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