CROSSING THE FINISH LINE 2012

NEARING THE HOME STRETCH FOR COVERING KIDS AND PARENTS IN ARKANSAS

35 YEARS
ARKANSAS ADVOCATES
FOR CHILDREN & FAMILIES

TABLE OF CONTENTS

We thank The Annie E. Casey Foundation and The David & Lucile Packard Foundation for their support but acknowledge that the findings and conclusions presented in this report are those of the authors alone and do not necessarily reflect the opinion of the foundations.

Arkansas Advocates for
Children and Families
1400 W. Markham, Suite 306
Little Rock, AR 72201
(501) 371-9678
www.aradvocates.org

Northwest Arkansas Office
614 E. Emma Ave., Suite 107
Springdale, AR 72764
(479) 927-9800

CROSSING THE FINISH LINE 2012

A report by Anna Strong, Health Policy Director
Arkansas Advocates for Children and Families
March 2013

EXECUTIVE SUMMARY

ARKids First and Medicaid support Arkansas children and their families. Despite one of the highest child poverty rates in the country, Arkansas ranks fourth in the nation at enrolling eligible children in ARKids First and Medicaid, with 92.5 percent of children who are eligible for this coverage enrolled. New data from the American Community Survey shows that Arkansas has made remarkable progress since 1997, when almost a quarter of the state's children were uninsured.

Today, six percent of children lack health coverage in Arkansas. Breakdowns by income ranges, geography, and race/ethnicity show significant disparities for some Arkansans. The following groups are more likely to be uninsured:

- Children in west, northwest, and central Arkansas
- Hispanic and Marshallese children and those whose home language is not English
- Children age 11 to 18

Even an insurance card does not guarantee access to care. Seven percent of children enrolled in ARKids First or Medicaid do not have an assigned primary care provider, though many of the unassigned children access care in some way each year. Additionally, less than half of children who have ARKids First or Medicaid received even one of the well-child screens they should have in 2011. Improved access to care can help connect families to the care they need.

Parent coverage is a critical factor in insuring more children. However, almost half of low-income adults are uninsured, and 80,000 of them are parents. Race, age, and education again are correlated with whether an individual has health coverage.

Arkansas has an opportunity to cover more parents and children thanks to the Affordable Care Act (ACA). Almost half a million uninsured Arkansans could gain coverage through Medicaid and the health insurance exchange marketplace opening January 1, 2014. Additionally, Arkansas has remaining opportunities to cut the red tape from ARKids First eligibility and enrollment as called for in Act 771 of 2011. Much work remains to reach the goal of affordable, comprehensive coverage for all Arkansans in the next few months. Specific recommendations to help Arkansas children and families access the coverage and care they need include the following:

- Ensure children are protected during health care reform decisions
- Improve parent coverage
- Capitalize on new outreach funds to cover children
- Cover the Marshallese
- Strengthen access to care for children
- Ensure new eligibility and enrollment systems are easy-to-use

INTRODUCTION

As Arkansas's economy has begun to recover from the recession, ARKids First has been a vital resource to thousands of Arkansas families. The latest data on poverty in Arkansas shows that 27 percent of children under age 18 live in poverty compared to 20 percent nationally.[1] ARKids First ensures that children in Arkansas have access to comprehensive, affordable health coverage even during tough economic times.

In fact, Arkansas ranks fourth in the nation at enrolling eligible children in Medicaid and ARKids First, with 92.5 percent of eligible children enrolled.[2] It's not often that Arkansas can claim to be among the top states in health-related statistics, and we should continue working toward reaching number one.

We know that, for children who are enrolled in coverage, ARKids First works. ARKids First ensures children can get their well-child screens, specialist visits, dental exams, and eyeglasses, helping them succeed in school and at home. ARKids First means parents have the peace of mind that their child can get needed health care, no matter what. As we move toward a world where nearly all Americans have access to affordable, comprehensive coverage, it is important to keep a focus on helping children Cross the Finish Line where they ALL have health coverage.

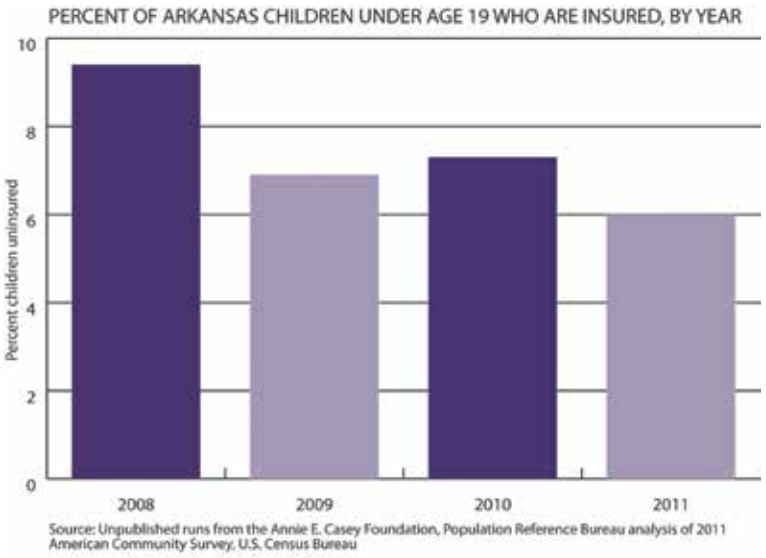
This report will:

- Examine data demonstrating progress in covering children
- Identify areas that need more attention in order to cover all children
- Outline policy and outreach opportunities to strengthen coverage
- Explore why covering parents is important to children
- Examine the status of Affordable Care Act implementation in Arkansas
- Make recommendations for Crossing the Finish Line for Arkansas children

The Status of Children's Health Coverage in Arkansas

The number of uninsured children in Arkansas has continued to drop, thanks to hard work by child advocates, child care programs, schools, health care providers, and state employees, but we still have too many children without health coverage. A recent national report from the Georgetown Center for Children and Families showed that for all children under age 18, Arkansas ranked 20th in the U.S. for percent of all children who are uninsured in 2011. This is despite the fact that Arkansas is fourth in the nation for enrolling ARKids First-eligible children.[3]

Since 2008, the Census Bureau's American Community Survey has provided more accurate data than ever before to track uninsured children in Arkansas. We know that in 1997, 22 percent of children were uninsured. As of 2011, the newest data available, just 6 percent of children under age 19 lack health coverage. Since 2008, the number of uninsured children across all incomes has dropped by 32 percent, from 68,000 to 46,000.



ARKids First has dramatically helped reduce the number of uninsured children in families who earn less than 200 percent of the federal poverty level (FPL). In 2012, 200 percent FPL was about $46,100 for a family of four. The largest reduction in the number of uninsured children between 2008 and 2011 has been for those who qualify for ARKids First, decreasing by 15,000. However,

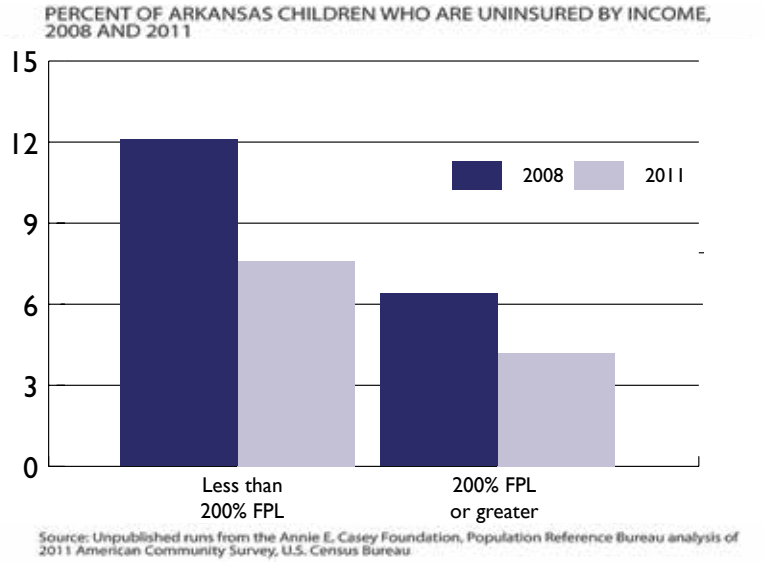
CHANGE IN NUMBER OF INSURED CHILDREN UNDER AGE 19 IN ARKANSAS, 2008-2011	2008	2009	2010	2011	Change '08-'11
Total Number of Uninsured Children	68,000	51,000	54,000	46,000	-22,000
Earning Less than 200% FPL	46,000	29,000	34,000	31,000	-15,000
Earning more than 200% FPL	22,000	22,000	20,000	15,000	-7,000

Source: Unpublished runs from the Annie E. Casey Foundation, Population Reference Bureau analysis of 2011 American Community Survey, U. S. Census Bureau

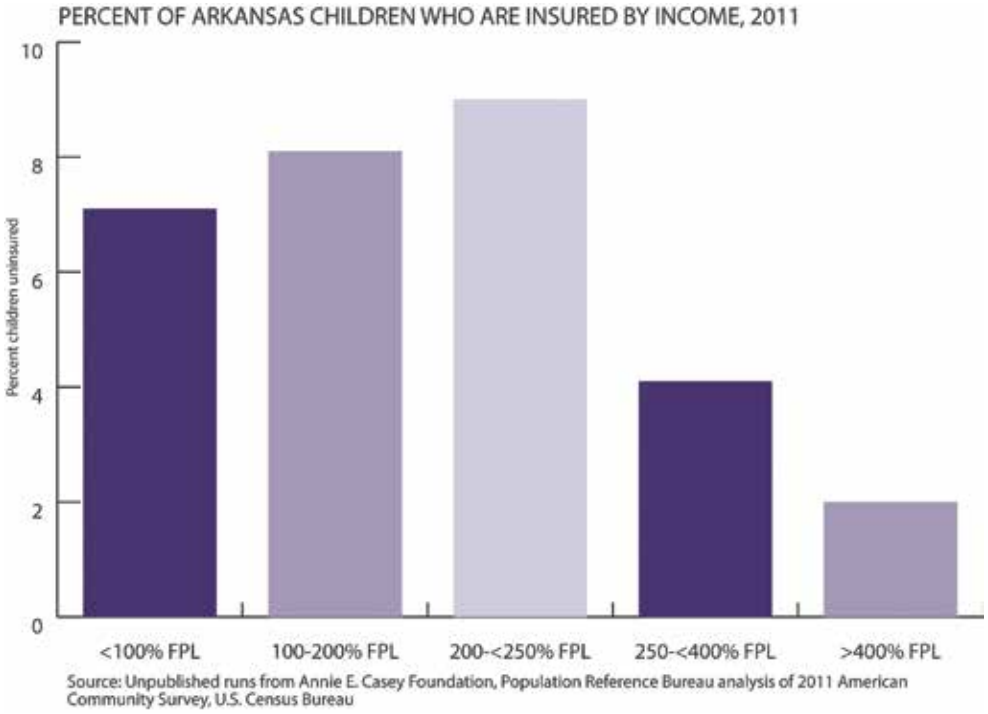
about two thirds of children who remain uninsured could qualify for ARKids First.
In 2008, 12.1 percent of children who could qualify for ARKids First, based on family income being below 200 percent FPL, were uninsured. In 2011 that rate had dropped by more than a third to just 7.6 percent.

One reason for the reduction in uninsured children is improved enrollment in ARKids First.

If we look at more detailed income breakdowns, we can see that children just above the income limit for ARKids First have the highest uninsured rate of all incomes at nine percent. Children in this income range cannot qualify for ARKids and employer coverage or comprehensive private insurance may not be affordable for families.



Legislation passed in 2009 to extend coverage to these families up to 250 percent FPL has not yet been implemented due to budget concerns. Thankfully, the Affordable Care Act (ACA) will help make coverage more affordable for families just above the ARKids First limit in 2014.

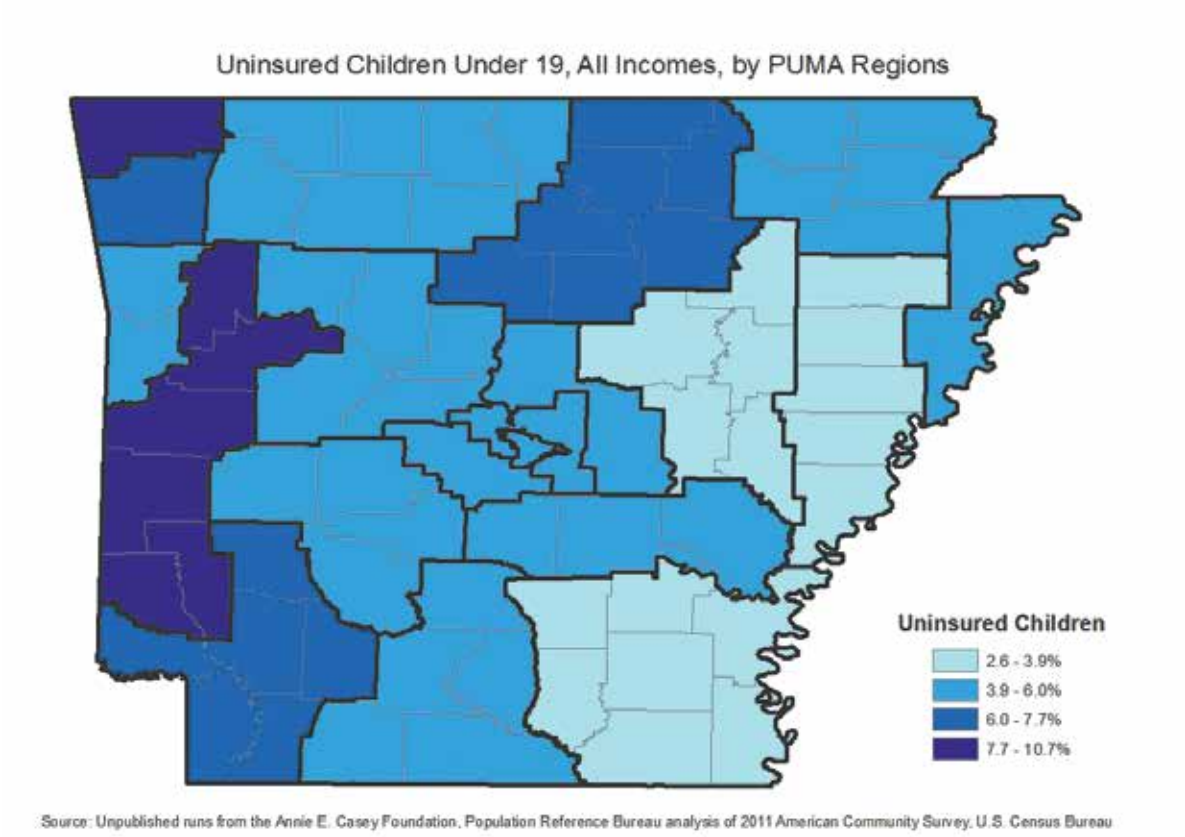


IMPORTANCE OF OUTREACH AND CHILD HEALTH COVERAGE POLICIES

With 46,000 children in Arkansas lacking health insurance, stakeholders working to insure every child must be strategic. Outreach efforts and policy changes based in data can help reach even more children.

Where do Uninsured Children Live?

The map below shows regional variations in the percent of all children under age 19 who are uninsured. As is evidenced by the map, western and north-central Arkansas have the highest rates of uninsured children compared to the rest of the state. The Mississippi River Delta region, in contrast, has some of the lowest rates of uninsured children.



Source: Unpublished runs from the Annie E. Casey Foundation, Population Reference Bureau analysis of 2011 American Community Survey, U.S. Census Bureau

Breakdowns by Arkansas's congressional districts show a slightly different picture. In this breakdown, children under age 18 in Central Arkansas (Second District) are less likely to have health coverage than in any other region, while children in the northeast corner of the state (First District) have the lowest uninsured rate of any other district. Note that 18-year-olds, who still qualify for ARKids First, are not included in this set of data.

UNINSURED CHILDREN UNDER 18, ALL INCOMES, BY 112TH CONGRESSIONAL DISTRICTS

First District(Northeast)	4.5%
Second District (Central)	6.3%
Third District (Northwest)	5.6%
Fourth District (South and Southwest)	6.1%

Source: American Community Survey, 2011 1-year data access via American FactFinder Table B27001 on February 21, 2013

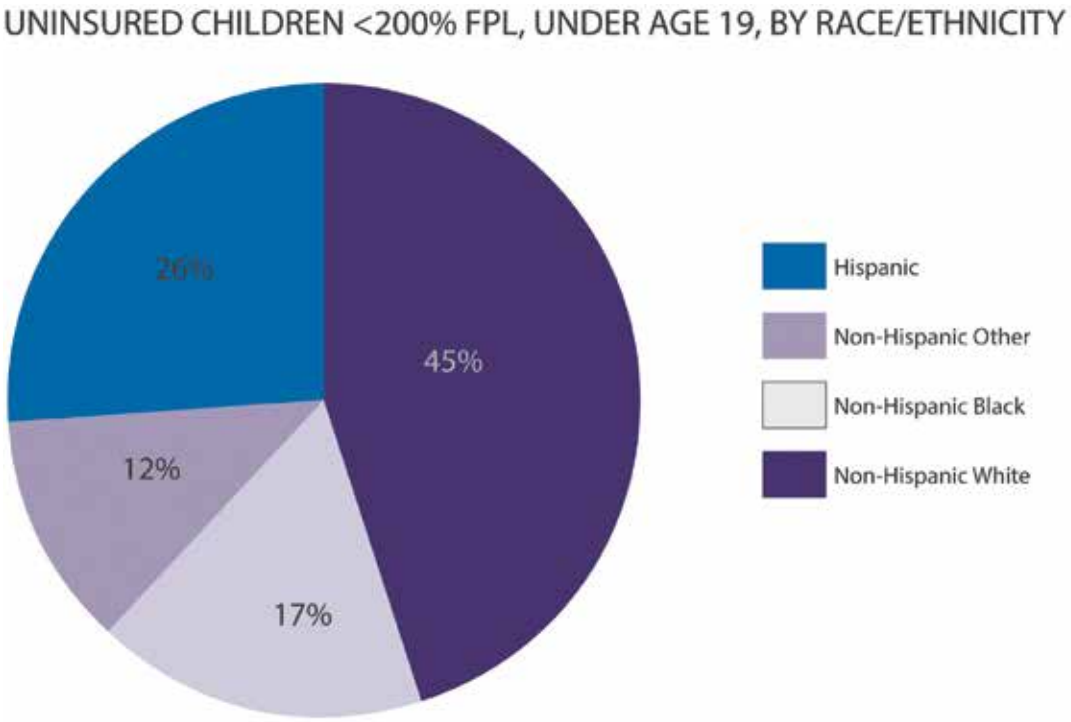
New data based on three-year Census Bureau averages shows county-level data on uninsured children under age 19 for all but Arkansas's smallest counties, where the data is not as reliable. Uninsured rates for the 37 largest counties in the state are shown below. The state's three-year average rate for the same population is 6.3 percent. (This is slightly different from the 2011-only rate of 6 percent).

County	# Uninsured Children Under 18	% Uninsured Children Under 18
Logan	800	13.9%
Yell	600	11.2%
Polk	500	10.8%
Hot Spring	700	9.5%
Cleburne	500	9.4%
Sebastian	2,800	8.8%
Johnson	500	8.6%
Conway	400	8.0%
Washington	4,100	8.0%
Benton	4,800	7.7%
Faulkner	2,000	7.4%
Independence	600	7.2%
Baxter	500	7.2%
Garland	1,400	7.2%
White	1,300	6.9%
Saline	1,700	6.4%
Crawford	1,000	6.4%
Union	600	6.1%
Hempstead	300	5.8%
Pulaski	5,300	5.8%
Carroll	400	5.7%
Pope	700	5.0%
St. Francis	300	4.7%
Ouachita	300	4.6%
Jefferson	800	4.5%
Poinsett	300	4.4%
Lonoke	800	4.4%
Craighead	1,000	4.3%
Crittenden	600	3.9%
Ashley	200	3.6%
Columbia	200	3.5%
Miller	300	3.1%
Greene	300	2.9%
Boone	200	2.8%
Phillips	100	2.1%
Mississippi	200	1.8%
Clark	100	1.5%

Outreach efforts that target areas with high uninsured rates could drastically reduce the number of uninsured children. For example, more than a third of the state's uninsured children live in just four counties: Pulaski, Washington, Benton, and Sebastian. Intense efforts within those counties could have an enormous impact on Arkansas's overall progress in covering the uninsured.

How Do Race/Ethnicity, Language, and Citizenship Play a Role?

Outreach efforts to enroll eligible children in ARKids First and Medicaid must be culturally and linguistically appropriate. Although 45 percent of uninsured children who could qualify for ARKids based on their family's income are white, a growing number are Hispanic, Black, or another race/ethnicity. The pie chart below shows the breakdown by race of uninsured children 0-18 whose family income is less than 200 percent of the federal poverty level.



Source: Unpublished runs from the Annie E. Casey Foundation, Population Reference Bureau analysis of 2011 American Community Survey, U.S. Census Bureau

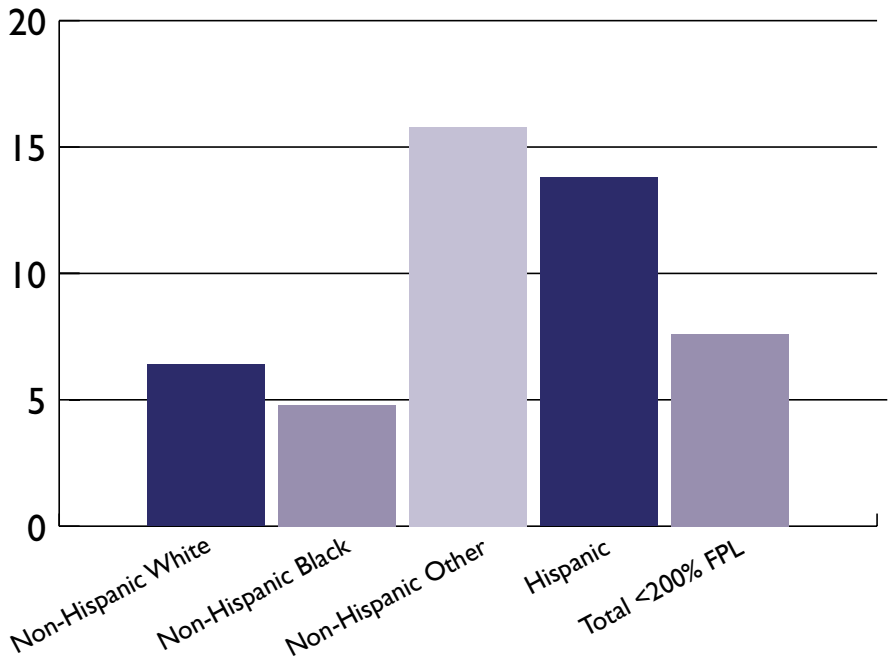
The graph below shows the percent of children income-eligible for ARKids First who are uninsured within each racial/ethnic category. White and black children have uninsured rates below the average across all racial and ethnic groups, demonstrating effective enrollment efforts toward these populations. The two groups with the highest uninsured rate are non-Hispanic "other" races and Hispanic children.

- **Non-Hispanic children who are not white or black** have the highest uninsured rate, with one in six lacking coverage. This "other" category includes the Marshallese, non-citizens who have a compact with the United States to live here legally, but without a path toward citizenship. Some Marshallese children were born in the United States

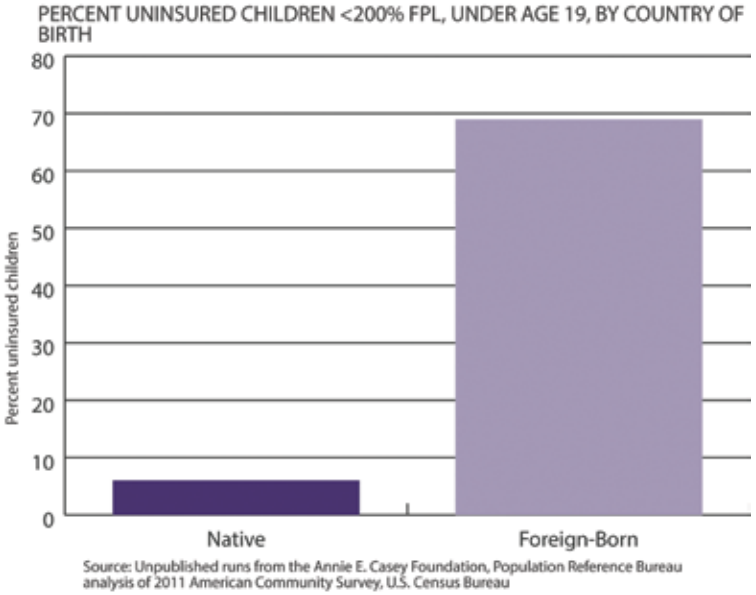
and are therefore citizens, but many have emigrated here and are not eligible for ARKids First under current rules. Even Marshallese children who are citizens face language barriers, and the community's perception that benefits are not available to the Marshallese can be another challenge.[4] Additionally, the concept of health coverage is new to those who recently arrived in the United States.

- **Hispanic children** are also disproportionately uninsured, with almost 14 percent lacking coverage. Again, language barriers likely play a role, although ARKids First and Medicaid applications are available in Spanish. The Department of Human Services's Access Arkansas website is also available in Spanish. Families who have mixed citizenship status may fear the application process even for citizen children because it could identify them as undocumented. Even children who came to the United States legally face a significant barrier: Arkansas does not let them enroll in ARKids First until they have been in the United States at least five years.

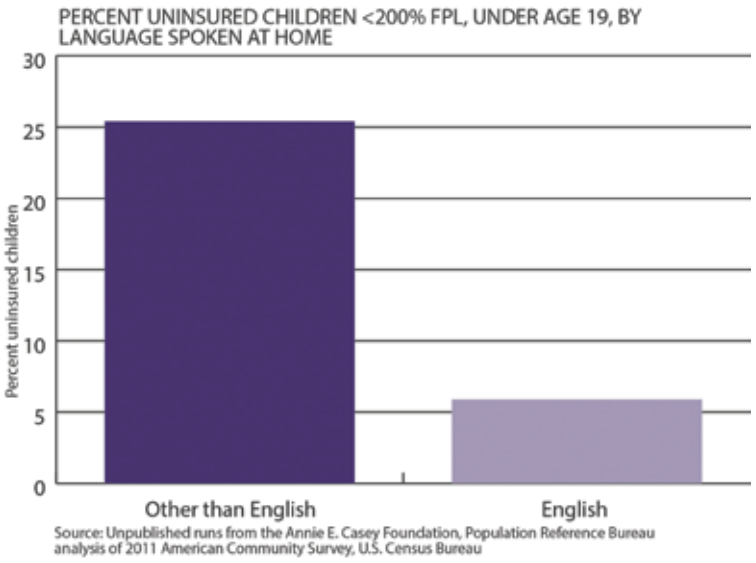
PERCENT UNINSURED CHILDREN <200% FPL, UNDER AGE 19, BY RACE/ETHNICITY



The challenges facing foreign-born children are evident in the data. Almost seven in 10 children who were not born in the United States lack health coverage. This is in stark contrast with the six percent of citizen children who lack coverage.



A quarter of children whose families speak a language other than English at home are uninsured. This is four times higher than the uninsured rate of English-speaking families.



Several potential solutions exist to help both Hispanic and Marshallese children access coverage. The 2009 Children's Health Insurance Program Reauthorization (CHIPRA) included two options that could be helpful in Arkansas.

- Arkansas can eliminate the "**five year bar"** that prevents immigrant children from enrolling in coverage for five years after they arrive in the U.S. If Arkansas elects to make this change, as 24 states have already done, it also expands coverage to all lawfully

residing, non-immigrant Marshallese children.[5] Changing this rule could potentially cover up to about 1,000 children who were not previously eligible.[6]

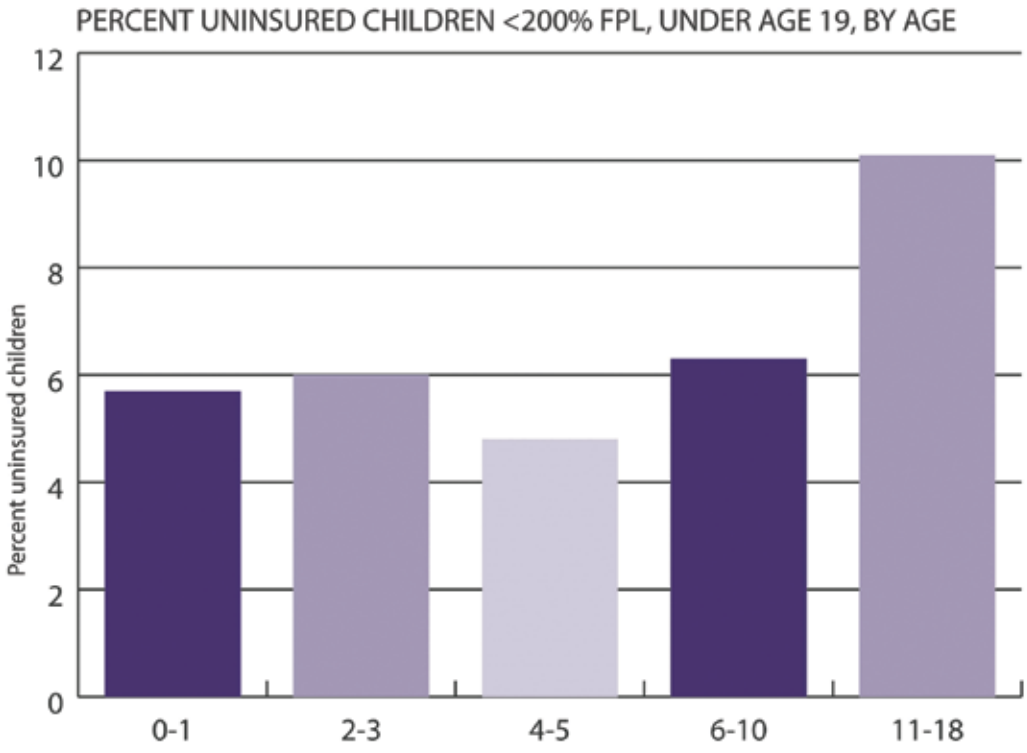
- Arkansas can get a higher Medicaid matching rate from the federal government for language access services such as written translation of health-related materials and spoken translation in a health care setting.[7] Improved language accessibility will help more families feel comfortable with the ARKids First enrollment process and with accessing health care services.

Targeted outreach efforts need to be developed to reach racial and ethnic minority families. Arkansas should take advantage of opportunities for additional funding for outreach as they arise, increasing capacity for reaching those who need additional help to get coverage.

How does age affect coverage?

In the past, targeted efforts to tie health coverage to quality child care have helped reduce the number of young uninsured children. Children need certain health services such as vaccinations in order to enter school, which is likely why 4- and 5-year-olds have the highest rates of coverage.

Data shows that as children grow up, they are less likely to have coverage. Many factors could affect enrollment as children age, including fewer required vaccinations for school or fewer childhood illnesses that need to be treated by health care providers. Ten percent of adolescents ages 11 to 18 lack coverage during a critical point in development. The highest rates of obesity occur in Arkansas's sixth-grade students, and the changes that come along with puberty mean that check-ups with a primary care provider are very important.[8] Schools can play an important role in ensuring that students enroll in coverage, and middle and high schools may need to increase their efforts.



Source: Unpublished runs from the Annie E. Casey Foundation, Population Reference Bureau analysis of 2011 American Community Survey, U.S. Census Bureau

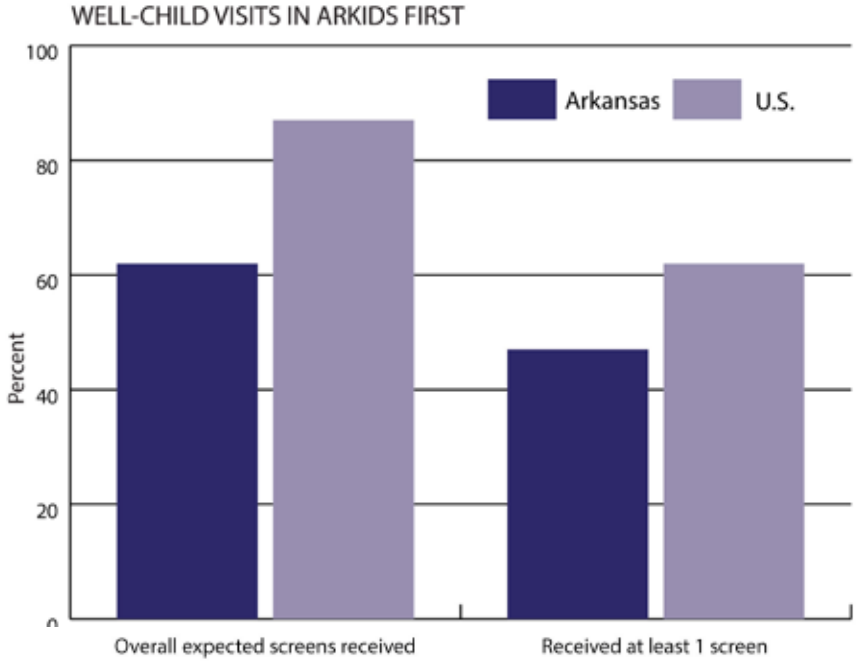
Children Need Better Access to Primary Care

Holding a Medicaid card is only the first step in ensuring children can access the services they need. Access to a primary care provider and appropriate well-child screenings that ensure healthy development are both important measures of access to care. These two areas remain a challenge for children who use ARKids First.

In July 2012, seven percent of children enrolled in ARKids First or Medicaid (22,000 children) did not have an assigned primary care provider. However, close to half of those children did have a PCP at some point in the previous year, and most accessed health care services at some point during that time. Only 267 enrolled children (less than one percent) lacked a PCP and had no medical claims in the year prior to July 2012. However, the data shows that 13,000 children enrolled in ARKids First lacked a primary doctor at some point in the previous year, potentially limiting their access to a clinic for sick visits or well-child checks. Certain areas of the state seem to be challenged by access to care based on anecdotal evidence, including northwest Arkansas.

Children in Arkansas who are enrolled in ARKids First and Medicaid do not necessarily receive all of the well-child screens that they should have. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a Medicaid requirement that ensures low-income children covered by Medicaid receive comprehensive primary care. The EPSDT coverage helps identify and treat physical or mental problems that could interfere with growth or development.[9] Unfortunately, the data shows that only 47 percent of children under age 21 enrolled in Medicaid or ARKids First received at least one of the screens they should have during 2011. Nationally, 62 percent of children received the screens they should have, far better than the rate in Arkansas.[10]

Some children, such as infants, should get multiple screens each year. In 2011, 62 percent of all screens expected for children enrolled in ARKids First were received. The national rate is 87 percent.



Source: Centers for Medicare and Medicaid Services, Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment. 2011 National and State data.

Arkansas can make improvements in access to care for children who have an ARKids First or Medicaid card. There are many factors that affect whether or not a child has good access to care, including parental involvement, health literacy, transportation, provider availability, or lack of sick days for parents. Strengthening opportunities for children to get care, such as through school-based health care, can help make sure children stay healthy even if parents cannot take of work to visit the doctor.

PARENTS: THE KEY TO BETTER CHILD COVERAGE

Research shows that when parents have health coverage, children are more likely to have coverage and get the care they need.[11] However, many low-income parents have no affordable, quality health coverage available. Health coverage keeps family budgets secure by avoiding big medical bills and makes sure children have healthy, hardworking, engaged parents. The Georgetown Center for Children and Families released an Arkansas Fact Sheet that explores the 80,000 parents earning less than 138 percent FPL ($31,800 for a family of four or $15,400 for an individual) who lack health insurance.

Of the 80,000 uninsured low-income parents in Arkansas:

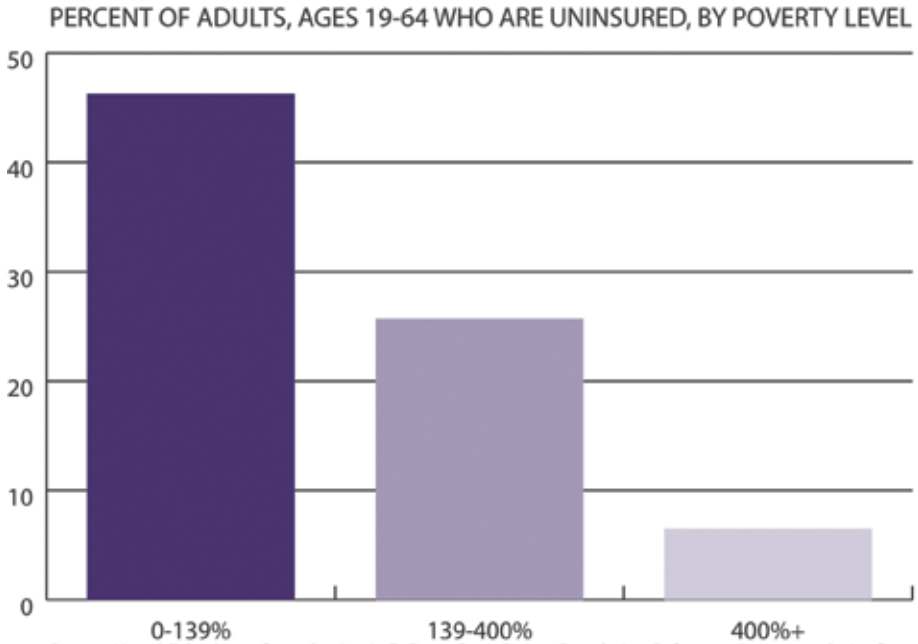
- 23 percent are currently eligible for Medicaid but not enrolled
- 39 percent earn less than half the poverty level, about $11,755 per year for a family of four
- 58 percent work
- 70 percent are white; 21 percent are black, and 7 percent are Hispanic

Who are the uninsured adults in Arkansas?

Arkansas has the opportunity to provide affordable health coverage to uninsured adults, including parents, who earn up to 138 percent of the federal poverty level. Arkansas can do this simply by accepting federal funds that have been allotted to the state by the Affordable Care Act.

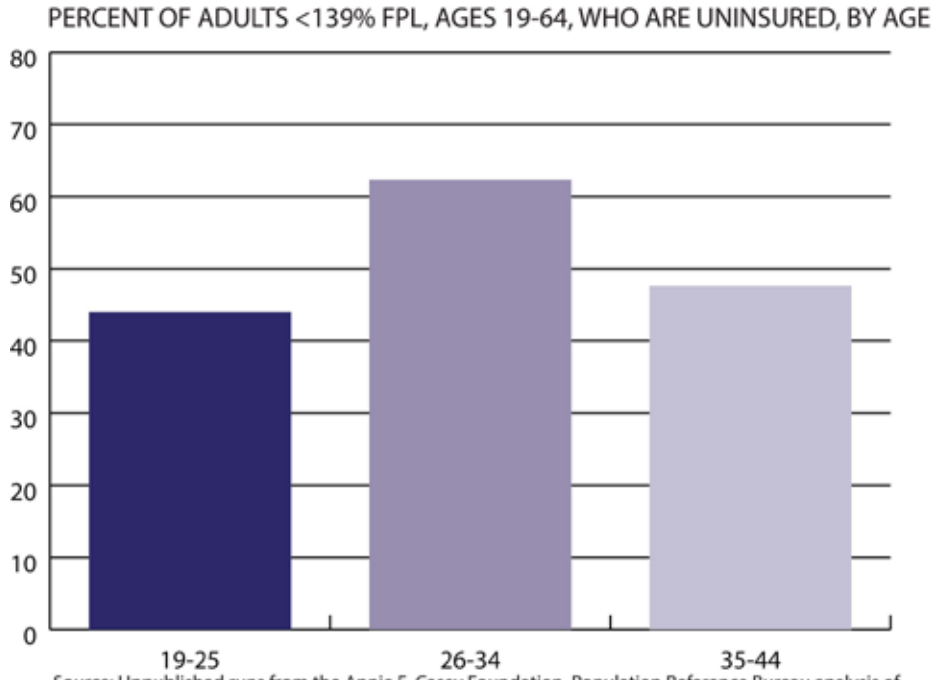
Accepting the funds means that adult coverage is paid for 100 percent by the federal government for three years. After that, Arkansas must chip in part of the cost, but no more than 10 percent.

This opportunity to strengthen options for affordable, comprehensive coverage in Arkansas means parents, future parents, and other adults in a child's life have access to health care that keeps them healthy. Low-income adults are much more likely to lack health coverage than their higher-income neighbors.



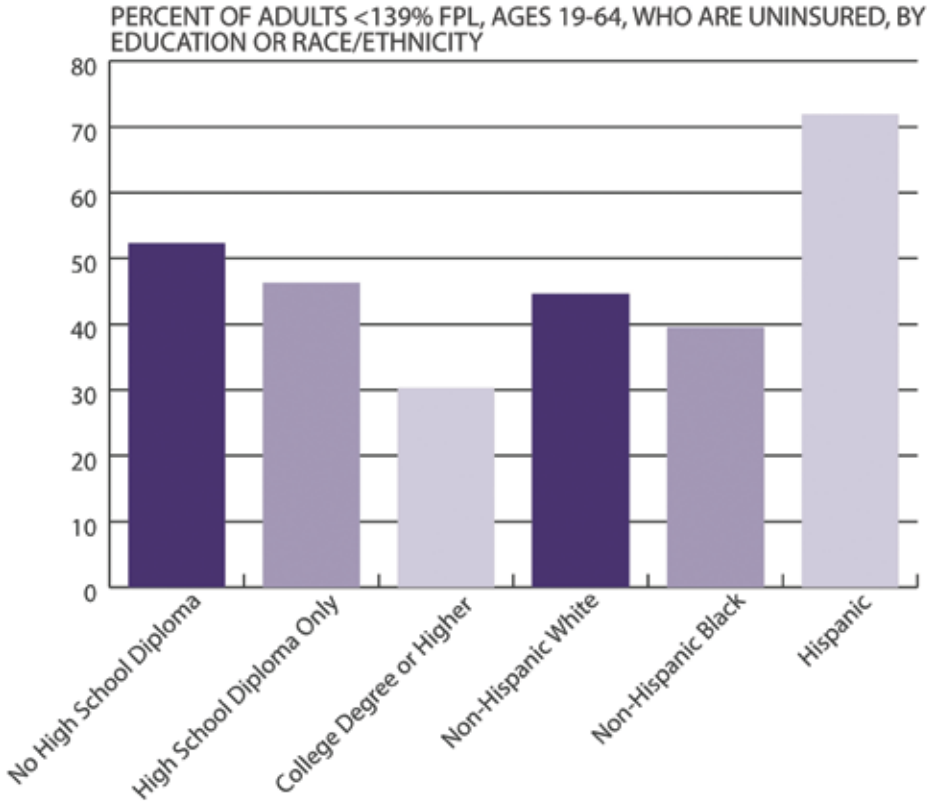
Source: Unpublished runs from the Annie E. Casey Foundation, Population Reference Bureau analysis of 2011 American Community Survey, U.S. Census Bureau

Many low-income adults of childbearing and parenting age are uninsured. Sixty-two percent of low-income adults between the ages of 26 and 34 lack coverage, the highest rate of any group.



Source: Unpublished runs from the Annie E. Casey Foundation, Population Reference Bureau analysis of 2011 American Community Survey, U.S. Census Bureau

Low-income adults with lower education levels are more likely to lack health insurance than college graduates. More than 70 percent of Hispanic adults lack health coverage.



Source: Unpublished runs from the Annie E. Casey Foundation, Population Reference Bureau analysis of 2011 American Community Survey, U.S. Census Bureau

Taking advantage of the opportunity to cover uninsured adults benefits all of Arkansas by strengthening families and allowing families to work. The financial security provided by health coverage allows families to grow their assets – one component of escaping poverty.

HEALTH COVERAGE POLICY UPDATE

The world of health coverage has undergone a variety of changes in the past year. With the Supreme Court upholding the Affordable Care Act (ACA), President Obama's re-election eliminating the possibility of repealing the Act, and local implementation of health care payment reform and new eligibility/enrollment systems, Arkansas's health system is evolving rapidly.

The Affordable Care Act: Affordable, Comprehensive Coverage for More Arkansans

The Supreme Court upheld the Affordable Care Act in June 2012, paving the way for more Americans to have access to affordable, comprehensive health care coverage come January 1, 2014. The Supreme Court did, however, find that states cannot be required to strengthen their Medicaid programs, leaving the decision to offer extended coverage to uninsured adults up to each state. Research shows that covering parents means that more children get the coverage and care they need, which would help Arkansas reach the 46,000 children who still lack coverage. If Arkansas chooses to strengthen Medicaid, 250,000 individuals could gain coverage funded by Medicaid, including 80,000 uninsured, low-income parents.

Arkansas is working in partnership with federal officials to implement the state's health insurance exchange, a marketplace where more than 200,000 higher-income families can purchase private health insurance. Through this marketplace, most uninsured Arkansans earning more than 138 percent of the federal poverty level will receive subsidies on a sliding scale to help them afford comprehensive health coverage. The website through which plans can be bought will allow consumers to compare plans and benefits side-by-side with cost information clearly displayed. This marketplace will benefit those children just above the income cut-off for ARKids First, the income group with the highest rate of uninsured kids. Much like with ARKids First, outreach and enrollment efforts will be critical in letting families know about the new coverage that is available and applying for coverage.

Together, Medicaid and the health insurance marketplace are projected to increase economic activity by $550 million annually and create 6,200 new jobs in the state. Most importantly, the ACA has the potential to save 2,300 lives each year through the health coverage it affords Arkansans.[12]

As the law is implemented, advocates must ensure that the needs of families are met. Some families may have multiple types of coverage, such as a family in which the father has employer coverage, the mother has private exchange coverage, and the child has ARKids First. These families need special consideration to ensure that they can use the same health care providers and maintain reasonable cost-sharing limits for the family. Changing jobs or coverage can also mean gaps in care, so policies need to be set to minimize disruption in care when coverage changes. Enrollment efforts should focus on getting coverage for families, and sites such as schools, child care centers, and community-based organizations need to be part of the outreach effort.

Despite the need for continued implementation work, several provisions of the ACA are already making a difference in AR children's lives.

- As of December 2011, 35,000 young adults in Arkansas had gained health insurance through the provision that allows children to stay on their parents' coverage until age 26.[13]
- Access to preventive care has been improved or maintained for 64 percent of Arkansas children (456,000 children) through both ARKids First/Medicaid and in private insurance plans. Better coverage of preventive services and elimination of cost-sharing such as copays for preventive services helped children get the care they need.[14]
- Gurdon and Springdale school districts each received about $500,000 to help expand their school-based health clinics, improving access to health care for children.[15]
- Moms received some help, too. Almost 400,000 women in Arkansas received improved access to new preventive services with no cost-sharing.[16]
- Children were protected from being denied coverage due to a pre-existing condition.

Even more protections will be in place for children as the full law goes into effect in January 2014.

- Each year, around 200 Arkansas children who age out of the foster care system without finding a "forever" family will be able to remain on Medicaid until age 26.[17]
- Lifetime limits on insurance coverage will no longer be allowed.
- The federal matching rate for ARKids First will increase to 100 percent in 2015, ensuring that Medicaid and CHIP remain strong for children until 2019.
- Parents will be able to access affordable coverage, allowing them to focus on being a great parent rather than medical bills.
- Affordable coverage will be available for other adults in a child's life. Low-income workers most likely to be uninsured work in fields such as child or elder care, education, restaurants, construction, or retail businesses.[18]

Increasing capacity for school-based health care in Springdale thanks to the ACA

Jones Elementary School in Springdale, Arkansas received a grant to build capacity in its school-based health center thanks to the Affordable Care Act. The grant will help provide additional health center space to meet the needs of its students and their families. The school district partners with Ozark Guidance Center and Community Clinic of Northwest Arkansas to provide mental and physical health services above and beyond those that are available from the school nurse or school counselor. Approximately 98 percent of the students at Jones live in poverty, and most speak English as a second language. The school-based health center removes barriers to receiving care. When services are available on campus, students may avoid absences related to poor access to health care or to lack of management of chronic conditions such as asthma or diabetes. Families, teachers, and other staff members are also able to utilize the services provided.

Marc's Story: Furthering his education thanks to the ACA

In 2012, Marc Peters was a student at the Clinton School of Public Service in Little Rock, Arkansas. Since high school, Marc has been in treatment for mental illness including depression and bipolar disorder. He depends on several prescriptions, ongoing psychiatric treatment, and regular therapy to remain a high-achieving student in a competitive graduate program. Thankfully, Marc has been able to stay on his mother's health insurance plan until age 26 while furthering his education. However, Marc turned 26 just before graduation, which meant that he had to pay more than $600 each month to keep health coverage. The Affordable Care Act's protections that prohibit turning people away from coverage due to pre-existing conditions do not go into place until 2014, so buying insurance in the private market was unaffordable for Marc. He had to find employment quickly that offered comprehensive health care coverage in order to afford the care he needed. Marc is thankful to the Affordable Care Act for allowing him to continue his education and begin a career he cares about.

Update on Cutting the Red Tape

During the 2011 legislative session, Act 771 was passed to help remove "red tape" from ARKids First enrollment and coverage renewals by using existing databases to verify a child's eligibility. This was designed to be done in several ways:

- "Ex-Parte" or paperless renewals that check eligibility electronically
- "Express Lane Enrollment" uses data from other programs to enroll uninsured, eligible children
- Twelve-month continuous coverage ensures income fluctuations don't disrupt coverage
- Pre-populated paper renewal forms simplify the current paper-form renewal system

Unfortunately, the majority of the law has not yet been implemented; only the paper form has been updated. Louisiana has shown savings of $12 million annually by using Express Lane Enrollment, and they reduced the number of uninsured children by 45 percent in just one year.[19] As DHS implements its new eligibility and enrollment system, slated to interface with the health insurance exchange, the agency should build in functionality for compliance with Act 771 of 2011 for everyone who is enrolled in Medicaid. Advocates should continue to push for implementation of the provisions in Act 771 to help cover more children.

In early 2012, a positive change was made to the ARKids First enrollment process: self-declaration of income was accepted without requiring a check for consistency with the Workforce Employment Security Division database, much as the program has been intended to function since 1997. The old verification process could cause unsubstantiated enrollment delays based on a case worker's determination if a few dollars per month difference was "inconsistent" or not. Of course, if a case worker suspects an income discrepancy based on eligibility for other programs, a family's income would be verified. As part of the state's policies, errors stemming from erroneous self-declaration fall on the consumer, avoiding state liability.

DHS has invested in new efforts to reach more Arkansans. Eight high-tech mobile enrollment units connect low-income people in rural and underserved areas to food and medical assistance programs. Each enrollment van is equipped with five computers, a satellite, and an on-board generator. The vans travel to food bank events, health fairs, flu clinics, job fairs, volunteer tax sites, and many other community events

and enroll families on the spot. The Access Arkansas website is enrolling even more families, too: in January 2013, more than 1,000 applications for ARKids First were received via Access Arkansas.

DHS has made strong efforts to enroll more children and families. The agency's new eligibility and enrollment system should undergo substantial consumer testing to ensure that it incorporates Act 771's policy changes and that it is simple to use for consumers.

RECOMMENDATIONS

1) Ensure children are protected during health care reform decisions. ARKids First and Medicaid care for Arkansas children. They allow children to receive the care they need, and they protect families' pocketbooks no matter the severity of their children's health needs. As Arkansas implements health care reform policy changes, children covered by ARKids First should remain in the coverage they have. Down the road, new coverage options may make sense once they are fully implemented, but in the short term, ARKids First should not change. Thankfully, the ACA's "Maintenance of Effort" prevents eligibility or enrollment from changes that could reduce access to care for children until 2019.

2) Improve parent coverage. Arkansas should take advantage of the social and economic benefits of strengthening Medicaid coverage for low-income adults. Higher income adults will be able to get coverage through the health insurance exchange marketplace. Both avenues offer affordable coverage for adults so they can support their children and grow assets without worrying about medical bills, and together they will help reduce the number of uninsured children by 40 percent.[20]

3) Capitalize on new outreach funds to cover children. Ensure children are included in targeted outreach efforts that are supported by the health insurance exchange and strengthened Medicaid coverage. Millions of federal dollars will be used to advertise new adult coverage opportunities and full-family insurance, but families need to know that children can get coverage, too. In-Person Assisters need to know where Arkansas's uninsured children live and what their characteristics are. Special efforts should be made to reach the state's growing Hispanic community and others with language or cultural barriers using the increased matching rate available for language access services.

4) Cover the Marshallese. Marshallese children could be covered by ARKids First if the state makes a simple rule change. They live here, work here, and have families here, but many are

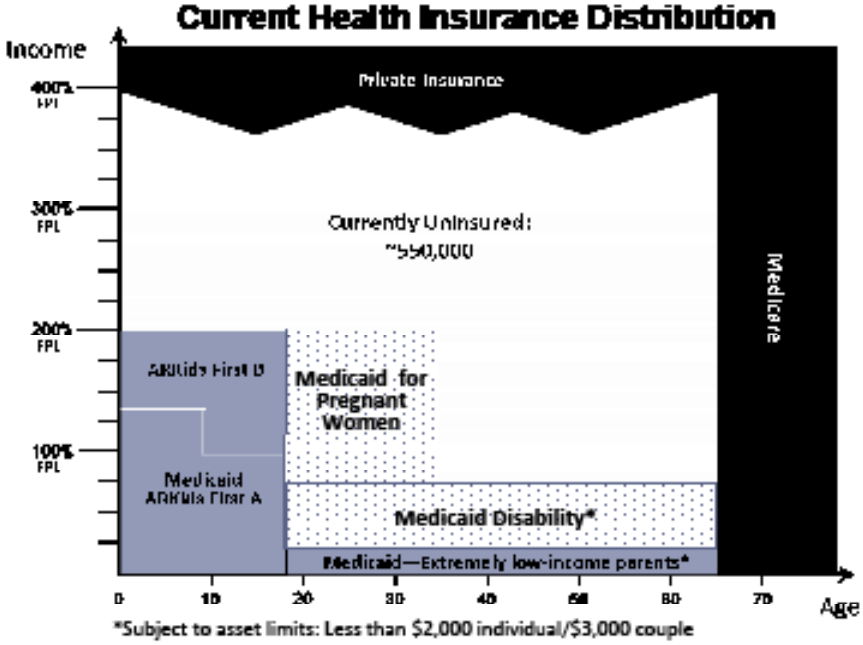
uninsured. It makes sense to help them access preventive care so they do not end up in the emergency room with serious conditions.

5) Strengthen access to care for children. Continued investment in school-based health care can bring care to children, easing the mind of parents who have no sick days or unreliable transportation. Health literacy should to be improved on both the provider and patient side through improved communication, simplified forms and information, and public health media campaigns.

6) Ensure new eligibility and enrollment systems are easy-to-use. As DHS implements the upgraded eligibility and enrollment system and the exchange portal is released, advocates should push for end-user testing to ensure the systems meet the needs of families, especially those with complex coverage situations or language access issues.

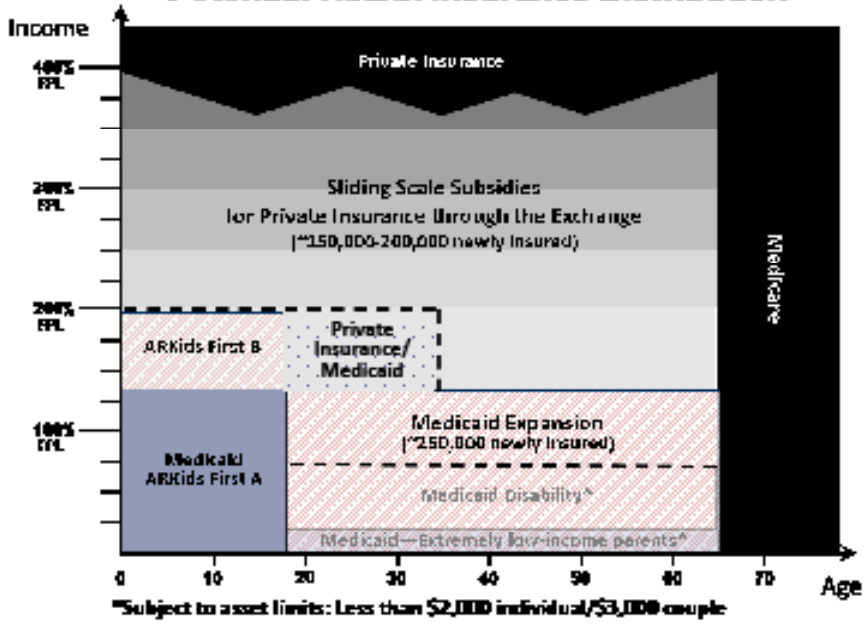
Overview of Potential Health Insurance Distribution for Arkansans Via Full Implementation of the Patient Protection and Affordable Care Act (January 2013)

Current Health Insurance Distribution



*Subject to asset limits: Less than $2,000 individual/$3,000 couple

Potential Health Insurance Distribution



*Subject to asset limits: Less than $2,000 individual/$3,000 couple

These graphics represent the current and potential future patchwork of primary sources of health insurance coverage for Arkansas based upon existing policy.

At present, Medicaid provides coverage to children and pregnant women below 200 percent of the Federal Poverty Level (FPL) which varies by family size. Medicaid also covers a limited number of individuals—very low-income parents and those with disabilities—based upon income tests and asset limits (less than $2000/individual or $3000/couple).

If expanded as depicted in the second graphic, Arkansas Medicaid would increase eligibility to adults earning less than 139 percent of the FPL, regardless of assets. In addition, ARKids B would become 100 percent federally funded. Current Medicaid programs for pregnant women and the disabled would have fewer participants over time as enrollment is transitioned to expanded Medicaid benefits or private insurance coverage through the Exchange that would not require individuals to dispose of assets to be eligible.

Private insurance expansion will occur through the Health Insurance Exchange with sliding scale subsidies available for those earning between 139-400 percent FPL—as income increases. Subsidies reduce as depicted by the tiers above 138 percent FPL.

2012 Federal Poverty Level[1]				
Household Size	100% FPL	138% FPL	200% FPL	400% FPL
1	$11,170	$15,415	$22,340	$44,680
2	$15,130	$20,879	$30,260	$60,520
3	$19,090	$26,344	$38,180	$76,360
4	$23,050	$31,809	$46,100	$92,200

[1]U.S. Department of Health and Human Services. 2012 HHS Poverty Guidelines.

ACHI

Arkansas Center for Health Improvement

A nonpartisan, independent, health policy center that serves as a catalyst for improving the health of Arkansans.

ARKids First and Medicaid Enrollment Data by County, January 2013

County	ARKids First A	ARKids First B	Other Medicaid Categories	Total Medicaid or ARKids First U19
Arkansas	1,882	511	441	2,834
Ashley	2,420	572	520	3,512
Baxter	2,938	991	544	4,473
Benton	16,794	5,736	2,715	25,245
Boone	2,953	1,006	761	4,720
Bradley	1,430	389	290	2,109
Calhoun	372	125	88	585
Carroll	2,675	792	339	3,806
Chicot	1,450	260	503	2,213
Clark	1,710	563	500	2,773
Clay	1,322	462	285	2,069
Cleburne	1,936	674	324	2,934
Cleveland	783	206	161	1,150
Columbia	2,072	530	769	3,371
Conway	1,966	513	530	3,009
Craighead	8,768	2,265	3,267	14,300
Crawford	6,113	1,664	1,045	8,822
Crittenden	6,452	1,231	2,596	10,279
Cross	1,749	594	537	2,880
Dallas	740	201	278	1,219
Desha	1,690	348	471	2,509
Drew	1,776	479	508	2,763
Faulkner	8,093	2,510	1,714	12,317
Franklin	1,630	433	293	2,356
Fulton	1,030	255	248	1,533
Garland	9,236	2,499	2,105	13,840
Grant	1,354	436	258	2,048
Greene	4,315	1,211	1,032	6,558
Hempstead	2,757	633	664	4,054
Hot Spring	3,006	992	571	4,569
Howard	1,630	429	367	2,426
Independence	3,535	937	830	5,302
Izard	1,089	326	267	1,682
Jackson	1,787	348	465	2,600
Jefferson	7,566	1,673	3,022	12,261
Johnson	3,052	766	497	4,315
Lafayette	735	150	210	1,095
Lawrence	1,550	570	434	2,554

ARKids First and Medicaid Enrollment Data by County, January 2013, continued

County	ARKids First A	ARKids First B	Other Medicaid Categories	Total Medicaid or ARKids First U19
Lee	856	219	529	1,604
Lincoln	1,063	304	275	1,642
Little River	1,052	307	345	1,704
Logan	2,319	631	473	3,423
Lonoke	5,259	1,652	1,150	8,061
Madison	1,577	490	235	2,302
Marion	1,360	383	238	1,981
Miller	3,993	968	1,696	6,657
Mississippi	5,094	1,263	2,183	8,540
Monroe	862	202	261	1,325
Montgomery	839	300	126	1,265
Nevada	1,069	206	195	1,470
Newton	688	261	130	1,079
Ouachita	2,709	656	741	4,106
Perry	896	253	212	1,361
Phillips	3,013	506	1,465	4,984
Pike	1,259	374	162	1,795
Poinsett	2,801	708	753	4,262
Polk	2,349	625	339	3,313
Pope	5,346	1,646	1,055	8,047
Prairie	732	236	145	1,113
Pulaski	32,039	8,500	12,796	53,335
Randolph	1,716	551	404	2,671
Saline	7,156	2,579	1,203	10,938
Scott	1,302	319	197	1,818
Searcy	749	292	123	1,164
Sebastian	12,749	2,944	2,767	18,460
Sevier	2,583	616	310	3,509
Sharp	1,658	504	451	2,613
St. Francis	2,684	677	1,662	5,023
Stone	1,224	361	190	1,775
Union	4,236	1,146	1,020	6,402
Van Buren	1,505	453	224	2,182
Washington	19,580	5,286	3,124	27,990
White	6,817	2,107	1,413	10,337
Woodruff	752	166	224	1,142
Yell	2,638	707	422	3,767
TOTAL	**266,880**	**73,678**	**69,687**	**410,245**

Children's Primary Care Provider and Claims data, by county, July 2012

County	Enrolled Children under age 21	Percent with no PCP in July 2012	Percent with no PCP July 2011 - July 2012	Percent with no PCP and no claims July 2011 - July 2012
Arkansas	2,171	5.0%	2.6%	0.0%
Ashley	2,754	5.0%	2.9%	0.1%
Baxter	3,149	4.4%	2.9%	0.1%
Benton	17,204	7.2%	5.1%	0.0%
Boone	3,367	5.5%	3.8%	0.1%
Bradley	1,590	5.3%	2.9%	0.1%
Calhoun	441	6.3%	3.4%	0.0%
Carroll	2,733	8.0%	5.5%	0.0%
Chicot	1,872	5.3%	3.3%	0.1%
Clark	2,059	4.2%	2.9%	0.1%
Clay	1,518	7.0%	4.2%	0.0%
Cleburne	2,012	5.6%	3.5%	0.0%
Cleveland	869	4.5%	2.9%	0.1%
Columbia	2,685	6.4%	3.9%	0.1%
Conway	2,372	4.0%	2.4%	0.2%
Craighead	11,181	6.1%	3.4%	0.1%
Crawford	6,600	6.1%	3.8%	0.1%
Crittenden	8,490	7.6%	5.0%	0.1%
Cross	2,088	5.0%	2.8%	0.1%
Dallas	903	5.5%	3.2%	0.0%
Desha	2,049	6.0%	3.1%	0.1%
Drew	2,129	5.2%	2.9%	0.0%
Faulkner	8,900	6.6%	4.0%	0.1%
Franklin	1,736	6.6%	3.9%	0.0%
Fulton	1,141	5.9%	3.9%	0.0%
Garland	10,720	4.8%	3.1%	0.1%
Grant	1,470	7.3%	4.7%	0.1%
Greene	4,796	5.0%	2.9%	0.0%
Hempstead	3,134	7.4%	4.7%	0.2%
Hotspring	3,267	3.6%	2.1%	0.0%
Howard	1,802	7.3%	6.0%	0.1%
Independence	3,945	6.1%	3.6%	0.0%
Izard	1,219	18.2%	3.9%	0.0%
Jackson	2,077	5.8%	3.2%	0.0%
Jefferson	10,221	8.9%	6.3%	0.1%
Johnson	3,015	5.0%	2.8%	0.0%
Lafayette	897	6.2%	4.1%	0.1%
Lawrence	1,912	4.8%	2.5%	0.1%

Children's Primary Care Provider and Claims data, by county, July 2012, continued

County	Enrolled Children under age 21	Percent with no PCP in July 2012	Percent with no PCP July 2011 - July 2012	Percent with no PCP and no claims July 2011 - July 2012
Lee	1,333	5.5%	3.2%	0.2%
Lincoln	1,245	5.3%	2.9%	0.0%
Littleriver	1,252	7.4%	3.6%	0.3%
Logan	2,538	4.7%	3.0%	0.0%
Lonoke	5,917	7.7%	4.5%	0.0%
Madison	1,656	5.4%	4.3%	0.0%
Marion	1,475	7.3%	5.8%	0.1%
Miller	5,126	10.9%	8.5%	0.5%
Mississippi	6,892	6.4%	4.1%	0.1%
Monroe	1,026	6.4%	4.1%	0.0%
Montgomery	915	3.7%	2.6%	0.2%
Nevada	1,154	4.9%	2.4%	0.2%
Newton	756	2.9%	2.6%	0.4%
Ouachita	3,220	6.4%	3.4%	0.1%
Perry	1,010	4.9%	2.1%	0.1%
Phillips	4,279	3.8%	2.1%	0.2%
Pike	1,297	5.6%	3.3%	0.0%
Poinsett	3,415	5.9%	3.6%	0.1%
Polk	2,398	4.7%	3.0%	0.0%
Pope	5,767	4.5%	2.4%	0.1%
Prairie	819	4.8%	2.4%	0.0%
Pulaski	43,280	11.3%	5.1%	0.1%
Randolph	1,944	4.5%	2.7%	0.0%
Saline	7,640	7.2%	4.2%	0.1%
Scott	1,408	7.1%	5.3%	0.0%
Searcy	808	6.2%	4.1%	0.0%
Sebastian	14,119	7.8%	4.7%	0.0%
Sevier	2,712	4.6%	3.1%	0.1%
Sharp	1,948	5.4%	3.3%	0.1%
St.francis	4,143	6.1%	3.7%	0.0%
Stone	1,298	2.8%	1.8%	0.1%
Union	4,976	8.7%	4.4%	0.2%
Vanburen	1,622	4.7%	2.8%	0.1%
Washington	20,673	7.4%	5.3%	0.1%
White	7,597	5.5%	3.1%	0.1%
Woodruff	952	5.0%	2.3%	0.0%
Yell	2,837	5.5%	3.1%	0.1%
TOTAL	**311,751**	**7.1%**	**4.2%**	**0.1%**

ARKids First Income and Eligibility Data

INCOME AND ELIGIBILITY FOR ARKIDS FIRST A (MEDICAID)

2012 Federal Poverty Line	Age	1 person	2 people	3 people	4 people	Each add'l person
Up to 100%	6 to 19	$11,170	$15,130	$19,090	$23,030	$3,960
Up to 133%	Under 6	$14,856	$20,123	$25,390	$30,657	$5,267

Source: Arkansas Department of Human Services ArKids First eligibility. www.arkidsfirst.com.

INCOME AND ELIGIBILITY FOR ARKIDS FIRST B (CHIP)

2012 Federal Poverty Line	Age	1 person	2 people	3 people	4 people	Each add'l person
100-200%	6 to 19	$22,340	$30,260	$38,180	$46,100	$7,920
133-200%	Under 6	$22,340	$30,260	$38,180	$46,100	$7,920

Source: Arkansas Department of Human Services ArKids First eligibility. www.arkidsfirst.com.

REFERENCES

[1]Reeve. 2012 Arkansas Child Poverty Update. Arkansas Advocates for Children and Families (2012). http://www.aradvocates.org/assets/PDFs/Child-Welfare/2012-Arkansas-Child-Poverty-Update.pdf

[2]Kenny, Lynch, Huntress, Haley, Anderson. "Medicaid/CHIP Participation Among Children and Parents. (2012). http://www.urban.org/UploadedPDF/412719-Medicaid-CHIP-Participation-Among-Children-and-Parents.pdf

[3]Alker, Mancini, Heberlein. Uninsured Children 2009-2011: Charting the Nation's Progress. (2012). http://ccf.georgetown.edu/wp-content/uploads/2012/10/Uninsured-Children-2009-2011.pdf

[4]Jimeno S., Rafael A. 2013. A Profile of the Marshallese Community in Arkansas, Volume 3. Little Rock, AR, and Fayetteville, AR: Winthrop Rockefeller Foundation and University of Arkansas. http://www.wrfoundation.org/assets/files/pdfs/Immigrant%20Study%202012/Volume%203%20-%20A%20Profile%20of%20the%20Marshallese%20Community%20In%20Arkansas.pdf

[5] For more information, see AR Advocates for Children and Families' report "Critical Generation: Improving the well-being of children of immigrants in Arkansas." (2012).

[6]Estimate based on Population Reference Bureau analysis of 2008-10 ACS PUMS data, US Census Bureau and a model for estimating immigrant coverage by Dr. Leighton Ku at George Washington University. Dr. Ku developed estimates based on "national and regional data compiled from various sources, including the Urban Institute and the Pew Hispanic Center."

[7]Families USA. Improving Language Access: CHIPRA provides increased funding for language services. (2010). http://familiesusa2.org/assets/pdfs/chipra/improving-language-access.pdf

[8]Arkansas Children's Hospital. Natural Wonders: The state of children's health in Arkansas, third edition. (2011). http://www.archildrens.org/documents/News/NatWon-report-2011.pdf

[9]Arkansas Advocates for Children and Families. Arkansas Children: Lacking Preventive Health Care. (2011).

[10]Centers for Medicare and Medicaid Services. Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment. 2011 National and State Data. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html

[11]Strong. Strengthening Medicaid Helps Families. Arkansas Advocates for Children and Families. (2012).

[12]Carter, Saltzman. The economic impact of the affordable care act on Arkansas. RAND Corporation. (2013). Retrieved from http://www.achi.net/MiscDocs/130103RAND%20Final.pdf.

[13]HealthCare.gov. State level estimates of gains in insurance coverage among young adults. (2012) Last retrieved from http://www.healthcare.gov/news/factsheets/2012/06/young-adults06192012a.html.

[14]Georgetown University Health Policy Unit, Center for Children and Families. ACA protects and improves access to preventive care for children. (2012). Last retrieved from http://ccf.georgetown.edu/wp-content/uploads/2012/03/ACA-Protects-and-improves-access-to-preventive-care-for-children-3-24-2012.pdf.

[15] U.S. Department of Health and Human Services. HHS announces new investment in school-based health centers. (2011). Retrieved from http://www.hhs.gov/news/press/2011pres/07/20110714a.html

[16] HealthCare.gov. How the Health Care Law is making a difference for the people of Arkansas. (2012). Last retrieved from http://www.healthcare.gov/law/information-for-you/ar.html.

[17]AR data from Arkansas Division of Child and Family Services. ACA coverage information from First Focus. ACA Coverage for Youth Aging out of Foster Care. (2013). Retrieved from http://www.firstfocus.net/sites/default/files/ACA%20Foster%20Care.pdf.

[18] Kincaid, Reeve. Extending Health Coverage to Arkansas Workers: Which industries benefit the most? Arkansas Advocates for Children and Families. (2013). Retrieved from http://www.aradvocates.org/assets/PDFs/Health/Medicaid-Industry-Report.pdf.

[19]Dorn, Hill, and Adams. Louisiana breaks new ground: The nation's first use of automatic enrollment through Express Lane Eligibility. Urban Institute. (Revised April 2012).

[20]Health Affairs. Improving Coverage for children under health reform will require maintaining current eligibility standards for Medicaid and CHIP. 2011. Last retrieved from http://content.healthaffairs.org/content/30/12/2371.full?ijkey=6QEmwQdpdoGds&keytype=ref&siteid=healthaff And sourced from Georgetown Center for Children and Families blog at http://ccf.georgetown.edu/ccf-resources/improving-coverage-for-children-under-health-reform-will-require-maintaining-current-eligibility-standards-for-medicaid-and-chip/?issue=aca%2F.

35 YEARS

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

www.aradvocates.org