Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize Gains and Prevent Harm?

Timely Analysis of Immediate Health Policy Issues

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Summary

Moving toward universal coverage has the potential to increase access to care and improve the health and well-being of uninsured children and adults. The effects of health care reform on the more than 25 million children who currently have coverage under Medicaid or the Children's Health Insurance Program (CHIP) are less clear. Increased parental coverage will help these children since many have uninsured parents with unmet health needs. However, proposals to move children from Medicaid and CHIP into a new health insurance exchange could make these children worse off through the potential loss of benefits and legal protections and possible exposure to higher cost-sharing. At the same time, if reimbursement rates are higher in the exchange than paid under Medicaid and CHIP, children's access to providers could improve.

Medicaid and CHIP cover vulnerable groups of children who are at higher risk for worse health outcomes than other children. Children with public coverage are disproportionately likely to be poor, to belong to racial or ethnic minority groups, to have parents with limited English proficiency, and to have chronic health care problems. Medicaid and CHIP cover nearly half of African-American and Latino children and more than a third of children with special health care needs.

While both public and private coverage fall short in meeting children's needs, public coverage has been more effective than private coverage at providing preventive care to low-income children. No existing research documents the effectiveness of so-called "wrap-around" benefits in supplementing children's coverage offered by private plans. Policymakers should therefore proceed with caution before moving publicly covered children into an exchange that depends on a system of wrap-around coverage that has never been rigorously evaluated. Any movement of Medicaid and CHIP children into an exchange should be tested with demonstration projects to allow careful evaluation before implementing on a large scale. In the meantime, it will be important to improve access to care, quality, and outcomes for the millions of low-income children with Medicaid and CHIP (for example, by raising reimbursement rates in Medicaid).

Ideally health care reform would take positive steps to promote the emotional, cognitive, and physical health of children, enabling them to reach their full potential. Such a focus would draw attention to policy changes that could remedy deficits in the current system and reduce disparities in access, quality, and outcomes.

Introduction

Plans to overhaul our nation's health care system are gaining momentum. Both houses of Congress are drafting health reform bills, and the president has identified health care reform as a top domestic policy priority for his first year in office. The broad goals of these health care reform proposals include moving the nation toward universal coverage, improving quality of care, and slowing the rate of health care cost growth. Detailed proposals have not yet been made public. However, available information suggests that reforms are likely to involve new subsidies for health insurance coverage, new enrollment approaches, some type of mandate for coverage and the creation of a health insurance exchange. A health insurance exchange would provide an organized health insurance market for the uninsured and others that would be more efficient and transparent relative to the current market for private insurance.[1] Options under consideration that specifically pertain to children with public coverage include shifting individuals who currently have Medicaid and CHIP into commercial plans participating in the new exchange, perhaps with supplemental coverage from Medicaid or CHIP; increasing provider reimbursement rates under Medicaid and CHIP; and expanding Medicaid to additional parents and children.[2]

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Low-income children have much riding on the outcome of health care reform. On the one hand, health care reform has the potential to reduce uninsurance among children, which in turn should expand their access to needed care and improve their health outcomes.[3] Likewise, if reform decreases uninsurance rates among parents, more of their health care needs will be met, which should improve their children's health and well-being.[4] On the other hand, if children with Medicaid and CHIP are shifted into commercial plans participating in the new exchange, the impacts on their access to care and health outcomes are not clear a priori since Medicaid and CHIP coverage differ from private coverage in several important ways. The effects will likely depend on what happens to covered benefits, the standard used to determine medical necessity, cost sharing requirements, and provider access and networks. The impacts will also likely depend on which children are shifted into commercial plans and on the health status and circumstances of the individual child, including the presence of special health care needs and the family's financial capacity.

This brief provides background information on current coverage and access to care for low-income children and considers the potential implications of shifting children with public coverage into exchange plans. It closes with a discussion of how health care reform could be structured to take these implications into account.

Considering health care reform through the lens of how it might affect children is critically important. Improving the developmental trajectories and health behaviors of children and adolescents could yield large potential payoffs in the form of better health and functioning and lower chronic disease burdens during both childhood and adulthood.[5]

Background

Uninsurance. As indicated above, one of the chief aims of health care reform is to move closer to universal coverage. However, achieving universal coverage would have a more profound impact on non-elderly adults than on children. Non-elderly adults are twice as likely as children to lack health insurance; among low-income families, uninsurance is 2.5 times as likely for adults as for children (table 1). As a consequence, non-elderly adults constitute 82 percent of all the uninsured.[6] Children have lower uninsured rates than adults due to much broader Medicaid/CHIP eligibility for children.[7]

Table 1. Health Insurance Coverage of Adults and Children, 2007

	All				Income Less than 200% FPL			
	Children, 0-18		Adults, 19-64		Children, 0-18		Adults, 19-64	
	(millions)	%	(millions)	%	(millions)	%	(millions)	%
Total	78.6	100.0%	182.8	100.0%	33.6	100.0%	57.5	100.0%
Medicaid/CHIP	25.1	31.9%	14.6	8.0%	19.6	58.3%	11.6	20.2%
ESI/other	45.8	58.2%	132.0	72.2%	8.7	25.8%	22.7	39.5%
Uninsured	7.8	9.9%	36.1	19.8%	5.4	15.9%	23.2	40.3%

Source: Urban Institute Health Policy Center tabulations of the 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS). Estimates reflect an adjustment for the underreporting of public coverage on the CPS.

While children have higher coverage rates than adults, millions of children remain uninsured. They could gain health insurance under health care reform, increasing their access to needed care. Over two-thirds of uninsured children are already eligible for Medicaid or CHIP, and the vast majority have parents who say they would enroll their children in public programs if they were eligible.[8] Thus, addressing barriers to enrollment and retention in public programs will be essential to achieving universal coverage for children. Achieving that goal will also require affordable coverage options for the families with uninsured children whose incomes are too high to qualify for CHIP but who lack access to employer-sponsored insurance.[9]

Children would also benefit if health care reform increases their parents' health insurance coverage. It is expected that uninsured children will be more likely to enroll in coverage if their parents become eligible for subsidized coverage through health care reform.[10] By reducing barriers to needed care, increased coverage for parents would also improve their health status and functioning, leading to gains in their children's health status, health care use, and general well-being.[11]

Public Coverage. Changes to the structure and functioning of Medicaid and CHIP could affect large numbers of children, particularly among poor and near-poor families, members of racial or ethnic minority groups, and children with chronic health care problems. Recent estimates suggest that as many as 25.1 million children are enrolled in Medicaid/CHIP at any given point in time (table 2).[12] Relative to privately insured children, those with public coverage are more likely to live in lower-income families, to be Hispanic or black, to have parents of limited English proficiency, and to have health problems.[13]

Over three-quarters of children enrolled in Medicaid/CHIP coverage are in families with income less than 200 percent of the federal poverty level (FPL)—almost half (48.7 percent) are in poor families, and 29.3 percent are near-poor (table 2). Medicaid enrollment for children is over five times as high as CHIP enrollment, since so many publicly insured children live in poor families.[14]

Medicaid and CHIP together cover almost half of all Hispanic and black children (46 and 48 percent respectively);[15] together these groups make up 52.9 percent of all children enrolled in public coverage (table 2). Moreover, children whose parents have limited English proficiency are more likely to have Medicaid/CHIP coverage than private coverage.[16] Language barriers put these parents at

Table 2. Estimates of Racial/Ethnic and Income Distributions of Children, 0-18, Enrolled in Medicaid/CHIP

	Race/Ethnicity	
	(millions)	%
Hispanic	7.6	30.5%
White	10.1	40.3%
Black	5.6	22.4%
Other	1.7	6.9%

	Family Income	
	(millions)	%
<100% FPL	12.2	48.7%
100%-199%	7.3	29.3%
200%+	5.5	22.0%

Note: Income is based on the income of the nuclear family unit in the past year.

Source: Urban Institute Health Policy Center tabulations of the 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS). Estimates reflect an adjustment for the underreporting of public coverage on the CPS.

higher risk of communication problems with providers, raising their need for translation and interpretation services.[17]

Children with Medicaid/CHIP coverage are nearly five times as likely as those with private insurance to be in fair or poor health.[18] Even the publicly-covered children who qualify for reasons other than meeting SSI disability criteria experience greater health problems compared to other children at similar income levels; among the poor, for example, chronic health conditions are 60 percent more likely with non-SSI publicly enrolled children than for children with private coverage.[19] Overall, Medicaid and CHIP cover 35.5 percent of all children with special health care needs.[20]

Compared to children with commercial insurance, children with public coverage are thus more likely to require broader benefits, greater protection from cost sharing, and additional assistance obtaining care. Their greater health needs, together with their lower incomes and racial/ethnic composition, put them at higher risk of experiencing barriers to care.[21]

Public versus Private Coverage for Low-Income Children. Currently, private coverage differs from public coverage in several important ways. On the one hand, private insurance reimburses providers at higher rates compared to public coverage, which in turn may broaden access to providers.[22] On the other hand, existing commercial benefit packages tend to be narrower than the broad benefit package available under Medicaid, which includes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, a medical necessity definition that promotes the healthy physical, behavioral, and emotional development of children, and other services such as interpretation/translation and case management that are targeted to the needs of low-income families.[23] In addition, existing commercial coverage tends to involve significantly more out-of-pocket cost sharing in the form of copayments, coinsurance, and deductibles.[24]

Some Medicaid programs have sought to provide supplemental coverage—known as wrap-around coverage—to low-income children who have private insurance.[25] Some studies have found that wrap-around programs can involve high administrative costs.[26] In addition, qualitative research evidence from a small number of states suggests that problems with wrap-around programs can include lack of awareness among providers and parents about how to use wrap-around services, administrative complexity, and incentives for each system of care to shift costs to the other.[27] However, there is no published study that provides definitive evidence on how successful existing wrap-around programs are at supplementing shortcomings in commercial coverage for low-income children.

Both private and public health care delivery systems suffer from shortfalls. A major study of children's medical records found that children (of whom 82 percent had private coverage) received appropriate care only 46.5% of the time.[28] Regardless of whether the child has public or private coverage, 43% of parents reported that their child had not received a developmental assessment by age three.[29] Moreover, one-third of all low-income children have untreated tooth decay,[30] and many low-income children who have health insurance coverage do not receive well-child care or preventive dental care.[31] Close to one-third of insured children with special health care needs were reported to lack adequate coverage, defined as coverage that usually or always covers needed services, has reasonable out-of-pocket costs, and allows the child to see needed providers, whether covered by private (34%) or public (31%) insurance.[32] In addition, many insured adolescents do not receive confidential health services and lack access to comprehensive health promotion, mental health care, and substance abuse treatment.[33]

While both public and private coverage have deficits in providing care to children, on balance public coverage seems to be more effective than private coverage at providing preventive care to low-income children. Low-income children with public coverage are more likely than their privately-insured counterparts to receive a well-child visit (41% vs. 36%) and more likely to receive advice about diet, exercise, smoking, seat belt use, and helmet use during preventive visits.[34] Other things equal, low-income publicly-insured children are also more likely than low-income privately insured children to receive dental care.[35]

Relative to existing private coverage, Medicaid also appears to provide care at lower cost.[36] Controlling for differences in the socio-demographic and health characteristics of Medicaid and privately insured children, one study estimated that if Medicaid children were to be covered by private coverage, medical care costs would rise by 3 to 11 percent, on average.[37] In addition, the administrative costs associated with Medicaid are lower on average than the costs associated with existing private coverage.[38]

In short, Medicaid and CHIP cover a disproportionate number of our nation's most vulnerable children, as reflected in the racial and ethnic characteristics, income, and health status of children enrolled in these public programs. While there are deficits in both public and private systems of care for children, low-income children are better served in important ways by public programs than by private coverage as it has existed to date. No published, peer-reviewed research assesses the effectiveness of current wrap-around coverage in supplementing the limitations of private insurance provided to low-income children.

Implications

If lawmakers shift children from Medicaid or CHIP into commercial plans participating in a health insurance exchange, children could gain or lose, depending on how the policy is constructed. Potential gains include the following:

- *Higher provider reimbursement rates, hence improved access to care.* If the exchange plans into which children enroll pay commercial-level reimbursement for Medicaid and CHIP children, some providers will be more willing to participate, and children may experience improved access to care, particularly for specialty care. This is probably the most significant potential gain from shifting children's primary source of coverage into an exchange. However, policymakers could achieve those same gains by raising Medicaid and CHIP reimbursement levels without moving children into commercial plans.
- *Less vulnerability to state-level problems.* If federal dollars, without state matching requirements, finance subsidies for coverage offered through the exchange, children will be less vulnerable to cutbacks states make during economic downturns to meet state balanced budget requirements. Federal subsidies could likewise avoid significant state disparities in eligibility. However, restructuring federal financing for public programs and establishing uniform eligibility standards could achieve similar results without shifting children out of Medicaid and CHIP.
- *Greater continuity of care.* Household income changes over time. Including children in the exchange offers the possibility of continuing to receive care from the same plan, with the same providers, whether family income rises or falls.[39]
- *Greater coordination with parental coverage.* Permitting children and parents to enroll in the same plan may yield some gains, including the potential for greater parental convenience. However, the benefits of a common health plan for all family members may not be great. Often, adults and children are served by completely different provider networks, even within a common plan. And while research shows that when parents receive health insurance, children are more likely to enroll in available health coverage and to access necessary care,[40] no published studies show any measurable gains when parents and children receive the same health coverage (as opposed to health coverage through different plans). In any case, if policymakers want to see parents and children served through the same health plan, parents could be allowed to enroll in Medicaid and CHIP along with their children.

Potential losses for children include the following:

- *Reduction in covered benefits.* Particularly Medicaid, but also CHIP to some degree, provides dimensions of service coverage that go beyond most commercial plans in addressing children's needs.[41]
  - › *A narrower definition of medical necessity.* Existing public programs, particularly Medicaid, define necessary care to include promoting children's healthy development. By contrast, commercial plans sometimes categorize care as unnecessary unless it remedies illness or injury. For example, one federal appellate case ruled that a commercial plan properly denied speech and physical therapy to a child with cerebral palsy since, under the insurance contract, coverage was limited to services that restored a prior level of function, excluding services that children need to attain a function for the first time.[42]
  - › *Fewer covered screenings and preventive visits.* Children in Medicaid (and in most states, CHIP) receive coverage of all approved vaccinations, dental care, and, in most cases, well-baby and well-child visits provided in accordance with the recommendations of the American Academy of Pediatrics. By contrast, no state law requires private plans to provide even nationally-approved vaccinations,[43] many commercial plans offer less than the full set of recommended preventive visits for children, and private insurance often covers no pediatric dental care.
  - › *No assurance of meeting children's individual needs for care.* The Medicaid statute guarantees that, if a particular child needs a service that is potentially reimbursable under federal law, the child can receive that service. As a result, if a small number of children need, for example, long-term speech therapy or motorized wheelchairs, they can receive those services. Relatively few children require such services, so the overall cost of this safeguard is modest;[44] but for the small proportion of children who need an unusual type or amount of care, this statutory guarantee can make a major difference.[45] Nothing like this safeguard exists in commercial insurance, which increasingly incorporates limits on covered services that apply regardless of individual need and clinical evidence.[46]
  - › *Less assistance overcoming challenges in obtaining care.* Medicaid covers services like

transportation, translation and interpretation, and case management that address difficulties that frequently arise in the complex lives of low-income families. This is part of a broader obligation Medicaid imposes on states to notify families about available services for children and to provide or arrange for them to receive needed screening and treatment.[47] Commercial insurance does not typically furnish this assistance. Without it, poor and near-poor children may have greater difficulty obtaining necessary services.

- *Increased financial burdens for families.* Medicaid and CHIP programs keep both premiums and out-of-pocket costs to very low levels for poor and near-poor children. Limited cost sharing is important to providing these children with coverage their parents will take up and health care they will use. Existing commercial plans typically have much higher cost-sharing levels, for both out-of-pocket costs and enrollee premium payments; such plans can also include both annual and lifetime caps on covered benefits, subjecting families to very high costs if children experience serious health problems. Of course, policymakers could address this problem by subsidizing plans in the exchange to limit the amount of cost-sharing charged to low-income families.
- *Less cultural and linguistic competence in care delivery.* Many Medicaid and CHIP managed care plans have contractual relationships with community providers, including community health centers and school-based health care providers, with expertise meeting the unique needs of low-income families.[48] In addition, the plans themselves have often developed strategies for effectively working with low-income members, including those with severe limits on English proficiency, discretionary income, time off work, and other constraints. Existing commercial plans and their networks may be less skilled in addressing these issues.
- *Less accountable systems of care and coverage.* Medicaid and CHIP often provide care through fully capitated networks (sometimes with carve-outs for particular services like behavioral health care or dental care) or through care coordinated by primary care case managers. These systems offer at least the potential to hold a defined entity accountable for meeting standards related to children's health care. Further, states themselves can be held accountable for complying with federal law. Violations can be rectified administratively, through intervention by the Centers for Medicare and Medicaid Services. Beneficiaries and providers can also hold states accountable through the courts, particularly with Medicaid, which offers enforceable, legal rights to health care.[49] By contrast, if responsibility for children's coverage is bifurcated between commercial plans and a separate system of wrap-around coverage, it may be more difficult to hold either system accountable. And commercial plans are typically governed by contracts that avoid anything like the enforceable, legal duties to children's necessary care that apply through Medicaid.[50]

In assessing whether children will continue to benefit from the positive aspects of Medicaid and CHIP, policymakers who are considering shifting publicly covered children into exchange plans need to ask questions along the following lines about benefits, cost-sharing protections, and other features of current public programs that go beyond typical commercial insurance in helping low-income children:

- Do the current legal protections of Medicaid or CHIP continue to apply after reform legislation is passed?
- Which public or private entity is legally responsible for providing children with necessary care? If such entities fail to perform their duty, what remedies are available to the affected families?
- If two separate systems (i.e., the exchange and Medicaid) are responsible for distinct sets of covered services, does each system have an incentive to deny care and to shift costs to the other?
- If Medicaid or CHIP provides wrap-around services to fill gaps in services offered by highly diverse private plans participating in an exchange, how will these supplemental services be customized to take into account variations in covered benefits?
- How will plans ensure that, when CHIP and Medicaid children encounter limits on covered services, the parents learn about available wrap-around coverage?
- How easy will it be for low-income families to seek and obtain coverage of supplemental services and limits on cost-sharing needed by their children?
- What data-gathering and other monitoring mechanisms are established to track how well the legal duty is being carried out?

Other questions are important as well, including the choice of populations to be transferred from public programs to the exchange, details about coverage offered through the exchange,[51] and mechanisms to ensure a smooth transition. Clearly, the balance of gains and losses from shifting children from Medicaid and CHIP into an exchange will depend crucially on the applicable policy details.

Discussion

Health care reform has the potential to greatly reduce uninsurance, thereby increasing access to care and the health and well-being of low-income children and their parents. But children have much less to gain than adults from coverage expansions since uninsurance is much less common among children and the majority of uninsured children already qualify for coverage. In order to substantially reduce uninsurance among children, health care reform will

have to address the barriers that have kept uninsured children from obtaining and retaining public coverage. The bill that reauthorized CHIP earlier this year—the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)—contains provisions that may increase take-up and retention in public programs, but additional policy changes will likely be needed to achieve near-universal participation.[52] The uninsured children who gain coverage as a result of health care reform are expected to experience improved access to care, including fewer unmet health needs and greater receipt of preventive care. Low-income children will also benefit from health care reform to the extent that it reduces the high uninsured rates among their parents, as noted above.

The effects of health care reform on the low-income children who have public coverage today are less clear. The fundamental dilemma is that moving children from Medicaid and CHIP into private insurance entails a number of risks, including the potential loss of benefits and legal protections and possible exposure to higher cost-sharing. These children could be worse off if effective access to needed benefits, affordability, and legal protections were reduced, despite the theoretical availability of wrap-around coverage. At the same time, increasing reimbursement rates for the providers who serve publicly enrolled children could increase such children's access to care.[53]

One possible solution would be to enroll these children in plans that pay commercial reimbursement rates and to use such plans, rather than more fragmented wrap-around structures, to provide the full set of child-friendly benefits, with EPSDT medical necessity standards and current-law protections against unaffordable out-of-pocket and premium costs. Commercial health plans are accustomed to delivering different services with different cost-sharing amounts to various populations. However, some functions unique to meeting the needs of low-income populations may be a challenge for commercial plans. Moreover, if preserving Medicaid and CHIP benefits and cost-sharing protections while raising provider reimbursement rates and increasing administrative loads prove untenable for budgetary reasons, putting Medicaid or CHIP children into exchange plans with more limited benefits (even if supplemented by wrap-around coverage) could harm the children who are shifted from public to private coverage.

In sum, the lack of solid evidence on the effectiveness of current wrap-around structures combined with inherent complexities associated with providing wrap-around services in the context of an exchange with multiple commercial plans, potentially with different benefit structures, introduces significant uncertainty about the effects of shifting millions of children with public coverage into exchange plans. Experimenting on these children would be particularly worrisome because the children who could be made worse off are disproportionately likely to be poor, to belong to racial or ethnic minority groups, to have parents with limited English proficiency, and to have chronic health care problems. These are vulnerable groups of children who are already at risk for worse health outcomes than other children.[54] Any movement from the current, relatively integrated structures into more fragmented, wrap-around systems should be tested through demonstration projects and, if such demonstrations succeed, then phased-in slowly, with careful evaluation to allow mid-course corrections. Alternative strategies will need to be tested that improve the effectiveness and coordination of wrap-around service provision.

Medicaid and CHIP have evolved over time to meet the unique needs of America's low-income children. It would be risky to shift large numbers of children from public coverage into a commercial-style system that may not be well-adapted to meet their needs. At the same time, access problems have been documented in Medicaid that should be addressed as part of health care reform. Such steps could include increasing provider reimbursement rates, ensuring timely payment, reducing paperwork burdens and providing greater incentives for the provision of high-value care that improves health outcomes.[55] Public programs will need to assess access and quality of care delivered by various providers for important subgroups (defined by age, race, ethnicity, language, health status, etc.) and identify solutions when problems emerge. CHIPRA created The Medicaid and CHIP Payment and Access Commission (MACPAC) and included a number of other provisions aimed at improving quality and health outcomes for children; together, such policies offer important new mechanisms for addressing these issues.

Improving outcomes for children will also require addressing access and quality problems experienced by children with private coverage, particularly those in low-income families and those with chronic health care problems. Such issues as well as the unique health care needs of children will need to be considered when policymakers define the pediatric benefit package offered to children through the exchange and develop policies to supplement the benefits of children with private coverage.

While this brief has focused on minimizing harm to children, ideally health care reform would take positive steps to promote the emotional, cognitive, and physical health of children, enabling them to reach their full potential. Such a focus would draw attention to policy changes that remedy deficits in the current system and that reduce disparities in access, quality, and outcomes.[56] To that end, it will be critical to identify policies that succeed in improving children's access to high quality care, that enhance children's health and development and maximize their school readiness and performance, and that strengthen children's long-term capacity to contribute to our country as healthy, high-functioning adults.

Notes

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12 This estimate is for 2007; it is likely that the number of children enrolled in Medicaid and CHIP is even higher at the present time, given that the unemployment rate has risen since then (Holahan J and Garrett AB. 2009. "Rising Unemployment, Medicaid, and the Uninsured." Washington, DC: Kaiser Commission on Medicaid and the Uninsured).

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[32] These estimates are derived from the "2005-2006 National Survey of Children with Special Health Care Needs," Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health, Indicator #5 by Insurance Type. www.cshcndata.org. Ideally, this comparison would control for differences in the health, demographic, and socioeconomic characteristics of children with special health care needs with public as compared to private coverage. The published evidence is not clear on whether public or private insurance offers better access to care for children with special health care needs and the extent to which that differs across services, particularly for those in low-income families. See: Tu H and Cunningham P. 2005. "Public Coverage Provides Vital Safety Net for Children with Special Health Care Needs." Washington, DC: Center for Studying Health Systems Change. Newacheck et al. 2009 op cit. Jeffrey AE and Newacheck PW. 2006. Role of Insurance for Children With Special Health Care Needs: A Synthesis of the Evidence. *Pediatrics* 118: e1027-e1038; Dusing SC, Skinner AC, and Mayer ML. 2004. Unmet need for therapy services, assistive devices, and related services: data from the National Survey of Children With Special Health Care Needs. *Ambulatory Pediatrics* 4:448-454. Weller WE, Minkovitz CS, and Anderson GF. 2003. Utilization of medical and health-related services among school-age children and adolescents with special health care needs (1994 National Health Interview Survey on Disability [NHIS-D] Baseline Data). *Pediatrics* 112: 593-603; Newacheck PW, McManus M, Fox HB, Hung YY, and Halfon N. 2000. Access to health care for children with special health care needs. *Pediatrics* 113: 760-766; Liu J, Probst JC, Martin AB, Wang JY, Salinas, CF. 2007. "Disparities in Dental Insurance Coverage and Dental Care Among U.S. Children: The National Survey of Children's Health." *Pediatrics* 119: S12-S21.

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[34] Perry and Kenney op cit.

[35] Dubay L and Kenney G. 2001. "Health Care Access and Use Among Low-Income Children: Who Fares Best?" *Health Affairs* 20(1): 112-121; Low-income children with private health insurance coverage that does not include dental coverage are less likely than other privately insured children to receive dental care and more likely to have unmet health needs (see Kenney, McFeeters, and Yee op cit.) The reasons for unmet needs for dental care vary with the type of insurance—for children with private coverage, financial barriers are commonly cited, whereas for children with public coverage, access to providers is often cited as a barrier (Kenney G, Ko G, and Ormond BA. 2000. "Gaps in Prevention and Treatment: Dental Care for Low-Income Children." Washington, DC: Urban Institute). Likewise, children with special health care needs who have private as compared to public coverage were reported to have fewer problems getting to see needed providers but higher cost burdens (Newacheck et al. 2009 op cit.).

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[37] Hadley and Holahan 2003/2004, op cit.

[38] Smith C, Cowan C, Sensenig A, Catlin A, and the Health Accounts Team. 2005. "Health Spending Growth Slows in 2003." *Health Affairs* 24(1): 185-194; Grady A. 2008. "State Medicaid Program Administration: A Brief Overview." CRS (Congressional Research Service) Report for Congress. Order Code RS22101. Washington, DC: Library of Congress.

[39] Rosenbaum S. 2009. "Creating Comprehensive and Stable Health Insurance Coverage for All Children: Identifying and Working to Resolve the "Four-Pathway" Challenge." Washington, DC: George Washington University School of Public Health & Health Services and First Focus. http://www.firstfocus.net/Download/Rosenbaum_5.5.09.pdf (Accessed 29 May 2009).

[40] Davidoff A, Dubay L, Kenney G, and Yemane A. 2003. "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children." *Inquiry* 40(3):254-268; Dubay and Kenney 2004 op cit.

[41] The relevant Medicaid standard is codified at 42 U.S.C. §1396d(r).

[42] *Bedrick v. Travelers Insurance Co.*, 93 F. 3d 149 (4th Cir., 1996), described in Sara Rosenbaum and Paul H. Wise, "Crossing The Medicaid–Private Insurance Divide: The Case Of EPSDT," *Health Affairs* 26(2):382-393, March/April 2007.

[43] Rosenbaum and Wise, op cit.

[44] As noted above, per capita costs of children's coverage under Medicaid are less than under private insurance, notwithstanding the statutory safeguards that apply to Medicaid benefits.

[45] For example, a Florida court overturned the Medicaid agency's decision to reduce the number of personal care service hours for a nine-year-old child with mental retardation and brain damage, concluding that the state improperly applied a narrower definition of medical necessity than federal law required, *C.F. v. Dep't Children and Families,* 934 So.2d 1 (Fl. Dist. Ct. App. 2005); a federal court in Arizona required the Medicaid agency to provide incontinent children with briefs needed to avoid skin breakdown and infection, *Ekloff v. Rodgers,* 443 F. Supp. 2d 1173 (D. Ariz. 2006); the Vermont Supreme Court overturned the Medicaid agency's refusal to provide certain types of orthodontic treatment needed to prevent persistent pain and malocclusion, *Jacobus v. Dep't of PATH,* 177 Vt. 496, 857 A.2d 785 (S.Ct. 2004); and a federal district court in Massachusetts required that state to provide home-based assessments, care coordination, and integrated treatment planning to children with serious emotional disturbances, *Rosie D. v. Romney,* No. 01-30199MAP, 2007 WL 51340 (D. Mass. July 16, 2007) (judgment), earlier decision, 474 F. Supp. 2d 238 (2007) (adopting state's proposed plan with provisos), same case, 410 F.Supp.2d 18 (2006) (judgment for children as to liability), same case, 256 F.Supp.2d 115 (2003) (regarding discoverable documents), same case, 310 F.3d 230 (1st Cir. 2002) (denying state's motion to dismiss).

[46] Rosenbaum and Wise, op cit.

[47] 42 U.S.C. §1396a(a)(43).

[48] One review of Medicaid managed care contracts found that 36 states imposed a duty involving subcontracts with community health centers, and 30 states required establishing, at a minimum, care coordination and referral relationships with school-based health care providers. George Washington University Center for Health Policy Research, *Negotiating the New Health System, Fourth Edition,* 2002.

[49] Despite this general feature of public programs, some judicial decisions have limited the right of affected beneficiaries to bring suit in federal court.

[50] Rosenbaum and Wise, op cit.

[51] Of course, if policymakers are willing to fund the resulting cost increases, exchange plans could likely be structured to avoid the problems of current private insurance.

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[53] S. Berman et al., "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics* 110, no. 2, Part 1 (2002): 239–248; Griffin S, Jones KA, Lockwood S, Mosca NG, and Honore PA. 2007. "Impact of Increasing Medicaid Dental Reimbursement and Implemented School Sealant Programs on Sealant Prevalence." *Journal of Public Health Management and Practice* 13(2): 202-206; Medicaid fees are currently 72 percent of Medicare fees on average (Zuckerman, Williams, and Stockley op cit.)

[54] Flores and Tomany-Korman op cit; Shi and Stevens op cit.

[55] Cunningham PJ, O'Malley AS. "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" *Health Affairs* 2009; 28(1):w17-w28; Cunningham PJ and Hadley J, "Effects of Changes in Incomes and Practice Circumstances on Physicians' Decisions to Treat Charity and Medicaid Patients," *Milbank Quarterly* 86, no. 1 (2008): 91–123. Kaiser Commission on Medicaid and the Uninsured. 2009. "Medicaid as a Platform for Broader Health Reform: Supporting High-Need and Low-Income Populations." Washington, DC: Kaiser Commission on Medicaid and the Uninsured; Wilhide S and Henderson T. 2006. "Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries." Washington, DC: American Academy of Family Physicians; Rosenbach M and Young C. 2000. "Care Coordination in Medicaid Managed Care: A Primer for States, Managed-Care Organizations, Providers, and Advocates." Washington, DC: Center for Health Care Strategies. http://www.chcs.org/publications3960/publications_show.htm?doc_id=212944 (Accessed 29 May 2009).

[56] Flores and Tomany-Korman op cit; Shi and Stevens op cit.

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