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Improving Coverage For Children Under Health Reform Will Require Maintaining Current Eligibility Standards For Medicaid And CHIP

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ABSTRACT When the Affordable Care Act of 2010 is fully implemented, it will extend health insurance coverage to many adult Americans who currently lack it. It is not known, however, how the health reform legislation will affect children and parents who would otherwise be uninsured. Based on our analysis, the Affordable Care Act has the potential to cut the number of uninsured children by about 40 percent, from 7.4 million to 4.2 million, and the number of uninsured parents by almost 50 percent, from 12.7 million to 6.6 million. However, the actual impact will depend on increasing the share of children and parents who are enrolled in public coverage and on other implementation outcomes. Most strikingly, if the requirement that states continue their Medicaid and Children's Health Insurance Program (CHIP) coverage is rescinded and if Congress does not continue funding CHIP, the uninsurance rate of children could more than double, increasing from 4.2 million to 7.9–9.1 million children. In that case, the uninsurance rate among children would be higher than if the Affordable Care Act had not been adopted.

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The Affordable Care Act of 2010 poses a unique set of opportunities and issues for the nation's seventy-six million children and their families. Yet to date there has not been an in-depth quantitative analysis of the law's likely impact on them. The United States has made far more progress in providing insurance coverage for children than for adults, largely through expansions in Medicaid and the Children's Health Insurance Program (CHIP). In 2010 the uninsurance rate among children was 9.8 percent—one of the lowest uninsurance rates for children during the past two decades—even as the weak economy and high unemployment rate drove the uninsurance rate of nonelderly adults up to 21.8 percent.[1] Among the children who remain uninsured, 65 percent are eligible for coverage under current Medicaid and CHIP rules but are not enrolled.[2]

The more extensive coverage provided to children under Medicaid and CHIP largely explains the disparity in uninsurance rates among children and adults. As a result of expansions adopted since the creation of the Children's Health Insurance Program in 1997, the median Medicaid and CHIP income eligibility threshold for children is 241 percent of the federal poverty level. In contrast, the median Medicaid income eligibility threshold for parents is 64 percent of poverty.[3]

With the reauthorization of CHIP in February 2009, states were given new funding and tools to sustain and expand existing coverage and to reach more eligible uninsured children.[4] Despite the fiscal challenges confronting states, most have held steady in their coverage of children, and a dozen have either expanded eligibility for coverage or introduced new enrollment or retention policies aimed at covering more children.[3]

For children, then, the impact of the Afford-

able Care Act should be assessed in part based on whether the law sustains and builds on the progress that has already been made. In addition, coverage for children and their overall health and well-being also depend on the extent to which the mental and physical health needs of their parents are met. Thus, children have a strong stake in whether the legislation improves coverage and access to care for their parents.[5]

Our analysis presents estimates of the impact of the Affordable Care Act on coverage for children and their parents. It also examines how the estimates will vary depending on the outcome of key implementation decisions and actions by states, Congress, and the administration in the months and years ahead. These include whether states will continue to be required to maintain existing Medicaid and CHIP coverage for children; whether Congress will choose to provide ongoing funding for CHIP; and the extent to which states will take action to enroll eligible children and parents in Medicaid and CHIP.

Continuation Of Coverage For Children

Under the Affordable Care Act, it is anticipated that adults and children in families with incomes below 138 percent of the federal poverty level will secure coverage through Medicaid.[6] Most adults above this income threshold will either obtain private coverage through an employer or buy it with the aid of federal subsidies through state-based insurance exchanges. Specifically, for eligible people below 400 percent of the federal poverty level, the federal government will provide a tax credit to support the purchase of an insurance plan through an exchange. If people have an "affordable" coverage option, they are expected to buy insurance or face a penalty.

The structure, however, will be different for many children in families with incomes of 138–400 percent of poverty, largely because far more of them are expected to continue to secure insurance through Medicaid or CHIP. During the creation of the Affordable Care Act, Congress debated whether it would be better to keep these children enrolled in Medicaid and CHIP or to move them into exchange plans. Ultimately, Congress chose to require states to maintain their existing Medicaid and CHIP eligibility for children through 2019.[7] Congress also extended federal funding for CHIP through the end of fiscal year 2015.[8]

Many governors and some members of Congress now are calling for repeal of "maintenance of effort" requirements, which would allow states to roll back coverage for children under Medicaid or CHIP to 138 percent of poverty (the minimum federal standard).[9]

If Medicaid and CHIP coverage in this income range is allowed to lapse—that is, for children in families with incomes of 138–400 percent of the federal poverty level—some of these children will be eligible for federal subsidies to defray the costs of private coverage purchased through the exchanges. Others may be excluded from subsidized coverage bought through exchanges based on a parent's access to employer-based insurance.

This is a greater possibility in light of recently proposed regulations[10] that would exclude dependents from eligibility for subsidized exchange coverage if an adult in the family has employee-only coverage that is deemed "affordable." (Under the Affordable Care Act, *affordable coverage* is defined as consuming less than 9.5 percent of family income.) As a result, some parents may be expected to spend well in excess of 9.5 percent of their income to secure coverage for themselves and their children.[11]

Under either scenario, the cost to families of securing coverage for their children would be markedly higher than enrolling in Medicaid or CHIP, which would increase the risk that children would go without coverage.[12] The prospect that the maintenance-of-effort provisions could be repealed make it important to assess what would happen if Medicaid and CHIP coverage were discontinued for children in families above 138 percent of poverty.

If Congress does not act to fund CHIP past fiscal year 2015, states with separate CHIP programs could be expected to stop enrolling children. This is because the Affordable Care Act retains state authority to end these programs if they run out of federal matching funds. (States that operate CHIP-financed Medicaid expansions are required to revert to using Medicaid funds if they run out of federal CHIP funds.) Particularly in light of the intense fiscal pressures facing the federal government, it is important to evaluate the impact of the legislation on children's coverage with and without continued funding for CHIP.

Effectiveness Of Enrollment Efforts

A key determinant of the Affordable Care Act's impact on children will be whether it increases coverage under public programs for poor and near-poor parents and the two-thirds of uninsured children who already are eligible for Medicaid or CHIP but not enrolled. To this end, the law requires states to create "no wrong door" enrollment systems under which families are screened and evaluated for Medicaid, CHIP, and subsidy eligibility, regardless of whether

they initially apply through an exchange or a public program.

States also must adopt streamlined application and enrollment procedures that allow families to apply for coverage online, by phone, or through the mail, relying on technology to verify information to the maximum extent possible. Finally, the law includes some funding for outreach and requires exchanges to support "navigators" that can help people assess their coverage options.

For children, these provisions and how they are implemented are particularly important. The reason is that as many as twenty million children live in situations that may make obtaining health insurance difficult because of within-family variation in eligibility for coverage. For example, children may be eligible for Medicaid or CHIP while their parents are not, because of different income eligibility thresholds for adults and children or differences in citizenship and documentation status among family members.[13]

As outlined in more detail below, our analysis highlights the fact that the impact of the Affordable Care Act on coverage of children and their parents will depend heavily on how these key policy areas are addressed. Our results indicate that the Affordable Care Act has the potential to cut the number of uninsured children and parents by almost half. However, gains in coverage will depend on the take-up rates of Medicaid and CHIP among eligible children and parents. Moreover, children's coverage might not improve and might even deteriorate, particularly if CHIP funding were allowed to lapse and Medicaid coverage for children were rolled back.

Study Data And Methods

Our analysis used a microsimulation model to derive estimates at baseline and under the Affordable Care Act of insurance coverage and Medicaid and CHIP eligibility for children and parents. The model allowed for variation in assumptions about key implementation choices and outcomes.

The Urban Institute Health Policy Center's Medicaid and CHIP Eligibility Simulation Model, which underlay the estimates, is based on the 2010 and 2009 March supplements to the Current Population Survey. An important policy variable that the analysis considered was the effect on children in separate, stand-alone CHIP programs of allowing CHIP funding to lapse after fiscal year 2015. We derived estimates of the share of children in families with incomes above 138 percent of the poverty level with Medicaid and CHIP who are enrolled in separate CHIP programs, based on the income data that are available through the survey.[14]

We used the Urban Institute's Health Insurance Policy Simulation Model to estimate the effects of health reform on children and their parents.[15] The model simulated the decisions of businesses and individuals in response to policy changes such as Medicaid expansions, subsidies for the purchase of health insurance, and insurance market reforms. The model included estimates of the health care costs for individuals, so that once coverage was simulated, the spending impact of a given policy on the government, employers, and families could be computed. We simulated the main coverage provisions of the Affordable Care Act as if they were fully implemented in 2011 and compared the results to the model's prereform baseline results for 2011.

We estimated impacts under two alternative implementation scenarios. First, federal CHIP funding was allowed to lapse, resulting in states' elimination of separate CHIP programs. Second, the Affordable Care Act requirement to continue current Medicaid and CHIP coverage for children was discontinued, allowing states to scale back coverage of children to those in families at 138 percent of poverty.

We examined the sensitivity of the results for children to different assumptions about the extent to which children losing CHIP and Medicaid coverage would gain employer or exchange coverage. We estimated one scenario with low take-up and another scenario with high take-up of employer and exchange coverage. Under the first scenario, parents would purchase family coverage only if they found it affordable. In contrast, under the second scenario, parents would be willing to relax their normal standard of affordability in order to provide coverage for their children. Differences in take-up rates would clearly have meaningful effects on the projected coverage impacts (see the online Appendix for details).[16]

For this analysis, our model assumed that dependents would not incur mandate penalties if the lowest available family premiums were above 8 percent of income.[17]

The model predicted that Medicaid and CHIP participation would increase for both children and parents under the reform legislation. CHIP participation rates were projected to increase by more than Medicaid rates because so many CHIP-eligible children are in families that could face penalties under the Affordable Care Act's individual mandate. In contrast, more of the Medicaid-eligible families have incomes below the tax-filing limits and would not be subject to penalties under the individual mandate provision. The model also predicted increased participation among parents relative to participation before the Affordable Care Act but lower

participation rates for parents than for children, which is consistent with existing patterns.

Under our Affordable Care Act simulation, the affordability exemption to the mandate was based on the lowest premium for single (as opposed to family) coverage faced by the adults in a family, which must be at least 8 percent of the family's modified adjusted gross income in order to qualify for an exemption. Thus, only single premiums, not family premiums, were used in determining eligibility for exchange subsidies.

Changes in uninsurance rates were examined by income (less than 138 percent of poverty; 138–250 percent of poverty, which is the upper limit on CHIP eligibility in many states; 251–400 percent of poverty; and above 400 percent of poverty); race or ethnicity (white, non-Hispanic; black, non-Hispanic; Hispanic; and other); age (0–5 years; 6–12 years; and 13–18 years); citizenship status of members of the health insurance unit—in which everyone can be covered under a single insurance product (all citizens; a mix of citizens and noncitizens; and all noncitizens); and affordability exemption (at least one parent would be exempt from the mandate, and all parents would fail to qualify for an exemption from the mandate).

Limitations

This analysis has a number of limitations. First, we estimated the number of children covered by Medicaid and CHIP, overall and by program type, in families with incomes above 138 percent of poverty. To the extent that we have understated or overstated the number of children in these coverage categories, our estimates of the impacts of discontinuing Medicaid and CHIP coverage in that income range will also be understated or overstated. In particular, the results are sensitive to assumptions made about the children who were classified as having Medicaid and CHIP coverage but who had no identifiable eligibility pathway. Moreover, the impacts of the Affordable Care Act's mandate structure on children's coverage are difficult to assess.

This analysis relied on a Medicaid and CHIP simulation model based on data from 2008 and 2009. Thus, to the extent that underlying parameters have changed, both the baseline and the estimated impacts of the Affordable Care Act would change as well. In particular, several states expanded eligibility for CHIP in late 2009 or 2010, which could lead to even greater reductions in uninsurance for children and greater impacts associated with eliminating the requirement to continue Medicaid and CHIP coverage above 138 percent of poverty than suggested by the estimates presented here.

Full implementation of the Affordable Care Act is projected to cut the uninsurance rate for children by more than 40 percent.

In addition, the estimates presented here assumed that families did not qualify for exchange subsidies as long as the premium for single, employee-only coverage consumed less than 9.5 percent of income. If eligibility for exchange subsidies was determined exclusively by this method, fewer children would be eligible for exchange subsidies than if eligibility for subsidies were based on the costs of family coverage.

This policy choice would probably have much greater ramifications for children in the event that Medicaid and CHIP coverage were pulled back for children with family incomes above 138 percent of poverty. In future research, it will be important to fully consider the implications of alternative interpretations of the affordability test under the Affordable Care Act on children's uninsurance rates and on the financial burdens associated with obtaining family coverage.

Study Results

UNINSURANCE AMONG CHILDREN UNDER REFORM

The number of uninsured children is projected to drop from 7.5 million to 4.2 million under full implementation of the Affordable Care Act relative to what coverage would look like without the legislation (Exhibit 1). Coverage gains for children under the Affordable Care Act will be driven in large part by increases in Medicaid and CHIP coverage and by new coverage provided through the health insurance exchanges, although a slight increase in employer-sponsored insurance coverage is also projected (Exhibit 2).

The projected reduction in uninsurance among children depends on achieving a Medicaid and CHIP participation rate for children of 92.7 percent under the act. To the extent that Medicaid and CHIP participation is higher or lower than this level nationally, the coverage gains for children will be higher or lower than projected.

Among the 4.2 million children who would

EXHIBIT 1

Number And Characteristics Of Children Who Are Uninsured At Baseline And Under Alternative Affordable Care Act (ACA) Implementation Scenarios

					ACA implementation: alternative scenarios							
					CHIP funding allowed to lapse[b]				Maintenance-of-effort requirement repealed[c]			
	Without the ACA		With the ACA[a]		Lower ESI/ exchange take-up[d]		Higher ESI/ exchange take-up[e]		Lower ESI/ exchange take-up[d]		Higher ESI/ exchange take-up[e]	
	Millions	%	Millions	%	Millions	%	Millions	%	Millions	%	Millions	%
Total uninsured	7.50	100.0	4.22	100.0	6.59	100.0	5.97	100.0	9.09	100.0	7.94	100.0
Eligible for public coverage	4.90	65.3	2.26	53.4	2.00	30.4	1.99	33.4	1.90	20.9	1.90	23.9
Undocumented immigrant	0.71	9.5	0.64	15.1	0.68	10.4	0.68	11.4	0.70	7.7	0.69	8.7
Other	1.89	25.2	1.33	31.5	3.90	59.2	3.30	55.3	6.49	71.4	5.34	67.3
Family exempt[f]	—[g]	—[g]	0.26	6.2	1.00	15.2	0.90	15.0	1.58	17.4	1.40	17.6
Family not exempt[h]	—[g]	—[g]	1.07	25.3	2.90	44.0	2.40	40.2	4.90	53.9	3.95	49.7

SOURCE Urban Institute's Health Insurance Policy Simulation Model, 2011. **NOTES** CHIP is Children's Health Insurance Program. ESI is employer-sponsored insurance. [a]We simulated the provisions of the ACA as fully implemented in 2011, including the continuation of Medicaid/CHIP coverage of children in families above 138 percent of poverty. [b]These simulation estimates represent full implementation of the ACA in 2011 but with the discontinuation of separate CHIP programs as a result of the loss of federal funding. [c]These simulation estimates represent full implementation of the ACA in 2011 but with the discontinuation of Medicaid/CHIP Programs above 138 percent of poverty as a result of the rescission of the maintenance-of-effort requirement for states to maintain their Medicaid/CHIP coverage through 2019 for children. [d]With lower ESI/exchange take-up, affordability of family coverage is the most important factor for insured parents as they decide whether or not provide coverage for their children (see Appendix; Note 16 in text). [e]With higher ESI/exchange take-up, parents with coverage place a high priority on insuring their children even when faced with expensive dependent coverage options (see Appendix; Note 16 in text). [f]At least one parent in the health insurance unit qualifies for an affordability exemption. [g]Categories were created under the ACA and do not exist at baseline. [h]Both parents in the health insurance unit fail to qualify for an affordability exemption.

remain uninsured, more than half would be eligible for Medicaid or CHIP but not enrolled; 15 percent would be ineligible because of their immigration status; and the remaining 32 percent would be in families that could enroll in employer-based or exchange coverage but do not do so for cost or other reasons (Exhibit 1). Of these children, 80 percent (25 percent of all remaining uninsured children) would be in families bound by the mandate and subject to penalties, and 20 percent (6 percent of all remaining uninsured children) would be in families that would not be subject to mandate penalties because they would lack access to an "affordable" coverage option.

Full implementation of the Affordable Care Act is projected to cut the uninsurance rate for children by more than 40 percent, reducing it from 9.4 percent to 5.3 percent (Exhibit 2). Uninsurance rates are projected to decline for children in each income, race or ethnicity, age, and family citizenship group. The steepest decline in uninsurance rates is projected to occur among children in families with incomes of 138–250 percent of poverty. This decline can be attributed to increased take-up of Medicaid and CHIP coverage among already eligible children, the new subsidized exchange coverage, and the coverage effect of the individual mandate.

Among children of different races or ethnicities, Hispanic children are projected to see the largest gains in coverage under the health reform legislation, but they continue to be uninsured at substantially higher rates than other children (9.6 percent for Hispanic children versus 3.5 percent for white, non-Hispanic children and 5.1 percent for black, non-Hispanic children). Children living in families whose members are not citizens are projected to have the highest uninsurance rates under the Affordable Care Act: 27.8 percent. This is due in large part to the more restrictive eligibility for Medicaid, CHIP, and exchange subsidies for noncitizens under the act.

Under full implementation of the Affordable Care Act, 95 percent of children are projected to have health insurance coverage: 41 percent through Medicaid and CHIP, 5 percent through some type of exchange coverage, and 47 percent through employer-sponsored coverage outside the exchange (Exhibit 3).

CHILDREN ABOVE 138 PERCENT OF POVERTY If funding were not provided for CHIP after fiscal year 2015 or if the requirement to continue Medicaid and CHIP coverage of children through 2019 were eliminated, the number of uninsured children would be much higher than under our core set of estimates, which assumed the con-

EXHIBIT 2

Uninsurance Rates Among Children At Baseline And Under Alternative Affordable Care Act (ACA) Implementation Scenarios

			ACA implementation: alternative scenarios			
			CHIP funding allowed to lapse		Maintenance-of-effort requirement repealed	
	Without the ACA	With the ACA	Lower ESI/ exchange take-up	Higher ESI/ exchange take-up	Lower ESI/ exchange take-up	Higher ESI/ exchange take-up
Total	9.4%	5.3%	8.3%	7.5%	11.4%	9.9%
INCOME AS PERCENT OF POVERTY						
Less than 138	13.6	8.3	8.3	8.3	8.3	8.3
138–250	12.1	4.2	17.7	14.1	26.9	21.2
251–400	7.2	4.5	6.6	6.2	11.0	9.8
More than 400	3.7	2.8	2.9	2.9	5.0	4.4
RACE/ETHNICITY						
White, non-Hispanic	6.6	3.5	5.7	5.1	8.5	7.2
Black, non-Hispanic	9.4	5.1	8.2	7.6	11.7	10.4
Hispanic	16.2	9.6	14.5	13.3	18.3	16.4
Other	9.1	5.2	7.8	7.0	10.7	9.2
AGE (YEARS)						
0–5	8.1	4.3	6.8	6.2	10.7	9.2
6–12	8.8	4.5	7.7	6.9	10.5	9.2
13–18	11.4	7.1	10.4	9.4	13.1	11.6
FAMILY CITIZENSHIP STATUS						
All citizens	7.6	4.2	6.5	5.9	9.4	8.1
Mixed (citizens and noncitizens	13.2	6.9	12.4	11.0	16.4	14.2
All noncitizens	34.1	27.8	30.4	29.8	33.1	31.7

SOURCE Urban Institute's Health Insurance Policy Simulation Model, 2011. **NOTES** Details on the simulations are available in Exhibit 1. CHIP is Children's Health Insurance Program. ESI is employer-sponsored insurance.

tinuation of CHIP and Medicaid coverage for children (Exhibit 1). Without an extension of CHIP funding, states would be expected to eliminate their separate CHIP programs. We estimated that if all states eliminated their separate CHIP programs, this would mean an additional 1.8–2.4 million uninsured children, compared to our estimates of continued separate CHIP coverage under the Affordable Care Act.

If policy makers allowed states to discontinue both CHIP and Medicaid coverage for children in families above 138 percent of poverty by rescinding the maintenance-of-effort requirements, the effect would be even more dramatic. Instead of cutting the number of uninsured children by more than 40 percent, an estimated 7.9–9.1 million children would be uninsured. This range is higher than the estimated number of uninsured children if the Affordable Care Act had not been adopted. Thus, our estimates indicate that without the continuation of Medicaid and CHIP for children in families above 138 percent of poverty, the legislation could increase uninsurance among children by between 400,000 and 1.6 million, relative to current levels.

Similarly, the uninsurance rate for children would be much higher under the Affordable Care Act if CHIP and Medicaid coverage were not continued as currently envisioned. Uninsurance rates among children in families with incomes of 138–250 percent of poverty could jump to 14.1 percent or higher (Exhibit 2). This is much higher than the rate of 4.2 percent that would prevail under the act if CHIP and Medicaid coverage continue. It also is above the uninsurance rate of 12.1 percent that would apply if the legislation had never been enacted.

Children in each race or ethnicity, age, and family citizenship group studied would also experience higher uninsurance rates if CHIP and Medicaid coverage were discontinued for children in families above 138 percent of poverty, despite the availability of exchange or employer-based coverage for many of them.

There are a number of reasons why so many of the children who would lose Medicaid and CHIP coverage would not gain employer-based or exchange coverage. First, many of them have parents who are projected to be uninsured under the Affordable Care Act, which means that the marginal costs of covering the children through

EXHIBIT 3

Children's Coverage Status Under Alternative Affordable Care Act (ACA) Implementation Scenarios

					ACA implementation: alternative scenarios							
					CHIP funding allowed to lapse				Maintenance-of-effort requirement repealed			
	Without the ACA		With the ACA		Lower ESI/ exchange take-up		Higher ESI/ exchange take-up		Lower ESI/ exchange take-up		Higher ESI/ exchange take-up	
	Millions	%	Millions	%	Millions	%	Millions	%	Millions	%	Millions	%
Insured	72.32	90.6	75.60	94.7	73.23	91.7	73.85	92.5	70.74	88.6	71.88	90.1
Employer (nonexchange)	39.67	49.7	37.76	47.3	38.69	48.5	38.90	48.7	39.60	49.6	40.08	50.2
Employer (exchange)	0.00	0.0	1.91	2.4	2.03	2.5	2.17	2.7	2.08	2.6	2.25	2.8
Nongroup (nonexchange)	2.82	3.5	0.38	0.5	0.39	0.5	0.42	0.5	0.40	0.5	0.45	0.6
Nongroup (exchange)	0.00	0.0	2.04	2.6	3.13	3.9	3.37	4.2	3.90	4.9	4.34	5.4
Medicaid/CHIP	28.81	36.1	32.49	40.7	27.98	35.1	27.98	35.1	23.74	29.7	23.74	29.7
Other (including Medicare)	1.01	1.3	1.01	1.3	1.01	1.3	1.01	1.3	1.01	1.3	1.01	1.3
Uninsured	7.50	9.4	4.22	5.3	6.59	8.3	5.97	7.5	9.09	11.4	7.94	9.9
Total	79.82	100.0	79.82	100.0	79.82	100.0	79.82	100.0	79.82	100.0	79.82	100.0

SOURCE Urban Institute's Health Insurance Policy Simulation Model, 2011. **NOTES** Details on the simulations are provided in Exhibit 1. CHIP is Children's Health Insurance Program. ESI is employer-sponsored insurance.

either employer-based or exchange coverage would be high compared to any additional penalties that the families would face for not covering the children.

Second, children in families whose parents are covered by employer-based single policies that cost less than 9.5 percent of family income would be ineligible for subsidized coverage in the exchanges. Employer-based family coverage would be much more expensive than the single policies that the parent or parents currently have, particularly if the employer did not contribute toward dependent coverage. Many affected children live in families with incomes of 138–300 percent of poverty, who would probably consider employer-based family coverage unaffordable.

Third, although many of the children losing Medicaid or CHIP coverage do not live in families that would qualify for exchange subsidies, those who do would probably gain exchange coverage at high rates but would face higher premiums and cost sharing than currently prevails under CHIP and Medicaid. Thus, take-up would be lower than with CHIP or Medicaid.

DISCONTINUING CHIP Discontinuing separate CHIP coverage for children in families above 138 percent of poverty would lower government spending on the program. If federal funding for CHIP were allowed to lapse, the federal government would spend $8.2 billion less, and the states, $3.7 billion less.

Although federal and state spending on CHIP would be lower, federal and state spending would rise in other areas, and families would pay a high share of their children's health care expenses. Because some CHIP enrollees would end up in subsidized exchange coverage, federal subsidies would increase by $1.0–$1.2 billion. Moreover, the shift of children out of separate CHIP coverage and toward exchange coverage, employer-sponsored insurance, and uninsurance would lead to increases of $3.4 billion in additional financial burdens on families with children, $400 million in additional employer costs, and $2.0 billion in additional government spending on uncompensated care (data not shown).

UNINSURANCE AMONG PARENTS Under full implementation of the Affordable Care Act, the number of uninsured parents is projected to drop by close to 50 percent, from 12.7 million to 6.6 million (Exhibit 4). These gains in coverage are primarily because of the Medicaid expansion (in many states, income-based eligibility thresholds for adult parents are set at low levels) and subsidized coverage in an exchange (Exhibit 5). The individual mandate would also lead to slightly higher coverage under employer-sponsored insurance.

Of the 6.6 million parents who would remain uninsured, 38.2 percent would be eligible for Medicaid or CHIP but not enrolled, 38.1 percent would not be eligible for coverage because of

EXHIBIT 4

Uninsurance Among Parents: Number, Rate, And Characteristics At Baseline And Under The Affordable Care Act (ACA)

	Without the ACA		With the ACA[a]	
	Millions	%	Millions	%
Coverage category				
Total uninsured	12.67	100.0	6.62	100.0
Eligible for public coverage	3.23	25.5	2.52	38.2
Undocumented immigrant	2.83	22.3	2.52	38.1
Other	6.62	52.2	1.57	23.8
Exempt from mandate	—[b]	—[b]	0.26	4.0
Bound by mandate	—[b]	—[b]	1.31	19.8
Uninsurance rate	—[b]	18.5	—[b]	9.7
Less than 138 percent of poverty	—[b]	41.6	—[b]	26.7
138–250 percent of poverty	—[b]	27.5	—[b]	11.0
251–400 percent of poverty	—[b]	10.9	—[b]	4.8
More than 400 percent of poverty	—[b]	4.4	—[b]	1.4

SOURCE Urban Institute's Health Insurance Policy Simulation Model, 2011. [a]We simulated the provisions of the Affordable Care Act as fully implemented in 2011, including the continuation of Medicaid/CHIP coverage of children in families above 138 percent of poverty. [b]Categories were created under the Affordable Care Act and do not exist at baseline.

their immigration status, and 23.8 percent either would be bound by the mandate and subject to penalties (19.8 percent) or would not be bound by the mandate and would qualify for hardship exemptions from the penalties (4.0 percent). The Affordable Care Act is projected to cut the uninsurance rate for parents nearly in half: from 18.5 percent to 9.7 percent.

As with children, the number of uninsured parents could be much higher or lower, depending on the Medicaid participation rate that prevails under the legislation. The Affordable Care Act is projected to decrease the uninsurance rate among parents in all four income groups that are examined. It has the effect of narrowing differences in uninsurance rates among parents across income levels. However, even after full implementation, 26.7 percent of parents with incomes under 138 percent of poverty are projected to be without coverage.

Discussion

By increasing access to affordable health care for both children and their parents, the Affordable Care Act has the potential to greatly improve the lives of children. Under full implementation of the act, including the continuation of CHIP and Medicaid coverage for children in families above 138 percent of poverty, the number of uninsured children is projected to fall to 4.2 million—a decrease of 3.2 million. The number of uninsured children would decline even further if participation in Medicaid and CHIP coverage for

EXHIBIT 5

Parents' Coverage Status At Baseline And Under The Affordable Care Act (ACA)

	Without the ACA		With the ACA[a]	
Coverage category	Millions	%	Millions	%
Insured	55.83	81.5	61.89	90.3
Employer (nonexchange)	44.26	64.6	43.00	62.8
Employer (exchange)	0.00	0.0	3.09	4.5
Nongroup (nonexchange)	3.16	4.6	0.59	0.9
Nongroup (exchange)	0.00	0.0	4.63	6.8
Medicaid/CHIP	6.91	10.1	9.09	13.3
Other (including Medicare)	1.50	2.2	1.50	2.2
Uninsured	12.67	18.5	6.62	9.7
Total	68.51	100.0	68.51	100.0

SOURCE Urban Institute's Health Insurance Policy Simulation Model, 2011. [a]We simulated the provisions of the Affordable Care Act as fully implemented in 2011, including the continuation of Medicaid/CHIP coverage of children in families above 138 percent of poverty.

Children have much to lose if efforts to simplify enrollment are lackluster.

children under the act exceeded 92.7 percent nationally. An even larger impact on coverage is projected among parents, reducing uninsurance among them by more than six million, which is expected to have a number of positive spillover effects on children's lives.

At the same time, the results of our analysis demonstrate that the Affordable Care Act's impact on children and their parents is highly dependent on important policy choices. Of particular note is the fact that exchanges and related subsidies as currently designed might not provide an adequate "backup" source of coverage if CHIP and Medicaid for children in families above 138 percent of poverty is disrupted.

If public coverage in this income range were allowed to lapse, some of these children would be eligible for exchange subsidies, but many others might be excluded based on a parent's access to employer-based insurance. If this occurred, uninsurance among children would decline by much less under the act and could, in fact, increase.

Although government outlays would be lower without the continuation of Medicaid and CHIP coverage for children in families above 138 percent of poverty, millions of additional children would be uninsured. Moreover, for the children who maintained coverage but switched from CHIP or Medicaid into an exchange plan or an employer policy, financial burdens would be higher for their families. In addition, they would probably have a less comprehensive benefit package and face higher cost sharing than under their current coverage.[12]

The coverage effects of the Affordable Care Act will also be heavily dependent on the degree to which Medicaid and CHIP programs achieve high rates of coverage. Even before the enactment of the legislation, states had made great strides in enrolling eligible children in coverage. Higher participation rates than modeled here have already been achieved in Arkansas, the District of Columbia, and Massachusetts.[18] Now the issues are whether other states will build on these gains to create the simple, streamlined enrollment systems envisioned in the act and whether they can make comparable progress for adults.

States' current fiscal challenges and the political controversy surrounding implementation of the Affordable Care Act may make it harder to achieve this goal. Children will continue to be more likely to be eligible for Medicaid and CHIP than adults and often will reside in families with mixed coverage status. Given these realities, children have much to lose if efforts to simplify enrollment and offers to help people enroll are lackluster, and the most to gain if states succeed in these efforts.

Although exchange subsidies are substantial for families with incomes of 138–200 percent of poverty, exchange enrollees in this income range would still face average premium costs of about $1,200 and out-of-pocket cost sharing of about $400 each year, according to our estimates. The Basic Health Program option would allow states to provide coverage comparable to Medicaid or CHIP for such families using federal funding.[19] If current Medicaid and CHIP eligibility for children were maintained, this program would largely be an adult program. But without maintenance of Medicaid and CHIP coverage for children, it could become an important source of affordable family coverage.

Conclusion

The Affordable Care Act has the potential to cut the number of uninsured children and parents by more than 40 percent; however, success is not assured. As implementation of the legislation moves forward, states, Congress, and the administration will make a number of key decisions that will determine whether that potential is reached. If CHIP is not financed beyond 2015 and if Medicaid coverage for children is not maintained for children in families with incomes above 138 percent of poverty, reform could unravel the success that this nation has had in covering children. ■

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NOTES

1 DeNavas-Walt C, Proctor B, Smith J. Income, poverty, and health insurance coverage in the United States: 2010. Washington (DC): Census Bureau; 2011.

2 Kenney G, Lynch V, Cook A, Phong S. Who and where are the children yet to enroll in Medicaid and the Children's Health Insurance Program? Health Aff (Millwood). 2010;29(10):1920–9.

3 Heberlein M, Brooks T, Guyer J, Artiga S, Stephens J. 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, 2010–2011. Washington (DC): Georgetown University Center for Children and Families, Kaiser Commission on Medicaid and the Uninsured; 2011.

4 Georgetown University Center for Children and Families. The Children's Health Insurance Program Reauthorization Act of 2009: overview and summary. Washington (DC): The Center; 2009.

5 Kenney G, Pelletier J. How will the Patient Protection and Affordable Care Act of 2010 affect children? Washington (DC): Urban Institute; 2010.

6 A standard disregard of 5 percent will be applied.

7 Specifically, the Affordable Care Act requires states to maintain the Medicaid and CHIP eligibility rules and enrollment procedures in effect on March 23, 2010, for children through 2019.

8 Starting October 1, 2015, states are slated to receive an increase of twenty-three percentage points in their CHIP matching rate if new federal funding becomes available.

9 State Flexibility Act, S. 868, 112th Cong., 1st Sess. (2011).

10 Department of the Treasury. Health insurance premium tax credit. Fed Regist. 2011;76(159):50931–49.

11 There is controversy over whether the Affordable Care Act requires the use of an employee-only affordability test when assessing whether families are eligible for exchange subsidies. A proposed rule issued by the Department of the Treasury in August 2011 adopts this interpretation (as did the Joint Committee on Taxation in its modeling of the impact of the Affordable Care Act). Analysts have argued that the law could be read as excluding families from exchange subsidies only if the cost of family-based insurance (rather than employee-only insurance) is less than 9.5 percent of income. For purposes of this analysis, we followed the Joint Committee on Taxation's assumption that the employee-only test applies, but this issue is the subject of further work and analysis (see Note 10).

12 Watson Wyatt Worldwide. Implications for health care reform for children currently enrolled in CHIP programs [Internet]. Washington (DC): Watson Wyatt Worldwide; 2009 [cited 2011 Nov 15]. Available from: http://www.firstfocus.net/sites/default/files/r.2009-10.1.watson.pdf

13 McMorrow S, Kenney G, Coyer C. Addressing coverage challenges for children under the Affordable Care Act. Washington (DC): Urban Institute; 2010.

14 The analysis takes into account the fact that children in families below 138 percent of poverty in separate CHIP programs will move into Medicaid when the Affordable Care Act requirement to provide Medicaid up to 138 percent of poverty goes into effect.

15 More about the Urban Institute's Health Insurance Policy Simulation Model and additional details on the methods are provided in the Appendix (see Note 16).

16 To access the Appendix, click on the Appendix link in the box to the right of the article online.

17 The preamble of the Internal Revenue Service premium tax credit regulation states that future proposed regulations are expected to rely on the family-based affordability test in applying the individual responsibility requirement to related individuals (see Note 10).

18 Kenney G, Lynch V, Haley J, Huntress M, Resnick D, Coyer C. Gains for children: increased participation in Medicaid and CHIP in 2009. Washington (DC): Robert Wood Johnson Foundation and Urban Institute; 2011.

19 Dorn S, Buettgens M, Carroll C. Using the Basic Health Program to make coverage more affordable to low-income households: a promising approach for many states. Washington (DC): Urban Institute; 2011.

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In this month's *Health Affairs*, Genevieve Kenney, Matthew Buettgens, Jocelyn Guyer, and Martha Heberlein report on their study of the impact of the Affordable Care Act on reductions in the number of uninsured children and their parents.

They found that the law, when fully implemented, could reduce the number of uninsured children by 40 percent and the number of uninsured parents by almost 50 percent. However, these outcomes will be highly dependent on other actions—for example, on whether the legal requirement remains in place that states maintain their current eligibility standards for children. If it doesn't, the uninsurance rate among children would be higher than if the Affordable Care Act had not been enacted.

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