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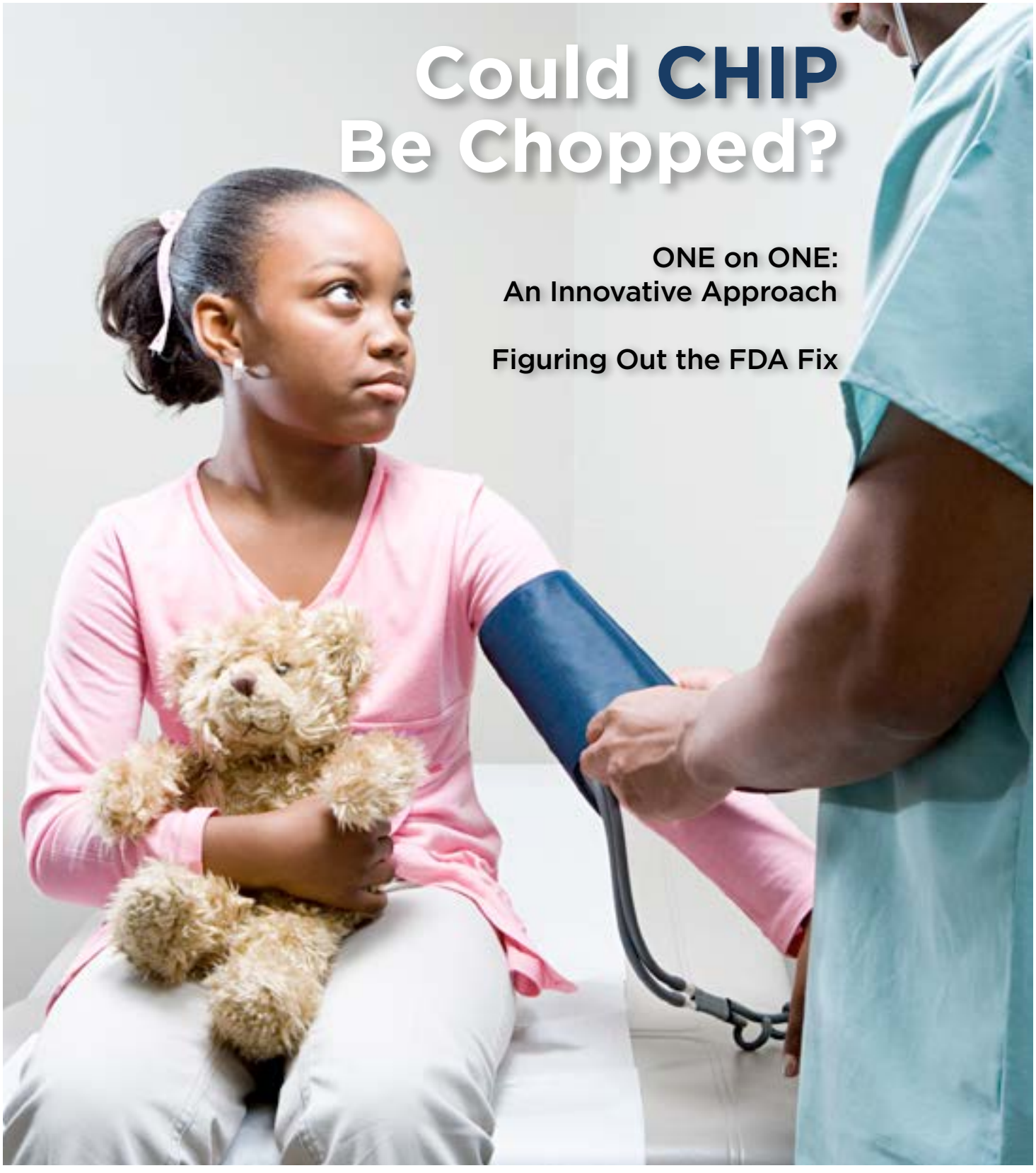

Could CHIP Be Chopped?

ONE on ONE: An Innovative Approach

Figuring Out the FDA Fix

LACHIP, MEDICAID, AND THE FUTURE OF CHILDREN'S HEALTHCARE IN LOUISIANA

By Claudia S. Copeland, PhD

Could CHIP Be Chopped?

LaCHIP, Louisiana's children's health program, provides healthcare for more than 130,000 children from low-to middle-income families on top of the more than 600,000 children covered by traditional Medicaid. CHIP, the joint federal-state Children's Health Insurance Program that provides funding for LaCHIP, was created to complement Medicaid's mission of providing healthcare to low-income children. CHIP filled a gap by providing coverage for children from families earning too much to qualify for Medicaid, but too little to afford private health insurance. In Louisiana, the LaCHIP program has allowed working-class and small-business owning families to receive the same care as traditional Medicaid-eligible families, either for free or at an affordable cost, for almost two decades. Federal funding for CHIP, however, is set to expire in 2017. In the current climate of political uncertainty, LaCHIP's future is in question—what would happen if federal funding for CHIP failed to be reauthorized?

One way to look at the consequences of CHIP nonrenewal or funding cuts is to revisit Louisiana in the years before CHIP existed. In November of 1998, when LaCHIP was first introduced, Louisiana had the third highest rate of uninsured children, according to former Medicaid director Ruth Kennedy.

Today, Louisiana is among the leading states for lowest rate of uninsured children nationwide, with only Illinois, New Jersey, and Michigan reporting lower percentages of uninsured individuals in the 0-18 age range, according to the Kaiser Family Foundation.

What is LaCHIP?

Before 1998, healthcare coverage was provided to very low-income children through traditional Medicaid. Created in 1965, Medicaid is provided on the basis of income and age thresholds that are the same throughout the U.S. There are no per-state caps on spending, so anyone who falls within the income and age limits will receive Medicaid. CHIP was introduced in 1997 to address the needs of children whose families earned too much to qualify for traditional Medicaid, but who could also not afford private health insurance. Many small business owners and hourly wage earners fall into this category, as do creative professionals like musicians and artists. Unlike traditional Medicaid, the federal funding for the program is provided as block grants, with considerable flexibility given to states in how to implement the funds.

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In Louisiana, CHIP-funded care is provided through expanding the Medicaid system to accommodate lower-to-middle income families. (In other states, other models and practices are employed–some states address the funding limitations through waiting lists, for example.) Louisiana has been nationally recognized for its continued work in expanding eligibility, enrollment, and retention; for example, expanding eligibility from 133% of the Federal Poverty Level to 200% FPL in 2001, and providing coverage to pregnant women through the LA-MOMS program in 2002.

LACHIP AFFORDABLE PLAN. In addition to free LaCHIP coverage for families earning up to 200% of the Federal Poverty Level, in 2007, Louisiana expanded coverage to many middle-income families through a low-premium ($50/month) plan called the LaCHIP Affordable Plan, a non-Medicaid plan administered through the state's Office of Group Benefits. Coverage eligibility limits are generous, designed to ensure that all children in the state have access to healthcare. For example, a family of four can earn up to $61,968 annually and still be eligible for the LaCHIP Affordable Plan.

CHIPRA and MACRA. By 2008,

CHIP, originally designed to be funded by a tobacco tax, was facing shortfalls in several states. The CHIP Reauthorization Act, or CHIPRA, was enacted in 2009 to extend and improve CHIP coverage, while mandating increased vigilance; for example, requiring allotments to be reassessed every two years on the basis of the amount of care actually provided by the states. The new authorization was generous, allowing and incentivizing expansion to more children, and Louisiana took advantage of most of the provisions. (One notable exception: while CHIPRA explicitly allows Medicaid/CHIP coverage for legally resident immigrant children and pregnant women in their first five years in the United States, Louisiana chose to retain the previous 5-year waiting period for new immigrants.) In 2015, CHIP was once again extended through the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. Meanwhile, as part of the ACA, CHIP programs' funding was mandated to increase by 23% starting in October 2015, raising the federal share of CHIP funding for Louisiana to 96%.

Together, LaCHIP and the LaCHIP Affordable Plan were designed so that, with the exception of new immigrants, there would essentially be no economic reason any child lawfully residing in Louisiana should be uninsured. However, there are social/psychological reasons for not enrolling—from a lack of knowledge about the program to a sense of "pride" that repels some families from taking advantage of public services.

According to the Urban Institute, Louisiana has been unique among states in its proactive approach to such issues: "A critical factor that has permitted Louisiana's success over the last decade has been the significant effort to change the 'culture' of the eligibility staff that performs these functions for Medicaid/LaCHIP. Specifically, this change involved reshaping staff attitudes toward eligibility, and moving away from a gatekeeper frame of mind toward a more facilitative, client-centered approach aimed at making enrollment and renewal processes as minimally burdensome as possible. To accomplish this goal, DHH drew upon the expertise and experience of those working in the field—the Medicaid analysts themselves—to solicit their input on process improvements."

Outreach efforts have included participation in health fairs and community gatherings, distribution of flyers with key messages such as "applying for LaCHIP is easy!", and the branding of both Medicaid and LaCHIP as a single, seamless program. While the behind-the-scenes structure of the two programs (traditional Medicaid vs. block-grant funded CHIP) are very different, consumers generally have no idea whether their children are enrolled in traditional Medicaid or CHIP—it is all called LaCHIP and treated as a unified program, a single application, single renewal process, and single program in terms of the healthcare provided to the children.

LaCHIP beyond 2017?

The outlook for U.S. healthcare in the coming years is, at the moment, a big question mark, and this extends to children's healthcare programs. The ACA specified the continuation of the federal CHIP matching rate through 2019, but this guarantee will disappear if the ACA is repealed. In addition, while it authorized the program through 2019, federal funding has not been allocated past September of 2017. Trump campaign promises included repealing and replacing the ACA, but few details have been offered on how healthcare will be restructured, either for adults or children.

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Dr. Rebekah Gee

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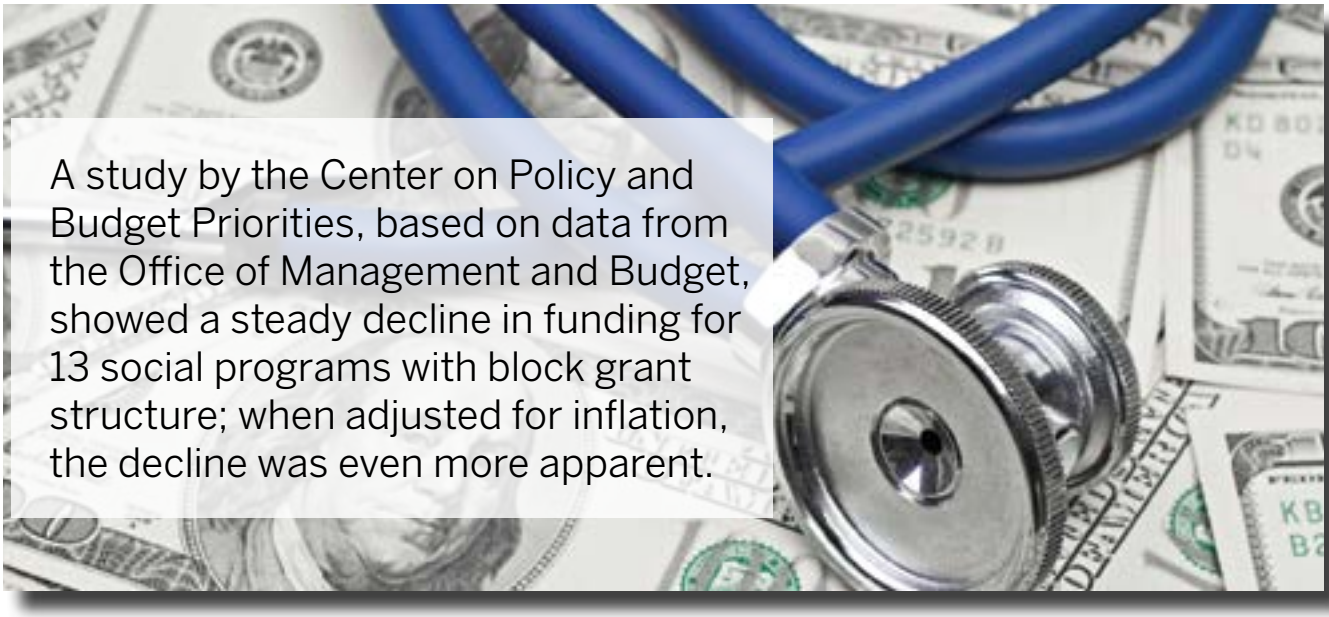
While the most immediate concern of the Louisiana Department of Health is adult Medicaid expansion, a key component of the ACA brought to Louisiana last summer and now under direct threat, the future of our children's healthcare programs is also uncertain. According to Dr. Rebekah Gee, Secretary of the Louisiana Department of Health, "While it is much too early to speculate about President-elect Trump's health care plans – especially as they relate to the Affordable Care Act – we are aware of existing plans that call for reduced federal funding for the Children's Health Insurance Program, the elimination of federal funding for Medicaid expansion to low-income adults in states such as Louisiana, and plans that would make Medicaid a block grant program. We are currently analyzing the financial impact to the state for each of the different options that have been proposed so far. Also, the Department and the Edwards Administration are sharing our concerns, and the impact to Louisiana and its health care community, with our legislative delegation, and we are committed to working with President-elect Trump's Administration to ensure continued access to affordable health care to Louisiana residents."

Both CHIP and Medicaid are funded jointly by the federal government and states, but not in the same way. The federal share of funding for CHIP has been consistently higher than that for Medicaid, and while the federal share of Medicaid funding has been essentially level for the past several years, CHIP federal funding has steadily risen, from just over 72% to over 96%. This high level of funding has allowed Louisiana to expand LaCHIP into the robust program it is today, but it also means that the impact will be harder if that funding is not renewed in 2017. Furthermore, a proposal to switch traditional Medicaid funding to block grants, one of the seven cornerstones of the Trump healthcare policy, could have key implications for the future of LaCHIP as a whole.

The problem with block grants

The success of LaCHIP is undisputed.



A study by the Center on Policy and Budget Priorities, based on data from the Office of Management and Budget, showed a steady decline in funding for 13 social programs with block grant structure; when adjusted for inflation, the decline was even more apparent.

However, the fact that the CHIP portion is built on a foundation of federal block grants builds in a degree of instability that would only be increased if the Medicaid portion were to be switched to a similar structure. Block grants provide funding as capped allotments, meaning that once the funds run out, the state will be responsible for any remaining costs. Block grant proponents tout this structure as allowing states—assumed to know their people's needs better than the federal government—to choose how best to administer social programs. While the CHIP grants have been well-funded in recent years, the inherent structure of block grants makes them uniquely susceptible to budget cuts and fiscal erosion.

A study by the Center on Policy and Budget Priorities, based on data from the Office of Management and Budget, showed a steady decline in funding for 13 social programs with block grant structure; when adjusted for inflation. In general, when block grants are first used to replace traditionally funded programs, they are structured to provide the same amount of funding as the previous version of the program. However, over time, they tend not to keep up with inflation and population growth—most block-granted programs show a steady decline in real funding over time.

In addition, all funds with built-in flexibility are more vulnerable to being "raided" than strictly allocated funding. Diversion of funding away from clearly intended purposes is far from unknown in Louisiana; in one health-related example, according to a 2012 Urban Institute report, several million dollars in performance bonuses for excellence in the management and expansion of the LaCHIP program did not go back into the program; instead, the money went directly into the General Fund to fill budget shortfalls.

In addition to the issue of instability, conversion of Medicaid to a block grant structure would be problematic because, in times of economic stress, block-grant funded programs are not forced to respond when they are needed most. For example, during 2008-2009, the unemployment rate skyrocketed. In response, SNAP program ("foodstamps"; a traditionally funded program) expenditures grew steadily, and have since declined along with the unemployment rate. In contrast, TANF (Temporary Assistance to Needy Families), funded with a block-grant structure, rose by only 13% in response to a 200% increase in unemployment. The flexibility of the TANF funding was originally touted as a mechanism for states to take innovative approaches like job training and childcare.

None of these reforms have materialized, though—the percentage of funding allocated for such services has declined since changing from the previous program, AFDC, to the block-grant funded TANF. If economic hard times were to hit Louisiana families, capped funding for traditional Medicaid could mean a shortfall in funding for the state's poorest children, creating pressure to lower income thresholds for CHIP to allow those funds to be used for low income children formerly insured through traditional Medicaid.

Families, Insurance Companies, and Hospitals

While CHIP funding cuts would hurt low- to middle-income families, recipients would not be the only entities to be affected. The five insurance providers for the program—Aetna Better Health of Louisiana, Amerigroup Louisiana, Inc.,

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AmeriHealth Caritas Louisiana, Inc., Louisiana Healthcare Connections, and UnitedHealthcare Community Plan—would be directly affected by cuts. On the other hand, other insurance companies might actually come out ahead, since children are medically inexpensive and perhaps some of the former CHIP population would move to private insurance. Most families in the LaCHIP program, however, will most likely revert to being uninsured if they lose their public health insurance. In the past, the healthcare behavior of this population has tended towards forgoing primary and preventative care. Then, when severe sickness or injury strikes, they seek care at the local emergency department.

Since 1986, when the Emergency Medical Treatment and Labor Act (EMTALA) was passed as an unfunded mandate, emergency departments have been required to screen and stabilize all patients, regardless of their ability to pay. In the past, many uninsured families turned to emergency rooms as the only care available for their kids, saddling hospitals located in low-income areas with staggering uncompensated care costs. Such hospitals, known as safety-net facilities, made up only 2% of acute care hospitals, but provided 20% of uncompensated care to the uninsured before the ACA. In the past, the associated costs were partially offset by federal funding known as the disproportionate share hospital program, or DSH. DSH funds, however, are being steadily reduced in line with increased insurance coverage through ACA-based insurance subsidies and Medicaid expansion. If the ACA is repealed, will DSH funds be reinstated? If they are not reinstated, will there be any other, new mechanism to compensate safety-net hospitals for treating uninsured patients in their emergency rooms?

The low cost of insuring children through Medicaid. Amid all of the complicated legislative and financial details surrounding children's healthcare, it is easy to forget one simple fact: providing children with healthcare coverage through Medicaid is cheap, relatively speaking. Medicaid has very low administrative costs, and while children make up 44% of Medicaid enrollment, they generate only 19% of Medicaid expenditures, because they incur fewer costs than other groups. The cost per child as of 2015 was less than $125 per child per month. Children can be insured for less than a quarter of the cost of insuring the elderly and less than a sixth of the cost of insuring disabled adults. The vast majority of LaCHIP care is preventative and primary healthcare, which is relatively inexpensive. For this and many other reasons, the wise and compassionate choice for 2017 is clear: retain the CHIP program, for the sake of families, insurance companies, and hospitals, but most of all, for the children themselves. ■