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## Recommendations for Improving MO HealthNet for Kids

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### MO HealthNet for Kids: An Overview

According to US Census Data, there are over 45 million uninsured individuals in the United States and over eight million of those are children. Of Missouri's nearly 730,000 uninsured, over 20 percent (150,000) are children.<sup>i</sup> Missouri's children's health insurance program, entitled MO HealthNet for Kids, provides low- and middle-income families with the opportunity to ensure their children's health and well-being.

In 2007, Missouri's Medicaid program was redesigned. The Medicaid program for children and the State Children's Health Insurance Program (then called MC+ for Kids) were consolidated into MO HealthNet for Kids. MO HealthNet for Kids insures children whose families fall below 300 percent of the Federal Poverty Level (FPL).

Children whose family gross income falls below 150 percent of the FPL are eligible for completely subsidized coverage under Medicaid, whereas those who have gross income between 151 and 300 percent of the FPL may be eligible for CHIP health insurance. These families are required to make monthly premium payments, ranging from 12 to 294 dollars, based on income. Above 300 percent of the FPL, families are not eligible for any state-sponsored health insurance program.<sup>ii</sup>

### Enrollment of Eligible Children is Dropping

Although Missouri offers a substantial number of children quality health insurance, the number of children enrolled in the program has dropped significantly in the last few years. From 2002 to 2007, the state of Missouri had an average of 77, 593 children enrolled in MOHealth Net in a given month. In June 2007, however, this number dropped to 61, 936 children.<sup>iii</sup> Importantly, this drop in enrollment was *not* due to the fact that more children are receiving coverage through private insurance, nor that there were fewer children requiring state-sponsored coverage.

According to the Kaiser Family Foundation, Employer Sponsored Insurance (ESI) fell among children of employees around the country. In 2000-01, 73.4 percent of children of employees had benefits from ESI, but in 2007 this fell to 65.9 percent.<sup>iv</sup>

Trends are similar in Missouri as well. The most recent data from the Kaiser Family Foundation indicates that only 55 percent of Missouri firms (businesses) and 42 percent of Missouri's small businesses (those with 50 or fewer employees) offered employer sponsored insurance to employees by 2006.<sup>v</sup> This startling reality is coupled with the fact

that the rate of uninsured children in Missouri has seen no significant decline over the last several years.

### **New Challenges for Missouri**

One of the most significant challenges Missouri is facing is that thousands of eligible, low-income children are not enrolled in MO HealthNet for Kids, resulting in the high number of uninsured children. In 2005-06, Missouri saw a 35 percent drop in monthly MO HealthNet for Kids enrollment, whereas the US had a 2 percent increase in overall Children's Health Insurance Programs (CHIP) enrollment. Similarly, from 2006-2007, enrollment in MO HealthNet for Kids increased 1 percent, while the nationwide enrollment increased 7 percent.<sup>vi</sup>

There are several strategies Missouri can employ in order to combat the low enrollment and high uninsurance rates. Below are recommendations based on programs other states have implemented in order to fight dropping enrollment and to insure more eligible children.

### **Recommendations for Outreach to Increase CHIP Enrollment**

Research suggests that many parents are not knowledgeable that their children may be eligible for CHIP in their states. Parents indicated to the Kaiser Family Foundation that multi-faceted outreach could aid low-income families in identifying their eligibility for CHIP and therefore increase enrollment.<sup>vii</sup> As discussed below, there are two specific outreach tools that could effectively increase awareness and child enrollment in CHIP.

### **National School Lunch Program**

In 1998, The United States Department of Agriculture (USDA) presented methods of using the National School Lunch Program (NSLP) as a referral mechanism for Medicaid and CHIP. The USDA recommended that school districts provide Medicaid/CHIP information with school lunch applications. In addition, applicants could use the school lunch application to authorize their information to be shared in order to receive Medicaid/CHIP eligibility information.

In 2007, 366,458 children in Missouri were enrolled in the NSLP. To qualify for free or reduced lunch, families must be at or below 185 percent of the federal poverty level, which is well below Missouri's threshold of 300 percent of the FPL for CHIP eligibility. This tool has the potential to increase enrollment of the many eligible, yet uninsured, children in Missouri.<sup>viii</sup>

Some states that have started using the NSLP as an outreach tool for Medicaid/CHIP include: Alaska, Arkansas, Connecticut, Georgia, Florida, California and Washington.

### **Tax Returns**

Another innovative tool for outreach to increase enrollment of those eligible requires parents to indicate on their tax returns whether each child listed as an exemption has healthcare coverage. If children are identified as eligible and uninsured based on the income threshold for coverage, the state would send the taxpayer a notice informing them of eligibility and enrollment information.

For example, Maryland has focused on extensive outreach measures to increase enrollment. In 2008, Maryland passed legislation to implement the tax return method to identify eligible, uninsured children.

## **Recommendations for Expansion**

### **CHIP Buy-in Program**

Buy-in programs have been implemented in seven states in order to expand access to middle-income families who do not have access to non-group insurance or ESI. A buy-in program gives parents the option of buying in to the CHIP program if their income is above the state's cut off for subsidized eligibility. Families pay full premiums for their children to be enrolled in the program. The buy in program is known to cost states very little since the purpose of families paying full premiums is to ensure they are paying enough for the buy-in program to operate.

### **A buy-in program would expand access to all children in Missouri by giving families an opportunity to gain affordable healthcare coverage for their children.**

Buy-in programs are most successful when directed at families with moderate to upper-middle-incomes. These families are more likely to have the financial ability to afford to pay full premiums for their children's health insurance.

For example, in 2008 New York raised subsidized children's healthcare coverage to 400 percent of the FPL. Above 400 percent, families have the option of buying-in to New York's CHIP program at full premium rates.<sup>ix</sup> At this income level, it is easier for families to pay full premiums for their children. There is not data concerning the take-up of New York's buy-in program due to its recent implementation. Take-up will most likely be higher than that other states' buy-in programs because the buy-in was implemented at 400 percent of the FPL.

### **Use Net Income to Determine Eligibility**

Currently, MO HealthNet uses a family's gross income to determine CHIP eligibility<sup>x</sup>, however, this is not an accurate reflection of a family's financial situation. For those children who qualify for non-CHIP Medicaid, the state of Missouri looks at the family's net income after taxes. However, uninsured children whose families do not meet the income criteria for this program may still be eligible if they fall below 150 percent of the FPL, but eligibility at that time is determined by gross income, not net income.

Similarly, for children between 151 and 300 percent of the FPL who would qualify for MO HealthNet for Kids' CHIP program, the income criteria are based on gross income.<sup>xi</sup>

Changing the way Missouri determines income eligibility from gross income to net income will ensure that more uninsured children are receiving quality, affordable health insurance. It will also help to streamline the administrative processes when determining eligibility, because it will be based on the same income criteria - namely a family's net income.

## **Choose the Option to Cover Legal Immigrant Children Without a 5 year Waiting Period**

Non-citizen immigrants with legal status generally do not have access to affordable healthcare. Although legal immigrants may work full-time, they typically hold low-paying jobs that do not offer ESI.<sup>xii</sup> Until recently, a further barrier for legal immigrant children was due to a restriction by the federal government. Under this restriction, federal CHIP funding could not be used to cover legal immigrant children until they had lived in the U.S. for five years.<sup>xiii</sup>

The reauthorization of CHIP in 2009 rescinded this restriction. States are now given the option to use federal CHIP funding to cover legal immigrant children during their first five years in the US.<sup>xiv</sup> Now that funds are available for legal immigrant children under CHIP, Missouri has the ability to expand coverage to many uninsured legal immigrant children. Expanding eligibility to legal immigrant children ultimately reduces barriers to decreasing the number of uninsured children.

## **Recommendations to Simplify the Enrollment/Re-enrollment Process**

There are numerous steps that Missouri can take to simplify the enrollment/re-enrollment process to reduce administrative costs and make it easier for parents to enroll, and keep their children enrolled, in state-sponsored health insurance.

### **12-Month Continuous Eligibility**

Allowing families to enroll their children in MO HealthNet for Kids for a continuous 12 month period will reduce the number of children who lose coverage due to an increase in income that is often temporary and fluctuates. This will ensure that enrolled children have coverage for 12 months without interruption.

According to the Kaiser Commission on Medicaid and the Uninsured, 27 states adopted continuous eligibility in their CHIP Programs as of January 2008.<sup>xv</sup>

Continuous 12 month eligibility promotes the well-being of children by ensuring they will have coverage for a specified amount of time without interruption. This eases the burden on low and middle-income families as they are guaranteed their children will not suddenly lose coverage due to a slight increase in income.

### **Eliminating the Asset Test**

The asset test is used as a method of verification for families to show eligibility for Medicaid/CHIP. The asset test was eliminated by various states because it was ineffective in judging a family's need for access to children's health insurance. By eliminating the time-consuming asset test, eligibility could be determined through Administration Verification. Administration Verification involves states using government sources to determine eligibility. This simplifies the enrolment/re-enrollment process for families.

## **Conclusion**

It is certainly within Missouri's best interest to adopt these procedures, which can not only insure more children, but also reduce administrative costs by simplifying the enrollment and reenrollment processes. Through the newly passed Children's Health

Insurance Program Reauthorization Act (CHIPRA) of 2009, states can receive between 15 and 62.5 percent of the cost of insuring a child, depending on their ability to meet and exceed target enrollment rates.<sup>xvi</sup> States must meet five of eight enrollment simplification measures in order to qualify for the bonuses.

These measures include:

- Adopt 12-month continuous eligibility for all children;
- Eliminate the asset test for children. A state can also meet this requirement by allowing applicants to self-certify their assets or resources or by verifying assets by other means that do not require the family to provide unnecessary documentation;
- Eliminate in-person interview requirements at application and renewal;
- Use joint applications and supplemental forms and the same application and renewal verification process for the two programs;
- Allow for administrative or paperless verification at renewal through the use of pre-populated forms or *ex parte* determinations (when a state uses information available to it through other databases to verify ongoing eligibility);
- Exercise the option to use presumptive eligibility when evaluating children's eligibility for coverage;
- Exercise the new option in the law to use Express Lane; and
- Exercise the new options in the law in regard to premium assistance.<sup>xvii</sup>

MO HealthNet for Kids already incorporates some of these requirements, including eliminating in-person interviews, joint applications, and presumptive eligibility in Children's Hospitals, Federally Qualified Health Centers and Rural Health Clinics. Adopting the recommended 12-month continuous eligibility and the elimination of the asset test would qualify Missouri to receive the bonus monetary incentives.

Overall, Missouri has made great advances in ensuring that low-income children have access to adequate, affordable health insurance. However, there are still thousands of children in Missouri who are uninsured and whose families would benefit greatly from the insurance provided by MO HealthNet for Kids. By adopting these recommendations, further advancements can be made to insure more children.

*The Mission of the Missouri Budget Project is to advance public policies that improve economic opportunities for all Missourians, particularly low and middle income families, by providing reliable and objective research, analysis and advocacy. Contact the MBP through our website at [www.mobudget.org](http://www.mobudget.org)*

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<sup>i</sup> [http://pubdb3.census.gov/macro/032007/health/h05\\_000.htm](http://pubdb3.census.gov/macro/032007/health/h05_000.htm)

<sup>ii</sup> <http://www.dss.mo.gov/mhd/>

<sup>iii</sup> <http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=61&rgn=27>

<sup>iv</sup> <http://www.kff.org/uninsured/upload/7840.pdf>

<sup>v</sup> <http://www.statehealthfacts.org/profileind.jsp?ind=175&cat=3&rgn=27>

<sup>vi</sup> Ibid.

<sup>vii</sup> <http://kff.org>

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- <sup>viii</sup> <http://www.pfc.org>
- <sup>ix</sup> <http://www.kff.org/medicaid/upload/7855.pdf>
- <sup>x</sup> <http://www.dss.mo.gov/fsd/mchild.htm>
- <sup>xi</sup> Ibid.
- <sup>xii</sup> <http://www.kff.org/medicaid/upload/7761.pdf>
- <sup>xiii</sup> Ibid.
- <sup>xiv</sup> <http://www.kff.org/medicaid/upload/7743-02.pdf>
- <sup>xv</sup> <http://www.kff.org/medicaid/upload/7855.pdf>
- <sup>xvi</sup> <http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20schip%20policy/ccf%20chip%20summary%202-13.pdf>
- <sup>xvii</sup> Ibid., p.11.