Support for the Children's Health Insurance Program Paves the Way for Broader Consensus on Coverage Policy

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THE ROBERT WOOD Johnson Foundation has long been committed to the expansion of health insurance coverage, and coverage for children is a priority issue. Research and evaluation have always been important aspects of our coverage programming investments, so we are very pleased to support the publication of this special supplement of *Academic Pediatrics* on an evaluation of the Children's Health Insurance Program (CHIP).

Health insurance for children has expanded during the recent years before the Affordable Care Act, even as coverage among adults stagnated or declined. Because of the decrease in offers and take-ups of employer-sponsored insurance during the recession, the role played by Medicaid and CHIP in counteracting these economic trends was critical. During the period from 2009 to 2012, the uninsurance rate among children declined from 9.7% to 7.5%, and only changed from 20.7% to 20.3% among adults aged 18 to 64 years. During this time period, the proportion of children covered by Medicaid or CHIP increased from approximately 25% to a little over one-third.[1] Clearly, the role played by these programs in the growth of children's coverage in recent years has been very significant.

CHIP was enacted in 1997, and was designed for children whose family incomes were slightly higher than those in Medicaid, usually between 100 to 200 percent of the federal poverty limit. CHIP has a different, somewhat less permanent legal status than does Medicaid. CHIP is not an entitlement, but an allotment of funds to states that must be renewed to continue. With the passage of the CHIP Reauthorization Act in 2009, one of the requirements included an evaluation of the program.

The articles published here are drawn from an evaluation that was publicly released in September 2014. In short, the studies show that CHIP achieved its goal of expanding coverage. Uninsurance among children has decreased, particularly among low-income children. Racial and ethnic disparities in coverage rates have been reduced. A relatively low proportion of children enrolled in CHIP had previous access to private coverage.

The evaluation also shows that children enrolled in CHIP have access to medical and dental care that far exceeds that of the uninsured, and is comparable with coverage of those with private insurance. This is also true for children with special health care needs. Utilization of health services among children enrolled in CHIP exceeds that among the uninsured. The evaluation also found that "express lane eligibility" programs that use administrative data from other programs to simplify enrollment procedures largely achieve their goal of fostering enrollment and impeding disenrollment. The evaluation also points to some room for improvement; significant churn between Medicaid and CHIP still exists, and some types of access to care could be strengthened. There are still uninsured children, most of whom are eligible for Medicaid or CHIP.

The passage of the Affordable Care Act created some important changes for CHIP. At the time of this writing, although there is bipartisan support for renewal, there remains a number of outstanding issues to be resolved. Yet, the existing consensus suggests that both sides understand that CHIP is still needed. A recent actuarial study that we funded compared benefits and out of pocket costs between CHIP and qualified health plans offered through the Marketplaces in 35 states. The results suggested that there would be large increases in cost-sharing and out of pocket costs if families were to transition from CHIP to qualified health plans available in the Marketplace. In some states there would be a 10-fold increase in cost-sharing. Increases were estimated to be even greater for families with children that have special health needs.[2]

Although the creation of the Marketplace plans and the expansion of Medicaid in many states might at some point create a path toward a more simplified system of publicly subsidized children's health coverage, our desire for simplicity and efficiency in administering public funds must be balanced with the need for continuity of coverage, regarding eligibility and benefits. This recent actuarial analysis has shown us that at the present moment, qualified health plans are imperfect substitutes for CHIP.

At a time when partisan rancor characterizes so much public discourse about redistributive policies generally and health care in particular, the existing bipartisan support for the renewal of CHIP suggests that the health and well-being of our most vulnerable children is important to all Americans. Starting from that basic point of agreement, perhaps we can move forward and attempt to achieve broader consensus on the nature and scope of public involvement in our nation's health care.

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