United States Government Accountability Office

Report to Congressional Requesters

February 2015

CHILDREN'S HEALTH INSURANCE PROGRAM

Effects on Coverage and Access, and Considerations for Extending Funding

GAO-15-348

February 2015

CHILDREN'S HEALTH INSURANCE PROGRAM

Effects on Coverage and Access, and Considerations for Extending Funding

GAO Highlights

Highlights of GAO-15-348, a report to congressional requesters

Why GAO Did This Study

CHIP is a joint federal-state program that finances health insurance for over 8 million children. Since the program's inception, the percentage of uninsured children nationwide has decreased by half, from 13.9 percent in 1997 to 6.6 percent in the first three months of 2014. This year, Congress will decide whether to extend CHIP funding beyond 2015.

GAO was asked to provide information on the effect of CHIP on children's coverage, and what key issues may be considered in determining the ongoing need for CHIP. In this report, GAO examines (1) what assessments of CHIP suggest about its effect on children's health care coverage and access; and (2) what key issues identified by GAO's work the Congress may wish to consider in determining whether to extend CHIP funding.

For the assessments of CHIP's effect, GAO reviewed reports on CHIP, including a mandated evaluation and annual HHS reports on quality, which publish data that states report on Child Core Set measures, which are quality measures identified by HHS that states can use to monitor health care provided to children in CHIP and Medicaid. GAO also reviewed relevant federal statutes and regulations. To identify key issues that the Congress may wish to consider, GAO reviewed its own relevant reports and testimony; reviewed letters from state governors regarding CHIP; and interviewed CHIP officials in 10 states, which were selected based on variation in location, program size, and design.

HHS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-15-348. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Assessments of national data GAO reviewed identify positive effects of the State Children's Health Insurance Program (CHIP), and the quality measures reported by states help identify areas needing improvement.

- A mandated evaluation of CHIP published in 2014 noted that CHIP enrollees (1) had substantially better access to care, service use, and preventive care when compared with uninsured children; and (2) experienced comparable access and service use when compared with privately insured children. These findings are generally consistent with prior GAO work, which used national survey data to compare CHIP enrollees' access and service use with children who were uninsured or privately insured. When comparing CHIP enrollees with privately insured children, the mandated evaluation and prior GAO work differed regarding the utilization of certain services, such as emergency room use and dental services, which may be due to differences in when the data were collected and the particular measures that were used.
- The Department of Health and Human Services (HHS) also publishes data on quality measures that states voluntarily report annually. These Child Core Set measures show mixed results regarding service utilization among CHIP and Medicaid enrollees. For example, states reported that nearly all children aged 12 to 24 months enrolled in CHIP or Medicaid had at least one primary care physician visit during fiscal year 2013. However, states reported that far fewer children obtained dental prevention or treatment services, with a mean of 46 percent of children receiving a preventive dental service, and a mean of 25 percent receiving dental treatment services. HHS officials said that they use these data to help identify areas for improvement in the care provided in CHIP and Medicaid.

GAO's prior work has identified important issues related to cost, coverage, and access that Congress may wish to consider when determining the ongoing need for CHIP, many of which were similar to issues raised by officials from the 10 states GAO reviewed.

- With regard to cost, GAO's prior work found that costs—defined as deductibles, copayments, coinsurance, and premiums—were almost always less for selected CHIP plans when compared with states' benchmark health plans, which were the models for health plans available in health insurance exchanges established under the Patient Protection and Affordable Care Act. Officials in five states expressed concerns about the higher cost of exchange plans compared with CHIP and the implications for families' finances.
- With regard to coverage, GAO previously reported that selected CHIP and state benchmark plans were generally similar in terms of their coverage of selected services and the services on which they imposed limits. However, officials from several of the 10 states pointed out that for many services needed by children with special health care needs, CHIP coverage was more comprehensive than exchange plans.
- With regard to access, several states raised concerns about negative implications for children's coverage if CHIP funding is not reauthorized, including concerns that their states would lose gains made in covering children, who would also lose access to providers and dental care.

Contents

Abbreviations

AHRQ	Agency for Healthcare Research and Quality
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARTS	Children's Health Insurance Program Annual Reporting Template System
CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
CPS-ASEC	Current Population Survey Annual Social and Economic Supplement
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FPL	federal poverty level
HHS	Department of Health and Human Services
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SADP	stand-alone dental program

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

February 27, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

The State Children's Health Insurance Program (CHIP), a joint federal-state program that was established by Congress in 1997, finances health insurance for over 8 million children whose household incomes are above the threshold for Medicaid eligibility. Prior to CHIP, private health insurance coverage for children had been declining every year since 1987—reaching its lowest level of about 66 percent of children in 1994. While Medicaid helped to cushion the effect of this decline, many of the children losing coverage were ineligible for Medicaid coverage.[1] Since the inception of CHIP, the percentage of uninsured children nationwide has decreased by half, from 13.9 percent in 1997 to 6.6 percent in the first 3 months of 2014.[2] The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), oversees CHIP, with states designing, managing, and administering the operations of their individual programs. States administer CHIP under broad federal requirements, and the programs vary, for example, in the services covered, costs to individuals and families, and eligibility requirements.[3]

[1]See GAO, *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate,* GAO/HEHS-96-129 (Washington, D.C.: June 17, 1996).

[2]The uninsured rate for children varies considerably among states. See Cohen, R.A, Martinez, M.E., *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey*, January-March 2014.

[3]Most states' CHIP eligibility levels are between 200 and 300 percent of the federal poverty level (FPL), with the highest eligibility level being 400 percent of the FPL.

Over the course of the program, Congress has enacted legislation at various times authorizing continued funding for CHIP. Most recently, the Patient Protection and Affordable Care Act (PPACA) appropriated federal CHIP funding through fiscal year 2015.[4] PPACA requires that beginning in October 2015, if a state's CHIP funding is insufficient to cover all CHIP-eligible children, the state must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid.[5] If such children are determined to be ineligible for Medicaid, the children may be enrolled in a qualified health plan (QHP)—which are plans offered by private issuers through health insurance exchanges in that state—that has been certified as comparable to CHIP by the Secretary of HHS, if such a QHP is available.[6] Over the longer term, PPACA requires states to maintain eligibility levels for children in CHIP and Medicaid until fiscal year 2019. Thus, under current law, some states could choose to eliminate or scale back their programs beginning in fiscal year 2020, even if federal funds are available.

Given that the Congress will decide whether to extend CHIP funding beyond 2015, you asked us to provide information about the effect that CHIP has had on children's health care, and what key issues may be considered in determining the ongoing need for the CHIP program. In this report, we examine (1) what assessments of CHIP suggest about the effect of the program on children's health care coverage and access across states; and (2) what key issues the Congress may wish to consider in determining whether to extend CHIP funding.

[4]Pub. L. No. 111-148, § 10203, 124 Stat. 119, 927 (2010). In this report, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), unless otherwise indicated.

[5]Although federal appropriations for the program will end on September 30, 2015, any unexpended amounts allotted to the states in fiscal year 2015 will be available for expenditure through September 30, 2016.

[6]PPACA required the establishment of health insurance exchanges by January 1, 2014—marketplaces where eligible individuals can compare and select among QHPs offered by participating private issuers of health coverage. The Secretary is required to report by April 2015 on comparability of benefits and cost sharing between CHIP and QHPs. As of January 2015, CMS had not issued guidance on how comparability between QHPs and CHIP will be defined. CHIP regulations also generally require that, for children found ineligible for CHIP, either at the time of initial application or during a follow-up eligibility determination, the state must screen the child for Medicaid eligibility and, if ineligible for Medicaid, the state must then screen for potential eligibility for other insurance affordability programs, including subsidized coverage in a QHP.

To examine what assessments of CHIP suggest about the program's effect, we synthesized information from HHS reports on CHIP, including a mandated national evaluation on the evolution of the program (referred to as the mandated evaluation) and its role in providing health coverage to low-income children.[7] We also reviewed HHS's annual CHIP and Medicaid reports on quality for fiscal years 2011 through 2014, relying primarily on the 2014 report (referred to as the annual quality report), which use state-reported data to assess the quality of care provided to children enrolled in CHIP and Medicaid for the applicable fiscal year, and a series of issue briefs on state practices to improve the quality of care for children enrolled in these programs.[8] To obtain information on state CHIP reporting requirements and states' efforts to report data for the annual quality report, we reviewed federal statutes and regulations governing CHIP; and interviewed CHIP officials from 10 states, which were selected based on variation in states' CHIP program design, income eligibility level, program enrollment, and states' rate of uninsured children.[9] The 10 selected states were Alaska, Arizona, Indiana, Mississippi, Nevada, New Hampshire, Pennsylvania, Rhode Island, South Carolina, and Wisconsin. For the purposes of the annual quality report, states have the option to report CHIP and Medicaid data separately, but commonly report combined data for the two programs. We supplemented HHS's findings with relevant findings from our own issued reports, when applicable.

[7]To carry out this mandated evaluation, HHS used the services of a contractor, Mathematica Policy Research, and its subcontractor, the Urban Institute. See Mathematica Policy Research and Urban Institute, *CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings* (Washington, D.C.: Aug. 1, 2014), located at http://aspe.hhs.gov/health/reports/2014/chipevaluation/rpt_chipevaluation.pdf. The findings included in this national evaluation were based on multiple sources of data, including a survey of CHIP program administrators; state eligibility and enrollment data; and a survey of CHIP enrollees and disenrollees in 10 states: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. An interim report on the evaluation was delivered to Congress in December 2011.

[8]For HHS's most recent report see The Department of Health and Human Services, *2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP* (Washington, D.C.: Nov. 2014). The issue briefs that we reviewed are published by HHS's Agency for Healthcare Research and Quality (AHRQ) and are available at http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/index.html (accessed December 18, 2014).

[9]In selecting states, we also excluded those with fewer than 10,000 children and states that were included in the Mathematica review. Our findings related to information collected from these states cannot be generalized.

To identify key issues that the Congress may wish to consider in determining whether to extend funding for CHIP, we reviewed relevant reports and testimony that we issued from February 2009 through December 2014. In addition, we interviewed CHIP officials in selected states about considerations for the extension of CHIP funding, and reviewed letters from state governors regarding their respective programs and implications for the future of CHIP.[10]

We conducted this performance audit from November 2014 through February 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Federal law provides states with flexibility in how they operate their CHIP programs and how states implement more recent coverage options under PPACA. For example, states may operate CHIP as a separate program, include CHIP-eligible children in their Medicaid programs, or use a combination of the two approaches.[11] States with separate CHIP programs may modify certain aspects of their programs, such as coverage and cost-sharing requirements.[12] However, federal laws and regulations require states' separate CHIP programs to include coverage

[10]In July 2014, the Senate Finance Committee and the House Energy and Commerce Committee sent a joint letter to state governors requesting information on their CHIP programs, as well as their thoughts on extending CHIP funding and any additional policy changes that could be made to the program. The committees released states' responses on December 3, 2014. These responses are available at http://energycommerce.house.gov/letter/responses-bipartisan-bicameral-letters-governors-regarding-chip (accessed January 21, 2015).

[11]As of February 2015, 42 states operated separate CHIP programs (2 states had a separate CHIP program only and 40 states covered CHIP children through both a separate program and an expansion of their Medicaid program). The other 9 states covered CHIP children through an expansion of their Medicaid program, which we refer to as a "CHIP Medicaid expansion." States' CHIP spending has been reimbursed by the federal government at a matching rate that is generally about 15 percent higher than the Medicaid rate and varies by states, ranging from 65 percent for the wealthiest state to about 82 percent for the poorest state in 2015.

[12]States that opt to include CHIP-eligible children in their Medicaid programs must extend Medicaid covered services to them.

for routine check-ups, immunizations, inpatient and outpatient hospital services, and dental services defined as "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions."[13] In addition, CHIP premiums and cost-sharing may not exceed maximum amounts as defined by law.[14] Similarly, PPACA provides states with flexibility in how they opt to implement certain coverage options included in the law. For example, PPACA allows states to expand eligibility for Medicaid to most non-elderly, non-pregnant adults who are not eligible for Medicare and whose income is at or below 133 percent of the FPL.[15] As of January 2015, 29 states have implemented this expansion.[16] PPACA required the establishment of health insurance exchanges by January 1, 2014, to allow consumers to compare individual health insurance options available in each state and enroll in coverage. In states electing not to operate their own exchange, PPACA required the federal government to establish and operate an exchange in the state, referred to as a federally facilitated exchange. States with federally facilitated exchanges may enter into a partnership with HHS to assist with the operation of certain exchange functions. As such, a state could establish the exchange (referred to as a state-based exchange), cede the responsibility entirely to HHS (referred to as a federally facilitated exchange), or enter into a partnership with HHS (referred to as a partnership exchange).[17] As of January 2015, 17 states established state-based exchanges, 27 states were using the federally

[13]42 U.S.C. § 1397cc(c).

[14]For example, states may not impose premiums and cost-sharing, in the aggregate, that exceed 5 percent of a family's total income for the length of the child's eligibility period in CHIP. This annual cumulative cost-sharing maximum applies to all services with cost-sharing requirements, irrespective of the number of children in the family that are enrolled in CHIP.

[15]PPACA, § 2001(a)(1),124 Stat. 119, 271 (2010). PPACA also imposes a 5 percent income disregard when calculating modified adjusted gross income, which, in effect, raises this income limit to 138 percent of the FPL.

[16]For purposes of this report, we consider the District of Columbia as a state. The Henry J. Kaiser Family Foundation, "*Medicaid Moving Forward*," (Menlo Park, CA: January 2015).

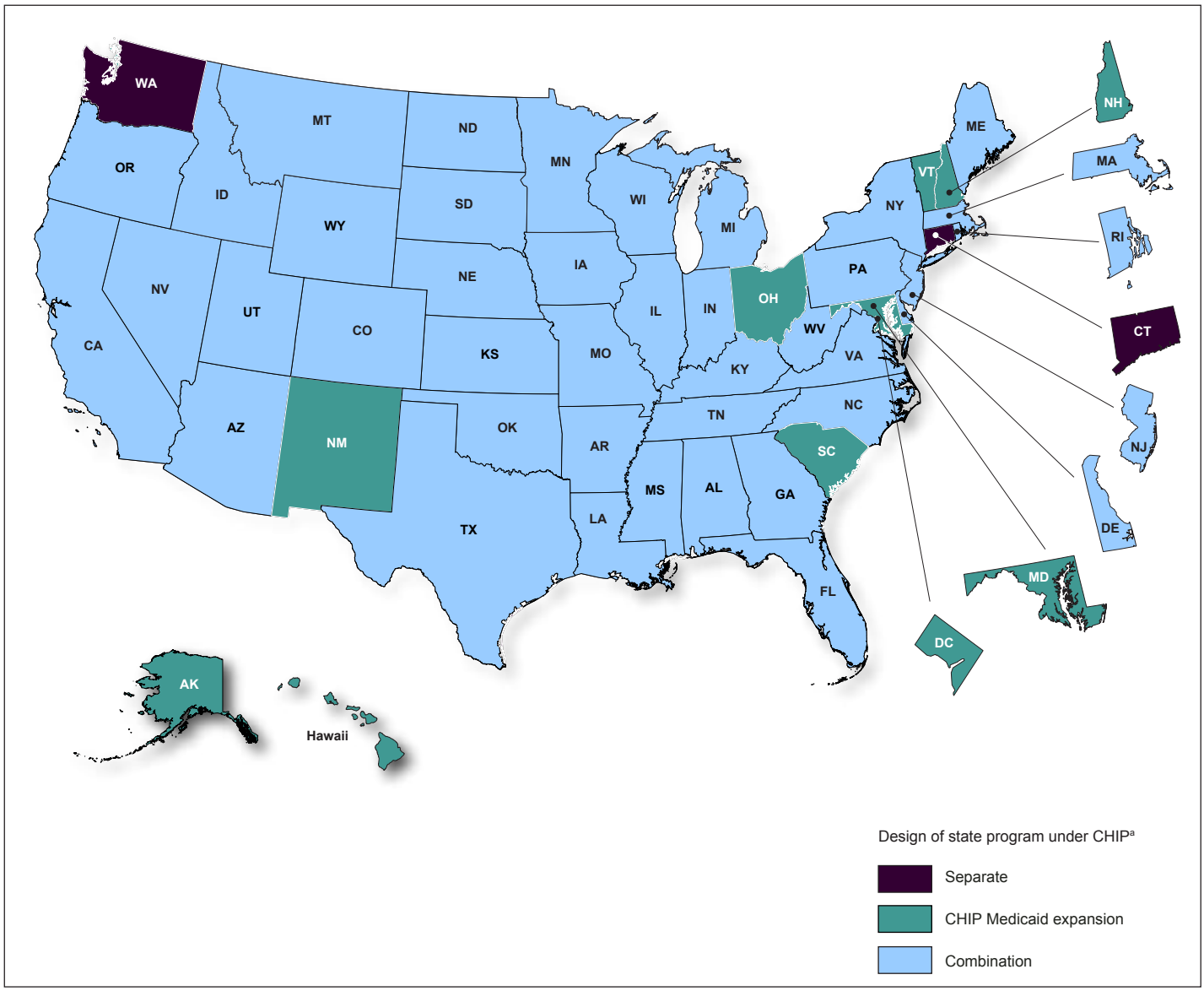
[17]A partnership exchange is a variation of a federally facilitated exchange. HHS will establish and operate this type of exchange with states assisting HHS to carry out certain functions of that exchange.

facilitated exchange, and 7 states established partnership exchanges.[18] See fig. 1 for information on the variation in children's uninsured rates, CHIP characteristics, and coverage approaches under PPACA by state; and see appendix I for the information in tabular form.

[18]The Henry J. Kaiser Family Foundation, *State Health Insurance Marketplace Types, 2015*, accessed January 7, 2015, http://Kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/#table.

Figure 1: Variation in Children's Uninsured Rates, CHIP Characteristics, and Coverage Approaches under the Patient Protection and Affordable Care Act (PPACA), by State

Interactivity instructions: Roll over on each state to see CHIP data. See appendix I for the non-interactive, printer-friendly version.



Sources: GAO based on information from the Centers for Medicare & Medicaid Services (CMS), as of February 2015, State Medicaid and State Children's Health Insurance Program (CHIP) Income Eligibility Standards as of October 1, 2014; The Henry J. Kaiser Family Foundation, State Health Insurance Marketplace Types, 2015; U.S. Census Bureau, 2013 American Community Survey (data); Map Resources (map). | GAO-15-348

[a]As of February 2015, 42 states operated separate CHIP programs (2 states had a separate CHIP program only and 40 states covered CHIP children through both a separate program and an expansion of their Medicaid program). The other 9 states covered CHIP children through an expansion of their Medicaid program, which we refer to as a "CHIP Medicaid expansion."

[b]PPACA specifies that an income disregard equal to five percentage points of the Federal Poverty Level (FPL) be deducted from an individual's income when determining Medicaid and CHIP eligibility. The FPL eligibility standards in this graphic do not reflect this income disregard.

[c]Minnesota and New Mexico have CHIP income eligibility levels that vary by age group; therefore, we reported the highest income eligibility level reported for these states—which are ages 0 to 1 year in Minnesota and ages 0 to 5 years in New Mexico.

[d]These state-based marketplaces use the federally facilitated marketplace's information technology platform for applicants to apply and enroll in their respective states.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions aimed at improving the information available from states on the quality of health care furnished to children in both CHIP and Medicaid.[19] Specifically, CHIPRA required the Secretary of HHS to conduct an independent evaluation of CHIP and to submit the results to Congress.[20] The mandated evaluation, for which the final report was issued in August 2014, documents what is known about CHIP; explores the program's evolution since inception; and examines the role CHIP has played in covering low-income children. In addition, CHIPRA required HHS to identify quality measures, known as the Child Core Set measures, to serve as a tool for states to use to monitor and improve the quality of health care provided to children enrolled in CHIP and Medicaid. CHIPRA also required HHS to develop a standardized format for states to voluntarily report these measures. These measures assess the quality of care provided through CHIP and Medicaid, and include a range of health conditions, such as asthma, obesity, attention deficit hyperactivity disorder, and perinatal care.[21] (See table 1.)

[19]Pub. L. No. 111-3, 123 Stat. 8 (2009) (hereafter, "CHIPRA").

[20]CHIPRA, § 603, 123 Stat. at 99. The CHIPRA mandated evaluation was patterned after an earlier evaluation mandated in the Balanced Budget Refinement Act (BBRA) of 1999.

[21]CHIPRA also requires state CHIP programs to report annually on quality of care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. States can choose among the available types of CAHPS surveys to address this requirement, but HHS recommends that they use the version listed in the Child Core Set measures. The survey, developed by HHS's AHRQ, asks consumers and patients to report on and evaluate their experiences with health care.

Table 1: Child Core Set Measures by Clinical Area, 2014

Clinical area	Child Core Set measures
Access to care	• Children and adolescents' access to primary care practitioners
Acute care and chronic conditions	• Follow-up care for children prescribed attention-deficit hyperactivity disorder medication • Medication management for people with asthma
Behavioral health	• Behavioral health risk assessment (for pregnant women)[a] • Follow-up after hospitalization for mental illness
Consumer experience	• Consumer assessment of healthcare providers and systems health plan survey
Oral health	• Dental treatment services • Preventive dental services
Perinatal care	• Percentage of live births weighing less than 2,500 grams • Frequency of ongoing prenatal care • Cesarean rate for nulliparous singleton vertex • Timeliness of prenatal care • Pediatric central line-associated bloodstream infections
Preventive care and screening	• Development screening in the first three years of life • Body mass index assessment for children and adolescents • Chlamydia screening in women • Childhood immunization status • Immunization status for adolescents • Well-child visits in the first 15 months of life • Well-child visits in the third, fourth, fifth, and sixth years of life • Adolescent well-care visits • Human papillomavirus vaccine for female adolescents • Ambulatory care: emergency department visits

Source: Department of Health and Human Services. | GAO-15-348

[a]States may elect to cover low-income pregnant women whose incomes are too high to qualify for Medicaid through their CHIP programs.

In 2013, as required by CHIPRA, HHS began annually publishing recommended changes to the Child Core Set measures in an effort to improve upon the measures and align them with national quality measurement activities, which can result in changes to the number of

measures.[22] With the use of state reported data on the Child Core Set, HHS conducts an annual assessment and publishes its findings in its annual quality report, as required under CHIPRA. States report CHIP service utilization and other measures through systems developed by HHS; specifically, the CHIP Annual Reporting Template System (CARTS), a web-based data submission tool, and through the Form CMS-416, an annual report submitted by states on the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provided for enrolled children.[23] States that use managed care plans to deliver CHIP benefits are also required to report outcomes and performance measures from External Quality Review Organizations and performance improvement projects.[24]

CHIPRA also provided funding for the Quality Demonstration Grant Program to identify strategies for enhancing the quality of health care for children enrolled in Medicaid and CHIP.[25] HHS's AHRQ is evaluating the implementation of 52 projects in five general categories: (1) using quality measures to improve child health care; (2) applying health information technology for quality improvement; (3) implementing provider-based delivery models; (4) investigating the use of a model format for pediatric

[22]For example, HHS recommended that three measures be retired from the 2014 Child Core Set: appropriate testing for children with pharyngitis, asthma patients with one or more asthma-related emergency room visits, and annual pediatric hemoglobin A1c testing. In addition, an HHS-funded National Qualify Forum workgroup convenes a public-private partnership to provide input to HHS on the selection of performance measures for public reporting and performance-based payment programs. The public-private partnership makes recommendations to HHS for strengthening and revising measures in the Child Core Set.

[23]State Medicaid programs are required to cover EPSDT benefits for children under age 21. EPSDT benefits include comprehensive screenings, preventive health care services, and other services necessary to correct illnesses or conditions identified by the screenings. The Form CMS-416 is an annual report submitted by states on EPSDT benefits provided for children who are enrolled in Medicaid.

[24]States are required to perform an annual external quality review for each contracted managed care plan and prepaid inpatient health plan, which includes information and analysis of quality outcomes and performance measures for the populations served by the plans.

[25]In February 2010, CMS awarded 10 grants—which funded 18 states to implement projects that include using quality measures to improve child health. CMS also provided funding to AHRQ to lead a national evaluation of these demonstrations, to be completed by September 30, 2015.

electronic health records, and (5) assessing the utility of other innovative approaches to enhance quality.

Assessments of National Data Largely Show Positive Effect of CHIP on Coverage and Access, and Identify Areas for Improvement

Available assessments of national data we reviewed identify positive effects of CHIP, including a reduction in the rate of uninsured children and children's improved access to care, and these findings are often consistent with our prior work. HHS also has ongoing efforts to enhance state reporting of the Child Core Set measures and publishes data from these quality measures to identify areas for improving the care provided in CHIP.

Mandated Evaluation Highlights Reduction in the Rate of Uninsured Children and Improved Access to Health Care

HHS's mandated evaluation identified several positive effects of CHIP across states, particularly with regard to children who are uninsured.[26] For example, based on an analysis of data from the Current Population Survey Annual Social and Economic Supplement (CPS-ASEC), the evaluation reported that Medicaid and CHIP contributed to the decline in the national rate of uninsured children between 1997 and 2012, with coverage rates improving for all ethnic and income groups.[27] Most notably, coverage rates for Hispanic children increased dramatically, rising from 42 percent to 65 percent during this time. Changes to state CHIP programs also contributed to the decline in the national uninsured rates among children. For example, many states expanded CHIP coverage by raising upper income eligibility limits and covering newly eligible groups, such as immigrant children who have resided legally in the United States for less than 5 years, which was newly permitted under

[26]See Mathematica Policy Research and Urban Institute, *CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings* (Washington, D.C.: Aug. 1, 2014).

[27]According to the mandated evaluation, the percentage of all children who were uninsured fell from 15 percent in 1997 to 9 percent in 2012. Further, among low-income children, the percentage of uninsured fell from 25 percent in 1997 to 13 percent in 2012. For purposes of this evaluation, low-income children were defined as children between the ages of 0 and 18, with income below 200 percent of the FPL. The mandated evaluation relied on the CPS-ASEC, which provided time series of data on health insurance coverage over the 15-year period—1997 through 2012—since CHIP's enactment.

federal law.[28] In addition, state outreach and enrollment activities also reduced the number of children eligible for—but not enrolled in—Medicaid or CHIP by about 1.2 million from 2008 to 2012.[29]

In addition, based on a survey of the parents of CHIP enrollees and disenrollees in a sample of states, the mandated evaluation also identified positive effects of CHIP with regard to access to services. For example, 96 percent of CHIP parents surveyed reported feeling confident that their child would be able to get needed health care, and 86 percent reported that their child had seen a doctor or health care professional in the last year.[30] The mandated evaluation further contrasted the experiences of CHIP enrollees who had been enrolled in CHIP for at least 12 months (referred to as CHIP enrollees) with the pre-CHIP experiences of two comparison groups: recent CHIP enrollees who were uninsured for at least 5 of the 12 months prior to enrollment (referred to as the uninsured), and recent CHIP enrollees who had 12 months of private coverage prior to enrollment (referred to as the privately insured). When compared to the uninsured children, the mandated evaluation found that CHIP enrollees reported having substantially better access to primary care, including preventive care, and higher utilization of covered services. For example,

- an estimated 88 percent of CHIP enrollees had a regular source of care compared with an estimated 78 percent of uninsured children;

[28]For example, CHIPRA allowed states to expand CHIP eligibility to include legally residing immigrant children and pregnant women, regardless of how long they have been legally residing in the United States. As of August 2014, 24 states expanded CHIP eligibility to include one or both of these groups. In addition, PPACA allowed states to expand CHIP eligibility to include children of low-income state employees, which had been previously prohibited. As of August 2014, 16 states had extended CHIP eligibility to children of state employees.

[29]While GAO has not estimated the effect of CHIP on the uninsured rate of children, the mandated evaluation notes that previous research has also documented substantial declines in the uninsured rate among low-income children following CHIP's implementation.

[30]To determine whether factors other than insurance coverage may affect differences in responses about obtaining care or utilization of health care services, the mandated evaluation controlled for age, sex, race/ethnicity and language groups, more than three children in the household, highest education of any parent, parents' employment status, parent citizenship, and local area or county.

- CHIP enrollees were an estimated 38 percentage points more likely to have a usual source of dental care, and were an estimated 39 percentage points more likely to have had a dental check-up in the past year;
- CHIP enrollees were an estimated 25 percentage points more likely to have an annual well-child checkup visit, and were more likely to receive a range of health services, including mental health visits, specialty care, and prescription drugs;
- CHIP enrollees were more likely to receive most preventive care measures, including flu vaccinations, vision screenings, and height and weight measurements; and
- parents of CHIP enrollees were less likely to report having trouble paying their child's medical bills, and were substantially more confident in their ability to get needed health care for their child.[31]

Based on our assessment of HHS's Medical Expenditure Panel Survey from 2007 through 2010, we also found that children enrolled in CHIP have better access to care and service use than children who are uninsured. In particular, when compared with uninsured children, we found that CHIP enrollees fared better, and the differences we identified were statistically significant in most cases.[32] For example, a higher proportion of CHIP respondents reported

- having a usual source of care; ease in getting a person the care, tests, or treatment that the parent or a doctor believed necessary; and ease in seeing a specialist; and
- using certain health care services, including office-based provider visits, outpatient department provider visits, and dental care visits.

[31]We previously reported that lower-income households paid a larger percentage of their income on premiums, with households with incomes below 227 percent of the FPL paying 7.3 percent of their income on premiums. See GAO-09-252.

[32]See GAO-14-40. In conducting our logistic regressions, we controlled for the following factors: age, race, income, total number of parents in the household, parent education, family size, health status, mental health status, children with special needs, total number of workers in the household, metropolitan statistical area, sex, whether the respondent was born in the United States, and English versus non-English speakers.

When the mandated evaluation compared CHIP enrollees with the privately-insured group, it also found that CHIP enrollees experienced comparable access and service use for many, but not all, measures, and that parents of children enrolled in CHIP experienced less financial burden in paying their children's medical bills.

- CHIP enrollees used a similar level of preventive care and other health care services; however, CHIP enrollees had higher usage of prescription medication and lower levels of emergency department visits and hospital stays.
- CHIP enrollees had similar rates of health and development screenings, but were 9 percentage points less likely to receive a flu vaccination.
- CHIP enrollees had higher rates of dental access and utilization of certain services. For example, 92 percent of CHIP enrollees reported having access to dental coverage in 2012, compared with 77 percent of privately insured children. In terms of utilization, 84 percent of CHIP enrollees reported having a dental checkup or cleaning in the previous 12 months compared with 79 percent of privately insured children.
- Parents of CHIP enrollees reported substantially less trouble paying their children's medical bills and had much lower out-of-pocket spending levels.

For our assessment of the Medical Expenditure Panel Survey, we also compared CHIP enrollees' access and service use with children who were privately-insured, and our findings were consistent with some of the findings in the mandated evaluation.[33]

- When asked about access to care, we found that respondents with children enrolled in CHIP reported experiences that were generally comparable with privately insured children for 5 of the 6 measures reviewed, including having a usual source of care; ability to make needed appointments; and ease in seeing a specialist.[34]

[33]To describe access to care for children in CHIP compared with those with Medicaid, private insurance, or without insurance, we analyzed nationwide data from HHS's Medical Expenditure Panel Survey from 2007 through 2010.

[34]Respondents' reported ease in getting needed care was the only measure for which we identified a statistically significant difference.

- CHIP families faced a lower financial burden than families with private insurance because of the federal requirement that states' CHIP programs may not impose premiums and cost-sharing that, in the aggregate, exceed 5 percent of a family's total income for the length of the child's eligibility period.

However, with regard to the utilization of certain services, our prior work is less consistent with the findings of HHS's mandated evaluation.[35] For example, when asked about their use of certain medical and dental services, we found that access to care for CHIP enrollees was lower than that of the privately-insured for several services, and these differences were often statistically significant. Specifically, we previously reported that

- a lower proportion of CHIP enrollees reported visiting dentists (42.4 percent compared with 50.9 percent) and orthodontists (4.9 percent compared with 11.2 percent) within the past 12 months than did those who were privately insured; and
- a higher proportion of CHIP enrollees reported having an emergency room visit (14.1 percent compared with 10.4 percent).

Differences between our findings and those included in the national evaluation may be related to the timeframes of the data and the measures used. For example, some of the data used in our analyses predate the CHIPRA requirement that CHIP programs offer comprehensive dental benefits coverage beginning in 2009. The timeframes for both bodies of work also predate the implementation of the PPACA requirement that most individual and small group market health plans provide pediatric dental coverage.

Finally, while the mandated evaluation noted that, overall, CHIP programs were meeting the health care needs of most enrollees, it identified areas for program improvement. Specifically, many CHIP enrollees did not receive recommended preventive care or reported an unmet health care need. For example, slightly less than half of CHIP enrollees received a flu vaccination, and only about one-third received a developmental screening for children under age 6. In addition, one in four CHIP enrollees had an unmet health care need, with the highest unmet need being for dental care.

[35]See GAO-14-40.

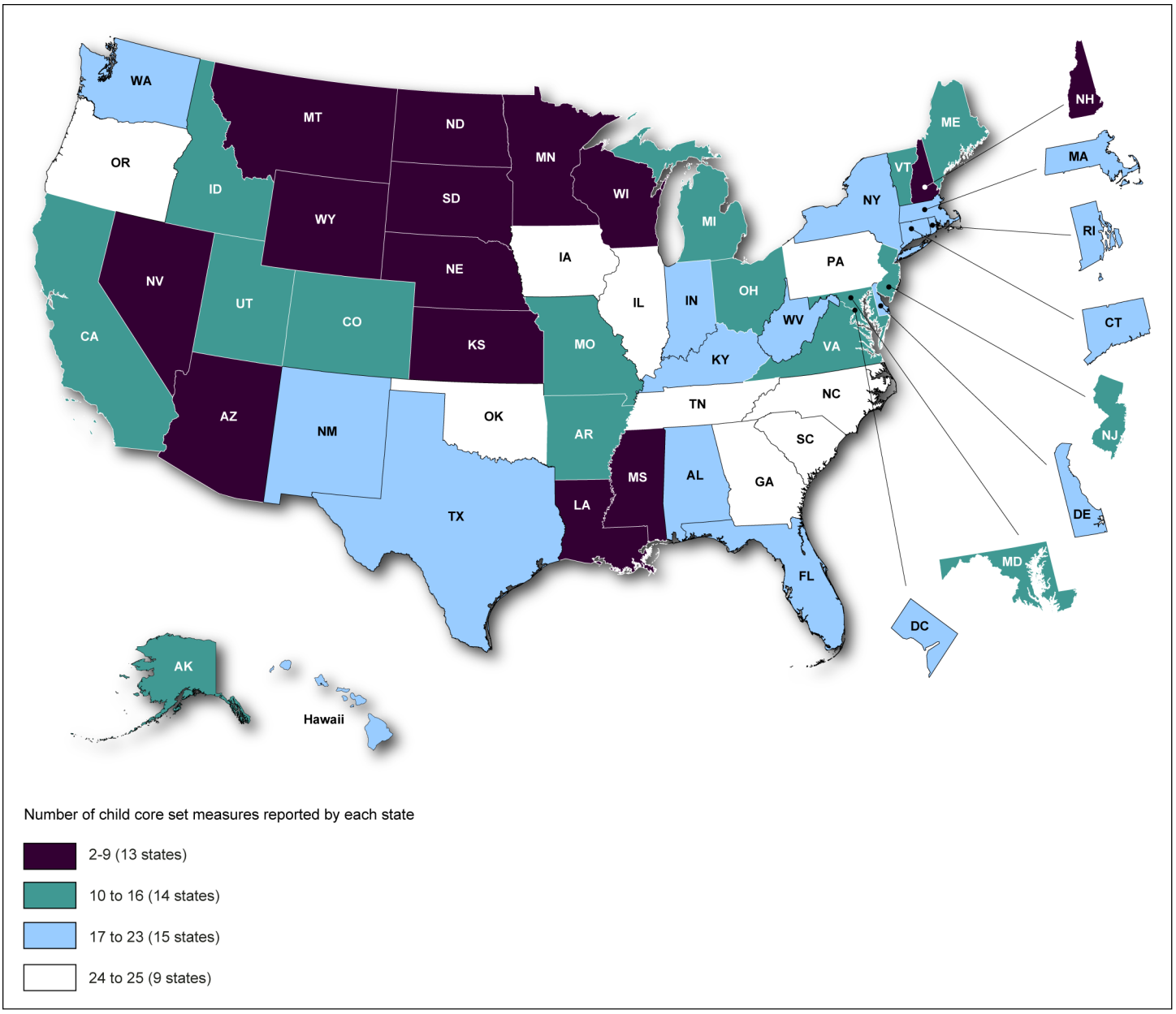
HHS Has Ongoing Efforts to Enhance State Reporting of Quality Measures and Identify Areas for Improvement to Care Provided in CHIP

HHS publishes data that states report on the Child Core Set measures in its annual quality report. While reporting on the Child Core Set measures is voluntary for states, the number of states reporting these quality measures and the median number of measures each state reports has increased steadily since reporting of the measures began in 2010. For example, beginning in fiscal year 2012, all 51 states have reported at least two or more measures, a notable increase from the 43 states that reported at least one measure for fiscal year 2010.[36] Similarly, the median number of Child Core Set measures that states report has increased from about 7 measures in fiscal year 2010 to 16 measures in fiscal year 2013. HHS attributed the rise in state reporting to increased familiarity with the Child Core Set measures and the department's efforts to streamline state reporting and provide technical assistance and guidance to states. For example, CMS established a Quality Measures Technical Assistance and Analytic Support Program in May 2011, which works with states to support their efforts in collecting, reporting, and using quality measures for their CHIP and Medicaid programs.

However, states varied considerably in the number of measures they reported in fiscal year 2013, ranging from 2 measures in Nebraska and Wisconsin to 25 measures in North Carolina and South Carolina. (See fig. 2.)

[36]There were 24 Child Core Set measures in both fiscal years 2010 and 2012.

Figure 2: Number of Child Core Set Measures Reported by States in Fiscal Year 2013



Sources: Department of Health and Human Services (data); Map Resources (map). | GAO-15-348

Several factors can affect a state's ability to report the Child Core Set measures. Officials from the states we reviewed provided the following examples of challenges they face reporting the Child Core Set measures.

- Mississippi and Pennsylvania officials cited difficulty reporting certain measures, such as the extent of follow-up care for children prescribed medication for attention-deficit/hyperactivity disorder, due, in part, to their not having access to the data required to report the measure.[37]
- Arizona, New Hampshire, Nevada, and Wisconsin officials cited the difficulty and cost of reporting certain measures, in particular those measures that require medical record reviews as opposed to the reporting of measures that use only encounter data.[38] For example, HHS suggests that medical record reviews be used to calculate a perinatal measure related to the performance of caesarean sections and none of these states reported this measure in fiscal year 2013.[39]
- Rhode Island officials noted that it can be difficult to collect data for measures that are not nationally endorsed—and as a result, they may not report them. For example, in fiscal year 2013, Rhode Island did not report the Child Core Set measure of a developmental screening in the first 3 years of a child's life, which had not been endorsed by the National Committee for Quality Assurance, but developed by a university in Oregon.

[37]The Mississippi official told us that the state was in the process of hiring a contractor to collect data that were previously unavailable to the state.

[38]There are different types of quality measures—such as structural, process, outcome, and patient experience—and measures of each type vary greatly in their breadth. Additionally, the data used to apply these different types of measures can come from a number of sources. Clinical data extracted from medical records can provide important clinical details needed to more fully adjust provider performance assessments for differences in the severity of illness of the patients that they treat—a process known as risk adjustment—but such data are typically costly and time-consuming to collect. By contrast, claims data—also known as billing or administrative data—are already collected to process provider payments, and therefore are more readily available for a large number of patients. However, because claims data are collected for payment purposes, they contain only a limited set of information relevant for quality measures or for making risk adjustments. Encounter data are records of services delivered to beneficiaries enrolled in managed care plans that receive a per-member-per-month payment. See GAO, *Health Care Transparency: Actions Needed to Improve Cost and Quality*, GAO-15-11 (Washington, D.C.: Oct. 20, 2014).

[39]Wisconsin also noted that it only reported on two Child Core Set measures in fiscal year 2013 due to HHS's deadline to report the information.

- Noting that the state does not have a department dedicated to measuring quality, Alaska cited a lack of internal expertise needed to collect and report reliable data for the measures. As such, an official cited the need to leverage resources and work with other agencies within the state that have the expertise to analyze measures and set targets for quality improvement.

In light of difficulties cited by states in reporting on the Child Core Set measures, HHS reported ongoing efforts to assist states with reporting the measures. For example, to streamline state reporting, HHS began calculating three Child Core Set measures on behalf of states in fiscal year 2012. Specifically, HHS began calculating the preventive dental and dental treatment measures from the Form CMS-416. At this time, HHS also began using data available from the Centers for Disease Control and Prevention to calculate the neonatal central-line associated blood stream infection measure. In addition, HHS assists states by allowing states to report Child Core Set measures for the Medicaid population, CHIP population, or combined Medicaid and CHIP populations.

Additionally, HHS reported efforts to assist states in improving their reporting of the Child Core Set measures through the Quality Demonstration Grant Program.[40] Through this program, HHS awarded 10 grants providing funding to 18 states to implement various projects to improve the information available on the quality of care provided to children enrolled in CHIP, including undertaking efforts to improve their reporting of the Child Core Set measures. For example, in one such project, Pennsylvania is testing the use of financial rewards to encourage certain health systems—which include hospitals, primary care practice sites, and other facilities—to use the Child Core Set measures to drive quality improvement projects.[41] Pennsylvania also reported that it is recruiting health systems to determine the extent to which electronic

[40]While AHRQ anticipates releasing a final evaluation of the state activities in the fall of 2015, it has issued 10 issue briefs that provide preliminary findings on the activities participating states are pursing to improve the quality and delivery systems for children's health care. These briefs can be found at http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/index.html (accessed December 18, 2014).

[41]According to AHRQ, participating health systems are financially rewarded for reporting any Child Core Set measures from electronic health records and for improved reporting on a subset of such measures. Health systems generally use their financial rewards to fund quality improvement projects related to the Child Core Set measures.

health records can provide data for the Child Core Set measures for children.[42]

From the measures submitted by states, HHS reports states' performance to assess the quality of care for children enrolled in CHIP and Medicaid, and the results of this assessment are mixed.[43] HHS calculates mean rates for most of the Child Core Set measures—which it calls performance rates—including primary and preventive care, perinatal health, management of acute and chronic conditions, and dental services, among the states reporting those measures.[44] Based on this assessment, HHS determined that states had high performance rates for some measures, such as young children's access to primary care. For example, a mean of 96 percent of children aged 12 to 24 months enrolled in CHIP or Medicaid had at least one primary care physician visit during fiscal year 2013.[45] In contrast, states had lower performance rates for other measures. For example, a mean of 46 percent of children received at least one preventive dental service, and a mean of 25 percent of children received at least one dental treatment in fiscal year 2013.[46] (See table 2.) As such, HHS specified that children's access to oral health care

[42]Five health systems are participating in Pennsylvania's model format of pediatric health records project, including three children's hospitals and affiliated ambulatory practice sites, one federally qualified health center, and one small hospital.

[43]HHS contracted with Mathematica to provide technical assistance to the states in submitting their data for the Child Core Set measures.

[44]With analytic and technical assistance support available from Mathematica, states submit numerator and denominator information on the Child Core Set measures, and attest to the accuracy of the quality measure being reported to HHS.

[45]HHS also reported mean performance rates for children ages 25 months to 6 years, aged 7 to 11 years, and aged 12 to 19 years. About 88 percent of children in each of these age groups had at least one primary care physician visit during fiscal year 2013.

[46]The dental measures in the Child Core Set are obtained from the Form CMS-416, which reports on the receipt of EPSDT benefits for children in Medicaid. Therefore, the measures include children aged 1 to 20 enrolled in Medicaid and CHIP Medicaid expansion programs, but may not include children enrolled in separate CHIP programs. Additionally, these are separate performance rates for dental preventive and dental treatment services, whereas the mandated evaluation reported the percentage of children that had any type of dental visit. HHS officials also specified that the preventive dental services measure includes only those preventive services performed by or under the supervision of a dentist—and do not include oral health services, such as fluoride varnish, performed by non-dental professionals. As such, HHS officials noted that in most states these data undercount the extent to which enrollees are receiving preventive dental and oral health services.

continues to be a primary focus of improvement efforts in CHIP and Medicaid.

Table 2: Mean Performance Rates and Number of States Reporting Certain Child Core Set Measures, Fiscal Year 2013

Child Core Set measure	Mean performance rate	Number of states reporting measure
Children's (aged 12 to 24 months) access to primary care practitioners	96[a]	45
Timeliness of prenatal care	77	33
Appropriate testing for children with pharyngitis[b]	68	36
Well-child visits in the 3rd, 4th, 5th, and 6th years of life	66	47
Childhood immunization status	64	30
Immunization status for adolescents	63	30
Well-child visits in the first 15 months of life	60	44
Frequency of ongoing prenatal care	56	27
Chlamydia screening in women	49	37
Follow-up care for children prescribed attention-deficit/hyperactivity disorder medication	46[c]	31
Follow-up after hospitalization for mental illness	47[d]	27
Preventive dental services[e]	46	49
Adolescent well-care visits	45	43
Body mass index assessment for children and adolescents	34	25
Dental treatment services[e]	25	49

Source: Department of Health and Human Services (HHS). | GAO-15-348

Note: This table reports the mean performance rates for the most frequently reported Child Core Set measures in fiscal year 2013. These rates represent service utilization for State Children's Health Insurance Program (CHIP) and Medicaid enrollees. Rates were rounded up to the nearest whole number.

[a]HHS also reported mean performance rates for children aged 25 months to 6 years, aged 7 to 11 years, and aged 12 to 19 years. About 88 percent of children in each of these age groups had at least one primary care physician visit during fiscal year 2013.

[b]HHS retired this measure from the Child Core Set in 2014.

[c]The table reports the mean performance rate for follow up visits for children prescribed medication for attention deficit hyperactivity disorder during the first 30 days of an initial visit in fiscal year 2013. The mean performance rate for follow up visits for children prescribed such medication within the first 90 days of an initial visit is 54 percent.

[d]The table reports the mean performance rate for follow up visits for children with mental illness within 7 days. The mean performance rate for follow up visits within 30 days is 65 percent.

[e]HHS began reporting Child Core Set measures on behalf of states from data states submit on the Form CMS-416 in fiscal year 2012. Data on these measures include children enrolled in Medicaid and CHIP Medicaid expansion programs, but does not include children enrolled in separate CHIP programs.

In addition to HHS's review of states' reporting on the Child Core Set measures, the department's annual quality report includes the results of its review of external quality review reports and performance improvement projects from states that contract with managed care plans to deliver services for CHIP and Medicaid enrollees.[47] States are required to annually review their managed care plans to evaluate the quality, timeliness, and access to services that the plans provide to enrollees, and HHS must include this information in its annual quality report. For the most recent annual quality report, 40 of the 42 states that contract with managed care plans to deliver services to CHIP and Medicaid enrollees submitted external quality review reports.[48] Based on its review of these reports, HHS found that the most frequently reported performance measures from states' external quality reports—which included well-child care, primary care access, childhood immunization rates, and prenatal/postpartum care—mirrored states' most frequently reported Child Core Set measures in fiscal year 2013. In terms of HHS's review of states' performance improvement projects, 38 of the 40 states that submitted external quality review reports included at least one project targeted to improve the quality of care for children and pregnant women enrolled in managed care; for example, by implementing projects related to behavioral health and improving childhood immunization rates for children, and prenatal and postpartum care for pregnant women.

[47]About 66 percent of publicly insured children obtained care through managed care plans in fiscal year 2013.

[48]According to the annual quality report, two states did not submit their external quality review reports by a specified timeframe for inclusion in HHS's analysis.

Cost, Coverage, and Access to Care Are Key Considerations in Determining the Reauthorization of CHIP Funding

Our prior work has identified important considerations related to cost, coverage, and access when determining the ongoing need for CHIP, many of which were echoed by officials from the 10 states we reviewed. With regard to cost, our prior work comparing CHIP plans to states' benchmark plans, which were the models for health plans available under health insurance exchanges established under PPACA, found that costs—defined as deductibles, copayments, coinsurance, and premiums—were almost always less for CHIP plans.[49]

- CHIP plans we reviewed typically did not require the payment of deductibles, while all five states' benchmark plans did.[50]
- The cost difference in copayments between CHIP plans and benchmark plans was considerable for physician visits, prescription drugs, and outpatient therapies. For example, an office visit to a specialist in Colorado would cost a CHIP enrollee $2 to $10 per visit, depending on their income, compared to $50 per visit for benchmark plan enrollees.
- Families could face higher dental costs in states where dental coverage through the exchange is optional and offered as a stand-alone dental plan (SADP) as opposed to CHIP plans where dental benefits are included.[51]

Officials from five selected states also expressed concerns about the higher costs of QHP coverage and the implications this would have for families.

[49]To prepare for the offering of QHPs in 2014, HHS asked states to select benchmark health plans—plans intended as models for the benefits that will be offered through QHPs—by December 26, 2012.

[50]See GAO-14-40. The five states evaluated in our prior work were Colorado, Illinois, Kansas, New York, and Utah. These findings were subsequently discussed in a hearing before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives on December 3, 2014. See GAO, *Children's Health Insurance: Cost, Coverage, and Access Considerations for Extending Federal Funding.* GAO-15-268T (Washington, D.C.: Dec. 3, 2014); We are currently examining how CHIP coverage and consumer costs compare to selected QHPs that were available on the exchanges in these five states in 2014.

[51]PPACA allows exchanges in each state the option of providing pediatric dental services using a SADP. In exchanges with at least one participating SADP, the QHPs have the option of excluding pediatric dental benefits from their covered services.

- Based on a review of QHPs available on the state's exchange in 2014, Nevada officials estimated that the average annual premium for a child in a family with an income of 168 percent of the FPL was more than two and a half times higher than the $200 premium for coverage in a CHIP plan. This price difference does not account for differences in co-pays, which the state does not charge under CHIP.[52] The extent to which QHPs in the state apply co-pays to covered services could increase this price differential further. As such, Nevada officials were concerned that absent CHIP, families would not purchase QHP plans due to their higher cost.[53]
- Due to the additional premiums and cost-sharing associated with SADPs, New Hampshire officials expressed concern that families will forego dental care if they must purchase a SADP.[54] The officials noted that cost-sharing particularly affects families with incomes from 185 to 250 percent of the FPL, which is 75 percent of the state's CHIP population.

We also previously reported that coverage is a relevant consideration, and that separate CHIP and benchmark plans were generally similar in terms of their coverage of selected services and the services on which they imposed limits, with some variation.[55] For example, the plans we

[52]Additionally, Nevada officials indicated that under CHIP, premiums—which are determined based on family size and income—are charged per family, not per child. Thus, CHIP costs do not increase by the number of children covered, as they would under a QHP. Up to three covered children may be taken into account in determining family premiums for QHPs.

[53]PPACA requires that most individuals, subject to certain exceptions, obtain health insurance coverage or pay a federal tax penalty, known as a shared responsibility payment. Among other exceptions, individuals for whom the cost of coverage is considered unaffordable are not subject to the penalty.

[54]SADPs have out-of-pocket maximum costs that are in addition to the QHP maximum costs, which may increase potential maximum costs for families who purchase them.

[55]See GAO-14-40. We reviewed the following services: ambulatory patient services (primary care physician and specialist office visits, and outpatient surgery); emergency care; inpatient physician and specialist office visits, and outpatient surgery); emergency care; inpatient hospital services (facility, professional, and ancillary); maternity care; mental health services (inpatient and outpatient); substance abuse services (inpatient and outpatient); prescription drugs; preventive care (well-child care, immunizations, and chronic disease management); outpatient therapies (physical, speech, and occupational for rehabilitation and habilitation); pediatric dental services (routine, emergency, and other); pediatric vision services (exams and corrective lenses); laboratory services (inpatient and outpatient); pediatric hearing services (testing and hearing aids); durable medical equipment; hospice; and home and community-based health care.

reviewed were similar in that they typically did not impose any limits on ambulatory patient services, emergency care, preventive care, or prescription drugs; but commonly imposed limits on outpatient therapies, and pediatric dental, vision, and hearing services. Officials from several selected states pointed out that CHIP coverage was more comprehensive than QHPs for certain services, particularly for services needed by children with special health care needs.

- Alaska and Pennsylvania officials noted that coverage of services—including orthodontics, vision, audiology, outpatient therapies, language disorders, and durable medical equipment—was more comprehensive in CHIP when compared with QHPs in their states.
- Rhode Island officials highlighted the state's coverage of comprehensive pediatric dental services and any medically necessary services deemed warranted as a result of the EPSDT benefit to which all CHIP-eligible children in the state are entitled. According to the state officials, these same services are either unavailable or unaffordable through QHPs in the state.
- Arizona officials specified that coverage of certain enabling services, such as non-emergency medical transportation, family support services, and behavioral health services are included in the state's CHIP plan, but may not be offered in QHPs.[56]

With regard to access, our work found that CHIP enrollees generally reported positive responses in their ability to obtain care that was generally comparable to those with private insurance, with some exceptions, including lower utilization of dental and orthodontia services. Some of the states we reviewed also raised concerns related to access to care if CHIP funding is not reauthorized. For example, Nevada officials raised concerns about the ability of certain populations—specifically, children of undocumented parents—to access care if CHIP is no longer available. Nevada officials stated that these children could lose CHIP coverage since a significant portion of them have parents who may not file federal income tax returns that would expose them to tax penalties for failing to enroll their children in alternative health coverage. In addition, an

[56]Enabling services, such as case management/care coordination, non-emergency transportation, and translation services, are services that are designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals. Enabling services are generally used to reduce nonfinancial barriers and to facilitate access to care among lower income populations.

Alaska official noted the need for further work on the comparability of benefits between QHPs and CHIP to ensure that the former could be an adequate substitute, and that children moving to QHPs would not experience decreased access to health care. The official noted that comparability across benefit packages is particularly important for children in households whose income changes would result in movement between CHIP and QHPs.

Agency Comments

We provided a draft of this report to HHS for comment. The department provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from its date. At that time, we will send copies to the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Carolyn L. Yocom
Director, Health Care

Appendix I: Uninsured Rates, State Children's Health Insurance Program (CHIP) Characteristics, and Coverage Approaches

State	Percentage of uninsured children in 2013	Design of state program under CHIP[a]	CHIP enrollment in 2013	CHIP upper income eligibility standard (percent of the FPL), as of 2014[b]	Whether the state expanded Medicaid to newly eligible adults under the Patient Protection and Affordable Care Act (PPACA)	State health insurance marketplace design, 2015
Alabama	4.3	Combination	113,490	312	No	Federally facilitated
Alaska	11.6	CHIP Medicaid expansion	16,566	203	No	Federally facilitated
Arizona	11.9	Combination	80,238	200	Yes	Federally facilitated
Arkansas	5.5	Combination	109,301	211	Yes	Partnership
California	7.4	Combination	1,603,283	261	Yes	State-based
Colorado	8.2	Combination	90,397	260	Yes	State-based
Connecticut	4.3	Separate	18,999	318	Yes	State-based
Delaware	4.5	Combination	13,180	212	Yes	Partnership
District of Columbia	2.4	CHIP Medicaid expansion	9,057	319	Yes	State-based
Florida	11.1	Combination	473,415	210	No	Federally facilitated
Georgia	9.6	Combination	269,906	247	No	Federally facilitated
Hawaii	3.0	CHIP Medicaid expansion	30,979	308	Yes	State-based
Idaho	8.9	Combination	45,399	185	No	State-based
Illinois	4.2	Combination	337,097	313	Yes	Partnership
Indiana	8.2	Combination	152,415	250	Yes	Federally facilitated
Iowa	4.1	Combination	83,670	302	Yes	Partnership
Kansas	6.1	Combination	76,164	242	No	Federally facilitated
Kentucky	5.9	Combination	84,069	213	Yes	State-based
Louisiana	5.7	Combination	149,968	250	No	Federally facilitated
Maine	5.9	Combination	29,712	208	No	Federally facilitated
Maryland	4.4	CHIP Medicaid expansion	135,454	317	Yes	State-based
Massachusetts	1.5	Combination	148,719	300	Yes	State-based

State	Percentage of uninsured children in 2013	Design of state program under CHIP[a]	CHIP enrollment in 2013	CHIP upper income eligibility standard (percent of the FPL), as of 2014[b]	Whether the state expanded Medicaid to newly eligible adults under the Patient Protection and Affordable Care Act (PPACA)	State health insurance marketplace design, 2015
Michigan	4.0	Combination	89,670	212	Yes	Partnership
Minnesota	5.6	Combination	3,835	283[c]	Yes	State-based
Mississippi	7.6	Combination	93,120	209	No	Federally facilitated
Missouri	7.0	Combination	92,918	300	No	Federally facilitated
Montana	10.1	Combination	44,661	261	No	Federally facilitated
Nebraska	5.5	Combination	55,783	213	No	Federally facilitated
Nevada	14.9	Combination	28,626	200	Yes	State-based[d]
New Hampshire	3.8	CHIP Medicaid expansion	19,450	318	Yes	Partnership
New Jersey	5.6	Combination	206,761	350	Yes	Federally facilitated
New Mexico	8.5	CHIP Medicaid expansion	9,368	300[c]	Yes	State-based[d]
New York	4.0	Combination	490,114	400	Yes	State-based
North Carolina	6.3	Combination	260,964	211	No	Federally facilitated
North Dakota	7.9	Combination	11,281	170	Yes	Federally facilitated
Ohio	5.3	CHIP Medicaid expansion	286,817	206	Yes	Federally facilitated
Oklahoma	10.0	Combination	147,911	205	No	Federally facilitated
Oregon	5.8	Combination	128,061	300	Yes	State-based[d]
Pennsylvania	5.4	Combination	267,073	314	Yes	Federally facilitated
Rhode Island	5.4	Combination	26,577	261	Yes	State-based
South Carolina	6.7	CHIP Medicaid expansion	76,191	208	No	Federally facilitated
South Dakota	6.3	Combination	17,632	204	No	Federally facilitated
Tennessee	5.7	Combination	106,473	250	No	Federally facilitated

State	Percentage of uninsured children in 2013	Design of state program under CHIP[a]	CHIP enrollment in 2013	CHIP upper income eligibility standard (percent of the FPL), as of 2014[b]	Whether the state expanded Medicaid to newly eligible adults under the Patient Protection and Affordable Care Act (PPACA)	State health insurance marketplace design, 2015
Texas	12.6	Combination	1,034,613	201	No	Federally facilitated
Utah	9.5	Combination	63,001	200	No	Federally facilitated
Vermont	3.1	CHIP Medicaid expansion	7,393	312	Yes	State-based
Virginia	5.4	Combination	196,911	200	No	Federally facilitated
Washington	5.9	Separate	44,073	312	Yes	State-based
West Virginia	5.3	Combination	37,065	300	Yes	Partnership
Wisconsin	4.7	Combination	167,292	301	No	Federally facilitated
Wyoming	5.7	Combination	8,815	200	No	Federally facilitated

Source: GAO based on information from the Centers for Medicare & Medicaid Services (CMS), as of February 2015; State Medicaid and State Children's Health Insurance Program (CHIP) Income eligibility Standards as of October 1, 2014; The Henry J. Kaiser Family Foundation, *State Health Insurance Marketplace Types*, 2015; U.S. Census Bureau, 2013 American Community Survey. | GAO-15-348

[a]As of February 2015, 42 states operated separate CHIP programs (2 states had a separate CHIP program only, and 40 states covered CHIP children through both a separate program and an expansion of their Medicaid program). The other 9 states covered CHIP children through an expansion of their Medicaid program, which we refer to as a "CHIP Medicaid expansion."

[b]PPACA specifies that an income disregard equal to 5 percentage points of the federal poverty level (FPL) be deducted from an individual's income when determining Medicaid and CHIP eligibility. The FPL eligibility standards in this table do not reflect this income disregard.

[c]Minnesota and New Mexico have CHIP income eligibility levels that vary by age group; therefore, we reported the highest income eligibility level reported for these states—which are ages 0 to 1 year in Minnesota and ages 0 to 5 years in New Mexico.

[d]These state-based marketplaces use the federally facilitated marketplace's information technology platform for applicants to apply and enroll in their respective states.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the contact named above, Susan T. Anthony, Assistant Director; Sandra George; Seta Hovagimian; Drew Long; JoAnn Martinez-Shriver; Vikki Porter; Lisa Rogers; Eden Savino; Laurie F. Thurber; and Kate Tussey made key contributions to this report.

Related GAO Products

Health Care Transparency: Actions Needed to Improve Cost and Quality. GAO-15-11. Washington, D.C.: October 20, 2014.

Children's Health Insurance: Cost, Coverage, and Access Considerations for Extending Federal Funding. GAO-15-268T. Washington, D.C.: December 3, 2014.

Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance. GAO-14-40. Washington, D.C.: November 21, 2013.

Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance. GAO-12-648. Washington, D.C.: June 22, 2012.

Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care. GAO-11-624. Washington, D.C.: June 30, 2011.

Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families. GAO-11-264. Washington, D.C.: February 4, 2011.

State Children's Health Insurance Program: CMS Should Improve Efforts to Assess whether SCHIP Is Substituting for Private Insurance. GAO-09-252. Washington, D.C.: February 20, 2009.

Health Insurance For Children: Private Insurance Coverage Continues to Deteriorate. GAO/HEHS-96-129. Washington, D.C.: June 17, 1996.