyeglass replacement lenses or contact lenses to "correct an impairment directly caused by a single instance of accidental ocular injury or intraocular injury;" eye examinations for specific medical conditions; nonsurgical treatment for amblyopia and strabismus from birth through age 12. Eyeglasses and routine eye examinations specifically excluded, as are eye exercises, visual training, and orthoptics except in connection with the specific diagnosis of amblyopia or strabismus.
Durable medical equipment (DME)	Covered without limitations, as medically necessary.	Certain DME covered but only if prescribed for the treatment of "illness or injury."
Home nursing	Covered without limitations, as medically necessary; home visits can cover health educators, therapists, health aides, and others.	Covered for two hours per day, 25 visits per year, when furnished by a nurse or licensed practical nurse and under a physician's orders.

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