The Children's Health Insurance Program as Adolescence Ends: Nearly 2 Decades of Children's Coverage

Nancy De Lew, MA, MAPA; Arnold M. Epstein, MD; Cynthia Mann, JD

From the Office of the Assistant Secretary for Planning and Evaluation (Ms De Lew and Dr Epstein), and Center for Medicare and Medicaid Services (Dr Mann), the Department of Health and Human Services, Washington, DC
The authors have no conflicts of interest to disclose.
Address correspondence to Nancy De Lew, MA, MAPA, Office of the Secretary, US Department of Health and Human Services, 200 Independence Ave, Washington, DC 20201 (e-mail: nancy.delew@hhs.gov).

ACADEMIC PEDIATRICS 2015;15:S7–S8

DESPITE A STEADY expansion of Medicaid eligibility over the 1980s, persistently high rates of children without health insurance coverage led the Congress in 1997 to enact the Children's Health Insurance Program (CHIP); it passed with bipartisan support and was the major health insurance coverage expansion of the decade. As we approach the end of the second decade of the program and implement the Affordable Care Act (ACA), it is an apt time to evaluate the effect of the program.

BACKGROUND ON CHIP

As originally designed, CHIP provided funding to states to cover children in families with incomes greater than Medicaid limits, but not high enough that they were likely to be able to afford private health care coverage (currently 100%-250% of Federal Poverty Level in many states). Over a period of several years, every state took advantage of the new opportunity to cover children, either by expanding Medicaid (7 states) or by establishing a separate child health program (15 states), or by doing a combination of both (28 states). The funding for the CHIP program is structured as an allotment to states with funds authorized and appropriated for specific periods of time; it is not an entitlement to individuals like Medicaid or Medicare. Thus, the program requires periodic reauthorization and appropriations by the Congress. The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) provided significant new support; it also required the Secretary of Health and Human Services to conduct an independent evaluation of the program. The articles in this issue of *Academic Pediatrics* are drawn from the work commissioned by Assistant Secretary for Planning and Evaluation in the CHIPRA evaluation.

CHIPRA EVALUATION

The CHIP evaluation report to Congress was released publicly in September of 2014.[1] Its key findings suggested that CHIP has in general been a very successful program, albeit with room for improvement. The CHIP evaluation report and its companion CHIPRA report on Express Lane Eligibility[2] review the important advances in enrolling and retaining children in coverage.

COVERAGE EXPANSION

The key findings of the evaluation report suggest that CHIP has achieved the goal of improving access to health care services by making coverage affordable. The uninsured rate for all children has decreased from 15% in 1997 to 9% in 2012, largely because of CHIP. The decline in the uninsured rate for low income children was even greater, from 25% to 13% over the same period. Health insurance coverage rates for children improved for all racial and ethnic groups, especially among Hispanic individuals, whose uninsured rate decreased from 34% to 17%. Among children eligible for Medicaid or CHIP who do not have private coverage, approximately 88% are enrolled nationally. With the expansions of Medicaid and CHIP, after the elderly, children are the age group second most likely to have health insurance coverage.[3]

In the "could use improvement" category, nearly 10% of children have no insurance coverage, and most of these children, 7 of 10, are eligible for Medicaid or CHIP, suggesting that more progress is needed.

ACCESS TO HEALTH CARE SERVICES

Children with public coverage had better access to care and fewer unmet health needs than uninsured children. Nearly all CHIP enrollees had seen a medical or dental provider in the past year. CHIP children also had better access to dental benefits and their families had greater financial protection and less stress about meeting their children's health care needs than those with private coverage.

In the "could use improvement" category, CHIP children were less likely than those with private insurance to have a

Table. Selected Changes in CHIP Made by the Affordable Care Act

- Extended the authorization of CHIP through 2019 and funding through 2015.
- Transitioned all CHIP children in households with incomes less than 133% of the Federal Poverty Level, who were covered through separate CHIP programs, to Medicaid.
- Adopted a single application for public programs and combined renewals to address concerns about continuity.
- Increased the federal matching rate for CHIP children in Medicaid by 23% so that the federal share would move from 73% to 91%.

CHIP indicates Children's Health Insurance Program.

regular source of medical care or night and weekend access to a provider at that source of care.

Continuity of Health Insurance Coverage

CHIP's effect on continuity of coverage was less than ideal. Many children moved between Medicaid and CHIP and some experienced gaps in coverage of between 2 and 6 months. Coverage gaps were more common for children who moved from Medicaid to separate CHIP programs (40%) than from separate CHIP programs to Medicaid (16%). New transition rules, and more coordinated eligibility and enrollment systems prompted by the ACA hold the promise of improvement in this area.

Affordability for Families

CHIP succeeded in making coverage affordable. The financial burden of paying for their children's health coverage was less for CHIP families than for families who were uninsured or who had private coverage. CHIP parents reported substantially less stress and less trouble paying for their children's health care services and had lower out-of-pocket spending than those with private insurance.

The ACA and the Future of CHIP

The ACA reauthorized CHIP through 2019 and funded it through 2015. It also made numerous changes in CHIP and addressed some of the continuity issues (Table). However, more important than any specifics, the changes brought about by the ACA have altered the context in which CHIP operates by creating a world in which CHIP sits between Medicaid and qualified health plans that are available in the Marketplace with subsidies if one's income is within a defined range.

According to many important measures of performance, CHIP has served the nation well. All programs need occasional updating and modification. In the coming months Congress will decide whether CHIP should still be used to provide coverage to children and if so, what programmatic changes seem in order.

References

1. Harrington M, Kenney GM, Smith K, et al. *CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings. Report submitted to the Office of the Assistant Secretary for Planning and Evaluation*. Ann Arbor, Mich: Mathematica Policy Research; 2014.
2. Hoag S, Blavin F, Swinburn A, et al. *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings. Report submitted to the Office of the Assistant Secretary for Planning and Evaluation*. Ann Arbor, Mich: Mathematica Policy Research; 2013.
3. Finegold K, Gunja MZ. *Survey Data on Health Insurance Coverage for 2013 and 2014. ASPE Issue Brief*. Washington, DC: Assistant Secretary for Planning and Evaluation; 2014.