ANNALS OF HEALTH LAW
Advance Directive

VOLUME 20 SPRING 2011 PAGES 104-111

Children's Health Insurance Program: Who Will Be Left Behind?

*Elizabeth Piekarz**

> We are not a nation that leaves struggling families to fend for themselves. No child in America should be receiving her primary care in the emergency room in the middle of the night. No child should be falling behind at school because he can't hear the teacher or see the blackboard. I refuse to accept that millions of our kids fail to reach their full potential because we fail to meet their basic needs. In a decent society, there are certain obligations that are not subject to tradeoffs or negotiation—health care for our children is one of those obligations.[1] - President Barack Obama

I. INTRODUCTION

Although President Obama has said that ensuring the health and well-being of our nation's children is "one of the highest responsibilities we have," eight million American children remained uninsured in 2009.[2] That is not to say that the federal government has not tried to reduce this shocking statistic. In fact, large strides have been taken over the past fifteen years since the creation of the Children's Health Insurance Program (CHIP), which provides health care coverage to over five million uninsured children.[3]

The effect of a lack of access to insurance is clear—uninsured children are at a greater risk for preventable health problems because they are often likely to forego needed

* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2012. Ms. Piekarz is a staff member of *Annals of Health Law*.

1. President Barack Obama, Remarks on Children's Health Insurance Program Bill Signing (Feb. 4, 2009), *available at* http://www.whitehouse.gov/the_press_office/RemarksbyPresidentBarackObamaOnChildrensHealthInsuranceProgramBillSigning/.

2. *Id.*

3. U.S DEP'T OF HEALTH & HUMAN SERV. – CMS, NATIONAL CHIP POLICY OVERVIEW, http://www.cms.gov/NationalCHIPPolicy/ (last visited May 4, 2011) [hereinafter POLICY OVERVIEW].

medical care.[4] However, children who are enrolled in CHIP have reported much lower unmet health care needs, increased access to care, and better communication with providers than those who are uninsured.[5] Without the establishment of CHIP, it is likely that the number of uninsured children could be more than double what it is today.[6] Nevertheless, CHIP still leaves a gap in coverage. With the passage of the Patient Protection and Affordable Care Act (PPACA)[7], portions of CHIP were altered—some for the better and some without effectively increasing access to the program or access to health care for uninsured children at all. This article will address the sweeping changes brought by PPACA to CHIP and evaluate their potential successes or shortcomings.

II. HISTORY OF CHIP

CHIP began in 1997 when it was created as part of the Balanced Budget Act.[8] Written by the late Senator Edward Kennedy, a long time proponent of expanding health care to all Americans, the bill planned to increase the federal tax on tobacco products to help finance health care for children.[9] In its original form under Title XXI of the Social Security Act, it provided annual appropriations through fiscal year 2007.[10]

Like Medicaid, CHIP is jointly financed by the federal government and the states and

---

4. KIDS AND HEALTH CARE: USING INSURANCE, CASH AND GOVERNMENT PROGRAMS TO MAKE SURE YOUR CHILDREN GET THE BEST DOCTORS, HOSPITALS AND TREATMENTS POSSIBLE 87 (Silver Lake Editors 2004) [hereinafter Silver Lake].

5. Jeanne M. Lambrew, *The Children's Health Insurance Program: Past, Present, and Future*, THE COMMONWEALTH FUND, vii (Jan. 2007), http://www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf (comparing 2 percent unmet needs to 11 percent unmet needs).

6. FAMILIES USA, IN PERSPECTIVE: A CLOSER LOOK AT HOW THE AFFORDABLE CARE ACT HELPS EVERYONE, 1 (Oct. 2010) http://www.familiesusa.org/assets/pdfs/health-reform/in-perspective/Reframing-the-Medicaid-Debate.pdf.

7. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010).

8. Silver Lake, *supra* note 4; *see* 42 U.S.C. § 1397aa (2006).

9. Robert Pear, *Hatch Joins Kennedy to Back a Health Program*, N.Y. TIMES, Mar. 13, 1997, http://query.nytimes.com/gst/fullpage.html?res=980CE4D81E39F937A25750C0A961958260. Senator Kennedy recognized that many Americans were essentially excluded from the health care system, and he devoted much of his time serving the state of Massachusetts to establishing universal access to health care. Mona Sarfaty, *Senator Kennedy's Legacy to U.S. Health and Health Care*, NEW ENG. J. MED. E31(1), Sept. 30, 2009,
http://www.nejm.org/doi/pdf/10.1056/NEJMp0908059. His tenure ran from just before Medicare and Medicaid
were voted into law, and ended with his death in August of 2009, just months before the Patient Protection and
Affordable Care Act was signed by President Obama. *Id.*

10. ELICIA J. HERZ , CHRIS L. PETERSON & EVELYNE P. BAUMRUCKER, CONG. RESEARCH SERV., STATE CHILDREN'S HEALTH INS. PROGRAM (CHIP): A BRIEF OVERVIEW 1 (2009) [hereinafter BRIEF OVERVIEW].

is administered by the states themselves.[11] However, CHIP was created for the purposes of filling in the gaps that Medicaid left in the health care system. Many families with children earn too much money to qualify for Medicaid, but do not earn enough to afford private health insurance.[12] Provided with the extra federal funds, states are given flexibility to design a program to fill in such gaps in coverage by: (1) expanding traditional Medicaid coverage; (2) creating new and separate programs aimed at kids; or (3) creating a combination of both a separate program and an expanded Medicaid program.[13]

In order to reach the targeted population, CHIP eligibility is usually limited to "low-income" children. To meet this "low-income" requirement, most states require that the child be less than 19 years of age, with no health insurance, who would not have been otherwise eligible for Medicaid under the rules in effect in the state on March 31, 1997.[14] Furthermore, states are able to set upper income limits up to 200 percent of the federal poverty line or 50 percentage points above the applicable pre-CHIP Medicaid income level.[15] Alternatively, a state may apply for a waiver to expand eligibility to all individuals under 19-years-old, no matter what their income level.[16] Yet, the state will not receive *unlimited* federal funding to maintain such a program.[17]

When funding was set to expire in 2007, Congress tried to expand the program only to face a veto from President George W. Bush, who feared it was a move towards the "federalization of health care."[18] While waiting for a new Presidential pen, Congress made an effort to alleviate some of CHIP's most obvious shortcomings. The result was

---

11. POLICY OVERVIEW, *supra* note 3.
12. Silver Lake, *supra* note 4.
13. *Id.* at 88.
14. BRIEF OVERVIEW, *supra* note 10.
15. SENATE FIN. COMM., DESCRIPTION OF POLICY OPTIONS: EXPANDING HEALTH CARE COVERAGE: PROPOSALS TO PROVIDE AFFORDABLE COVERAGE TO ALL AMERICANS 19, May 14, 2009, http://finance.senate.gov/download/?id=1DD95955-E95D-4AC7-919D-DAA62490D249.
16. BRIEF OVERVIEW, *supra* note 10.
17. *Id.* One such program was implemented in Illinois, where in 2005 All Kids was created to build on Medicaid and CHIP to fill the need for children from families who earned too much for public support and not enough for private insurance. *Illinois All Kids Program: A First in Universal Health Care*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=14296 (last visited May 4, 2011). However, the idea that "all kids" would be eligible, even if paying small amounts on a sliding scale, came to a halt on January 25, 2011 when Governor Pat Quinn signed legislation that will re-introduce income limits to the program. *Quinn signs Medicaid reform bill*, WGN NEWS, Jan. 25, 2011, http://www.wgntv.com/wgntv-quinn-signs-medicaid-reform-jan25,0,801631.story.
18. David Stout, *Bush Vetoes Children's Health Bill*, N.Y. TIMES, Oct. 3, 2007, http://www.nytimes.com/2007/10/03/washington/03cnd-veto.html?_r=1.

the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).[19] Calling it a "down payment on [his] commitment to cover every single American," President Obama signed CHIPRA into law extending financing for CHIP through fiscal year 2013.[20]

CHIPRA made an effort to improve some of the flaws in CHIP's original design. Besides renewing funding for the program, CHIPRA added an optional state plan amendment to cover pregnant women.[21] Additionally, CHIPRA terminated the so-called five-year ban present under CHIP, which restricted access to the program for legal immigrants until they had resided in the United States for five years.[22] Under the new Act, states are permitted to waive the five-year bar for CHIP coverage to pregnant women and children who are lawfully residing in the United States and are otherwise eligible for such coverage.[23] However, the choice to remove the five-year requirement is optional, and remains in place in many states.[24] As a result, even after implementing CHIPRA, CHIP continues to be imperfect and millions of American children remained uninsured.

III. HEALTH REFORM ATTEMPTS NEW SOLUTIONS TO OLD PROBLEMS

In early 2010, President Obama signed yet another bill into law for the purposes of making health care and health care coverage available to all Americans, the Patient Protection and Affordable Care Act.[25] PPACA contains several provisions that bolster CHIP, building on the advances of CHIPRA and extending coverage to an estimated 7.3 million children.[26] While many of the provisions will likely prove to be an effective

19. Children's Health Insurance Reauthorization Act (CHIPRA), Pub. L. No. 111-3, 123 Stat. 8 (2009).

20. POLICY OVERVIEW, *supra* note 3.

21. BRIEF OVERVIEW, *supra* note 10, at 3.

22. KAISER COMMISSION ON MEDICAID & THE UNINSURED, CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 at 2 (Feb. 2009), http://www.kff.org/medicaid/upload/7863.pdf.

23. BRIEF OVERVIEW, *supra* note 10, at 4.

24. *See* NATIONAL IMMIGRATION LAW CENTER, MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES, 1-4 (Jul. 2010), http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-07-28.pdf (providing a table of immigrant eligibility in each state). For example, Ohio goes so far as to deny Medicaid eligibility to a legal immigrant even after residing in the United States for the five-year period. *Id.* at 3.

25. FAMILIES USA, EXPRESS LANE ELIGIBILITY: EARLY STATE EXPERIENCES AND LESSONS FOR HEALTH REFORM, 1 (Jan. 2011), http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf; Sheryl Gay Stolberg, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES, Mar. 24, 2010, at A19, *available at* http://www.nytimes.com/2010/03/24/health/policy/24health.html.

26. FAMILIES USA, HOW HEALTH REFORM HELPS LOW-INCOME CHILDREN, 1 (2010), http://www.familiesusa.org/assets/pdfs/health-reform/Low-Income-Children.pdf [hereinafter HOW HEALTH

means of increasing access to the program, shortcomings remain.

a. Increased Federal Matching Funds

Without the help of the federal government, most states cannot carry the fiscal burden of increasing eligibility under CHIP on their own. PPACA begins by providing two additional years of federal funds for CHIP, thereby ensuring that the program continues to be available through the end of fiscal year 2015.[27] Yet, PPACA assumes that CHIP will continue even beyond 2015, calling for a twenty-three percent increase in each state's federal matching rate between 2016 and 2019.[28] Consequently, for the extended years, the federal matching rate will be *at least* eighty-eight percent in every state participating in the program.[29] Additionally, the PPACA requires that states maintain their current eligibility levels for children at the risk of losing *all* federal funding for *all* of the state's Medicaid programs.[30]

The bottom line is that the more money that is made available to the states, the more each is encouraged to utilize CHIP to supply health coverage to low-income children thereby preventing children from falling through the cracks and seeking medical care only after an emergency arises. In order to receive funds under PPACA, states are prohibited from enacting policies that would prevent additional children from enrolling, such as by increasing waiting lists, requiring more frequent renewals, or adding new eligibility criteria.[31] Additionally, the Act includes 40 million dollars solely for increasing promotional outreach in the community.[32]

So far, the financial incentives have had a positive effect on the number of children utilizing CHIP programming. In 2010, thirteen states expanded eligibility and fourteen states made improvements in enrollment and renewal procedures.[33] At the same time,

---

REFORM HELPS LOW-INCOME CHILDREN].

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.* at 2. Such a threat proved effective in Arizona, when in early 2010 the Congress abandoned proposed legislation to eliminate its CHIP program entirely which would have left 47,000 low-income children without health coverage. *Id.*

31. *Id.* at 1.

32. *Id.* at 2.

33. MARTHA HEBERLEIN ET AL., HOLDING STEADY, LOOKING AHEAD: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY RULES, ENROLLMENT AND RENEWAL PROCEDURES, AND COST SHARING PRACTICES IN MEDICAID AND CHIP, 1 (Jan. 2011), http://www.kff.org/medicaid/upload/8130.pdf.

only two states have implemented restrictions in eligibility.[34] Such stability in CHIP can be directly attributed to supplying the states with fiscal relief.[35] The next hurdle will have to be faced in 2019, when the financial incentives disappear and states are left to their own devices.

b. Updated and Modernized Enrollment Procedures

Another of CHIP's biggest roadblocks since its inception has been finding a way to get all eligible children enrolled in the program. Almost seventy percent of all uninsured children are eligible, but not enrolled in CHIP (or some Medicaid equivalent).[36] PPACA works to make enrolling in CHIP easier than ever before.

First, PPACA mandates that the Secretary of the Department of Health and Human Services establish a system to allow families to apply for any form of assistance for which they are eligible.[37] The Secretary will provide each state with a single, simple application for three programs (the state exchange, Medicaid, and CHIP) and then applicants will be referred by the state's Medicaid department to the appropriate program for enrollment.[38] This ensures that children receive health coverage regardless of which program they initially apply through. To facilitate this process, PPACA requires that a secure, electronic interface be created to allow for determination of eligibility based on one application.[39] Finally, each state must establish a website to collect applications no later than 2014.[40]

As soon as enrollment is successfully simplified, the number of children with access to CHIP will increase dramatically.[41] At that point, the response must turn to outreach, because as the number of families who learn that CHIP is available for their children increases, so too will the utilization of services. Retention strategies will then become the

34. *Id.* at 9.
35. *Id.* at 1.
36. REACHING ELIGIBLE BUT UNINSURED CHILDREN IN MEDICAID AND CHIP, CTR. FOR CHILDREN & FAMILIES, 3 (Mar. 2009), http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy+center%2Feligibleuninsured%2Feligibleuninsuredccf.pdf [hereinafter REACHING].
37. ENROLLMENT POLICY PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, FAMILIES USA, 1 (Dec. 2010), http://www.familiesusa.org/assets/pdfs/health-reform/Enrollment-Policy-Provisions.pdf [hereinafter ENROLLMENT POLICY].
38. *Id.*
39. *Id.* at 2.
40. *Id.* at 3.
41. *See* REACHING, *supra* note 36, at 2.

key to success.[42] The fewer hoops that are required to jump through in order to remain in the system, the more likely a child will be to stay covered and have access to their health care provider without accumulating large bills in the meantime.

c. Addressing the Plight of Legal Immigrants

As previously mentioned, CHIPRA lifted the bar so that legally residing immigrant children and pregnant women could enroll in Medicaid and CHIP.[43] However, PPACA does not go far enough to ensure that all eligible, legal immigrants have access to the program. States are still not *required* to lift the five-year bar in their programs; rather they have the choice whether or not to do so.[44] In addition, they can choose to cover both legally residing immigrant children and pregnant women, just children, or just pregnant women.[45] Legally residing immigrants are not barred from receiving services, but the federal government does not mandate coverage either, because a state can still choose to restrict access to immigrant children until they have lived in the United States for five years.[46]

Under PPACA, states that do pick up the option to cover all legally residing children will receive a higher federal CHIP matching rate for providing that coverage.[47] As an extra incentive, the additional funds are only available for those children who would have been barred under the old five-year rule.[48] Unfortunately, as of July 2010, only 24 states had included some form of the option to cover children and/or pregnant women who were "legally residing" in their state.[49] If additional states do not feel compelled to change

42. *Id.*

43. EXPANDING COVERAGE FOR RECENT IMMIGRANTS: CHIPRA GIVES STATES NEW OPTIONS, FAMILIES USA, 1 (Aug. 2010), http://familiesusa2.org/assets/pdfs/chipra/immigrant-coverage.pdf [hereinafter EXPANDING COVERAGE].

44. ROBERT WOOD JOHNSON FOUNDATION, STATE OF THE STATES, 7.4-7.5 (Feb. 2011), http://www.statecoverage.org/files/u34/SOS%20chapter%207.pdf [hereinafter STATE OF THE STATES]. In practice, the harsh citizenship requirements imposed prior to the passage of CHIPRA had the effect of delaying benefits to a number of eligible United States citizens who did not have ready access to the paperwork to prove it. Donna Cohen Ross, *New Citizenship Documentation Option for Medicaid and CHIP is Up and Running*, CTR. ON BUDGET & POLICY PRIORITIES, 1 (Apr. 20, 2010), http://www.cbpp.org/files/4-20-10health.pdf.

45. EXPANDING COVERAGE, *supra* note 43, at 1.

46. *See* STATE OF THE STATES, *supra* note 44. However, a state electing to cover lawfully residing children must offer coverage to *all* children who meet the definition—not just a subgroup of this population. Memorandum from Cindy Mann to State Health Officials (Jul. 1, 2010) *available at* https://www.cms.gov/smdl/downloads/SHO10006.pdf.

47. EXPANDING COVERAGE, *supra* note 43, at 3.

48. *Id.*

49. Informational Bulletin from Cindy Mann, Dir., Cntr. for Medicaid, CHIP & Survey & Cert. (Jul. 9,

their enrollment criteria in response to the new financial incentives, then the federal government must find a different way to encourage the inclusion of these children in CHIP across the states—even if it means prohibiting the five-year ban in its entirety.

IV. CONCLUSION

Since its inception in 1997, CHIP has provided health care to millions of our nation's children. Still, eight million more children remain without health care and it is time for a solution. PPACA made some important changes to CHIP—including increased federal matching funds and simplifying enrollment procedures—but when it comes to opening access to CHIP for legal immigrants, a great deal of work remains to be done. Until states are required to open up access to all children legally residing in their state, far too many will be left without support during some of their most important years of development.

2010), *available at* https://www.cms.gov/CMCSBulletins/downloads/07-09-2010-CHIPRA-and-ACA.pdf.