CLEARING THE HURDLES TO COVERAGE

KIDS' HEALTH COVERAGE IN 2016

NOVEMBER 2016

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

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KIDS' HEALTH COVERAGE IN 2016

by Marquita Little, Health Policy Director
Arkansas Advocates for Children and Families
November 2016

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

EXECUTIVE SUMMARY

The health care system in Arkansas is practically unrecognizable when compared to just a few years ago. Although we had made progress to improve coverage for kids, one out of four adults in the state was uninsured. Today's health care landscape is very different. Now, we offer comprehensive coverage to many of the Arkansans who were left out of the health care system for decades. This report examines the impact of the new coverage option created by the Affordable Care Act (ACA) a year after implementation. Data from the American Community Survey will offer a look at the impact of expanding health coverage and the remaining opportunities for further progress.

In 2014, the number of uninsured children under 19 years old dropped to a historic 4.9 percent as more children enrolled in coverage with their parents. Despite these gains in coverage, access to important screening, preventative and treatment services lags behind. For example, Arkansas children are far less likely to receive early medical screenings – 13 percentage points below the national average.

Low-income adults in Arkansas also experienced a major boost because of Medicaid expansion. With more than 270,000 adults enrolled in coverage today, Arkansas soared ahead as a national leader at reducing uninsured rates. Many of the persistent gaps between families at different income levels even dwindled as the state has moved toward a seamless health coverage environment.

Because of new affordable coverage options within the ACA, we have been hugely successful in increasing access to coverage for children and their families. But we can do even better. The following recommendations would help Arkansas cross the Finish Line and achieve coverage for all:

- Remove the administrative hurdles to enrolling and staying enrolled in coverage
- Invest in consumer outreach and education
- Remove coverage barriers for legally residing immigrant children
- Improve access to health care services for children
- Protect funding for children's coverage

Those changes would help close unnecessary coverage gaps among:

- Legally residing immigrant children
- Older children and youth
- Families in consistently uninsured regions of the state, like Northwest Arkansas

The health care system continues to change as we move closer to the Finish Line. For example, the state has a new version of the successful Medicaid expansion program and will soon transition to a state-based health insurance marketplace. As we do this, it will be critical to effectively roll out these system changes to protect the recent achievements in health coverage. Access to care is within reach of every Arkansan if we continue to clear the remaining hurdles to crossing the health coverage Finish Line.

We have been hugely successful in increasing access to coverage for children and their families. But we can do even better.

INTRODUCTION

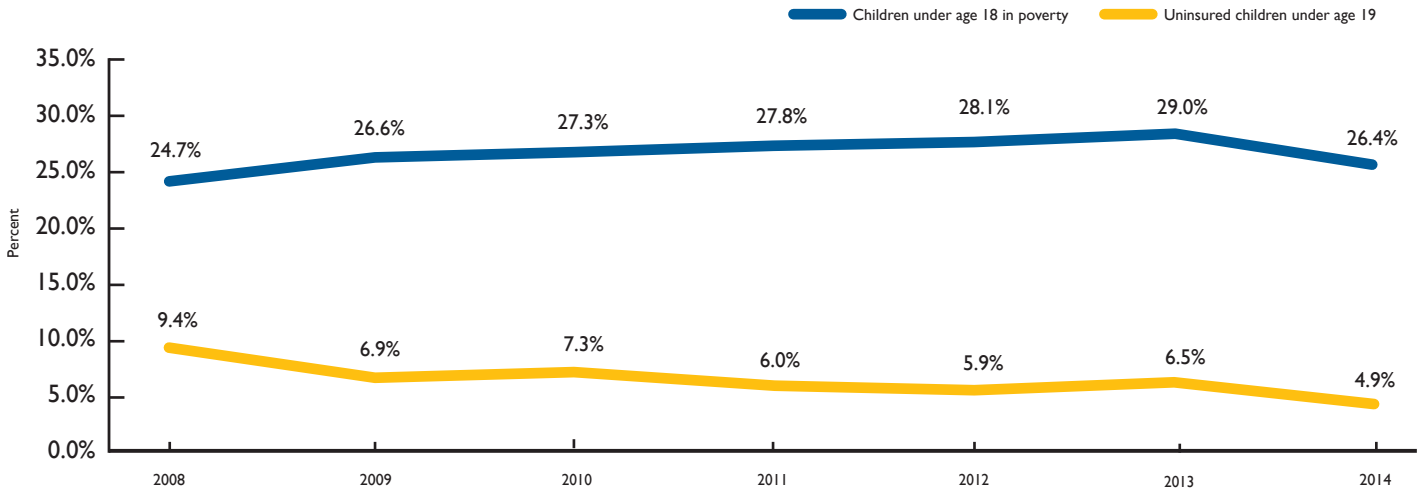
In recent years, the health care system has changed significantly. Most of the changes we've experienced in Arkansas have been a result of implementing Affordable Care Act (ACA) and other federal health reforms. Insurance companies can no longer deny someone coverage because of a pre-existing condition and many young adults can remain on their parents' coverage. Arkansas also adopted opportunities like Medicaid expansion and the insurance marketplace to expand affordable coverage options for children and their families. Today, more parents and caregivers have access to coverage, which means kids are also more likely to have coverage and stay enrolled.

Ensuring children and families have consistent access to coverage has been critical, as the economy improves from a period of economic downturn. For several years, poverty rates in Arkansas continued to climb, but children were protected from dangerous losses in coverage. The state not only avoided coverage losses for kids, but continued to reduce insurance rates. With new, affordable coverage options for families in 2014 and a drop in child poverty for the first time in many years, Arkansas has entered a new stage of the race to build a strong health care system that serves everyone.

This report offers a close look at the impact of the Medicaid expansion program and the health insurance marketplace. These two major policy decisions helped reduce health insurance disparities based on income levels and provided many low-income adults with coverage for the first time. Several hurdles remain before Arkansas can cross the Finish Line by reaching 100 percent coverage for kids. This report will:

- Present data on the current state of coverage for children and families
- Provide demographic information on uninsured Arkansans
- Examine remaining barriers to coverage and care
- Make recommendations to improve access to coverage

CHILD POVERTY RATES COMPARED TO UNINSURED CHILDREN 2008-2014



Source: PRB analysis of American Community Survey PUMS, U.S. Census Bureau and U.S. Census Bureau, Small Area Income and Poverty Estimates

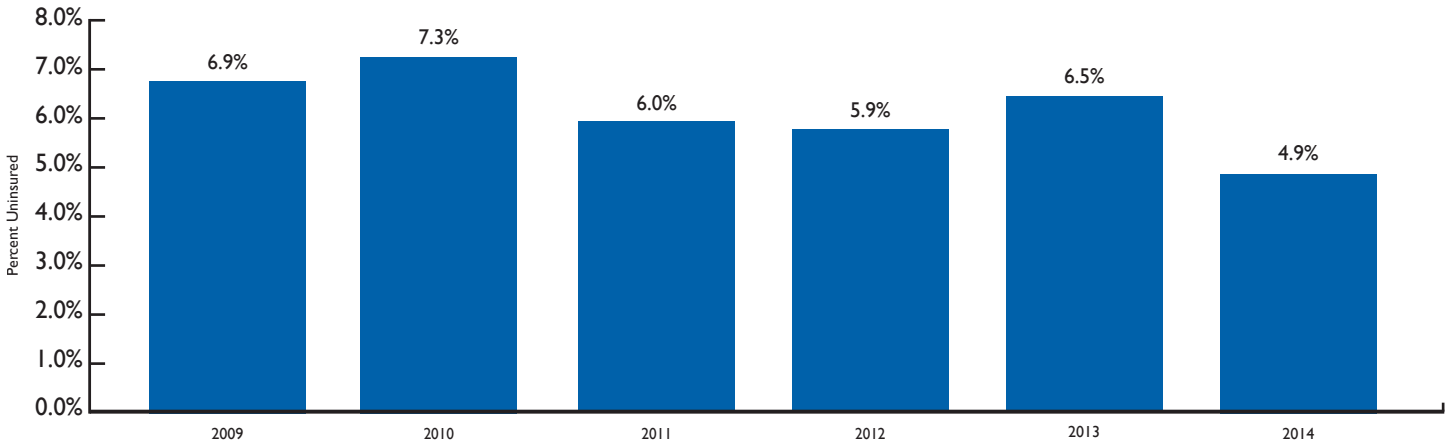
Arkansas has entered a new stage of the race to build a strong health care system that serves everyone.

SNAPSHOT OF CHILD HEALTH COVERAGE IN ARKANSAS

Based on the most recent data from the American Community Survey, the number of uninsured children under 19 years old has reached a historic low — just under 5 percent. After several years of remaining steady, 2014 was a year of major progress. The steady gains are due in large part to the ARKids First program, which has provided a consistent, affordable source of coverage for many families since 1997.

In 2014, we took a large leap forward when families were able to enroll in insurance through the Health Insurance Marketplace and the Health Care Independence Program (also known as the Private Option). After one year of implementation, Arkansas established its position as a national leader in reducing rates of uninsured adults.

PERCENT OF ARKANSAS CHILDREN UNDER 19 WHO ARE UNINSURED HAS DROPPED



Source: PRB analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

THE DATA

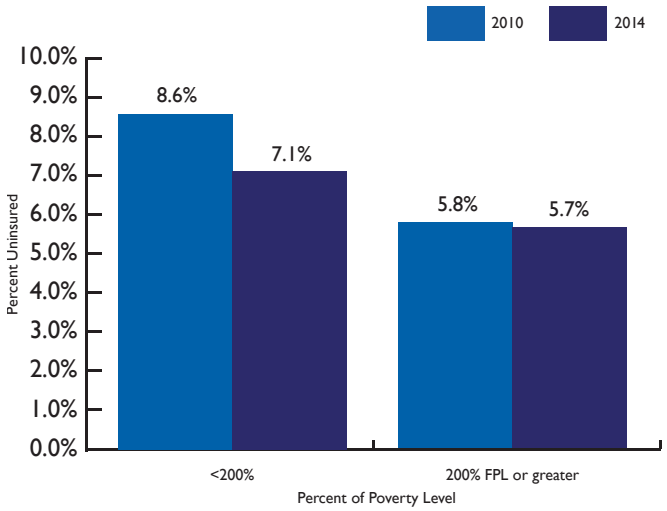
CHILDREN

The state has continued to make impressive progress toward the goal of ensuring every child in Arkansas is healthy by providing them with comprehensive coverage. With more than 95 percent of children enrolled in coverage, this monumental progress is due in part to the ACA, which created new, affordable coverage options for the entire family. When parents are covered, kids are more likely to be covered, too.

The focus should now be on identifying the children and families who are still uninsured and removing remaining barriers to enrollment and retaining coverage.

REDUCTIONS IN THE RATE OF UNINSURED CHILDREN ACROSS INCOME LEVELS

Percent of uninsured children who are uninsured by income, 2010-2014

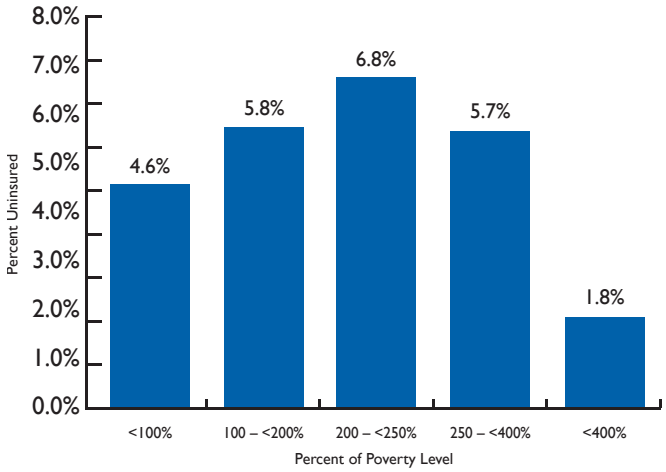


Source: PRB analysis of 2010 and 2014 American Community Survey PUMS, U.S. Census Bureau

Income level often impacts coverage status because of the high cost of insurance. We've continued to see the number of uninsured children remain steady or decline regardless of family income level. In line with national findings, state-level data from the previous year showed children in families between 100-199% of the federal poverty line were disproportionately uninsured. Since this was likely a result of families not enrolling children who were eligible in ARKids First, we've seen this income-related disparity change due to the "welcome mat effect." That is, many eligible children enrolled in coverage when their caregivers enrolled in Private Option and marketplace plans.

HOUSEHOLD INCOME HAD A MODEST IMPACT ON CHILDREN'S ACCESS TO COVERAGE

Percent of Arkansas children who are uninsured by income, 2014



Source: PRB analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

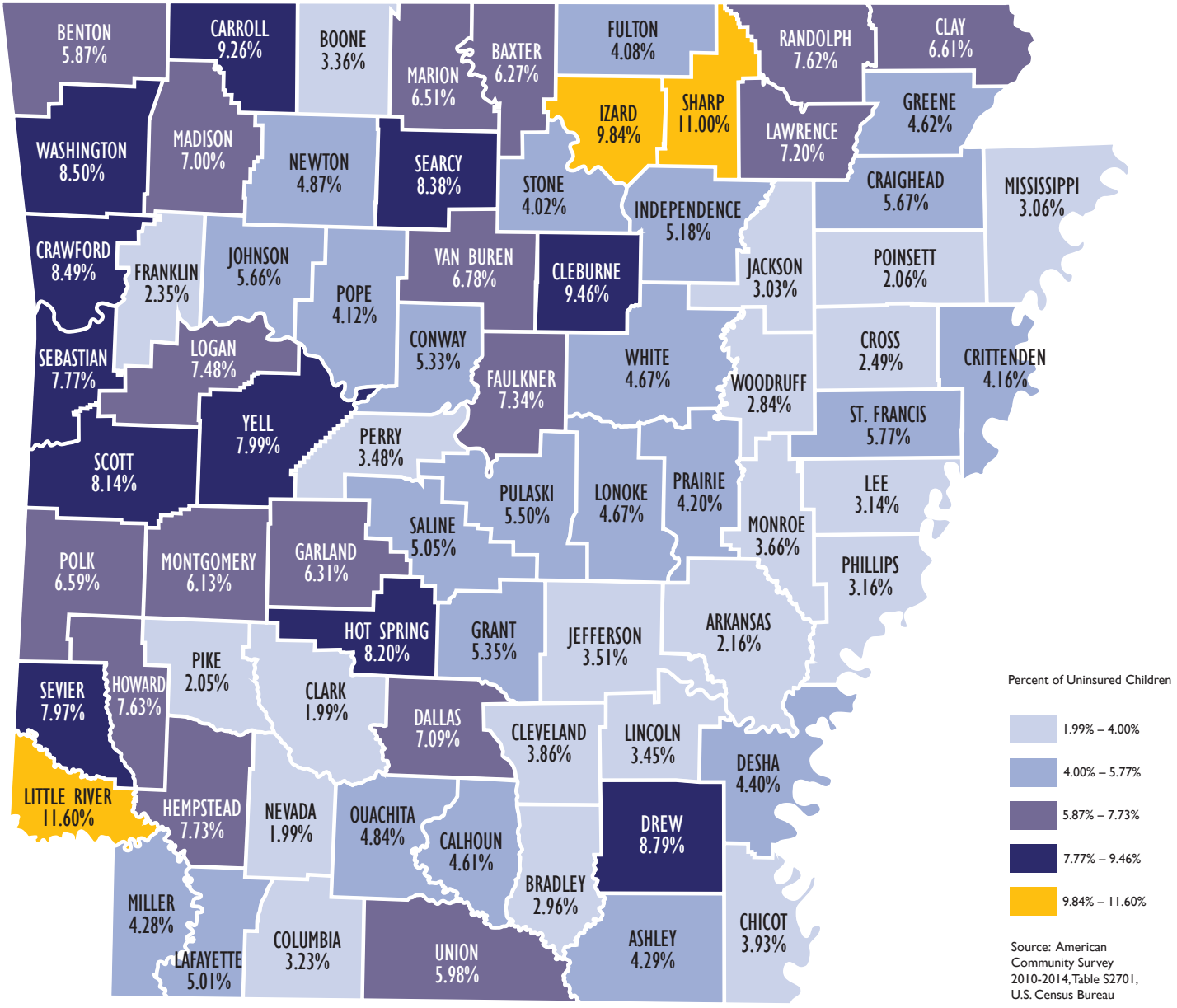
UNINSURED CHILDREN BY CONGRESSIONAL DISTRICTS

Geography	Uninsured	Percent
Congressional District 1 (East)	5,000	3%
Congressional District 2 (Central)	11,000	6%
Congressional District 3 (Northwest)	11,000	6%
Congressional District 4 (Southwest)	7,000	5%

Source: American Community Survey 2014 1-year data accessed by American FactFinder

Although more children are enrolled than ever before, there are still major geographical differences in coverage. The data show that children in the northwest region of the state continue to have reduced access to coverage. We have also seen a slight increase in uninsured children in the central region of the state. Since the northwestern and central regions of the state have higher Hispanic populations and these children are more likely to be uninsured, this may be a major driver for the geographic disparities. This is discussed in greater depth later in the report.

UNINSURED CHILDREN UNDER AGE 18 BY COUNTY



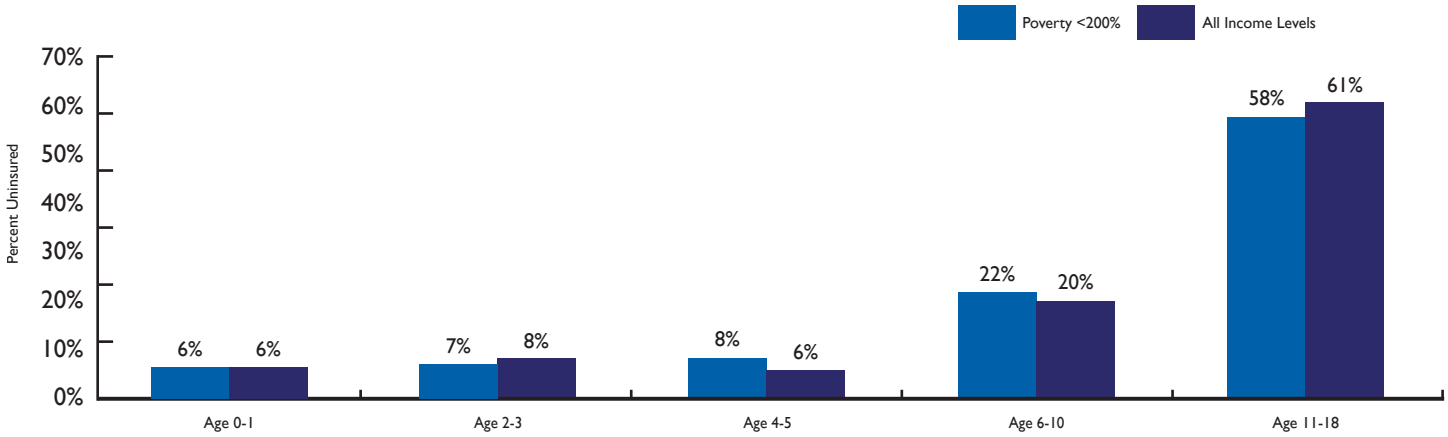
Source: American Community Survey 2010-2014, Table S2701, U.S. Census Bureau

The 2014 Census data continued to show a major age difference between insured and uninsured children. It has consistently been the trend that children are much more likely to be uninsured as they get older. Outreach strategies should focus on how to increase enrollment of school-age and high school students. Even with expanded coverage options, we see major differences by age.

Race and ethnicity also still play a role in health coverage status for children. The data show Hispanic children are more likely to be uninsured when compared to other children in Arkansas. A national report by the Georgetown Center for Children and Families and the National Council of La Raza shows that the uninsurance rate for Hispanic children reached a historic low in the first year after implementation of the ACA.[1] This drop was more likely in Medicaid expansion states, which explains the 1.5 percent drop in Arkansas.

MOST LOW-INCOME CHILDREN WHO ARE UNINSURED ARE 11-18 YEARS OLD

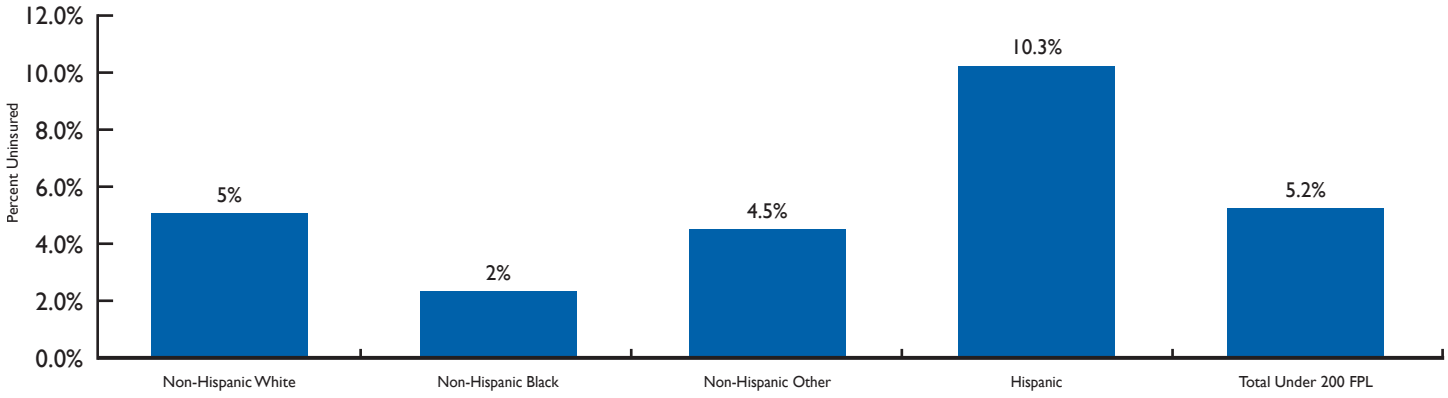
Percent of uninsured children under 19 by household income



Source: PRB Analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

HISPANIC CHILDREN ARE MOST LIKELY TO BE UNINSURED

Percent of uninsured children under 19 with household incomes below 200 percent of poverty by race/ethicity

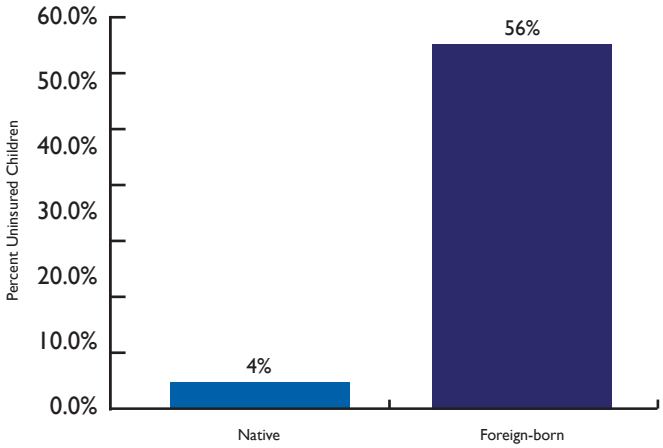


Source: PRB analysis of 20104 American Community Survey PUMS, U.S. Census Bureau

Among its suggestions, the national report recommends raising Medicaid and CHIP eligibility levels[2] and removing the five-year waiting period on lawfully residing immigrant children to enroll in Medicaid and CHIP (ARKids First).[3] Arkansas has never fully implemented Act 435, passed in 2004, to increase eligibility to 250 percent of the federal poverty level, or removed the five-year enrollment ban for legally residing immigrant kids.

IMMIGRANT CHILDREN ARE MORE LIKELY TO BE UNINSURED

Percent of uninsured children under 19 with household incomes below 200 percent of poverty, by country of birth

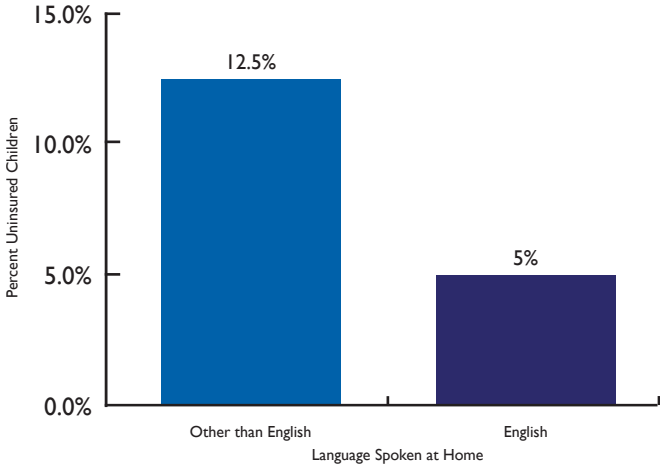


Source: PRB Analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

National data show that more than two-thirds of uninsured Hispanic children are eligible to enroll in Medicaid and CHIP because they are citizens and low-income. But they remain unenrolled because of language barriers, complex eligibility requirements, and lack of knowledge of their eligibility. Arkansas data also show that children who should be eligible based on income, but speak a language other than English at home, are much more likely to be uninsured.

CHILDREN WHO SPEAK ENGLISH AS A SECOND LANGUAGE ARE MORE LIKELY TO BE UNINSURED

Percent of uninsured children under 19 with household incomes below 200 percent of poverty, by language spoken at home



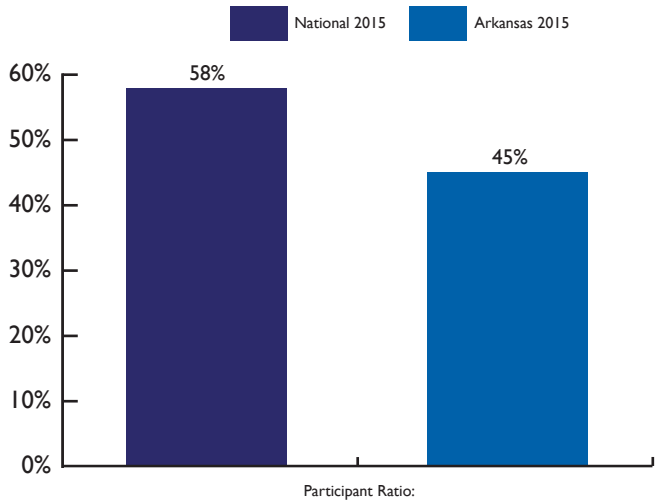
Source: PRB Analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

More than two-thirds of uninsured Hispanic children are eligible to enroll in Medicaid and CHIP because they are citizens and low-income. But they remain unenrolled.

CHILDREN'S ACCESS TO HEALTH CARE SERVICES

Access to health coverage is important to ensure children can thrive and live healthy lives by getting the care and treatment they need. While we've made significant gains in expanding access to health coverage, the major measure of success is getting high-quality treatment and preventive care. One consistent measure of that is whether children receive checkups known as Early Periodic Screening Diagnosis and Treatment (EPSDT). The EPSDT benefit is federally required for Medicaid beneficiaries up to 21 years old.[4] It follows a recommended schedule for screenings and ensures that children also receive the preventive, dental, mental, developmental, and specialty services they need.

CHILDREN RECEIVING A WELL-CHILD VISIT IN ARKANSAS BELOW NATIONAL RATES
ARKids A Children who received screens, 2015



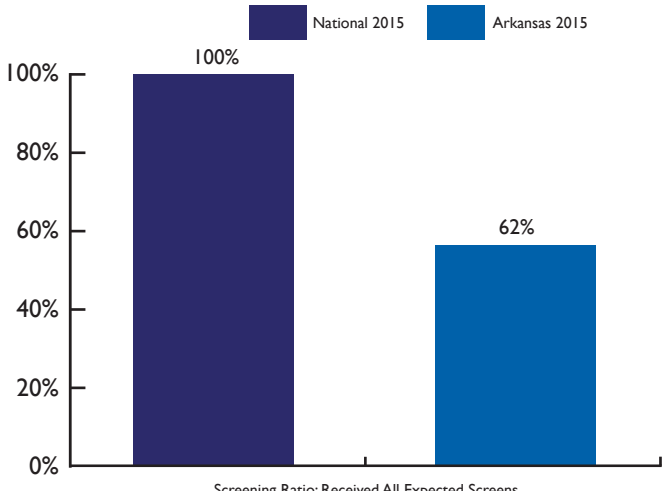
Source: Annual EPSDT Participation Report, 2015 National and State data, Centers for Medicare and Medicaid Services

Like with coverage trends, older children are less likely to have a well-child visit and receive all recommended screens.

The participant ratio shows the number of children who had at least one expected screen, i.e. one well-child visit. The number of children in Arkansas who had at least one screen remains below the national average by 13 percentage points. The screening ratio data examines the proportion of all recommended screenings a child has received. Arkansas data shows that this figure has been at a standstill for the past five years, and remains well below the national rate. Also, like with coverage trends, older children are less likely to have a well-child visit and receive all recommended screens.

There is plenty of room to improve participation in screenings. Some common barriers – such as lack of transportation or a caregiver who is unable to take time off – can be addressed with innovative models like school-based health clinics and telemedicine.[5] Additionally, we may not be counting all the screenings that children receive. Medicaid billing processes make it hard to accurately capture data. For example, some doctors may perform a screening during a sick visit. The doctor may then bill Medicaid for the sick visit, but the data will not reflect that the child was also screened.

SCREENING RATES FOR LOW-INCOME CHILDREN IN ARKANAS LAG BEHIND NATIONAL RATES
ARKids A Children who received screens, 2015



Source: Annual EPSDT Participation Report, 2015 National and State data, Centers for Medicare and Medicaid Services

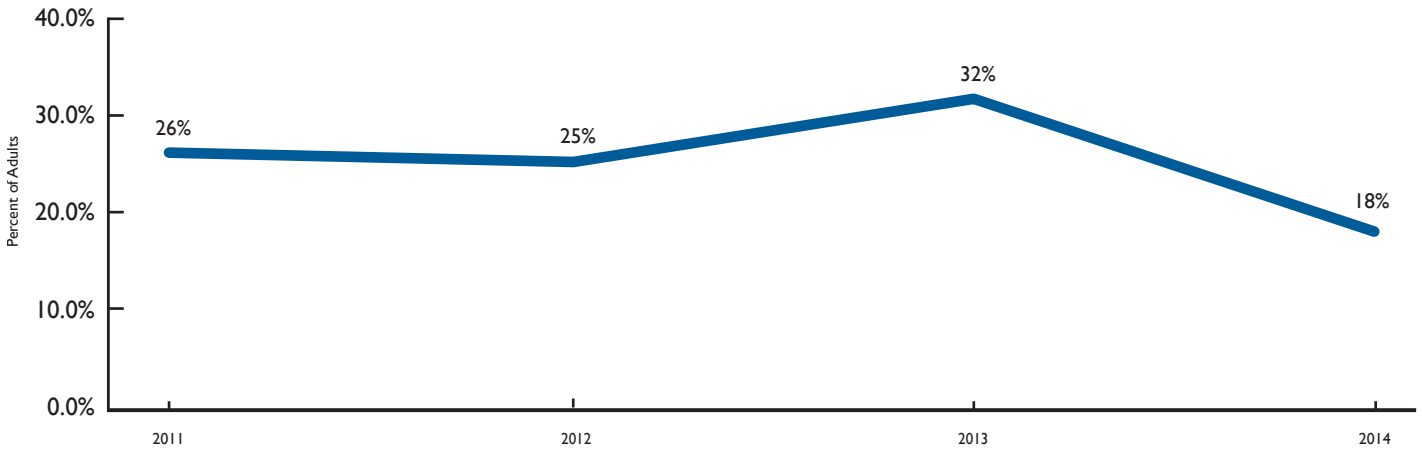
ADULTS

In 2014, some of the most significant changes in adult coverage happened in the Arkansas health care system as the state implemented the ACA. After passing legislation during the 2013 legislative session to expand health coverage to low-income adults, the state saw the positive impact after the first year of implementation.[6] During this same time, families could shop in the newly established health marketplace to purchase coverage and potentially receive assistance with their monthly payment if they qualified for a tax credit. The American Community Survey data provides a complete look at the impact of expanding affordable coverage options.

The most significant achievement was sharply cutting the number of uninsured adults in the state, which made Arkansas a national leader. Prior to expanding coverage, more than 500,000 adults in Arkansas were uninsured. That number dropped by more than half as they enrolled in the expanded Medicaid program and marketplace plans.

Arkansas saw similar reductions in coverage across all income levels. Individuals meeting the eligibility requirements for Medicaid expansion (0-139% FPL) saw the largest drop in uninsured rates, which supports the theory that most of these people had no other affordable source of coverage prior to expansion.

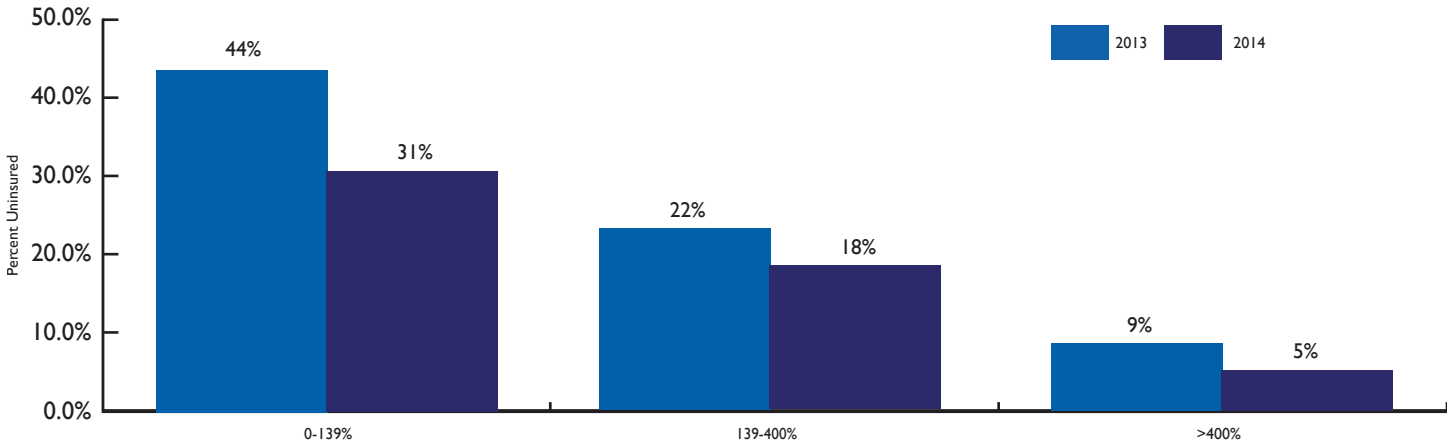
PERCENTAGE OF ARKANSAS ADULTS AGE 19-64 WHO ARE UNINSURED



Source: PRB Analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

ADULTS ACROSS ALL INCOMES REDUCED RATE OF UNINSURED

Percent uninsured adults age 19-64, by poverty level



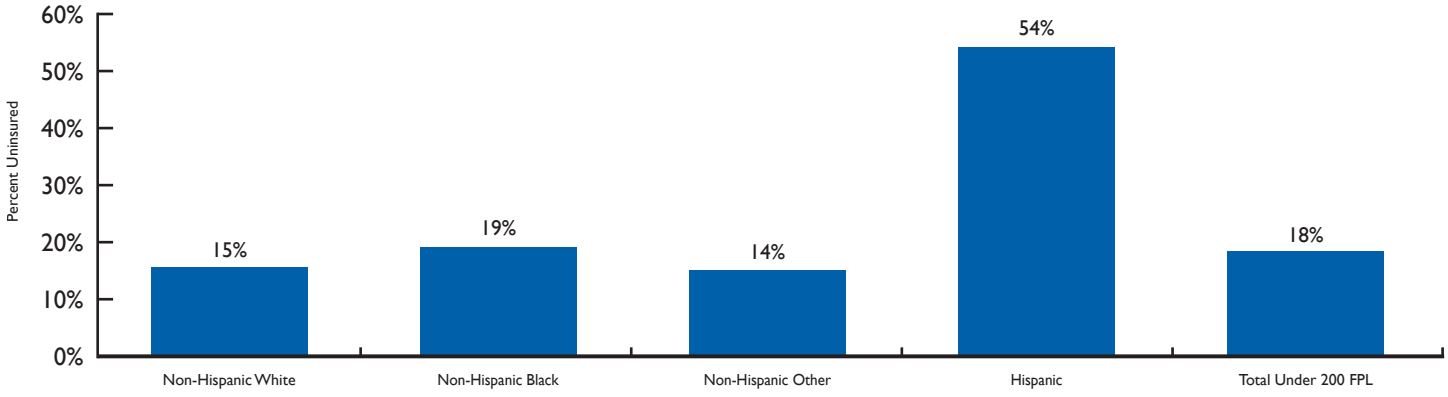
SOURCE: PRB Analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

Despite the progress we've made to almost eliminate the coverage gap for adults, some individuals are still left out of coverage. Mirroring the data for children, findings show that Hispanic adults are much more likely to be uninsured. Similar hurdles affect children and adults, including language barriers, lack of knowledge about eligibility requirements, and residing in mixed-citizenship status households. These barriers make it less likely that Hispanic families have information about their coverage options and will enroll.

While Arkansas greatly improved access to coverage for adults in the state, it proved to be a major challenge to keep them enrolled. The annual renewal process was full of technical issues, as the state struggled to complete automated renewals for the first time. Tens of thousands of Arkansans lost coverage. DHS reported a backlog of applications as high as 146,000 that needed to be processed, or were delayed due to problems with the computer system.[1] Some individuals had their coverage restored and others were subject to a lengthy backlog to process applications. The full impact is yet to be seen, as the state continues to process pending applications.

HISPANIC ADULTS ARE MOST LIKELY TO BE UNINSURED

Percent of uninsured adults age 19-64, by race/ethnicity



Source: PRB Analysis of 2014 American Community Survey PUMS, U.S. Census Bureau

CLEARING THE HURDLES IN 2016

EXPANDED HEALTH COVERAGE IS WORKING

Without a doubt, the Medicaid expansion program pushed Arkansas closer than we've ever been to the coverage Finish Line. In addition to reducing the rates of uninsured children and adults, the expansion has had a positive impact on businesses and the state economy:[8]

- Arkansas dramatically cut the rate of uninsured adults, from 22.5 percent in 2013 to about 9 percent midway through 2015.
- A year after implementation, Arkansas hospitals saw a 55 percent or $149 million reduction in financial losses from treating uninsured patients.
- The state is estimated to save up to $757 million by 2021, even after including the state's share of costs for the Private Option.
- Over 30,000 children also got covered during the first year enrolling their parents and caregivers.

ARKANSAS WORKS

In 2015, with a newly elected Governor and changes in the legislature, the future of expanded coverage in Arkansas was uncertain. Gov. Asa Hutchinson created a 16-member legislative task force to make recommendations, and he convened a special health care session in 2016. After much debate, the Legislature voted to pass a bill to implement Gov. Hutchinson's plan for expanded coverage, which he and they named "Arkansas Works." If the proposed changes are approved at the federal level, this new model will allow the state to continue to have a Medicaid expansion program that enrolls individuals in private health insurance. There are several more politically conservative features in the "Arkansas Works" program, as summarized in the chart on page 12.[9] Although more dangerous changes like disenrollment for missing a premium payment were avoided, these changes could still serve as coverage barriers for families. Additional outreach and education to families enrolled in these programs will be critical in ensuring they are aware of the changes to their coverage and any new requirements.

The Medicaid expansion program pushed Arkansas closer than we've ever been to the coverage Finish Line.

SUMMARY OF ARKANSAS WORKS FEATURES

Arkansas Works Feature	Description of Policy
Subsidized Employer-Sponsored Insurance	Individuals who are eligible for "Arkansas Works" and employed will be required to enroll in their employer-sponsored insurance plan (if the employer has a plan). The health plan will be subsidized with Medicaid dollars to cover the premium.
Work Training and Referrals	Individuals eligible for "Arkansas Works" who are not working will be referred to the Department of Workforce Services to find employment and receive work training. Students and full-time caregivers will be exempt. Participation will not impact eligibility for coverage.
Premiums and Cost-Sharing for populations above 100 percent of the Federal Poverty Level (FPL)	Individuals enrolled in "Arkansas Works" whose incomes are above the poverty level will be required to pay co-payments and monthly premiums. A monthly rate up to $19 was proposed. Failure to pay after a 90-day grace period will result in a debt to the state and failure to qualify for incentive benefits, such as dental treatment.
Healthy Behavior Incentives	Individuals enrolled in "Arkansas Works" will be encouraged to visit a doctor for a wellness visit within six months of enrollment. Enrollees may be eligible for incentive benefits if they meet this goal.
Eliminate 90-Day Retroactive Eligibility	Retroactive eligibility is a standard feature in state Medicaid programs and covers expenses incurred before an individual enrolled in coverage. This policy would eliminate retroactive eligibility. However, interim coverage from the time of application to the enrollment date will be available.
Eliminate Non-Emergency Transportation	The state would eliminate access to non-emergency transportation to doctor's appointments for "Arkansas Works" enrollees covered through an employer-sponsored plan. Currently, they receive the same access to transportation support as other Medicaid enrollees.

THE STATE-BASED MARKETPLACE

The state is also transitioning to a state-based health insurance marketplace, which will require careful planning and implementation. Since 2014, Arkansas has relied on the federal marketplace for families to shop for coverage, while the state has been responsible for providing consumer assistance activities like a call center and appeals process. Next year, the Arkansas Health Insurance Marketplace will become fully responsible for marketplace administration.[10] This will include coordination on the rollout of "Arkansas Works" and ensuring consumers have access to navigators and guides in their local communities to assist them.

WINNING THE RACE: RECOMMENDATIONS FOR IMPROVING ACCESS

For all the historic gains in the Arkansas health care system, opportunities remain to ensure all Arkansas children and their families have access to coverage and care:

1. **Remove the administrative hurdles to enrolling and staying enrolled in coverage.** One of the biggest threats to the state maintaining the current momentum in the health care system is difficulties enrolling and renewing coverage. As previously mentioned, tens of thousands of children and adults have been subject to long waiting periods and a complex process to enroll and renew coverage. The state has had to make a $2 million investment into clearing a backlog of applications.[11]

   Because of these types of issues, implementing Express Lane Eligibility (ELE) is even more critical. Though the Legislature approved this streamlined enrollment and renewal process with Act 771 of 2011, Arkansas has not implemented it. It would simplify the enrollment process by using existing income data from programs like Supplemental Nutrition Assistance Program (SNAP) to determine eligibility. Using existing data could potentially eliminate coverage gaps for kids. This type of system could also improve efficiencies within DHS and produce administrative savings of at least $1 million. Other states have achieved such savings.

2. **Invest in consumer outreach and education.** Outreach is very important to ensure families are aware of the affordable coverage options available to them. Such outreach efforts should be targeted to populations that are most likely to be uninsured, such as Spanish-speaking families. Family outreach will also be critical to successfully transition to "Arkansas Works" and a state-based marketplace. Based on a statewide survey of enrollment assisters, many newly enrolled people lack information about their specific benefits and how to use their coverage.[12] This type of investment will be important as families navigate a complex health care system.

3. **Remove coverage barriers for legally residing immigrant children by implementing the Immigrant Children's Health Improvement Act (ICHIA).** Based on Census data, immigrant children and their families are much more likely to be uninsured. The federal government recently increased funds for children who would be covered by ICHIA, so the state can extend coverage to kids that live, attend school, and play in Arkansas communities with ***no additional state dollars.*** This policy could also lead to savings, because the state currently pays for health services for many children who may be covered if we adopted this policy. For example, the state funds health services for some immigrant children in foster care and those who access emergency Medicaid. Recently, Utah and Florida joined the list of 31 states that have adopted this policy.

4. **Improve access to health care services for children.** As the state continues to celebrate our coverage gains, it's equally important to ensure children receive the care they need. Research shows that kids with improved health have better school performance and better economic stability long-term.[13] Currently, low-income children in Arkansas lag behind on important screenings and treatment. We could change that by increasing the number

of school-based health centers (we have 26 now). That way, children could get the care and checkups they need at a convenient location. The state also passed legislation in 2015 that made it easier for local doctors to bill Medicaid for telemedicine. The state should continue to support these innovative models that remove barriers to care.

5. **Protect funding for children's coverage.** Many children in Arkansas rely on the ARKids First program as their only comprehensive, affordable, and consistent option for coverage. While lawmakers debated on legislation to continue Medicaid expansion during the special session on health care, coverage for children hung in the balance, because funding for the entire Medicaid program was in peril. We cannot afford to risk the health and wellbeing of children. When the Arkansas General Assembly convenes for the legislative session next year, protecting Medicaid funding must be a priority. Also, federal funding for the CHIP program will end in September 2017 without action by Congress. It will be important that the increase in federal dollars for CHIP remains in place as part of the federal vote.

We have a lot to celebrate. We've made remarkable progress toward ensuring all children have the health care they need. Today's system is practically seamless for every child, regardless of their family's income. Arkansas also continues to lead the nation with an innovative Medicaid expansion program. But so much is at risk as the state considers the future of health care in Arkansas. There is no doubt the health care system will continue to evolve, but the investment in a healthy future for our children must remain the same as we make the last strides to reach the Finish Line.

So much is at risk as the state considers the future of health care in Arkansas.

APPENDIX

UNINSURED CHILDREN IN ARKANSAS BY COUNTY 2010-2014

County	Total Number of Children	Number of Uninsured Children	Percent of Uninsured Children	County Ranking of Uninsured Children
ARKANSAS	4,392	95	2.16%	5
ASHLEY	5,077	218	4.29%	28
BAXTER	7,400	464	6.27%	48
BENTON	63,724	3,741	5.87%	45
BOONE	8,461	284	3.36%	15
BRADLEY	2,631	78	2.96%	9
CALHOUN	977	45	4.61%	30
CARROLL	6,166	571	9.26%	71
CHICOT	2,649	104	3.93%	21
CLARK	4,480	89	1.99%	1
CLAY	3,315	219	6.61%	52
CLEBURNE	5,125	485	9.46%	72
CLEVELAND	2,073	80	3.86%	20
COLUMBIA	5,292	171	3.23%	14
CONWAY	4,877	260	5.33%	39
CRAIGHEAD	24,861	1,410	5.67%	43
CRAWFORD	15,859	1347	8.49%	68
CRITTENDEN	14,194	590	4.16%	25
CROSS	4,344	108	2.49%	7
DALLAS	1,707	121	7.09%	55
DESHA	3,250	143	4.40%	29
DREW	4,129	363	8.79%	70
FAULKNER	28,236	2,073	7.34%	57
FRANKLIN	4,250	100	2.35%	6
FULTON	2,475	101	4.08%	23
GARLAND	19,973	1,261	6.31%	49
GRANT	4,282	229	5.35%	40
GREENE	10,680	493	4.62%	31
HEMPSTEAD	5,888	455	7.73%	61
HOT SPRING	7,370	604	8.20%	66
HOWARD	3,618	276	7.63%	60
INDEPENDENCE	8,864	459	5.18%	38
IZARD	2,551	251	9.84%	73
JACKSON	3,601	109	3.03%	10
JEFFERSON	17,442	612	3.51%	18
JOHNSON	6,295	356	5.66%	42
LAFAYETTE	1,576	79	5.01%	36
LAWRENCE	3,820	275	7.20%	56

County	Total Number of Children	Number of Uninsured Children	Percent of Uninsured Children	County Ranking of Uninsured Children
LEE	2,005	63	3.14%	12
LINCOLN	2,583	89	3.45%	16
LITTLE RIVER	2,974	345	11.60%	75
LOGAN	5,136	384	7.48%	58
LONOKE	18,923	883	4.67%	32
MADISON	3,729	261	7.00%	54
MARION	2,886	188	6.5%	50
MILLER	10,480	449	4.28%	27
MISSISSIPPI	12,422	380	3.06%	11
MONROE	1,748	64	3.66%	19
MONTGOMERY	1,842	113	6.13%	47
NEVADA	2,113	42	1.99%	2
NEWTON	1,642	80	4.87%	35
OUACHITA	5,863	284	4.84%	34
PERRY	2,297	80	3.48%	17
PHILLIPS	5,735	181	3.16%	13
PIKE	2,677	55	2.05%	3
POINSETT	5,821	120	2.06%	4
POLK	4,824	318	6.59%	51
POPE	14,410	593	4.12%	24
PRAIRIE	1,787	75	4.20%	26
PULASKI	92,668	5,100	5.50%	41
RANDOLPH	3,965	302	7.62%	59
SALINE	26,760	1,351	5.05%	37
SCOTT	2,714	221	8.14%	65
SEARCY	1,682	141	8.38%	67
SEBASTIAN	31,455	2,445	7.77%	62
SEVIER	5,043	402	7.97%	63
SHARP	3,628	399	11.00%	74
ST. FRANCIS	6,377	368	5.77%	44
STONE	2,589	104	4.02%	22
UNION	9,740	582	5.98%	46
VAN BUREN	3,438	233	6.78%	53
WASHINGTON	53,749	4,570	8.50%	69
WHITE	18,538	866	4.67%	33
WOODRUFF	1,587	45	2.84%	8
YELL	5,593	447	7.99%	64

Source: PRB Analysis of 2010-2014 American Community Survey PUMS, S701, U.S Census Bureau

ENDNOTES

1 Schwartz, S, Chester, A., Lopez, S., and Poppe, S. (2016). "Historic gains in health coverage for Hispanic Children in the Affordable Care Act's First Year." Georgetown Center for Children and Families and National Council of La Raza.

2 The income eligibility level in Arkansas was approved for up to 250% FPL in 2009, but was never implemented.

3 Adopting the Immigrant Children Health Improvement Act (ICHIA) would also cover the costs for legally residing Marshallese children to enroll in coverage who are completely eligible today.

4 Medicaid website. Early and Periodic Screening, Diagnostic, and Treatment. Retrieved on: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

5 Top ten principles for health reform in Arkansas. (2015). Retrieved on http://www.aradvocates.org/wp-content/uploads/Top-Ten-Principles-for-Health-Reform-in-AR.pdf.

6 To enroll in expanded coverage (soon to become Arkansas Works), an individual must be 19-64 years old, a lawful resident of the state, and make under $16,243 per year (138 percent of the federal poverty level). A family of four can earn no more than $33,465.

7 Health Care Reform Legislative Task Force Meeting. July 2016.

8 "Expanded Health Coverage Works for Families and Our Economy," Arkansas Advocates for Children and Families (March 2016)

9 Little, M. (2016) Arkansas works on changes to the Private Option. Arkansas Advocates for Children and Families. Retrieved from: http://www.aradvocates.org/publications/arkansas-works-on-changes-to-health-coverage/

10 Although the Arkansas Marketplace, will transition to a state-based model, we will lease use of the federal online portal for families to shop for and sign-up for coverage.

11 Health Care Reform Legislative Task Force Meeting. July 2016.

12 Pearce, S. (2016) Let's Make it Better: in-person assisters' recommendations on improving health outreach and enrollment. Arkansas Advocates for Children and Families. Retrieved from: http://www.aradvocates.org/publications/lets-make-it-better-in-person-assisters-recommendations-for-improving-health-outreach-and-enrollment/.

13 Paradise, J. (2014) The impact of children's health insurance program: What does the research tell us. Kaiser Family Foundation.

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