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Do Not Pass Go and Do Not Collect $200: Denying Medical Insurance to Parents Who Register Themselves Before Registering Their Children

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DO NOT PASS GO AND DO NOT COLLECT $200: DENYING MEDICAL INSURANCE TO PARENTS WHO REGISTER THEMSELVES BEFORE REGISTERING THEIR CHILDREN

INTRODUCTION

Health care is a divisive issue in American society, but citizens and government agree the health of American children is a priority. As such, governments, non-profit organizations, and other groups are constantly improving the quality and quantity of health care provided to American children. It is therefore unsurprising that the enacting of the Affordable Care Act and the Patient Protection Act resulted in changes to federal and state provisions for child health care. These changes have continued the efforts to increase health insurance options for children. Beginning as early as the 1930s, the United States Government and the state governments created programs that provide public health insurance coverage to children, particularly those within the lower income brackets. These programs included first Medicaid,[1] and now the Children's Health Insurance Program, or CHIP,[2] which have been successfully decreasing the number of children without health insurance for the last half century.

Studies show that children are more likely to develop normally, do better in school, and participate more in society if they have health insurance which caters to their specific preventative and treatment needs.[3] However, not all efforts to increase child health insurance rates are equally beneficial. In particular, changes in policy that

1. Grants to States for Medical Assistance Programs, 42 U.S.C. § 1396 et. seq. (2010).
2. *Id.*
3. Kristine A. Lykens & Paul A. Jargowsky, *Medicaid Matters: Children's Health and Medicaid Eligibility Expansions*, 21 J. POL'Y AND ANALYSIS MGMT., no. 2, 2002, at 220–22.

burden parents cause a great deal of harm with little positive return. This Note examines one such policy found in a Medicaid eligibility requirement in the State plan section of the United States Code. Medicaid relies in part on State plans to implement recent health care reforms. The requirements, administration, and outcomes for such plans are found in § 1396a of the United States Code. Within the State plan regulations, there is a section entitled "Minimum coverage for individuals with income at or below 133 percent of the poverty line."[4] While the first two subsections of this clause, § 1396a(k)(1) and § 1396a(k)(2) explain the individuals' eligibility for medical insurance coverage, § 1396a(k)(3) denies health insurance to otherwise eligible individuals who fail to register their children in a health insurance plan.[5]

At first glance, this policy seems acceptable, considering parents' duties to their children, the benefits to the child from having health insurance, and the fact that the individual will regain eligibility for coverage after the child is registered. However, this Note will prove this regulation does more harm than good. First, statistics show that families headed by single mothers are most likely to be affected by this clause.[6] This is a group society does not want to further disadvantage. Second, children benefit when their parents have health insurance. These benefits include: increased child health insurance coverage rates; increased access to child health services; and increased use of appropriate health care services.[7] Finally, studies suggest a variety of alternative methods to increase children's access to health care without burdening parents.[8] In fact, most of the suggested methods make accessing the health care system easier for parents.[9] Section 1396a(k)(3) implies that the benefits to children from increased health insurance coverage are greater than the burdens to their parents who are denied access to health insurance.[10] However, an objective analysis of relevant factors shows § 1396a(k)(3) burdens parents, adversely affects children, and may not even increase child health insurance rates.[11] Therefore, this Note concludes that § 1396a(k)(3) requiring parents to register their children before they can be considered for medical coverage under Medicaid should be removed from the United States Code.

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4. 42 U.S.C. § 1396a(k).
5. *Id.*
6. *See infra* text and accompanying note 91.
7. *See infra* text and accompanying notes 102–10.
8. *See infra* text and accompanying notes 111–12.
9. *Id.*
10. 42 U.S.C. § 1396a(k).
11. *Id.*

I. OVERVIEW OF CHILDREN'S HEALTH INSURANCE IN THE UNITED STATES: MEDICAID, THE CHILDREN'S HEALTH IMPROVEMENT PROGRAM (CHIP), AND THE AFFORDABLE CARE ACT

The benefits of providing children with basic health services are well documented.[12] Most children experience illness or injury at some point in their lives, and in between those episodes, even healthy children need immunizations, preventative care, and vision and hearing tests. These basic medical services greatly improve a child's ability to stay healthy, succeed in school, and participate in beneficial after school activities, as many of these programs require medical checkups before a child can join. The earliest and most basic measures of child health care are infant and child mortality rates.[13] In the 1990s, researchers added to these traditional methods additional health measures particularized to healthy child development, such as the number of days a child is absent from school, "school loss days," and the number of days a child is restricted from too much activity, "restricted activity days."[14] Today, research continues to explore how child health care needs differ from adult needs, and how those needs should be measured and met.[15] However, what has always been clear, is that children with access to health care services are healthier and that a child without health insurance is far more likely to have unmet health care needs than a child with health insurance.[16] Additional studies have shown that insured children are more likely to have access to primary care services than uninsured children.[17] The children least likely to have health insurance come from low-income families, as demonstrated by the statistics in Table 1. Considering that Table 1 considers only those children at or below the federal poverty line, it is highly possible that if the children were grouped according to children with income at or below 133% of the poverty line—the level

12. *See* Lykens & Jargowsky, *supra* note 3, at 222.

13. *Id.* at 220.

14. *Id.* at 222.

15. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *Key Facts About Americans Without Health Insurance*, 11 (2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7451-08.pdf, *archived at* http://perma.cc/8AEB-5P2Q ("Uninsured children are significantly more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance.").

16. Cindy Mann, Diane Rowland, & Rachel Garfield, *Historical Overview of Children's Health Care Coverage*, 13 PACKARD J. ON THE FUTURE OF CHILD, no. 1, 2003, at 32, *available at* http://ccf.georgetown.edu/wp-content/uploads/2012/03/uninsured_historical-overview.pdf, *archived at* http://perma.cc/26F6-PF5S.

17. *See* Paul W. Newacheck, Jeffrey J. Stoddard, Dana Hughes, & Michelle Pearl, *Health Insurance and Access to Primary Care for Children*, 338 NEW ENG. J. MED., no. 8, 1998, at 513–18.

identified in § 1396a(k)—there would be an even larger percentage of the uninsured children within the lower income bracket.

TABLE 1. DISTRIBUTION OF CHILDREN WHO ARE UNINSURED DIVIDED BY INCOME LEVEL

Children Grouped by Income Level[18]	**Percentage Uninsured**
All children	8.9% of children of all incomes
Children in poverty	12.9% of children living at or below the poverty level
Children not in poverty	7.7% of children living above the poverty level

Because child health insurance improves child health, the United States Government has a long history of providing public health insurance for children.[19] These efforts are closely linked with cash assistance programs designed to support low-income families, and began with the 1935 Social Security Act, which allowed states to provide families receiving welfare with additional funds for medical costs.[20] The 1950 amendments to the Social Security Act allowed states to give medical care providers reimbursement for medical care provided to families on welfare.[21] However, it was the 1965 enactment of Title XIX of the Social Security Act, better known as Medicaid, that increased health insurance coverage for low-income families.[22] Medicaid is a joint federal-state program, where states administer the health care programs and determine specific eligibility and benefits, while the federal government provides matching funds and broad, mandatory guidelines for coverage.[23] States can choose to participate in Medicaid, while also having the flexibility to expand benefits and eligibility beyond the federal minimum requirements.[24] In 1965, most families who qualified in states with Medicaid, were single-parent households

18. FIGURE 11. UNINSURED CHILDREN BY POVERTY STATUS, HOUSEHOLD INCOME, AGE, RACE AND HISPANIC ORIGIN, AND NATIVITY: 2012, http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2012/figure11.pdf, *archived at* http://perma.cc/5XTS-CTEL.

19. Mann, Rowland, & Garfield, *supra* note 16, at 33.

20. *Id.*

21. *Id.* at 32.

22. *Id.*

23. *Id.* at 32–33.

24. *Id.*

with very little income.[25] Amendments to Medicaid in 1967 allowed states to base Medicaid eligibility for children on family income, though most retained the welfare status formula.[26] The 1982 amendments ended cost sharing for children, which meant families could get health care for their children at no cost.[27] Despite these progressive changes, child enrollment in Medicaid slowed during the mid-1970s to 1990, because most eligibility requirements were still based on welfare status, which was becoming more and more difficult to acquire.[28] Congress reacted to this in 1989 and 1990, by changing Medicaid so that first pregnant women and children under the age of six, and then children under the age of eighteen, could qualify for Medicaid based solely on family income.[29]

While Congress attempted and failed to pass comprehensive health care reform in the mid-1990s, it did increase public health coverage for children.[30] However, disagreement between those who wanted to extend Medicaid eligibility and those who wanted a federal block grant which gave the states complete control resulted in an entirely new program known as the State Children's Health Insurance Program (CHIP).[31] Enacted in 1997, CHIP assists states in providing health insurance coverage to children whose family incomes are above Medicaid eligibility.[32] Given 40 billion dollars over a period of ten years, CHIP requires states to contribute to the program costs but provides a 30% higher match rate than the federal government provides for Medicaid.[33] States could choose to use the funds provided by CHIP to either expand Medicaid, create their own separate child health insurance program, or some combination of the two.[34] Despite this flexibility, CHIP requires all states to cover a "specified level of services" and limit any co-pays or similar payments beneficiaries

25. Mann, Rowland, & Garfield, *supra* note 16, at 33.
26. *Id.* at 33, 36.
27. *Id.*
28. *Id.* at 36.
29. *Id.*
30. *Id.* at 38.
31. Mann, Rowland, & Garfield, *supra* note 16, at 38. It should be noted that the literature refers to the program as both the Children's Health Insurance Program (CHIP) and the State Children's Health Insurance Program (SCHIP), because the program was originally known as SCHIP but has since been shortened to CHIP. This Note uses the CHIP title only for convenience.
32. *Id.*
33. *Id.* This perhaps shows the government's bias for children's health over adults within the lower income brackets, considering Medicaid covers children and adults, while CHIP covers only children.
34. *Id.* ("As of July 2002, 16 states had elected to develop separate SCHIP programs with no Medicaid expansion, 16 states . . . relied on Medicaid to expand coverage, and 19 states used a combination approach.").

might have to pay.[35] However, there were potential significant drawbacks to the federal block grant type funding provided for CHIP. Because the program does not have open-ended federal funding, states with separate programs may cap or freeze enrollment at any time if there is a need to limit costs, while states with Medicaid expansions can rollback or eliminate their expansions at any time.[36] Thankfully, CHIP was enacted during a boom in the United States' economy, and as such, within the first two years of the program, all fifty states had expanded coverage for children.[37] By 2000, Medicaid covered 21 million children, while CHIP provided an additional three million children with coverage.[38] The combined total of 24 million children covered meant that by 2000, 41% of children from low-income families were covered by one of the two programs.[39]

In 2007, CHIP's ten-year authorization ended, but President Bush and Congress were unable to agree on reauthorization terms and simply extended the program through March 2009.[40] However, on August 17, 2007 a Directive was sent to state officials which "imposed conditions on states and limited their options to provide coverage to uninsured children."[41] In February 2009, Congress passed the Children's Health Insurance Program Reauthorization Act, which informed states that the August 17 Directive restrictions had been lifted.[42] The next year, on March 30th, President Obama signed the Patient Protection and Affordable Care Act, which extended federal funding for CHIP through September 30, 2015.[43] It also expanded Medicaid coverage for children up to 133% of the federal poverty level.[44] A new condition of receiving federal Medicaid funding was included, which forbade states from reducing their income eligibility

35. *Id.* at 39.

36. *Id.* (Separate SCHIP programs/combination programs may also rollback or eliminate any expansions of coverage at any time. However, only separate programs may change enrollment, as any program with Medicaid ties may not cap or freeze enrollment by law.).

37. Mann, Rowland, & Garfield, *supra* note 16, at 39.

38. *Id.*

39. *Id.*

40. *Children's Health Insurance Program*, NAT'L CONFERENCE OF STATE LEGISLATURES (2014) http://www.ncsl.org/research/health/childrens-health-insurance-program-overview.aspx, *archived at* http://perma.cc/N6F8-XNZ2.

41. *Id.*

42. *Id.* It is at this time that the State Child Insurance Program was renamed the Child Health Insurance Program.

43. *Id.*

44. *Summary of Medicaid, CHIP, and Low-Income Provisions in Health Care Reform*, GEORGETOWN U. HEALTH POL'Y. INST. CTR. FOR CHILD. FAM. 3 (Apr. 2010), *available at* http://ccp.georgetown.edu/wp-content/uploads/2012/03Health-reform-summary.pdf, *archived at* http://perma.cc/BW6S-RHGX [hereinafter *Summary of Medicaid*].

levels for Medicaid or CHIP from what they were as of March 23, 2010.[45] Though CHIP is federally funded only through September 2015, it is maintained until 2019 with states allowed to provide coverage for children through a separate program if CHIP funding runs out.[46] From October 1, 2015 until the fiscal end of 2016, states will receive a 23% increase in their federal match rates, and 40 million dollars in additional funding for enrollment and renewal activities have been provided through 2015.[47] Finally, Medicaid coverage now extends to foster children up to the age of twenty-six, and children of state employees who meet the income requirements are eligible for CHIP.[48] As of the publication of this Note, twenty-eight states have accepted the Medicaid expansion offered by the Affordable Care Act and thus must meet the requirements outlined in the previous paragraphs, while an additional four states are considering accepting the expansion.[49]

Between the original Medicaid requirements, CHIP requirements, and the states with Medicaid expansion requirements, government efforts have resulted in an increasing number of children receiving health insurance coverage and in certain areas of the country, child health insurance coverage rates are approaching 100%.[50] Tables 2–5 contain statistics that provide an overview of current child health insurance rates across the fifty states. Table 2 depicts the rates of eligible children's participation in either Medicaid, CHIP, or a combination program by state in 2011.[51] The nation has an average rate of 87.2% participation of eligible children in either Medicaid, CHIP

45. *Id.*

46. *Id.* As most states have voluntarily expanded their eligibility levels under Medicaid or CHIP up to 200 percent of the federal poverty level, these states could reduce their income eligibility levels a great deal and still meet the federal eligibility level requirements of 133 percent of the federal poverty level, which may explain President Obama's inclusion of the condition to maintain previous state eligibility levels.

47. *Id.*

48. *Id.*

49. *Where the States Stand on Medicaid Expansion*, THE ADVISORY BOARD CO. (Feb. 15, 2015, 5:03 PM), http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap, *archived at* http://perma.cc/U45J-C3QQ.

50. *See infra* Tables 2–5.

51. *See infra* Table 2. The information in Tables 2–4 come from the years of 2008, 2009, 2010, and 2011; while Table 5 has data from 2013. See GEORGETOWN U. HEALTH POL'Y INST. CTR. FOR CHILD. & FAM., ELIGIBILITY LEVELS IN MEDICAID AND CHIP, CHILDREN, PREGNANT WOMEN, PARENTS, AND CHILDLESS ADULTS 1–2 (2013) [hereinafter GEORGETOWN U., ELIGIBILITY LEVELS]; Genevieve M. Kenney, Nathaniel Anderson, & Victoria Lynch, *Medicaid/CHIP Participation Rates Among Children: An Update*, TIMELY ANALYSIS IMMEDIATE HEALTH POL'Y ISSUES (Robert Wood Johnson Found.), Sept. 2013, at 2–3 [hereinafter Kenney et al., *Participation Rates*]; *Where the States Stand on Medicaid Expansion*, *supra* note 49. This is due to what data was available and could be used to form a coherent view of current child health coverage trends. *See id.*

or a combination program.[52] Table 3 shows how the national rates of participation of eligible children in Medicaid, CHIP, or a combination program increased almost 6% from 2008 to 2011.[53] Table 4 provides the same data, but in a different format and concludes that almost one million eligible children received health insurance from 2008 to 2011.[54] Finally, Table 5 contains each state's current eligibility levels for children based on the federal poverty level, along with whether that state is involved in the Medicaid expansion.[55]

TABLE 2: CHILDREN'S MEDICAID/CHIP PARTICIPATION RATES BY STATE, 2011[56]

State[57]	**Percentage**	**State**	**Percentage**
Vermont	96.7%	Virginia	88.1%
Massachusetts	96.1%	Ohio	87.8%
Connecticut	94.7%	New Jersey	87.7%
District of Columbia	94.3%	Oregon	87.6%
Illinois	93.9%	South Dakota	87.6%
Arkansas	93.6%	California	87.0%
Michigan	93.0%	Missouri	86.5%
Delaware	92.8%	Kansas	86.4%
Maine	92.3%	South Carolina	86.0%
Rhode Island	91.8%	Nebraska	85.5%
New York	91.7%	Idaho	85.1%
New Hampshire	91.6%	Oklahoma	84.8%

52. Kenney et al., *Participation Rates*, *supra* note 51, at 2 (Exhibit 1: Children's Medicaid/CHIP Participation Rates by State, 2011).

53. *See infra* Table 3.

54. *See infra* Table 4.

55. *See infra* Table 5.

56. Kenney, et al., *Participation Rates*, *supra* note 51, at 2.

57. States are listed from highest to lowest participation rates.

State	Percentage	State	Percentage
Louisiana	91.1%	Minnesota	84.5%
Alabama	91.1%	Georgia	84.0%
Tennessee	90.4%	Florida	83.4%
West Virginia	90.3%	North Dakota	83.3%
Wisconsin	90.3%	Indiana	83.0%
Maryland	90.3%	Texas	82.0%
Kentucky	90.2%	Wyoming	81.5%
New Mexico	90.0%	Colorado	81.3%
Hawaii	89.9%	Arizona	80.0%
Mississippi	89.5%	Alaska	77.0%
Washington	88.9%	Montana	73.7%
Pennsylvania	88.5%	Utah	73.1%
Iowa	88.4%	Nevada	69.8%
North Carolina	88.4%		

TABLE 3: CHILDREN'S MEDICAID/SCHIP PARTICIPATION RATES FOR THE NATION, 2008–2011[58]

Year	Percentage	Increase in Participation Rates[59]
2008	81.7%	N/A
2009	84.3%	3.2%
2010	85.8%	1.8%
2011	87.2%	1.6%

58. Kenney et al., *Participation Rates*, *supra* note 51, at 2 (Exhibit 3).
59. Increase in participation rates calculated by author.

TABLE 4: NUMBER OF ELIGIBLE-BUT-UNINSURED CHILDREN FOR THE NATION, 2008–2011 (NUMBERS IN MILLIONS)[60]

Year	Number	Increase in Eligible Children Insured[61]
2008	4.9	N/A
2009	4.6	300,000
2010	4.4	200,000
2011	4.0	400,000

TABLE 5. ELIGIBILITY LEVELS IN MEDICAID BY AGE AND MEDICAID EXPANSION ACCEPTANCE[62]

State	Ages 0–1	Ages 1–5	Ages 6–19	Accepted Expansion (Yes/No/ Maybe)[63]
Alabama	133%	133%	100%	No
Alaska	175%	175%	175%	No
Arizona	140%	133%	100%	Yes[64]
Arkansas	200%	200%	200%	Yes
California	200%	133%	100%	Yes
Colorado	133%	133%	133%	Yes
Connecticut	185%	185%	185%	Yes

60. Kenney et al., *Participation Rates*, *supra* note 51, at 2 (Exhibit 4).

61. Increase in number of children insured calculated by author.

62. GEORGETOWN U., ELIGIBILITY LEVELS, *supra* note 51, at 1–2; *Where the States Stand on Medicaid Expansion*, *supra* note 49.

63. *Where the States Stand on Medicaid Expansion*, *supra* note 49.

64. Some of the states that have accepted the expansion do not yet have rates that meet federal requirements, considering these rates were updated on July 23, 2013, and states who have accepted the expansion do not have to fulfill the new eligibility requirements until January 1, 2014.

State	Ages 0–1	Ages 1–5	Ages 6–19	Accepted Expansion (Yes/No/ Maybe)
Delaware	200%	133%	100%	Yes
District of Columbia	300%	300%	300%	Yes
Florida	200%	133%	100%	No
Georgia	185%	133%	100%	No
Hawaii	300%	300%	300%	Yes
Idaho	133%	133%	133%	No
Illinois	200%	133%	133%	Yes
Indiana	200%	150%	150%	Yes
Iowa	300%	133%	133%	Yes
Kansas	150%	133%	100%	No
Kentucky	185%	150%	150%	Yes
Louisiana	200%	200%	200%	No
Maine	185%	150%	150%	No
Maryland	300%	300%	300%	Yes
Massachusetts	200%	150%	150%	Yes
Michigan	185%	150%	150%	Yes
Minnesota	280%	275%	275%	Yes
Mississippi	185%	133%	100%	No
Missouri	185%	150%	150%	No
Montana	133%	133%	133%	No
Nebraska	200%	200%	200%	No
Nevada	133%	133%	100%	Yes

State	Ages 0–1	Ages 1–5	Ages 6–19	Accepted Expansion (Yes/No/ Maybe)
New Hampshire	300%	300%	300%	Yes
New Jersey	200%	133%	133%	Yes
New Mexico	235%	235%	235%	Yes
New York	200%	133%	133%	Yes
North Carolina	200%	200%	100%	No
North Dakota	133%	133%	100%	Yes
Ohio	200%	200%	200%	Yes
Oklahoma	185%	185%	185%	No
Oregon	133%	133%	100%	Yes
Pennsylvania	185%	133%	100%	Yes
Rhode Island	250%	250%	250%	Yes
South Carolina	200%	200%	200%	No
South Dakota	140%	140%	140%	No
Tennessee	185%	133%	100%	Maybe
Texas	185%	133%	100%	No
Utah	133%	133%	100%	Maybe
Vermont	225%	225%	225%	Yes
Virginia	133%	133%	133%	No
Washington	200%	200%	200%	Yes
West Virginia	150%	133%	100%	Yes
Wisconsin	300%	185%	150%	No
Wyoming	133%	133%	100%	Maybe

II. SECTION 1396A(K) MINIMUM COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE

42 U.S.C. § 1396a is the section of United States Code that concerns State plans for medical assistance.[65] Sections 1396a(a)–1396a(k)(k) cover everything from how state plans must be administered to explicit details concerning the services provided to particular individuals.[66] Subsection (k) of § 1396a is entitled "Minimum coverage for individuals with income at or below 133 percent of the poverty line" and contains three further divisions.[67] Section 1396a(k)(1) details the medical coverage a state plan must provide to individuals who qualify under this section,[68] while § 1396a(k)(2) allows a state to provide coverage to qualifying individuals before § 1396a comes into effect on January 1, 2014, so long as the state proceeds to offer coverage to individuals in order of lowest to highest income.[69] Subsection (3) of § 1396a(k) contains the only limiting language in the subsection. The entirety of § 1396a(k)(3) is quoted below.

> If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2)[)], the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1396u-1 of this title.[70]

Section 1396a(k)(3) denies basic medical insurance to parents who would otherwise be eligible for the State plan.[71] In order to assess § 1396a(k)(3), the group of affected individuals must be determined.

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65. 42 U.S.C. § 1396a (2010).
66. *Id.* § 1396a(a)–(k).
67. *Id.* § 1396a(k).
68. *Id.* This subsection has important implications because these are the services being denied to individuals who attempt to register themselves before they register their children.
69. *Id.*
70. *Id.* § 1396a(k)(3).
71. 42 U.S.C. § 1396a(k)(3).

First, § 1396a(k)(3) references subclause VIII of § 1396a(a)(10)(A)(i), which is part of a series of subclauses stating which individuals are eligible for medical assistance under the state[72] plan.[73] Subclause VIII goes into force on January 1, 2014.[74] It excludes from coverage (1) individuals who are over the age of 65; (2) pregnant women; and (3) individuals enrolled under Part A, Hospital Insurance for Aged and Disabled, or Part B, Supplementary Medical Insurance Benefits for Aged and Disabled, of subchapter XVIII of Chapter 7, Social Security.[75] It also excludes any individuals covered by the previous subclauses within § 1396a(a)(10)(A)(i), subclauses I–VII.[76] These subclauses granted coverage to (1) individuals of increased age; (2) individuals considered blind for the purposes of social security funds; (3) individuals who are permanently and totally disabled; (4) individuals receiving aid under Part A, Temporary Assistance for Needy Families of subchapter IV of Chapter 42 and their qualified family members; (5) individuals in foster care or adoption facilities; (6) pregnant women; and (7) children born after September 30, 1983 who have not yet reached nineteen years of age.[77] Finally, these individuals must have an income at or below 133% of the poverty line.[78] Though the list of exclusions appears to be extensive, subclause VIII of § 1396a(10)(A)(i), and thus § 1396a(k)(3), provide coverage to individuals with children, statistically reported as families by the Bureau of the Census, within the necessary income bracket who are over nineteen but under 65 so long as they are not blind, disabled, or pregnant.[79]

However, § 1396a(k) does not currently apply to all fifty states. When the Affordable Care Act provided health insurance to all individuals with an income at or below 133% of the poverty level, it did so by expanding Medicaid.[80] As was mentioned previously, Medicaid is a state administered program with federal oversight and partial federal funding.[81] Depending on state income, the federal matching rate is

72. In this instance, "state" stands in for any of the fifty states or U.S. territories.
73. 42 U.S.C. § 1396a(a)(10)(A)(i).
74. *Id.* § 1396a(a)(10)(A)(i)(VIII).
75. *Id.*
76. *Id.*
77. *Id.* § 1396a(a)(10)(A)(i)(I)–(VIII).
78. *Id.* § 1396a(k).
79. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(I)–(VIII), 1396a(k).
80. *Affordable Care Act: Eligibility*, MEDICAID.GOV (last visited Feb. 28, 2015), http://medicaid.gov/AffordableCareAct/Provisions/Eligibility.html, *archived at* http://perma.cc/CS9G-QYDW.
81. *About Medicaid*, GEORGETOWN U. HEALTH POL'Y INST. CTR. FOR CHILD. AND FAM., *available at* http://ccf.georgetown.edu/medicaid/about-medicaid/, *archived at* http://perma

anywhere between 50–74%.[82] As of winter 2014, only twenty-eight states had accepted the Medicaid expansion funding, while four more are considering the expansion.[83] Thus, § 1396a(k)(3) applies to populations residing in over half of the states and will possibly be applicable to other states in the coming years.[84]

III. THE STATISTICS OF § 1396A(K)(3)

Section 1396a(k)(3)'s possible impact can be seen using the completed data recorded by the Bureau of the Census for 2009.[85] In 2009, there were a recorded 35,635,000 families, consisting of individuals with their own children, living in the United States.[86] Of the over 35 million families, 7,956,000 lived below the poverty level.[87] When the poverty level was expanded to include those with incomes up to 125% above the poverty line, the number of families recorded jumped to 8,792,000.[88] To compare, the Temporary Assistance for Needy Families program, which is one of the limiting factors in subclause VIII of § 1396a(a)(10)(A)(i),[89] only assisted 1,769,000 families in 2009.[90] As seen in Table 6, it is likely that women, particularly single mothers, will be disproportionally affected by § 1396a(k)(3) because poverty rates are highest for households headed by single women.[91]

.cc/477C-UH8Y.

82. *Id.*

83. *Where the States Stand on Medicaid Expansion*, *supra* note 49.

84. Because of the difficulty of extracting, from national data, only the information on the thirty-two states that are relevant at this time, the charts and numbers presented throughout this Note will mostly include data about the entire population in the United States that could fit § 1396a(k) requirements. This is considered an acceptable expansion due to the fact that more states could accept the funding as the program matures.

85. This was the last year for which the level of detailed data was available.

86. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES TBL. 59, HOUSEHOLDS, FAMILIES, SUBFAMILIES, AND MARRIED COUPLES: 1980 TO 2010 (2012), *available at* http://www.census.gov/compendia/statab/2012/tables/12s0059.pdf, *archived at* http://perma.cc/XM5N-R73P.

87. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES TBL. 709, INDIVIDUALS AND FAMILIES BELOW POVERTY LEVEL—NUMBER AND RATE BY STATE: 2000 AND 2009 (2012), *available at* https://www.census.gov/compendia/statab/2012/tables/12s0709.pdf, *archived at* http://perma.cc/88F7-WAJF.

88. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES TBL. 715. FAMILIES BELOW POVERTY LEVEL AND BELOW 125 PERCENT OF POVERTY LEVEL BY RACE AND HISPANIC ORIGIN: 1980 TO 2009 (2012), *available at* https://www.census.gov/compendia/statab/2012/tables/12s0715.pdf, *archived at* http://perma.cc/A7EF-JTXJ.

89. 42 U.S.C. § 1396a(a)(10)(A)(i)(I)–(VIII).

90. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES TBL. 566. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)—RECIPIENTS BY STATE AND OTHER AREAS: 2000 AND 2009 (2012), *available at* https://www.census.gov/compendia/statab/2012/tables/12s0565.pdf, *archived at* http://perma.cc/R2BU-9MZA.

91. *Poverty in the United States Frequently Asked Questions*, NAT'L POVERTY CTR.

TABLE 6. FAMILIES BELOW POVERTY LEVEL BY SELECTED CHARACTERISTICS[92]

Type of Family	Number Below Poverty Level
Married Couple	3,409,000
Male householder; no spouse present	942,000
Female householder; no spouse present	4,441,000

For comparison, Table 7 contains similar data from 2012. The statistics in Table 8 and Table 9 reflect the exceedingly small budget of a family with an income at or below 133% of the poverty line, which puts into perspective how daunting medical expenditures can be for either a parent or a child.[93] Finally, Table 10 shows that households with a single parent female as head of household account for more than half of families living at or below the poverty level.[94]

TABLE 7. BREAKDOWN OF FAMILIES WITH RELATED CHILDREN LIVING BELOW THE POVERTY LEVEL, 2012

Type of Family	Number of Families
All Families[95]	6,971,000
Married Couple Families[96]	2,078,000

(last visited Feb. 28, 2015), http://npc.umich.edu/poverty, *archived at* http://perma.cc/KVG7-SABX.

92. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES TBL. 716. FAMILIES BELOW POVERTY LEVEL BY SELECTED CHARACTERISTICS: 2009 (2012), *available at* http://www.census.gov/compendia/statab/2012/tables/12s0716.pdf, *archived at* http://perma.cc/6UQ8-QXTC.

93. *See* discussion *infra* Part IV.

94. *See infra* Table 10.

95. *Families with Related Children That Are Below Poverty By Family Type*, KIDS COUNT DATA CTR. (2013), http://datacenter.kidscount.org/data/tables/55-families-with-related-children-that-are-below-poverty?loc=1&loct=1#detailed/1/any/false/868,867,133,38,35/any/345,346, *archived at* http://perma.cc/82DM-HLWW.

96. *Id.*

Type of Family	Number of Families
Single Parent Families[97]	4,893,000

TABLE 8. CURRENT POVERTY INCOME GUIDELINES AT OR BELOW 133 PERCENT OF THE POVERTY LEVEL, 2013

Persons in Family	Poverty Guideline[98]	133% of Poverty Line[99]
1	$11,490	$15,282
2	$15,510	$20,628
3	$19,530	$25,975
4	$23,550	$31,322

TABLE 9. SINGLE-PARENT HOUSEHOLD PER DAY EXPENDITURES AT THE POVERTY LEVEL AND 133 PERCENT OF THE POVERTY LEVEL

Number of Family Members	Average Per Day Expenditure Per Person at Poverty Level[100]	Average Per Day Expenditure Per Person at 133% of Poverty Level
Parent + 1 child	$21.25	$28.26
Parent + 2 children	$17.84	$23.72
Parent + 3 children	$16.13	$21.45

97. *Id.*

98. 78 Fed. Reg. 5115, 5183 (Jan. 24, 2013).

99. *2013 Federal Poverty Guidelines*, FAMILIES USA, http://www.familiesusa.org/resources/tools-for-advocates-guides/federal-poverty-guidelines.html (last visited Feb. 28, 2015), *archived at* http://perma.cc/VN68-2CYU (calculations made based on Health and Human Services statistics). These numbers apply only to the continental United States. The United States government calculated slightly higher amounts for the poverty level in both Hawaii and Alaska. *See* 78 Fed. Reg. 5115, 5183 (Jan. 24, 2013).

100. These numbers are calculated based on dividing the 2013 Poverty Guideline Figures by the number of members of the family and then again by the number of days in a normal year. These figures assume that all of the family income is spent each year.

TABLE 10. INCOME IN THE PAST 12 MONTHS BELOW POVERTY LEVEL, 2012

Type of Family[101]	**Number of Families**
Married Couple-Family	3,246,140
Male Householder; no wife present	985,398
Female Householder; no husband present	4,822,578

IV. BENEFITS OF HAVING PARENTS WITH HEALTH INSURANCE

Children benefit greatly from routine health care services, and children with health insurance coverage are more likely to receive those services. However, multiple studies have also shown that there are clear health benefits to children when their parents also have health insurance coverage.[102] These studies looked at how parental health insurance coverage affected: child health insurance coverage; access to child health care services; and appropriate child health care use.[103] A George Washington University (GWU) research project reviewed the findings of nine separate studies in different states concerning the three previous categories.[104] The project found that all of the previous nine studies reported that there were positive coverage effects on children when their parents acquired health insurance.[105] One of the reviewed studies noted that expanding Medicaid coverage of parents led to an "increased . . . likelihood of Medicaid

101. *Poverty Status in the Past 12 Months of Families by Family Type By Social Security Income By Supplemental Security Income (SSI) and Cash Public Assistance Income, 2012 American Community Survey 1-Year Estimates*, UNITED STATES CENSUS BUREAU, http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_B17015&prodType=table (last visited Feb. 28, 2015), *archived at* http://perma.cc/LXW3-LKDJ.

102. Sara Rosenbaum & Ramona Perez Treviño Whittington, *Parental Health Insurance Coverage as Child Health Policy, Evidence from the Literature*, GWU/SPHSS FOR FIRST FOCUS 4–5 (June 2007) (citing L. Ku & M. Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings About State Health Reforms*, CTR. ON BUDGET AND POL'Y PRIORITIES (2000); A. Davidoff, L. Dubay, G. Kenney & A. Yemane, *The Effect of Parents Insurance Coverage on Access to Care for Low-Income Children*, 40 INQUIRY 254, 254–68 (2003); S. Guendelman & M. Pearl, *Children's Ability to Access and Use Health Care*, 23 HEALTH AFFAIRS, no. 2, 2004 at 235–44).

103. Rosenbaum & Whittington, *supra* note 102, at Appendix 1.

104. *Id.* at 4.

105. *Id.* (noting that some of the studies showed "in some cases modest, and in some substantial" benefits in child health coverage from parental coverage).

coverage for both minority parents and children."[106] As for the two measures of access to care and appropriate use of health care services, the GWU project showed that in six of the nine individual studies there were positive effects in access to child health care and appropriate use of child health care services when both parent and child had health insurance.[107] In particular, the studies noted: increased use of child preventative health services; increased sources of regular child health care; and decreased unmet child health needs.[108] In addition, insured parents demonstrated better understanding of the health care system, and made more informed choices concerning their children's care.[109] Finally, children felt less stigmatized by accepting public health services when they knew that their parents used such services regularly.[110]

V. ESTABLISHED METHODS TO INCREASE CHILD HEALTH INSURANCE COVERAGE

Finally, alternative methods are available to increase child health insurance coverage without burdening parents the way that § 1396a(k)(3) currently does. Numerous studies have been conducted about possible methods for increasing participation in child health insurance programs.[111] Within each study, anywhere from one to several methods are examined, and it is interesting to note that not a

106. *Id.* at Appendix 2 (citing A. Aizer & J. Grogger, *Parental Medicaid Expansions and Health Insurance Coverage*, NBER WORKING PAPER 9907 (2003)) (emphasis omitted). This is important because minority children from low-income families have the worst health insurance coverage rates amongst similar income/age groups. *See* Lykens & Jargowsky, *supra* note 3, at 233–34.

107. Rosenbaum & Whittington, *supra* note 102, at 5.

108. *Id.*

109. *Id.* at Appendix 6 (citing L. Ku & M. Broaddus, *Coverage of Parents Helps Children, Too*, CTR. ON BUDGET AND POL'Y PRIORITIES (2000)).

110. *Id.* at Appendix 5–6 (citing L. Guendelman, M. Wier, V. Angulo, & D. Omen, *The Effects of Child-Only Insurance Coverage and Family Coverage on Health Care Access and Use: Recent Findings Among Low-Income Children*, 41 CAL. HEALTH SERVS. RESEARCH 125, no. 1, 2006 at 125–47).

111. *See* Genevieve M. Kenney & Stan Dorn, *Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize Gains and Prevent Harm?*, TIMELY ANALYSIS OF HEALTH AND POLICY ISSUES 4–5 (June 2009); Catherine Hess & Maureen Hensley-Quinn, *Building on Success to Effectively Integrate Current Children's Coverage with National Health Reform: Ideas from State CHIP Programs*, NAT'L ACAD. FOR STATE HEALTH POL'Y 2–5 (August 2009); AM. ACAD. OF PEDIATRICS, *Medicaid Policy Statement*, 131 PEDIATRICS, no. 5, 2013, at e1702–e1703; Lauren E. Wisk & Whitney P. Witt, *Predictors of Delayed or Forgone Needed Health Care for Families with Children*, 130 PEDIATRICS 1027, Dec. 1, 2012 at 1027; COMM. ON CHILD. HEALTH FIN., *State Children's Health Insurance Program Achievements, Challenges, and Policy Recommendations*, 119 PEDIATRICS, no. 6, 2007, at 1225–26 [hereinafter COMM. ON CHILD. HEALTH, *Achievements*].

single study suggests burdening parents in any way.[112] In order to increase and expand enrollment, the American Academy of Pediatrics suggested providing states with performance based rewards to encourage innovative enrollment strategies.[113] It also suggested administrative simplification techniques such as shortened forms and automatic enrollments based on other factors than income, like participation in a school lunch program.[114] A final suggestion was to allow families with multiple children to consolidate their health care coverage under one program, instead of spreading out coverage in multiple state plans.[115] Another analysis of Medicaid and CHIP programs suggested providing greater continuity of care, as household incomes are known to fluctuate over time, and better coordination of parental and child health insurance, which would be more convenient for many families.[116] A briefing by the National Academy for State Health Policy advised that there be increased flexibility in programs so that states could better serve their unique populations and cultures.[117] The briefing also echoed previous sentiments that health insurance programs needed to be better coordinated and more streamlined in their administration, particularly forms.[118] Another study by the American Academy of Pediatrics showed that the costs of health care were especially likely to affect a family's utilization of health care services, and as such, states should work to lower costs to beneficiaries, if at all possible.[119] The final and most recent recommendations, made in May 2013, by the American Academy of Pediatrics suggested five different methods for increasing enrollment in Medicaid and CHIP, and thus decreasing the rate of uninsured children.[120] These methods were (1) use multiple sites for enrollment campaigns, (2) optimize coordination of programs, (3) consider home enrollment programs, (4) have a "no wrong doors" approach to enrollment, where there are multiple correct ways for parents to enroll their children, and (5) increase federally supported incentives to states.[121]

There are three important takeaways from these five studies. The first is that these studies were performed over a series of years and were recorded by numerous health organizations, particularly the

112. Kenney & Dorn, *supra* note 111, at 5–6.
113. COMM. ON CHILD. HEALTH, *Achievements*, *supra* note 111, at 1225–26.
114. *Id.* at 1225.
115. *Id.* at 1226.
116. Kenney & Dorn, *supra* note 111, at 4.
117. Hess & Hensley-Quinn, *supra* note 111, at 3.
118. *Id.*
119. Wisk & Witt, *supra* note 111, at 1027, 1029, 1036.
120. AM. ACAD. OF PEDIATRICS, *supra* note 111, at e1702 to e1703.
121. *Id.*

American Academy of Pediatrics. As such, their data and advice are likely to represent a solid understanding of health care insurance coverage rates and to be motivated by a sincere desire to assist in improving children's health. The second is that there are numerous ways that child health insurance coverage can be increased, some of which the studies have suggested multiple times, while others they have noted only for particular years or areas. Finally, and most importantly, none of the studies mentioned burdening parents. In fact, many of the suggestions centered on the need to make the enrollment process easier for parents, through either coordinated programs or through better administration.[122] It is quite telling that these organizations at no point suggested the restrictions that can be found in § 1396a(k) and may even imply that those restrictions are counterproductive to increasing child health insurance coverage.

CONCLUSION

Children are healthier when they have access to proper health care services, and children with health insurance are much more likely to receive those services than children who do not have health insurance.[123] Decades worth of statistics have shown that children from low-income families are much more likely to go without insurance than those from middle- and upper-income families.[124] As such, it is a priority for public health officials to increase the number of children with health care coverage, particularly focusing on the lower income brackets. Clearly, federal and state governments have done so with increasing success in recent years, with some states having participation rates as high as 96.7%, and the national average of participation as of 2011 being 87.2%.[125] However, there is still some room for improvement, which is presumably the logic behind § 1396a(k)(3).

Section 1396a(k)(3) requires otherwise eligible parents to register their children for health insurance coverage before the parents can register themselves.[126] The policy behind this clause is quite clear: increasing children's health coverage is more important than the adverse affects of denying parents coverage. At first glance, this appears to be a reasonable trade-off, especially considering that parents are presumably eligible for public health insurance coverage after they

122. Hess & Hensley-Quinn, *supra* note 111, at 3.
123. Lykens & Jargowsky, *supra* note 3, at 222, 233; Mann, Rowland, & Garfield, *supra* note 16, at 32.
124. Lykens & Jargowsky, *supra* note 3, at 233–34.
125. Kenney et al., *Participation Rates*, *supra* note 51, at 2.
126. 42 U.S.C. § 1396a(k).

have registered their children.[127] However, the evidence presented previously in this Note shows that there are far more factors at issue than a balancing test between a child having health insurance and a parent having to wait to get health insurance. The first issue is that § 1396a(k)(3) applies only to parents who fall into the income bracket of 133% of the federal poverty level and below.[128] Over half of the parents who make up this group are female-headed single-parent households.[129] Already at a large disadvantage due to income restraints, social stigma, and the difficult balance of caring for a child while generating income, § 1396a(k)(3) denies these mothers health care. Even for only a short period of time, life without health services can place an adult parent at risk of complications due to unmet health needs, job loss due to illness, and large out-of-pocket medical expenses.[130]

In addition, while children clearly benefit from having health insurance, children also benefit from having parents with health insurance.[131] Extending public health insurance to parents results in: increased child health insurance coverage rates; increased access to basic child health care services; and increased use of appropriate health care services.[132] Other benefits include: children feel less stigmatized using a public service, when their parents make use of the same service;[133] parents with health insurance better understand the health care system and make more informed child health care decisions;[134] and expanded insurance coverage can potentially reach minority families, the most likely to be uninsured.[135]

Finally, there are numerous alternative ways to increase child health insurance coverage. A sampling of five studies conducted by various health organizations suggested: coordinating coverage between programs; simplifying enrollment procedures; and having enrollment campaigns at multiple places across the state.[136] None of

127. *Id.* §§ 1396a(a)(10)(A)(i)(VIII), (k)(3).

128. *Id.* § 1396a(k)(3).

129. *See supra* notes 106–10; *see also* Leighton Ku & Matthew Broaddus, *Coverage of Parents Helps Children, Too*, CTR. ON BUDGET AND POL'Y PRIORITIES (last visited Feb. 28, 2015), *available at* http://www.cbpp.org/cms/?fa=view&id=754, *archived at* http://perma.cc/PT8S-4LH9.

130. Sylvia Guendelman et al., *The Effects of Child-Only Insurance Coverage and Family Coverage on Health Care Access and Use: Recent Findings Among Low-Income Children in California*, 41 HEALTH SERVS. RESEARCH, no. 1, 2006, at 142.

131. *See* Kenney & Dorn, *supra* note 111, at 2.

132. *Id.* at 2–3.

133. Rosenbaum & Whittington, *supra* note 102, at Appendix 6.

134. *Id.*

135. *Id.* at Appendix 2.

136. AM. ACAD. OF PEDIATRICS, *supra* note 111, at e1702 to e1703.

these suggestions even hinted at restricting parents' access to health insurance as a method for increasing child health insurance coverage.[137] In fact, numerous suggestions, such as coordinating programs and simplifying the enrollment process, were clearly designed to make it easier for parents to access all parts of the health care system, not just those parts that assist their children.

Therefore, this Note concludes that the third subclause of section 1396a(k) should be struck from the United States Code. The reasoning is that (1) it is inequitable, (2) it inhibits the beneficial impact parental coverage has on child health care, and (3) there are much more effective methods for increasing child health insurance coverage that do not require placing such burdens on parents.

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137. Hess & Hensley-Quinn, *supra* note 111, at 2.

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