The Children's Health Insurance Program Reauthorization Act Evaluation Findings on Children's Health Insurance Coverage in an Evolving Health Care Landscape

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ABSTRACT

The Children's Health Insurance Program (CHIP) Reauthorization Act (CHIPRA) reauthorized CHIP through federal fiscal year 2019 and, together with provisions in the Affordable Care Act, federal funding for the program was extended through federal fiscal year 2015. Congressional action is required or federal funding for the program will end in September 2015. This supplement to *Academic Pediatrics* is intended to inform discussions about CHIP's future. Most of the new research presented comes from a large evaluation of CHIP mandated by Congress in the CHIPRA. Since CHIP started in 1997, millions of lower-income children have secured health insurance coverage and needed care, reducing the financial burdens and stress on their families. States made substantial progress in simplifying enrollment and retention. When implemented optimally, Express Lane Eligibility has the potential to help cover more of the millions of eligible children who remain uninsured. Children move frequently between Medicaid and CHIP, and many experienced a gap in coverage with this transition. CHIP enrollees had good access to care. For nearly every health care access, use, care, and cost measure examined, CHIP enrollees fared better than uninsured children. Access in CHIP was similar to private coverage for most measures, but financial burdens were substantially lower and access to weekend and nighttime care was not as good. The Affordable Care Act coverage options have the potential to reduce uninsured rates among children, but complex transition issues must first be resolved to ensure families have access to affordable coverage, leading many stakeholders to recommend funding for CHIP be continued.

KEYWORDS: Affordable Care Act; Children's Health Insurance Program; Children's Health Insurance Program Reauthorization Act; health care access; health care utilization; health insurance coverage; Medicaid

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THIS IS A crucial time for the Children's Health Insurance Program (CHIP), enacted in 1997 and now a mainstay of coverage for children with family incomes above Medicaid levels but lacking private insurance. Unlike Medicaid, CHIP is subject to periodic reauthorization and continued approval of federal funding. The CHIP Reauthorization Act (CHIPRA) reauthorized CHIP through federal fiscal year (FFY) 2019 and, together with provisions in the Affordable Care Act, federal funding for the program was extended through FFY 2015. Congressional action is required or federal funding for the program will end in September 2015. Options for CHIP's future are currently being discussed, and decisions will have far-reaching implications because >8 million low-income children were covered by CHIP in 2013.

This special supplement to *Academic Pediatrics* is intended to inform these discussions and contribute to the substantial body of research about CHIP's role and effect on low-income children and their families.[1–14] Most of the new research presented in this supplement comes from a large evaluation of CHIP mandated by Congress in CHIPRA, patterned after an earlier evaluation Congress mandated in the Balanced Budget Refinement Act of 1999.[15] Mathematica Policy Research led both of these evaluations in partnership with the Urban Institute, under contract with the Office of the Assistant Secretary for Planning and Evaluation. Findings are also included from the CHIPRA-mandated evaluation of Express Lane Eligibility (ELE), a policy tool designed to simplify and optimize enrollment and retention in Medicaid and CHIP.[16] This overview article begins with a description of important features of the CHIP evaluation, especially the enrollee/disenrollee survey, and related administrative data used in many of the articles included

in this supplemental issue of *Academic Pediatrics*. It then highlights findings in 3 thematic areas: program design and implementation experiences; health insurance coverage; and health care access, use, and content of care.

CHIPRA Evaluation of CHIP

The CHIPRA evaluation of CHIP addressed questions about the design and evolution of CHIP programs; coverage and participation rates; previous coverage experiences of new enrollees and their access to private coverage; enrollment and retention trends and coverage experiences after leaving CHIP; family perceptions of CHIP and their experiences applying, enrolling, and renewing coverage; and access, service use, and family well-being. The evaluation drew on the following major data sources: a large household survey of CHIP enrollees and disenrollees in 10 states, fielded largely in 2012 (a complementary survey of Medicaid enrollees and disenrollees was administered in 3 of the 10 states); case studies with site visits and focus groups in the same 10 states, also conducted in 2012; state Medicaid and CHIP enrollment data from the 10 study states for the 2007 to 2012 time period; a survey of state CHIP program administrators in nearly every state, in early 2013; and data from several national surveys (National Survey of Children's Health, Current Population Survey, and the American Community Survey).[17]

Congress specified that the evaluation select 10 states that represent varied geographic areas and urban/rural populations, diverse program designs, and a large proportion of the low-income, uninsured children in the United States.[18] Together, the selected states (Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia) cover the 4 census regions, reflect diverse CHIP program designs, and when the survey was conducted in 2012, represented 57% of children enrolled in CHIP.[19] The survey of CHIP enrollees and disenrollees used state eligibility and enrollment files to construct the sample frame and randomly select children (≤18 years of age) in each state in 3 strata based on status at the time of sampling: 1) established enrollees, enrolled in CHIP for 12 or more consecutive months, 2) recent enrollees, enrolled in CHIP for 3 consecutive months, preceded by a gap in public coverage of at least 2 months, and 3) recent disenrollees, disenrolled from the program for 2 months, and enrolled for at least 3 months before disenrollment. The final survey data included responses from parents of 5518 established enrollees, 4142 recent enrollees, and 2537 disenrollees. The overall survey response rate was 51% for established enrollees, 46% for recent enrollees, and 43% for recent disenrollees. Additional details on the survey, including the questionnaire, are available elsewhere.[20] The study was reviewed and approved by the New England Institutional Review Board (NEIRB #12-200).

The analysis of access, service use, and family well-being used a comparison group design. The experiences of established CHIP enrollees who had been in the program for at least 1 year were compared with the pre-enrollment experiences of 2 subgroups of recent enrollees. Recent enrollees who were uninsured for 5 to 12 months before enrollment were used to compare CHIP with being uninsured, and recent enrollees who were privately insured for 12 months before enrollment were used to compare CHIP with private coverage. Established enrollees were asked about their experiences during their past 12 months of enrollment, and recent enrollees were asked about their experiences during the 12 months before their enrollment in CHIP.

Characteristics of the 3 survey groups are shown in the Table. Approximately half of the children in each group were Hispanic, reflecting the large Hispanic populations in several large sample states. Most enrollees had household incomes <150% of the federal poverty level and at least 1 working parent. Most enrollees were healthy, but more than one-fourth had at least 1 special health care need and 7% of enrollees had fair or poor parent-reported overall health.

Results

Program Design and Implementation Experiences

In legislation that enacted CHIP in 1997, Congress gave states more control over the CHIP program design compared with Medicaid so that they could experiment with providing coverage that more closely resembles options available in private insurance markets. States can 1) expand their existing Medicaid program (this is called a Medicaid expansion CHIP program), 2) create a separate CHIP program, or 3) blend the 2 approaches to create a combination program. Although many states initially implemented a Medicaid expansion CHIP program, in part because that approach could be implemented quickly, over time more states began administering separate CHIP and combination programs, which offer greater flexibility in program design. States quickly implemented CHIP and enrollment tripled in the first 3 program years, from approximately 1.0 million in 1998 to 3.3 million in FFY 2000.[2,6]

As reported by Hill and colleagues,[21] in recent years CHIP continued to grow and adapt to changing circumstances, expanded eligibility and outreach efforts, further streamlined enrollment and renewal procedures, and made new investments in quality measurement and care improvements for children. CHIP enrollment increased by approximately 20% from 2006 to 2012 as many states expanded children's coverage by increased upper income eligibility limits or coverage of new groups made eligible by CHIPRA. States continued to focus on simplification of the rules and procedures for enrollment and renewal, and CHIPRA's outreach grants played an important role in support and supplementation of state outreach efforts. CHIPRA's mandatory requirements for comprehensive dental benefits coverage and mental health parity along with federal Maintenance of Effort rules might have protected CHIP when state budget shortfalls during the economic downturn could have led to program cuts.

ELE, a new policy option permitted by CHIPRA, lets state Medicaid and/or CHIP programs use eligibility findings from another program to qualify children at the time of either initial enrollment or renewal. As reported in the article by Hoag, ELE processes have the potential to

Table. Characteristics of CHIP Enrollees and Disenrollees in 10 States, 2012

Characteristics	Weighted Percentage		
	Recent Enrollees	Established Enrollees	Disenrollees
Child characteristics			
Age in years			
0–5	23	15	15
6–12	43	43	34
≥13	33	43	51
Race/ethnicity/language			
Hispanic, primary language English	27	21	24
Hispanic, primary language Spanish	22	32	27
Non-Hispanic white	30	26	26
Non-Hispanic black	12	10	13
Other	8	8	7
Health and functional status			
Overall physical health is fair/poor	6	7	8
Overall mental health is fair/poor	5	5	6
Has special health care need	23	26	24
Household and parent characteristics			
One or both parent not US citizen	30	28	34
Family structure			
Two parents	58	62	53
One parent	32	29	35
One parent and step-parent/other guardian	8	8	11
Other	2	1	1
More than 3 children in household	16	13	15
Employment status			
One parent, employed	30	27	41
Two parents, 1 employed	32	30	17
Two parents, both employed	25	25	20
Highest education level of parent/guardian			
Less than high school	17	22	21
High school or equivalent	27	28	28
Some college, trade school, or other higher education	56	45	47
Household income by federal poverty level			
<150% Federal poverty level	66	60	54
150–199% Federal poverty level	17	19	18
≥200% Federal poverty level	11	8	16
Sample Size*	4142	5518	2537

*The sample sizes reported are for the total numbers in each group; sample sizes for some characteristics were lower because of nonresponse to individual questions.

Source: 2012 CHIPRA Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees.

identify large numbers of eligible individuals and reduce the effort involved in getting them and keeping them enrolled in Medicaid or CHIP.[22] The evaluation of ELE explored how states were using ELE and how it influenced Medicaid and CHIP enrollment, retention, and program costs. Automatic approaches that integrate data across programs were found to work best, but few states had adopted this type of approach, in part because Congress has not yet made ELE a permanent policy option. Automatic ELE processes, which enable states to use eligibility findings from partner agencies to automatically enroll or renew children, serve the most children and generate, on average, $1 million annually in administrative savings. Given the size of renewal caseloads and the recurring nature of renewal, using ELE for renewals holds substantial promise for administrative cost savings and keeping children covered.

Health Insurance Coverage for Low-Income Children

The CHIP evaluation found continued impressive decreases in uninsured rates after CHIP's enactment.[15] Uninsurance among children overall decreased from 15% when CHIP was enacted in 1997 to 9% in 2012. The decline for CHIP's target population of low-income children was even greater, decreasing from 25% to 13% over the 15-year period. Coverage gains for low-income children were not matched by similar gains for low-income adults, pointing to the importance of public coverage in driving the decline in uninsurance among children. Uninsured rates fell for children in all groups defined according to race/ethnicity and language but the decline was greatest among Hispanic children, falling from 34% to 17%, and the coverage disparity between non-Hispanic white and Hispanic children narrowed from 13 percentage points in 1997 to 5 percentage points in 2012.

Kenney et al[23] document impressive rates of participation in Medicaid and CHIP among eligible children, with rates increasing even as the base number of eligible children has grown. Nationwide, Medicaid and CHIP participation rates among children increased from 82% in 2008 to 88% in 2012, and were >90% in

21 states in 2012. Still, the authors estimate that more than two-thirds of the remaining 3.7 million uninsured children are eligible for Medicaid or CHIP. Based on 2011/2012 data from the National Survey of Children's Health, they report that interest in enrolling uninsured children in Medicaid or CHIP is high (>90% of parents said they would enroll their child), but that many families had knowledge gaps and perceived that enrolling would be difficult.

Findings reported by Trenholm et al[24] provide evidence that state efforts to simplify enrollment and retention systems and procedures have been successful. Most recent CHIP enrollees reported positive impressions of the application process; 89% found the process very or somewhat easy and 90% of those who received assistance found it very helpful. Families had similarly favorable impressions of the renewal process, including those who had been recently disenrolled. Most children who left CHIP did so because they were no longer eligible rather than because they had some problem with the program or renewal process. Survey and Medicaid and CHIP enrollment data were used to document the coverage situation of disenrollees. After leaving CHIP, children were far more likely to gain Medicaid coverage (49%) than private insurance (18%), and a sizeable percentage became uninsured (32%). The likelihood of becoming uninsured was especially high among 18- and 19-year-olds (62%), who become ineligible for CHIP because of their age.

In their article, McMorrow and colleagues[25] examine the extent to which children enrolled in CHIP have access to private insurance and thus considers the potential for substitution of public for private coverage. They found that only 13% of new enrollees had any private coverage in the 12 months before enrolling in CHIP and most were found to have lost that coverage because of a parental job loss. Approximately 40% of established CHIP enrollees had a parent with an employer-sponsored insurance (ESI) policy, but only half reported that the policy could cover the child. Furthermore, affordability was a serious concern for parents even when they had potential access to ESI. The authors conclude that access to affordable private coverage for CHIP enrollees was relatively limited, making it possible that many children could remain uninsured in the absence of CHIP.

Orzol and colleagues[26] document how common it is for children to move between Medicaid and CHIP, and how often this results in a break in coverage. Although most children remained enrolled in Medicaid or CHIP through the annual renewal period, there is room for improvement in reducing the percentage of children who cycle off and back on to Medicaid and CHIP, and in reducing gaps in coverage associated with moving between Medicaid and separate CHIP programs. Children typically move between programs because their income or other family circumstances change, which occurs frequently for lower-income families. Breaks in coverage happened for as many as 40% of children who moved between Medicaid and separate CHIP programs, and a sizable portion of children moved out of and then back into the same program after a short period of time (20% of exits from Medicaid were enrolled in the program again 7 months later, and 10% for CHIP).

Health Care Access, Use, and Content of Care for Low-Income Children

Coverage alone does not guarantee that a child will get the care they need and that the content of care received aligns with recommended standards. When services are not available, affordable, and/or acceptable to the patient or family, unmet health care needs and delays in the diagnosis and treatment of health care problems can arise. A trio of articles by Smith et al[27] and Clemans-Cope et al[28,29] report findings on access to care in CHIP and how it compares with access for children who are uninsured and those with private insurance. Overall, they found that CHIP enrollees experienced good access to providers; nearly all had seen a medical and dental provider within the past year, and parents of CHIP enrollees reported being very confident that their child is able to get needed health care. Parents of CHIP enrollees reported positive care experiences with their child's providers at high rates on most aspects of patient-centered care. Most parents reported they had no problem getting referrals when needed (74%) and had received effective care coordination across a number of care coordination elements (68%). A relatively high proportion of CHIP enrollees' parents also reported having family-centered care interactions with their child's provider across the 6 dimensions of this care component. However, only 47% of CHIP enrollees' parents reported positive care experiences on all 6 of these dimensions of family-centered care.

There is room for additional improvement in some areas. Access to after-hours and weekend medical care continues to be relatively limited under CHIP, and many children do not receive recommended preventive health care services on a regular basis (including flu vaccinations, some health-related screenings, and anticipatory guidance), despite high rates of annual preventive care visits. Similar gaps in care were also found among children with private coverage, which suggests that there are broader issues with systems of care that serve children. Regarding oral health, 12% of CHIP enrollees had an unmet need for dental care reported by a parent, and a substantial share (68%) did not get follow-up dental treatment when it was recommended by a dentist.

Compared with being uninsured, the experiences of children enrolled in CHIP were more positive in nearly all areas examined. The parents of children enrolled in CHIP reported substantially more confidence in their ability to get needed health care for their children, their children were more likely to have received a range of health services, and they reported fewer financial burdens associated with the child's health care. The largest positive differences were found for having a usual source of dental care

and a dental checkup or cleaning, lower stress and greater confidence about meeting the child's health care needs, obtaining referrals for medical care when needed, receipt of preventive care or a well-child checkup, and fewer problems paying medical bills for the child's care. Rates of use for emergency department care and hospital stays were comparable among children enrolled in CHIP and uninsured children, and children in CHIP were just as likely as uninsured children to have had a dental procedure after a dentist recommended dental follow-up care.

Compared with private coverage, access and service use for CHIP enrollees was comparable for many measures and not as good for some. CHIP enrollees were more likely than children with private coverage to have dental benefits and a regular source of dental care and to have their medical care coordinated effectively. The parents of children enrolled in CHIP also reported having had substantially less trouble paying their child's medical bills and much lower out-of-pocket spending levels. The greater financial protection provided by CHIP coverage likely contributed to findings that parents of CHIP enrollees reported being more confident about meeting their children's health care needs and feeling less stress about doing so than parents of children with private insurance. CHIP enrollees were less likely than children with private insurance to have a regular source of medical care and access to that source of care at night or on weekends.

For the approximately one-fourth of CHIP enrollees with a special health care need, Zickafoose and colleagues[30] report that CHIP had significant benefits compared with being uninsured, and also some benefits compared with private insurance. Compared with being uninsured, parents of children with special health care needs who were established CHIP enrollees reported greater access to and use of medical and dental care, less difficulty meeting their child's health care needs, fewer unmet needs, and better dental health status for their child. Compared with having private insurance, parents of children with special health care needs who were established CHIP enrollees reported similar levels of access to and use of medical and dental care and unmet needs, and less difficulty meeting their child's health care needs.

CONCLUSION

Since CHIP started in 1997, millions of low- and moderate-income children have secured health insurance coverage and needed care, and thus reduced the financial burdens and stress on their families. CHIP programs continued to evolve and innovate under CHIPRA, leading to streamlined enrollment and renewal procedures, expanded eligibility and outreach efforts, and new investments in quality measurement and care improvements for children. States made substantial progress in simplifying enrollment and retention so that eligible children enroll and stay enrolled. When investments in systems changes are made to maximize the benefits of ELE, this policy lever has the potential to help cover more of the millions of eligible children who remain uninsured. Transitions between coverage programs are common because income and other family circumstances change, especially in lower income families. The evaluation documented how frequently children move between Medicaid and CHIP, and how many children experience a gap in coverage when they make these transitions. It remains to be seen whether state efforts to further strengthen the "no wrong door" approach called for and supported by the Affordable Care Act will reduce gaps in coverage that result when children experience transitions in eligibility for different types of coverage.

CHIP enrollees experienced good access to providers; nearly all had seen a medical and dental provider within the past year, and parents of CHIP enrollees reported being very confident that their child is able to get needed health care. For nearly every health care access, use, care, and cost measure examined, CHIP enrollees fared better than uninsured children. Compared with private coverage, access in CHIP was similar for most measures, but financial burdens were substantially lower with public coverage, and access to weekend and nighttime care was not as good. Parents reported being more confident that they will be able to meet their children's health care needs and feeling less stress about doing so with Medicaid and CHIP coverage as opposed to private insurance. It is important to keep in mind that the evaluation compared CHIP with private insurance options available when the survey was conducted in 2012, before health insurance Marketplaces and other Affordable Care Act reforms were introduced. It will be important to consider the generosity and affordability of CHIP versus Marketplace coverage options available to children in the absence of CHIP. Recent work documented substantially lower levels of financial protection in qualified health plans versus CHIP.[31]

Further progress could be made to enroll the nearly 4 million children estimated to be eligible for Medicaid or CHIP and to reduce coverage gaps associated with movements between these programs. Also, 1 in 4 children enrolled in CHIP had some type of unmet need reported by parents, most often for dental services, and although 84% of CHIP enrollees received annual dental checkups, a significant share was not getting recommended follow-up dental treatment and many had oral health problems, according to their parents. Although most CHIP enrollees received annual well-child checkups, many did not receive key preventive services such as immunizations and health screenings during those visits. Similar gaps in care were also found among children with private coverage, suggesting improvements are needed in systems of care for all children.

CHIP's future is currently being debated, and major coverage-related changes under the Affordable Care Act are continuing to take shape. The Affordable Care Act coverage expansions are expected to improve the health and well-being of parents and other low-income adults, particularly in states that choose to expand Medicaid. Further reductions in uninsurance among children are also possible because of the availability of Marketplace subsidies and health insurance reforms, the individual mandate, and the new outreach, enrollment, and renewal processes that are being implemented. Although new

coverage options under the Affordable Care Act have the potential to reduce uninsured rates among children, some families might still experience financial burdens. Furthermore, as currently structured, some uninsured children will not be eligible for Marketplace coverage subsidies because the family has access to affordable employee-only ESI coverage, though ESI coverage for dependents could be quite costly. As complex transition issues are resolved, some stakeholders have recommended a 2-year extension of federal CHIP funding and other proposals call for funding to be extended until current authorization ends in September 2019.[32,33] The central question for policy makers is how to build on CHIP's accomplishments to achieve additional coverage, access, and quality gains for children.

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