RACING TOWARD THE FINISH LINE

KIDS' HEALTH COVERAGE IN 2015

MAY 2015

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

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

RACING TOWARD THE FINISH LINE:
KIDS' HEALTH COVERAGE IN 2015

by Marquita Little, Health Policy Director
Arkansas Advocates for Children and Families
May 2015

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

EXECUTIVE SUMMARY

The Arkansas health care system has changed dramatically in recent years. While ARKids First and Medicaid have continued to be a vital and stable source of coverage for half of the children in the state, new coverage options are also available for uninsured adults. Recent data from the American Community Survey shows where there are still gaps in coverage and opportunities to increase access for children and families.

The number of uninsured children in the state has remained relatively consistent over the past five years and is currently at 6.5 percent. Also, we continue to see historical patterns when we look at the children and families that remain uninsured. For example, immigrant children continue to lack access because of ongoing coverage barriers. However, the Affordable Care Act has begun to change these historical trends. We've already seen the rate of uninsured adults cut in half and about 32,000 more children gained access to coverage in just one year.

Although we've experienced major success covering more Arkansans, many are still left out. Children and families most likely to be uninsured include:

- Children in households just on the brink of poverty.
- Children in the Northwest region of the state.
- Middle and high-school aged children.
- Immigrant children and families.

There are a number of things we can do to improve access, but the major recommendations highlighted in this report are:

- Invest in outreach and enrollment activities.
- Protect the Children's Health Insurance Program (CHIP) at the federal level.
- Remove remaining red tape barriers to coverage.
- Extend coverage to legally present immigrant children.
- Provide coverage options for the entire family.

Our ability to achieve a comprehensive, family-based coverage system hinges on many key policy decisions in the next year. Federal policy decisions will determine the fate of coverage for children and adults. Similarly, the Arkansas Legislature will have to make some tough decisions about the future design of Medicaid. As the race to insure all children and families continues, the focus should remain on protecting the gains we've made and on improving access to health coverage for even more Arkansans.

The number of uninsured children in Arkansas is currently at 6.5 percent.

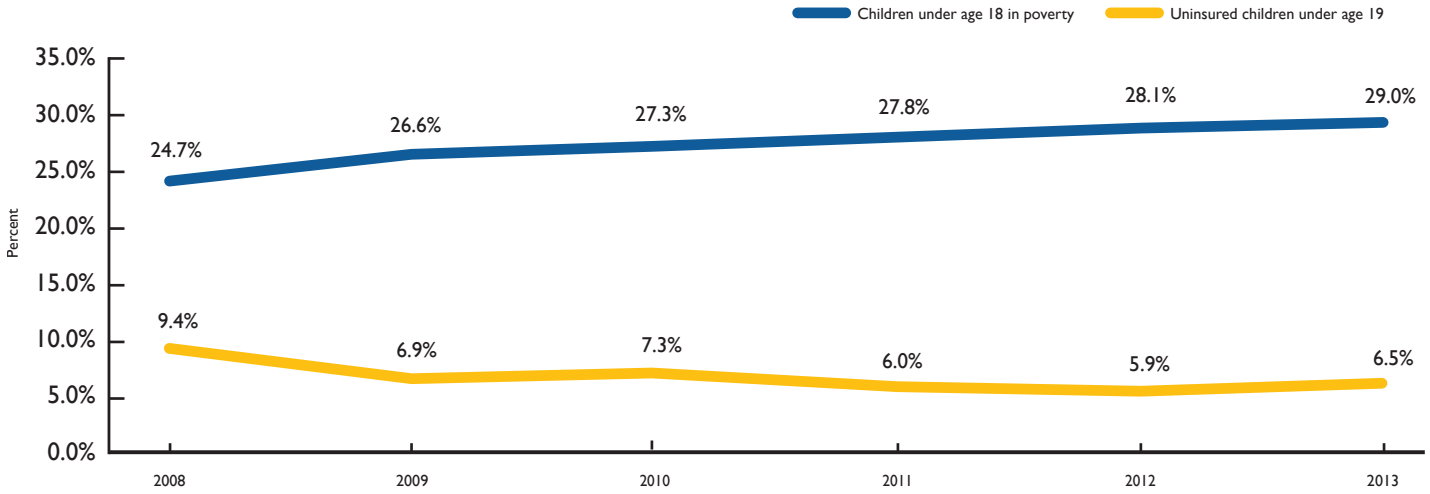
INTRODUCTION

As the health coverage landscape changes in Arkansas, the Medicaid and ARKids First program remain key vehicles for insuring children and making sure they have access to services. Even during tough economic times and with a lean state budget, we have made gains in children's health. While the number of children living in poverty has increased to almost 30 percent since 2008, they have been mostly protected from dangerous losses in health coverage. In fact, the rate of uninsured children in Arkansas has remained relatively steady despite high poverty levels. That means ARKids First is doing its job.

to shop for affordable coverage on the Arkansas Health Insurance Marketplace. Also, many adults are newly eligible for coverage through the Private Option, which was created after the state opted to expand Medicaid eligibility by purchasing private plans for qualified individuals using Medicaid funds. We have also seen increases in the number of children who get covered when their parents enroll. As implementation of the ACA continues, it will drive improvements in access to coverage for children and families.[2]

While we have made impressive strides in our race to the finish line of covering all kids, it is increasingly important

CHILD POVERTY RATES COMPARED TO UNINSURED CHILDREN 2008-2013



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

Arkansas saw a significant drop in uninsured children between 2008 and 2009, before rates leveled over the past several years. Much of the trend can be explained by examining the national policy landscape, which has resulted in little fluctuation in children's health insurance in many states over the past five years.[1] This suggests that a national conversation about children's health coverage is necessary in order to regain the momentum achieved through historical investments in Medicaid and the Child Health Insurance Program (CHIP). Of particular importance was the recent action from Congress to reauthorize CHIP, which was set to expire in September 2015. Although advocates hoped for a four-year reauthorization, a bipartisan vote reauthorized the program through 2017.

The Affordable Care Act (ACA) has improved health coverage in Arkansas. The ACA gave states new opportunities to provide affordable, comprehensive health coverage to entire families. As a result, Arkansans are now able

that we continue to prioritize access to affordable coverage for all children and families. With looming policy decisions about the future of the Medicaid program on a state and national level, protecting coverage and expanding access to preventative and quality health services must remain a high priority to ensure the healthy development and well-being of children in Arkansas.

This report will:

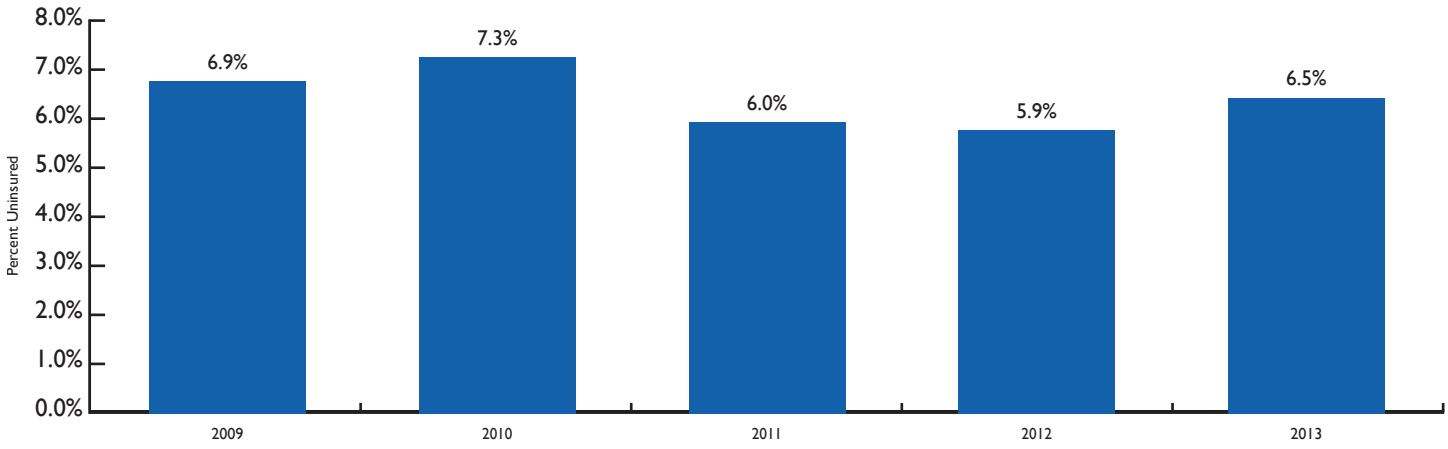
- Present data on the current status of coverage for children and families.
- Examine factors influencing access to coverage.
- Explore the future of the coverage landscape in Arkansas.
- Make recommendations to remove remaining coverage barriers.

CURRENT SNAPSHOT OF CHILDREN'S HEALTH COVERAGE IN ARKANSAS

Based on data from the American Community Survey, the number of uninsured children under the age of 19 has remained relatively steady since 2009. In 2013, the percentage of kids without coverage was 6.5, an increase of about 5,000 children over the previous year. While the coverage rates have leveled during this five year period, this is a remarkable improvement since 1997 when 22 percent of children (nearly one quarter!) were uninsured and legislation was passed to create the ARKids First program.

The good news is that's not the end of the story. The past year ushered in a new era in health care for the state, following the first open enrollment period of the Affordable Care Act (ACA). Insurance coverage through the Arkansas Health Insurance Marketplace and Private Option began in January 2014.[3] Within the first year of implementation, the rate of insured adults had dropped at astonishing rates with over half of this group gaining coverage midway through 2014.[4] Similarly, over 32,000 children enrolled in coverage when their caregivers enrolled.[5] As a result of this *welcome mat effect,* more uninsured children gained coverage through Medicaid, ARKids First, and the Marketplace.

PERCENT OF ARKANSAS CHILDREN UNDER 19 WHO ARE UNINSURED HAS REMAINED STEADY



SOURCE: PRB analysis of 2013 American Community Survey PUMS, U.S. Census Bureau and U.S. Census Bureau

Because of the ACA, children have a greater chance of enrolling and maintaining coverage because they are likely to share the same coverage status as their parents. While many children who already met the eligibility requirements for ARKids First enrolled in the program in the past year, over 12 percent of the children who gained access to coverage enrolled in a private health plan on the health insurance Marketplace.

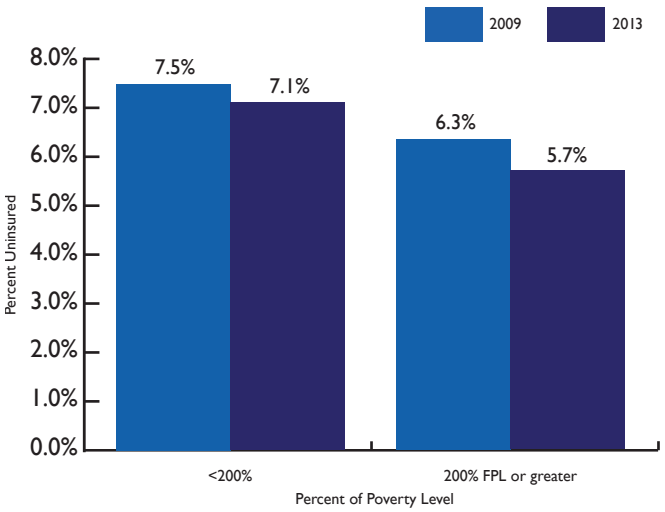
A DETAILED LOOK AT THE DATA

CHILDREN

Health coverage remains a key issue in Arkansas mainly because increasing access to coverage has proven to be one of the greatest ways to improve the overall health of children in the state. A 2014 report from the Annie E. Casey Foundation highlighted the legislative advocacy and outreach successes in Arkansas around kid's coverage. Since 1990, Arkansas went from 47th in the country to a national leader in enrolling eligible children in coverage.[6] Working to remove enrollment and renewal barriers has been key in keeping the number of uninsured children under age 19 at historically low rates.

A steady decline in uninsured children is seen at all income levels, even as family income begins to exceed eligibility requirements for ARKids First. This trend across income levels is more recent, and is likely the result of increased participation rates in ARKids First and an overall reduction in uninsured low-income children because of investments in outreach. We have been so successful at enrolling children that differences by income level have reduced!

REDUCTIONS IN THE RATE OF UNINSURED CHILDREN ARE SIMILAR ACROSS INCOME LEVELS.
Percent of uninsured children who are uninsured by income, 2009-2013

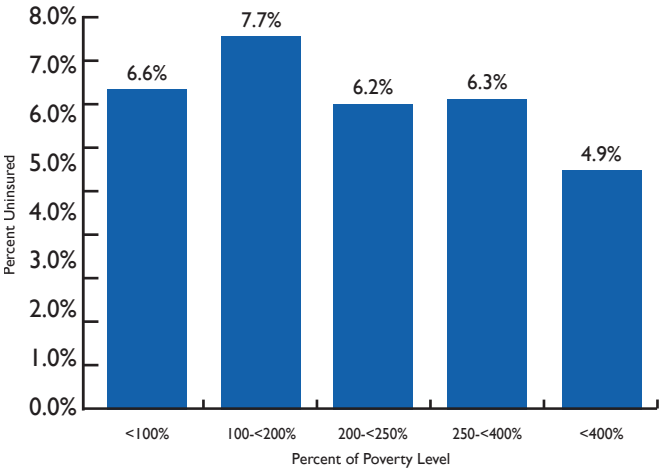


SOURCE: PRB analysis of 2009 and 2013 American Community Survey PUMS, U.S. Census Bureau

Over 32,000 children enrolled in coverage when their caregivers enrolled.

In previous years, Arkansas data showed that the children most likely to be uninsured were in households earning just a little over the limit to qualify for ARKids First (200-250 percent of FPL). However, 2013 figures indicate a shift. The data show children are most likely to be uninsured in families just on the brink of poverty. This is in line with findings from Georgetown University's Center for Children and Families analysis on five-year trends in children's coverage. This analysis found that children in families earning between $19,530 and $38,865 per year (100-199 percent of Federal Poverty Line (FPL)) are less likely to have coverage. This finding speaks to the fact that some children are eligible to enroll in ARKids First, but have not signed up for coverage. It also underscores the importance of access to affordable coverage options for these families through CHIP. Additionally, we have seen that children who were already eligible enrolled in coverage as their parents sign up for coverage.

ARKANSAS CHILDREN LIVING ON THE BRINK OF POVERTY ARE DISPROPORTIONATELY UNINSURED
Percent of Arkansas children who are uninsured by income 2013



Source: PRB analysis of 2013 American Community Survey PUMS, U.S. Census Bureau

UNINSURED CHILDREN UNDER AGE 18 IN 2013

	Uninsured	Percent
Congressional District 1 (East)	9,100	5.3
Congressional District 2 (Central)	7,592	4.3
Congressional District 3 (Northwest)	12,493	6.5
Congressional District 4 (Southwest)	10,074	6.0

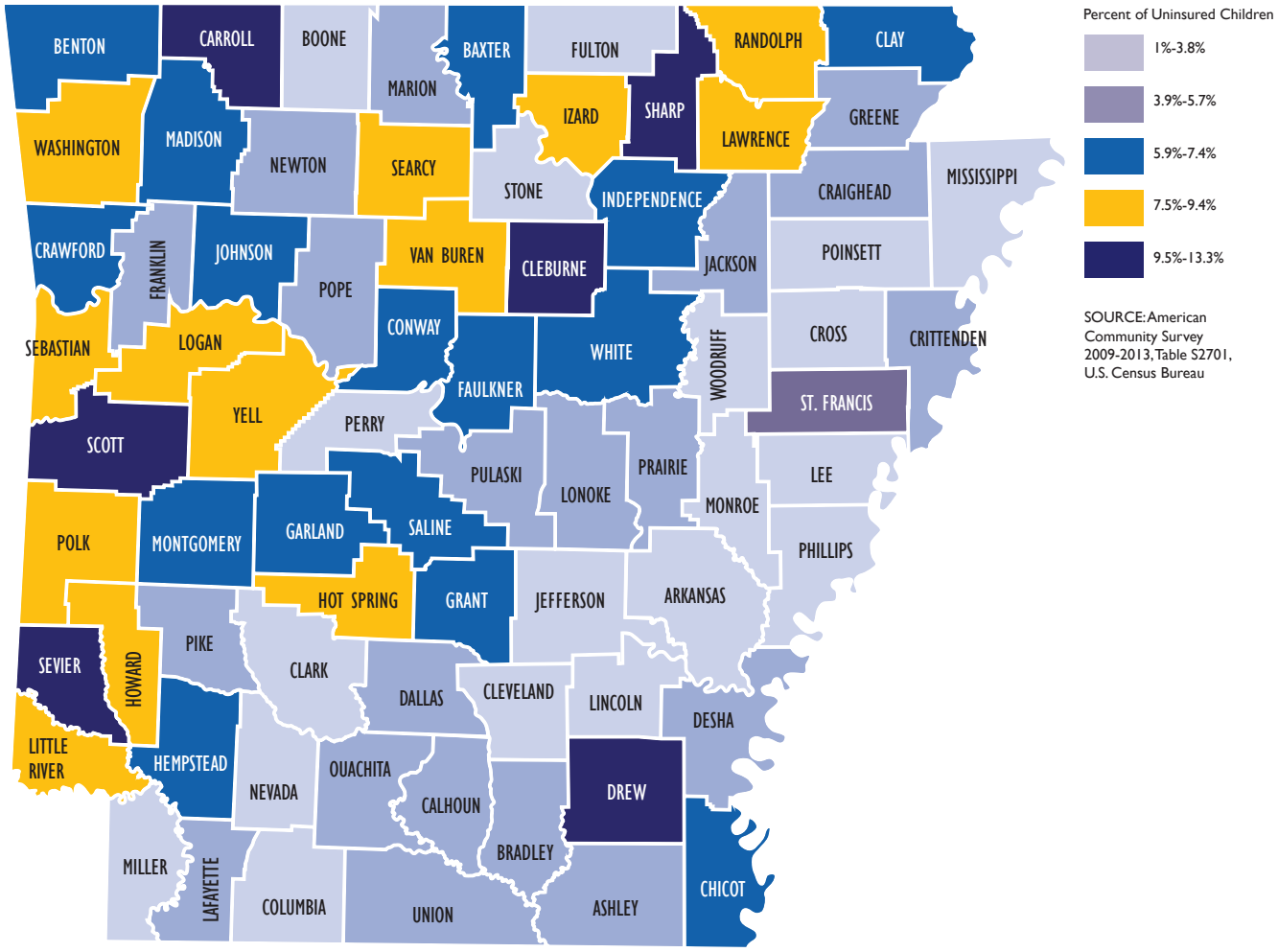
SOURCE: American Community Survey 2013 1-year data access via American FactFinder table B27001

CHILDREN MOST AT RISK

Coverage disparities based on geographic regions in the state have long been a concern. Based on 2013 data, the highest rate of uninsured children continues to be within the northwest part of the state. A higher percentage of children in the region is Hispanic, and low-income Hispanic children are much more likely to be uninsured than non-Hispanic whites at the same income levels, as we report below.

Similarly, county-level data reflects disparate rates of uninsured children across the state. The northwest portion of the state tends to have a greater concentration of counties with the highest rates of uninsured children. It should be noted that there has been some progress in this region resulting in fewer uninsured children than in previous years. In fact, only two counties in Northwest Arkansas (Carroll and Scott) are among those with the most uninsured children in the state. In these counties, the percentage of uninsured children is up to twice as high as the state average.

UNINSURED CHILDREN UNDER AGE 18 BY COUNTY



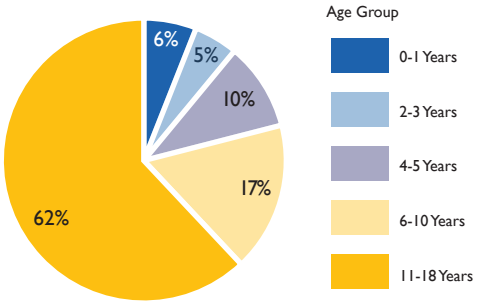
DEMOGRAPHICS OF UNINSURED CHILDREN

When examined by age, it's very clear that children between 11 and 18 years old make up the largest number of uninsured children that are income-eligible for ARKids First. This suggests that identifying strategies to target enrollment of middle and high-school aged children would be beneficial.

There are also differences when you look at race and ethnicity. Since there are a larger number of non-Hispanic white children in the state, this group accounts for over 40 percent of uninsured children that are income-eligible for ARKids First. However, low-income Hispanic children are more likely to be uninsured. A greater percentage of this population of children currently lack coverage when compared to other children in the state.

MOST LOW-INCOME CHILDREN WHO ARE UNINSURED ARE AGE 11-18

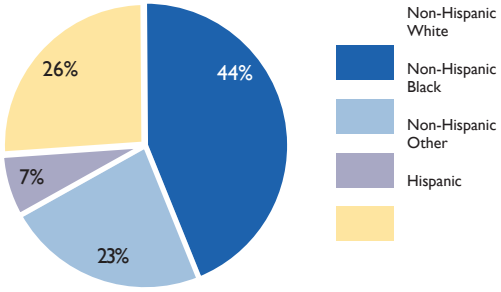
Percent of uninsured children under 19 with household incomes below 200 percent of poverty, by age



SOURCE: PRB Analysis of 2013 American Community Survey PUMS, U.S. Census Bureau

WHITE CHILDREN MAKE UP LARGEST PORTION OF UNINSURED CHILDREN IN ARKANSAS

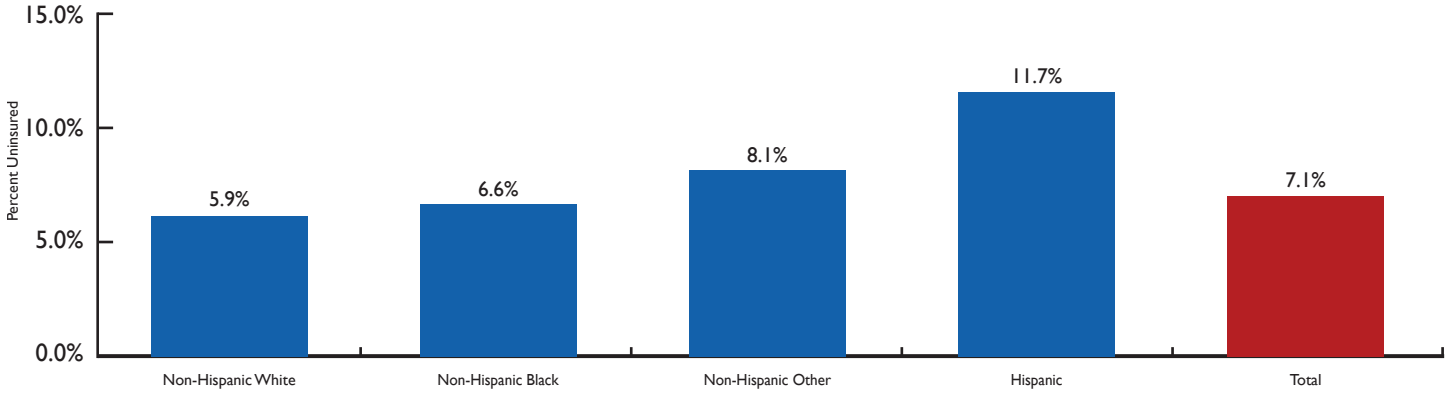
Percent of uninsured children under 19 with household incomes below 200 percent of poverty, by race/ethnicity



SOURCE: PRB Analysis of 2013 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/ethnicity



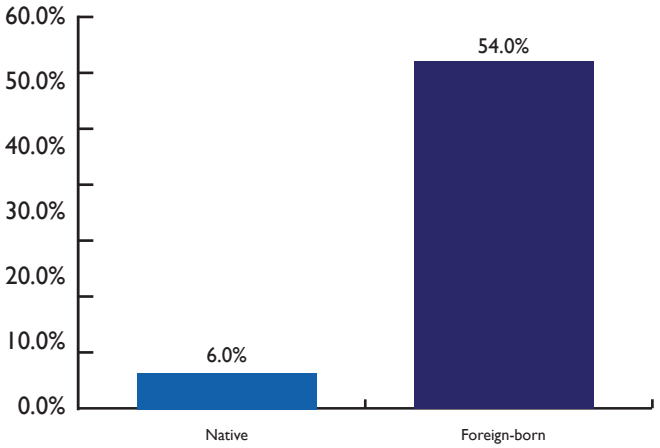
SOURCE: PRB Anaysis of 2013 American Community Servey PUMS, U.S. Census Bureau

Immigrant children are also much less likely to have coverage. Current ARKids First policies create barriers for immigrant children to gain access to coverage, even when they are legally residing in the state. Over half of low-income immigrant children in Arkansas are uninsured. Arkansas has yet to take advantage of the federal option to extend ARKids First coverage to legally residing immigrant children, who are subject to a five-year waiting period on enrollment or left out altogether. The Immigrant Children Health Improvement Act (ICHIA) makes it possible to eliminate this waiting period for eligible children and allow coverage of Marshallese children, who are currently shut out of coverage in ARKids First. In previous years, budget constraints have been identified as a barrier to adopting ICHIA, although estimated to cost the state less than $1 million to implement. However, the state cost will be eliminated due to federal approval to increase federal funds to CHIP. Since the option to cover more lawfully residing immigrant children has been available, 29 states and the District of Columbia have taken advantage of the opportunity. It is also important to note that many of these children can receive emergency Medicaid, but are denied access to the more cost effective, preventative care that's critical to a child's healthy development.

Language barriers often stand in the way of health coverage. When children speak English as a second language, they are more than twice as likely to be uninsured. This suggests that making sure outreach materials and information are available in multiple languages (and the availability of multi-lingual workers) is essential.

IMMIGRANT CHILDREN ARE MOST LIKELY TO BE UNINSURED

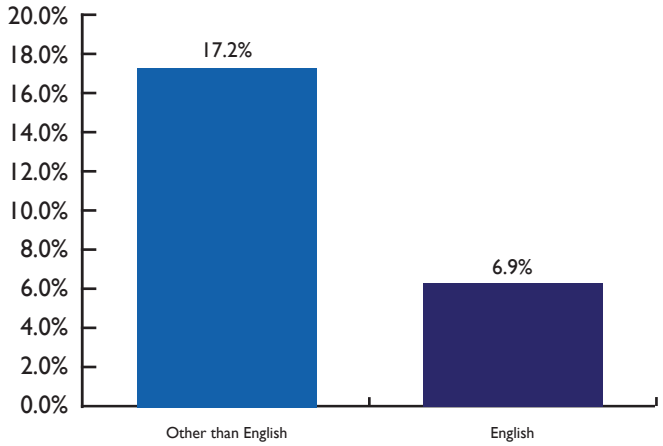
Percent of uninsured children under 19 with household incomes below 200 percent of poverty, by country of birth



SOURCE: PRB Analysis of 2013 American Community Survey PUMS, U.S. Census Bureau

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 2013 American Community Survey PUMS, U.S. Census Bureau

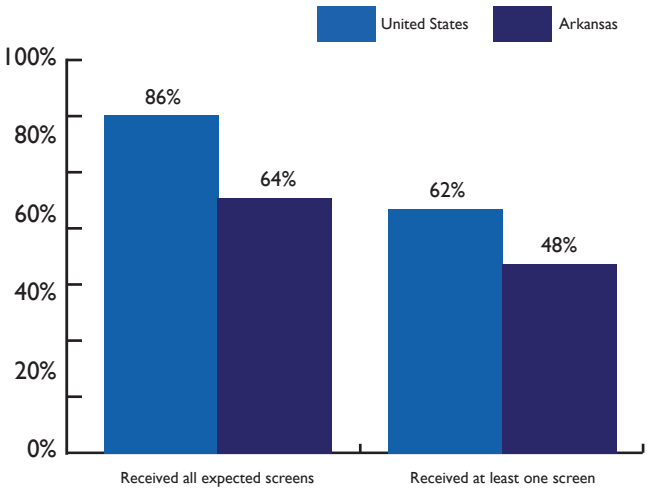
PRIORITIZING PREVENTATIVE CARE FOR CHILDREN

The goal of increased coverage for kids also enhances access to treatment. Promoting a prevention-focused model of health care is especially important for children to guarantee their healthy development and early treatment of any illnesses. Regular well-child visits are a primary indicator of our success in prioritizing preventative care for kids enrolled in ARKids First A and Medicaid. ARKids A and Medicaid beneficiaries are entitled to full Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefits because it is a federally mandated benefit. For Arkansas children, screening rates have remained below the national average. Also, some children are expected to receive multiple screens each year. In Arkansas, less than two-thirds of children received all expected screens. Even though there is much room for improvement, the number of children receiving at least one screening has improved greatly in the past five years.

While the ACA did not significantly change eligibility or benefits in ARKids First, it has allowed more children in the program access to full EPSDT benefits. Prior to the ACA, the income eligibility for the ARKids A program varied for children based on their age, resulting in "stair-step eligibility."[7] Because of the alignment of ARKids A eligibility regardless of age, about 8,000 children moved from the ARKids B program to ARKids A.[8] These children can now receive full EPSDT benefits in ARKids A. In addition, private health plans must now offer preventative care without any co-pays or deductibles for families. These important policies will encourage more screenings and address preventable health conditions.

SCREENING RATES FOR LOW-INCOME CHILDREN IN ARKANAS LAG BEHIND NATIONAL RATES

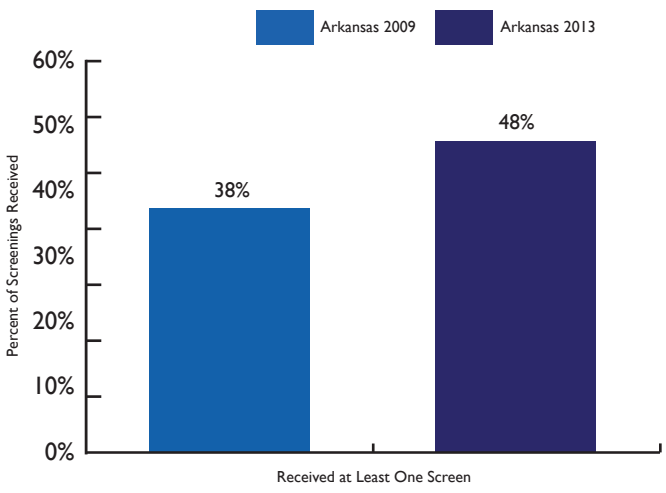
ARKids A Children who received screens in 2013



SOURCE: Annual EPSDT Participation Report, 2013 National and State data, Centers for Medicare and Medicaid Services

PERCENT OF LOW-INCOME CHILDREN RECEIVING A WELL-CHILD VISIT HAS IMPROVED

ARKids A Children who received at least one expected screen in 2009 and 2013



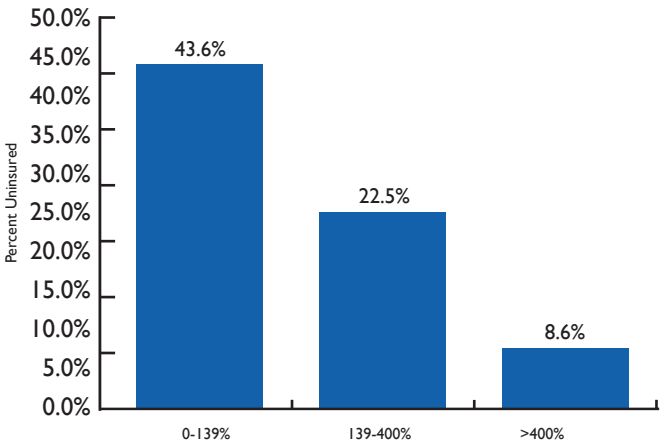
SOURCE: Annual EPSDT Participation Report, 2009 and 2013 State data, Centers for Medicare and Medicaid Services

ADULTS

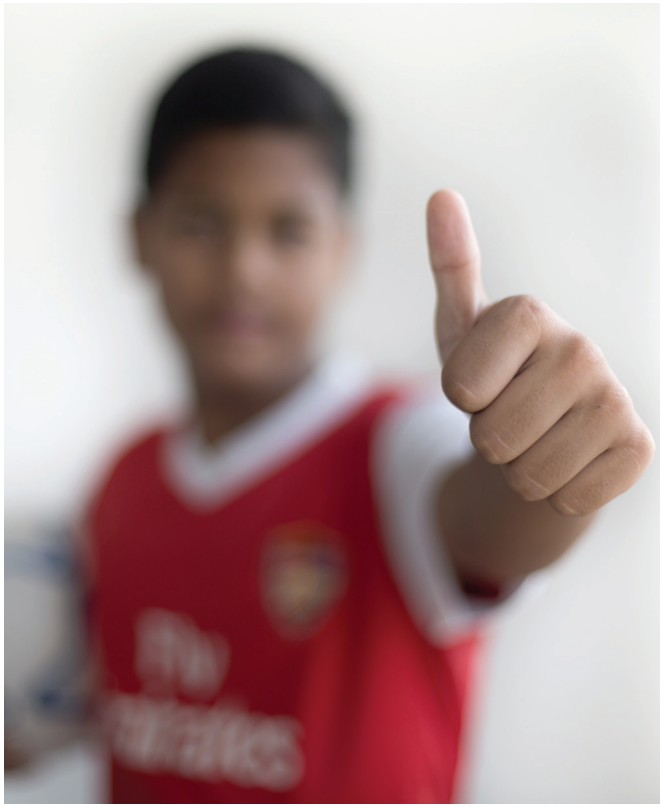
Research shows that children are more likely to have coverage if their parents are insured. By targeting parents and caregivers, we are also ensuring children are enrolled in coverage and have access to preventative care and other important health services. The data show that low-income adults are the group most likely to be uninsured. With very stringent guidelines in traditional Medicaid in Arkansas, these uninsured adults were historically left with few options for affordable, comprehensive coverage.

ADULTS WITH THE LOWEST INCOMES ARE MOST LIKELY TO BE UNINSURED

Percent uninsured adults age 19-64 by poverty level



SOURCE: PRB Analysis of 2013 American Community Survey PUMS, U.S. Census Bureau



Prior to the ACA, there were 500,000 uninsured adults in Arkansas. In 2013, almost half of the adults meeting income-eligibility guidelines (those who make $16,105 per year, or up to 138 percent FPL) for the Private Option were uninsured. After the Private Option was signed into law in April 2013, outreach efforts to enroll these newly eligible adults began in the fall of that same year. Taking advantage of a federal option to use a streamlined process to conduct enrollment, DHS used information from the Supplemental Nutritional Assistance Program (SNAP or food stamps) to identify adults eligible for the Private Option. Information was also sent to families about children in the household who were eligible for Medicaid. A streamlined enrollment process was key to this approach, which only required notification letters be signed and returned. This approach had a huge pay-off and resulted in 65,138 adults and 3,007 children enrolling in coverage.[9] Today, about 230,000 adults are enrolled in the Private Option.

2014 INCOME ELIGIBILITY LIMITS FOR THE PRIVATE OPTION (138% FPL)

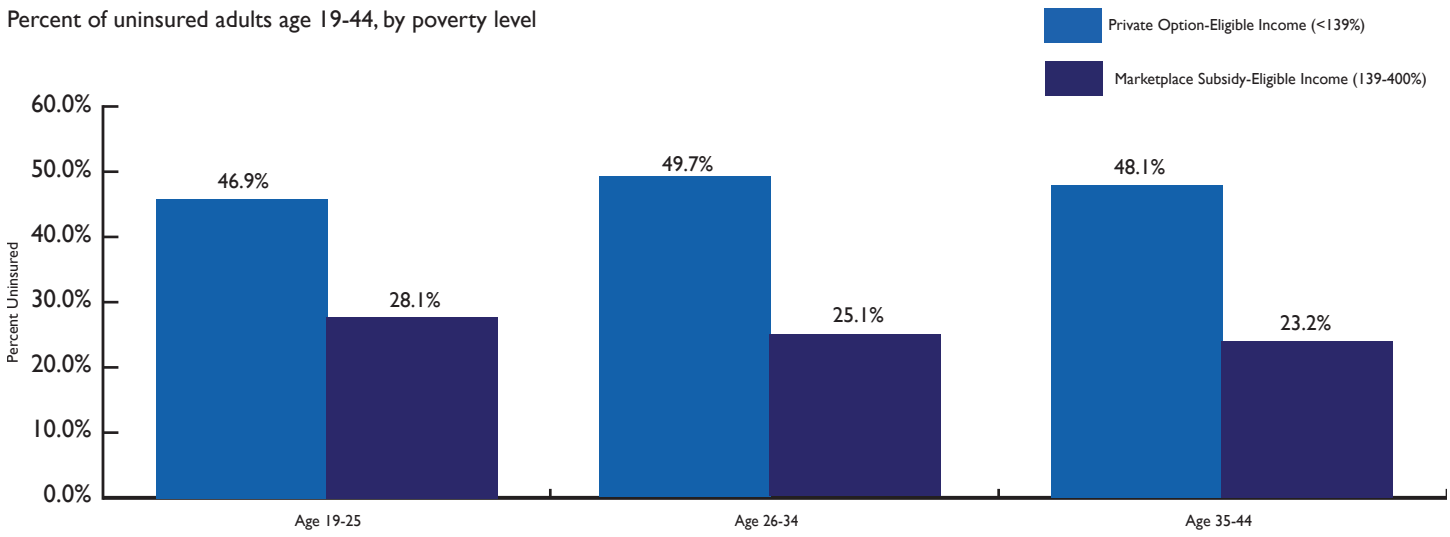
Family Size	1 person	2 people	3 people	4 people	Each add'l person
Yearly Income	$16,105	$21,707	$27,310	$32,913	$5,603

Research shows that children are more likely to have coverage if their parents are insured.

While about half of these uninsured 19-44 year olds were estimated to meet the income eligibility requirements for Private Option in 2013, another quarter were eligible to receive tax subsidies to help pay the cost of their monthly premiums for plans purchased on the marketplace. With such a large number of uninsured adults of childbearing age, these new coverage options with financial assistance could virtually eliminate the coverage gap among adults in the state. We know that many of the adults in this group now have access to affordable coverage based on the increase in Private Option coverage.

ADULTS OF CHILDBEARING AGE LIKELY TO BE UNINSURED

Percent of uninsured adults age 19-44, by poverty level



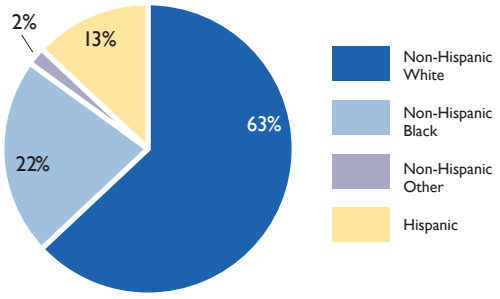
SOURCE: PRB Analysis of 2013 American Community Survey PUMS, U.S. Census Bureau

The majority of uninsured, low-income adults are non-Hispanic white.

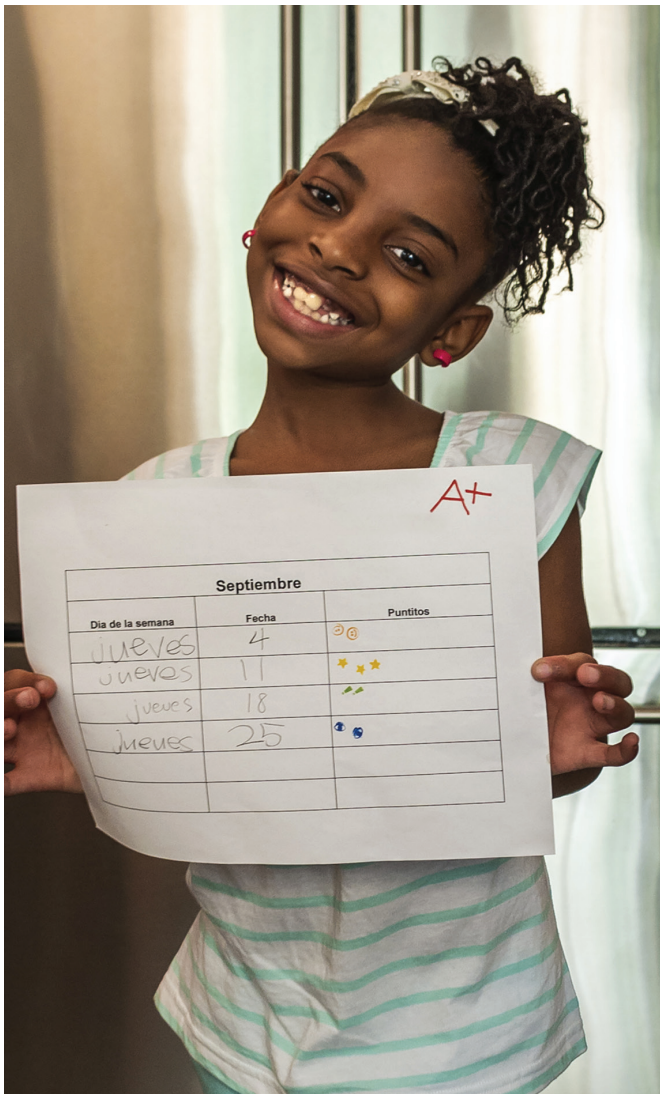
Demographic data on low-income, uninsured adults mirrors that of children in Arkansas when it comes to race and ethnicity. The majority of uninsured, low-income adults are non-Hispanic white, making up over 60 percent of the group because they represent a larger portion of the population in the state.

While adults with a college degree are the least likely Arkansans to be uninsured, the number of uninsured adults with a high school diploma is much higher. Also among low-income adults, over a fourth of people with a high school diploma are uninsured and half of adults with less than a high school diploma are uninsured. This supports the notion that educational achievement often leads to improved economic opportunity and better jobs, which tend to offer health care coverage.

UNINSURED ADULTS <139% FPL, AGE 19-64, BY RACE/ETHNICITY

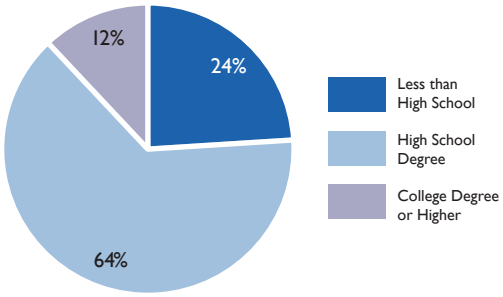


SOURCE: PRB Analysis of 2013 American Community Survey PUMS, U.S. Census Bureau



ADULTS WITH A COLLEGE DEGREE ARE LESS LIKELY TO BE UNINSURED

Percent of insured adults age 19-64, by educational achievement



SOURCE: PRB Analysis of 2013 American Community Survey PUMS, U.S. Census Bureau

RACING AHEAD IN 2015

Arkansas has made history by taking great leaps to transform the health care system. This transformation effort has been innovative and it has placed the state in the national spotlight as a leader in health coverage. In addition to the national conversation about the future of the health care system, much debate is taking place locally among advocates, consumers, health care providers, business owners, and policymakers. At the center of this debate is the Private Option.

THE PRIVATE OPTION

Pre-ACA, one out of four adult Arkansans was uninsured. After ACA, although many were eligible to receive financial help (through tax subsidies) to pay their monthly premiums, thousands were caught in the coverage gap. These people earned too much for traditional Medicaid, but not enough for tax subsidies. The Private Option solved this problem by extending coverage to up to 250,000 individuals. Since Medicaid funds are used to cover the cost of private plans purchased on the marketplace, Private Option enrollees do not have monthly premiums costs.

Despite restrictions the legislature placed on state agencies in 2014 prohibiting the use of public funds for education and outreach activities, enrollment in the program has been impressive. Over 230,000 people have been approved for coverage in the program. While opposition to the Private Option has continued from some vocal opponents, the program has continued to receive the necessary three-fourths vote both by the House and Senate to continue on each year. Even though the future of Private Option hangs in the balance, the program has helped Arkansas families and the economy.

Our ability to achieve a comprehensive, family-based coverage system hinges on many key policy decisions in the next year.

IT'S WORKING FOR THE ECONOMY AND FAMILIES

The Private Option has created savings in the Medicaid budget, which was once at risk of serious cuts to services to address a shortfall. By 2020, it is estimated that the state will save over $376 million even when you include the state's share of the costs. Here's how the Private Option leads to savings in state dollars:

- The federal government covers the full costs of the program for the first three years. After 2017, the state gradually increases its contribution, which peaks at 10 percent. Thereafter, federal funds will cover 90 percent of the costs for Private Option enrollees.

- Many people who were already enrolled under other Medicaid categories – for coverage of tuberculosis, breast and cervical cancers, for example – shifted to the Private Option. Before the Private Option, the state was responsible for picking up 30 percent of their costs and the federal government covered up to 70 percent at the traditional Medicaid matching rate.

- The state also supports several programs for the uninsured population with state dollars. These uncompensated care dollars may go towards behavioral health treatment and other health services. Most of the people served by these programs are now eligible for the Private Option. Savings from uncompensated care are estimated to reach $46 million in 2020.

Hospitals also win. Within the first six months of rollout, the Private Option resulted in a 54.5 percent or $69 million reduction in uncompensated care losses due to treating people who were uninsured and unable to afford to pay for their treatment.[10] AACF's publication "Arkansas's Private Option Works for Families and Our Economy" provides additional details on the positive impact of the Private Option.

A YEAR OF CRITICAL DECISIONS

There are a number of major policy decisions on the horizon in 2015 that will shape the future of coverage in Arkansas.

Health Reform Task Force. With a newly elected Governor and a more conservative shift in the legislature, the future of the Private Option has been heavily debated. Governor Asa Hutchinson recently put forth a plan to maintain the program until the current federal waiver ends, which gives Arkansas the authority to expand Medicaid using this premium assistance model until the end of 2016. In the meantime, a 16-member legislative task force has been created to make recommendations about the program after the current waiver ends and to transform the Medicaid program in the state.

Federal Extension of CHIP. In April 2015, Congress voted for a two-year reauthorization of the CHIP program, which was set to expire in September 2015. Although the President's recent budget proposal included funding for CHIP through 2019, a bipartisan compromise resulted in a two-year authorization without any major structural changes to the program.[11] The CHIP reauthorization also extends the Express Lane Eligibility (ELE) option for states and includes a 23 percentage-point increase to the federal CHIP match, which will mean huge savings in state costs for ARKids First. There are more details on the importance of ELE in the recommendations section, and opportunities to cover even more children because of the increased federal match. With about 60,000 children in Arkansas enrolled in ARKids B or CHIP who would have potentially lost coverage, this extension is a big win!

***King v. Burwell* Decision.** A major provision of the Affordable Care Act has recently been brought before the U.S. Supreme Court. This case takes up the issue of tax credits (also cost-sharing reductions) and who can access these credits to help reduce the costs of their premiums for marketplace plans. There is disagreement on the interpretation of the ACA regarding whether tax credits and cost-sharing reductions are only available through a state-based marketplace. This would prevent access in states like Arkansas that have not fully established a state-based marketplace. This decision could also negatively impact children's access to coverage. Many children enrolled in CHIP and Medicaid have parents who are enrolled in marketplace plans. Without access to these tax credits, fewer adults would seek coverage, and this would also reduce the number of children who enroll.[12]

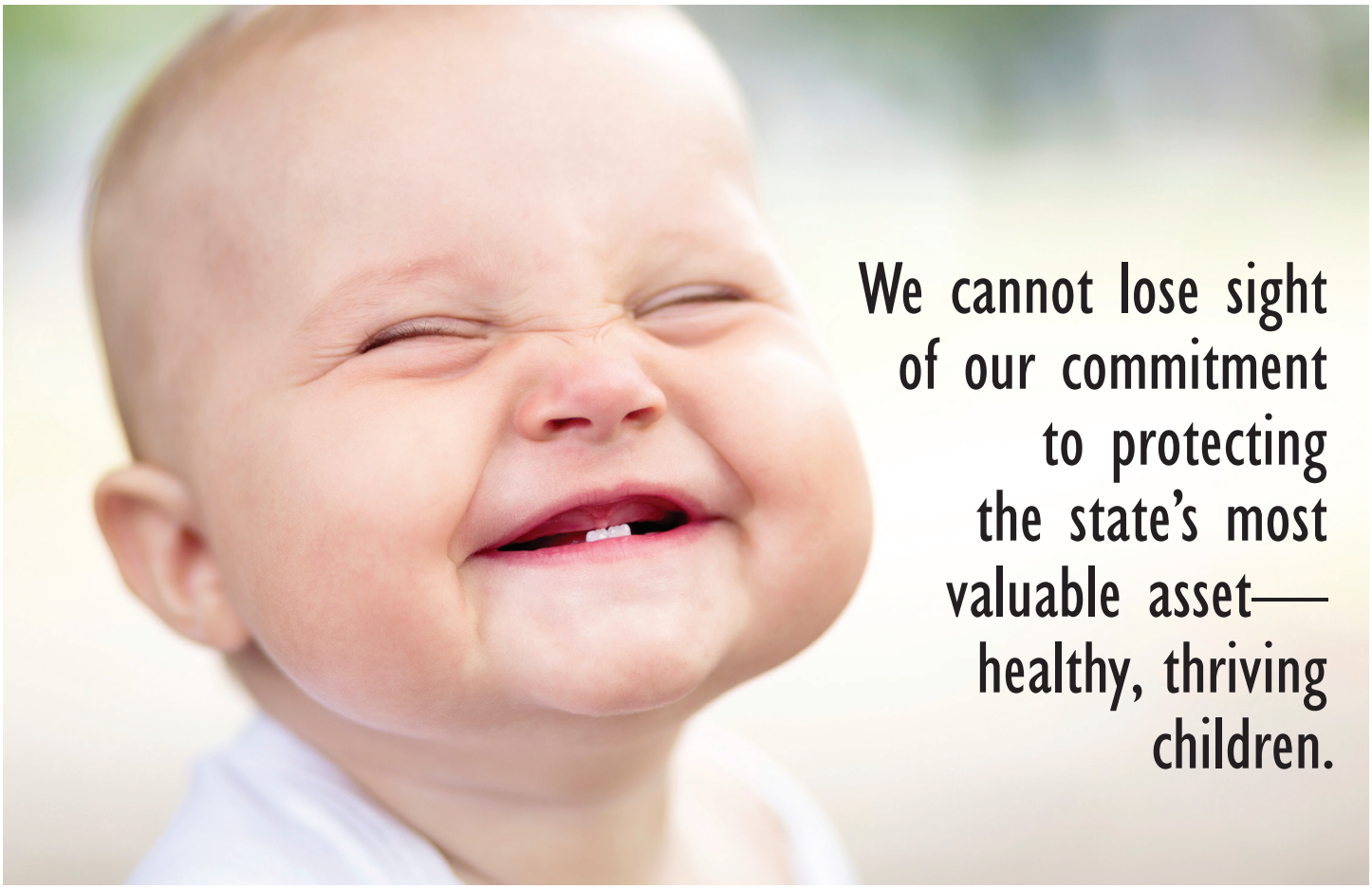
WINNING THE RACE: RECOMMENDATIONS FOR IMPROVING COVERAGE

Amid many gains in improving access to coverage for children and families, there are still many opportunities that remain to make even more progress:

1) **Make investments in outreach to uninsured children and families.**
Outreach to inform uninsured children and families about the coverage options available to them is critical to increasing enrollment. Our successful outreach around ARKids First has resulted in remarkable drops in the number of uninsured children. Prior to legislative restrictions on the use of public funds for outreach and enrollment in Private Option and Marketplace plans, Arkansas had a robust outreach campaign and in-person assistance program. In-person assistance is one of the most effective methods of increasing enrollment in coverage. Research suggests that uninsured people have the least knowledge of insurance terminology and information.[13] Preventing any future actions to restrict outreach is key to continuing to ensure families are aware of their coverage options.

2) **Protect children's coverage at the federal level.**
Continued federal funding for the CHIP program is a necessity in order to provide children with consistent coverage and access to comprehensive health benefits. With the recent federal vote to extend CHIP for two years, it remains critical that children continue to have access to a stable coverage source beyond 2017. It will also be important to keep provisions like the additional federal contribution in place, as states develop long-term strategies for covering children and build their budgets around the assumption that CHIP coverage will not undergo any major structural or funding changes in the future.

3) **Extend coverage to lawfully present children.**
According to American Community Survey data, immigrant children have the lowest access to coverage. Arkansas should take advantage of the opportunity to cover lawfully residing immigrant and Marshallese children by implementing The Immigrant Children Health Improvement Act (ICHIA). Since the 23 percentage-point increase in federal contributions to the CHIP program was included in the two-year funding extension,



potential budget constraints have been addressed. Arkansas will no longer have to contribute any state dollars to cover the ARKids B population, even for this potentially newly covered population. Language barriers also prevent enrollment, so if Arkansas extends this coverage, it will be important to have outreach materials available in multiple languages in order to get information to families who were once left out of coverage.

4) Eliminate all bureaucratic barriers to enrollment.

Waiting Periods. Currently, families with children who qualify for ARKids B are subject to a three-month waiting period without insurance before they can enroll in coverage. This was reduced from six months due to a federal mandate, but children still have to wait too long for coverage. Sixteen states have taken steps to eliminate waiting periods and create a health care system that allows seamless transitions to coverage options, such as transitioning between ARKids B and a Marketplace plan. Arkansas should also take advantage of this opportunity to eliminate unnecessary interruptions in coverage.

Express Lane Eligibility. While the state has made much progress in eliminating red tape barriers with measures like prepopulated forms and improved efficiency of annual renewals, DHS has not yet taken the next steps to implement Express Lane Eligibility (ELE). Act 771, passed in 2011, directed DHS to improve ARKids First program enrollment and coverage retention rates by simplifying the enrollment and annual renewal process. ELE will allow DHS to use income information from other programs, such as SNAP, to determine eligibility for ARKids First. This same approach was very successful when used for the Private Option. States that have implemented ELE have saved at least $1 million annually by reducing their administrative burden.

5) Protect affordable coverage for the entire family, especially children.
The ACA has provided Arkansas with the opportunity to create a family-based coverage system that addresses a broad range of health care needs from prevention to chronic illnesses. Future policy decisions should ensure children have stable coverage, in addition to uninsured parents and childless adults. Also, families should not be forced to choose between health coverage and other basic needs due to added costs that can be particularly burdensome for low-income families. Coverage options must be comprehensive as well as affordable. The return on investments in the health care system has already yielded significant benefits.

As health coverage continues to evolve in the state, it becomes even more important to prioritize children and families. This is especially true for low-income families with few affordable health care options. As we push forward with innovative coverage programs, payment models, and quality initiatives, we cannot lose sight of our commitment to protecting the state's most valuable asset—healthy, thriving children. With the Finish Line now in sight, it's time for the final push to cover all Arkansans that will guarantee a strong finish!

APPENDICES

UNINSURED CHILDREN IN ARKANSAS BY COUNTY 2009-2013

County	Total Number of Children	Number of Insured Children	Percent of Uninsured Children	County Ranking of Uninsured Children
ARKANSAS	4,376	88	2.0%	2
ASHLEY	5,198	236	4.5%	24
BAXTER	7,453	488	6.5%	48
BENTON	62,746	4,371	7.0%	54
BOONE	8,471	270	3.2%	11
BRADLEY	2,664	152	5.7%	40
CALHOUN	1,023	55	5.4%	37
CARROLL	6,181	632	10.2%	74
CHICOT	2,679	170	6.3%	46
CLARK	4,496	46	1.0%	1
CLAY	3,464	228	6.6%	49
CLEBURNE	5,154	526	10.2%	72
CLEVELAND	2,117	62	2.9%	7
COLUMBIA	5,375	191	3.6%	15
CONWAY	4,956	335	6.8%	51
CRAIGHEAD	24,518	1,228	5.0%	33
CRAWFORD	16,031	1192	7.4%	56
CRITTENDEN	14,318	686	4.8%	27
CROSS	4,456	135	3.0%	8
DALLAS	1,791	96	5.4%	36
DESHA	3,308	142	4.3%	23
DREW	4,239	433	10.2%	73
FAULKNER	27,992	1,662	5.9%	42
FRANKLIN	4,333	226	5.2%	35
FULTON	2,518	89	3.5%	14
GARLAND	19,982	1,388	6.9%	53
GRANT	4,292	279	6.5%	47
GREENE	10,644	500	4.7%	26
HEMPSTEAD	5,926	371	6.3%	45
HOT SPRING	7,554	622	8.2%	61
HOWARD	3,655	315	8.6%	65
INDEPENDENCE	8,840	538	6.1%	43
IZARD	2,548	229	9.0%	67
JACKSON	3,619	145	4.0%	20
JEFFERSON	17,797	645	3.6%	17
JOHNSON	6,261	417	6.7%	50
LAFAYETTE	1,634	79	4.8%	28
LAWRENCE	3,867	313	8.1%	59

County	Total Number of Children	Number of Insured Children	Percent of Uninsured Children	County Ranking of Uninsured Children
LEE	2,080	78	3.8%	19
LINCOLN	2,635	94	3.6%	16
LITTLE RIVER	3,031	283	9.3%	68
LOGAN	5,301	454	8.6%	64
LONOKE	18,872	791	4.2%	21
MADISON	3,785	261	6.9%	52
MARION	2,916	141	4.8%	29
MILLER	10,469	295	2.8%	6
MISSISSIPPI	12,702	446	3.5%	13
MONROE	1,821	68	3.7%	18
MONTGOMERY	1,914	139	7.3%	55
NEVADA	2,164	56	2.6%	4
NEWTON	1,647	91	5.5%	39
OUACHITA	5,964	307	5.1%	34
PERRY	2,360	76	3.2%	12
PHILLIPS	5,890	182	3.1%	10
PIKE	2,729	134	4.9%	32
POINSETT	5,890	163	2.8%	5
POLK	4,882	415	8.5%	63
POPE	14,406	670	4.7%	25
PRAIRIE	1,837	78	4.2%	22
PULASKI	92,282	4,501	4.9%	31
RANDOLPH	4,034	318	7.9%	58
SALINE	26,425	1,538	5.8%	41
SCOTT	2,756	274	9.9%	71
SEARCY	1,645	154	9.4%	69
SEBASTIAN	31,616	2,821	8.9%	66
SEVIER	5,036	672	13.3%	75
SHARP	3,625	353	9.7%	70
ST. FRANCIS	6,528	357	5.5%	38
STONE	2,692	83	3.1%	9
UNION	9,847	479	4.9%	30
VAN BUREN	3,512	268	7.6%	57
WASHINGTON	52,370	4,400	8.4%	62
WHITE	18,464	1,124	6.1%	44
WOODRUFF	1,617	37	2.3%	3
YELL	5,596	457	8.2%	60

SOURCE: PRB
Analysis of 2009-2013
American Community Survey
PUMS, S701,
U.S Census Bureau

ARKIDS FIRST, MEDICAID, PRIVATE OPTION ENROLLMENT BY COUNTY*

County	ARKids First A	ARKids First B	Other Medicaid <19	Total Medicaid, ARKids <19	Private Option (19-64)
ARKANSAS	1,870	352	361	2,583	1,862
ASHLEY	2,319	390	392	3,101	2,235
BAXTER	2,940	683	483	4,106	3,240
BENTON	17,777	4,404	2,620	24,801	10,542
BOONE	3,001	680	549	4,230	3,314
BRADLEY	1,401	278	230	1,909	1,120
CALHOUN	354	91	67	512	398
CARROLL	2,818	501	296	3,615	2,309
CHICOT	1,469	149	371	1,989	1,451
CLARK	1,701	386	381	2,468	1,871
CLAY	1,235	337	274	1,846	1,507
CLEBURNE	1,928	498	324	2,750	2,054
CLEVELAND	750	128	160	1,038	662
COLUMBIA	2,035	387	613	3,035	2,176
CONWAY	1,972	339	490	2,801	1,872
CRAIGHEAD	8,853	1,678	2,980	13,511	8,081
CRAWFORD	5,973	1,021	1,034	8,028	4,484
CRITTENDEN	6,395	859	2,136	9,390	6,012
CROSS	1,812	359	415	2,586	1,824
DALLAS	757	159	257	1,173	769
DESHA	1,679	218	301	2,198	1,780
DREW	1,702	333	394	2,429	1,810
FAULKNER	8,139	1,830	1,846	11,815	7,531
FRANKLIN	1,717	287	285	2,289	1,572
FULTON	939	171	202	1,312	1,231
GARLAND	9,437	1,877	1,897	13,211	9,227
GRANT	1,398	303	203	1,904	1,262
GREENE	4,163	805	1,023	5,991	3,704
HEMPSTEAD	2,706	513	561	3,780	2,029
HOT SPRING	3,116	640	549	4,305	2,536
HOWARD	1,577	330	293	2,200	1,331
INDEPENDENCE	3,517	670	668	4,855	2,958
IZARD	1,155	220	192	1,567	1,246
JACKSON	1,596	273	362	2,231	1,950
JEFFERSON	7,640	1,162	2,563	11,365	7,664
JOHNSON	3,018	591	442	4,051	2,075
LAFAYETTE	673	108	180	961	729
LAWRENCE	1,548	371	334	2,253	1,798

County	ARKids First A	ARKids First B	Other Medicaid <19	Total Medicaid, ARKids <19	Private Option (19-64)
LEE	832	120	352	1,304	1,220
LINCOLN	1,200	205	204	1,609	1,088
LITTLE RIVER	1,098	200	262	1,560	871
LOGAN	2,284	406	370	3,060	1,661
LONOKE	5,212	1,147	1,018	7,377	4,315
MADISON	1,638	340	234	2,212	1,252
MARION	1,317	262	208	1,787	1,436
MILLER	3,929	748	1,303	5,980	3,637
MISSISSIPPI	4,957	828	1,794	7,579	4,438
MONROE	865	131	183	1,179	936
MONTGOMERY	893	183	99	1,175	973
NEVADA	902	155	153	1,210	835
NEWTON	781	167	94	1,042	847
OUACHITA	2,571	515	558	3,644	2,631
PERRY	895	177	155	1,227	916
PHILLIPS	2,719	322	1,198	4,239	2,998
PIKE	1,264	239	143	1,646	1,134
POINSETT	2,830	446	627	3,903	2,679
POLK	2,248	423	261	2,932	1,790
POPE	5,266	1,218	1,049	7,533	4,507
PRAIRIE	706	158	136	1,000	716
PULASKI	32,588	6,258	12,135	50,981	31,582
RANDOLPH	1,736	371	319	2,426	1,973
SALINE	7,678	1,849	1,156	10,683	5,573
SCOTT	1,170	212	204	1,586	1,015
SEARCY	706	205	96	1,007	921
SEBASTIAN	12,581	2,193	2,636	17,410	8,597
SEVIER	2,625	459	258	3,342	1,160
SHARP	1,641	321	322	2,284	1,886
ST. FRANCIS	2,586	422	1,195	4,203	2,996
STONE	1,175	272	182	1,629	1,369
UNION	4,289	819	896	6,004	3,631
VAN BUREN	1,525	291	215	2,031	1,410
WASHINGTON	20,593	4,217	2,890	27,700	11,873
WHITE	7,102	1,457	1,332	9,891	6,180
WOODRUFF	763	122	151	1,036	819
YELL	2,677	495	380	3,552	1,473
Total	268,922	52,734	61,496	383,152	233,554

*Based on DHS data, the total number of children enrolled in ARKids First as of January 31, 2015 is 438,074. DHS converted to new IT platform in January 2014 and data is not currently available by county. SOURCE: Arkansas DHS. Medicaid and ARKids First data, February 2015; Private Option data, February 2015.

SOURCES

1 Alker and Chester. (2014). Children's Coverage at A Crossroads: Progress Slows. Georgetown University Center for Children and Families

2 Ibid.

3 To enroll in the Private Option, you must be 19-64 years old, a lawful resident of the state, and make under $16,105 per year (138 percent of the federal poverty level). A family of four must make under $32,913.

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5 "Arkansas's Private Option Works for Families and Our Economy," Arkansas Advocates for Children and Families (January 2015)

6 The Annie E. Casey Foundation. (2014). Kids Count Data Book. Baltimore, MD. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-2014kidscountdatabook-2014.pdf#page=5

7 Before the ACA, ARKids A eligibility was 133% FPL for children under 6, but it was 100% FPL for children between 6 and 18. This stair-step eligibility was addressed by aligning the income requirements regardless of a child's age.

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