Providing the next generation with the opportunity to prosper starts with preventive health care when they are small children. Immunizations, screenings, regular dental care, well-child visits and access to nutritious food are all part of ensuring a healthy start for children. Just like a power grid relies on many power plants to produce electricity, the preventive and comprehensive care children receive when they have health insurance keeps the lights on for their entire childhood and into adulthood, so that they can become productive citizens. In other words, health insurance coverage is the point of entry from which connections to care occur.

The State of Children’s Health Care sets a clear agenda and provides specific steps which are more thoroughly explained throughout this report. Strengthening and repairing access to health care where it is patchy and uneven will energize Pennsylvania’s children for optimal development and learning. Because the benefits of healthy children stretch beyond the individual’s quality of life, we all benefit from their increased ability to engage with and contribute to our communities.

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HOW CAN WE KEEP KIDS PLUGGED IN TO HEALTH CARE?

Increase the number of kids with health care insurance.
✓ Focus on those most at risk to be uninsured in Pennsylvania: children less than six years of age, children from low-income families, and children who are American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some Other Race and Hispanic or Latino. Just as with a grid, focusing first on the parts where the connection is spotty makes the whole system work better.
✓ Keep Medicaid and the Children’s Health Insurance Program (CHIP) strong by warding off policy or financial threats that would reduce children’s access to affordable, quality health care coverage. This includes opposing efforts to repeal the Affordable Care Act that would hurt our kids who rely on Medicaid, as well as, ensuring additional state funding for CHIP as the federal share decreases again in 2020.
✓ Seek implementation of enrollment and renewal policies such as continuous eligibility, express lane eligibility and auto-renewals in order to remove barriers to coverage or reduce breaks in coverage.
✓ Ensure the formation of the State-based Exchange provides robust preventive benefits for children in families who use the Marketplace to purchase health insurance and when necessary, that it provides smooth pathways to Medicaid or CHIP.

Improve the quality of care for kids who have health insurance.
✓ Improve compliance of the blood lead testing mandate for kids on Medicaid and CHIP.
✓ Advance legislation for universal blood lead testing to require all Pennsylvania kids be tested at a young age, allowing plans of care to be put into action more quickly for those exposed to this deadly toxin.
✓ Improve children’s oral health, especially among low-income children, by increasing the number of kids receiving dental sealants and increasing dental care access through regular dental visits and services by non-dental providers such as pediatricians.
✓ Increase the participation rates of well-child screenings in Medicaid’s EPSDT to ensure that children are receiving early diagnoses and timely treatments for identified illnesses or conditions.

Address the social factors that affect children’s health such as food insecurity.
✓ Support policies that remove barriers and better connect children and families to healthy, nutritious food by increasing enrollment in WIC and SNAP.

Support policies that improve maternal health as it directly impacts child health outcomes.
✓ Extend the Medicaid postpartum coverage to 12 months to provide continuous health care to moms during a medically vulnerable time after giving birth.
✓ Expand home visiting services by increasing state investments as well as other funding sources including Medicaid in order to assist additional families and provide them with the tools and resources to build the foundation for a successful future.
Imagine the city of Allentown in the dark – more children than this entire city’s population are in a health insurance blackout. That’s why Pennsylvania Partnerships for Children is working to ensure that every Pennsylvania child has health insurance, because a healthy Pennsylvania is one in which our kids and communities shine bright.

And for the past decade, we’ve been seeing good progress on insuring kids within Pennsylvania and across the country. However, the positive trend is starting to reverse. While Pennsylvania’s uninsured rate falls below the national average, it remains stagnant at 4.4 percent, and we rank 24th among the states placing us squarely in the middle of the pack. National data from last year shows a decrease in enrollment of both Medicaid and the Children’s Health Insurance Program (CHIP) by more than 828,000 kids, with nearly 13,000 from Pennsylvania alone.

These latest figures compel us to look deeper at health care policies or practices that may be impacting children’s access to coverage, and ultimately their overall health. We can and should strive to make Pennsylvania a great place to be and raise a child.
The key takeaway from the latest American Community Survey data is that the uninsured rate of Pennsylvania's children under age six rose considerably since last year, meaning more of our youngest children are not plugged in to necessary access to health care. They are less likely to have health insurance than school-age children in Pennsylvania, and they are also less likely to have health insurance compared to other young children across the country.

Nationally, we’ve seen more younger children gain health insurance coverage at a steady rate over the past decade. This is in large part due to the positive ripple effects of more people receiving health care through the Affordable Care Act and Medicaid expansion; however, there is an uptick in the national uninsured rate this year, likely attributed to the recent enrollment declines in Medicaid and CHIP. Pennsylvania’s rate for children under six only saw an improvement when we expanded Medicaid eligibility in 2015, yet it continued to be higher than the national rate for the past five straight years.

This latest data demonstrates that part of our strategy to increase the number of kids in Pennsylvania with health insurance starts with our youngest citizens because the early years of a child’s life are a critical period of brain development. Just as with a construction project, early development lays the foundation for their lifelong health, learning, growth and behavior.

### Uninsured Rates for Young Children in PA Lost Ground in 2018

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
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</thead>
<tbody>
<tr>
<td>United States</td>
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<td>4.3</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>4.5</td>
<td>5.0</td>
</tr>
</tbody>
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At the same time, we are seeing that school-age children in Pennsylvania are receiving health insurance at a significantly better rate than last year and are much more likely to be insured than their national peers. In fact, while the national uninsured rate has climbed (again likely due to the change in Medicaid and CHIP enrollment across the country), Pennsylvania’s uninsured rate for the school-age category made progress spreading the gap even farther and signaling that Pennsylvania is moving in the right direction. This may be in part due to CHIP’s new marketing ads in 2017 and their intentional efforts on “Back to School” campaigns focusing on specific counties with higher numbers of uninsured children. The success of these campaigns could easily be replicated to specifically focus on those most at risk to be uninsured.

### Uninsured Rates for School-Age Children in PA Made Progress in 2018

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>5.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>4.4</td>
<td>4.1</td>
</tr>
</tbody>
</table>
A person’s economic, social and physical environments all play a factor in determining health outcomes because they influence one’s ability to engage in healthy behaviors, and where disadvantages exist, they further magnify health inequities.

We now know more about what it means to be healthy, including the nonmedical factors – known as social determinants of health – which include access to nutritious food, affordable and safe housing and reliable transportation to doctor appointments, among many other factors. Oftentimes these policies and programs are siloed, which makes it challenging to address the overall health of a person. But the approach of addressing the health of a person – or a child – as a whole has been steadily gaining ground, which is necessary to inspire change, especially among policymakers. We can keep up the momentum by continuing to support initiatives that factor in social determinants of health, which we expand upon further in this report.

When we respond to factors that affect children’s health and healthy development, we can shrink existing health gaps early in childhood and, at the same time, it may prevent problems and reduce health care costs down the road.
CREATING A LEAD-FREE PENNSYLVANIA

One way to ensure that our children thrive is to limit their exposure to toxins like lead. Research shows that there is no safe level of lead exposure – even the smallest amount can damage a child’s ability to learn. Young children are most at-risk of lead toxicity because of normal hand-to-mouth activities and because they more efficiently absorb lead than adults. This is why it is so important to ensure children are tested at a young age and referred as early as possible when they are exposed.

Lead-based paint is the most widespread source of exposure, although additional sources can include water, toys and other consumer products.

The Pennsylvania Department of Health has declared that the entire Commonwealth is “at risk” for lead exposure. And it’s no wonder, since Pennsylvania has some of the oldest infrastructure in the country. Many of Pennsylvania’s homes, schools and child care centers were built decades before the lead-paint ban in 1978 and the lead in drinking water ban in 1990.

The first step to understanding whether kids have been exposed is through testing blood lead levels. Although Medicaid requires testing and CHIP opts to follow the Medicaid mandate, there is no statewide requirement for all children. That is why approximately 70 percent of Pennsylvania’s youngest kids are not being tested.

Furthermore, the Medicaid measure that is used to report the percent of two-year-olds who had one or more blood tests for lead poisoning prior to their second birthday doesn’t precisely capture whether the Medicaid requirement – testing at 12 months and again at 24 months – is being met. Even though the current measure doesn’t give a complete picture, it shows that 8 out of 10 kids on Medicaid and 6 out of 10 kids on CHIP had at least one blood lead test before their second birthday. This clearly demonstrates that many kids at risk of exposure are missing important preventive care.

Once a child has been identified as having an elevated blood lead level, we need to ensure they are receiving the necessary care and supports. This may include referrals for home inspections to identify and remediate the source of exposure, or referrals to early intervention for assessment of developmental or behavioral delays.

Recognizing that we each have an important role to play in creating a lead-free environment for Pennsylvania children, we applaud the efforts by the Wolf Administration and legislative champions on bringing this issue to the forefront and urge the immediate passage of a universal blood lead testing law.
Not surprisingly, the physical and mental health of a mother, especially maternal depression or anxiety, has a direct and measurable impact on her ability to participate in interactions that build healthy brain development for her infant or child. That is why it is so important to ensure that moms have access to health insurance coverage to receive necessary care. One place to start is with Medicaid as it covers more than a third of all births in Pennsylvania vii.

When a baby is born to a mom with Medicaid coverage, the baby is eligible for coverage for the first 12 months of life regardless of the mom’s eligibility throughout that period of time. However, the postpartum year is an especially medically vulnerable time for a mother. The United States has the worst maternal mortality rate of any developed nation and is one of the few countries seeing an increase.viii The Centers for Disease Control and Prevention (CDC) recently released a report that found 60 percent of all pregnancy-related deaths could be prevented, and one third of all maternal mortalities occurred up to one year after delivery.ix Yet Medicaid in Pennsylvania only covers a mom for 60 days after delivery. The result is that many Pennsylvania moms – an estimated 13,000 annuallyx – lose coverage due to the shift in eligibility guidelines and could likely go without coverage all together cutting off their access to care. Extending Medicaid postpartum coverage for 12 months after delivery – in line with what is already provided for infants under age one – will be essential to supporting optimal health and potentially life-saving care for our families and communities.

Another way to improve maternal and child health is through evidence-based home visiting programs supported by the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). Strong families are the foundation of our communities, and children from strong families have a greater chance of becoming healthy, productive citizens. Parents and caregivers are, of course, their child’s primary teachers and influence. But we all need help from time to time weathering life’s storms, and that’s when voluntary home visiting programs can fit in. Home visiting can be the bricks and mortar to building and maintaining well-being, along with other community services or supports related to health, school readiness, child development and social and economic prosperity. It is tailored to meet the needs of the individual family. Maternal health is one particular objective and would include a nurse or other home visitor assisting with prenatal or other doctor visits, smoking cessation, reducing stress, breastfeeding education and other supports. These are all measures that contribute to creating the environments that we know best support healthy brain development.

However, only 5 percent of low-income children under age six in Pennsylvania are receiving evidence-based home visiting services. In order to expand home visiting to more Pennsylvania families, increased state investments as well as other funding sources including Medicaid are necessary to address the significant unmet need. The key to building healthy families is to start at home, helping children and their families prosper.
We all need nourishment to thrive. It’s hard to think of little else when you are hungry. When a child is hungry at school, concentration is lowered, making learning an uphill climb. Hunger and lack of nutrition negatively impact a child’s cognitive development and impairs a healthy foundation at a critical time of growth.

Fortunately, there are several core programs that are designed to safeguard against hunger, and we can and should focus on ensuring policies that better connect children and families to healthy, nutritious food.

The Special Supplemental Nutrition Program for Women, Infant and Children, more commonly known as WIC, provides breastfeeding support, baby formula and nutritious food for nearly 200,000 moms and their young children up to age five in Pennsylvania.\(^{\text{xii}}\) Despite its important mission and during a time when concentrated poverty in Pennsylvania has been increasing\(^{\text{xii}}\), WIC enrollment has been declining in our state. In fact, WIC enrollment has dropped more than 19% during the past five years.\(^{\text{xiii}}\) Specifically, the largest category drop is among infants; there are one in five fewer infants now in the program than five years ago according to the latest preliminary data from USDA. This mismatch signals a gap between need and nutrition assistance.

While the Supplemental Nutrition Assistance Program or SNAP is available to help all low-income Pennsylvanians buy food, including older and disabled Pennsylvanians, well over one third (or around 677,000) of its participants are children. That’s more than twice the population of the city of Pittsburgh!

Over the past five years, SNAP participation has also decreased – although not as starkly as WIC – dropping five percent during that timeframe.\(^{\text{xiv}}\) Children’s health and well-being depends on access to nutritious meals. Our task ahead is to seek program policy changes to reduce the barriers to nourishment that kids need to think and grow.
Poor oral health can impact the health of the whole body and a child’s overall quality of life. No child should have to fall behind in school because a toothache or severe mouth pain distract from learning.

Dental coverage has been historically separate from medical insurance plans. While it remains an optional benefit for most adults, fortunately dental care for children is mandated as a critical component of both Medicaid and CHIP. Those dental care policies recognize that oral health means much more than healthy teeth or healthy mouth – it is directly connected to general health and well-being.

Tooth decay ranks as the most common chronic childhood disease, even greater than asthma, according to the Centers for Disease Control and Prevention (CDC). Untreated tooth decay can cause pain and infection, leading to difficulty eating, speaking, concentrating in school and even sleeping, but tooth decay is largely preventable. It’s cheaper and better to stop cavities from occurring in the first place, and this begins with access to routine dental care including exams and access to healthy foods.

Children living in poverty are at greater risk of poor dental health. Nearly half of the kids with untreated dental caries – another term for cavities – in our country are living in low-income families. With this in mind, there are several policy solutions that can help treat tooth decay and improve oral health.

Dental sealants are coatings applied to molars for school-age children that can prevent cavities for years. This is especially important for children on Medicaid as low-income children have a greater risk of untreated cavities; however, Pennsylvania data shows that only 14% of school-age children on Medicaid receive dental sealants leaving a stark gap for improvement.

Since less than half of kids on Medicaid receive preventive dental services from a dental provider, another strategy to improve children’s oral health is to integrate dental care by applying fluoride varnish to strengthen tooth enamel during a well-child visit.

In Pennsylvania, only about 6% of kids on Medicaid received oral health services from a non-dentist provider, like a primary care doctor. Oral health and general health are interconnected. When children have access to regular dental visits for prevention and treatment, they are on a path to be healthier, ready to learn and grow.
As a society, we have an obligation to improve children’s health outcomes by ensuring they are connected to what they need to thrive, starting with health insurance coverage. *Every Pennsylvania child regardless of income level, age, race or geography deserves equal access to plug into opportunities to be healthy and well.*

As we try to identify the 124,000 uninsured children through the most currently available data, we better understand those most at risk to be uninsured in Pennsylvania: children less than six years of age, children from low-income families, and children who are American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some Other Race and Hispanic or Latino. We must first focus on addressing our efforts to the parts of the grid where it is most in need of repair.

### UNINSURED BY POVERTY LEVEL

One third of kids in Pennsylvania live in a low-income family, and an increasing number of children in our state are living in high poverty neighborhoods. Our societal responsibility is to ensure that publicly funded supports are in place to support the health and well-being of all Pennsylvanians, especially fundamental needs such as safety and health. When we know that kids in low-income families are 1 ½ times likelier to be uninsured, it is vital to reduce any barriers to Medicaid and CHIP, making them easily accessible options.

28 of Pennsylvania’s 67 counties have a higher rate of children living in low-income families without health insurance than the statewide rate.
Nearly half of Pennsylvania’s 67 counties have higher rates of uninsured children than the statewide average, and the vast majority of these counties are Rural or Rural-mix. Rural areas have unique challenges that can impede both coverage and access to care including a shortage of health care provider options as well as fewer community resources.

The top 10 counties with the highest uninsured rates for children range from 11 percent to 17 percent and include: Clinton, Crawford, Franklin, Indiana, Juniata, Lancaster, Lebanon, Mifflin, Snyder and Union.
40 Percent of Pennsylvania’s Uninsured Kids Live in Five Counties

Forty percent of uninsured children in Pennsylvania live in just five counties: Allegheny, Berks, Chester, Lancaster and Philadelphia, which are Urban or Urban-mix counties xxvi.
We can also look at uninsured data in terms of race to help us identify where structural barriers or historical inequities may be preventing access. Disproportionality shows the level at which groups of children are insured at higher or lower rates than in the general population. Ideally, we would expect the makeup of uninsured children to mirror the makeup of the population of children under age 19. However, the state level data shows that is not the case, as there are four race/ethnicity categories that are underrepresented compared to the general population, meaning their rates are higher, and two race/ethnicity categories that are overrepresented, meaning their rates are lower. Two race/ethnicity categories (Asian and White) are proportional or nearly so to their rates in the general population.

Comparison Between Percent of Population Under 19 by Race to Percent Uninsured Children Under 19 in Pennsylvania:

- **American Indian/Alaska Native**
  - Disproportionately higher uninsured rate at state level
  - AI/AN children are uninsured at a rate two times their rate in the general population

- **Asian**
  - No disproportionality at state level

- **Black or African American**
  - Lower than expected uninsured rate at state level

- **Hispanic/Latino children***
  - Disproportionately higher uninsured rate at state level
  
  *Refers to ethnicity; people of Hispanic/Latino origin may be of any race
WHILE WE DO NOT AIM TO PROVIDE THE ANSWERS AS TO WHY DISPARITY IS OCCURRING THAT COULD DRIVE HIGHER UNINSURED NUMBERS, LIKELY EXPLANATIONS MAY INCLUDE LACK OF ACCESS TO TRANSLATED MATERIALS OR CONFUSION AND FEAR AMONG FAMILIES WITH MIXED IMMIGRATION STATUS THAT HAS RESULTED FROM FEDERAL CHANGES TO THE “PUBLIC CHARGE” RULE. KNOWN AS THE “CHILLING EFFECT,” THIS HAS DRIVEN SOME INDIVIDUALS TO WITHDRAW THEIR ELIGIBLE CHILDREN FROM ESSENTIAL PROGRAMS PROVIDING HEALTH CARE, FOOD AND HOUSING. THIS DATA IS INTENDED TO ILLUSTRATE FOR WHOM ACCESS IS PATCHY AND WHERE WE SHOULD FOCUS ON REDUCING BARRIERS TO HEALTH CARE COVERAGE THAT WE ALL NEED IN ORDER TO DO WELL.

### Percent of Uninsured Children Under 19 in Pennsylvania

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Percent Under 19</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0.02%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Some Other Race</td>
<td>2.9%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>5.4%</td>
<td>3.3%</td>
</tr>
<tr>
<td>White</td>
<td>74.5%</td>
<td>77.0%</td>
</tr>
</tbody>
</table>
The following graph illustrates the disproportionality index for each racial group of uninsured children in Pennsylvania. Bars to the right of 1.0 show overrepresentation, meaning the uninsured rates are higher; bars to the left of 1.0 indicate underrepresentation, meaning the uninsured rates are lower.

*Refers to ethnicity; people of Hispanic/Latino origin may be of any race.
With a 16 percent rate of uninsured children, Lancaster County has the highest number of uninsured children in our state with almost 22,000 kids – even higher than populous Philadelphia – and nearly all of whom are White. This is likely attributable to the large Amish population which resides in the county and does not participate in health insurance but rather relies on its community structure to pay their medical bills in cash.

Lancaster County also has one of the largest Hispanic populations in the state, yet its uninsured rate for Hispanic and Latino children remains very low, outperforming every other county. While a low number, the county’s American Indian and Alaska Native children are disproportionately the highest uninsured racial group in the county signaling more efforts are required to reduce barriers for these children to plug in to health care access.
UNINSURED CHILDREN BY DEMOGRAPHIC CHARACTERISTICS

Percent of Uninsured

Some Other Race
- Lower than expected uninsured rate in Lancaster County

Two or More Races
- Lower than expected uninsured rate in Lancaster County

White
- Disproportionately higher uninsured rate in Lancaster County

No Native Hawaiian/Pacific Islander children under 19 years are known to reside in the county
The following graph illustrates the disproportionality index for each racial group of uninsured children in Lancaster County. Bars to the right of 1.0 show overrepresentation, meaning the uninsured rates are higher; bars to the left of 1.0 indicate underrepresentation, meaning the uninsured rates are lower.

*Refers to ethnicity; people of Hispanic/Latino origin may be of any race

NOTE: No Native Hawaiian/Pacific Islander children under 19 years of age are known to reside in the county.
Now that we understand why keeping kids healthy benefits both individuals and communities, and those who are most likely to be uninsured, we turn our attention to how the 124,000 uninsured children can get plugged in to coverage.

There are multiple sources of health insurance coverage; most commonly families access employer-sponsored insurance. For families that may not otherwise be able to afford coverage, public insurance through Medicaid or the Children’s Health Insurance Program (CHIP) makes health insurance well within reach. Other pathways to coverage include buying individual insurance through the Marketplace, TRICARE or Military, or a combination of two or more types of coverage.

For the purposes of this report, we will focus on publicly-funded or supported options: CHIP, Medicaid and the Health Insurance Marketplace within the following sections.

**How Children Are Covered in Pennsylvania**

- **31.4%** Medicaid and CHIP
- **57.9%** Private Insurance
- **4.4%** Public and Private Insurance
- **6.3%** Not Covered

**TRANSITION FROM FEDERAL TO STATE HEALTH INSURANCE MARKETPLACE**

Individuals can purchase their own health insurance through the health insurance marketplace thanks to the Affordable Care Act. Currently, Pennsylvania relies on and pays to use the federal marketplace (also known as an “exchange”) available through healthcare.gov. Over 400,000 Pennsylvanians currently use the marketplace to purchase their coverage.xxii

The Pennsylvania state legislature recently passed a bill that will allow Pennsylvania to run its own state-based health insurance exchange with the end goal of lowering health insurance premiums and saving implementation costs for the state. It will take time to transition from the current federal insurance marketplace and plans are to have the state-based exchange in operation for January 2021.

We are monitoring the transition to ensure benefits for kids would include robust preventive services and to ensure smooth pathways to Medicaid and/or CHIP as needed. Ensuring a successful marketplace transition is imperative for families’ coverage since research shows that children are more likely to have health insurance when their parents have it.
CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

Pennsylvania has been a leader among states in providing health insurance to kids through the Children’s Health Insurance Program (CHIP), launching the first CHIP in the country in 1992 after then-Governor Bob Casey, Sr. established a plan to offer health care insurance for children who were neither eligible for Medical Assistance nor could afford private insurance. The federal version of CHIP was modeled after Pennsylvania’s program several years later.

Today, CHIP covers nearly 185,000 kids in Pennsylvaniaxxviii, which is the highest level since the program began. While the full-cost option is the smallest category, it is the fastest growing and may indicate that more families who cannot afford private insurance are turning to CHIP as an affordable option.

There is no income eligibility cap for CHIP in Pennsylvania. Rather, income levels determine whether CHIP is free or whether there is a cost to the family based on a sliding scale. For the vast majority of families, CHIP is free which means no monthly premiums and no co-pays for services such as doctors’ visits or prescriptions. Additionally, there are no deductibles which makes CHIP very affordable for families who make payments based on their income range.

For example, the following apply based on a family of four with an annual income of:

<table>
<thead>
<tr>
<th>Income</th>
<th>Percentage of FPL</th>
<th>CHIP Type</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$41,000</td>
<td>&gt;133% and ≤208%</td>
<td>Free CHIP</td>
<td>No copays or monthly premiums</td>
</tr>
<tr>
<td>$61,000</td>
<td>&gt;208% and ≤314%</td>
<td>Low Cost CHIP</td>
<td>Low cost copays and monthly premiums</td>
</tr>
<tr>
<td>$81,000</td>
<td>&gt;314%</td>
<td>Full Cost CHIP</td>
<td>Average monthly premium of $233 per child, plus co-pays for services</td>
</tr>
</tbody>
</table>

*Incomes below the FPL of Free CHIP are likely eligible for Medicaid

CHIP Legislative Action

State and federal commitment to CHIP remains strong. Thanks to bi-partisan legislative actions at both levels, CHIP was reauthorized through 2028, providing long-term program stability and a win for Pennsylvania kids’ health outlook.

To live up to this commitment, we need to pay attention to things that could impact funding of the program. One such threat is another planned decrease of the federal CHIP match rates. While the Affordable Care Act (ACA) temporarily increased the federal CHIP rates for states during a period when the health care system was facing many changes, the rates were scheduled to be phased down over two years.

For Pennsylvania, the federal CHIP match rate decreased to 78% this year and will revert back to 66% next year, the percentage allocated prior to the ACA.

Not having state funds to offset the loss of federal funding for CHIP would likely mean fewer Pennsylvania kids with health care. Fortunately, Governor Wolf and the state legislature accounted for the first year of the decreasing match in the current state budget, and we urge them also to fully offset the second year of the match reduction in the 2020-21 state budget in order to keep kids covered and to ensure we are not reversing course on the progress of the largest number of kids enrolled in CHIP to date. CHIP is a critical component of the grid that offers families an affordable insurance option to keep kids on track to grow up healthy.
Sources of Health Care Coverage for Pennsylvania Kids

Medicaid is an important piece of the overall healthcare coverage system. It provides health insurance for working families with children whose net incomes are below the poverty line, or for children with special health care needs.

It is noteworthy that Medicaid is the single largest health insurer for children in the country and in Pennsylvania. In fact, one in three kids in our state has health insurance thanks to Medicaid. xxix

What is EPSDT?

A critical component of Medicaid specifically for children is the preventive services and comprehensive care benefit known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Screenings available under EPSDT include: physical and mental health, developmental, hearing, dental, and vision. These screenings are required at age-appropriate intervals and are based on the Bright Futures periodicity schedule developed by the American Academy of Pediatrics. For example, there are six well-child visits for infants under 1 year of age included in the Bright Futures schedule.

One of the reasons EPSDT is so important is because it requires coverage of any resulting medically necessary treatment or services for the individual child, regardless of whether it is covered under the state’s Medicaid plan.

Pennsylvania has been losing ground on well-child screening participation rates dropping from nearly 80% to only 60% in one year.

EPSDT detects and treats illnesses or conditions early in order to correct or control them before they become complex health problems. However, state data shows that there are gaps in the well-child screening participation rates, meaning that screenings are not occurring for all kids when they should be. Only about 60 percent of Pennsylvania children who should have received at least one initial or periodic screening actually received one. xxx While it is on par with the national average, Pennsylvania’s rate has dropped significantly from the year prior and is now back to the same level as five years ago. xxx Pennsylvania has been losing ground on well-child screening participation rates dropping from nearly 80% to only 60% in one year. The participation rate varies by age range, with infants and toddlers having the highest participation rates and school-aged and older teens having the lowest participation rates. Well-child visits are important to ensure up-to-date immunizations in early childhood and should continue into middle childhood and adolescence, when it is especially important for mental and behavioral health assessments including depression screening.
Sources of Health Care Coverage for Pennsylvania Kids

Medicaid Managed Care

Nearly all Pennsylvania kids in Medicaid are enrolled in managed care organizations (MCOs). The Pennsylvania Department of Human Services contracts with MCOs to manage and provide health services through their networks of providers to Medicaid enrollees. Pennsylvania has a long history as a managed care state dating back over four decades. Pennsylvania’s Medicaid Managed Care Program, known as HealthChoices, has a physical health network and a separate behavioral health network for mental health and drug and alcohol services. MCOs in Pennsylvania provide coverage based on county of residence.

Medicaid is a major health care payer that drives system change. For example, the Pennsylvania Department of Human Services, the state’s Medicaid agency, has been working with MCOs and moving to a new payment model of value over volume by introducing value-based payments for quality and outcomes of care rather than traditional fee-for-service payments for each service performed. This priority of pursuing health outcomes is promising for overall health and well-being because the approach seeks to holistically manage and consider the needs of the individual beyond medical care, including social determinants of health.

Managed Care Organizations and Networks in Pennsylvania*

**Physical Health MCOs**
- Aetna Better Health of Pennsylvania
- AmeriHealth Caritas
- AmeriHealth Caritas Northeast
- Gateway Health
- Geisinger Health Plan Family
- Health Partners Plans
- Keystone First
- United Healthcare Community Plan
- UPMC for You

**Behavioral Health MCOs**
- Community Behavioral Health
- Community Care Behavioral Health Organization
- Magellan Behavioral Health of Pennsylvania
- PerformCare
- Value Behavioral Health

*Networks Are Part of Pennsylvania’s HealthChoices Managed Care Program

In mid-October 2019, DHS released a Request for Applications (RFA) for the provision of physical health services by MCOs. The new procurement may result in changes to the PH-MCOs listed above which were first selected in 2015.
Multiple policy strategies have been employed across the country to get kids enrolled in Medicaid or CHIP health insurance and then to minimize or eliminate gaps in coverage once they are enrolled due to changes in income or during annual renewals. This is the single biggest moment when eligible individuals lose coverage. Pennsylvania children would be well-served by these best practices since eligible children who lose coverage often go without health care services, missing immunizations and other preventive care. In addition, these policies would reduce interruptions in coverage from kids moving on and off Medicaid, also known as “insurance churning,” which is disruptive to overall health, not to mention administratively and programmatically costly.

Allowing kids to stay continuously enrolled in Medicaid for 12 months regardless of changes in family income would provide continuity of coverage and continuity of treatment. This policy known as “continuous eligibility” is available for all CHIP kids and was implemented in April 2018 for Medicaid kids under the age of 4. Pennsylvania should take the next step to continue building the coverage network by expanding this policy to all kids in Medicaid from age 4 to age 18 so that their continued coverage does not interrupt their preventive and necessary care mid-year. Another benefit of this policy would be the improved quality of data collection, since only children continuously covered are required to be reported. This policy would close the data gap for those who are currently not included allowing for more accuracy.

Adopting a simplified process to allow Medicaid eligibility for kids to be determined by other income eligible programs such as the Supplemental Nutrition Assistance Program (SNAP). This policy known as “express lane eligibility” is a commonsense approach for ensuring quicker access to health coverage by looking at income information for multiple purposes. The sooner a child has health insurance, the sooner they can receive immunizations and other preventive care, or access to health services for chronic conditions such as asthma or diabetes.

Improving automated renewals, also called “ex parte renewals,” is another tool we can use to help eligible Medicaid and CHIP kids keep their coverage. We know that the annual renewal period risks a break in coverage, so automating the process by reviewing electronic data sources without requiring the individual to sign a form provides a greater chance of retaining eligible children and eliminating unnecessary gaps in coverage.
WHILE THIS REPORT AIMS TO BE COMPREHENSIVE, IT IS NOT INTENDED TO BE ALL-INCLUSIVE OF EVERY FACET THAT COULD IMPACT THE HEALTH OF A CHILD. FUTURE REPORTS MAY EXAMINE ADDITIONAL SUBJECTS SUCH AS CHILDHOOD MENTAL HEALTH, ADVERSE CHILDHOOD EXPERIENCES KNOWN AS ACES, MATERNAL MORTALITY AND MORBIDITY, AND BIRTH OUTCOMES.

NO CHILD SHOULD EXPERIENCE A HEALTH INSURANCE BLACKOUT, AND IT IS OUR RESPONSIBILITY TO KEEP THE GRID RUNNING SMOOTHLY. AS OUTLINED THROUGHOUT THIS REPORT, POWERING UP HEALTHY KIDS BEGINS WITH HEALTH INSURANCE COVERAGE. IT SERVES AS THE CONNECTOR TO ACCESS PREVENTIVE AND COMPREHENSIVE CARE TO MEET CHILDREN’S PHYSICAL, MENTAL AND BEHAVIORAL HEALTH CARE NEEDS. THIS ENABLES HEALTHY CHILDREN TO BE ENERGIZED FOR LIFE-LONG LEARNING AND FUTURE SUCCESSES, IMPROVING BOTH THEIR INDIVIDUAL HEALTH AND OUR COLLECTIVE WELL-BEING.

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17. County types defined as Urban (75% or more urbanized) and Urban-mix (50% to 74% urbanized)
23. U.S. Census Bureau, American Community Survey (ACS), 2013-2017 estimates; using <200% FPL
24. U.S. Census Bureau, American Community Survey (ACS), 2013-2017 estimates; using <200% FPL. Statewide rate 7.2%
25. U.S. Census Bureau, American Community Survey (ACS), 2013-2017 estimates
26. County types defined as Rural (no urbanized population) and Rural-mix (up to 49% urbanized)
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