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**RE: CHIPRA-Mandated Evaluation of the Children’s Health Insurance
Program: Final Findings**

The Medicaid and CHIP Payment and Access Commission (MACPAC) is pleased to submit comments on the report to the Congress by the U.S. Department of Health and Human Services (HHS) released in September 2014: *CHIPRA Mandated Evaluation of the Children’s Health Insurance Program: Final Findings*. MACPAC is required by statute to review and comment on reports to the Congress submitted by the Secretary of HHS within six months of the submission date and provide written comments to the Secretary and appropriate committees of the Congress.

The future of children’s coverage, including the State Children’s Health Insurance Program (CHIP), is among the highest priorities of MACPAC. The findings of the evaluation mandated by the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) reinforce many of the Commission’s prior recommendations and underscore issues that the Commission continues to examine. The Commission offers comments in the following areas:

- extending CHIP funding;
- eliminating waiting periods;
- eliminating premiums for children below 150 percent of the federal poverty level (FPL);
- improving enrollee understanding of renewal requirements; and
- monitoring transitions between Medicaid, CHIP, and exchange coverage.

Report summary

CHIPRA requires HHS to conduct an independent, 10-state evaluation of CHIP and submit a report to the Congress on the evaluation's findings related to outreach, enrollment, retention, cost sharing, and the coordination between Medicaid and CHIP.

The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with Mathematica Policy Research and the Urban Institute to evaluate 10 states with varied geographic representation and diverse approaches to program design (AL, CA, FL, LA, MI, NY, OH, TX, UT, and VA). Within these 10 states, the evaluators surveyed parents of CHIP enrollees about their experiences with CHIP and also analyzed state eligibility data to track how long children were enrolled and where they went after leaving CHIP coverage. The evaluation's 10-state analysis was complemented by a review of existing national data on trends in children's coverage over time.

The seven major findings from the evaluation are summarized below, along with some of the supporting data highlighted in the report. Although the report did not make any formal recommendations to the Congress, it highlighted certain areas for improvement.

1. CHIP contributed greatly to the decline in uninsured rates among low-income children.

- The national uninsured rate for low-income children fell from 25 percent in 1997 to 13 percent in 2012.

2. Medicaid and CHIP participation rates increased even as the number of eligible children has grown.

- Medicaid and CHIP participation rates increased nationwide from 82 percent in 2008 to 88 percent in 2012. As a result, the number of children eligible for Medicaid or CHIP yet uninsured fell from 4.9 million in 2008 to 3.7 million in 2012.
- Additional outreach efforts could be needed to target the remaining 3.7 million eligible yet uninsured children nationwide. The evaluation estimates that 68 percent of all uninsured children are eligible for Medicaid or CHIP.

3. Relatively few low-income children in CHIP have access to employer-sponsored insurance coverage.

- Thirteen percent of CHIP enrollees in the 10 states surveyed reported private coverage in the year prior to enrolling. Of these enrollees, 72 percent reported an involuntary reason for disenrolling from private coverage, such as loss of a job. As a result, direct substitution of private coverage, often referred to as crowd-out, was estimated to be 4 percent.
- In the 10 states surveyed, approximately 40 percent of established CHIP enrollees had a parent with employer-sponsored insurance, but only half of them (approximately 20 percent of the total) reported that they had employer-sponsored insurance that could cover their children.

4. Medicaid and CHIP programs worked as intended to provide an insurance safety net for low-income children, especially during times of economic hardship.

- Enrollment, particularly in Medicaid, grew substantially across the country during the economic recession.
- The majority of established children enrolled in CHIP in the 10 states studied (69 percent) had household incomes below 150 percent of the FPL.

5. Although half of CHIP enrollees remained enrolled in public coverage for at least 28 months, transitions between Medicaid and separate CHIP programs were common and often resulted in coverage gaps.

- In half of the 10 states studied, coverage gaps occurred for at least 40 percent of enrollees transitioning from Medicaid to separate CHIP programs; coverage gaps for enrollees transitioning from separate CHIP programs to Medicaid were less prevalent. The evaluation notes the need to reduce these coverage gaps and cites premiums and waiting periods in separate CHIP programs as potential factors that may contribute to gaps in coverage between Medicaid and separate CHIP programs.
- Within seven months of disenrolling, between 2 and 19 percent of separate CHIP enrollees were re-enrolled in CHIP; the corresponding churn rate for Medicaid disenrollees was between 8 and 36 percent. The evaluation highlights the need to reduce churning in both Medicaid and CHIP.

6. Medicaid and CHIP enrollees report better health care experiences than uninsured children and generally comparable experiences to children with private insurance, although unmet needs remain.

- In the 10 states surveyed, children in Medicaid and CHIP experienced better access to care, fewer unmet needs, and greater financial protection compared to children who were uninsured.
- Compared to children with private insurance, CHIP enrollees had better access to dental benefits and their families experienced much lower stress in meeting the child's health care needs. However, about one in eight CHIP enrollees reported an unmet dental need.
- One in four CHIP enrollees surveyed reported some type of unmet health need. The evaluation identifies these unmet health needs as an area for improvement in CHIP.

7. Most low-income families knew about Medicaid and CHIP, and those with children enrolled in one of the programs reported positive application experiences.

- In the 10 states surveyed, 95 percent of low-income families with an uninsured child had heard of Medicaid or CHIP and of these, 91 percent said that they would enroll if they were told that their child was eligible.
- About half of new CHIP enrollees understood the renewal requirements of the program.

MACPAC Comments

The findings of the CHIPRA-mandated evaluation reinforce the Commission's prior recommendations on CHIP and underscore issues that the Commission continues to examine in its public meetings and ongoing analytic work.

The Commission recognizes the important role that CHIP has played in improving children's health coverage and offers the following comments for the Congress to consider as it crafts its approach for the future of CHIP and children's coverage:

1. **Extending CHIP funding.** The Commission recommends that the Congress act soon to extend CHIP so that states do not respond to uncertainty around CHIP's future by implementing policies that reduce children's access to appropriate care. The CHIPRA-mandated evaluation found that, at the time of the analysis, many states had not yet made contingency plans for the pending exhaustion of CHIP funding, which further reinforces the urgent need for Congressional action to reduce this uncertainty. The Commission's June 2014 *Report to the Congress on Medicaid and CHIP* recommended that the Congress extend federal CHIP funding for a transitional period of two additional years, during which time the key issues regarding the affordability and adequacy of alternative options for children's coverage can be addressed.
2. **Eliminating waiting periods.** The CHIPRA-mandated evaluation's finding that only 4 percent of children voluntarily dropped employer-sponsored insurance prior to enrolling in CHIP in the 10 states studied reinforces the Commission's prior recommendation to eliminate waiting periods in CHIP, since the potential pool of children who might be targeted by waiting periods is small and does not justify the added administrative burden and complexity that waiting periods create. In the Commission's March 2014 *Report to the Congress on Medicaid and CHIP*, the Commission also noted that eliminating waiting periods would help promote continuity of coverage for children and would be consistent with the trend in state actions to eliminate waiting periods voluntarily.
3. **Eliminating premiums for children below 150 percent of the FPL.** The CHIPRA-mandated evaluation's findings that premiums may contribute to increased gaps in coverage for children transitioning between Medicaid and separate CHIP programs reinforces the Commission's prior recommendation to eliminate premiums for children with family incomes below 150 percent of the FPL. The Commission's March 2014 report justified this recommendation by citing additional research findings that children in families below 150 percent of the FPL are much more price sensitive than higher-income enrollees and by noting that the revenue loss to states of the Commission's recommendation would be small. CHIP premiums below 150 percent of the FPL are generally less than \$10 a month and, after the expansion of Medicaid eligibility to all children below 133 percent of the FPL. Approximately 110,000 CHIP children would be affected by this proposed policy change.
4. **Improving enrollee understanding of renewal requirements.** The CHIPRA-mandated evaluation's finding that only half of new CHIP enrollees understood the renewal requirements of the program indicates that greater assistance with the renewal process is needed. At MACPAC's September 2014 public meeting, the Commission reviewed

MACPAC focus group findings that also found low awareness about renewal requirements among adults who were newly enrolled in Medicaid during the exchange's first open enrollment period, suggesting that confusion about renewal requirements is an issue affecting both children and adults.

5. **Monitoring transitions between Medicaid, CHIP, and exchange coverage.** The evaluation's finding that, in half the states studied, at least 40 percent of enrollees transitioning between Medicaid and separate CHIP programs experienced a gap in coverage is instructive about the need for mechanisms to smooth transitions when changing sources of coverage, whether between Medicaid and CHIP or between Medicaid/CHIP and exchange coverage.

Improved data collection and monitoring of individuals moving between Medicaid, CHIP, and exchange coverage is needed to effectively evaluate efforts to close coverage gaps. At MACPAC's September 2014 meeting, the Commission reviewed recent state experiences with major CHIP changes and noted the challenges of tracking former CHIP enrollees as they transition to new sources of coverage. Although CMS has established some performance indicators for tracking the effectiveness of new Medicaid and CHIP eligibility systems, these indicators do not currently include measures of seamless transfers between programs. The measures of seamless transfers used by the CHIPRA-mandated evaluation, which are based on linking data from different eligibility systems, should be added to CMS's set of performance indicators so that they can be collected from all states and made publicly available in a standard format that enables analysis.

MACPAC appreciates the opportunity to provide comments on the important policy issues raised in the CHIPRA-mandated evaluation of CHIP.

Sincerely,

A handwritten signature in black ink that reads "Diane Rowland". The signature is written in a cursive, flowing style.

Diane Rowland, ScD
Chair