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Operator: Ten, nine, eight, seven, six.

Rachel Griffith: Hello and welcome to the Trends and Disparities in Children's Health Insurance webinar.

To receive the full analysis of the items we'll be discussing today, please visit www.shadac.org/kidsreport2017. And if all people would please mute your phones during the webinar, we would appreciate it. To ask questions during the webinar, please use the Q&A function located at the bottom left hand of your screen. Lastly, today's webinar will be recorded and available at shadac.org.

Now I'd like to turn it over to today's Moderator Lynn Blewett, Director of SHADAC.

Lynn Blewett: Hi everyone. Welcome to today's webinar. It's great to have so many folks on the phone. My name is Lynn Blewett. I'm Director of the State Health Access Data Assistance Center. I'll be facilitating today's webinar. And we're happy to be cohosting with State Health and Value Strategies.

SHADAC is a Robert Wood Johnson Foundation funded, multi-disciplinary health policy research center located at the University of Minnesota's School of Public Health. SHADAC faculty and staff are recognized experts on collecting and applying state health policy data to inform policy decisions with expertise in both federal and state survey data resources.

We are pleased to join with State Health and Value Strategies, who is another organization associated with the Princeton University Woodrow Wilson School of Public and International Affairs who works to transform health and health care by providing targeted technical assistance to state officials and agencies.

State Health and Value Strategies is led by Heather Howard and Dan Meuse. This program connects states with experts and peers to undertake health transformation. The program engages states and experts to provide lessons learned, highlight successful strategies, and brings together states with experts in the field.

To learn more go to SHVS.org.

Today's webinar and the analysis we're highlighting are supported with funding from the Robert Wood Johnson Foundation. We want to thank the Robert Wood Johnson Foundation for their continued support of our core efforts to increase the availability and use of relevant state and national data to inform state health policy.

Joining me for today's event are Elizabeth Lukanen from SHADAC and Heather Howard from State Health and Value Strategies. Elizabeth Lukanen is the Deputy Director of SHADAC where she manages SHADAC's technical assistance to states in the areas of data use and analysis and evaluation.

Heather Howard is Program Director at State Health and Value Strategies. She also lectures in public affairs at Princeton University's Woodrow Wilson School of Public Affairs, and she teaches courses on health policy and administration.

Just to give everybody some framing for our discussion today, the most recent data that we're going to be looking at today comes from the Census Bureau's American Community Survey. And what

we've seen is a historic increase in the rate of the uninsured for children nationwide. This has interrupted a years long run of decreases in uninsurance for children. The increase in uninsured children is seen across states and across demographic groups.

There are several potential reasons for the coverage developments and the state variation that we're seeing and we'll discuss some of these today. In the midst of our current policy development, there is a lot to be learned from the states on promising strategies to increase coverage for children and to reduce health disparities.

Today we'll be discussing findings from the newest data on children coverage across the states and nationwide. We're looking forward to a rich discussion of both data and policy and we encourage the attendees to submit questions and comments at any time during today's call.

At this point I'll hand the call off to Elizabeth Lukanen.

Elizabeth Lukanen: Thanks, Lynn. And thanks everyone for joining us. So you know, SHADAC has been analyzing trends in children's health insurance coverage for more than a decade. Reducing the number of uninsured children has been a policy focus both at the state and national level for a long time.

And so annually we look at data from the Census Bureau to monitor these trends to identify areas of progress in this area and to explore variations across the states. And I think what really surprised us this year is that for the first time in almost a decade we saw the uninsured rate among children go up between 2016 and 2017.

And more surprisingly, this increase in uninsurance was significant across almost every demographic group that we looked at. Something that wasn't new unfortunately -- and we'll dig into this -- is at the state level, disparities in uninsurance persist. And we'll look at those trends shortly.

So this is a chart that sort of shows our main story line here, that nearly decade long decline in children's health insurance with a steep drop between 2014 and '16 -- likely corresponding with the enactment of the Affordable Care Act -- was suddenly interrupted between '16 and '17. So this trend breaks where we've seen an increase for the first time in nearly a decade. And while that increase looks small, this represents an additional almost 270,000 additional children do not have health insurance.

And as I mentioned, you know, we think this is of great importance to states and state policymakers because we really see that this increase in uninsurance is driven by a decline in public coverage.

And what we're also seeing and it's worth noting is that this is in spite of the fact that we've actually seen an increase in employer-sponsored coverage. So the decline in public coverage is offsetting an increase in employer-sponsored coverage among children between 2016 and '17.

And as I noted, what was really sort of concerning to us is this increase in uninsurance was present in nearly all the demographic groups we looked at. So children of various incomes, White and Nonwhite children saw an increase in uninsurance. And we also look at children in households of varying levels of parental education and again across all groups we saw this increase in uninsurance.

Something that wasn't new is that the disparities in children's uninsurance persisted. This is something that has been an issue for the many years that we've been looking at this issue. And even despite these declines in uninsurance across 2000, you know, across the last decade, we continue to see that lower-income children, Hispanic children, and children who have parents with lower educational attainments are just much more likely to be uninsured.

So why does this matter? There is, you know, sometimes people do ask us “Look, kids are healthy, the majority are pretty healthy.” But there really is a robust body of research showing the value of insurance for children. Uninsured children have fewer physician visits, fewer visits to address things like chronic conditions, and fewer preventive health visits.

And on the flip side of this, children with health insurance are more likely to get the care they need. So they fill their prescriptions at a greater rate; they are more likely to get their immunizations. And it's not surprising then that these health benefits have even broader impact. So insured children are less likely to miss school. And these benefits really persist long term and turn into better educational and economic outcomes.

And I would say if you need to make this case to stakeholders, I would really recommend reading the work done by the Centers for Children and Family at Georgetown. They have really nice briefs summarizing the benefits of insurance for children.

And most people on this webinar probably know that while the majority of children do get their insurance through employer-sponsored coverage through their parent, more than a third are on Medicaid or CHIP. So you know, Medicaid and CHIP who are co-funded by states and the federal government, you know, state policy makers really have a huge role in shaping Medicaid policy and can have a considerable impact on children's uninsurance rates.

So with that we will turn to the state story. And you know, there is considerable variation in children's uninsurance across the states. Rates range from 10% in Texas to 1.4% in Vermont. And this is really because states are in different places -- both in terms of their economic situation such as the number of kids in low income households – but they also have very different policies and eligibility levels for Medicaid which impacts children's uninsurance.

So this shows the 10 states with the lowest rates of uninsured children in 2017. And really what we see is that states with low insurance typically have either high rates of Medicaid or high rates of employer-sponsored coverage. So two examples – Massachusetts, more than 60% of children have employer-sponsored coverage which is much higher than the rate nationally that is 54%. On the flip side, Louisiana almost half of their children are on Medicaid. And that's a lot higher than the national average of 35%. And we're going to dig in a little bit on some of these states.

So as I said Massachusetts has you know, a really low rate compared to the nation. But it also has a really low rate across subgroups. So we see that low-income children have a much lower rate than in the nation -- 2% of low-income children in Massachusetts are uninsured.

We also see that Hispanic children in Massachusetts have a rate of less than 2%. And we also see that kids in households of low education have a much lower rate than the nation. And, you know, in Massachusetts the story is really about that high rate of ESI.

When we look to Louisiana, what we see is a similar picture but it's really driven by this incredibly large group of kids -- almost 50% -- that are in Medicaid. So, again, in Louisiana they have a low rate of uninsurance compared to the U.S. -- 3% compared to 5%. And like Massachusetts we really see these low rates across different subgroups of interest.

So for example, Nonwhite children have a much lower rate compared to the national average at 2.5% in Louisiana compared to 4.6% nationwide. And we also see that this persists in kids whose parents have lower educational attainment. Again, a much lower rate of uninsurance compared to the national rate of 8.3%.

It's really important to note, too, that uninsured children are really concentrated in a small number of states. So more than half of these kids live in just seven states. So you can imagine that the policy choices in these states have a really big impact. And this includes New York and California,

both of which have uninsured rates that are low but because they're such populous states, they have a lot of uninsured children.

And Texas, the state with the highest uninsured rate at 10.7% also has the most uninsured children. And they had the largest increase in uninsured children between 2016 and 2017. So that meant an additional 82,000 uninsured children in that time period.

And Texas is a really interesting case because this was driven by a decline in both insurance for kids in the individual market and Medicaid, but in spite of an increase in kids who have employer-sponsored coverage. So while we think economic gains are probably leading to increases in employer-sponsored coverage in Texas, it wasn't a big enough jump to offset these declines in public coverage.

And you see some disparities in Texas. Uninsured rates were particularly high among middle-income kids likely eligible for subsidized coverage, for Hispanic children, and also for children in families with low parental education.

So when we look at states that have low you know, with high rates of uninsurance for low-income kids in particular, it's probably not surprising that these states also have low rates of Medicaid. So for example in Utah almost 53% of low-income children have Medicaid compared to 74% in the U.S. In addition these states typically have large disparities in uninsurance between children with high and low incomes. So, again, you can really see how Medicaid plays a role in insuring some of these kids.

So digging into Utah a little bit, they have a high rate overall compared to the U.S. -- you know, almost 7% compared to 5%. And this is in spite of having a very robust employer-sponsored market. And they also have high rates of uninsurance across some key subgroups such as low-income children and Hispanic children. But, again, we really feel like this is correlated to the fact that they

have very low rates of Medicaid in the state because the state hasn't expanded Medicaid to adults and we know that adults often, you know, adults who get coverage often lead to having their children get coverage. So having a Medicaid rate of under 17% is likely a factor.

These are just some of the subgroups that we highlighted. So the storyline that hasn't changed, you know, we've seen this historic increase in uninsured children but as I've said a few times disparities really persist. There are national disparities, and these disparities are really mirrored at the state level.

So this chart shows states with the largest difference in uninsured rates between Hispanics and Whites. We highlight this because this is where the disparities are the greatest both within the nation and within states. And it's notable that eight states did see a significant increase also in uninsured for Nonwhites, which you can find in our report.

In Minnesota, we wanted to highlight Minnesota because Minnesota is a state that has a really low rate of uninsurance compared to the nation but it does have these persistent disparities. And this is why we really encourage policymakers to dig into the data that we've produced for each individual state because if you just look at your average, it's not going to tell the whole story.

So in Minnesota like I said a low rate but particularly high rates for low-income kids and Hispanic kids and Nonwhite kids compared to all of their children in the state.

So if you're interested in learning more about the story in your state, we really encourage you to visit the landing page for this report and explore the state profiles that we put together which have all sorts of detail and data on your state.

We also have a broader report of the full analysis which includes a summary chartbook, again the state profiles, and 50-state comparison tables. And if you have any questions about these data or want to discuss them more, you're very welcome to contact us.

So I've laid the groundwork now for the data story. And I'm going to turn it over to Heather Howard at State Health Values and Strategies at Princeton to talk about some policy implications.

Heather Howard: Thank you Elizabeth and Lynn and the great team at SHADAC for all you all do to help states understand data and your work on tracking coverage trends and more broadly of course all the great work you do.

And I really do want to reiterate for state folks who are on the webinar the great resources you have for states and the ability states can have to go on, look at your comparison tables, and to really dig into the state-level data.

As Lynn mentioned, we are also a program at the Robert Wood Johnson Foundation working with states. And so encourage folks to visit our website if you're interested in learning more.

If you go to the next slide, we thought you know Lynn and Elizabeth have laid out what really is an alarming uptick and the first-time reversal in our nation's historic progress in covering kids, and it really is a concern.

If you go to the next slide, we don't yet know - we have a good story to tell showing this alarming trend but we don't yet know what is causing it. But there are some potential contributing factors that we're digging into. And as Elizabeth noted, even though the coverage drop is driven by the drop in coverage in public programs, we know that the overall coverage trends may be affected by broader trends in health policy.

And that's really these first two which is that we know that under the ACA there's been in the last couple years a reduction in marketing and outreach funding and general confusion about the status of the ACA and its programs, and so that may be leading people to not sign up for programs. So that's one concern.

But then more broadly, we know as Elizabeth mentioned -- and we're going to get to hear from some terrific state leaders on this front -- we know that state policies matter, especially on the public program side. And so we're seeing more states more proactively conduct Medicaid review and redetermination processes which may lead the kids losing coverage. And that's something we're digging into more because we want to understand these causes and help states understand what policy leverage they have.

If we go to the next slide, we know that state policy choices matter, but we also know that states are operating in what we call a "dynamic federal policy environment." The second point here is the litigation about the constitutionality of the ACA hangs over a lot of what's happening at the states. And the first point is that there is that general consumer confusion about the status of programs and whether they are eligible for them.

And finally, we know that immigration policy debates and especially the draft -- it's only a draft, but the draft public charge rule which would affect how enrollment in health programs may affect immigration status -- that we're seeing across the country that that's having a chilling effect on enrollment in health programs.

So again, it's hard to tease out the exact impact of these various causes but we think it may be this perfect storm that's coming together and again causing this first time drop and reversal of the progress we've made in covering kids, which is really a great concern to people in public health. Because I think Elizabeth noted so well why coverage for kids matters.

To help us understand what states can do, if you go to the next slide, we are fortunate to be joined by two great state leaders who are on the front lines of thinking about getting kids covered and keeping them covered. And they're going to help us tease out what these promising enrollment strategies are. And from Louisiana -- we'll go to her first but I'll do introduction -- from Louisiana we have Jen Steele who is Louisiana's Medicaid Director. And for anybody who has followed kids' coverage issues over the years, Louisiana has really been a leader in children's coverage and the data really demonstrates it, as Elizabeth elucidated.

And then from Minnesota, Minnesota of course has a really good story to tell about overall coverage rates but they have been grappling with the challenge of persistent disparities in racial and ethnic coverage especially for kids. And there we're joined by Alisha Baines-Simon who is the Supervisor for the Access and Cost Containment Unit in the Health Economics Program at the Minnesota Department of Health.

So I'm going to start by turning it over to Jen to talk about that Louisiana story and then we'll hear from Alisha about Minnesota. Jen?

Jen Steele: Yes, Heather thank you. So let me just start by saying that from a policy perspective, Louisiana Medicaid covers children, between Medicaid and CHIP we go up to 250% of poverty, and that's a pretty significant coverage level when you consider that nearly 40% of our residents are under 200% of poverty and in even higher number when you just consider children.

So the way that Louisiana got here was not accidental. My predecessor Ruth Kennedy was a relentless advocate for streamlined eligibility and enrollment. And she really oversaw the expansion of CHIP in Louisiana with a very aggressive "boots-on-the-ground" outreach strategy to enroll eligible but uninsured children.

For many years, Louisiana is a state that the state Medicaid agency employees the individuals who do eligibility determinations. So of roughly 900 staff in the agency, nearly three quarters are folks throughout the state who work in our parish offices. We don't have counties; we have parishes. But they work in the parish office and they serve the eligibility determination function.

When during the time of the CHIP roll out we had offices in 46 parishes -- 46 of the 64 parishes -- and we were at every school kick-off, every health fair, everything you could possibly - every church event -- everything you could possibly imagine. We had the luxury of paid overtime for people to go out and do these events and there was a lot of energy around it.

And through that when you pair that with policies and the state choices such as 12 months continuous enrollment, SNAP assisted enrollment or what we call express lane eligibility, and then things that were just more procedural such as a procedural requirement that staff attempt to contact with the member particularly if we were trying to avoid procedural closures -- so closures simply for reasons such as failure to respond.

So we had a policy that the case worker before closing the case would have to make three attempts -- three different phone numbers, three different times of day, three different days of the week -- and that had to be documented in the case record before a procedural closure could occur. And so, you know, we had very high rates of enrollment, very high rates of retention as a result.

Fast forwarding a little bit, so in 2008 to 2016 we had an administration that was pretty conservative when it came to state employment, was a big advocate of privatization, and so our workforce was reduced about 25% over that period. Our parish offices dwindled from 46 to 9. And our ability to do that "boots-on-the-ground" work, the outreach funding dried up and again just because the enrollment continued to grow while our eligibility workforce continued to decrease, our ability to do that kind of "boots-on-the-ground" activity was greatly diminished.

In addition more recently in 2016 Louisiana became -- well until the most recent round of elections -- we were the most recent state to expand Medicaid to include low-income adults. And with that expansion came the enrollment of today nearly 500,000 adults and consequently our role in the state budget, our reach in terms of total state participation in the program, it's just astronomically larger than it used to be during the CHIP era.

And so with that growth has come a lot of scrutiny about that adult enrollment. Some of the same discussions you hear nationally about whether or not that adult enrollment is crowding out, you know, is consuming resources and crowding out opportunity for others in the Medicaid program, the traditional Medicaid program people with disabilities, et cetera.

And so through a series of activities on the part of our legislature, our legislative auditor, there has been intense pressure to tighten our eligibility policy. You know, fortunately we did exercise the state option to have 12-month continuous eligibility. So under the maintenance effort of that requirement, you know, we are protected from you know, interests for example that want to have more frequent renewals.

But we did also, kind of independent but co-occurring with all of this, was the replacement of our legacy eligibility and enrollment system. That system was a green-screen mainframe type system where, you know, humans knew eligibility policy; they did manual queries for verification of eligibility factors and they made decisions and they manually input information and made, you know, closed cases or open cases.

In November of 2018, after several years in development, we replaced that system with you know, contemporary technology that not only automates data queries of more than 20 different sources for income, citizenship, other factors; it also automated decision making through the use of a business rules engine. So the policy was basically programmed into the system. The system

ingests as much information as it can. It makes as many decisions as it can and you know workers intervene to provide for gaps in information that are needed for the system to continue.

So today we've got automated data interfaces, automated business rules, and also automated closures. So the policy that I talked about where we would have three contact attempts before we did the procedural closure, we do not have that anymore.

We've also introduced, in response to some of the pressure that I described, quarterly wage checks. So we had always used our state workforce commission data to check eligibility at application and renewal, but recently introduced a quarterly interval where not just at those two points in the year but at two other points we also check to see whether or not individuals appear to have income over the limit.

For children for purposes of this discussion because of continuous eligibility, it does not have an impact but it does impact their parents. And so what we are paying great attention to now is -- and it's very, very early so it's hard for us to see the results -- but we are paying close attention to, given the volume of closures that we're experiencing -- and again the vast majority are in fact for failure to respond as opposed to a determination of ineligibility. We know that at a point in time in the recent past the person may have been ineligible or, you know, had income that was over the limit. But you know, in terms of the present given that someone did not respond to a request for information, we can't tell you that in fact their circumstances did not change to allow them to remain eligible.

So we're watching closely, gathering data, trying to determine watch the impact is in terms of kids who are cycling in and out of coverage. Again, this is primarily going to impact our adults on the wage data but children are impacted as well.

And then we're also spending a lot of energy thinking about, you know, we're in a different era technologically and people have cell phones. So is there a different kind of outreach? You know, we're focusing on text messaging, trying to really you know, again completely change what the recipe was that was successful in the past but what does the recipe look like in 2019 and 2020 to maximize enrollment of eligible individuals and to keep them enrolled.

So with that I'll pause.

Heather Howard: Thank you. Jen, that was great. This is Heather again. I mean you know, as everyone can hear why Louisiana has been a leader on children's coverage because of such a thoughtful approach. I mean, I heard you highlight the policies you pursued to streamline eligibility enrollment including 12-month continuous eligibility and fast track, that targeted outreach you're doing in the community, the policies, the sort of effective policies you've implemented with how your case workers contact families, your use of upgraded technology.

Even now as you're, using wage data you're focused on those kids turning on and off and how you're using new technology. So really an impressive suite of policies focused on getting kids and keeping kids covered that offers some important lessons for other states.

Now I hope we have Alisha. Are you still on and with us? We'd love to hear...

(Crosstalk)

Alisha Baines-Simon: I am.

Heather Howard: ...the Minnesota perspective.

Alisha Baines-Simon: I am here. Thank you.

Heather Howard: Terrific. Great. Thank you.

Alisha Baines-Simon: So I'm coming from the Public Health Department as opposed to the Medicaid office, so a slightly different focus. But it's always nice for us to know that Minnesota isn't really seeing the same overall big increases in children's uninsurance. And as Elizabeth mentioned, we do tend to kind of be on the low end of the uninsurance rate. But as is typical with Minnesota as Elizabeth also mentioned, we have a lot of disparities. And so that good statewide number generally masks some pretty significant disparities -- usually related to race, ethnicity, and income. And occasionally we also see some urban and rural disparities.

Overall, Minnesota from a policy perspective has had public coverage available for children up to 275% of poverty for a long time. Prior to 2014 they were covered by a program called Minnesota Care that involved a minimal premium – it was \$4.00 a month per child. And then after 2014 Medicaid eligibility was expanded up to 275% of poverty.

We also opted to have a state exchange rather than using healthcare.gov back when the ACA was enacted, so our state exchange is called “MNsure.” And what that means is it provides another access point outside of county offices for enrollment to Medicaid. And we're also maybe catching more children as their parents are shopping for insurance.

So if you go through the system in MNsure and the children qualify for Medicaid and the parents qualify for tax credit, the system would catch that and sign the children up for Medicaid.

That said, we're still concerned that there are still 46,000 children without coverage in our state. Minnesota, we do monitor coverage with our own population survey that's similar to the ACS.

Another thing that we've been able to do through MNsure is we didn't see the same drastic cuts in the kind of advertising budget that other states saw in 2018 mostly -- 2017-2018 and continuing on. And so MNsure has been able to continue advertising as a way for people to get access to health insurance.

And then we continue to focus our navigator population that are trained to help people get coverage of some kind. So MNsure does navigator as well as broker training and their navigators often will focus on areas or populations in the state that are disadvantaged in some way -- be it, you know, racial and ethnic minorities or income.

Our Children's Defense Fund office does a lot of work with navigators trying to get kids enrolled. So we sort of have a group of people that are concerned about getting our overall enrollment up in the state to help children.

So I would say that's kind of where we're at as far as our children kind of what we're doing to help children. Our governor is very focused kind of broadly on getting access to everyone but we're still in legislative sessions. So what will actually happen remains to be seen.

Heather Howard: Thank you, Alisha. That was great. I mean it's helpful I think for folks to hear even, as you know, even in a state with low numbers of uninsured kids the importance of tracking the data -- which I know is the heart of your Health Economics Program at the Department of Health at Minnesota -- monitoring. And then I think you highlighted some interesting advantages that Minnesota has had by running your own exchange and being able to continue to focus on robust advertising and outreach and to use your navigators to do real targeted outreach to be able to focus on addressing some of those equity concerns about the disparities by race, socioeconomic status, and geography. So that was helpful to hear from two states really taking a proactive approach to getting and keeping kids covered.

With that, Lynn I want to turn it back to you for some comments and then I can see we've already got a bunch of really good questions in the queue.

Lynn Blewett: Yes, thank you. Thank you, Jen and Alisha. This is really great to hear from the two states and interesting two perspectives. One, the Medicaid sort of on the ground getting people enrolled and then our Health Department who has been very involved in collecting data for Minnesota in our Minnesota health care access survey but also has a, you know, very concerted effort on health disparities with the legislative mandated report every year highlighting those and developing strategies to reduce them.

And again as you look at averages across states, as Elizabeth said, it's very important to dig into the different characteristics and subpopulations to think about how to better target scarce resources and public policy to get the kids with the high rates of uninsured enrolled. So, a couple different strategies.

We've got a couple questions coming in. And I want to start out with Elizabeth. You know, one of the things that we've seen with an improved economy and either an increase in employer-sponsored coverage and steady or increase in employer-sponsored coverage, why aren't we seeing a drop in public coverage? So isn't the employer-sponsor coverage picking up some of that drop in Medicaid?

Elizabeth Lukanen: Well nationally and in some of the states that we looked at, it's just not happening. So despite the fact that the economy seems to be, you know, in good shape and there are increases in employer-sponsored coverage for kids, the declines in both most notably in Medicaid but also in the individual market, they're just bigger than the gains in employer-sponsored coverage.

So we really think primarily this increase in uninsurance is related to things happening in the Medicaid program that are causing kids to lose public coverage.

Heather Howard: And can I jump in on that Lynn? And Elizabeth, I think that's right that what you're saying is really these are - that state policy matters. And these decisions I think as we heard from Jen that Louisiana follows does continuous eligibility and does annual redeterminations, where some states are doing more frequent redetermination and often that's when kids may be falling through the cracks. So those kind of, you know, especially in some of those states that have the highest drop-offs, that may be the cause.

Lynn Blewett: Yes, Heather. This is Lynn. Do you know states who have passed continuance eligibility for adults? It seems quite common for kids and it's a very effective strategy. I know we tried to do it in Minnesota without success. There is, you know, a cost attached to it. But it seems like that would be kind of a no brainer to get both parents and kids covered.

Heather Howard: Yes, it is an option. And you're right, because the research shows that not only of course would you be keeping the parents covered and ensuring continued access to care, but the research shows that when parents are covered, kids are covered, right? I mean that was the reason so many states under the CHIP program have covered parents in part because that has led to greater enrollment by kids and retention of kids.

So yes, it is. But, you know, it requires that sort of policy choice that not many states have made yet.

Lynn Blewett: Great, thanks. So Jen, could you elaborate on Louisiana's fast-track targeted enrollment operations? Was this a waiver or a state plan amendment? And is it tied to a process for getting auto-enrolled in SNAP and TANF?

Jen Steele: Yes, it is. So for children expressly in eligibility, but if they're under authority, and for children essentially if they're on SNAP we enroll them In Medicaid without a separate application.

For adults we have a spa as well. We did a big data match with the DCFS SNAP program at the initial implementation of expansion. And we did not do it since. For adults it was a little different.

We had to have them complete - we sent out what we call the canary yellow letter. It was a letter with four questions. There were four pieces of income-related information that we needed answers to for Medicaid purposes that we could not get answers to definitively from the SNAP eligibility determination.

So the individual had to either call, fax, or mail back their answer to those four questions. It was just a one-page letter. And on that basis, they were enrolled.

We are considering adding that back now that we can do it with the new system. But quite frankly we have a lot of instability right now in our enrollment because of the impact of the new system in terms of closures. And so right now we're just trying to evaluate the impact of those closures because as many states – as really every state does when you roll out a new eligibility system of this scale -- you typically suspend renewals while your staff kind of get over that learning curve and get a handle first on applications.

So we are just now in the process of phasing all the renewals back in. So we are looking forward to when the dust settles -- hopefully in the next coming months – to being able to reintroduce SNAP-assisted enrollment for adults.

Lynn Blewett: Great, thanks. This kind of ties into the continuous eligibility. And Heather I know you've been looking at this issue a lot, but this question is doesn't the family glitch affect the issue as well? Many employers don't contribute to family coverage so when they're signing up, you know, their families aren't covered under the employer-sponsored insurance.

Heather Howard: Yes. I mean that's an unfortunate the way that the ACA has that provision that's been interpreted. The family glitch has made it hard for families to get affordable coverage. It's true.

I mean I think some states have actually thought about could they address the family glitch, but of course that would require often might require more states dollars, which is hard for states to do in these tough times. So that is a structural problem that is hard for states to overcome.

Lynn Blewett: Yes, it seems like that would be -- that and the continuous enrollment for adults -- would go a long way and if we had support, you know, with federal match and ability to sort of do those two fixes we could go a long way in terms of, you know, changing this direction of the trend in uninsured kids.

Heather Howard: That's right.

Lynn Blewett: Elizabeth, this is a question about the data. This says nationally, the National Health Interview Survey conducted by the national center for health statistics is not reporting the same trend in more uninsured kids when they're looking at the early release from 2016 through 2018. What might account for the difference compared to the national data you're seeing from the American Community Survey?

Elizabeth Lukanen: Great question. I love the data questions. You know, I think we monitor the National Health Interview Survey Early Release really closely. And we basically think it's probably a sample size issue. That survey has considerably less sample than the ACS. But we are going to be monitoring the new data that will come out I think in the middle of this month, which will be the first full year (2018) estimates from the national health interview survey and we're going to be looking at that -- the kids' group -- to see if the coverage increases.

If it doesn't, then we're going to have to do a little more digging and see why the surveys seem to be giving counterintuitive results. But stay tuned. Mid-May we'll have some of the first full year 2018 data from that survey and we'll be looking at the kids' coverage in that data source.

Lynn Blewett: We're going to kind of go back to Jen and thinking about some of your comments that you made. This is the question -- some states have seen their number of people on Medicaid increase as the states paused Medicaid to sorry, redetermination and then the reduction as redetermination starts again. Louisiana is an example. Is there a difference? This is different from more proactive Medicaid redeterminations.

I know in Minnesota too in January the numbers go down because they're doing redeterminations and the enrollment goes down but then it kicks back up as sorry, redeterminations come in. So can you tell -- either Jen or Elizabeth or Heather -- can you tell if this is historic Medicaid rates with the restart of Medicaid redetermination? Or is that taken into account?

Jenn Steele: This is Jen. Given the fact that we just went live with the new system in November and that we suspended renewals entirely for the first couple of months and literally we've now just in the past month resumed renewals for everyone but our long-term care population. So it's too soon for us to know.

For example, we do know that we're closing people at a higher rate than we historically have. What we don't know yet because we just haven't had the run out is, you know, at what rate they're going to come back to us and how quickly. So that's the thing that I'm watching most closely right now. But it's just too early to know.

Lynn Blewett: Right. And you can look at that with your administrative data maybe.

(Crosstalk)

Jen Steele: I can.

Elizabeth Lukanen: I think from a...

(Crosstalk)

Jen Steele: Yes.

Elizabeth Lukanen: Yes, from a survey perspective this really is a survey that encompasses the experience of states in the nation across almost a full year. So I don't think that that's the reason.

We do however you know, just recently the federal government put out administrative data showing a decline in coverage, in public coverage for kids. So you know, we've gotten a lot of questions over the last few days. Do you think this is a blip? Do you see this trend continuing?

And at least based on that new administrative data, it seems pretty consistent with this survey. And so...

Lynn Blewett: Yes.

Elizabeth Lukanen: ...we're going to be monitoring trends carefully in forthcoming surveys to make sure to see whether this really is a trend.

Jen Steele: And I would just add -- this is Jen -- the data that you're observing in 2017 would not yet show what I'm describing in the last six months.

Elizabeth Lukanen: Exactly, yes.

Lynn Blewett: Yes. So Alisha I'm wondering, you know, Minnesota does their own state health insurance survey every two years. Are you expecting or do you have any indication that this trend will show up in the state level data?

Alisha Baines-Simon: Well, we didn't in our state level data from 2017 -- which is the last year we did the survey -- we didn't see significant decline in children's health insurance. That's what the ACS data is showing as well -- kind of an overall decline.

What we did notice is there were fewer children with employer-sponsored coverage. So that was something that we were seeing in the data. And just kind of in general overall, we noticed we maintained our insurance, our coverage rates with people under 100% of poverty and it was actually where we saw people losing coverage was actually in the higher income brackets, so.

Lynn Blewett: Interesting.

Alisha Baines-Simon: And that's something that even other surveys that haven't seen sort of overall increases in uninsurance have also seen kind of those higher income brackets. So I mean as Elizabeth was saying, this seems like it's something that is sort of crossing income groups beyond what maybe it used to do.

Lynn Blewett: Yes.

Alisha Baines-Simon: It used to seem to be concentrated in you know, lower income areas. And that's kind of sort of expanding out a little bit. We would probably pick this up if it hasn't changed for 2019. Our survey is going into the field in the next couple of months. So you know, early 2020 we'll have information to see what our children's uninsurance rates are. But that's...

(Crosstalk)

Alisha Baines-Simon: ...something that we always look at.

Jen Steele: I would actually jump back in. I didn't want to confuse matters with our state-based survey but Louisiana also has a biannual survey that it does at the state level. And we actually saw a decrease. So the information at the state level survey was contradictory to ACS.

Lynn Blewett: So what years was that, Jen?

Jen Steele: 2017.

Lynn Blewett: So 2016 to 2017? Is it every year? Every other year?

Jen Steele: 2015 to 2017.

Lynn Blewett: Okay.

Elizabeth Lukanen: And that's actually consistent. In Louisiana we did not see an increase.

(Crosstalk)

Elizabeth Lukanen: But we did nationwide and we did in a handful of states.

Lynn Blewett: Yes. Okay, yes. Okay. So stay tuned on the Minnesota state survey. And we look forward to that.

Elizabeth, this is a question that came in about uninsured children. Did you look at children who were uninsured but who were eligible for Medicaid and CHIP by state? So that would be uninsured and eligible.

Elizabeth Lukanen: Yes.

Lynn Blewett: Or eligible but not enrolled.

Elizabeth Lukanen: You know, we have talked a lot about that. Unfortunately that's challenging because you basically have to do 50 state specific -- very specific -- analyses because eligibility rates change. But we've gotten a lot of feedback about that and I think our plan is to think about the income breaks that we use and try to make them more similar to what Medicaid looks like. So that is a good piece of feedback for us to help make this even more relevant.

Lynn Blewett: There are a few questions coming in on Hispanic children. And one is that -- I'll ask a couple and we'll start with Elizabeth -- that they were surprised that the rate for Hispanic children has remained stable but while the rates for the uninsured kids overall has gone up.

And then is the citizenship status of parents related to the variation in children's coverage status across the states?

Elizabeth Lukanen: Yes. You know, we were also surprised that the rate of Hispanic children remained the same. And you know, as I've said we look forward to seeing how this trend continues. It's worth noting that the rate in general for Hispanic kids is much higher.

Lynn Blewett: Yes.

Elizabeth Lukanen: So while it didn't go down, it's still pretty high. And...

Lynn Blewett: High and stable.

Elizabeth Lukanen: High and stable, exactly.

Lynn Blewett: Yes.

Elizabeth Lukanen: So I don't know yes that's a good news story or a bad news story. We do you know of research that shows that parents in mixed-citizenship status households -- so potentially having an undocumented parent, for example -- do have lower rates of insurance. That's not research we do but that definitely seems to play a role in whether kids get coverage. And I'd really be interested if Heather has any take on that, too.

Heather Howard: I was just going to jump in and say the same thing - that the research is clear that in mixed-status families, it's that much harder to get eligible kids enrolled. And I think it goes to the challenge of doing targeted outreach and working with trusted community-based organizations. Those are the lessons we've learned -- that you need to work with trusted intermediaries when you're doing outreach, you know, because of those challenges.

Lynn Blewett: Maybe just to wrap up, I will ask Heather to maybe comment on is this trend -- and it's alarming to us because we haven't seen any uptick in uninsured kids for so long. It's just been a steady decline since the passage of the Children's Health Insurance Program and the ACA getting more parents covered, added more kids, and with outreach enrollment -- is this information and data, is it like penetrating policymakers both at the national and state level? Is this the kind of thing that they'll pay attention to and think about policy strategies that might prevent, you know, prevent this trend from continuing?

Heather Howard: I hope so, right? I think there is an ongoing debate at state levels of how do we shore up the progress we've made, what policy choices can we make, especially in this you know, dynamic federal policy environment, if there's a lot of noise going on at the federal level, questions about whether the ACA is constitutional, what programs are still in effect at the state level, how do we shore up? And then how do we make more progress?

And you see some states -- California is one example really saying we want to get all kids covered, we have more work to be done. But I think in most states it's how do we shore up and protect the gains we've made. And I think you know, reports like yours should really be a wakeup call for states that they need to focus on protecting the progress they've made.

Elizabeth Lukanen: Yes, and I would just add we talked to reporters in Utah today and they asked the question very plainly what will happen if this Medicaid expansion goes through. And I think we can pretty plainly say you'll probably see fewer uninsured kids.

Lynn Blewett: Yes, thank you. Thank you both. This has been just great. And I think, you know, there are some bright spots. And I think, you know, the efforts in Minnesota to address health disparities and the efforts in Louisiana to work on what, you know, is largely a lot of technology components of enrollment which are changing rapidly and are so critical to getting people and kids enrolled and maintain their enrollment.

So I want to thank our state respondents from Louisiana and Minnesota. And thank you to State Health and Value Strategies for cohosting this event, and to the Robert Wood Johnson Foundation for supporting it. And thanks everybody who attended and asked great questions. And please go to our website, and we have state reports for each state that provides information of the trends in your state and the national report, and we're happy to answer any other questions you might have. Just give us a call. And thank you. With that, we conclude our webinar for today.