

**The Racial Equity
Implications of Proposals
to Restrict Medicaid,
Children's Health Insurance
Program (CHIP) and the
Affordable Care Act (ACA)**

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A range of proposals are currently being considered to restructure the foundations of health insurance coverage for low-income children and families, including changes to Medicaid (Title XIX), the Children's Health Insurance Program (CHIP) and the Affordable Care Act (ACA). These three health care financing programs provide coverage for millions of poor families and children, and the consequences of change are likely to be very significant for their well-being.

Medicaid and CHIP together provided coverage for nearly 35.8 million children in 2016 and are especially vital for children of color, helping to reduce disparities in health care access and service provision, improve continuity in care and advance health equity over time. The ACA helped to further reduce the number of uninsured children by increasing awareness through outreach and enrollment campaigns that have resulted in notable gains in coverage, especially for Hispanic children. The ACA also importantly prevented states from lowering Medicaid and CHIP eligibility standards for children, requiring all states to have a minimum Medicaid eligibility level for children living in families with incomes of up to 138 percent of the federal poverty level (FPL) and increasing federal funding for CHIP.

Health care coverage is critical to ensuring healthy outcomes for all children and families, but also in addressing disparities in access and outcomes for children and families of color. The effects of structural and institutional racism, racial discrimination and chronic exposure to racism have an impact on health outcomes, including birth outcomes such as preterm birth and low or very low-birth weight in black women.¹ Specifically, a 2002 study found that black women were two to three times more likely to have had a preterm infant if they had experienced discriminatory treatment in seeking housing or in societal interactions² and another study found that perceived racism across the lifespan can both predict birth weight for black women and help to account for observed racial differences in birth weight.³

This is the first of a series of briefs developed by CSSP to identify the potential impacts of proposed policy changes on our most vulnerable populations of families and children. This brief provides basic information on the impact of Medicaid and CHIP on reducing disparities in coverage for children and families of color and the likely impacts of current reform proposals. Subsequent briefs focus on the effects of proposed policy changes on very young children and their families and on the child welfare population.

Health insurance coverage provides children and families with access to needed preventive care and a range of other essential medical and behavioral health services and supports that promote their health and well-being. Having health insurance is an important predictor of access to and use of health care services.

Medicaid is a means-tested entitlement program with no enrollment caps or waiting lists that is financed through a federal-state partnership and provides a coverage safety-net for millions of children and families. While the federal government establishes basic program requirements around eligibility, enrollment and renewal procedures, benefits, comparability and "statewideness,"¹ Medicaid provides broad flexibility to states in all aspects of program design. This flexibility has driven innovation aimed at reducing and controlling costs and improving care while also insuring basic protections for all eligible individuals.



Medicaid has long been the main public insurance program for low-income Americans, covering nearly 70 million people, with children representing slightly more than half of all enrollees in 2016. The Children's Health Insurance Program (CHIP) is a companion program to Medicaid, providing coverage for uninsured, low-income children who lack access to other coverage options, and whose family income is above the cut-off for Medicaid. In some states, CHIP also provides health care coverage for pregnant women.

The Affordable Care Act (ACA) augmented existing coverage pathways by further expanding Medicaid to nonelderly adults with incomes up to 138 percent FPL, streamlining eligibility and enrollment and creating new opportunities for delivery system innovations. This expansion in eligibility for adults has been associated with an increase in coverage for children as well. Notably, coverage gains for children continued with increases in participation on average larger in expansion states⁶ than in non-expansion states.⁷ By 2014, 32 states, including DC, had Medicaid/CHIP participation rates at over 90 percent, and coverage for children was near or above 80 percent in other states.⁸

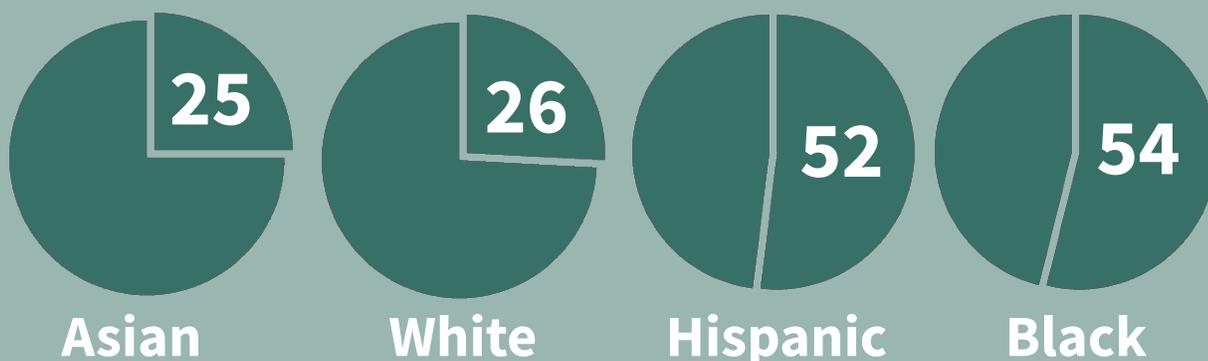
Medicaid and CHIP's Impacts on Reducing Disparities in Health Coverage

Medicaid and CHIP together provide health care coverage for one in three children and have led to a sizable reduction in the number of uninsured children in the U.S. The uninsured rate for children was cut in half between 1997 – when CHIP was created – and 2012 (from 14 percent to 7 percent),⁹ and even further reduced to a historic low of 6 percent following ACA implementation in 2014.¹⁰

Specifically, Medicaid and CHIP enrollment have helped to decrease disparities in health care coverage for children of color over time. In 2008, seven percent of non-Hispanic white children, ten percent of Black children and 19 percent of Hispanic children lacked health insurance coverage. However, by 2015 only four percent of both non-Hispanic white and Black children lacked coverage and eight percent of Hispanic children lacked coverage.¹¹ Additionally a study of New York's CHIP program that found enrollment in the program not only reduced preexisting racial and ethnic disparities in access to care, but also, reduced unmet need and improved continuity of care.¹² Currently, children of color are enrolled in Medicaid and CHIP at higher rates than white children, with roughly one in four white (26 percent) and Asian (25 percent) children covered by one of the two programs compared to over half of Hispanic (52 percent) and black children (54 percent).¹³

Figure 1.

Percent of Children Enrolled in Medicaid or CHIP (2014)



Research has shown that following enrollment in Medicaid or CHIP, children are more likely to have a usual source of care, regular visits to physicians and dentists, use preventive care, and are less likely to have unmet needs for health services including prescription drugs and care from doctors, dentists and specialists.¹⁴ However, progress in narrowing the coverage gap for children of color through Medicaid and CHIP for children of color has not fully addressed the systemic barriers that exist to accessing quality care – children of color are more likely to experience difficulties in accessing care, including specialty and mental health services,¹⁵ and to experience diminished quality of care as compared with white children.¹⁶ Children of color with special health care needs are also more likely to lack a regular health care provider, experience fewer physician visits, report being dissatisfied with care and encounter other barriers to service use.¹⁷ Medicaid data show that black children are less likely to receive well-child care, diagnosis and treatment for several pediatric conditions and have lower expenditures for outpatient and emergency department care and for prescriptions.¹⁸ Medicaid and CHIP provide dental coverage for children yet low-income children and children of color are less likely than their high-income peers to receive preventive dental care, even after controlling for insurance status.¹⁹

This is particularly significant since, due to compounding effects of disadvantage, children of color face greater threats to their health than white children and suffer disproportionately from a number of health conditions, including higher rates of elevated blood lead concentrations, asthma and obesity. Black children are more likely to be hospitalized for asthma than white children²⁰ and have substantially higher rates of asthma mortality.²¹ Native American and Hispanic children suffer from diabetes at rates 30 percent higher than white children.²² These disparities are not only applicable to medical conditions but include dental health as children of color are more likely to experience dental diseases, with untreated tooth decay twice as high for Hispanic and black children ages two to eight than white children.²³

While more remains to be done to ensure access to quality services for all children, including those of color, Medicaid and CHIP have improved access to primary and preventive care, reduced racial and ethnic disparities in children’s coverage and provided a critical safety-net for children and families.

Looking ahead, the future of these programs is uncertain, with proposals to block grant Medicaid or establish per capita caps being circulated and discussed. In the remainder of this brief, we highlight several concrete, actionable policy strategies that policymakers at the federal and state level can take to ensure children and families continue to have quality health care and health insurance through Medicaid, CHIP and the ACA, and that efforts to advance equity in health outcomes for children and families of color continue. In the wake of federal policy proposals that appear to be aimed at Medicaid, CHIP reauthorization and repeal of the ACA, advocates and policymakers must stand ready to protect policies that promote the health and well-being of all children and families, and particularly children and families of color, who experience lower rates of health care coverage, access and utilization than white children.

Protect and Preserve Medicaid

Proposals to restructure and restrict Medicaid – including block granting and per capita caps – are ongoing in Congress and many predict that a likely-to-pass ACA reconciliation bill will be used as a vehicle for restructuring Medicaid. Per capita caps are emerging as a consensus approach, although other proposals including block granting Medicaid; reducing the maximum eligibility level for the Medicaid expansion to 100 percent FPL; and revising (and reducing) the federal matching system for states' Medicaid programs are also on the table. Converting Medicaid to a block grant program or setting per capita caps would most likely lead to program cuts, including limiting services, reducing hospital or doctor payments, or finding other ways to fund the program including raising taxes or cutting non-health care programs.²⁵

Proposals to change the open-ended entitlement financing structure of Medicaid could pose a threat to the millions of children and families that depend on Medicaid for their health care coverage and almost certainly enable many states to cut services to people who need health care most. If states receive fewer federal Medicaid dollars, they will have to either make up those lost dollars

with state and local revenue or cut benefits or program eligibility, threatening the health care safety-net for low-income children, and in particular, children of color.

Specifically, block granting the program, as we have learned from past experience including the Social Services Block Grant (SSBG) and Temporary Assistance for Needy Families (TANF) programs, has the potential to erode the very fabric of Medicaid over time. A Center on Budget and Policy Priorities analysis of 13 major block grant programs found that funding for all but two had shrunk in inflation adjusted terms since their inception, highlighting that funding for TANF, after adjustment for inflation, had dropped by 32 percent since it was created.²⁶ Before converting into a block grant, the program (then AFDC), had provided cash assistance to 68 out of 100 poor families. In 2014, only 23 out of 100 poor families were receiving cash assistance through TANF. History tells us that block granting Medicaid is a likely path to destroying the program and represents a serious retreat from coverage gains made in recent years.

In addition to the schemes to restructure Medicaid, a proposed strategy to enhance and/or expand Health Savings Accounts (HSAs) for individuals and families ignores the lived realities individuals and families face, particularly those living at the intersection of race, poverty, ability, gender, sexual orientation and immigration status. These families face a unique set of stressors while trying to make ends meet – attempting to balance employment with responsibilities at home – and many find their budgets stretched to the maximum while struggling to manage the cost of necessities such as housing, food, health care and child care. These decisions leave families with little resources, if any, to save. Additionally, a proposal to provide monthly tax credits to low- and middle-income individuals and families who don't receive insurance through work or a government program, will disproportionately impact children and families who face barriers to employment that would make them ineligible to receive tax credits.

What Would a Block Grant Mean for Medicaid?

Under a Medicaid block grant, states would receive a pre-determined amount of federal funding for the program. A base year of Medicaid spending would be established and then the cap would increase by a specified amount each year, tied to either inflation or inflation plus some percentage. Designed to generate federal savings, the total amount of federal spending would be less than what is expected under current law. Under current law, Medicaid is an entitlement program with federal dollars used to match state spending (at a minimum of 50 percent or higher depending on a state's matching rate) for all eligible beneficiaries and services with no pre-set limit. Under current law, if state spending increases, federal spending increases. In contrast, under a block grant, if a state's Medicaid costs exceed the federal spending cap (for instance, due to increased enrollment during a recession), states would have to increase state spending, limit enrollment or cut services.

Under a per capita cap proposal, states would be reimbursed up to the capped amount for each of the defined Medicaid subpopulations regardless of how much each covered individual's care actually costs. Specifically, services for children would fare worse because the cap for children, given their relatively inexpensive overall coverage costs, would likely be far lower than for other Medicaid populations. With a low cap for each covered child, states would have less room to adjust their spending overall and would be less likely to adopt new initiatives to improve access to care or delivery of services for children. For example, states would have little incentive to increase payment rates for pediatric providers or to take advantage of innovative approaches to service delivery if doing so would have to be paid for using state-only funds.

What Would Per Capita Caps Mean for Medicaid?

The intention of imposing a per capita cap is to reduce federal Medicaid expenditures. Under a Medicaid per capita cap proposal, the federal government would set a limit on how much to reimburse states per enrollee. Unlike a block grant, a per capita cap would increase or decrease payments to states based on enrollment but would not reimburse for actual expenditures and thus not account for changes in the costs per enrollee beyond an established growth limit. Designed to achieve federal savings, the per capita growth amounts would be set below the projected rate of growth under current law.

Reauthorize CHIP and Keep the Program Strong

CHIP's coverage for children needs to be protected as it is an important means of reducing disparities and improving health outcomes for all children, including children of color. The last CHIP reauthorization extended the program through September 30, 2017. Importantly, in December 2016, the Medicaid and CHIP Payment and Access Commission (MACPAC) recommended five more years of federal funding for CHIP, calling for action "as soon as possible." MACPAC also recommended permanently extending states' authority to use Express Lane Eligibility (ELE)²⁷ to streamline and facilitate the application process. ELE reduces the burden on families applying for Medicaid and CHIP who also have applied for other safety-net programs including the Supplemental Nutrition Assistance Program (SNAP) and TANF, by using their eligibility for these programs to verify Medicaid eligibility.²⁸

Federal CHIP allotments are available to states until FY 2018. If funding for CHIP is not continued, when states exhaust their CHIP funding after FY 2017, the ACA's maintenance of effort (MOE) provision requires Medicaid-expansion CHIP programs to continue those children's Medicaid coverage through

FY 2019 at Medicaid's lower federal matching rate. States with separate CHIP programs however will not be subject to the MOE and could eliminate their programs. Congress should be urged to reauthorize CHIP and preserve coverage for the more than 8 million children in the program. Failing to do so means that states will not receive any new federal funds for CHIP beyond FY 2017, and coverage for millions of children who depend on CHIP will be lost.

Recently, there has been consideration of a plan to add provisions to restructure Medicaid as part of a separate funding renewal for CHIP (which is viewed as a must-pass bill with bipartisan support). This strategy could jeopardize both programs, threatening years of progress in increasing coverage rates for children.

Protect Medicaid Expansion in the Affordable Care Act (ACA) that Provides Coverage to Families with Incomes up to 138 percent FPL

The progress made to date in drastically reducing the uninsured rate in through expanding Medicaid in States ("expansion states") is now at stake. Policymakers should be urged to protect the ACA and specifically Medicaid expansion and its positive impacts on reducing health disparities and achieving equity for children and families of color.⁹

State expansions in Medicaid and CHIP eligibility for children have reduced the gap in coverage between children of color and white children, although the gap in coverage for adults remains significant. For parents and adults, Medicaid eligibility is more narrow and limited incomes and lack of access to employer-sponsored health insurance leave people of color more likely to be uninsured than whites. Among adults, people of color are nearly twice as likely to be uninsured than whites – 20 percent compared to 11 percent – and Hispanic adults are at greatest risk, with 27 percent uninsured.

Importantly, the ACA gave states the option to expand Medicaid coverage to low-income adults with incomes at or below 138 percent FPL (\$27,820 per year for a family of 3 in 2016), making many more people of color newly eligible for the program, ensuring greater access to coverage and care and promoting greater health equity for families. Thirty-two states, including DC, have expanded Medicaid to cover adults with low incomes, up to 138 percent FPL. Even so, blacks still lack health care coverage at disproportionate rates – recent data suggest that over 1.7 million adults of color fall into a coverage gap.³¹ A Kaiser Family Foundation study found that black adults are twice as likely to fall into the coverage gap³² as white or Hispanic uninsured adults because of where they live – a greater share of blacks live in the South where fewer states have adopted the Medicaid expansion.



Among adults, people of color are nearly twice as likely to be uninsured than whites, and Hispanic adults are at greatest risk, with one in four uninsured.

Parent's health care coverage has impacts on children's coverage and care. Low-income families with uninsured parents are three times as likely to have eligible but uninsured children as compared to families with parents covered by either private insurance or Medicaid. As we've seen in previous expansions of Medicaid coverage for parents, these efforts have led to a sizable increase in enrollment of eligible children and helped to reduce the number of uninsured children.³³ **Importantly, coverage for parents translates to improved health and economic security for families, and data show that covering parents means that more eligible children will enroll, stay enrolled and receive needed health care, including preventive care.**

The ACA also created opportunities to reduce disparities in access to care, and continue progress toward eliminating health disparities and achieving equity, including its provisions regarding the Maternal, Infant, Early Childhood Home Visiting (MIECHV) program; coverage of preventive health services; patient-centered medical homes, which create team-based, continuous and holistic care for patients; opportunities to address the social determinants of health and to establish demonstration projects to expand health professional training in cultural competency, among others.

The ACA has helped to further reduce the uninsured rate for children through awareness, outreach, and enrollment campaigns that have resulted in notable gains in coverage. In 2014, over 93 percent of children under age 6 who were eligible for Medicaid or CHIP were enrolled. Other noteworthy provisions include policy changes to increase the enrollment of children in Medicaid or CHIP by preventing states from lowering Medicaid and CHIP eligibility standards for children, requiring all states to have a minimum Medicaid eligibility level for children in families with incomes up to 138 percent of the FPL³⁴ and increasing federal funding for CHIP. While outreach and enrollment efforts have helped to significantly reduce the number of uninsured children, there is need for continued outreach, enrollment and retention efforts to ensure that eligible but unenrolled children have access to health coverage. Data suggest that Hispanic children are disproportionately uninsured and one and a half times more likely to be uninsured compared to all children.³⁵ In 2012, 66.1 percent of uninsured Hispanic children in the U.S. were eligible for either Medicaid or CHIP but not enrolled.³⁶ Policymakers must continue to advance policies that reduce barriers to coverage for children and streamline enrollment processes, including incentivizing use of ELE strategies, school-based outreach strategies to increase enrollment, and ending state waiting periods for Medicaid and CHIP among others.³⁷

A Call to Action

As policy proposals continue to put Medicaid on the chopping block, and the outlook for CHIP reauthorization and the ACA (including Medicaid expansion) remain uncertain, advocates and policy makers must be vocal about the critical importance of the coverage gains and progress to reduce health disparities made through these programs. Other CSSP briefs will highlight the role these programs play in promoting the health and wellbeing of specific populations, including young children and their families and children and youth involved in the child welfare system.



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